CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

12 September 2019

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Tettenhall Suite, Linden House, 211 Tettenhall Road, Wolverhampton, WV6 0DD

Membership

Chair Cllr Phil Page (Lab)
Vice-chair Cllr Paul Singh (Con)

Cllr Obaida Ahmed
Cllr Paula Brookfield
Cllr Bhupinder Gakhal
Cllr Milkinderpal Jaspal
Cllr Lynne Moran
Cllr Susan Roberts MBE
Cllr Wendy Thompson
Tracey Creswell (Healthwatch)
Sheila Gill (Healthwatch)
Dana Tooby (Healthwatch)

Quorum for this meeting is three voting members.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**
[To receive any apologies for absence from Members of the Panel].

2 **Declarations of Interest**

3 **Minutes of previous meeting** (Pages 3 - 12)
[To approve the minutes of the previous meeting as a correct record.]

4 **Matters Arising**
[To consider any matters arising from the minutes.]

DISCUSSION ITEMS

5 **Tettenhall Wood GP Surgery Consultation**
[The Panel will discuss the current consultation on the Tettenhall Wood GP Surgery].

6 **The Royal Wolverhampton NHS Trust - Quality Accounts** (Pages 13 - 158)
[A presentation on, The Royal Wolverhampton NHS Trust Quality Accounts will be given. The presentation slides and the Quality Accounts Document are attached].

7 **National Audit End of Life Care** (Pages 159 - 236)
[To receive a report from, The Royal Wolverhampton NHS Trust on the National Audit of End of Life Care].

8 **Verbal Update on Brexit Preparations**
[A verbal update on the preparations for Brexit will be given by the attendees representing the health sector].

9 **Work Programme** (Pages 237 - 240)
[To receive the Health Scrutiny Work Programme].

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 6 June 2019 Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Cllr Paula Brookfield
Cllr Bhupinder Gakhal
Sheila Gill
Cllr Lynne Moran
Cllr Phil Page (Chair)
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Cllr Wendy Thompson
Dana Tooby

In Attendance
Cllr Sohail Khan

Witnesses
Dave Martin (Outgoing Chair of Suicide Prevention Stakeholder Forum)
Steven Marshall (Director for Strategy and Transformation – CCG)
Cathy Higgins (Consultant Paediatrician – Royal Wolverhampton NHS Trust)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director for Public Health)
Dr. Ankush Mittal (Consultant in Public Health)
Neeraj Malhotra (Consultant in Public Health)
Lina Martino (Consultant in Public Health)
Parpinder Singh (Public Health Specialist)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
An apology for absence was received from Tracey Cresswell.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Minutes of previous meeting**
The minutes of the meeting held on 21 March 2019 were confirmed as a correct record.

4 **Matters Arising**

Clarification was sought on the term “gaming,” which was used in the minutes of the previous meeting, which the Scrutiny Officer explained.

Healthwatch Chair and Panel Member, Sheila Gill referred to the section in the minutes where the Chief Executive of the Royal Wolverhampton Trust had invited Healthwatch representatives to talk to staff working in cancer treatment services about pathways and support. She stated that this had not taken place and asked if the Panel could facilitate the process. The Scrutiny Officer, with the endorsement of the Panel, gave an undertaking to help.

5 **Public Health Performance Report**

The Director for Public Health presented a performance report on Public Health for the year 2018-2019. To achieve the ambitious targets detailed in the vision, Public Health had focussed on different approaches to issues where traditional approaches had been unsuccessful in achieving change. He outlined some of the priorities in the Public Health Vision, as detailed within the report. Critical to achieving overall success was ensuring a good start to life, having a good education, obtaining skills and good employment, living in quality housing, and living within a good community. If all of these elements could be achieved for a person, the probability was that health campaigns on matters such as obesity and smoking would not be required as people would be educated and comfortable enough to make the right decisions.

The Director for Public Health remarked that NHS health checks performance had significantly improved in the last year. NHS checks were now solely provided through primary care. Through closer collaborative working with Wolverhampton Clinical Commissioning Group (CCG), Primary Care Group Managers and GP Practice Staff across the City and a complete review of the system there had been an unprecedented rise in the access and uptake of NHS health checks. Wolverhampton had gone from the bottom 8% in the country to the top quartile in the past year. This meant health problems could be identified earlier with ultimately better health outcomes achieved.

The Director for Public Health commented that they had been working more in partnership rather than the usual commissioner provider relationship, they previously had with the Royal Wolverhampton NHS Trust. They were working on getting the basics right on health visitor checks and school nursing. Performance in this area was at its best since Public Health had moved back into the Local Authority in 2013. On the matter of rough sleeping he commented there had been 33 people sleeping rough as of last May. Bucking the national trend, the number had been driven down to 16 people as of the present day. Rough sleepers would be provided accommodation if they sought help.

The Director for Public Health stated that they had achieved the best coverage in flu vaccinations in schools since Public Health had moved back to the local authority in 2013. There was also more coverage within social care settings than before and the lowest number of outbreaks of flu in social care settings had been achieved in the last year. Public Health had helped to shape the ICS (Integrated Care System), working with the CCG and NHS Trust. Partnership working was critical to addressing the health problems faced by the City. Earlier in the month they had solidified a joint intelligence unit for the City to help all partners make better decisions through the flow of information on the health of the population of the City.

The Director for Public Health remarked that they had undertaken considerable more work with the Police on Community Safety. They had obtained some pump prime funding for intervention work to help tackle the problem and perceived problem with youth violence and knife crime. They were trying to increase the number of people receiving chlamydia tests, some people who had the condition were unaware, as they were not necessarily symptomatic. Wolverhampton in the last twelve months had moved from bottom in their comparative region to second to top for chlamydia testing in the region. A congratulatory note had been sent from Public Health England for the innovative work that the Public Health team in Wolverhampton had undertaken in collaboration with the Royal Wolverhampton NHS Trust.

The Director for Public Health stated that one of the challenges they faced was the continued decrease in funding received year on year in Public Health. This emphasised the need to work better in partnership. A spending review was about to be announced, which the team awaited in anticipation.

The Chair, Vice-Chair and several Members of the Panel complimented the Director for Public Health on the refreshing approach that had been taken by the department and for their considerable achievements in the past twelve months.

A Panel Member asked for some feedback from the conference on child obesity which the Director for Public Health and a Consultant in Public Health attended on 31 May 2019. He also asked if Public Health were looking at any new innovative ways of combating childhood obesity. The Director for Public Health responded that there was a real issue with childhood obesity in the City. The evidence suggested that you could not “treat” your way out of the problem. It was therefore not about providing additional services. The conference on child obesity had been a coming together of stakeholders across the City which had been hosted by Eleanor Smith MP. There had been a concentration at the conference on service provision. He had spoken about the importance of creating a good environment for people to make better choices, which would help tackle the obesity problem. The conference had discussed some of the forthcoming NHS policies. There had been two papers recently published, “Prevention is Better than a Cure” in November and the NHS Long-Term Plan which had been published in January.

The Consultant in Public Health added that childhood obesity rates were measured by school nurses in reception year and again in year 6. There was a high prevalence of overweight and obese children in reception year and an even greater amount in year 6. In the past letters had been sent to parents informing them of a concern about a child’s weight, but these letters had not been received very well. She wanted to make sure more work was completed before the children were even measured in reception year. It was then, important to work effectively with the children who were at risk of not being a healthy weight. There was a place element to their strategy to tackle childhood obesity, if there was an attractive environment for people to be active, it was hoped obesity rates would fall. As party of the policy work stream it was clear that supermarkets had a vital role to play and it was important for the Public Health Team to work closely with the WMCA, Public Health England and the Department for Health on the issue. There was also a people’s workstream where Public Health wanted maternity services to work with pregnant women on how to have a healthy pregnancy and to advise on healthy child development. They wanted the healthy development and growth message to be consistently reinforced by health

visitors, early year settings and in primary and secondary care. A systematic partnership approach she saw as the way forward.

The Consultant in Public Health remarked that a partnership with the working title, “the Healthy Growth Partnership” was about to be launched, with their inaugural meeting in July and a second meeting planned in the Autumn. The Children and Families Together Board had asked for an update on the new partnership’s work, at their meeting scheduled for December.

A Panel Member asked about the percentage of children who received a health check at 2 - 2.5 years old in Wolverhampton. The Director for Public Health responded that it had been historically poor in Wolverhampton. It had been as low as 50% in May 2018, but they had managed to improve the figure to 62% as at November 2018. More improvement was still required, which he very much wanted to achieve. The checks were ultimately aimed at ensuring that the child was ready for school, to ensure the best start to life.

A Member of the Panel asked if the GP extended opening hours in the City were making a difference. The Director of Strategy and Transformation at the CCG responded that he could provide the figures on the effect of the GP extended opening hours on A&E admissions after the meeting. He believed it was having a positive effect on reducing A&E admissions.

There was a discussion about the activities being undertaken to help combat begging in the City, this included information on the charity which had been setup called “Alternative Giving”.

A Member of the Panel asked about the use of the nasal flu vaccine for children which had an ingredient derived from a pork product. She said that for some people in certain communities this was considered a prohibitive reason to give their children the flu vaccine. She asked about the alternative arrangements available and any future plans. The Consultant in Public Health confirmed that it was true the nasal flu vaccine did contain an ingredient that was derived from a pork product. Regionally NHS England were in control of how vaccines were provided across the West Midlands. It was Public Health’s role to try and ensure the population had the best protection available. He had recently been in discussions with a local Imam about the matter. There was a national debate about whether there was now an equality issue, which was prohibiting certain sections of the community from accessing the vaccine. Public Health were doing various consultations with different groups. The animal-based stabiliser was better than plant-based stabilisers, with the Pork one being the best. There were two vaccines, however the jab was not commissioned by NHS England and therefore could not be offered from a Local Authority perspective. There were also many tablets which contained a pork product.

The Chair of the Panel asked what definition was used for “rough sleeper” for compiling the statistical analysis in the Public Health performance report. The Director for Public Health stated that he would circulate the current definition that was used.

The Chair asked if the good practice from the Public Health team had been shared with other Local Authorities. The Director responded that they probably hadn’t celebrated and shared their good work enough, but they could do more in the future.

The Chair commented that he wanted to increase the publicity of the good work taking place.

6 **Update on Suicide Prevention**

The outgoing Chair of the Suicide Prevention Stakeholder Forum presented an update report on suicide prevention. The incoming Chair of the Forum had sent her apologies due to sustaining an injury. He had been the Chair of the Forum for three years since its initial inception. His background was working with the Local Samaritans, he also had a regional role with the Samaritans working with the twelve prisons in the West Midlands Region.

The outgoing Chair of the Suicide Prevention Stakeholder Forum remarked that nationally there had been 5821 suicides in the year 2017. This equated to 16 suicides a day. It was estimated that there were ten times as many suicides attempts as completed suicides. Nationally, approximately 75% of people who took their own life were male. The peek for men was age 45-49 and for women age 50-54. 72% of the people had not been in contact with secondary mental health services in the year prior to taking their own life. It was estimated that the direct and indirect cost to the economy of one suicide equated to £1.7 million. It was the single biggest killer of men under the age of 45 in the country. On a local level there had been 25 suicides in Wolverhampton in 2017. Broadly there had been a downward trend since 2002. Slightly more men had taken their own life than women in Wolverhampton in 2017.

The outgoing Chair of the Suicide Prevention Stakeholder Forum commented that the national strategy had two key aims, to achieve a reduction in the suicide rate in the general population of the country and to offer better support for those bereaved or effected by suicide. The national report recommended 60 areas where organisations should be placing their efforts, particularly focusing around suicide audits and suicide prevention action plans as part of a multi-agency approach. The Centre for Public Scrutiny had produced some guidance on the scrutiny of suicide prevention work. The report circulated with the agenda answered the questions that the Centre for Public Scrutiny had suggested should be asked by a Scrutiny Panel. He supported the Centre for Public Scrutiny Guidance suggestions on the ten areas that a Scrutiny Panel should seek answers.

The outgoing Chair of the Suicide Prevention Stakeholder Forum stated that in 2014-2015 a comprehensive Needs Assessment had been carried out by a Consultant in Public Health. The assessment looked at the perceived needs, the services available, where the gaps were and what could be done to rectify them. The Needs Assessment had resulted in a strategy being drawn up which was refreshed on an annual basis. The Forum's work was very much driven by the strategy. It was important to sustain momentum in suicide prevention work. He was pleased that the Forum was independently Chaired, which helped to cement the concept that a multi-agency approach was required, rather than suicide prevention being seen as solely a Local Authority function in conjunction with a limited amount of certain partners. There were now 70 people on the Suicide Prevention Forum mailing list. Every meeting of the Forum was attended by between 15-20 people. There were targets as to the most needed groups with refugees and migrants and the LGBT community

being high on the list. A considerable amount of work had gone into improving bereavement support and training agencies on suicide.

The outgoing Chair of the Suicide Prevention Stakeholder Forum commented that one of the key challenges remaining was the provision of real-time information. Up to date information was important, it was however a real struggle to obtain information from the Black Country Coroner. There was a greater push for regional activity on areas such as data sharing with the Coroner. The Suicide Prevention Strategy had to be live, meaningful and kept up to date. In 2020 there would be a fundamental review of the strategy, focussing on areas such as raising awareness of suicide, training and support to Bereavement Services and further joined up working on a national and regional basis.

Members raised a concern that the Coroner had not shared important information to help in the work of the Suicide Prevention Stakeholder Forum.

A Member of the Panel remarked that suicide prevention should be a compulsory component of health training. They commented that children should see school nurses more often and that teachers should also proactively identify bullying, loneliness, behavioural changes, self-harm and identity issues. A Panel Member added that social media had made it more difficult to obtain a full understanding of all the issues.

The outgoing Chair of the Suicide Prevention Stakeholder Forum commented that they were pro-actively working to try and introduce suicide prevention into the training for GPs. His successor as Chair was very clear about having a universal training programme that could be rolled out in the City. As a Forum it was their responsibility to engage with as many different people as possible from different organisations.

A Member of the Panel commented that the risk of suicide increased after a recent bereavement, particularly for men. The outgoing Chair of the Suicide Prevention Stakeholder Forum responded that they had been working with “Cruse Bereavement Care” on a regional level and they also worked specifically with Compton Care and other organisations. He thought men were particularly affected after a bereavement because they were less likely to talk about their emotional wellbeing and seek support. They were putting a great deal of effort into this area. A Panel Member remarked that football teams could play an important role in helping men obtain support.

There was a discussion about where the most suicides took place in the City, which seemed to be happening in the most deprived areas of the City. Members raised the importance of the role of the community in providing support to people in despair.

The Consultant in Public Health remarked that suicide prevention was much wider than the medical health system. There were various contributors as to why someone became suicidal. Identifying support to find employment and conditions in school were examples of where targeted work could help. It was therefore not just about identifying people with mental health issues and then giving them access to mental health services.

A Member of the Panel asked if there was any data on attempted suicides. The outgoing Chair of the Suicide Prevention Stakeholder Forum stated that it was difficult to obtain because self-harm incidences were not necessarily all suicide attempts. A far greater number of women self-harmed relative to men. Judging intention was very difficult and therefore accurate data on suicide attempts was hard to gather.

There was a discussion about the most common methods that men and women used to take their own life, and which were most likely to be fatal. The Senior Public Health Specialist commented that it was possible that the suicide figures for women were lower, as women tended to use less fatalistic methods. It was crucial to obtain more data from the Coroner to be able to have a full understanding of the picture in Wolverhampton and to help prevent suicides in the future.

The Chair asked if any data was captured for suicides under the age of 15. The outgoing Chair of the Suicide Prevention Stakeholder Forum stated that accurate data collation was even more difficult for under 15's. Since 2011 the figures were for confirmed suicides. There was more sensitivity and reticence in this area because of the prospect of parents and guardians blaming themselves for the suicide of their child. The Public Health Specialist commented that nationally there had been a significant increase of suicides under the age of 15, but thankfully this had not been the case in Wolverhampton, where the numbers remained small.

The Public Health Specialist stated that the figures for suicide were likely to increase. This was because since 2018 the Coroner now could judge his verdict of suicide on the balance of probabilities rather than the criminal standard of beyond reasonable doubt. The Coroner therefore had a broader scope to reach a verdict of suicide.

A Member of the Panel made reference to the report which stated that 72% of those who died by suicide were not in touch with secondary mental health services within one year prior to death. He asked if it was known how many people were in touch with primary care service and were being treated for depression, pain or anxiety and on medication such as benzodiazepines, antidepressants or opioids. He added that if it was not known, whether the data could be captured in the future. The Consultant in Public Health responded generally stating that it was not always a medical issue which was the cause for suicide. They were training GPs in suicide prevention work.

Resolved: That the Chair of the Health Scrutiny Panel write to the Black Country Coroner on the matter of improving data sharing between the Coroner and the City of Wolverhampton Council's Public Health Team.

7 **Transition from Children's to Adults' Services for Young People**

The Consultant Paediatrician at Newcross Hospital presented a report on the transition from children's' to adults' services for young people. At Newcross there were some areas where there was very good practice, such as the Diabetes Transition Service and the Epilepsy Transition Service. They were looking at introducing a Trust wide strategy for transition which was based on NICE Guidance along with some of the relevant legislation. It was being developed with support from adults' and children's services in collaboration with parents. Transition was important to achieving good outcomes. She gave a presentation, the slides of which, containing the information she relayed to the Panel, were sent out with the agenda.

As part of the changes they were piloting the concept of health passports which contained substantial information on the young person.

A Councillor relayed to the Panel his own personal experience of having a child who had been receiving treatment from the National Health Service and had transitioned from children to adult services. It had been a challenging and difficult time for the family.

The Consultant Paediatrician at Newcross Hospital raised the importance of adult services liaising with the GP of someone who had transitioned to adult services of which the health professionals had no personal knowledge. A Councillor commented that he had personal experience of GPs not being as helpful as perhaps they could have been, his experience had been mixed.

The Director for Adult Services stressed the importance of a system wide strategy as many organisations were involved in a person's life. He was cautious of the NHS Trust having their own standalone transition strategy and wanted to ensure that the processes and systems could work collectively as effectively as possible. He was keen to ensure that the Trust were supported in their work by the wider sector, citing special educational needs as an example. The Consultant Paediatrician at Newcross Hospital responded that there was a special educational needs and disability health workstream which had representation from many partners. More generally there was also the Centre Partnership Board which was looking at the work being done to prepare children for adult services. She was keen to ensure that the strategy worked in synergy with other partners.

A Panel Member asked if it was an absolute requirement that when a person reached 18 that they had to transfer to adult services. The Consultant Paediatrician responded that some people over the age of 18 were kept in children's clinics if they were still at school. The reason why a person normally transitioned to an adult ward at 18 was because at that age you were legally classed as an adult with different rights to a child.

A Member of the Panel asked how much weight was put on a person's opinion if they were under the age of 18 and in particular if their wishes were different to those of their parents. The Consultant Paediatrician responded that they did take into account the child's opinion and it was vitally important to engage them. A child had legal rights to decline consent in certain situations.

8 **Update on Child Death Overview Panel**

The Consultant in Public Health presented a report updating the Panel on the Child Death Overview Panel. The way child deaths were reviewed was a process which followed national guidance and new guidance had been released last year. They were currently in a state of transition to make sure they complied with the new guidance. She was pleased to report that Walsall, Wolverhampton, Sandwell and Dudley were working jointly together on the project. She believed that the new national guidance was a positive change. They were in the process of appointing a Black Country Child Death Overview Panel Co-ordinator. They had adopted a system known as e-CDOP which was a cost effective, secure, flexible and web-based solution which allowed the Child Death Overview Panel process to be managed efficiently, with effective and secure sharing of multi-agency information.

The Chair congratulated Public Health on working collaboratively with other Black Country Local Authorities alongside health partners on the Child Death Overview Panel.

A Panel Member asked about data capturing surrounding learning disabilities and social economic factors which may have had a bearing on the death of a child. The Director for Public Health responded that the really important question was about ensuring that the data collected and the themes arising were put to good use in the appropriate manner and directed to the right area within the system. The new system e-CDOP was a very effective data-based system and some of the data captured was of an excellent standard.

A Member of the Panel asked about how the new role of Medical Examiner had affected the processes. The Consultant in Public Health responded that the new processes were not expected to commence until 1 July 2019, so the impact of the new posts would not be felt until 6-12 months.

Resolved: That the Health Scrutiny Panel receives a report every twelve months on the Child Death Overview Panel.

9 **Health Scrutiny Work Programme**

A Member of the Panel asked for a verbal update on Brexit to be given at the next meeting of the Panel. The Panel agreed to add it to the Work Programme.

The Chair raised the matter of site visits. The Scrutiny Officer confirmed that there would be a site visit arranged to West Park Hospital at the end of September. The Chief Executive of the Royal Wolverhampton NHS Trust had also agreed that the Panel could have a site visit to Cancer Services at Newcross Hospital and A&E should they wish to do so.

The Health Scrutiny Work Programme was agreed.

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The Royal Wolverhampton NHS Trust

Quality Account 2018-2019

Health Scrutiny Panel Meeting

12th September 2019

Safe & Effective | Kind & Caring | Exceeding Expectation

Priority 1: Workforce

Overarching statement:

We aim to deliver safe patient care and good patient experience. Our wards and departments need to have the right levels of staff and skill mix for the acuity of the patients for which they are caring.

Priority 2: Safe Care

Overarching statement:

We aim to be the safest NHS Trust by “always providing safe & effective care, being kind & caring and exceeding expectation”, by making safe quality care a whole-system approach for every patient that accesses the Trust and its services.

Priority 3: Patient Experience

Overarching statement:

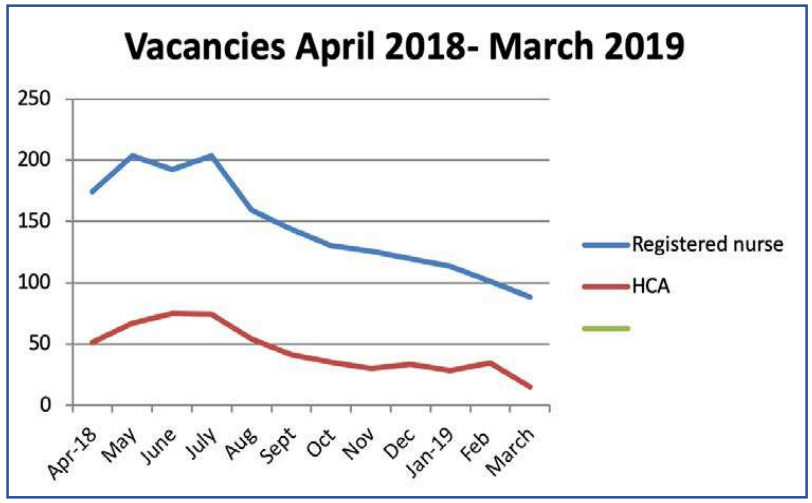
We are committed to providing high quality clinical care and aim to provide an excellent experience for patients, their relatives and carers.

Priority 1: Workforce

The Royal Wolverhampton NHS Trust

Key achievements included:

- Registered nurse and midwife vacancies reduced from n=175 to n=88.
- Healthcare assistant vacancies reduced from n=51 to n=14.
- % of student nursing placements increased by 54% when compared with 2017/18 and 80% by 2019.
- Apprenticeship opportunities maximised.
- Nursing Times award received for best international recruitment experience.
- Additional Advanced Clinical Practitioner roles introduced.
- Practice Education Facilitator network launched.
- Care to Share magazine launched aimed at nurses, midwives and health visitors.
- Nursing Fellowship Programme established.
- Trust was a first wave pilot site for the Nursing Associates role.

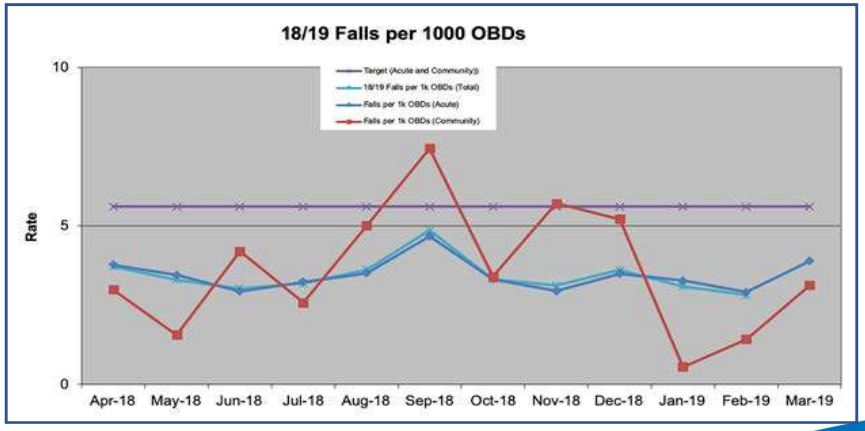


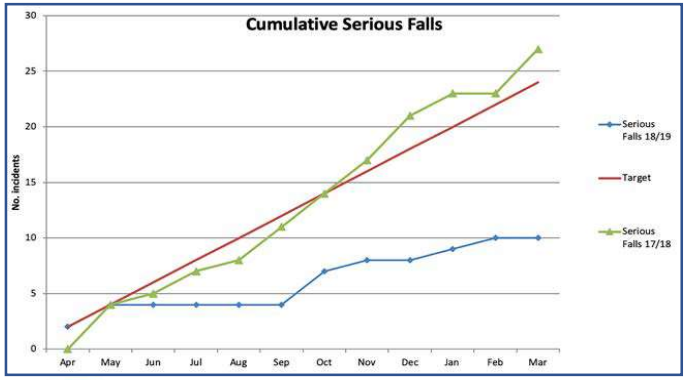
Priority 2: Safe Care

The Royal Wolverhampton NHS Trust

Key achievements included:

- Decrease of serious incidents categorised as “infection” (from 25 to 14) and of those categorised as “diagnostic” (from 29 to 12).
- Review of serious incidents to identify themes, key learning and inform actions.
- Learning from never events identified and implemented.
- Renewed focus on falls prevention with a multidisciplinary approach. Risk assessment process and documentation improved contributing to the reduction of serious incident falls by 61% and the number of falls remaining below the national benchmark.





Priority 2: Safe Care continued…

The Royal Wolverhampton NHS Trust

Key achievements included:

- **A variety of projects and actions associated with preventing infection:**
  - *Clostridium difficile* remained below agreed ceiling by n=3 cases (annual ceiling of n=34).
  - Device related bactaraemias remained within the internal trajectory of n=48.
  - Intravenous Resource Team continued to deliver 'line care' to an increasing number of patients.
  - Successful recruitment into the Sepsis Team achieved.
  - Partnership working fostered, for example, health economy gram negative blood stream infection plan continued to be delivered in line with set priorities.

- **Sepsis recognition and treatment:**
  - Notable improvement in performance (recognition and treatment of sepsis) within the Emergency Department (ED), inpatients and haematology/oncology.
  - As at February 2019, antibiotics administered to patients within an hour in ED improved by 49% when compared with 2016-17 data.
  - As at March 2019, antibiotic delivery within an hour to neutropenic sepsis patients improved by 57.9% when compared with 2016-17 data.
  - More recent data has demonstrated that the % of patients screened who met the sepsis criteria in ED was 99% for Q1 2019/20 and 100% in June 2019 and the % of patients who received antibiotics within an hour was 88% during Q1 2019/20 and 95% in June 2019.

- **Mortality:**
  - Oversight arrangements further strengthened – Mortality Review Group and Quality Improvement Programme Board – Mortality.
  - Health Economy Mortality Review Group established.
  - Mortality review process strengthened and aligned with the Learning from Deaths guidance -Structured Judgement Reviews (SJRs).
  - Key themes and learning from SJRs identified and taken forward.
  - Medical Examiner Model established.
  - New Bereavement Centre opened.
  - Mortality Strategy developed, including a mortality improvement plan.

Priority 2: Safe Care continued…

The Royal Wolverhampton NHS Trust

Key achievements included:

- **Venous thromboembolism (VTE):**
  - Alignment of the Trust's policy to national guidance.
  - Participation in the 'Triumvirate Leadership and Change' programme focusing on VTE management/treatment.
  - Renewed focus on achieving VTE assessment compliance and learning from incidents.
- **Pressure ulcer reduction:**
  - Average rate of pressure ulcers per 1000 inpatient bed days reduced from 0.94 reported during 2017/18 to 0.56 reported during 2018/19, which represents a 40% reduction.
  - Average rate of pressure ulcers per 10000 community population reduced from 0.62 reported during 2017/18 to 0.46 reported during 2018/19, which represents a 26% reduction.
- **Medication incidents:**

During 2018/19, the Trust conducted the following medicine related safety initiatives which included the following:

- ePMA (electronic prescribing and medicines administration system) has been successfully rolled out across all in-patient areas
- Cold Chain Policy designed for the maintenance of medicines stored at cold temperatures has been developed and approved and will be launched in quarter 1 2019/20
- Medication incident fields were expanded within datix to aid more accurate reporting
- Missed and Omitted Doses Audit was performed during May 2018 to obtain a baseline figure of the number of patients who did not receive a dose of medication during the five day audit period
- Incident reports are now based upon date of report rather than date of incident in order to ensure that all incidents are captured and included in Trust reports
- In response to a number of errors involving the use of medication patches, a new patch administration chart has been designed.

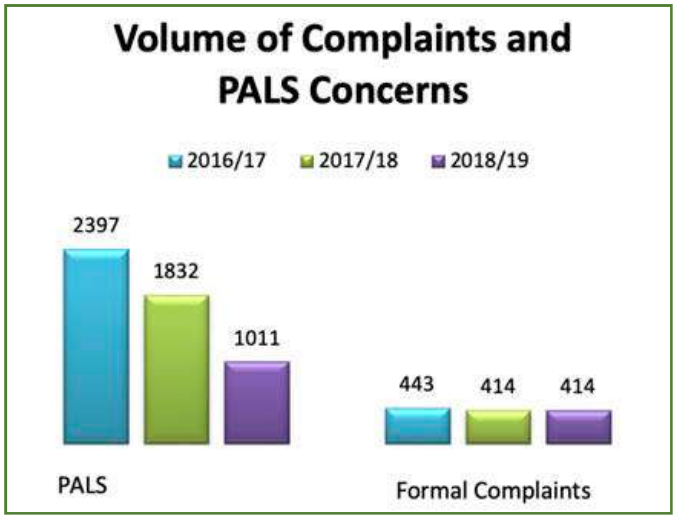
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		%	
Total Number of Medication Incidents Reported	144	146	133	179	178	161	201	188	175	160	203	183	2051		
Level of Harm Caused (Impact Assessed Using Trust Risk Matrix)	142	139	124	164	169	158	192	178	169	158	194	176	1963	95.71	No harm
	2	6	8	12	8	3	6	6	4	2	7	5	69	3.36	Low
	0	1	0	3	1	0	3	4	2	0	2	2	18	0.88	Moderate
	0	0	1	0	0	0	0	0	0	0	0	0	1	0.05	Severe
Number of Admissions	10259	11118	10844	11008	10718	10506	11734	11586	10905	11927	10394	11380		100	
Rate of Medication Error	1.40	1.31	1.23	1.63	1.66	1.53	1.71	1.62	1.60	1.34	1.95	1.61			
No harm	Low	Moderate	Severe												
95.71	3.36	0.88	0.05												

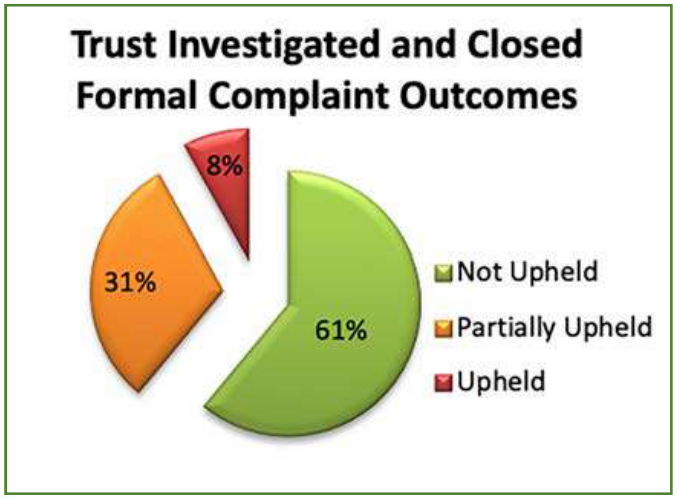
Priority 3: Patient Experience

The Royal Wolverhampton NHS Trust

Key achievements included:

- Complaints and PALS concerns reduced from n=1832 to n=1011. This represents a 44.81% reduction when compared with the previous year.
- Compliments increased from n=419 to n=2548. This represents a 508% increase, which was predominantly due to improvements in capturing these consistently.
- The patient friends and family test average response rate increased from 18.67% to 19.50%. In addition, the average recommendation rate increased from 91.75% to 92.42%.
- Regular audits of volunteer base and focus on increasing or volunteer numbers.
- Patient facing staff were provided with the opportunity to receive basic British Sign Language training to help staff communicate in non-clinical, basic communication.
- Raising awareness of patients from marginalised communities.
- The recruitment of a part time data analyst to enable a more detailed analysis of patient experience data to understand themes and drive improvements.





Priority 3: Patient Experience continued…

The Royal Wolverhampton NHS Trust

National Adult Inpatient Survey results (2018 survey published in June 2019):

Questions showing a significant reduction (5% or more) since last survey

Number	Question Group	Question	2017	2018	Diff
Q18	The hospital and ward	If you brought your own medication with you to hospital, were you able to take it when you needed to?	78%	69%	-9%
Q47	Operations & procedures	After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	84%	79%	-5%
Q70	Overall views of care and services	During your hospital stay, were you ever asked to give your views on the quality of your care?	13%	6%	-7%

	2015/16	2016/17	2017/18	2018/19
Involved as much as want to be in decisions about care definitely/to some extent	91%	92%	88%	89%
Treated with respect and dignity always/ sometimes	98%	98%	97%	97%

	2015/16	2016/17	2017/18	2018/19
Q68 Overall care rated as excellent/very good/good	95%	95%	93%	94%

About our strengths

- The hospital and ward – facilities, including cleanliness and food and disturbance at night time
- Nurses – confidence
- Care and Treatment – involvement in decision making, privacy, confidence in decision making, support and information giving
- Leaving hospital – involvement in decision making, and information and consideration of circumstances upon discharge

About our weaknesses

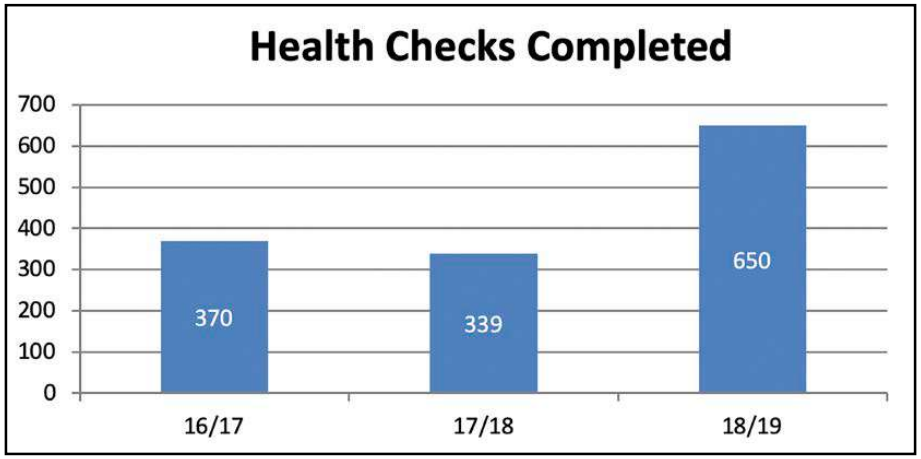
- The Hospital and the Ward – medication information, explanation for reasons for movement, help with mealtimes and support from non-clinical staff
- Nurses – volume of nurses on duty, knowing which nurse was in charge
- Operations and procedures – information giving pre and post operation or procedure

Priority 3: Patient Experience – Primary Care

The Royal Wolverhampton NHS Trust

Key achievements included:

- Health check appointments have doubled.



- CQC inspected 7 of our practices during 2018/19 and overall ‘Good’ rating was achieved for all.
- Number of schemes launched to trial new ways of working. For example, in-hours visiting service whereby Advanced Nurse Practitioners undertake triaged home visits rather than General Practitioners (GPs).
- Number of booked patient appointments with GPs and other General Practice staff continued to rise.

Priorities for 2019-2020

The Royal Wolverhampton NHS Trust

Priority 1: Workforce

- Development and utilisation of new roles.
- Strengthening our workforce planning.
- Shaping the Trust's future workforce model.
- Strengthening governance arrangements associated with workforce (Developing Workforce Safeguards (2018).
- Ongoing focus on growing and retaining the nursing workforce.
- Focus on education and development of staff.

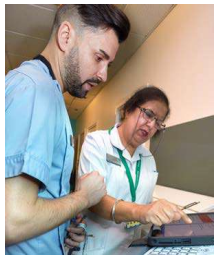
Priority 2: Safer Care

- Further focus on reducing harm – patient falls, pressure ulcers, venous thromboembolism, medication errors.
- Maximising the impact of the Sign up to Safety Programme.
- Response to the deteriorating patient and sepsis management.
- Maximising the impact and learning from Getting it Right First Time (GIRFT).
- A variety of projects pertaining to Allied Health Professionals.
- Driving forward priorities set out in the Trust's Quality and Safety Strategy 2019-2022.

Priority 3: Patient Experience

- Driving forward the Patient Experience, Engagement and Public Involvement Strategy 2019-2022, which includes key milestones and outcome measures.
- Maximising the opportunities afforded via the vertical and horizontal integration within the Trust and Integrated Care Alliance.





The Royal Wolverhampton NHS Trust

Thank You and Questions….

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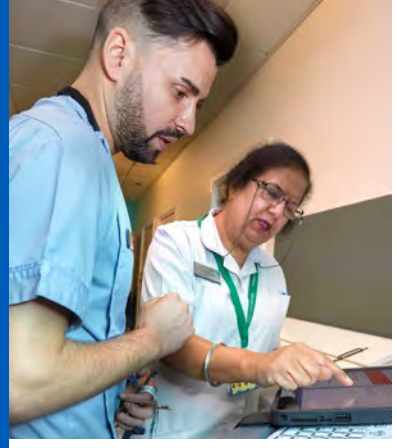
Safe & Effective | Kind & Caring | Exceeding Expectation



Quality Account 2018-19

NHS
The Royal Wolverhampton
NHS Trust

CONTENTS

The Quality Account

Why are we producing a quality account?

All NHS Trusts are required to produce an annual Quality Account, to provide information on the quality of the services it provides to patients and their families.[1]

The Royal Wolverhampton NHS Trust (RWT) welcomes the opportunity to be transparent and able to demonstrate how well we are performing, taking into account the views of service users, carers, staff and the public. We can use this information to make decisions about our services and to identify areas for improvement.

[1] *Quality Account (2009) Health Act*

Getting involved

We would like to hear your views on our Quality Account. If you are interested in commenting or seeing how you can get involved in providing input into the Trust's future quality improvement priorities, please contact:

Patient Experience Team

The Royal Wolverhampton NHS Trust

New Cross Hospital

Wednesfield Road

Wolverhampton

WV10 0QP

Email: rwh-tr.patientexperienceteam@nhs.net

Statement on Quality from the Chief Executive

INTRODUCTION

All staff working at The Royal Wolverhampton NHS Trust are committed to continually driving improvements in patient experience and outcomes and fostering a culture of excellence. We want our patients to have access to top quality services when they need them; we want our staff to feel valued and supported at all times, working in an environment in which they can thrive, and we want our local community and partner organisations to be confident in the Trust as provider of excellent care and an employer of choice.

The Trust strives to deliver high quality healthcare to the population of Wolverhampton, Cannock, the Black Country and beyond. To meet the needs of the population with increasingly complex health and social care needs is a significant challenge, especially in the current financial climate. In order to deliver the best quality health care, the Trust needs to ensure that its workforce is well-led and well-cared for in order to provide safe, effective and compassionate care to all our patients.

Building an Integrated Care System, working in partnership with General Practitioners, the Local Authority and the Clinical Commissioning Group is key in addressing some of these challenges. Partnership work at a local level has progressed from strength to strength with the expansion of the primary care function of the Trust and the creation of a dedicated Primary Care Directorate. This has enabled system-wide initiatives aimed at improving specific pathways such as Stroke, Frailty and End of Life which are at advanced stages of implementation. These will provide patients and families with support to access the best services required by those patients, enabling the right care, at the right time in the right location.

Innovation is central to shaping the future workforce and the focus on patient experience is rapidly evolving as a 'usual' method by which to measure and improve services. Improving chronic wound assessment, reducing patient falls with harm and healthcare associated infections, and optimising antimicrobial prescribing, are some of the examples of achievements of 2018/19. Since October 2018, the Trust has sustained harm-free care above the national ambition of 95%, measured using the Safety Thermometer. However, as an organisation we continuously strive to make patient care as safe as it can be.

Workforce has been our greatest challenge, particularly in medicine and nursing. We have made good strides in developing the Trust as an attractive and forward-thinking place to work with initiatives such as expansion of the Clinical Fellowship model into nursing, successful in attracting home grown and international nurses. In addition, the Clinical Fellowship programme has continued to attract international medical staff, supporting teams in the clinical areas and reducing the use of locum staff. New roles are being embraced with the successful completion of the Trust's first Nursing Associate programme, with many of the candidates now registrants with the Nursing and Midwifery Council (NMC), and others progressing towards registration. Advance Clinical Practitioner (ACP) and Nurse Consultant posts have also increased in number. Overall vacancies have reduced and work continues at pace.

The Trust has had a significant challenge in reducing in-hospital mortality and addressing specific alerting diagnostic groups. As part of our efforts to progress improvements required we have invested substantial resources to ensure an intelligent and sustainable approach to reducing the risk of misidentification of Sepsis. The Board has taken the elevated mortality indicators very seriously and supported a variety of quality improvement approaches, including strengthened governance pertaining to mortality throughout the year. The Trust has also extended its focus to learning from never events by way of a targeted approach to improving theatre processes. This was as a result of a cluster of never events reported in the first quarter of the year. Following the implementation of this targeted approach, no further never events had been reported for the remainder of the year.

The Trust recognises that there continues to be potential to further build upon our achievements to date, and make demonstrable improvements to the patient care and experience. Patient safety and the quality of services delivered remain key priorities, and we continue to build on feedback received from our patients, staff and external stakeholders, with the flowing areas of specific focus:

- Ensuring safer care by reducing the instances of harm
- Improving the experience of patients who use our services
- Further improving recruitment and retention in order to sustain the workforce.

This report provides information on progress against the above indicators for the past year and sets our quality improvement priorities and plans for 2019/20.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Signed:

David Loughton CBE
Chief Executive
4th June 2019

‘Our vision is to be an NHS organisation that continually strives to improve the outcomes and experiences for the communities we serve’

Achieving Our Vision - Strategic Objectives

Our Values

Safe and Effective	Kind and Caring	Exceeding Expectation
We will work collaboratively to prioritise the safety of all within our care environment	We will act in the best interest of others at all times	We will grow a reputation for excellence as our norm

Trust Strategic Objectives 2018-2021

To have an effective and well integrated health and care system that operates efficiently	Proactively seek opportunities to develop our services	Create a culture of compassion, safety and quality	Attract, retain and develop our staff and improve employee engagement	Maintain financial health - appropriate investment to patient services	Be in the top 25% for key performance measures
					

Looking back 2018/19

PRIORITIES

for Improvement

Workforce

We aim to deliver safe patient care and good patient experience. Our wards and departments need to have the right levels of staff and skill mix for the acuity of the patients for which they are caring.

Patient Safety

We aim to be the safest NHS Trust by “always providing safe & effective care, being kind & caring and exceeding expectation” (Trust Vision & Values September 2015) by making safe quality care a whole-system approach for every patient that accesses the Trust and its services.

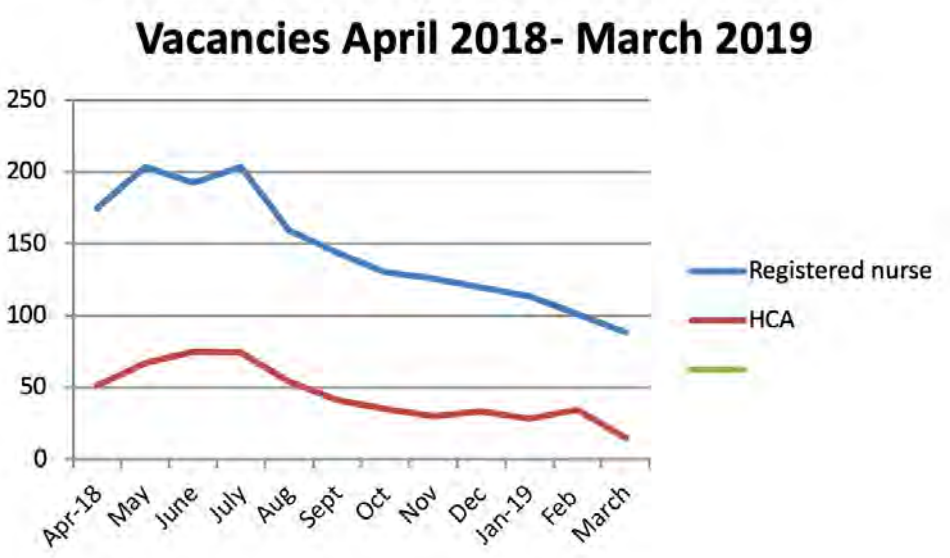
Patient Experience

We are committed to providing high quality clinical care and aim to provide an excellent experience for patients, their relatives and carers.

Priority 1: Workforce

2018/19 was a challenging year for registered nurse recruitment both nationally and locally. However, following the introduction of a centralised recruitment process, the Trust had seen a reduction in the number of registered nurse vacancies, and in the Emergency Department (ED) and Acute Medical Unit (AMU) we now have a waiting list of staff who wish work at the Trust.

The graph below illustrates the reduction of nursing and midwifery vacancies during 2018/19.



Apprenticeships

The Trust offered places on the following programmes to both internal and external candidates:

- Nursing Associate Apprenticeship (2 year level 5 apprenticeship) - 9 staff joined the March 2018 cohort and a further 9 joined the September 2018 cohort
- Registered Nurse Apprenticeship (3 year level 6 apprenticeship) - our first cohort commenced in September 2018 with 18 staff joining the programme. The Trust was the only employer to utilise this route to support the registered nurse pipeline.

Clinical supervision

The Trust's clinical supervision policy was updated and training sessions introduced for staff to aid them to understand the process and implement it in their workplace.

New role development

The Trust was a first wave pilot site for the Nursing Associate role which started 2017. The Trust has seen 12 of our staff attaining a foundation degree and registered nursing associate status in March 2018 with a further 5 awaiting completion of the course to enable them to register with the Nursing and Midwifery Council (NMC).

The Trust has also introduced Advanced Clinical Practitioner posts into additional clinical specialities including surgery, haematology and gastroenterology.

Awards

In September 2018, we won the Nursing Times Workforce Award for Best International Recruitment Experience. This was for the recruitment of non-European Union nurses and for the support and educational programme delivered to achieve their success in becoming registered nurses within the United Kingdom.

Other achievements

- In November 2018, the first edition of Care to Share was launched. This is a magazine aimed at nurses, midwives and health visitors. It has become an essential tool for learning and sharing across the Trust
- In June 2018, we launched our Practice Education Facilitators (PEF) Network, and delivered a study day for all clinical nurse educators in the Trust. Subsequently, we have developed a governance framework, educational standards and competencies for our educators. The network has continued to meet regularly and been deemed as a positive and beneficial resource for the educators themselves, and the Trust as a whole
- The Clinical Nurse Fellowship programme had commenced for internal and international registered nurses to support both retention of our existing, and the recruitment of new staff.

International recruitment - NMC Pathway

In 2018/19, a number of international registered nurses joined the Trust. Once they arrived in the UK, they were required to complete the Objective Structured Clinical Examination (OSCE) at an accredited unit, to proceed onto their NMC registration. With the support of the nurse education team, over 90% of cohorts passed and proceeded to register with the NMC. The following table provides details of the pass rate:

Timeframe	RWT pass rate 1st attempt	RWT pass rate 2nd attempt	RWT combined pass rate
January – March 2018	50%	50%	75%
April – June 2018	0%	100%	100%

As part of workforce development Health Education England West Midlands (HEEWM) provided funding for:-

Course title	Number funded
Advanced Clinical Practitioner course	1
18 Month Midwifery course	3
Practice Nursing	2
Health Visitor	2
Podiatry	4
Dietetics	2

In addition Learning Beyond Registration (LBR) funding supported 66 mentorship courses for qualified nurses to support students.

Priority 2: Safe Care

Number and Themes of Serious Incidents

The Trust has a robust reporting mechanism communicated through policy, training and management lines. The arrangements include processes for the timely reporting, investigation and management of serious incidents.

In the financial year April 2018 to March 2019[2], the Trust reported 66 serious incidents and 36 reportable incidents through the serious and reportable incident system (STEIS), this does not include incidents that have since been agreed for removal. This is a reduction from previous year of 102 serious incidents and 203 reportable incidents[3] through the serious and reportable incident system (STEIS). This reduction is predominantly associated with the change in reporting of pressure ulcers to bring it in line with the National Serious Incident Framework (2015) and the Pressure Ulcers: Revised Definition and Measurement Guidance (2018). The Trust had also seen a 61% reduction of falls resulting in serious incidents, which had contributed to the overall reduction of serious incidents.

Serious incidents are reported in line with commissioning targets and robustly investigated to ensure that the organisation learns and makes improvements to prevent harm to patients.

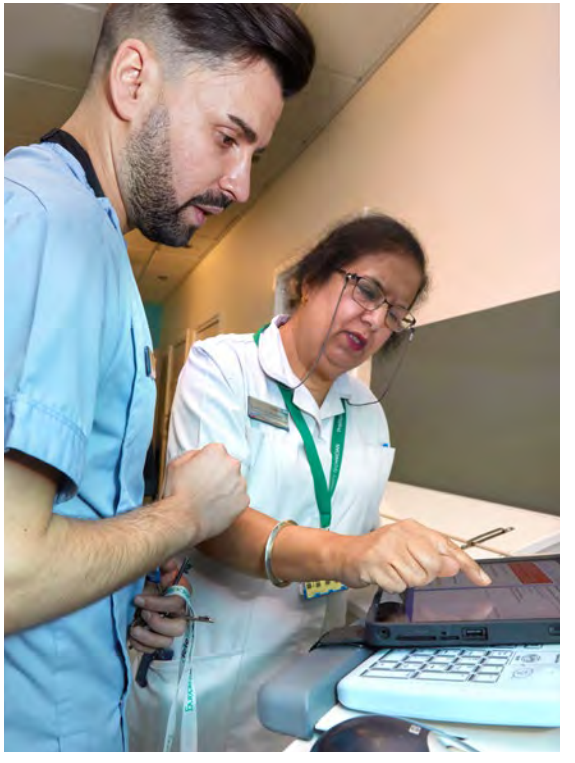
All serious and reportable incidents are reported in a timely manner and undergo robust investigation to ensure the Trust learns from these incidents to reduce the likelihood of recurrence and prevent further harm to patients. We also ensure that duty or candour requirements are met in all serious incident investigations. There was an overall reduction in the number of serious incidents reported in 2018/19, with significant reductions in Pressure Ulcers (from 175 to 18) and falls with harm (from 23 to 9).

During 2018/19 there was a noteworthy decrease of serious incidents categorised as “infection” (from 25 to 14) and of those categorised as “diagnostic” (from 29 to 12). That said, confidentiality breaches had continued to remain at a similar level (12 to 13).

* New Overall Total = 102. These figures are a true reflection as of this date and time. They do not include incidents that have since been agreed for removal by the CCG.

During 2018/19, the Trust conducted a review of the serious incident themes reported during the previous year (2017/18). The following actions were identified to address causal themes:

- Strengthen Local Procedural arrangements
- Review Results reporting systems and processes
- Review the impact of Human Factors including, for example, communication, handover practice, non- technical skills.



[2] As at Datix 15th April 2019
[3] Quality Accounts 2017/18 (The Royal Wolverhampton NHS Trust

Work has progressed throughout the year towards addressing these themes and will be ongoing into 2019/20 along with a further review of the serious incident themes for 2018/19.

Category	01/04/18 to 30/03/19
Accident	2
Confidential Breach	13
Diagnostic	12
Consent Not Given	1
Infection	14
(C.Diff)	(1)
(Infection)	(7)
(MRSA)	(6)
Medical Equipment	1
Medication	2
Never Event	4
(Retained Foreign Object)	(2)
(Wrong Site Surgery)	(2)
Screening	1
Sub Optimal Care	9
Surgical/Invasive Procedure	2
Treatment Delay	4
Unexpected Death	0
Unexpected Injury	0
VTE	1
TOTAL	**66**

Category	01/04/18 to 30/03/19
Maternity	9
Pressure Ulcers	18
(Community)	(4)
(Hospital)	(14)
Slip/Trip/Fall (with serious harm)	10
TOTAL	**37**

* New Overall Total = 103

The figures above do not include any agreed removals and are a true reflection as of this time.

Numbers and Themes of Never Events

Four Never Events were reported in the financial year April 2018 to March 2019.

Date	Location	Category	Level of Harm	Progress
April 2018	Neonatal	Wrong Site Surgery	None	Investigation completed
April 2018	Head & Neck	Wrong Site Surgery	Low	Investigation completed
June 2018	Theatres	Retained foreign object post-procedure	None	Investigation completed
June 2018	Delivery Suite Theatre	Retained foreign object post-procedure	Moderate	Investigation completed

The Trust aims to ensure that Never Events are reported in a timely manner and robustly investigated to ensure that it learns from them to reduce the likelihood of recurrence and/or prevent never events re-occurring.

To ensure the learning from the never events reported during 2017/18, the Trust has implemented a number of measures to prevent their recurrence, and as a result, had seen a reduction of these incidents by 2 during 2018/19.

From the total number of 4 never events, 2 did not cause patient harm, 1 caused low patient harm and 1 caused moderate patient harm.

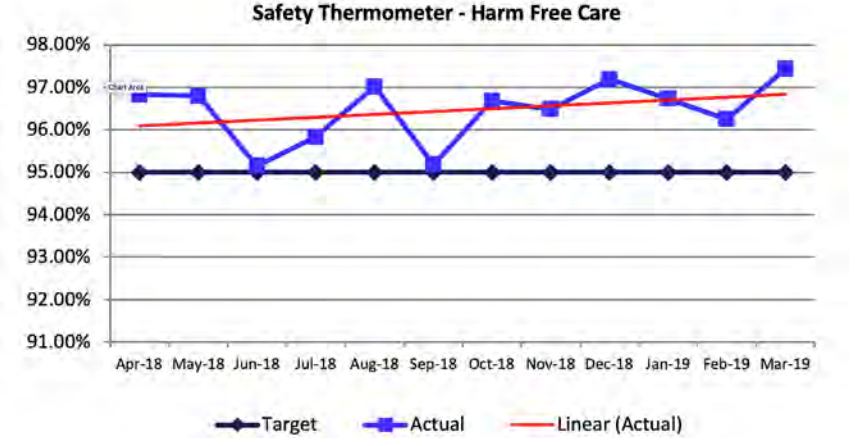
The key learning points from the 4 investigations included:

- Ensure that Local Safety Standards for Invasive Procedures (LocSSIPs) are identified and developed for all relevant invasive procedures
- Remind staff about the need for good communication and use of Situation, Background, Assessment Recommendation and Decision principles (SBARD) and the World Health Organisation (WHO) checklist
- Implement a Standard Operating Procedure (SOP) for the transfer and handover of neonates within the Women's and Neonatal centre requiring a procedure/ medication
- Implement use of name signs above bed/cots
- Emphasise to all relevant trainees the importance of re-assessing paediatric patients carefully prior to tooth extractions
- Explore service enhancements to reduce the delay between initial assessment and surgery for paediatric patients
- Provide educational and pastoral support for the staff involved
- Undertake competency assessments for all nursing scrub practitioners in line with the Association of Perioperative Practice (AfPP) guidance. In addition, invite AfPP to deliver human factors training for the Obstetric theatre teams
- Issue a Making it Better Alert to remind staff of the requirements of the policy for the safe management of swabs, instruments, needles and other

accountable items used during surgical procedures undertaken in operating theatres

- Neonatal equipment to be standardised with maternity resuscitation equipment to ensure familiarity between teams
- Re-design Accountable Items White boards to incorporate the insertion and removal times of packs used
- Empower theatre team leaders to challenge poor practice
- Undertake work to reduce refusal rate of women having perineal check prior to discharge from obstetric wards
- Introduction of new 'Swab Safe' disposal trays to ensure that all swabs are visible individually for both the first and final 'swab checks'.

Progress with identified improvement actions continues to be monitored at a local and Trust wide level through the well-established governance processes.



How have we performed against 2018/19 plans?

Falls

During 2018/19, a Falls Prevention Group continued to oversee and monitor a variety of quality improvement initiatives designed to reduce falls. This was aligned to the objectives agreed following the Trust's participation of the national falls collaborative.

Key areas of focus in 2018/19 included the following:

- Sustaining the multidisciplinary observation of patients assessed as at risk of falls
- Implementation of the revised falls policy
- Embedding of the delirium standard operating procedure
- Roll out of an on-line education package.

The final months of 2018/19 had seen a renewed focus on innovation around falls prevention with multidisciplinary groups of staff contributing their ideas to future quality improvement plans. A revised 'falls dashboard' and the Trust's new Quality Improvement Team have facilitated discussion, to ensure measurable outcomes and spread of successful projects during 2019/20 with the aim of further reductions in this important quality area.

By improving the risk assessment process and documentation, the number of falls defined as serious incidents reduced by 61% in 2018/19. In addition, data generated as part of this improvement work had demonstrated that the number of falls remained below the national benchmark.

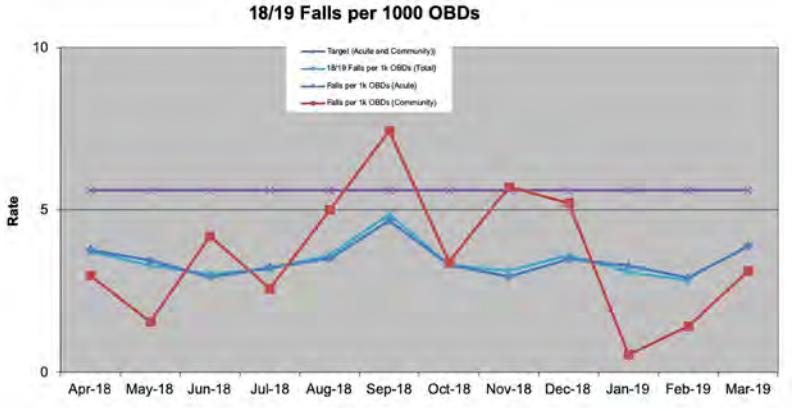


Table1 (Trust's own data – actual falls per 1,000 occupied bed days)

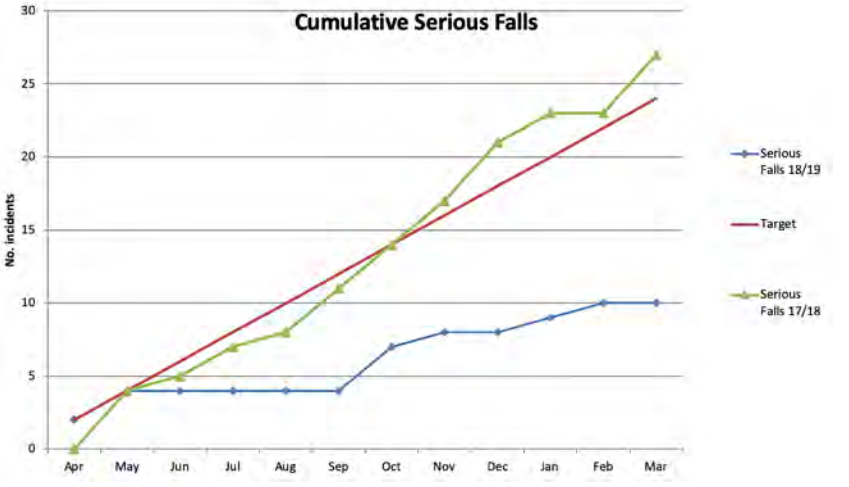


Table 2 (Trust's own data – cumulative serious falls)

Preventing Infection

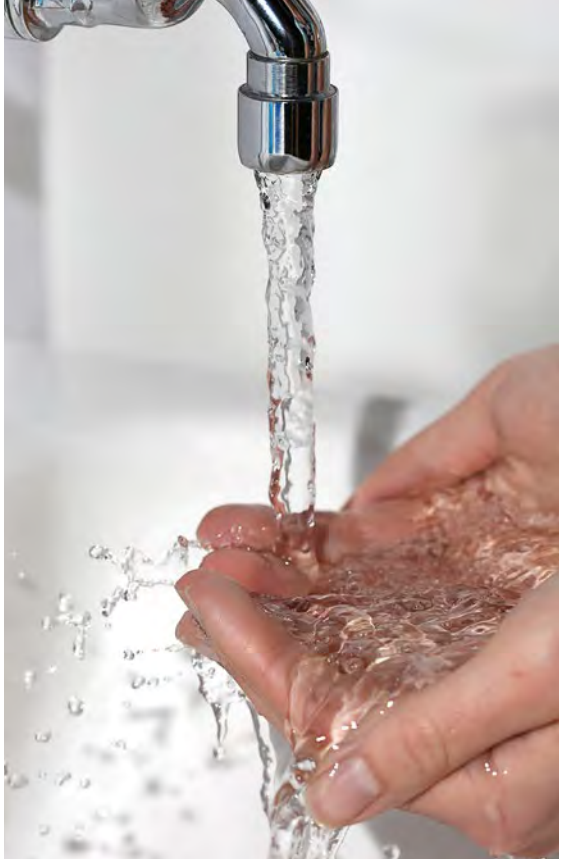
Infection Prevention remains a high priority for the Trust. There is a well-established team working with key stakeholders to deliver strategic objectives, focusing on ensuring consistent high standards, collaborative working and innovation to sustain and further reduce avoidable infection in healthcare. These are delivered through a health economy infection prevention and control 5 year strategy.

The challenge of acute and community incidence of Carbapenemase Producing Enterbacteriaceae (CPE) continues. With the introduction of the risk assessment in 2017/18 to ensure that we identified positive patients, isolation and standard precautions have been introduced in a timely manner to reduce transmission and maintain patient safety. Clostridium difficile has remained within trajectory this year however there have been 2 MRSA Bacteraemias which were attributed to the Trust and deemed avoidable. Environmental controls have been a top priority in our approach in tackling healthcare associated infections (HCAI). The deep clean schedule has been completed with great effect and there has been a good compliance with monthly environmental audits in in patient areas.

Antimicrobial stewardship, innovation in design and ensuring clinical practice such as hand hygiene is optimal has been key to the control of familiar organisms.

Specific achievements against last year's objectives include the following:

- *Clostridium difficile* has remained within trajectory this year. At the end of month 12 the Trust is 3 cases under an annual trajectory of 34
- Community Tuberculosis (TB) services have moved to Corporate Support Services. Proactive latent TB case find continues through contact screening and through collaborative working with City of Wolverhampton Council and the Refugee and Migrant Centre in the city. The team have commenced Bacillus Calmette–Guérin (BCG) vaccinations for eligible 1-17 year olds. The service continues to respond to TB incidents and work collaborative with Public Health England
- The Intravenous Resource Team continues to deliver a high standard of line care with increasing numbers of patients discharged on Outpatient Parenteral Antibiotic Therapy
- Surgical Site Infection (SSI) surveillance data is shared with consultant surgeons via a monthly dashboard; this will continue into 2019/20 to further support with a reduction in SSIs
- Device related bacteraemias remain within the internal trajectory. At the end of month 11 there have been 43 cases with an annual trajectory of 48. Continued communication of community acquired related device related bacteraemia cases remains in place



- Robust catheter management and surveillance continues with the Continence Team involved in reviewing residents in care homes for removal of urinary catheters
- Continued outbreak management support to care homes and very sheltered housing establishments across the Wolverhampton health economy, ensuring a seamless service across healthcare facilities throughout the city and reducing norovirus-related hospital admissions to acute services
- The infection prevention scrutiny process continues, which involves clinical areas presenting their investigations for each incidence of infection, to identify themes, risk, lessons learnt and to support with strengthening governance processes in relation to HCAI
- Partnership working with Walsall Healthcare NHS Trust to develop electronic sharing of infection risks
- Outbreak management for influenza included dedicated bays to prevent further movement of patients and ward closures
- A process for influenza outbreak management and treatment/prophylaxis in care homes continues to prevent admissions to hospital as implemented in 2017/18. This is joint working between the Infection Prevention and Control Team and the Rapid Interventions Team (RIT)
- Achieved 63% influenza vaccination uptake of front line staff
- A multi stakeholder and health economy gram-negative bloodstream infection action plan remains in place to reduce these infections by 50% by 2021
- Recruitment of Sepsis Team to support the sepsis lead consultants to help drive early recognition and management of sepsis at ward level, and support a cultural shift across the Trust and contribute towards reducing the number of preventable deaths due to sepsis.

Venous Thromboembolism (VTE)

Venous thromboembolism (VTE or blood clots) prevention is a trust priority for maintaining safe patient care. Implementation of National Institute for Clinical Excellence (NICE) guidance ensures that all admitted patients have their risk for developing VTE assessed and that the risk is reduced by using appropriate interventions and treatments. Compliance with this guidance is monitored, and the national standard is that 95% or more of patients should receive a VTE risk assessment. There is a VTE group in place driving improvements and associated VTE workstreams.

In April 2018, a new reporting system and process for data extraction was implemented. This has resulted in the Trust reporting risk assessments that have been completed on admission (within 24 hours). Further changes were also implemented in November 2018 within maternity services with a move to electronic VTE risk assessments, which allowed for more accurate and timely data collection.

In March 2018, NICE published 'NG89 Venous thromboembolism in over 16s: reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism'. This resulted in the guidance extending the requirement for VTE risk assessment to the Trust's paediatric areas. The VTE group have worked with paediatric teams to introduce a paper based VTE risk assessment process as well as ensuring all clinical guidelines were appropriate for this patient group.

As per the requirements of the Department of Health and Social Care, this group's data will be included in the UNIFY figures from Q1 2019/20.

The opening of the new stroke unit in April 2018 saw increased activity and the VTE group worked with the stroke teams to promote timely risk assessments of this patient group. Changes in activity through the Clinical Decisions Unit and introduction of the Ambulatory Emergency Care (AEC) also required patients admitted through these areas to have received VTE risk assessments.

The impact of these changes reduced the Trust's compliance against the national standard however these changes embeds the Trust's values ensuring VTE risk assessments are safe and effective.

During 2018/19, the VTE clinical nurse specialist was part of a team that were successfully awarded a place on the acute care and commissioning "Triumvirate Leadership and Change" programme. The aim of this project was to respond to changes in prescribing of treatments including those for the treatment of VTE by:

- Improving patient experience
- Improve safer discharge and reduce length of stay where possible
- Improve clinical pathways for anticoagulation care and improving patient safety (including primary care pathways)
- Review and optimise prescribing and local policies relating to anticoagulants, ensuring compliance with NICE guidance and the principles of a National Patient Safety Agency (NPSA) system.

This project will conclude in September 2019, but significant progress has been made towards the aims which has resulted in the provision of safer care and improved links with primary care.

The Trust continued to progress projects commenced during 2017/18 which included:-

- Closer working arrangements with admission portals
- Moving forward with the target to link VTE risk assessment to electronic prescribing and developing a VTE assessment tool within the prescribing system to be introduced
- Continuing to work towards implementation of the recommendations from last year's external audit report
- Updated the VTE e-learning package
- Strengthening existing prescribing guidelines and pathways for patients requiring anticoagulation
- Securing additional VTE nurse support/ resources

- Continuing the rolling programme of ward audits. Plans are in place to ensure timely feedback of audit data and actions to departments with VTE audit data being collected through health assure.

The Trust's performance against the 95% target based on the percentage of adult patients who were admitted and received a VTE risk assessment within 24 hours of admission was as follows:

2018/19 Q1	92.05%
2018/19 Q2	93.48%
2018/19 Q3	93.75%
2018/19 Q4	93.70%

VTE group remains committed to ensuring that as a Trust, we achieve and exceed the 95% target and improve outcomes for patients through driving associated quality improvements programmes.

Pressure Ulcers

Wound assessment is one of the most important elements of wound care. It enables patients to be treated holistically and will identify barriers to healing early, to aid wound healing. The Trust's Tissue Viability Strategy developed in 2016 had continued to be progressed as part of ongoing efforts to drive improvements in preventing avoidable wounds and to aid wound healing.

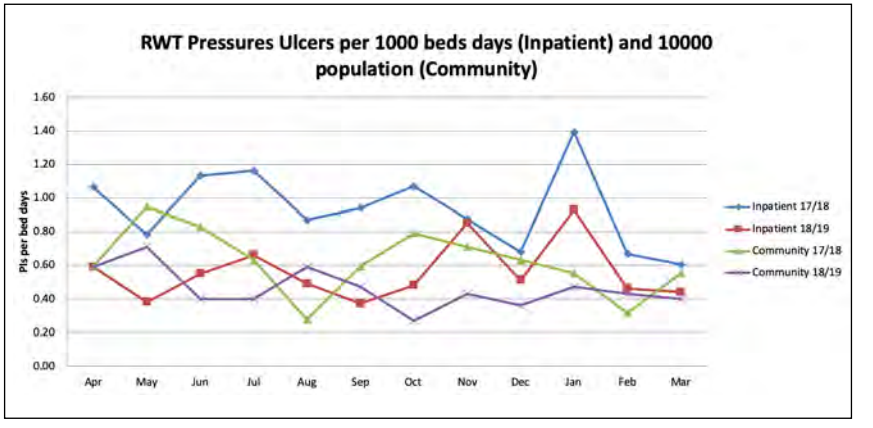
The Trust has continued to fully embed the NHS Improvement's (NHSI) framework which includes revised definition and measurement pertaining to pressure ulcers. The Trust had modified its policy, pathways and documentation to support these changes fully from October 2018. The Trust's acronym of ASSKINE (Assessment, Skin inspection, Surface, Keep moving, Incontinence and moisture and Escalation and communication) was modified by NHSI to "aSSKINg" which stands for Assessment, Skin Inspection, Surface, Keep Moving, Incontinence and moisture, Nutrition and hydration and Giving information.

A new wound assessment tool was designed for Adult Community Services. This has led to improvements in patients' quality of life and wound healing outcomes. The assessment for leg ulcers requires the use of an automated device that assesses a patient's arterial flow much quicker. As a result, it speeds up the process of applying compression therapy to help heal leg ulcers.

A proactive surgical healing pathway is being trialled within the cardiothoracic department. This includes a surgical dressing being selected depending on risk of infection or dehiscence (wound breaks open to form a cavity). In addition, prophylactic negative pressure wound therapy is used on closed wounds, and a photo is provided to patients at discharge to help them understand how to recognise early signs of infection. This pathway will also be trialled in other specialities during 2019/20.

The Trust has commenced reporting moisture associated skin damage, which includes incontinence associated dermatitis, intertrigo dermatitis (wound that form between skin folds), peri wound dermatitis and stomal dermatitis, as many of these can cause pain and discomfort as well as some will heighten the risk of pressure ulcers. Once more data is available, the plan is to start a quality improvement project aiming to reduce these incidents. The Trust has a moisture associated skin damage pathway for staff to refer to in order to prevent these wounds developing in patients who are in our care or those patients who present with these wounds on admission.

All pressure ulcers have continued to be reported via datix and termed as present at point of assessment (admission with no other trust service involved prior to admission) or described as "new", if developed after any admission across inpatient area and community services. The level of ulceration is categorised as category 1,2,3,4, unstageable (which was previously reported as at least category 3 or 4) or a deep tissue injury. Device related incidents continue to be included in our data. These recommendations have been launched by NHS Improvement in June 2018, through the Pressure Ulcers: Revised Definition and Measurement Guidance, to ensure there is consistent reporting across England. In addition, the investigation process has been modified to ensure lessons are learnt and shared. The term avoidable and unavoidable is no longer used; however serious incidents that meet the national criteria are taken very seriously and are reported. The Trust has seen a significant reduction in serious pressure ulcer incidents despite the changes to the reporting requirements. All audits, quality improvement plans and incident data is reported into the Tissue Viability Steering Group and Clinical Oversight Group.



Sign up to Safety (SU2S)

The Sign up to Safety (SU2S) project aimed at reducing harm and improving safety outcomes, has continued to be rolled out, targeting interventions that address safety culture, team effectiveness and performance, human factors including communication, relationship and interaction between healthcare staff.

The focus has been within the three SU2S areas (Emergency Department (ED), Obstetrics and Gynaecology (O&G) and Trauma and Orthopaedics (T&O), incorporating the promotion of Process Communication Model (PCM) as a method to improve communication, self-management and relational interaction with healthcare colleagues and the implementation of the Team Optimisation Model (TOM).

During 2018/19, the uptake of PCM by staff in the SU2S areas (ED, O&G and T&O) started to slow down, although there was a good uptake of PCM training continued for the wider Trust.

The total number of staff signed up by the end of September 2018 reached 284. This figure is made up those who have already completed and/or who had a place to complete the course in 2018.

This reduction in course uptake follows staff cancellations due to clinical challenges and on-going service pressures. These challenges have been running in parallel throughout the lifetime of the project, however the Trust had continued to encourage staff uptake.

SU2S completed delivery of its project in October 2018. However, the delivery of PCM courses will continue beyond the SU2S project as part of business as usual and the evaluation of PCM continued via Education and Training.

The breakdown per directorate is as follows:

E&T PCM Course Delivery @26.09.18	Spaces used by SU2S			Spaces used by wider trust	Total
	Emergency Department	Maternity	Trauma & Orthopaedics		
2014	3	0	1	50	54
2015	3	4	2	193	202
2016	8	56	22	364	450
2017	33	32	53	308	426
2018	15	31	21	217	284
Total no. of staff signed for PCM	**62**	**123**	**99**	**1132**	**1416**

During 2018, the SU2S project completed delivery of the Team Optimisation Model (TOM) intervention with the three SU2S priority areas and the Patient Experience Team. The final Project Steering Group meeting took place in October 2018 to conclude the project and to share the outcomes of activity.

The TOM is developed from research evidence on team effectiveness in healthcare and its impact on safety. The TOM programme is organised under four core headings: Goals, Roles, Processes and Relationships with a number of interventions under each section of the programme. It contains a combination of data reviews, diagnostic surveys, workshops, exercises, delivered session topics and team discussion which all seek to introduce effective team ingredients (based on research from Beckhard, West et al) and/or allows these to be uncovered. The programme instils and strengthens the basic foundations of teamwork and team effectiveness and makes links between staff and patient satisfaction and outcomes.

SU2S completed its implementation of TOM with the O&G Early Pregnancy Assessment Unit Team in February 2018, the Patient Experience Team in April 2018, the T&O team in July 2018 and the Emergency Department in October 2018. Each team identified its team vision, a set of objectives and values. Following completion of project delivery by the SU2S team, sustainability plans have been developed and agreed with each of the teams to ensure local ownership of activity initiated during the TOM programme.

Medication Incidents

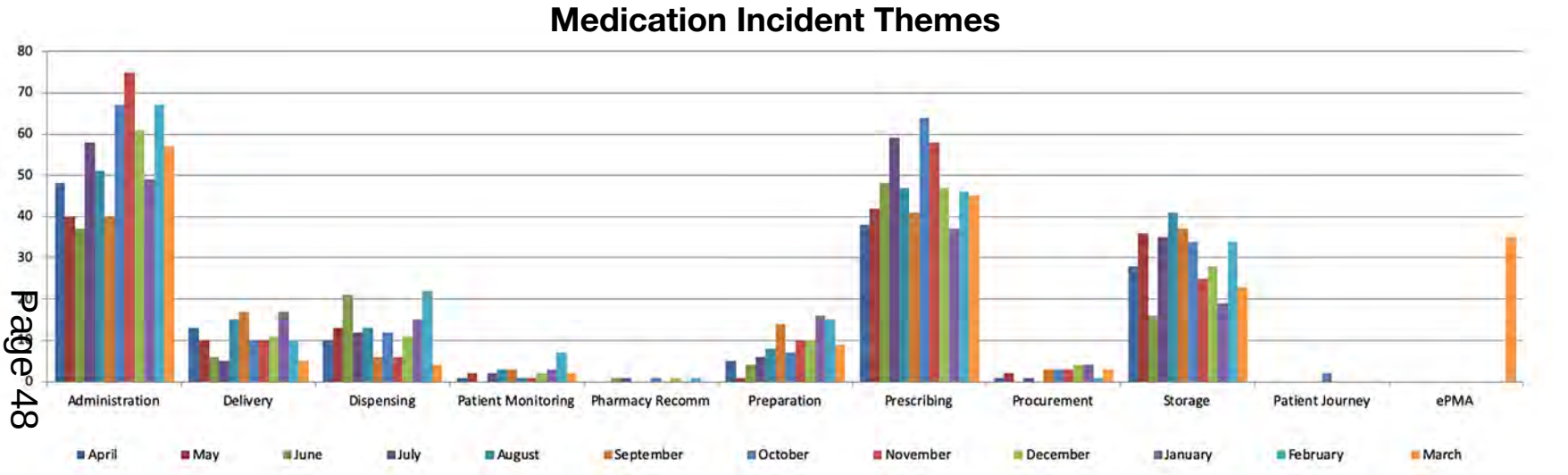
Administration of medication is the most common clinical intervention undertaken at a patient level. The Trust is responsible for ensuring that all medicines purchased meet United Kingdom standards, transported and stored appropriately, and prescribed and administered safely.

Staff are required to report all incidents involving medication to ensure learning and to continually monitor standards, thus ensure the integrity and safety of the medicines.

All incidents which are deemed to have caused patient harm are discussed monthly at the Trust Medication Safety Group and the learning is shared widely across the organisation through the existing governance processes.

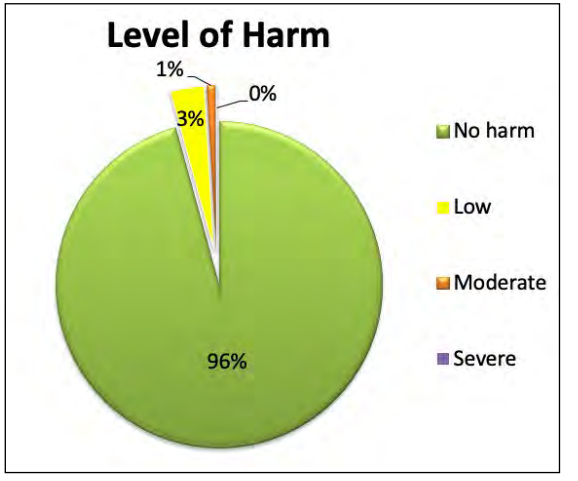
As part of the ongoing data quality checking processes, a discrepancy was identified between medication incidents entered onto datix and those included in the monthly Medication Safety Report. This arose from incomplete details being recorded at the point of final approval on the datix system. The problem has been rectified by a change within the reporting form which allows automatic completion of the data fields. It is therefore important to emphasise that there has not been a sudden increase in the number of incidents, but this is attributed to a change of how the data is captured.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19		%	
Total Number of Medication Incidents Reported	144	146	133	179	178	161	201	188	175	160	203	183	2051		
Level of Harm Caused (Impact Assessed Using Trust Risk Matrix)	142	139	124	164	169	158	192	178	169	158	194	176	1963	95.71	No harm
	2	6	8	12	8	3	6	6	4	2	7	5	69	3.36	Low
	0	1	0	3	1	0	3	4	2	0	2	2	18	0.88	Moderate
	0	0	1	0	0	0	0	0	0	0	0	0	1	0.05	Severe
Number of Admissions	10259	11118	10844	11008	10718	10506	11734	11586	10905	11927	10394	11380		100	
Rate of Medication Error	1.40	1.31	1.23	1.63	1.66	1.53	1.71	1.62	1.60	1.34	1.95	1.61			
No harm	Low	Moderate	Severe												
95.71	3.36	0.88	0.05												

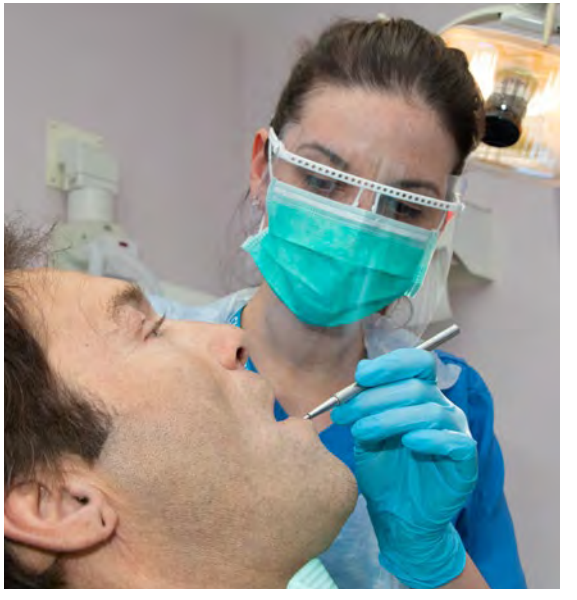


During 2018/19, the Trust conducted the following medicine related safety initiatives which included the following:

- ePMA (electronic prescribing and medicines administration system) has been successfully rolled out across all in-patient areas
- Cold Chain Policy designed for the maintenance of medicines stored at cold temperatures has been developed and approved and will be launched in quarter 1 2019/20
- Medication incident fields were expanded within datix to aid more accurate reporting
- Missed and Omitted Doses Audit was performed during May 2018 to obtain a baseline figure of the number of patients who did not receive a dose of medication during the five day audit period
- Incident reports are now based upon date of report rather than date of incident in order to ensure that all incidents are captured and included in Trust reports
- In response to a number of errors involving the use of medication patches, a new patch administration chart has been designed.



Sepsis



Sepsis and severe infection are perhaps the most common reasons for admission to hospital and cause of inpatient deterioration.

Reducing deaths from sepsis is a priority for the NHS and the Trust.

Following the appointment of a Trust sepsis lead, a three-year sepsis management strategy was developed in June 2017. The implementation and embedding of the sepsis management strategy continues to be led by the Trust sepsis leads and newly appointed sepsis nurses. Oversight of progress is maintained via the Deteriorating Patient Group.

With active engagement of clinical and nursing staff across various clinical areas, the following improvements have been achieved thus far:

- An improvement in performance (recognition and treatment of Sepsis) within the emergency department (ED), inpatients and haematology/oncology
- Recent audits have shown that antibiotics in ED are administered within an hour in over 66% (as at February 2019) of cases that trigger sepsis and that is a significant improvement compared to 17% reported in 2016-17
- In the neutropenic sepsis group of patients, antibiotic delivery within an hour has dramatically improved from 8.8% in 2017 to 66.7% as at March 2019.

Although some improvements have been demonstrated, the Trust's performance remains below the current CQUIN target. As a result the Trust has continued to drive systematic improvements aiming to result in better patient outcomes. Examples of these include:

- Consolidated and launched revised sepsis screening tools which include National Early Warning System 2 (NEWS2)
- Worked closely with information technology colleagues and the clinical coding team to improve the Trust's collection of sepsis data
- Worked with the education team to improve sepsis training and awareness amongst healthcare professionals and the general public
- Appointed two specialist sepsis nurses to help drive changes in practice and improve patient care and outcomes

- Implemented the sepsis module as part of Vital PAC upgrade along with NEWS2, to identify, risk-stratify and audit the delivery of appropriate care for patients with potential sepsis in accordance with published NICE guidance
- Utilising the Trust's mortality data and performing sepsis mortality audits to identify themes, learn and develop actions for further improvement.

The ongoing improvement work has resulted in the Trust being fully compliant with NICE, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and Royal College of Physicians (RCP) sepsis recommendations, which have been monitored and implemented through the Deteriorating Patient Group.

The Trust has also implemented processes for sharing and enhancing learning opportunities about missed cases for the nursing/ clinical staff through:

- The risky business newsletter
- Making things better alerts
- Care to share articles that have included missed sepsis management articles

Ongoing sepsis bundle compliance monitoring continues to take place via the following mechanisms:

- Mandatory quarterly CQUIN audits and multiple sepsis audits across the organisation
- Discussing sepsis performance and learning from it in multiple platforms including DPG, ED sepsis group and Haematology-Oncology group
- Datixing of cases where there is potential harm due to delays in the antibiotics or sepsis screening
- Reviewing mandatory sepsis e-learning which is integrated as part of infection prevention and control
- Reviewing sepsis mortality by using the "Trust mortality dashboard" and "SOS mortality dashboard" along with regular SHMI data
- The Trust has made significant strides with sepsis care in the past 12 months and it will continue to drive further improvements during 2019/20.

The new focused campaign, associated action plans and sepsis team expansion, will enable the Trust to progress it's ambition of improving sepsis related outcomes (early screening, antibiotic delivery within an hour, morbidity and mortality).

Responding to Safety Alerts

There are several types of alerts received by the Trust, mainly through the MHRA CAS system and specialist leads.

There are formal structures to receive and disseminate the alerts which is supported by the Health Assure (HA) system, monitoring of timely responses safety alerts; and reporting and monitoring of responses has improved.

NHS/PSA/RE/2018/005 Resources to support safer care for patients at risk of autonomic dysreflexia – currently sitting red, still open – ongoing actions. This is due to the action plan being returned to the clinical lead for further work.

The aim is for the Trust to respond to alerts 100% within timescales as per the requirements of the alert actions.

This year 2018/19 the Trust achieved 87% responses received within timescales. At the time of writing there is one PSA alert overdue response, throughout the year,

- 5 x MDA's were late response
- 2 X EFA alerts
- 1 x EFN alert
- 1 x PSA alert

Late responses were due to a delay in receiving confirmation of compliance from lead.

Safety alerts continue to be monitored by external bodies and internally via Health and Safety Steering Group, and Divisional Governance. The Trust works to ensure compliance within time-frames mandated.

There are two areas that the Trust monitors in terms of the completion of Safety Alerts, The first is that the alerts are responded to appropriately within the time frames mandated and secondly, where action plans remain open following official closure of the alert that all actions are completed.

Reporting is currently undertaken by the Health and Safety Steering Group (HSSG), bi-monthly reports are received and any issues highlighted within this report, there is a Divisional compliance report circulated to the Divisional Management Teams that identifies the status of NHSPSAs. The Medical Devices Group manages the responses to all Medical Device alerts and the Medicines Management Group receives reports in relation to all Drug alerts. For all alerts any areas of concern are escalated to Compliance Oversight Group (COG). Any areas of concern would be taken through to the Quality Information Safety Group (QSIG) where Divisions would be expected to provide assurance on actions they have taken to resolve closure.

The Patient Safety Alerts (NHS/PSA's) fall into 3 categories:

Stage 1 = Warning

Stage 2 = Requires Resource

Stage 3 = Directive giving instruction onimplementation of protocols

In the main the alerts require an action plan for implementation of the alert actions; the Trust is then required to monitor the action plans to completion. Action plans are monitored at the relevant local Governance meeting until it is agreed all actions are complete.

The Health & Safety Steering Group monitor the alerts and response times of which report to the Clinical Oversight Group.

All NHS organisations receive safety alerts these come under several headings each described below:

MDA (medical device alerts)	These relate to equipment or sundries used in patient care.
EFN (Estates Facilities Notice)	Inform Trusts of problems highlighted following incidents relating to Plant and Equipment.
EFA (Estates Facilities Alert)	Relate to procedures undertaken regarding Estates Facilities services/equipment.
NHS/PSA/W	Stage 1 – Issued in response to a new or under-recognised patient safety issue with the potential to cause death or severe harm.
NHS/PSA/Re	Stage 2 – Issued in response to a patient safety issue that is already well-known, either because an earlier warning alert has been issued or because they address a widespread patient safety issue.
NHS/PSA/D	Stage 3 - Issued because a specific, defined action to reduce harm has been developed and tested to the point where it can be universally adopted, or when an improvement to patient safety relies on standardisation.
FSN (Field Safety Notice)	Issued by suppliers/manufacturers to inform users of issues identified with their products.
SDA (Supply Disruption Alert)	Issued to inform organisations of major disruption to supply of equipment/sundries.

Table 1 provides the number and type of alerts received and responded to within the financial year 2018/19.

12 months April to March 2018/19:

The table below provides the number /type of alerts received within the last financial year 2017/18, RWT responses and any overdue.

YTD received (financial year)	
MDA's	41
EFN's	11
NHS/PSA/	9
EFA	9
NHSI	2
CHT	0
SDA	3
Total	75

YTD Closed	
MDA's	32
EFN's	11
NHS/PSA/	2
EFA	4
NHSI	2
CHT	0
SDA	3
Total	54

YTD Open	
MDA's	9
EFN's	0
NHS/PSA/	7
EFA	5
NHSI	0
CHT	0
SDA	0
Total	21

Open (YTD & Previous years still open)	
MDA's	9
EFN's	0
NHS/PSA/	7
EFA	5
NHSI	0
CHT	0
SDA	0
Total	21

Overdue Alerts x NHS PSA	1

To improve on completion of internal action plans within timescales, the Trust is continuing to develop the monitoring/reporting process through Health Assure. Guidance is issued to Leads on their responsibility to ensure compliance. To further improve the quality of assurance provided the Trust is building on the audit process of NHSPSAs through ensuring audit planning cycle considers (on a risk based process) which NHSPSAs to include on annual plans.

Getting it Right First Time (GIRFT) Programme

The Getting It Right First Time (GIRFT) programme is a national initiative designed to improve the quality of care within the NHS by reducing unwarranted variations.

GIRFT is led by frontline clinicians and focusses on tackling variations in the way services are delivered across the NHS using their own data to present opportunities. By sharing best practice between trusts, teams are able to identify potential improvements in the delivery of care and ultimately patient outcomes. The programme also identifies opportunities to deliver operational efficiencies; such as the reduction of unnecessary procedures and cost savings.

The Trust has participated in 13 GIRFT visits to date across all 3 clinical divisions and has developed subsequent action plans following each GIRFT review that are owned by individual specialities.

Attendance at the GIRFT reviews has been impressive, with multi-disciplinary engagement at the sessions, and the regional GIRFT programme team have commended the Trust on our level of engagement with the GIRFT programme.

Key achievements include:

- Increased productivity within theatre lists
- Changes to clinical practice to improve patient outcomes, for example, moving from open procedures to laparoscopic
- Pathway reviews across all divisions
- Review and consideration of alternative workforce models
- Implementation of enhanced recovery pathways in new specialties.

Allied Health Professionals

Key achievements during 2018/19

Orthotics

- We became the first research led orthotics service in the United Kingdom. This was achieved by collaborating with Staffordshire University on several research projects on orthotics and the service manager completed a PhD to become the first orthotics service manager with a PhD
- We achieved publication of our work in international peer reviewed journals and we have further research, which has been accepted for publication.

Physiotherapy

- We set out to pilot First Contact Practitioners (FCP) in one of our Vertical Integration GP practices. To that end, our first Consultant Physiotherapist has been recruited who will lead the project pilot. In addition, a GP practice in which to pilot the role has been identified
- We set out to appoint our first Clinical Academic Physiotherapist to drive forward the research agenda in our Stroke/Neurology service and to challenge existing practice working from within the service and contributing to a research-rich care environment. We have successfully recruited to the post.

Nutrition and dietetics

- We set out to improve our service to patients with gestational diabetes (GDM) by re-designing the service within our existing resource. This was due to the fact that previously, we provided a service to the gestational diabetes MDT clinic, which was not entirely efficient. In addition, we developed a structured education session

for ladies with GDM for midwives to refer into and started to deliver this in April 2018. The sessions evaluated really well, with participants having a much greater understanding of the condition and its dietary management and feeling equipped to make dietary changes to improve their health and that of their baby. An additional benefit of the group was that the mums-to-be, found it really useful to meet others going through a similar experience, which helped to manage their concerns. The diabetes team are looking to share this work at a Diabetes UK conference

- In terms of nutritional care in general, much work was undertaken during 2018/19 with improving nutritional management of patients with dysphagia. This included an introduction of International Dysphagia Diet Standardisation Initiative (IDDSI), new texture modified menus that are IDDSI compliant, and the launch of the 'Risk Feeding Guidelines' for managing patients where there are safety concerns regarding eating and drinking, and when artificial nutrition and hydration may not be suitable.

Speech and language therapy

- We developed and implemented a Trust-Wide Dysphagia policy
- We led a successful implementation of IDDSI across the Trust
- We worked with our partners in Education and Health across the Black Country to jointly secure £1.5M grant, on which Wolverhampton City Council are taking the lead, and the Trust is one of the key partners to develop and drive associated projects
- Training had commenced within the paediatrics teams to ensure all staff are trained to work effectively with bilingual and non-English speaking monolingual clients.

Priority 3: Patient Experience

The Trust is committed to working in partnership with patients, the public and local communities to ensure that its services are both relevant and responsive to local needs. We have established a variety of ways to gain feedback and seek patient opinion. This includes local and national surveys, Friends and Family Tests, PALS concerns, formal complaints, compliments and social media forums such as Patient Opinions and NHS Direct.

Listening and acting upon such feedback allows the Trust to improve its services to ensure we meet the needs of the patients.

The Trust knows that the experience of our patients is formed through every contact they have with our organisation, from the porter who helps them find the right ward, to the consultant who talks them through the next steps in their treatment. That means every member of staff has a responsibility to help provide the kind of care that the patients should expect.

The Trust knows that staff can only provide the quality of care expected if they work in an environment where they feel respected and valued, and are supported to deliver excellent care. The Trust's visions and values should be evident in everything we do, towards each other as colleagues/employees and to the patients and public we serve.

The Trust monitors and measures what people who use its services tell us about their experience. The Trust's quarterly patient experience reports capture feedback from engagement activities, PALS service, complaints, compliments and results from the Friends and Family Test (FFT).

How we performed in 2018/19

During 2018/19, the Trust had continued to focus on the holistic approach to patient experience recognising that a positive patient experience is not solely reliant on a good clinical outcome.

Several initiatives had been implemented which focused on improved processes, communication and inclusivity from a Equality, Diversity and Inclusion perspective.

These included:

- Having a patient voice heard at Trust Policy Group for every policy change ensuring that the patient is always at the centre of service change
- Undertook a comprehensive audit of the volunteer base, on a quarterly basis
- The Trust re-orientated its Service Re-design Team to focus primarily on supporting the continuous quality improvement programme
- By working with stakeholders, community groups and education facilities, the Trust has been promoting the benefits of volunteering to a younger audience. This supported the Trust's ambitions to broaden the current aging volunteer base
- Increased and established the Council of Members ensuring that members reflect the diverse population
- Patient facing staff have been given opportunity to receive basic British Sign Language training to help staff communicate in non-clinical, basic communication
- Raising awareness of patients from marginalised communities by the introduction of 'patient experience spotlight' articles. This included 'Ten tips to aid inclusion of people with learning disabilities'. The other three, 'The Missed Roma Community', 'Working with Transgender Patients and staff' and 'More than Words - Getting the most out of interpreting' will follow in 2019
- The recruitment of a data analyst to undertake more detailed analysis of the patient experience metrics at divisional level
- The triangulation of data from the various feedback mechanisms which is fed back directly to the area concerned in real time, allowing for any immediate remedial actions to be taken. Robust systems are now in place to evidence actions and improvements for lower performing areas
- A twice yearly audit of adult inpatient skill mix review to demonstrate the Trust's commitment to the National Quality Board (2016) which stipulates that patients have the right to be cared for by appropriately qualified, experienced /or competent staff in safe environments. The procedure for completing the review is aligned to Commitment 9 of Leading Change, Adding Value: a framework for nursing, midwifery and care staff (2016). In addition the Trust has started to progress actions required to be compliant with the developing workforce safeguards recommendations published by NHS Improvement in October 2018
- The New Nursing Strategy entitled the Nursing System Framework (NSF) was published in October 2018, which is based on six components including, Right staff, Team structure, Education Faculty, Excellence in care, Research and Technology and Communication.

There are specific outcomes for the nursing service to achieve which is monitored within the governance framework. There is research proposal that will evaluate any correlations of the strategy with patient outcomes

- Friends and Family Test (FFT) - the Trust remains above the national average for recommendation rates for Outpatients and some Maternity areas, as have the response rates for the Emergency Department, Inpatients & Day Case and Outpatients
- Further promotional work undertaken for FFT for paediatric services had seen an increase in the surveys undertaken and responses received with the paediatric Emergency Department and Children's Ward reporting recommendation rates of 96% and 100% respectively. The Trust's FFT provider have updated the paediatric locations on their system which will allow for additional surveys to be undertaken in each of these internal and external areas.

Complaints Management

The Trust continues to annually review its approach to complaints management to ensure that complaints are handled with sensitivity, timeliness and subject to a robust and thorough investigation and response. Formal complaints are managed in accordance with the relevant statutory regulations[4]. The Trust has continued to see improvement in the timeliness of complaint handling and informing the complainants of the progress of their complaint.

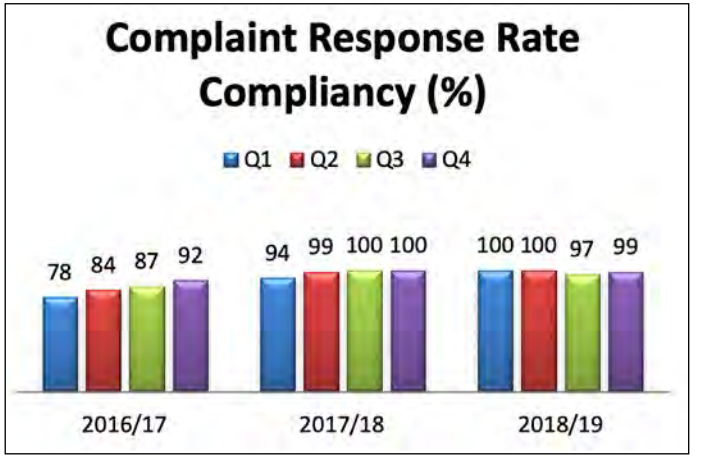
Key points for 2018/19 include:

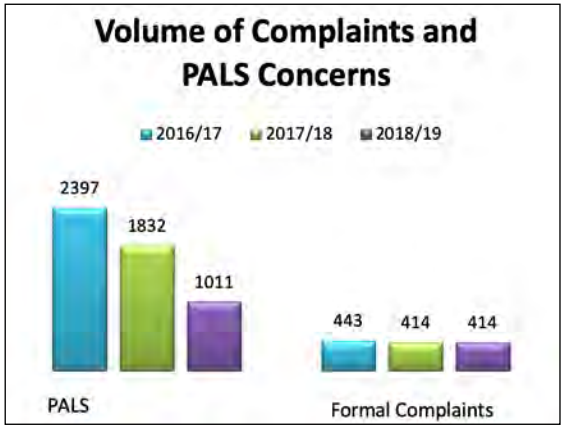
- A continued approach to compliance against policy with response times reaching 100% for six months
- Ensured that complaints resolution was timely and proportionate, and where possible, offering the complainant the option for early resolution through meetings and mediation
- 2018/19 had seen the same volume of formal complaints to the previous year, however the volume of PALS concerns raised had reduced from 1832 cases to 1011. This reduction had been achieved by a review of local processes and procedures and the implementation of a new telephony system allowing the appropriate allocation or signposting of patients' informal concerns
- Training and empowering front line staff to be more actively involved in early resolution of concerns
- The volume of complaints received for the year (414) represents 0.03% of the total volume of inpatient episodes, inpatient attendances and outpatient's attendances contacts for the year of 1,243,139.00 and it noted however that the reduction of PALS concerns has not had a direct negative affect on patients escalating to a formal complaint
- During the year there were 72 complaints which did not meet the safeguarding criteria section 42 and were subject to a complaint investigation, compared to 31 for year 2017/18
- 23 complainants were subject a full Parliamentary Health Service Ombudsman (PHSO) investigation. This represents 5.5% of the total of complaints received. Pleasingly this is an indication of the thoroughness of the response letters provided and of the remedial work undertaken to bring complaints to a resolution satisfactory
- In terms of the outcomes of PHSO investigations closed during the year (17 cases), it is noted that no cases were fully upheld and 47% of cases considered were not upheld. A financial redress of £1750 was noted in relation to 1 complaint (partly upheld). No other financial redress was awarded during the year.

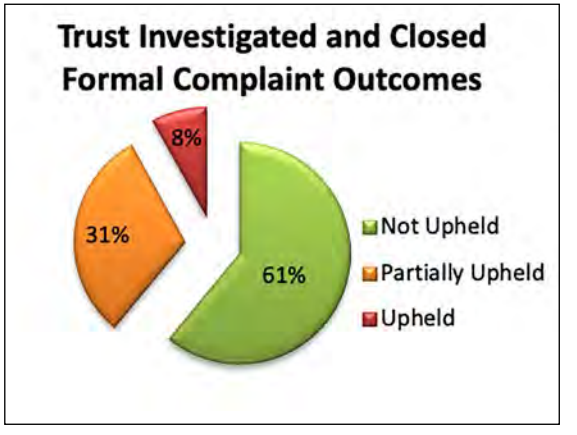
[4] http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf

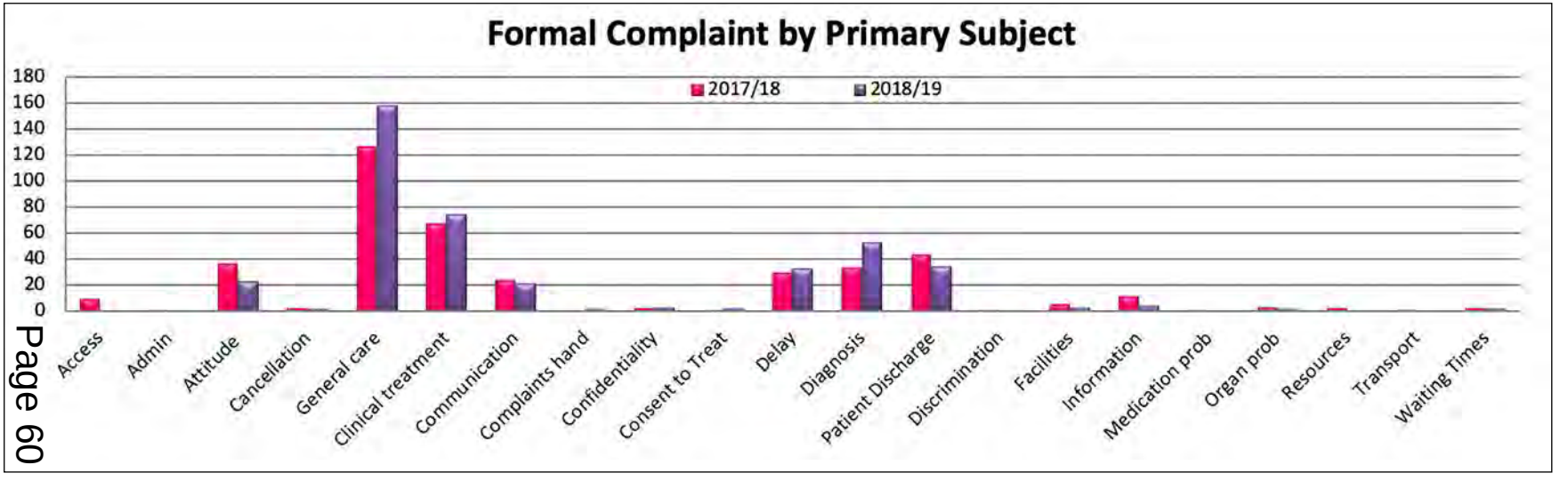
There is little variation between the key themes of complaints year on year, with the highest subjects being, general care of patient, clinical treatment and diagnosis.

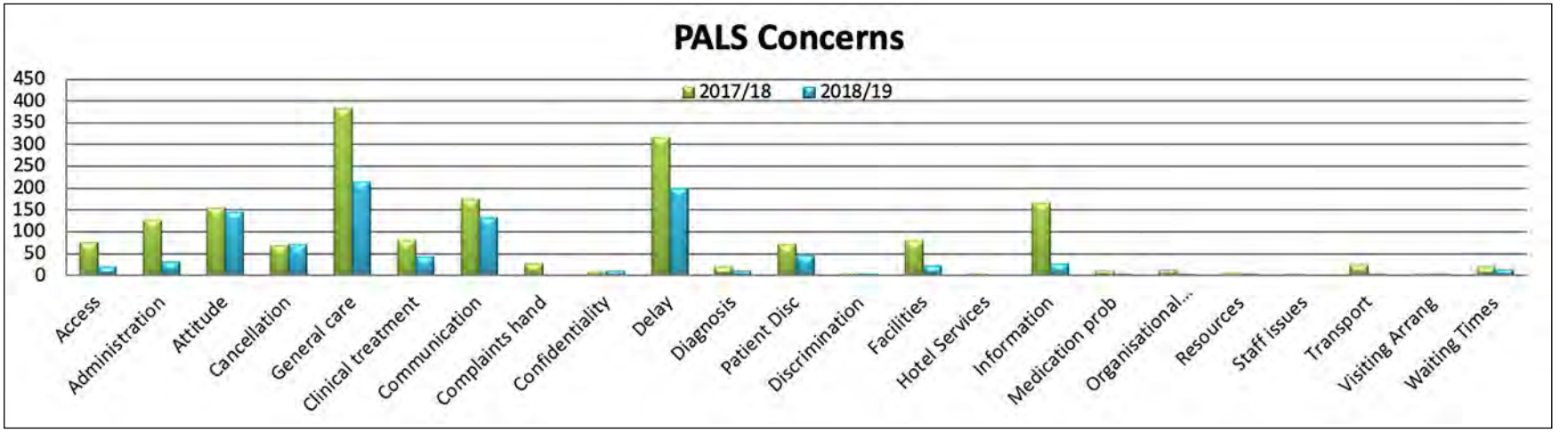
However there was a reduction in complaints relating to communication, information and cancellation. This can be seen as a positive indication that care and treatment being received is appropriate and meets the needs of our patients, and demonstrates that the Trust is effectively managing patients' expectations.








Formal Complaint by Primary Subject
2017/18
2018/19
180
160
140
120
100
80
60
40
20
0
Access
Admin
Attitude
Cancellation
General care
Clinical treatment
Communication
Complaints hand
Confidentiality
Consent to Treat
Delay
Diagnosis
Patient Discharge
Discrimination
Facilities
Information
Medication prob
Organ prob
Resources
Transport
Waiting Times


PALS Concerns
2017/18
2018/19
450
400
350
300
250
200
150
100
50
0
Access
Administration
Attitude
Cancellation
General care
Clinical treatment
Communication
Complaints hand
Confidentiality
Delay
Diagnosis
Patient Disc
Discrimination
Facilities
Hotel Services
Information
Medication prob
Organisational...
Resources
Staff issues
Transport
Visiting Arrang
Waiting Times

The Friends and Family Test (FFT)

The FFT provides patients the opportunity to submit feedback to the Trust by using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they would recommend the service to their friends and family if they needed similar care or treatment. Results of these surveys are received monthly and shared at directorate, divisional and Trust Board level in the form of divisional dashboards.

Throughout the year, the Trust had considered where there are gaps in surveying patients and worked with the provider to improve the feedback for those areas.

Improvements included:

- Timely and accurate real time feedback direct to ward level automatically, providing the ability to consider the feedback and make instant actions to improve the patient experience
- Continuation of hand held devices used to capture FFT responses in real time on wards
- Monthly metrics were analysed and the lowest five performing areas for response and recommendation rate were targeted with direct work for improvement
- Whilst the Trust had seen a fluctuation in recommendation rates over the year, it is pleasing to note that the response rates are much higher than the national average for most key areas, and the recommendation rates are higher than the national average for Outpatients and Birth. Further work is required with other key areas (ED and some inpatient areas) to target with improvement tools
- Some key areas may find it difficult to attract survey responses due to the nature of the patient, e.g. patients with dementia, elderly. The Trust met with its FFT provider to ascertain other methodologies for such areas. This includes agent calls and automated telephone surveys
- There had also been difficulties with maternity systems and 'touch points' for survey reporting, however a new system has been implemented and configuration is underway for the automatic transfer of data for all touch points to be delivered ensuring higher level of responses
- An increase in participation within the Paediatric Emergency Department and Children's Ward reporting recommendation rates of 96% and 100% respectively. The Trust's FFT provider had updated the paediatric locations on their system which allows for additional surveys to be undertaken in each of these internal and external areas.

Patient and Public Engagement and Co-production

The Trust is in the process of developing a 3 year strategy for Patient Experience, Engagement and Public Involvement, which will identify the benefits of local engagement, and provide a framework to achieve our objectives. The Trust is committed to the people of Wolverhampton, Cannock and the Black Country being involved at the heart of our work and decision making. The Trust will continue to listen and act upon individual and carer feedback to help inform and shape the services we provide and the experiences and aspirations of our patients.

Initiatives for the year had included:

- Patients and carers were encouraged to express how it feels to receive care from the Trust by the sharing of their 'Patient Stories'. Such stories provided the Trust with an opportunity to learn as an organisation, bringing experiences to life and making them accessible to other people. They can, and do, encourage the Trust to focus on the patient as a whole person rather than just a clinical condition or as an outcome
- In July 2018, the Trust participated in a job fair for people with a health condition or disability at Wolverhampton Job Centre.
- The Council of Members, established in 2017, had continued to make strides by working together more effectively as a group and as individuals contributing to initiatives and meetings at the Trust. This group of committed individuals from our local community was part of key work streams, for example:
    - The Policy Group Committee and the Equality and Diversity Steering Group
    - Supporting the hospital with the design of a new Bereavement Centre
    - Participating in PLACE assessments to assess the quality of the patient environment
    - Contributing to a stakeholder panel to recruit a new Chair for the Board of Governors for the Trust.

They had been fundamental in ensuring that the patients' views are always considered in the way in which we shape our services. The group meet on a regular basis and have now produced their own Council of Members Newsletter informing others of the various work streams they are part of. A new work plan has been developed for the forthcoming six months.

Volunteering

The Trust is fortunate to have the support of volunteers, who are unpaid members of our local community who offer their time willingly to help.

As always, the Trust holds provision of a positive patient experience at the forefront of its volunteering activity, and we aim to place volunteers into roles which complement, but do not replace, paid members of staff. Volunteers add an important additional factor to helping the Trust provide a positive patient and visitors experience at the Trust.

Volunteer services had seen a successful year achieving many of its objectives and a busy period for volunteer recruitment with new volunteers joining the organisation during 2018/19 in a variety of roles.

What we set out to achieve:

- More focus with recruitment of younger volunteers in the Trust, as statistics show this group is under represented
- Improving communication with our volunteers and reward initiatives
- Increasing volunteer support with uptake of patients Friends and Family Test
- Improving our collection and storage of volunteer data
- Streamlining processes and the way we work with our stakeholders

Achievements have included:

- Renewed focus with recruitment of younger volunteers, as statistics showed that this group was under represented. The Trust has now offers a supportive programme for younger volunteers, which provides regular reviews and one to ones to discuss their volunteer placements and offer interventions when there are challenges
- The collection of case studies of successful placements involving young volunteers. One of the Trust's successes included the creation of a film about two of our young volunteers and which was shown at the Charity and Volunteer Awards ceremony in November 2018
- Communication with our volunteers had been improved and reward initiatives introduced. The Trust held a consultation event in November 2018 with Patient Experience volunteers at New Cross Hospital. Following this consultation, the Trust developed a quarterly volunteers liaison forum, and held a coffee morning Christmas drop in session
- Trust volunteers had been instrumental in helping with uptake of patients undertaking the Friends and Family Test to ensure inclusivity. Particular areas of focus included, ophthalmology outpatients, maternity, care of the elderly and dementia wards.
- We had improved our collection and storage of volunteer data
- We had streamlined processes and the way we work with our stakeholders. As there are many volunteer involving organisations within the Trust that sit under the volunteering umbrella, we developed a toolkit for recruiting and managing staff to be able to recruit their volunteers to ensure compliance with Trust's procedures, returning their checklist when completed to volunteer services for data collection.

Equality, Diversity and Inclusion

As an employer for, and a provider of, health services in Wolverhampton, Cannock and surrounding areas, the Trust takes the matters of fairness, rights and equality very seriously. The Trust does not only observe equality and diversity principles because it is required to, but because it recognises the importance of instilling these values as part of our culture. The Trust recognises that they greatly improve its ability to provide the services that the Trust provides. The Trust will continue to develop its staff and to strive to ensure accessible services for everyone in its communities.

The Trust is fully committed to embedding equality, diversity and inclusion across workforce and service provision. The Trust understands that its diverse workforce is its greatest asset, and as a result it continues to create and maintain working environments in which people are valued, able to reach their full potential and flourish. This in turn will help the Trust to deliver high quality accessible services that are truly inclusive.

Equality is part of the Trust's values framework, through which the Trust ensures that all staff receive training in the subject. In addition, the Trust uses equality analysis and equality and diversity is embedded into its policies. The Trust uses the Equality Delivery System to record and evidence the work undertaken and the Trust's equality objectives are published on a regular basis.

The Trust is consistently looking for opportunities to engage with its communities, to help us to plan and deliver services in a fair and equitable way.

Services that treat people fairly, with respect, care, dignity, compassion and that are flexible, should improve the overall patient experience and health outcomes of the diverse population that we serve. Everyone should feel confident when accessing our services or joining our workforce that we are committed to eliminating discrimination, bullying, harassment, victimisation and that we promote equality, diversity, inclusion and fairness.

The Trust is committed to continue building on a culture of openness and transparency and this includes capturing, reporting and acting on a range of equality related information. By analysing this information, the Trust is able to identify possible issues of inequality and to seek to address them; specifically for people who have personal protected characteristics as defined by the Equality Act 2010.

A range of equality information is available within various reports which are published on the Trust's website and the trust publishes an Annual Equality, Diversity and Inclusion Report.

Key initiatives during 2018/19 included:

- Equality, Diversity and Inclusion training package: This mandatory e-learning package called 'A brief introduction into Equality, Diversity and Inclusion Level 1 (including Bullying and Harassment)' was launched in November 2017. As at 31st March 2019, 6730 employees (linked to an employee record) completed this package. NB: It is recognised that some people may have accessed this package more than once
- Trust Induction: This is a mandatory session at Trust Induction and was implemented in June 2017. The session is entitled 'Brief Introduction into Equality, diversity and Inclusion (including Bullying and Harassment)'. As at 31st March 2019, 1680 employees (linked to an employee record) have completed this training
- Learning Disabilities (LD): The Trust's All Age LD strategy was launched in January 2018. The strategy will support staff who have contact with patients with learning disabilities, to enable them to deliver care appropriate to the individual needs of the patient. To support this, the learning disability core care plan has been ratified and is now in use in addition to the LD Hospital Passport which is routinely offered in some areas for pre-op assessments. The Children's Health Passport is currently being piloted
- The Trust has a year-long programme of Equality and Raising awareness events in place to further develop a culture of inclusivity.

A number of employee voice forums had taken place during 2018/19, including Young Persons' Forum, Disability Forum, BAME Forum, Male Nurses group, Armed Forces Veterans and Reservists support groups. In addition, the Trust held 'Living Well' events to include healthy living and financial wellbeing support

- The Cultural Ambassadors have been in these roles for 12 months and a formal evaluation of the success of these roles will be undertaken in early summer 2019
- EDS2 goals 3 and 4 relate to the workforce and have been self-assessed and reported to CQC and CCG. All outcomes are incorporated within the Trust's Annual Equality, Diversity and Inclusion report. The Trust's self-assessment rating remains at the 'developing' stage, recognising the large agenda and the need for continuing development and learning
- Engagement in local and regional networks, for example: Wolverhampton City Council Covenant Board, network events with Health Education England, Inclusion and Leadership events, presentation at regional Freedom To Speak Up event on the Trust's Every Voice Matters campaign

The Trust is fully sighted on the challenges ahead, however has commenced its journey towards inclusion. The Trust is fully committed to making a difference to its workforce and to the people it serves with respect of equality, diversity and inclusion.

Seven Day Services

The Trust is currently compliant with priority standards 2 (review by Consultant within 14 hours of admission), 5 (7 day access to diagnostics) and 6 (7 day access to interventional procedures). The performance against standard 8 was not achieved during 2018/19. This standard requires that all emergency patients are seen daily. The Trust is aware of the areas of non-compliance and has identified actions with improvement expected by March 2020.

These actions include improving documentation, recruiting to consultants in Care of the Elderly and Urology and to work within the Sustainability and Transformation Plan (STP) system to redesign Ear, Nose and Throat (ENT) consultant rotas. Well-resourced systems, including adequate job planning, should mean that more than 90% of patients are reviewed daily by a consultant.

Patient experience element remains consistent across the 7 days. In addition, a pilot junior doctor experience survey was conducted which suggested overall satisfaction with working arrangements at the weekend.

The Trust has adopted the NHS Improvement's Board Assurance Framework for Seven Day Hospital Services including submission of a report on progress and actions to Trust Board.

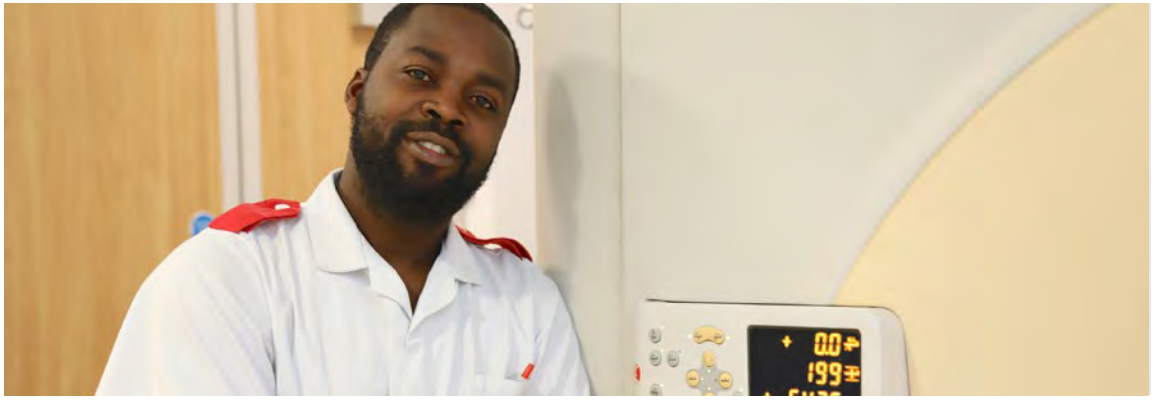
Areas of focus during 2018/19 will include, strengthening of the junior doctor rota on the medical wards at weekends, and the commitment to high quality handover by publication of a policy on medical handover.

PLACE Inspections

Patient Led Assessments of the Care Environment (PLACE) offer a non-technical view of buildings and non-clinical services. It is based on a visual assessment by patient assessors.

The assessment falls into 6 broad categories:

- Cleanliness
- Condition, appearance, maintenance
- Food
- Privacy, dignity and wellbeing
- Dementia
- Disability



The details for the inspection process were as follows;

Site	Date	No. of Patient Assessors	Number of Staff	Number of Wards Inspected	Number of Outpatient Areas Inspected	Number of Food Assessments Undertaken
New Cross	15/03/2018	16	10	11	10	5
West Park	25/04/2018	5	3	3	2	2
CCH	10/04/2018	8	4	2	6	2

The inspection process was led by the patient assessors supported by a staff member acting as scribe. Each team comprised of 50% patient assessors as a minimum.

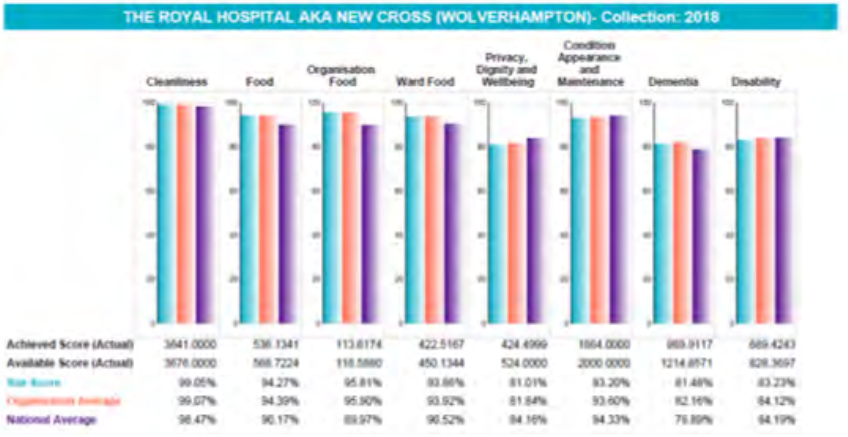
The patient assessors had received training on how to conduct the inspection and it was made clear that it was their opinion, and not the staff members, that would be documented and submitted.

The inspection process was not a technical audit; this is the patient's perception of the environment based on the training given to them.

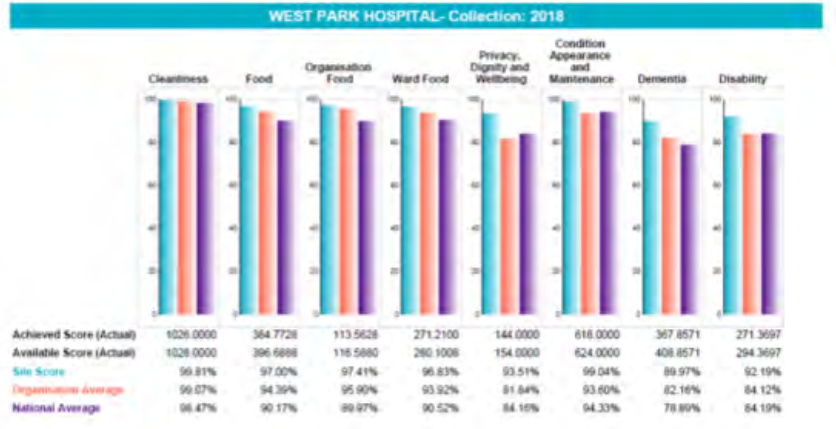
The scoring is clear and in most cases was either a pass (2 points), a qualified pass (1 point) or a fail (no points).

The site score is in blue; National average is in purple and organisational average in red.

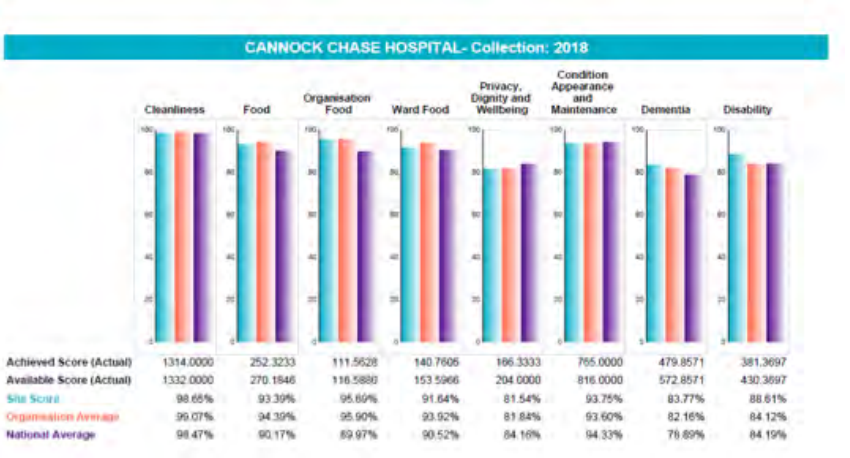
Results - New Cross



Results - West Park



Results - Cannock Chase Hospital



The organisational average scores across six of the eight domains was higher than the national average.

New Cross scored higher across all eight domains compared to 2017 results.

West Park scores were above the national average in all eight domains.

Cannock Chase Hospital scored above the national average in six of the eight domains.

Following receipt of the results from 2018, the Trust Environment Group have developed an action plan to deliver improvements to the general hospital environment for our patients.

Primary Care

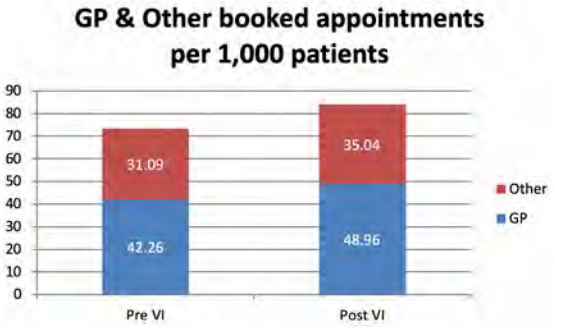
As of the 1st April 2018 Primary Care Services will be embedded as business as usual within the Trust and will be part of the newly formed Division 3. This demonstrates the Trust's commitment to the integration of Primary Care and will ensure that the service is able to flourish and build on the success to date.

From the very outset of the VI programme, the objectives were to have:

- Better Patient quality, outcomes & satisfaction
- Better access to GP services for patient services
- Better communication between GP Practices and the hospital to help enable better care
- Better use of integrated data and systems to help enable better care to be provide.

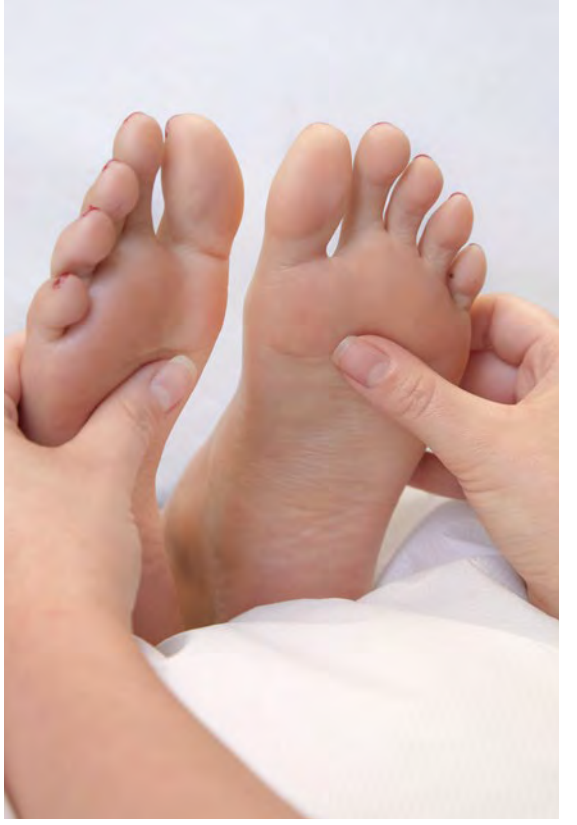
Appointment access data

Improving access to patients is important to the Trust, and we strive to ensure that patients have the access they need at the right time with the right clinical staff. The information below demonstrates continued improvement in booked appointments for our patients.



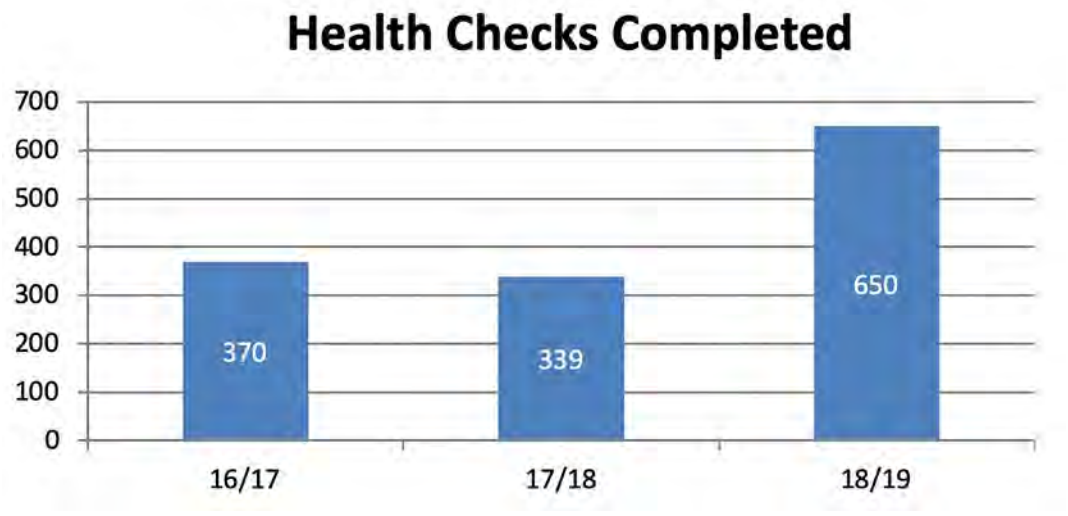
The table above demonstrates booked appointments by practice per thousand patients during the financial year 2018/19:-

	2016/17			2017/18			2018/19 as at 11/03/2019		
	GP	Other	All	GP	Other	All	GP	Other	All
Alfred Squire	41.78	49.39	91.17	50.99	53.54	104.53	54.86	60.67	115.52
Coalway Road							47.27	20.22	67.5
Ettingshall	34.27	31.07	65.34	25.13	37.01	62.14	47.16	30.55	77.71
Lakeside	42.03	59.15	101.18	27.85	72.99	100.83	37.47	73.42	110.89
Lea Road	43.88	31.07	74.94	53.32	33.01	86.33	55.92	39.89	95.82
Penn Manor	46.00	37.56	83.57	48.23	44.5	92.73	51.47	43.08	94.56
Thornley	40.49	18.67	59.15	37.12	16.44	53.56	35.76	17.64	53.4
Warstones	59.00	30.3	89.9	57.62	35.58	93.2	72.5	39.79	112.3
West Park	39.26	15.06	53.99	59.99	27.4	87.4	69.61	30.13	99.74
Average for year	**43.34**	**34.03**	**77.41**	**45.03**	**40.06**	**85.09**	**52.45**	**39.49**	**91.94**



Health checks

The diagram below demonstrates the Trust's completed health checks for our patients. The number of appointments has been doubled and has improved our national score, which is excellent demonstration of our success.



GP Patient Survey results

Since the last quality account publication, the content of the GP patient survey was changed significantly to reflect changes in the delivery of primary care services in England. In addition, the sample frame was extended to include 16-17 year olds for the first time to improve the inclusivity of the survey. These changes meant that it was necessary to consider the likely impact on comparison on survey estimates when looking at trend data. Following the assessment of the impact, the analyses suggests that comparison with previous years would be unreliable for the majority of questions at national level (and for all questions at CCG and practice level) even where question wording remained similar, and have informed the decision not to present trend data in the GP patient survey outputs for the 2018 publication. This information is based on the NHS England's narrative pertaining to this survey.

	Jul-16	Jul-17	Jul-18	Local CCG Average	National Average
Through to surgery phone	71.00%	76.40%	72.56%	66.00%	70.00%
Receptionists are helpful	86.60%	89.40%	89.44%	87.00%	90.00%
Patients satisfied with GP appointment times available			66.44%	65.00%	66.00%
Speak/See preferred GP	53.60%	57.60%	44.67%	47.00%	50.00%
Got an appointment the last time they tried contacting the surgery	82.60%	84.20%			
Last appointment was convenient	90.20%	80.40%			
Patients offered choice of appointment			57.11%	57.00%	62.00%
Patient satisfied with type of appointment offered			73.56%	70.00%	74.00%
Patient took the appointment they were offered			91.89%	92.00%	94.00%
Experience of making an appointment was good	73.80%	76.40%	65.56%	64.00%	69.00%
Wait 15 mins or less for an appointment	64.40%	67.80%	69.67%	69.00%	69.00%
Last Healthcare Professional they saw or spoke to gave them enough time			85.56%	83.00%	87.00%
Last Healthcare Professional they saw was good at listening to them			87.00%	85.00%	89.00%
Last Healthcare Professional they saw was good at treating them with care and concern			84.67%	83.00%	87.00%
Last Healthcare Professional they saw involved them in decisions about care			91.33%	90.00%	93.00%
Confidence and trust in the last Healthcare Professional seen			95.44%	93.00%	96.00%
Healthcare professional recognised or understood any mental health needs			85.44%	83.00%	87.00%
Felt their needs were met during their last general practice appointment			94.89%	93.00%	95.00%
Enough support from local services or organisations in the last 12 months for LTC			87.11%	74.00%	79.00%
Feel they do not need to wait to long to be seen	60.80%	62.80%			
Last GP saw or spoke to gave them enough time	90.80%	92.80%			
Last GP they saw was good at listening to them	92.80%	94.00%			

Last GP was good at explaining tests and treatments	86.80%	92.60%			
The last GP involved them in decisions about care	80.80%	88.40%			
Last GP was good at treating them with care	86.00%	91.00%			
Confidence in the last GP they saw	93.40%	97.20%			
The last nurse gave them enough time	81.40%	93.20%			
Last nurse was good at listening to them	81.80%	93.80%			
Last nurse was good at explaining tests	79.20%	91.60%			
Last nurse was good at involving them in discussions around care	70.80%	90.00%			
Last nurse treated them with care and concern	79.40%	91.80%			
Confidence and trust in the last nurse	85.80%	98.80%			
Satisfied with surgery's opening hours	79.00%	80.80%			
Overall experience as good	90.80%	92.20%	84.11%	79.00%	84.00%

We continue to monitor performance and quality through audits, scorecards, regular meetings, datix and evaluating what that data captures. This enables us to identify key themes and trends to encourage us to think differently on how we can continue to improve on our outcomes.

As part of our commitment for transparency we share our information with our teams, directorate and division through our performance and governance meeting structures to provide quality assurance. This shared learning offers further opportunities to provide the quality assurance.

Following a tender process, the Alternative Provider Medical Services (APMS) contract for Ettingshall GP Practice was awarded to Health and Beyond. The new contract will commence under Health and Beyond on 1st April 2019.

The CQC inspected 7 of our practices during 2018/19 and overall ‘Good’ rating was achieved for all. One remaining practice inspection is pending.

A number of schemes trialling new ways of working are currently underway including: the In-hours visiting service whereby Advanced Nurse Practitioners undertake triaged home visits rather than GPs; the Atrial Fibrilation pilot that uses the Kardia mobile device and new technology to streamline appointment time and use of the device during Pharmacist reviews; and increasing the role of Pharmacists within Primary Care.

Continuous Quality Improvement 2018/19

Use of the CQUIN payment framework

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) Payment Framework.

CQUINs enable the organisation to focus on the quality of the services delivered, ensuring that the Trust continuously improves and drives transformational change with the creation of new, improved patterns of care. These will impact on reducing inequalities in access to services, improve patient experiences and the outcomes achieved. CQUIN initiatives are owned by identified service leads, who develop action plans with support from the contracts team to ensure the required changes are delivered.

CQUINs are agreed during the contract negotiation rounds with input from clinical leads and Executive Directors including the Chief Operating Officer and the Deputy Chief Nurse. Any areas of clarification or concern are highlighted to Commissioners during this negotiation period to ensure the CQUIN requirements are relevant and achievable to the organisation.

Review of 2018/19:

For the first time, NHS England published a number of two year schemes (2017-19) with the aim of providing greater certainty and stability on the CQUIN goals, leaving more time for health communities to focus on implementing the initiatives. The CQUIN schemes are intended to deliver clinical quality improvements and drive transformational change. The table below details CQUIN delivery for 2017-18 where two year schemes are in place.

What we set out to achieve:

The 2018/19 schemes are outline below and where applicable performance against 2017/18 requirements has been provided.

Please note that the data in the table below relates to the 2017/18 performance due to the 2018/19 not being available at the time of publication.

CQUIN Indicator Name 2017-19	Description	Achievement 2017/18
Introduction of health and wellbeing		
(Staff Survey)	Improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. Outcomes are monitored via the National NHS Staff Survey.	0%
Healthy food for NHS Staff, visitors and patients	Providers are expected maintain the step-change in the healthy food provision required in 2016-17 and to introduce additional changes to continue the reduction in high sugar, salt and fat food content.	100%
Improving uptake of Flu Vaccinations for Front line clinical staff	The CQUIN aims to achieve 70% uptake of Flu Vaccinations of frontline staff.	50%
Timely identification and treatment for sepsis in ED and acute inpatient settings	This CQUIN assesses timely identification of patients who present with severe sepsis, red flag sepsis or septic shock and were administered intravenous antibiotics within the appropriate time-frame.	67.5%
Reduction in Antibiotic Consumption	Following on from 2016-17 the aim is a further 1% reduction in the use of antibiotics across the Trust.	66%
Empiric review of antibiotic prescriptions	This monitors the percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours. Ensuring appropriate monitoring of antibiotics usage and supporting the reduction antibiotic usage.	100%
Improving Assessment of Wounds	The aims to increase the number of full wound assessments undertaken in patients who have wounds which have failed to heal after 4 weeks.	100%
Personalised Care and Support Planning	The purpose of this CQUIN is to embed personalised care and support planning for people with long-term conditions. This will support people to develop the knowledge, skills and confidence to manage their own health and wellbeing.	100%
Secondary Dental Electronic Referral Management System (2018/19 only)	Implementation of Dental Electronic Referral Management System. This system allows General Dental Practitioners to refer all patients electronically into secondary care.	N/A
Bowel Cancer and Bowel Scope Screening	Improve access and uptake through patient and public engagement.	100%

Cost Effective prescribing of Recombinant Factor VIII Products for Haemophilia A patients (2018/19 only)	Optimising the use and management of medicines is a significant and realisable opportunity within the NHS and the Carter Review highlighted a high level of variation in use and medicines management costs which could be re-invested to support sustainable service delivery. This CQUIN relates specifically to Factor VIII blood products for Haemophilia A patients.	N/A
Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)	It is intended that all NHS England commissioned providers of chemotherapy move to prescribing a range of drugs in accordance with a nationally approved set of dose tables.	100%
Medicines Optimisation	This CQUIN has been designed to support Trusts and commissioners to realise benefits through a series of modules that improve productivity and performance related to medicines. The expectation is that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions.	91.5%
Paediatric Networked Care	This scheme aligns to both the national Paediatric Intensive Care Unit service review and the West Midlands review of Paediatric Critical Care services. Both work streams require delivery of robust information in order to understand the existing flows of care and meaningfully scope potential for change. In order to ensure delivery nationally it is expected that providers within a region should form a network of care, with Paediatric Intensive Care Unit providers taking on leadership.	100%
Neonatal Community Outreach	To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for Neonatal critical care beds and to enable reduction in occupancy levels.	100%

Final outcomes for 2018/19 will not be available until late May 2019 when final reconciliation has been completed.

Progress of the CQUIN programme is monitored via the Contracting and Commissioning Forum chaired by the Director of Strategic Planning and Performance. Any areas of concern or risk are discussed at this forum and actions identified for mitigating or escalating the risks. Financial progress is monitored via the Finance and Performance Committee.

Quarterly submissions are made to Commissioners via the Contracts Team which includes the data as specified within the CQUIN milestones and any additional evidence which provides assurance that the goals outlined within the CQUIN have been achieved.

These reports are collated and submitted to all Commissioning bodies where CQUIN schemes have been agreed. These reports are scrutinised and where needed additional clarification is requested from the Trust before the Commissioners provide feedback as to levels of achievement.

During 2019/20, the Trust will implement and embed its refreshed approach for driving continuous quality improvements across the organisation.


PHILIPS

Looking forward 2019/20

PRIORITIES

for Improvement

Workforce

Safe Care

Patient Experience

Priority 1 – Workforce

The availability of workforce, both nationally and locally, is challenging in terms of meeting the demand. Although the Trust has performed well in attracting more staff, this challenge will continue to be a key issue. As a result, it will be important to look at the development and utilisation of new roles, as well as ensuring that the Trust maximises the use of current roles. To this end, the Role Development Steering Group will provide focus and an organisational steer to achieve our objectives and ensure that the Trust progresses actions to comply with the Developing Workforce Safeguards recommendations published by NHS Improvements (2018).

The key areas of focus will include:

- The development and utilisation of new roles
- Workforce planning
- Future Trust's workforce model
- Governance arrangements associated with workforce.

The Trust's ambition is that we will enable our staff to be the best they can be in their chosen career. We will continue to explore and develop new roles, including widening our offer of Apprenticeships across the organisation, which will support care delivery that will be required by our patients in the future.

At the same time as enabling our staff, the Trust recognises that it needs to retain its workforce within the NHS, but more importantly within the Trust. In 2019/20, the Trust will have a particular focus on this topic and will be looking at how our offers of employment can be as flexible as possible to match the requests of the staff. This should support our staff that may be approaching their retirement age and would look for a different offer in their employment or those who may require a flexible approach to their working patterns for other reasons. This in turn should benefit our patients by retaining a highly skilled and experienced workforce.

Nursing Workforce

There remains a shortage of nurses nationally and applications to undertake nurse training remain on a downward trajectory. The Trust continues to work in partnership with Higher Educational Establishments to recruit the right students with the right attitude, retain students on the training programme by providing high quality placements, employ students upon completion of the course, demonstrating commitment to 'home grown' and invest and offer educational opportunities and career progression to retain the talent within the Trust to provide safe and effective care to patients. The Trust has widened its partnership with other Higher Educational Establishments and increased the number of students in terms of placement provision.

In terms of Healthcare Assistant recruitment, the Trust has set an aim to have a minimum of 95% of Healthcare Assistant in posts recruited at any one time.

The Trust is utilising the apprenticeship programme as a core nursing recruitment initiative to support our pipeline, as these programmes are providing a career pathway for development, add diversity to our workforce, which reflects the communities the Trust serves and provides a further entry route into a nursing profession. In line with the national agenda to increase Nursing Associates, the Trust will continue Apprentice Nursing Associate programme with a further cohort planned to commence in September 2019.

The Trust has developed a career framework for nursing and this has provided a baseline on which to modify and enhance our educational offers for our staff, to ensure they are equipped with the right knowledge and skills.

To attract new staff, the Trust has introduced a Clinical Nursing Fellowship programme for both international and UK registered nurses. This will add a breadth and depth to our workforce as these staff will have the opportunity to use their clinical skills whilst also studying for degree or master level study. As part of the international registered nurse recruitment, a specific project has been set up to recruit 30 registered nurses from the Philippines.

The Nurse Education Team is currently updating the development opportunities for staff in line with the draft career framework. This includes specifically:

- Aspiring Band 6 development programme for the nursing staff wishing to become a junior sister
- Aspiring Band 7 programme for the staff wishing to take the next step into a Band 7 role. This programme is currently being reviewed
- The preceptorship programme is aimed at newly qualified nurses, midwives and Allied Health Professionals to support them through their transition from student to registered practitioner. This programme has been revised following consultation with members of the faculty and members of staff across the Trust. The new programme is designed to meet the needs of professionals from different professions and also to meet the needs of the service.

The Trust has listened to the views of its stakeholders and partners, and during 2019/20 we will focus on further developing our current and future workforce. A joint workforce working group has been established with membership from the Trust and the City of Wolverhampton Council (CWC) representatives. The key priority areas of focus will include:

- Scoping potential for developing career opportunities for young people and those who are care experienced, working collaboratively with external partners such as the Prince's Trust
- Establishment of joint jobs recruitment fair
- Maximising employment opportunities for people with disabilities
- Enhancing digital media sharing
- Continuing to promote and support apprenticeships.

In addition, we have established and are developing further our Employee Voice approach "Every Voice Matters" which includes groups/forums such as Young Persons, lesbian, gay, bisexual, and transgender (LGBT), disability, black, asian, and minority ethnic (BAME), Armed Forces Reservists, Veterans and their families, and we are working collaboratively with our partners in holding events and including communicating shared learning.

Priority 2 – Safer Care

The Trust will continue to focus on driving improvements in safe care and maximise learning opportunities to continuously improve patient care and experience. During 2019/20, the focus will be on the following specific areas:

Falls

A range of quality improvement projects will be evaluated to determine the next steps to a further sustainable reduction in falls. As a minimum these will include:

- Enhanced education on patient teaching
- Improved lower leg assessment
- Improving access to walking aids
- Reducing outpatient department falls
- Introduction of an annual falls audit.

Preventing Infection

The Trust will continue to work effectively with colleagues in primary, secondary and social care to develop work streams and individual projects that will deliver the objectives of the Trust and our Clinical Commissioning Group (CCG).

A detailed annual programme of work has been developed, which includes the specific projects below:

- A strategy for reduction in gram negative bacteraemia (in particular E.coli) through a range of measures
- Robust prevention and management of MRSA, MSSA and Carbapenemase Producing Enterobacteriaceae
- Continued focus on the environment and sustaining improvements
- Influenza preparedness and prevention for patients and staff
- Improving compliance of uptake of the influenza vaccination for healthcare workers
- Implementing the OneTogether audit tool across all theatre environments to include assurance of adherence to NICE guidance
- Strengthened education delivery to include forging links with the University of Wolverhampton
- Sustain *Clostridium difficile* reduction with a lower tolerance of individual cases
- Increased awareness of antimicrobial resistance through delivery of an Antimicrobial Stewardship Programme
- Further reduction in device related bacteraemia both in the Acute and Community settings
- A strategy for reducing the use of urinary catheters
- Health and social care systems will work jointly to identify and reduce the risk of spread of tuberculosis
- Sepsis team will help drive early recognition and management of sepsis at ward level and support a cultural shift across the organisation and contribute towards reducing the number of preventable deaths due to sepsis
- Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data
- Develop an infection prevention and control system in the wider healthcare community setting, to include care agencies and hospice settings
- Expand research activity of the Infection Prevention and Control Team
- Sustain the Trust's excellent reputation for Infection Prevention and Control through team members' participation in national groups and projects.

Venous Thromboembolism (VTE)

During 2019/20, we will continue to focus our efforts on achieving compliance against the national standard for 95% of patients to have received a VTE risk assessment within 24 hours of admission.

Commencing April 2019, VTE clinical prevention audits will be undertaken via the health assure system. This will provide instant audit results to individual clinical areas and allow the VTE nurse to provide immediate feedback and recommendations for any actions.

We will continue to work towards linking VTE risk assessment to prescribing through the electronic prescribing system (EPMA).

A review of the VTE resources is planned and we will look for additional opportunities to improve patient safety and patient experience.

This will be underpinned by a comprehensive improvement plan which will be overseen by the VTE multi-disciplinary group.

Pressure Ulcers

The tissue viability strategy is due for renewal in June 2019 and an associated 3 year plan will be produced, to enhance further opportunities, to prevent avoidable wounds and improve healing rates. The strategy will also link to the national wound strategy.

In addition to this, in the coming year, the Tissue Viability team plan to:

- Review all wound care pathways as NHS supply chain contracts are confirmed for specific categories of wound products
- Identify sustainable pressure ulcer prevention strategies and to formulate a quality improvement plan
- Analyse moisture associated skin damage incident data and ensure that areas for improvement are included in the overall improvement plan
- Launch all new formulary pathways
- Evaluate a post operation wound pathway
- Design a Pilonidal sinus pathway and cavity wound pathway
- Analyse healing rates and review chronic wound caseloads managed by Adult Community Services
- Work collaboratively with the CCG to design a wound care centre of excellence for planned ambulatory wound care.
- Continue to support staff with education and training to prevent and heal wounds
- Plan the third wound prevention conference.

Sign up to Safety

Following the closure of the Sign up to Safety Project Group in October 2018, it has been agreed with the Compliance Oversight Group (COG), to provide a one year on report of outcomes in October 2019. Mid to longer term outcomes/KPIs for the project will be assessed after twelve months. The group has also agreed to produce a project report to include the project journey and activity; and to include current results of team diagnostics. To support sustainability, a proposal will be developed to consider the provision of TOM as an ongoing programme within the Trust.

Medication Errors

The Trust will continue to monitor medication incidents and share learning during 2019/20.

The key areas of focus will include:

- Revisit Patient Safety Alerts which have previously been published and assess the Trust's current performance against the alerts, and introduce regular audits where indicated
- Set up a 'Medication Safety Page' on the Trust's intranet to provide links to published patient safety alerts, MHRA drug safety information and medication safety initiatives
- Aim to reduce missed or omitted doses of antimicrobial agents by audit of patient drug charts, and provision of information and learning to clinical teams.

Sepsis

All healthcare professionals at the Trust have a responsibility and are accountable for ensuring patients with sepsis receive high quality and timely care.

Looking forward in 2019, we would like to embed a proactive culture in sepsis education and its early diagnosis and management. We aim to achieve that with our ongoing sepsis teaching and awareness programme.

"Sepsis module" as part of Vital PAC upgrade along with NEWS2 will deliver comprehensive functionality to identify, risk-stratify and audit the delivery of appropriate care for patients with potential sepsis, accordance with published NICE guidance. This will be launched on 28th March 2019. We believe sepsis detection and management will be quicker and the report generated electronically will be used to ensure ongoing real time feedback to challenge further improvements.

Also, we would like to consolidate collaborative sepsis work regionally and initiate research and innovation on early diagnosis and management of sepsis.

Getting it Right First Time (GIRFT) Programme

The Trust's priorities for the forthcoming year include:

- Maintaining robust links with the regional GIRFT Team to maximise the benefits that the GIRFT programme offers the Trust
- Further GIRFT visits planned, and the Trust will continue to support the feedback and next steps with a multi-disciplinary approach
- Embed GIRFT as a key component of the newly established Continuous Quality Improvement Team
- Scope opportunities to increase professional led discharge
- Working towards expanding shared services to support sign-posting patients
- Continued implementation of enhanced recovery pathways to support patient flow and improved outcomes.

Allied Health Professionals

Our plans for 2019/20 will include:

Physiotherapy

- Carry out the pilot of the First Contact Practitioners, share the learning and roll out the service
- Strengthen interdisciplinary research
- Mentor/share learning
- Support the research process
- Support dissemination and implementation of research findings
- Engage patients and carers in research.

Speech and Language (SLT)

- Complete the Standard Operating Procedure for the Speech and Language to work alongside the Trust-Wide Dysphagia policy
- Ensure that IDDSI is fully embedded
- Work with partners to highlight the Early Years preventative role of SLT in addressing potentially transient Speech, Language and Communication needs (SLCN) in Wolverhampton. In addition, ensure that we remain key members of the Strategic Board to influence policy for SLCN in the Black Country
- Deliver further training within our paediatrics teams and deliver this training to all relevant adult and administration teams to ensure all staff are trained to work effectively with bilingual and non-English speaking monolingual clients.

Priority 3 – Patient Experience

The Trust is in the process of developing a new Patient Experience, Engagement and Public Involvement Strategy.

The strategy will set out how the Trust will strengthen its approach to ensuring that patient experience, engagement and public involvement remains at the heart of its consideration, and achieve timely and robust public involvement across the organisation with regard to the planning, provision and evaluation of its services. This will be in line with the "Listen, Learn and Share" ethos introduced at the Trust in 2014, which encompasses the organisational approach to patient experience, engagement, public involvement and co-production.

The new strategy will encompass the Trust's overall objective and ambition to become an Integrated Care System with the aim to work in partnership with local councils and others, to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population served.

We will aim to ensure that patient experience, engagement and public involvement features as part of 'normal business' and be embedded in the decision making of service delivery and change.

Providing the best possible experience means getting the basics right, making sure our patients feel safe and cared for, that they have trust and confidence in the staff caring for them, and that they receive excellent quality of care in a clean and pleasant environment.

A key number of work streams will be implemented across three years to drive the implementation of the strategy and improve the patient experience. These include:

- Development of the Patient Experience and Engagement champions concept
- Triangulation of patient experience with wider quality, safety, workforce and performance metrics
- Implementation of the Observe and Act initiative initially as a pilot with a view for wider implementation. This initiative originates from the Shropshire Community Health NHS Trust
- Pilot the NHS England Initiative of 'Always Events' within paediatrics and design key always events as part of a co-production approach with patients
- Implementation of the Complaints Survey Toolkit to enhance feedback mechanisms and patient satisfaction
- Establishment of a formal complaints review panel with Council of Members as external reviewers
- Introduction of systematic co-production.

Primary Care

We will continue to work together to maximise the opportunities afforded by the vertical and horizontal integration within the Trust and within the Integrated Care Alliance. This will mean redesigned pathways of care for patients as well improved 'back office' functions. Similarly, the Trust's Community Transformation Programme will also provide opportunities to improve joint working with our practices and the outcomes and experiences for patients and the public we serve.

The emerging Primary Care Networks (planned for implementation in July 2019) are expected to provide further opportunities for the Trust to develop its primary care workforce, particularly for non-medical staff in the coming months and years as well as shape future service delivery models.

Statements of Assurance from the Board

MANDATORY QUALITY STATEMENTS

All NHS providers must present the following statements in their quality account; this is to allow easy comparison between organisations.

Review of services

Overall 40 services are provided and/or subcontracted by the Trust. There are a significant number of sub specialties and contracts in place which deliver these overarching services.

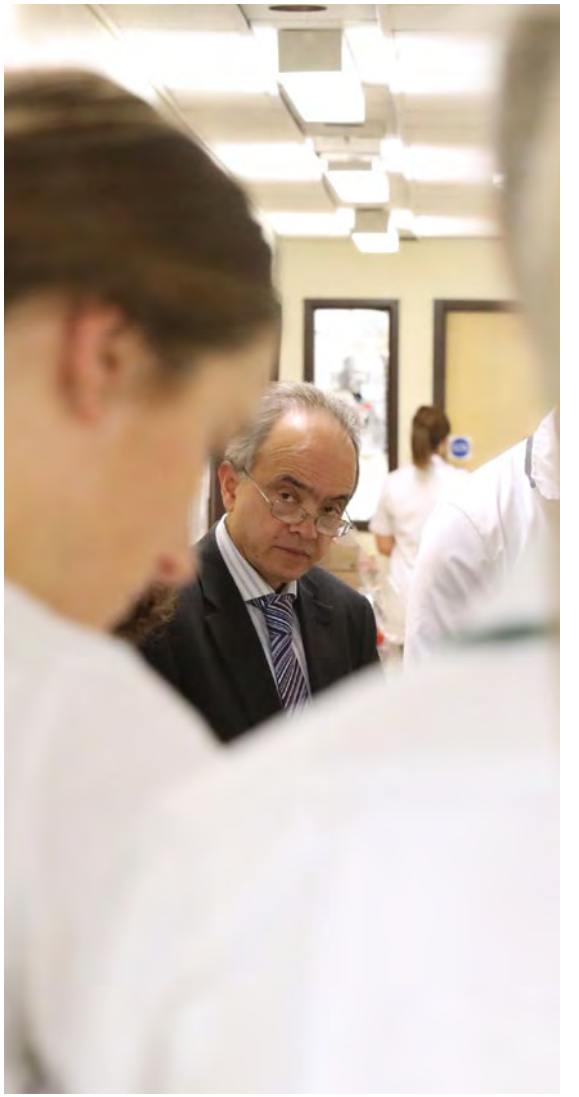
The Trust has reviewed all its data available on the quality of care of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19, represents 83% of the total income generated from the provision of relevant health services in 2018/19.

The Trust has reviewed the data against the three dimensions of quality including patient safety, clinical effectiveness and patient experience. The amount of data available for review has not impeded this objective.

The data reviewed included:

- Performance against national targets and standards, including those relating to the quality and safety of the services
- Clinical outcomes as published in local and national clinical audits, including data relating to mortality and measures related to patient experience as published in local and national patient survey, complaints and compliments.



Doctors and Dentists in Training – Statement on Rota Gaps and Plan for Improvement

There are approximately 360 doctors in training who rotate throughout the Trust at any one time.

In accordance with the Terms and Conditions of Service for doctors and dentists in training (England) 2016, each trainee is issued with a work schedule which sets out the intended learning outcomes mapped to the educational curriculum, scheduled duties, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted. However, there are circumstances under which trainee doctors may work more hours than they are contracted for and there is a formal exception reporting procedure for reporting hours or educational issues

that arise which are discussed with the doctors, educational or clinical supervisors, to agree an outcome.

All trainee work rotas at the Trust are compliant with the requirements of the new junior doctor contract. The Guardian of Safeworking (GoSW) reports for 2018/19 highlighted a limited number of exception reports submitted by doctors in training. One area that has been identified for improvement is to provide more guidance to trainees and supervisors regarding the exception reporting process. As a result, the Exception Reporting Procedure is being updated and additional guidance is also being produced. The full GoSW annual report for 2018/19 will be available in quarter two of 2019/20.

The Trust also has a Clinical Fellowship Programme (CFP) which was initiated as a method to attract and retain junior doctors, with the aim of supporting clinical areas by enhancing junior doctor numbers and ensuring vacancies in trainee numbers were backfilled, thereby maintaining quality and safety of service provision. The CFP also helps to reduce temporary staffing spend (Agency and Locum) on junior doctors and the CFP has been a considerable success and noted as an area of best practice by the CQC, NHS Improvement and NHS England.

There is also a quarterly trust-wide junior doctor forum attended by the Chief Executive and Medical Director which provides a regular opportunity for feedback in respect of the trainee experience at the Trust.

Participation in Clinical Audits

During 2018/19 there were 65 applicable national audit projects and 3 national confidential enquiries covering relevant health services that the Trust provides.

During this period, the Trust participated in 88% (57) of these national clinical audit projects and 100% (3) of the national confidential enquiries which it was eligible to participate in.

Some audits do not have a set number of required cases and instead criteria must be met in order for a case to be audited and therefore submitted to the audit project.

The reports of 43 completed national clinical audits projects that were reviewed by the provider in 2018/19 are shown below with the action the Trust intends to take to improve the quality of healthcare provided.

The National Confidential Enquiries that the Trust was eligible to participate in and actively collected data for are stated below.

National Confidential Enquiries	Participated
Perinatal Mortality and Morbidity confidential enquiries	Yes – Awaiting Report
Maternal Mortality surveillance and mortality confidential enquiries	Yes – Awaiting Report
Maternal morbidity confidential enquiries	Yes – Awaiting Report

The 8 national clinical audits that the Trust **did not** participate in during 2018/19 are as follows, including rationale as to why the Trust did not participate:

National Clinical Audit & Enquiry Project name	Work stream	Directorate	Rationale
Child Health Clinical Outcome Review Programme	Long-term ventilation in children, young people and young adults	Acute Paediatrics	The directorate does not have any long term ventilated children and young people.
Endocrine and Thyroid National Audit	N/A	General Surgery	Directorate does not meet the audits inclusion criteria that staff to be members of BAETS society in order to participate.
Medical and Surgical Clinical Outcome Review Programme	Acute Bowel Obstruction	General Surgery	The Directorate did not register for the audit in time.
National Audit of Dementia (in General Hospitals)	Dementia care in general hospitals	Care of the Elderly	Audit was completed previous year and to repeat so soon would not be a valuable exercise to a directorate whose capacity is already at maximum.
National Audit of Intermediate Care (NAIC)	N/A	Adult community/ CoE	Adult community will participate in future audits when dates are made available.
National Cardiac Arrest Audit (NCAA)	N/A	Resuscitation Team	Financial cost of participating in audit outweighs any impact upon safety or quality on service.
National Ophthalmology Audit	N/A	Ophthalmology	Ophthalmology will not be using the Medisoft system. The directorate is planning to use a system called 'Open Eyes'. This is an electronic system that will directly feed into the national database. Once the new system is in place, data submission for adult cataract surgery will commence.
VTE Risk in Lower Limb Immobilisation	N/A	Emergency Department	This is a new Directive in Royal College Emergency Medicine and that not many hospitals in the surrounding areas are doing this audit. New Cross has not started using the VTE Risk Assessment Guidelines. It will be discussed within the Directorate going forwards.

The national clinical audits that the Trust did participate in during 2018/19 are shown in **Appendix 1.**

The national clinical audits that the Trust had completed from those shown in Appendix 1 are shown in **Appendix 2.**

The reports of 43 completed national clinical audits projects that were reviewed by the provider in 2018/19 are shown in **Appendix 3**, with the action the Trust intends to take to improve the quality of healthcare provided:

Clinical Audit Activity

In total 457 clinical audits were registered on the Clinical Audit Database across the Trust, which included 355 (78%) of which were completed by the 31st March 2019. The adjusted completion rate (excluding national audits and Quality Improvements Projects) was 91%.

Clinical Audit Outcomes

The reports of 355 clinical audits were reviewed by the provider and a compliance rating against the standards audited agreed and are shown at **Appendix 4.**

74 audits demonstrated **moderate or significant non-compliance** against the standards audited. The Trust intends to take actions to improve the quality of healthcare provided and will re-audit against these standards in 2019/20. Details of these actions are shown at **Appendix 4.**

Participation in Clinical Research

National studies have shown that patients cared for in research active NHS trusts have better clinical outcomes. The availability of research across clinical services at the Trust provides a number of complementary additions to existing patient care and treatment. Ensuring patients are given an option to participate in clinically appropriate research trials is a national and local target, and identified by patients as an important clinical choice.

The Trust's performance in research continues to be on a par with the large acute trusts within the West Midlands region. The research culture, enhanced through the Trust's hosting of the West Midlands Clinical Research Network (CRNWM), has continued to be developed during the year.

The Trust is measured against a range of national performance indicators covering recruitment into studies, increasing access to commercially sponsored research, and reducing the time to set-up studies. The Trust has worked hard to improve its performance in these key areas, whilst ensuring that the high quality of care experienced by research patients is maintained.

The number of patients receiving health services provided or sub-contracted by the Trust in 2018/19 recruited to participate in research approved by a research ethics committee was in excess of 3,550. Over 200 studies have been active during the past year. 3564 patients were recruited into studies adopted onto the National Institute of Health Research (NIHR) Clinical Research Network (CRN) Portfolio (97% of overall activity). This exceeds the target of 3202 participants set by the CRN West Midlands for recruits at the Trust in 2018/19.

19 new NIHR adopted industry sponsored clinical research studies were opened at the Trust during 2018/19.

During 2018/19, the Trust's research teams had received national recognition for their recruitment into studies within a number of clinical areas including Cardiology, Rheumatology, Dermatology, Oncology and Paediatrics.

In addition, the Trust researchers were rewarded for their achievements at the 2018 CRN West Midlands Annual Network Awards. The individuals and teams recognised were:

- The Cardiovascular Research Team – Winners of the **Team of the Year**
- Lyndsay Bibb and the REACT study team – Highly commended in the **Collaboration in Research** category
- Marie Green – Highly commended in the **Creative Recruitment** category
- Professor Matt Brookes – Highly Commended in the **Investigator of the Year** category

78% reported the care provided was of the highest standard

78% felt communication from the research team was excellent

91% felt fully informed about the study prior to taking part

85% felt comfortable in being able to withdraw from the study

90% felt research staff maintained their privacy and dignity

"The research team were very professional as well as being kind, caring and respectful."

Participant in Rheumatology study.

"The care I received as part of my treatment for cancer was of exceptional quality. I cannot thank the staff at New Cross for the treatment I received, higher quality could not have been received anywhere"

Participant in Oncology study.

"I am very grateful for the chance to participate and would recommend to anybody else."

Participant in Cardiology study.

The Research and Development directorate at the Trust seeks feedback from research participants on their experiences of research activity. The results indicate how well the research team is displaying the Trust's values and behaviours of providing safe and effective care, being kind and caring and exceeding expectations.

Our 2018/19 patient experience survey completed by 155 participants of research, showed that 95% of them felt research is important to improve healthcare services.

The following levels of satisfaction were reported:

- 81% would consider participating in research again
- 82% would recommend participating in research to a friend or family member.

Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration statement is registered with no conditions.

The following service inspections took place during 2018/19:

Month	Service	Overall Result
July 2018	Lea Road Medical Practice	Good
July 2018	Alfred Squire Road Heath Centre	Good
July 2018	Warstones Health Centre	Good
July 2018	West Park GP Surgery	Good
October 2018	Thornley Street Medical Centre	Good
February 2019	Penn Manor Medical Practice	Good
February 2019	Lakeside Medical Centre	Good

The Care Quality Commission had not taken enforcement actions against the Trust during 2018/19. There was one requirement notice to improve the proper and safe management of medicines at Penn Manor Medical Practice and a requirement notice for safe care and treatment pertaining to Lakeside Medical Centre.

Statement on relevance of Data Quality and your actions to improve your Data Quality

The Trust is taking the following actions to improve data quality in accordance with the relevant information governance toolkit standards.

- Conducts regular audit cycles
- Performs monthly Completeness and Validity checks across inpatient, outpatient, ED and waiting list data sets
- Monitor activity variances and trends to spot outliers and erroneous numbers for investigation
- Use external/internal data quality reports to benchmark against peers and assess performance
- Use standardised and itemised data quality processes in Secondary Uses Service (SUS) data submissions monthly
- Hold bi-monthly meetings with a set agenda to discuss data quality items
- Hold bi-monthly Trust Data Quality Meetings to manage / review practices and standards
- Review Standard Operating Procedures for data collection to ensure consistency and standardisation across the Trust
- Recently created new forums to discuss data systems and data capture, with nominated ‘Champions’ disseminating key information across the Trust
- Recently employed additional resource into the Trusts’ Data Quality Team to provide training and support, ensuring data is entered correctly at source

NHS Number and General Medical Practice Code Validity

Clinical Coding Error Rate

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

Clinical Coding Audits were conducted and conformed to Data Security & Protection Standards Advisory Level. The area audited as part of this was Admitted Patient Care for General Medicine & Maxillo Facial (Surgical).

The error rates reported in the latest audit for that period are detailed below, and were based on a small sample of 100 finished consultant episodes for each specialty, total audited 200 finished consultant episodes.

Admitted Patient Care diagnoses and procedure coding (clinical coding) were:

General Medicine Speciality	Maxillo Facial (Surgical) Speciality
Primary Diagnoses correct 99%	Primary Diagnoses correct 97%
Primary Procedures correct 98.48%	Primary Procedures correct 95%

The overall Healthcare Resource Group error rate for the audit was 4% of the total number of episodes, which is a change of 2.2% absolute and 2.2% net. All recommendations following the audit have been completed.

Clinical Coding Error Rate

NHS Number and General Medical Practice Code Validity Updated as per **Month 12** 2018/19.

The Trust submitted records during 2018/19 to the secondary uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data shows an improvement in every area against the 2017/18 submission, which included the patient's valid NHS number:

- 99.8% for admitted patient care
- 99.9% for outpatient care
- 95.9% for ED care.

This included the patient's valid General Practitioner Registration Code as follows:

- 100% for admitted patient care
- 100% for outpatient care
- 99.9% for ED care.

Information Governance Toolkit

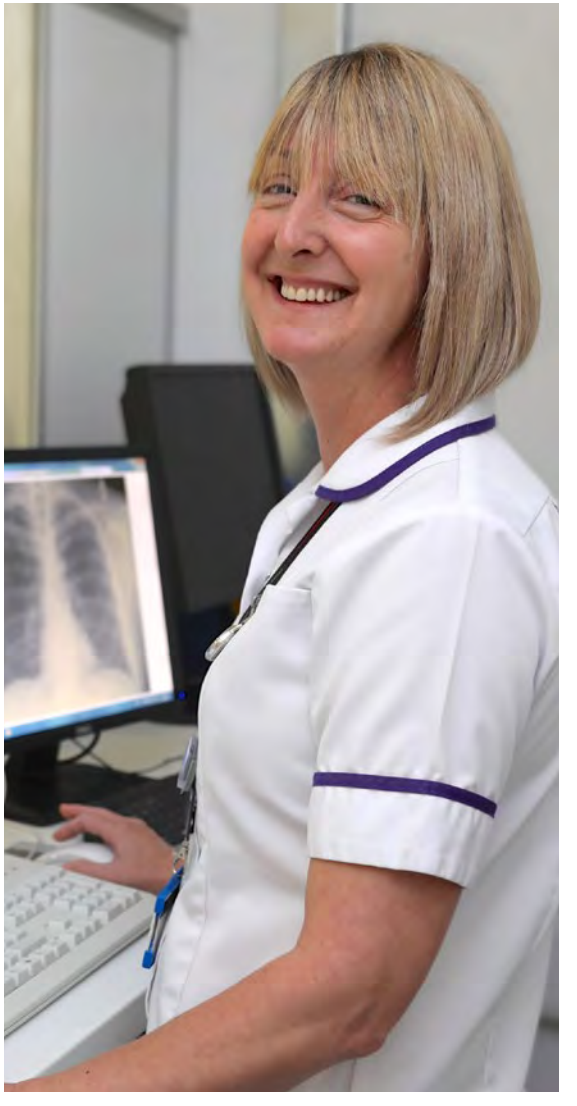
Data Protection and Security Toolkit (DPST) 2018/19 overall scores were as follows:

• The Royal Wolverhampton NHS Trust	RL4 – Standards Not Met (Improvement plan) (96/100)
• Alfred Squire	M92002- Standards Met (52/52)
• West Park Surgery	M92042- Standards Met (52/52)
• Thornley Street	M92028 - Standards Met (52/52)
• Ettingshall	Y02735- Standards Met (52/52)
• Lea Road	M92007- Standards Met (52/52)
• Penn Manor	M92011 - Standards Met (52/52)
• Coalway Road	M92006- Standards Met (52/52)
• Warstones	M92044 - Standards Met (52/52)
• Lakeside	M83132 - Standards Met (52/52)

Looking forward to 2019/20 for Information Governance and General Data Protection Regulation (GDPR)

The Trust will work with NHS Digital to ensure that an agreed action plan for the DSPT toolkit is implemented, ensuring the Trust's position is equivalent to standards met for the DSPT submission. The Trust is continuing to monitor patterns and trends of information governance incidents, and implementing measures to reduce these to the lowest level practicable.

The Trust is continuing to embed the requirements of GDPR into Trust practices, ensuring data privacy is at the forefront of the care that it provides. The Trust will continue working closely with its GP partnerships to align practices and share good practice.



Core Quality Indicators - Summary Hospital Level Mortality Indicator (SHMI)

The data made available to the Trust by the Information Centre with regard to the value and branding of the Summary Hospital-Level Mortality Indicator ("SHMI") for the Trust for the reporting period 2018/19;

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die. The expected number of deaths is not an actual count of patients, but is a statistical construct which estimates the number of deaths that may be expected at the Trust on the basis of average England figures and the characteristics of the patients treated there.

The SHMI includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.

Whether or not a death could have been prevented can only be investigated by a detailed case-note review.

	Reporting Period	
Indicator	July 2017 – June 2018	October 2017 - September 2018
SHMI RWT	1.21 (higher than expected)	1.22 (higher than expected)
SHMI England	1	1

SHMI data and banding are public data made available by NHS Digital.

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

The Trust has established reporting and investigation mechanisms for the SHMI, overseen by the Mortality Review Group (MRG). All diagnosis groups with a higher than expected SHMI are investigated through a case note review, results are reported at the MRG and action plans developed.

These include an action plan to improve data quality at the Trust, which has a direct impact on the SHMI indicator. Monitoring and compliance against clinical care pathways such as sepsis have been established. Progress against the agreed actions and the mortality improvement plan is reviewed monthly by the Quality Improvement Board. In addition, mortality associated reports are regularly presented to the Trust Board.

Core Quality Indicators – Summary of Patient Death with Palliative Care

The data made available to the Trust by the information centre with regard to the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period:

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

This contextual indicator shows the percentage of discharges and deaths reported in the SHMI dataset, where the patients received specialist palliative care as identified by the clinical coding. The rate of specialist palliative care coding (2015) at the Trust has declined over recent years and remains below the national average. It is also significantly lower than that of our comparative peers.

As part of targeted work linked to the Trust's overall mortality improvement plan, a review of the data capture methodology for this group has taken place to ensure that all spells are captured. It has become apparent that the contracted size of the team has had an impact on the number of patients receiving specialist palliative care provision and therefore impacting on the overall percentage of spells provided.

	Reporting Period	
Indicator	**July 2017 – June 2018**	**October 2017 - September 2018**
Percentage of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level – RWT*	21.2	22.1
Percentage of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level – England*	33.1	33.6

Data Source NHS Digital 2018

**This is an indicator designed to accompany the SHMI. The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care because there is considerable variation between trusts in the coding of palliative care. Using the same spell level data as the SHMI, this indicator presents crude percentage rates of deaths reported in the SHMI with specialist palliative care coding at either diagnosis or specialty level.*

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

- The Trust will continue to monitor the accuracy of palliative care coding by cross referencing with the Somerset database
- The Trust has expressed its interest in joining a national collaborative focusing at end of life care
- A series of educational events have commenced and will continue in 2019/20 in order to improve awareness of the Palliative and End Of Life (EOL) pathways
- The Trust will continue with its commitment to achieving gold standards framework aims
- The Trust is in the process of expanding the existing specialist palliative care service with appointments to additional specialist palliative care nursing and medical posts. Once additional staff are in post, this will enable an increase in the proportion of patients supported by the specialist palliative care service, and providing access to face-to-face specialist palliative care advice seven-days per week.

Core Quality Indicators – Learning from Deaths

Actions taken by The Royal Wolverhampton NHS Trust in relation to Mortality 2018/19

The Trust continued to work on implementing the Learning from Deaths guidance to ensure that we promote learning from mortality reviews and improve how we support and engage with the families and carers of those who die in our care. The Trust has an established Mortality Review Group (MRG), chaired by one of the Divisional Medical Directors. The group meets every month to oversee progress with the implementation of our Learning from Deaths Policy, quality improvement plan for mortality and the associated work streams. In addition, a health economy mortality group chaired by our commissioners has been established to enable system working and focus on the wider aspects of mortality and improvement required outside the hospital setting.

Reports are provided from this group to the Trust's Quality Governance Assurance Committee and Trust Board.

At present, mortality reviews are focussed on hospital deaths. Approximately 25% of deaths included in the Summary Hospital-level Mortality Indicator (SHMI) basket occur within 30 days post discharge. MRG is currently in discussion with our commissioners and primary care to set up the process for mortality reviews for deaths that occur in the community following hospital discharge.

During 2018/19, the Trust had implemented a medical examiner model as a quality improvement initiative. Through this process, all hospital deaths are subject to an initial scrutiny by medical examiners who also support the death certification process and interact with bereaved families to explain the cause of death and gather feedback. In addition, a new Bereavement Centre opened in December 2018 which facilitates availability of the registrar on site and it should improve compliance of death registration within the recommended timescales.

Between April 2018 and March 2019, the Trust recorded a total of 2211 hospital deaths (excluding patient deaths below the age of 18 years[5]). All hospital deaths are either scrutinised by mortality leads in each directorate or the medical examiner (since January 2019). 1000 of these deaths met the criteria for mortality review based on the Trust's Learning from Deaths Policy (OP87) and received either a Structured Judgement Review and/or investigation. In addition to mortality reviews, MRG supported the audit and case note review of deaths in the SHMI alerting diagnosis groups.

Overall themes and learning points arising from the Trust's inpatient mortality reviews have included:

- Palliative Care issues – identification, referral and documentation
- Documentation issues – correct recording of primary and secondary diagnosis / co-morbidities
- Policy and guideline compliance issues – identified with regards to infection prevention and control and sepsis management.

To strengthen our approach with regards to mortality and associated learning, the Trust had implemented a quality improvement programme for mortality during 2018/19. This programme underpins improvement work arising from the themes identified following case note reviews/structured judgement reviews. In addition, the Trust has developed a Mortality Strategy which is awaiting final ratification.

Plans for 2019/20

The MRG will continue to progress the Trust's mortality improvement programme and associated plan, underpinned by the Mortality Strategy. Key areas of focus will include:

- Delivery of the Quality Improvement Programme for Mortality
- Concentrating on the quality of mortality reviews to ensure there is sufficient rigour and professional objectivity
- Learning from partners and other trusts hence enabling examples of best practice to be implemented at Trust.

[5] There is a separate process to reviews all child and neonatal deaths (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) and Child Death Overview Panel – Wolverhampton (CDOP)

	Prescribed information	Form of statement
A	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During the period April 2018 and March 2019, 2211 adult patient hospital deaths were recorded at the Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period: • [515] in the first quarter • [500] in the second quarter • [616] in the third quarter • [580] in the fourth quarter
B	The number of deaths included in item A which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By the 31st March 2019, [980] case record reviews and [20] investigations have been carried out in relation to [2211] of the deaths included in item A. • In [6] 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: • [473] in the first quarter • [310] in the second quarter • [171] in the third quarter • [46] in the fourth quarter Please note: 92 Structured Judgement Reviews stage 1 (SJR1) remain outstanding across Q3/Q4 2018/19 which are actively being progressed. It is also important to note that the Medical Examiner (ME) process was implemented in December 2018 and the majority of deaths will have received initial scrutiny via the ME process.

C	An estimate of the number of deaths during the reporting period included in item B for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	A total of 2 cases [0.09%] representing [number as percentage of number in item A] % of the adult 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: • [0.09%] for the first quarter • [0.0%] for the second quarter • [0%] for the third quarter • [0%] for the fourth quarter These numbers have been determined using evidence from the Root Cause Analysis (RCA) investigations involving deaths that were subject to review under the serious incident framework. (The NHS Serious Incident Framework recommends this approach where unexpected deaths or omission of care where harm has been caused are investigated).
D	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C.	Learning from the reviews/investigations of those adult patient identified in item C are as follows: • The importance of ensuring that patients are fully re-assessed prior to surgery to exclude any potential risks. • Strengthen handover processes between specialties. • In circumstances where it is anticipated that a procedure takes longer, clear communication with the patient and their relatives must be ensured. • Continue our improvement work to improve the recognition/escalation of the deteriorating patient. • Strengthening and clarifying the escalation processes to specialist services.

E	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 (see item D).	A LocSSIP protocol for re-assessment of a patient whose operation has been deferred for medical reasons has been implemented. A Standard Operating Procedure (SOP) developed and implemented to communicate with patients' relatives when surgery is prolonged, past expected duration. Individual reflection, learning and identification of training needs for staff involved (all professions). Training for surgical junior doctors (and nurses where appropriate) pertaining to the escalation and management of critically ill patients. SOP implemented for the handover of surgical patients between surgical consultants in line with Handover Policy. Process for escalation of deteriorating patients improved and re-circulated to all staff. Trust to improve the recognition and escalation of the deteriorating patient. Regular monitoring blood tests for high risk patients implemented. Quantitative fluid balance charts for all high risk patients implemented. Reviewed and implemented low threshold for seeking a second opinion from an appropriate specialist for patients with complex clinical problems, especially if their clinical course does not proceed as expected. Arrangements for emergency radiological drainage documentation strengthened along with the adult sepsis guidelines implemented. Medical and nursing staff reminded of the need to question the need for anti-hypertensive medication in the setting of low blood pressures.
F	An assessment of the impact of the actions described in item E which were taken by the provider during the reporting period.	A key impact for the Trust is to continue full implementation of the mortality improvement programme and the associated plan which is underpinned by the Mortality Strategy. In addition, the focus will remain on ensuring that the learning identified though the Trust's mortality review process is systematically implemented.

G	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item B in the relevant document for that previous reporting period.	[0] case record reviews and [0] investigations completed after 31st March 2018 which related to deaths which took place before the start of the reporting period.
H	An estimate of the number of deaths included in item G which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0.0% 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.
I	A revised estimate of the number of deaths during the previous reporting period stated in item C of the relevant document for that previous reporting period, taking account of the deaths referred to in item H.	0% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Core Quality Indicators – Summary of Patient Reported Outcome Measures (PROMS)

The data made to the Trust by the information centre with regard to Patient Reported Outcome Measures (PROMS)

The data made to the Trust by the information centre with regard to Patient Reported Outcome Measures (PROMS):

PROMS assess the quality of care delivered to NHS patients from their perspective, regarding the health gains for the following two surgical interventions using pre and post-operative survey questionnaires:

- Hip replacement surgery
- Knee replacement surgery

The questionnaire does not differentiate between first time intervention or repeat surgery for the same procedure.

	April 16 - March 17	April 17 - March 18	National Average
Hip Replacement Surgery	0.79	0.81	0.80
Knee Replacement Surgery	0.75	0.76	0.75

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

For hip replacement, 267 patients completed the questionnaire. 91% of these patients reported improvement, 6% unchanged and 3% worsened. This has resulted in a score for the reporting period of 0.01 over the national average.

For knee replacement, 317 patients completed the questionnaire. 83.3% of these patients reported improvement, 6% unchanged and 10.7% worsened. This has resulted in a score for the reporting period of 0.01 over the national average.

For both hip and knee surgery, the data demonstrated the Trust score to be slightly above the national average with an improvement on the previous year's performance.

In terms of the groin hernia surgery and varicose vein surgery PROMS indicators, these are no longer being reported nationally in line with the notification received from NHS England in October 2017.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services by:

- A full review of the data was undertaken during the March 2019
- Education for patients continues to be provided pre-operatively, and the PROMS questionnaire explained and provided to patients at their pre-operative appointment
- Alongside commissioners, the Trust is reviewing its orthopaedic pathways to ensure optimum care is provided to patients post operatively through follow-up.

Core Quality Indicators - Readmission Rates

The data made available to the Trust from its internal PAS system with regard to Re-admission Rates

All data is from the Trust's own data recording system (PAS) using the national definition of a readmission.

Readmissions					Grand Total
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	
Aged 4-15	440	505	423	359	**1,727**
16yrs and over	5,966	5,443	5,165	5,677	**22,251**
Grand Total	6,406	5,948	5,588	6,036	**23,978**

Total Admissions					Grand Total
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	
Aged 4-15	5288	5429	5117	4,668	**20502**
16yrs and over	115288	118585	117355	117,669	**468897**
Grand Total	120576	124014	122472	122,337	**489399**

Percentage Readmissions					Grand Total
Age	**2015/16**	**2016/17**	**2017/18**	**2018/19**	
Aged 4-15	8%	9%	8%	8%	**8%**
16yrs and over	5%	5%	4%	5%	**5%**
Grand Total	5%	5%	5%	5%	**5%**

In order to benchmark ourselves against peers, the tables below detail the latest readmission data available nationally for benchmarking comparison. However this data is backdated to 2011/12 as there is no more up to date data available for comparison purposes.

Readmissions Data for 2011/12 standardised to persons 2007/08

Code	Trust Name	Value
RJC	South Warwickshire General Hospitals NHS Trust	9.61
RXW	Shrewsbury And Telford Hospital NHS Trust	9.75
RL4	The Royal Wolverhampton Hospitals NHS Trust	10.28
RWP	Worcestershire Acute Hospitals NHS Trust	10.30
RBK	Walsall Hospitals NHS Trust	10.50
RRK	University Hospital Birmingham NHS Foundation Trust	11.54
RTG	Derby Hospitals NHS Foundation Trust	11.54
RNA	Dudley Group of Hospitals NHS Trust	11.62
RJF	Burton Hospitals NHS Trust	11.71
RKB	University Hospitals Coventry And Warwickshire NHS	12.03
RLT	George Eliot Hospital NHS Trust	12.61
XK	Sandwell And West Birmingham Hospitals NHS Trust	12.69

Indicator Emergency readmissions to hospital within 28 days of discharge from hospital: adults of ages 16+

Statistic Indirectly age, sex, method of admission of discharge spell, diagnosis (ICD 10 chapter / selected sub-chapters within medical specialties) and procedure (OPCS 4 chapter / selected sub-chapters within surgical specialties) standardised rates

Age Group Ages 16+

Source of data Hospital Episode Statistics and National Statistics

Code	Trust Name	Value
RRK	University Hospital Birmingham NHS Foundation Trust	0.00
RTG	Derby Hospitals NHS Foundation Trust	7.31
RLT	George Eliot Hospital NHS Trust	7.44
RBK	Walsall Hospitals NHS Trust	7.98
RKB	University Hospitals Coventry And Warwickshire NHS	8.23
RNA	Dudley Group Of Hospitals NHS Trust	9.09
RJC	South Warwickshire General Hospitals NHS Trust	9.58
RXK	Sandwell And West Birmingham Hospitals NHS Trust	9.89
RXW	Shrewsbury And Telford Hospital NHS Trust	10.16
RJF	Burton Hospitals NHS Trust	10.46
RWP	Worcestershire Acute Hospitals NHS Trust	10.55
RL4	The Royal Wolverhampton Hospitals NHS Trust	14.94

Indicator Emergency readmissions to hospital within 28 days of discharge from hospital: children of ages 0-15

Statistic Indirectly age, sex, method of admission of discharge spell, diagnosis (ICD 10 chapter / selected sub-chapters within medical specialties) and procedure (OPCS 4 chapter / selected sub-chapters within surgical specialties) standardised percent

Age Group Ages 0-15

Source of data Hospital Episode Statistics and National Statistics

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

NHS Digital no longer publish readmission data and therefore the Trust's internal data has been used, however the Trust has provided the previous historical data collected by NHS Digital for benchmarking purposes.

This data forms part of the Chief Operating Officer's report to the Trust Board and Trust Management Team on a monthly basis.

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

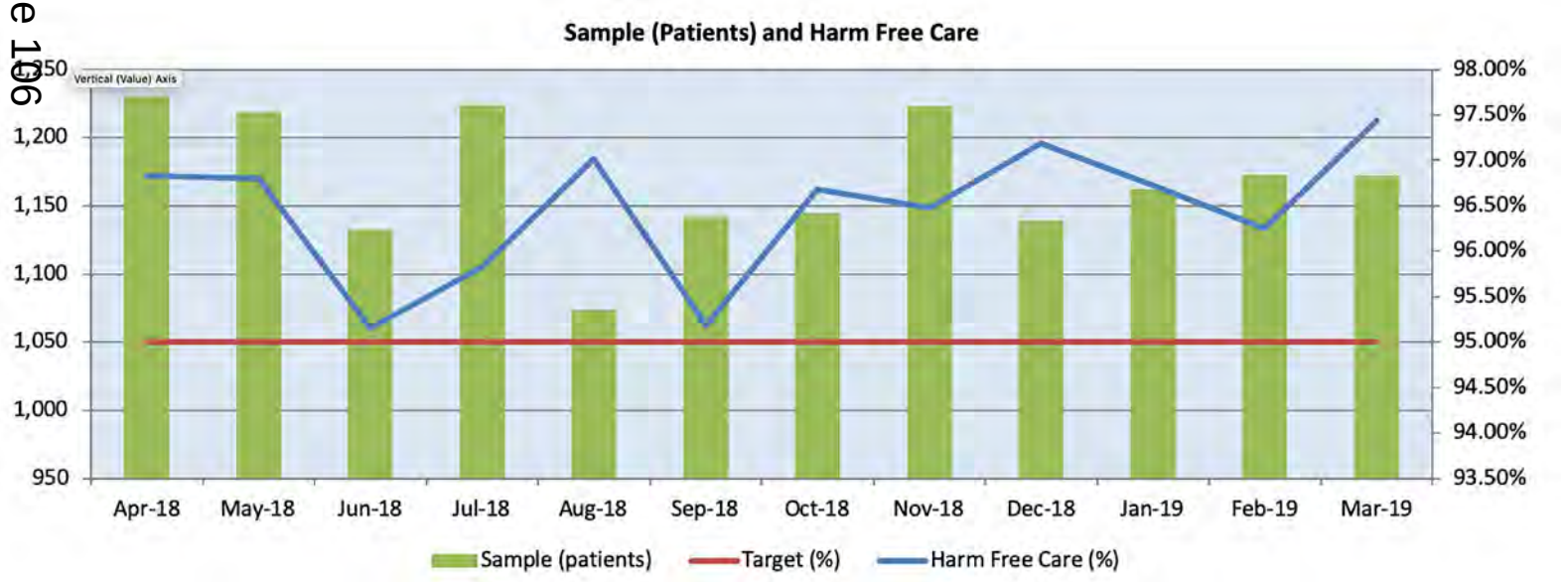
- Consistent adherence to the Red to Green day protocols and improved information with regards to discharge. In addition reporting mechanisms to capture Red to Green information will be finalised
- Continuing to work with local residential and nursing homes with regards transfer of patients back to their care
- Strengthening discharge planning at pre-operative assessment and at the point of admission
- Continuing to undertake reviews of 'stranded patients' to facilitate their discharge
- Undertake Multi Agency Discharge Events (MADE)
- Embed the principles of criteria led discharge.

Core Quality Indicators - Safety Thermometer

The data made to the Trust by the information centre with regard to Safety Thermometer:

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

- The data is collected monthly by each inpatient area and verified by the Senior Sister and Matron upon submission
- Safety Thermometer data is distributed and discussed on a monthly basis as part of a suite of key performance metrics used by the Trusts to analyses and triangulate performance
- Data for each of the four harms is triangulated with that of internal incidence data and reported via the Trust's incident reporting system
- Data is validated through by specialty services relating to each harm.

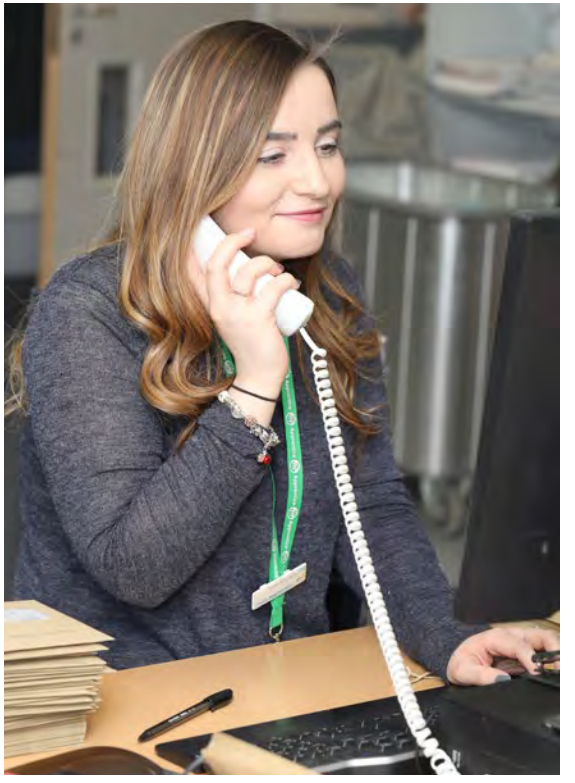


There has been a notable improvement in the data in the latter 2 quarters of 2018/19 which coincides with the launch of a new nursing strategy.

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

- The Senior Nursing Team will continue to promote the awareness of harm and associated learning in the Trust
- Pressure ulcers and falls are reviewed using an accountability model, whereby root cause analyses are reviewed together with commissioners for those incidents with serious harm. This therefore ensures that root causes and lessons learned are well evidenced and communicated. A trial of all falls being reviewed
- Using the accountability model will commence in 2019/20 following a successful trial of this process pertaining to stage 2 pressure ulcers
- A city-wide plan for the reduction of catheter-associated urinary tract infection is being implemented
- The Trust will continue to work collaboratively with stakeholders to ensure city-wide learning
- The new nursing strategy will continue to be embedded across the organisation.

(The NHS Safety Thermometer "Classic" allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, urinary tract infections (inpatients with a urinary catheter) , and venous thromboembolism. This point of care survey is carried out on 100% of patients on one day of each month).



Core Quality Indicators - VTE Prevention

The data made available to the Trust by the information centre with regard to VTE Prevention

	Q1 2017/18	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	18/19 Year End
RWT	95.59%	95.37%	95.72%	95.88%	92.05%	93.48%	93.75%	93.70%	93.26%
National Average	95.11%	95.25%	95.36%	95.18%	95.63%	95.49%	95.65%	95.74%	
Trust with highest score	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Trust with lowest score	51.38%	71.88%	76.08%	67.04%	75.84%	68.67%	54.86%	74.03%	

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

- The numerator is the number of adult in-patients that have received a VTE assessment upon admission to the Trust using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with published guidance)
- The denominator is the number of adult inpatients (including for example surgical, acute medical illness, trauma, long term rehabilitation and day case).

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

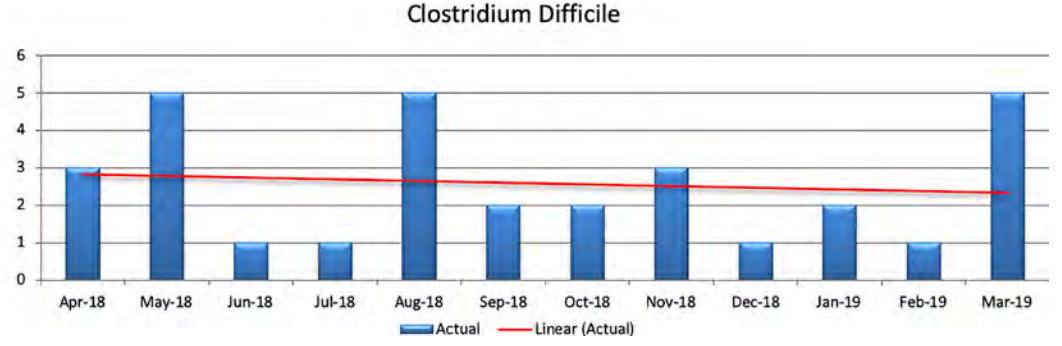
A variety of measures have been put in place and are planned to increase awareness of VTE prevention and management amongst all healthcare staff. These include:

- Only risk assessments completed within 24 hours of admission are reported
- During 2019/20, one of the key objectives will be to achieve optimal VTE risk assessment compliance > 95%
- Commencing in April 2019, updated NICE guidance NG89 will be implemented, and patients from the age of 16 and over will be required to have a VTE risk assessment completed and results be included in the Trust reportable data
- Mandatory VTE prevention training has been updated in line with new NICE guidance and this will be delivered to all clinical staff
- Commencing in April 2019, VTE prevention ward audit data will be available to clinical teams via the Health Assure application enabling prompt feedback and relevant actions for consideration.

The Trust intends to continue its efforts to ensure that the 95% VTE risk assessment target is achieved and exceeded during 2019/20, and ongoing quality improvement approaches are implemented and embedded, leading to improvement patient outcomes

Core Quality Indicators - *Clostridium difficile*

The data made available to the Trust by the information centre with regard to *C difficile*



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
The Royal Wolverhampton Trust	3	5	1	1	5	2	2	3	1	2	1	5	31

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

There are robust governance structures for monitoring delivery of the infection prevention and control annual programme of work, and this is supported by surveillance and indicator data including:

- NHS 'Safety Thermometer'
- Nursing quality metrics
- Laboratory data
- Domestic monitoring
- Mortality information
- National HCAI data capture system monitoring.

The Infection Prevention and Control Team provide data, assurance and the risks into various reporting structures, to include but is not limited to:

- Compliance Oversight Group
- Quality Standards Intelligence Group
- Environment Group
- Health and Safety Steering Group
- Decontamination Committee
- Trust Management Committee
- Trust Board
- Clinical Quality Review meetings
- Contract Monitoring meetings.

The Trust's Infection Prevention and Control Group continues to provide strategic direction, monitor performance, identify risks, and ensure a culture of openness and accountability is fostered throughout the organisation in relation to infection prevention and control. This is reinforced in the community by working closely with Public Health and Commissioners to manage risks within independently contracted services and care homes.

The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

Clostridium difficile remained within the set trajectory in 2018/19 and at the end of month 12, the Trust was 3 cases under an annual trajectory of 34. The challenge of acute and community incidence of Clostridium difficile meant that approaches were required in order to improve patient safety. These included:

- Human Probiotic Infusion (HPI) continues to be available for appropriate cases. This is incorporated into the treatment algorithm which ensures they are used more often with recurrent disease for improved outcomes
- Follow up of cases in the community to ensure treatment is completed and to facilitate appropriate intervention and advice if symptoms return
- Environmental controls have continued to be a top priority in the Trust's approach in tackling Clostridium difficile. The deep clean schedule has been completed with great effect, regular environment audits are being undertaken, results of which are monitored through the Environment Group which reports to the Trust Infection Prevention and Control Group.

During 2019/20 the Trust will focus on the following aspects:

- Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data
- Zero tolerance to avoidable health care associated infection
- Expand research activity of the Infection Prevention and Control Team
- Sustain the Trust's excellent reputation for infection prevention and control through team members' participation in national groups and projects
- Sustain Clostridium difficile reduction with a lower tolerance of individual cases

Core Quality Indicators - Incident Reporting

The data made available to the Trust by the internal systems with regard to Incident Reporting

2017/18 (Full Year Data)			2018/19 (April - September)		
Incidents	**% resulting in death**	**% resulting in severe harm**	**Incidents**	**% resulting in death**	**% resulting in severe harm**
9650	0.1% (13)	0.3% (26)	5213	0.2% (11)	0.2% (12)

Data source – Trust Data at present 2019

The Trust defines severe or permanent harm as detailed below:

Severe harm: a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care;

Permanent harm: harm directly related to the incident and not related to the natural course of a patient's illness or underlying condition is defined as permanent lessening of bodily functions; including sensory, motor, physiological or intellectual.

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

- The Trust has a well embedded reporting culture and promotes the reporting of near miss incidents to enable learning and improvement
- The Trust undertakes data quality checks to ensure that all patient safety incidents are captured and appropriately categorised in order to submit a complete data set as per the national requirement.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

- The Trust continues to train staff to facilitate prompt reporting and management review of incidents (including serious incidents)
- The Trust will continue to communicate lessons learnt via risky business newsletter, making it better alerts and through the Integrated Governance Reports (IGRs)
- Governance officers will continue to share Route Cause Analysis (RCA) summaries across all directorate governance meetings where applicable.

Core Quality Indicators - National Inpatient Survey

The data made available to the Trust by the information centre with regard to the National Inpatient Survey results:

The National Inpatient Survey for 2018, published by Care Quality Commission (CQC) on 20th June 2019, surveyed patients who were discharged from hospital during July 2018.

The survey is part of a national survey programme run by the CQC to collect feedback on the experiences of inpatients using the NHS services across the country. The results contribute to the CQC's assessment of NHS performance, in addition to ongoing monitoring and inspections. The programme also provides valuable feedback for NHS trusts, which can then be used to improve patient experience.

Obtaining feedback from patients is vital for driving improvements in the quality of care, and this is an excellent way for inpatients to directly influence services locally.

Analysis of the results data

- A total of 512 returned indicating a response rate of 42.6% compared to the previous year's response rate of 37.2%
- The average Mean Rating Score across all questions was 74%, which was marginally lower than in 2017
- The Trust's results were about the same as other Trusts for 62 questions
- No question indicated at least 5% improvement on the 2017 score, and 4 questions indicated a 5% or more worsening of score
- The remaining questions indicated less than 5% in change of score since 2017
- The categories for improvements are related to overall views of care and services, the hospital and ward, and operations and procedures
- Specific themes related to awareness, communication and information
- The sections where there were more questions having experienced a reduction in score was for Care and Treatment and Leaving Hospital. Notable points relate to information, emotional support and working well together for Care and Treatment and for leaving Hospital the themes were for support from Health and Social Care, and for medication to take home.
- No question showed at least 5% improvement on the 2017 score, and 3 questions showed a 5% or more worsening of score (out of 61 questions 2018 excluding new question).
- The remaining questions showed less than 5% in change in score since 2017 and the trust's results were about the same as other trusts for 62 questions.
- The were no statistically significant differences between last year's and this year's results for 58 questions
- The categories for improvements are related to overall views of care and services, the hospital and ward & operations & procedures. The themes are related to, awareness, communication & information.

About our strengths

- The hospital and ward – facilities, including cleanliness and food and disturbance at night time
- Nurses – confidence
- Care and Treatment – involvement in decision making, privacy, confidence in decision making, support and information giving
- Leaving hospital – involvement in decision making, and information and consideration of circumstances upon discharge

About our weaknesses

- The Hospital and the Ward – medication information, explanation for reasons for movement, help with mealtimes and support from non-clinical staff
- Nurses – volume of nurses on duty, knowing which nurse was in charge
- Operations and procedures – Information giving pre and post operation or procedure

Questions showing a significant reduction (5% or more) since last survey

Number	Question Group	Question	2017	2018	Diff
Q18	The hospital and ward	If you brought your own medication with you to hospital, were you able to take it when you needed to?	78%	69%	-9%
Q47	Operations & procedures	After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	84%	79%	-5%
Q70	Overall views of care and services	During your hospital stay, were you ever asked to give your views on the quality of your care?	13%	6%	-7%

	2015/16	2016/17	2017/18	2018/19
Involved as much as want to be in decisions about care definitely/to some extent	91%	92%	88%	89%
Treated with respect and dignity always/ sometimes	98%	98%	97%	97%

	2015/16	2016/17	2017/18	2018/19
Q68 Overall care rated as excellent/very good/good	95%	95%	93%	94%

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

Participation in the survey is mandatory, and part of a nationwide programme of surveys organised by the Care Quality Commission.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2019/20 by:

The development of an action plan to address the key findings of the report is being progressed. This will be reported on in due course and monitored through the Trust's governance arrangements to ensure that appropriate improvements are made.

Core Quality Indicators – Patient Friends and Family Test (FFT)

The data made available to the Trust by the information centre with regard to Patient Friends and Family Test

The Friends and Family Test (FFT) is a nationwide initiative which is a simple, single question survey which asks patients to what extent they would recommend the service they have received at a hospital department to family or friends who need similar treatment.

The tool is used for providing a simple, headline metric, which when combined with a follow up question and triangulated with other forms of feedback, can be used across services to drive a culture of change and of recognising and sharing good practice. The overall aim of the process is to identify ways of improving the quality of care and experience of the patients and carers using NHS services in England.

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons

- FFT data is published monthly
- FFT data is published nationally
- FFT data forms part of nursing metrics
- Analysis undertaken regards low performing areas and improvement plans implemented

Friends and Family Test Survey Response Rate

	Q1 2018/19				Q2 2018/19				Q3 2018/19				Q4 2018/19				2018/19 Average				2017/18 Average			
	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest
Emergency Department	15%	13%	46%	0%	16%	13%	33%	0%	16%	12%	32%	0%	16%	12%	37%	0%	12%	9%	28%	0%	14%	13%	46%	0%
Inpatients	29%	25%	100%	4%	30%	24%	100%	4%	30%	24%	100%	2%	31%	24%	100%	1%	22%	18%	75%	3%	29%	24%	100%	3%
Maternity	4%	21%	100%	0%	4%	20%	100%	0%	8%	18%	100%	0%	11%	22%	100%	0%	4%	15%	75%	0%	8%	22%	100%	0%
Outpatients	18%	6%	97%	0%	20%	6%	84%	0%	21%	6%	68%	0%	21%	7%	91%	0%	15%	5%	62%	0%	19%	6%	79%	0%

Percentage of Patients who would recommend the Trust

	Q1 2018/19				Q2 2018/19				Q3 2018/19				Q4 2018/19				2018/19 Average				2017/18 Average			
	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest
Emergency Department	86%	87%	100%	66%	86%	87%	100%	60%	87%	87%	100%	43%	86%	86%	100%	56%	65%	65%	75%	42%	83%	86%	100%	56%
Inpatients	91%	96%	100%	81%	93%	96%	100%	84%	93%	95%	100%	81%	93%	96%	100%	77%	69%	72%	75%	62%	92%	96%	100%	74%
Maternity	97%	97%	100%	78%	98%	96%	100%	79%	99%	96%	100%	78%	99%	96%	100%	80%	73%	72%	75%	59%	94%	97%	100%	70%
Outpatients	94%	93%	100%	76%	94%	93%	100%	75%	95%	94%	100%	67%	95%	94%	100%	57%	71%	70%	75%	55%	94%	93%	100%	75%

Percentage of Patients who would not recommend the Trust

	Q1 2018/19				Q2 2018/19				Q3 2018/19				Q4 2018/19				2018/19 Average				2017/18 Average			
	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest	RWT	England	Highest	Lowest
Emergency Department	9%	7%	23%	0%	8%	8%	27%	0%	8%	8%	57%	0%	8%	9%	26%	0%	6%	6%	27%	0%	10%	8%	30%	0%
Inpatients	4%	2%	8%	0%	3%	2%	9%	0%	3%	2%	12%	0%	3%	2%	11%	0%	3%	1%	7%	0%	4%	2%	16%	0%
Maternity	1%	1%	17%	0%	1%	2%	11%	0%	1%	2%	15%	0%	0%	2%	15%	0%	1%	1%	11%	0%	3%	1%	19%	0%
Outpatients	3%	3%	19%	0%	2%	3%	15%	0%	2%	3%	24%	0%	2%	3%	42%	0%	2%	2%	15%	0%	3%	3%	18%	0%

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2018/19 by:

- Benchmarking ourselves against our peers with aim to show continual improvements
- Robust systems in place to evidence actions and improvements for under-performing areas
- Monitoring against key performance indicators set as part of the Nursing System Framework.

Core Quality Indicators - Supporting Our Staff

The data made available to the Trust by the information centre with regard to Supporting Our Staff:

The Trust is one of the largest employers in its local community, employing over 9000 people.

The Trust has a number of ways of engaging with staff in order to improve employee engagement and to support staff to continuously strive for excellence in patient care. The efficacy of the Trust's staff engagement approach is measured principally through the annual national NHS Staff Survey and the quarterly national Friends and Family Test.

The data below is collected nationally each quarter and shows the percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends. In addition, the percentage of staff who would recommend the Trust as a place to work is shown for quarters Q1 2017/18 to Q4 2018/19.

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Recommendation Rates - Work

	Q1 2017/18	Q2 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q4 2018/19
RWT	73%	70%	77%	75%	78%	78%
England	64%	63%	63%	66%	64%	65%
Highest	97%	96%	98%	91%	94%	100%
Lowest	29%	25%	23%	24%	31%	30%

Recommendation Rates - Care

	Q1 2017/18	Q2 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q4 2018/19
RWT	82%	82%	86%	86%	88%	88%
England	81%	80%	80%	81%	81%	80%
Highest	100%	100%	100%	98%	100%	100%
Lowest	55%	43%	36%	53%	39%	44%

Not Recommended - Work

	Q1 2017/18	Q2 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q4 2018/19
RWT	10%	14%	10%	12%	10%	9%
England	17%	19%	18%	16%	17%	17%
Highest	57%	64%	59%	41%	48%	47%
Lowest	1%	0%	1%	3%	0%	0%

Not Recommended - Care

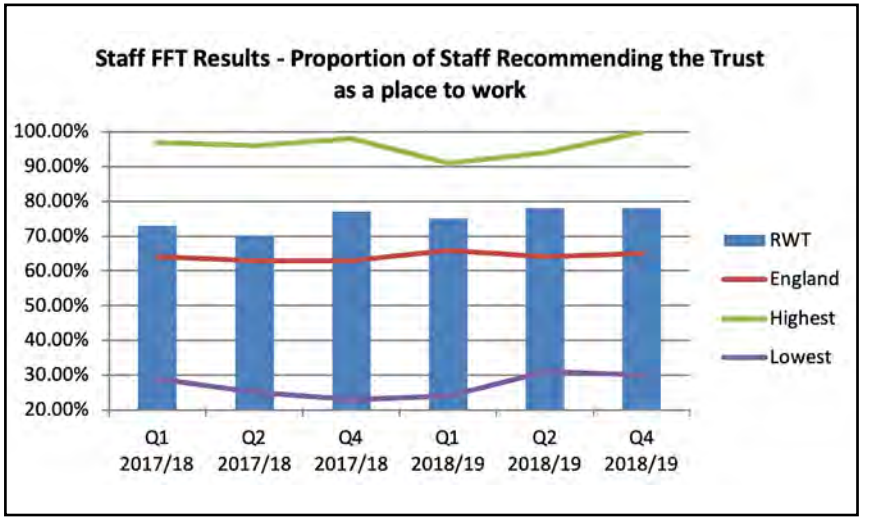
	Q1 2016/17	Q2 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q4 2017/18
RWT	4%	7%	4%	4%	4%	4%
England	6%	6%	6%	6%	6%	6%
Highest	20%	29%	34%	23%	45%	30%
Lowest	0%	0%	0%	0%	0%	0%

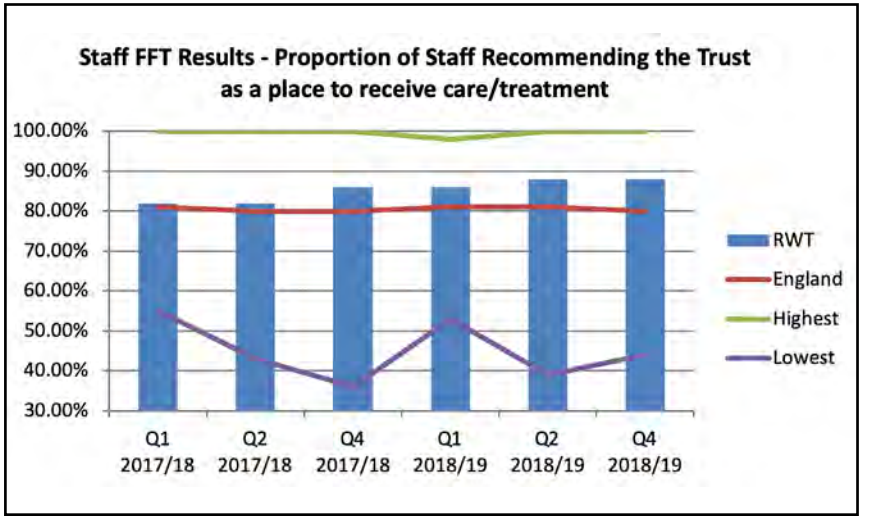
National NHS Survey

The Trust continues to undertake a census of all staff as part of the National Staff Survey such that all staff have the opportunity to provide feedback on their work.

The results from the National Staff Survey have been presented differently in respect of the survey conducted in 2018/19 and rather than being reported against approximately 30 key findings, comparative data in the benchmark report is reported against 10 themes.

The Trust's results in relation to these 10 themes is shown in the table below. Notably the Trust's performance is above average against all but one of the themes (Equality and Diversity). Encouragingly, of the 10 key findings, 4 have shown significant improvement and, critically, none have deteriorated over the last year.





Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity and inclusion	**9.1**	3229	**9.1**	3078	Not significant
Health and wellbeing	**6.1**	3256	**6.1**	3099	Not significant
Immediate managers	**6.8**	3251	**6.9**	3103	Not significant
Morale		0	**6.3**	3053	N/A
Quality of appraisals	**5.3**	2650	**5.6**	2613	↑
Quality of care	**7.7**	2701	**7.6**	2607	Not significant
Safe environment - Bullying and harassment	**8.2**	3220	**8.2**	3067	Not significant
Safe environment - Violence	**9.5**	3209	**9.6**	3065	↑
Safety culture	**6.6**	3231	**6.8**	3082	↑
Staff engagement	**7.0**	3257	**7.2**	3125	↑

The staff engagement measure has improved over the last year as shown in the chart above.

The Royal Wolverhampton NHS Trust considers that this data is as described for the following reasons:

- The results are shared across the Trust through the management structure to all local areas
- Results are discussed at monthly governance meetings
- Themes are identified at a Trust, Division and Directorate level for priority action, and initial action plans are being developed
- These action plans will be monitored through divisional governance structures and the newly established Staff Survey Oversight Group, chaired by the Director of Workforce
- Updates for assurance are provided at the Trust's Workforce and Organisational Development Committee

- **The Royal Wolverhampton Trust intends to take/has taken the following actions to improve this, and so the quality of its services in 2019/20 by:**
- The development of a strategic approach to employee wellbeing
- Increased focus on flexible working as part of work on staff retention
- Continued work to embed the Trust's equality objectives which were relaunched in 2018
- Embedding the new Workforce Disability Equality Scheme alongside the established Workforce Race Equality Scheme
- Work to support immediate line managers in leading their teams which is linked to the Trust's leadership development programme.

Supporting Staff through Speaking Up

Details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

In addition to the overall engagement approach, staff can speak up through a range of different methods which include the Speak Up Process linked to the Freedom to Speak Up Guardian. The Trust's Freedom to Speak Up Guardian works with a group of contact links who are available to listen to staff on a confidential basis in relation to any concerns to ensure a high level of accessibility across the organisation. Where concerns are raised with the contact links directly (even in the event that the individual retains their anonymity), the Freedom to Speak Up Guardian/contact link ensures that feedback is sought and provided to the individual.

In addition to staff being able to speak up to their line managers, or other managers and board members within the Trust, staff are able to anonymously raise a concern through the datix system. These concerns are directed to the relevant line manager and the Freedom to Speak Up Guardian.

Review of Quality

OUR PERFORMANCE IN 2018/19

Overview of the quality of care based on trust performance

As part of the standard NHS contract, the Trust is required to monitor and report performance against a set of key metrics. These indicators are all reported to the Trust Board on a monthly basis.

Performance against the National Operational Standards:

Indicator	Target 2018/19	Performance 2018/19	Performance 2017/18	Performance 2016/17
*Cancer two week wait from referral to first seen date	93%	**83.18%**	92.74%	93.59%
*Cancer two week wait for breast symptomatic patients	93%	**52.12%**	92.36%	95.39%
*Cancer 31 day wait for first treatment	96%	**90.15%**	97.24%	96.52%
*Cancer 31 day for second or subsequent treatment - Surgery	94%	**76.02%**	88.60%	86.49%
*Cancer 31 day for second or subsequent treatment - Anti cancer drug	98%	**100.00%**	100.00%	99.72%
*Cancer 31 day for second or subsequent treatment - Radiotherapy	94%	**87.95%**	97.81%	98.04%
*Cancer 62 day wait for first treatment	85%	**62.78%**	75.01%	77.84%
*Cancer 62 day wait for treatment from Consultant screening service	90%	**78.48%**	81.86%	86.97%
*Cancer 62 day wait - Consultant upgrade (local target)	88%	**81.90%**	90.71%	91.07%
Emergency Department - total time in ED	95%	**91.12%**	89.97%	90.66%
Referral to treatment - incomplete pathways	92%	**90.44%**	90.11%	90.89%
Cancelled operations on the day of surgery as a % of electives	<0.8%	**0.47%**	0.53%	0.42%
Mixed sex accommodation breaches	0	**0**	0	1
Diagnostic tests longer than 6 weeks	<1%	**1.50%**	0.8%	1.1%

*forecast final performance as final figures are not finalised at the time of publication.

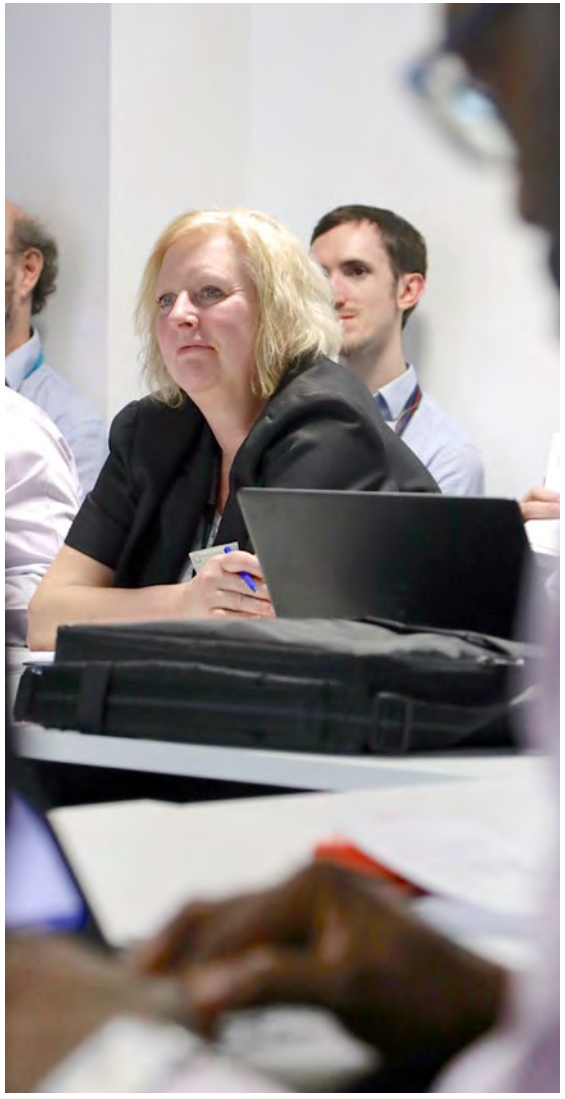
Performance against other national and local requirements

There are a number of other quality indicators that the Trust uses to monitor and measure performance. Some of these are based on the National Quality Requirements and others are more locally derived and are more relevant to the city of Wolverhampton and the wider population we serve.

Similar to the National Standards, these metrics are also reported to the Trust Board alongside a range of other organisational efficiency metrics. This gives the Board an opportunity to have a wide ranging overview of performance covering a number of areas

Performance against other National and Local Quality Requirements:

Indicator	Target 2018/19	Performance 2018/19	Performance 2017/18	Performance 2016/17
Clostridium Difficile	35	**31**	28	45
MRSA	0	**2**	2	0
Referral to treatment - no one waiting longer than 52 weeks	0	**0**	0	10
Trolley waits in A&E longer than 12 hours	0	**7**	4	0
VTE Risk Assessment	95%	**93.26%**	95.62%	96.00%
Duty of Candour - failure to notify the relevant person of a suspected or actual harm	0	**1**	3	3
Stroke - 90% of time spent on stroke ward	80%	**93.55%**	85.20%	89.16%
Maternity - bookings by 12 weeks 6 days	>90%	**90.80%**	91.50%	90.40%
Maternity - breast feeding initiated	>64%	**64.90%**	64.50%	65.20%




NHS

ENGAGEMENT IN THE DEVELOPING OF THE QUALITY ACCOUNT

Prior to the publication of the 2018/19 Quality Account, we have shared this document with the following:

- Our Trust Board, including combination of Non-Executive and Executive Directors
- City of Wolverhampton Council Health Scrutiny Board
- Wolverhampton CCG
- Trust staff
- Healthwatch
- Council of Members

In 2019/20 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

We would like to thank all of the patients, community representatives for their feedback and members of staff who gave their time to help us select our priorities and ensure that the document is clear and accessible

CITY OF WOLVERHAMPTON COUNCIL

Statement from City of Wolverhampton Council Health Scrutiny Panel

City of Wolverhampton Council's, Health Scrutiny Panel would like to acknowledge the spirit of co-operation and collaborative working that The Royal Wolverhampton NHS Trust has shown with the Scrutiny Panel. The Panel welcome the continued transparency and the Trust's compliance with information requests from the Panel.
The Panel wishes to pay tribute to the hard-working and dedicated staff of the Trust and acknowledges the commitment from the Chief Executive and Senior representatives from the Trust in regularly attending meetings of the Panel.
The Scrutiny Panel is particularly pleased to see that the number of appointments for health checks have doubled. The Panel acknowledges and welcomes the fact that the Board has taken the elevated mortality indicators, as detailed in the Quality Accounts, very seriously and is taking active steps in relation to this matter.
The Health Scrutiny Panel held a special meeting on the Trust's mortality statistics, to which all Staffordshire County Council - Health Scrutiny Panel Members were invited to attend. The meeting was most useful and led to a much greater understanding of the elevated figures. It is an area in which the Panel will ask to continue to receive updates and analysis on in the future and the Panel will wish to review the new Mortality Strategy as part of its Work Programme.
The Panel appreciates that there has been a surge in admissions for cancer treatment which helps to explain some of the low performance in many areas against national operational cancer standards. The area of most concern is the 52.01% performance against a target of 93%, for a two week wait for breast symptomatic patients. The Scrutiny Panel would like to work with the Trust to make recommendations to try and improve the Trust's performance in cancer treatment, increasing the take-up for cancer screening for Wolverhampton residents and enhancing the general preventative agenda.
The Panel takes Data Protection and Cyber Security matters very seriously and will watch with interest the ongoing work in this area by the Trust. The Panel is aware that there has been two recent CQC inspections at Lakeside Medical Centre and Penn Manor Medical Practice, the Panel will await the publication of the final reports before commenting.

The Panel would like to commend the Trust for their innovative work on apprenticeships and especially within the nursing programme. The Panel also pay tribute to the Trust in receiving the Nursing Times Workforce Award for Best International Recruitment Experience. The Panel is supportive of the collaborative working with external partners such as the Prince's Trust to develop career opportunities for young people. It was pleasing to read that patient facing staff have been given the opportunity to receive basic British Sign Language training.
The Panel hope that line managers will do all they can to encourage front line staff to participate. The Panel supports the 'Patient Stories' approach as we feel this can bring back the human element to decision making.
On the results of the Patient Led Assessments of the Care Environment, the Panel would like to see an improvement next year under the category of Privacy, Dignity and Wellbeing. The Panel note that the organisational average is below the national average by a few points. It is however acknowledged that the overall results were positive.
The Quality Accounts show that there were a small number of national audits the Trust participated in which showed significant non-compliance in certain areas such as "Pain in Children." The Panel will be asking for an update on these areas in the future to monitor progress and it will be added to the Scrutiny Work Programme.
City of Wolverhampton Health's Scrutiny Panel look forward to continuing to work together with the Royal Wolverhampton NHS Trust for the benefit of all Wolverhampton residents.

Cllr Jasbir Jaspal
Chair of Health Scrutiny Panel
City of Wolverhampton Council
9th May 2019

NHS
Wolverhampton
Clinical Commissioning Group

Statement from Wolverhampton Clinical Commissioning Group

As lead commissioner, Wolverhampton Clinical Commissioning Group (WCCG) welcomes the opportunity to provide this statement for The Royal Wolverhampton Trust quality account for 2018/19. In doing so, the WCCG reviewed the Quality Account in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Quality Review Meetings (CQRM) attended by commissioners. This evidence is triangulated with information and further informed through Quality Assurance visits to the Trust to gain assurance around the standards of care being provided for our population. The WCCG supports the Trusts' identified quality priorities for 2019/20. To the best of our knowledge, the report appears to be factually correct.

In the quality accounts for 2018/19 the Trust has demonstrated its passion and determination to continually improve the quality of care it delivers across the healthcare economy, following their common goal "to make sure that patients are at the centre of all we do". Whilst reviewing the Quality Account we were pleased to note many of the specific actions that the Trust has taken during 2018/19 to improve its services and the quality of care that it provides.

The Trust has addressed key areas to improve patient safety and have continued to strengthen learning from incidents, complaints and feedback with a focus on the following areas of specific focus:

- Ensuring safer care by reducing the instances of harm caused, in particular with reference to cancer services and mortality.
- Improving the experience of patients
- Maintaining Nurse staffing levels and enhancing the workforce with new roles

During 2018/19, as evidenced in the quality account, the workforce has been the greatest challenge, particularly across medicine and nursing. The WCCG recognise the significant focus on a range of trust initiatives such as expansion of the clinical fellowship programme model into nursing and medicine which is successfully attracting home grown and international nurses and medical staff to help achieve overall reduction in number of vacancies. The clinical leadership and focus afforded by the trust with regards these initiatives are to be congratulated.

WCCG has been working closely with the Trust with regards to significant challenges around the increase in Summary Hospital-level Mortality Indicator (SHMI) rates and very much understands this to require a local system response for improvement. That said the trust have responded quickly, effectively and collaboratively to address any immediate concerns with regards this indicator and it is clear from the mortality strategy recently published by the trust that the clinical leadership and corporate oversight provided ensures this indicator is at the forefront of trust business. This includes ensuring a robust process is in place for learning from deaths, in line with national policy and to promote learning from such reviews to improve support and engagement with the families and carers. We recognise the Trusts further emphasis and development of key quality initiatives such as Sepsis 6 bundle implementation, bereavement support, a focus on VTE (Venous thromboembolism) quality improvement initiative, introduction of medical examiner role, NEWS 2(National Early Warning Score) installation into VitalPAC which will support a focus on ongoing quality improvement. The WCCG will continue to work and support the trust to ensure that safe care remains at the heart of our commissioned services.

Cancer performance is an area of significant challenge and whilst demand has outstripped capacity in some clinical pathways the relentless focus on improving productivity of every clinical pathway has resulted in significant time reduction for those patients waiting for diagnosis and treatment. Again the WCCG have worked in partnership with the Trust to adopt a local system approach to improvement, this includes working with local primary care colleagues to ensure referral pathways are robust and commissioning additional diagnostic capacity to support the increased demand. The work of the urology team in particular requires recognition for the significant reduction in overall pathway for urological cancer patients waiting for RALP (Robot Assisted Laparoscopic Prostatectomy) and whilst demand continues to be a challenge for this pathway the work of the team has contributed to significant improvements in waiting times.

Priority 1 - Workforce

The Quality Account commits to continue to embrace the concept of attracting and retaining staff by reviewing pipelines into registration, the development of new

and existing roles and new ways of working, to ensure that the right staff are in the right place, at the right time. During 2018/19, the Trust has introduced a new centralised recruitment process and it is pleasing to see an overall reduction in the number of nurse vacancies in the Emergency Department and Acute Medical Unit and is positively working towards achieving the similar position in other clinical specialities. The WCCG would like to congratulate the Trust on winning the Nursing Times Workforce Award for Best International Recruitment Experience in 2018.

Priority 2 -Safer Care

Throughout 2018/19 The Royal Wolverhampton NHS Trust has demonstrated significant improvement in areas regarding patient safety, specifically the Trusts ongoing quality improvement and governance around learning from serious incidents, identifying focus on human factors involved in incidents, and detailed root cause analysis processes. Specifically, WCCG recognises the work undertaken by the Trust over the course of 2018/19 to achieve a significant reduction in the number of pressure ulcers and patient falls with harm serious incidents reported for 2018/19 which is a significant achievement compared to the previous year. WCCG also acknowledges the key safety measures been put in place by the trust to achieve a notable reduction in the number of Never Events and especially the reduction in the number of serious incidents reported for Neonatal, Maternity and Emergency Department for this reporting period. The WCCG welcome the

Trusts continuous commitment to 'Sign up to Safety' to improve safety culture and team performance thereby impacting on the quality and safety of patient care.

Priority 3 - Patient experience

The WCCG acknowledge the continued patient and public engagement work that has positively impacted on the expansion in the volunteer services and the commitment to the equality, diversity and inclusion objectives. It is good to see that the trust is in process of developing a Patient Experience, Engagement and Public Involvement Strategy and also that the Trust is working on the number of work streams to drive the implementation of the strategy to improve the overall patient experience. The WCCG also found it pleasing to note that the Trust has implemented several initiatives to improve processes, communication and inclusivity from an Equality, Diversity and Inclusion perspective.

Looking forward

Going into 2019/20 the WCCG will continue to work collaboratively with the Trust and will seek further improvements in all areas of clinical quality, including cancer performance, mortality, VTE and sepsis. We fully support the Trusts commitment to achieve continuous improvements for patients in both their experience and outcomes and welcome the particular focus on overall reduction in mortality and reducing all cancer performance targets for our population.

The quality account is comprehensive and the report reflects an accurate picture of the Trust based. The WCCG has been working closely with the Trust during the year, gaining assurance of the delivery of safe and effective services. A range of indicators in relation to quality, safety and performance is presented and discussed at regular meetings between the Trust and WCCG. The information presented within the Quality Accounts is consistent with information supplied to the commissioners throughout the year. There are notable areas of success as well as areas that continue to require focus and improvement. 2019/20 will be a year that will bring further change and challenge for the Trust, as commissioners we believe that the Trust's values will drive forward the objectives and they will continue to improve quality across the breadth of services we commission, their continuous improvement will benefit our patients in the care they receive.

The Wolverhampton Clinical Commissioning Group would like to thank The Royal Wolverhampton NHS Trust for the opportunity to review and provide a response to the 2018/19 Quality Account. It is encouraging to see from this Quality Account that the Trust is clear that providing high quality and safe care is their number one priority. This is clearly evident through the progress with the quality priorities for 2018/19 and the selection of new priorities for the year 2019/20.

Yours Sincerely

Dr Helen Hibbs
Chief Officer

8th May 2019

Statement from Wolverhampton Healthwatch

Healthwatch Wolverhampton response to the Royal Wolverhampton NHS Trust Quality Accounts 2018/2019

Healthwatch Wolverhampton will continue to work with the Trust to focus on improving patient experience and patient engagement especially being more visible in the community.

Healthwatch have carried out several Enter and View visits within the Trust. Healthwatch would like to be assured that the trust is ensuring that the members of The Council of Members are a representative of the community including the Deaf and hard of hearing group.

The Trust has a challenge ahead with the shortage of nurses and Healthwatch understand that this is a national shortage; however, it is assuring that the Trust have got a plan to recruit and retain staff. I believe staff that are recruited from overseas must have English assessments, however, the patients are struggling to understand them.

Healthwatch continues to work on the mortality "Learning from Deaths" to ensure that the patients relatives are engaged throughout the process.

Healthwatch continues to work with the Trust to ensure there is ongoing and meaningful conversations and engagement with patients and members of the public around the future service models to sustain and improve its service provision and to understand how the Trust are linking their Engagement Strategy into the City Vision.

Healthwatch Wolverhampton will continue to review the progress against the forthcoming years priorities and to ensure the residents of Wolverhampton are not impacted and their experience improves.

Kind regards

T. Cresswell

Yours sincerely

Tracy Cresswell

Wolverhampton Healthwatch Manager

8th May 2019

Statement of Directors Responsibilities in respect of the Quality Account 2018/19

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012)). In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance

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

By order of the Board

David Loughton, CBE

Chief Executive

4th June 2019

Professor Steve Field, CBE

Chairman

4th June 2019

Statement of Limited Assurance from the Independent Auditors

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF THE ROYAL WOLVERHAMPTON NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of the Royal Wolverhampton NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

- Patient Safety Indicator (PSI); and
- Venous thromboembolism (VTE).

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all

material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2018 to April 2019;
- papers relating to quality reported to the Board over the period April 2018 to April 2019;
- feedback from the Wolverhampton Clinical Commissioning Group dated 08/05/2019;
- feedback from the City of Wolverhampton Council dated 09/05/2019;
- feedback from Healthwatch Wolverhampton dated 08/05/2019;
- the latest national staff survey dated 2018;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 24/05/2019;
- the annual governance statement dated 24/05/2019; and
- the Care Quality Commission's inspection ratings report dated 27/06/2018.

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

This report, including the conclusion, is made solely to the Board of Directors of The Royal Wolverhampton NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Royal Wolverhampton NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the

Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Royal Wolverhampton NHS Trust.

Basis for qualified conclusion on the Patient Safety and Venous thromboembolism indicators

A random sample of 25 incidents were selected between April 2018 and March 2019 to confirm that the information held in Datix system is consistent with National Reporting and Learning System (NRLS) submissions and the Trust's grading of incidents.

From the data provided for the audit we found a total of 5,395 incidents of which 16 resulted in severe harm or death, giving a rate of 0.32%. This was compared to the external reporting to NRLS, a total of 5,213 incidents of which 23 resulted in severe harm or death, giving a higher rate of 0.44%.

The published reports from the NRLS use data cut-off two months after the reporting period from the date of extraction. As a result of continuous updates by the Trust to their data, there is an inherent risk that updates to the data by the Trust are not reflected in the NRLS published reports. From our sample testing, we found further timeliness issues, 10 out of 25 incidents were reported 5 days after the date of the incident.

From a sample of 25 instances selected between April 2018 and March 2019 to confirm that the information held in the VTE system is accurate and is consistent with that which is reported to NHSI and the Trust's Quality Account, we found four instances that had an assessment date either before the admission date or after the discharge date. This was limited to data between August and early October 2018.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the Patient Safety and Venous thromboembolism indicator section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP.

KPMG LLP

Chartered Accountants

Birmingham

28 May 2019

Actions following the Statement of Limited Assurance from the Independent Auditors

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Trust's response
1	1	**PSI: Strengthening the timely reporting of Patient Safety Incidents** The Trust's policy sets a target of 48 hours for reporting any incident. As part of our testing, we found that 10 out of 25 incidents sampled were reported after 5 days of the incidents occurred and 13 out of 25 incidents were uploaded to NRLS system after 30 days of the incidents added to the Datix system. The timely capture of incidents and their submission is important for serious incident investigation and resolution by the Trust's Quality and Safety Intelligence Group as well as identifying and addressing any potential gaps in understanding. **Recommendation** The Trust should evaluate options to upload its data to NRLS more frequently and develop agreed performance measures for timeliness. Some trusts upload their data weekly. The Trust should establish a process of reporting and escalation through to the Quality Assurance Governance Committee where adverse performance is experienced on agreed timeliness measures.	The Trust has agreed to: • Implement weekly uploads to NRLS. • Establish monitoring process for the weekly uploads to NRLS. • Re-inforce the requirement of reporting incidents within 48 hours of their occurrence as stipulated by the Trust's policy. • Develop a process for targeting those clinical areas where a delay in reporting of incidents within the 48 hour timescale has occurred. • Commence reporting of NRLS uploads via the Quality Safety Intelligence Group and the Quality Governance Assurance Committee.
2	2	**PSI: Maintaining a NLRS submission** We found differences across the indicator calculated based on the data provided for the audit, the figures used for internal reporting and the data submitted to the NRLS. **Recommendation** The Trust should undertake a reconciliation of the PSI figures between those reported to the NLRS and the underlying systems prior to creating the dataset for the audit.	The Trust has agreed to develop a Standard Operating Procedure for undertaking reconciliation of the PSI figures between those reported to NRLS and the underlying systems prior to creating the dataset for the audit.

#	Risk	Issue, Impact and Recommendation	Trust's response
3	2	**VTE: Improving the segregation of duties between manual input and submission sign-off** The same Trust officer is responsible for the manual input of data from the paper risk assessment forms into the database, the manual amendments to the VTE database reports and for signing off the SDCS submissions. A sepa-ration of duties between these tasks would mitigate against the risk of acci-dental or deliberate errors and protect the individual from any unwarranted criticism or suspicion of manipulation. The Trust has sought to refine its compilation of records prior to submission. However, it remains complex and prone to the occasional error. From our testing we found 4/25 instances where the VTE assessment date was either before the admission date or after the discharge date. The Trust's own test-ing, undertaken in response to our findings, also found instances where the Vitalpac software showed that VTE assessments were completed that the database records for the audit did not reflect. **Recommendation** The Trust should appraise options to better segregate duties for the formal review and approval process for manual changes and input of data from pa-per assessment forms. In addition, the Trust should evaluate options to clarify and share responsi-bilities among Information Services and VTE staff over future data validation procedures.	The Trust has agreed to: • Information services to review process to ensure accuracy of data submission to Strategic Data Collection Services. • Appraise options to better segregate duties for the formal review and approval process for manual changes and input of data from paper assessment forms. • Explore options to ensure greater clarity and sharing of responsibilities for future data validation procedures.
4	3	**PSI: Gaining assurance over 'No' harm and 'Low' harm incidents** Our testing found evidence that incidents were reviewed and approved by a local management level. Only 'moderate' harm or above incidents were systematically validated by the Governance team. There remains is a small risk that inconsistencies across the Trust may permeate over time and that low or no harm incidents might be more serious incidents on review. **Recommendation** The Trust should devise a systematic approach to reviewing a periodic sample of lower harm rated incidents. Any learnings should be fed back to frontline staff through the normal mechanisms.	The Trust has agreed to review governance team resources in order to develop a systematic approach to reviewing a periodic sample of lower harm rated incidents and ensure any learning is fed back to frontline staff.

Actions following the Statement of Limited Assurance

The following action is ongoing from 2017/18

#	Risk	Issue, Impact and Recommendation	Trust's response
1	2	**Quality Account -C-Difficile Indicator: Data entry omissions** When faecal samples are received in the microbiology laboratory they undergo a screening process and review against the prescribed criteria to determine if a C-Diff test is required. For 2017-18, the system recorded 4,361 samples with an acceptable exclusion result or reason. However, we found 3,993cases in which there were blank or undetermined fields and so the exclusion reason could not be immediately identified. A similar issue was reported in 2016/17 where the respective figures were 4,492 and 4,136 respectively. Using other fields or searches of source records it was possible for laboratory staff to identify the reason for no test being performed, with the exception of 13 cases, where tests for C-diff should have been completed but were not, and of these there were two cases that if tested and C-diff was identified could have been attributable to the Trust. In the unlikely event that both were positive cases, it would not make a difference to the overall achievement of the C-diff target. **Recommendation** Where the decision to exclude a sample from C-Diff testing is taken, the Trust should enforce mandatory recording of the reason in the system.	In order to implement this action fully, the Trust has agreed to develop a new laboratory system with the aim to use the new system to reduce the risk of human error and to avoid samples not being tested in line with Department of Health recommendations.

We have also followed up the recommendations from the previous years audit, in summary:

Total number of recommendations	Total number of recommendations implemented	Number of outstanding (repeated below)
5	4	1

How to give comments

We welcome your feedback on this Quality Account and any suggestions you may have for future reports.

Please contact us as indicated below:

Alison Dowling

Head of Patient Experience & Public Involvement

The Royal Wolverhampton NHS Trust

New Cross Hospital

Wednesfield Road

Wolverhampton

WV10 0QP

Email: rwh-tr.patientexperienceteam@nhs.net

Appendix 1 – National Clinical Audits that RWT participated during 2018/19

The 57 National Clinical Audits the Trust collected data for in for 2018/19 are as follows. The reports for the 2018/19 data will be reviewed and presented locally as and when they are made available to the Trust by the relevant Coordinating Centre.

National Clinical Audit & Enquiry Project name of audit	Work Stream / Component	Lead Directorate
Adult Cardiac Surgery	N/A	Cardiothoracic
Adult Community Acquired Pneumonia	N/A	Respiratory
BAUS Urology Audits	Radical Prostatectomy Audit	Urology
BAUS Urology Audits	Cystectomy	Urology
BAUS Urology Audits	Nephrectomy audit	Urology
BAUS Urology Audits	Percutaneous Nephrolithotomy (PCNL)	Urology
Breast and Cosmetic Implant Registry (BCIR)	Breast Implant – cosmetic augmentation and breast reconstruction with implant including revision and removal	General Surgery
Cardiac Rhythm Management (CRM)	N/A	Cardiology
Case Mix Programme (CMP)	N/A	Critical Care
Elective Surgery (National PROMs Programme)	N/A	T&O
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	Rheumatology
Falls and Fragility Fractures Audit programme (FFFAP)	National Hip Fracture Database	T&O
Feverish Children (care in emergency departments)	N/A	A&E
Head and Neck Cancer Audit	National Core Diabetes Audit	Diabetes
	N/A	Oncology / General Surgery

Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	N/A	Gastroenterology
Investigation and Detection of urological Neoplasia in patients referred with suspected Urinary Tract Cancer (IDENTIFY)	N/A	Urology
Learning Disability Mortality Review Programme (LeDeR)	N/A	Trust wide
Major Trauma Audit	N/A	A&E
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	N/A	Infection prevention and Control
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance (reports annually)	Obstetrics and Gynaecology
Medical and Surgical Clinical Outcome Review Programme	Pulmonary embolism	Trust wide
Myocardial Ischaemia National Audit Project (MINAP)	N/A	Cardiology
National Audit of Breast Cancer in Older People (NABCOP)	N/A	General Surgery
National Audit of Cardiac Rehabilitation	N/A	Cardiology
National Audit of Care at the End of Life (NACEL)	N/A	Oncology (Palliative Care Team)
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	N/A	Cardiology
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	N/A	Paediatrics
National Bowel Cancer (NBOCA) **Contract until March 2018.**	N/A	Oncology / General Surgery
National Asthma and COPD Audit Programme (NACAP)	Secondary Care	Respiratory
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	N/A	Rheumatology
National Comparative Audit of Blood Transfusion programme	Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	Pathology

National Comparative Audit of Blood Transfusion programme	Management of massive haemorrhage	Pathology
National Diabetes Audit - Adults	National Diabetes Foot Care Audit	Diabetes
National Diabetes Audit - Adults	National Diabetes Inpatient Audit (NaDia)	Diabetes
National Diabetes Audit - Adults	National Core Diabetes Audit	Diabetes
National Diabetes Audit - Adults	National Diabetes Transition	diabetes
National Diabetes Audit - Adults	National Pregnancy in Diabetes Audit	Obstetrics
National Emergency Laparotomy Audit (NELA)	N/A	Critical Care
National Heart Failure Audit	N/A	Cardiology
National Joint Registry (NJR)	N/A	T&O
National Lung Cancer Audit (NLCA)	Lung Cancer Clinical Outcomes Publication	Respiratory/Oncology
National Maternity and Perinatal Audit (NMPA)	N/A	Obstetrics and Gynaecology
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	N/A	Neonates
National Oesophago-gastric Cancer (NOGCA)	N/A	Oncology
National Paediatric Diabetes Audit (NPDA)	N/A	Paediatrics
National Prostate Cancer Audit	N/A	Oncology
Non-Invasive Ventilation - Adults	N/A	Respiratory
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Antibiotic Consumption	Pharmacy / Microbiology
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Antimicrobial Stewardship	Pharmacy / Microbiology
Sentinel Stroke National Audit programme (SSNAP)	N/A	Stroke

Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	Pathology (Maxine Boyd / Trust Wide)
Seven Day Hospital Services Self-Assessment Survey	N/A	Trust wide
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Acute Internal Medicine / General Internal Medicine	Acute Medicine
Surgical Site Infection Surveillance Service	N/A	Infection prevention and Control
UK Cystic Fibrosis Registry	N/A	Respiratory
UK Renal Registry	N/A	Renal
Vital Signs in Adults (care in emergency departments)	N/A	A&E

Appendix 2 – National clinical Audits that RWT continues to participate in and which remain in progress since 2018/19

There is only 1 audit from the 2018/19 National Clinical Audit programme that has been completed (detail below). The Trust are either still undertaking data submission or awaiting audit results from the National body for all other National clinical audits as detailed in Appendix 1.

National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Paediatrics Acute

Appendix 3 – National Clinical Audits reviewed by RWT in 2018/19 with actions intended to improve the quality of healthcare provided

Completed audits are reviewed by the provider to identify the outcomes of audits and confirm the compliance rating against the standards audited. It is crucial that where audits have identified moderate or significant non-compliance, that actions are taken to address gaps and implement changes to improve the quality of healthcare provided. All audits identified as moderate or significant non-compliance were (where appropriate) added to the 2019/20 audit plan for subsequent re-audit.

The reports of 43 completed National Clinical audit projects have been reviewed in 2018/19 by the provider to date and the actions being taken to continue improvement.

National Clinical Audit, Enquiry, Project name & Workstream	Lead Directorate	Compliance Rating	Actions identified to improve the quality of healthcare provided
BAUS National Complex Surgery Audits/ National Prostate Cancer	Urology	Fully Compliant	Not applicable
Cardiac Arrhythmia / Heart Rhythm Management (HRM) - 2016/17 data.	Cardiology	Fully Compliant	Not applicable
Child Health Clinical Outcome Review Programme (Chronic Neurodisability)	Children's Services - Community	Fully Compliant	Not applicable
Coronary interventions / Coronary angioplasty (BCIS) - 2016 data.	Cardiology	Moderate Non-Compliance	Steps within the department have already been taken to expedite Door To Balloon (DTB) times (meetings with ambulance team, ED teams from referring centres). Furthermore a previous audit highlighted deficiencies in entering data and this has been addressed. Therefore we would expect to see improvements in subsequent BCIS audits.
Exploration of neurodiagnostic practices for the diagnosis of MND	Neurology	Minor Non-Compliance	A future business case for the purchase of required pieces of equipment and employment of trained staff would be necessary to ensure full compliance.
Fractured Neck of femur (Royal College of Emergency Medicine)	Accident & Emergency	Significant Non-Compliance	Audit was presented to ED teaching. Audit findings shared with doctors and nurses in department.

Heart failure (HF) - 2016 / 17 data.	Cardiology	Moderate Non-Compliance	The Directorate is reviewing the inpatient care of HF patients, as well as ensuring that the data submitted to the National Audit is robust. The directorate is exploring the feasibility of expanding capacity for HF patients.
Management of patients at risk of Transfusion Associated Circulatory Overload (TACO)	Pathology	Minor Non-Compliance	An alert message will be added to the e-PMA system to remind prescribers of the requirement to complete a risk assessment where required. The Trust consent for transfusion sticker will be amended to include the requirement to consider TACO.
National (BASHH) SAS AUDIT	Sexual Health/GUM	Moderate Non-Compliance	To amend the proforma to document the reasons for not offering 1st line treatment and a tick box that signposting which includes written information / suitable online resources was provided to the patient.
National 30 day Mortality audit 18/19	Endoscopy	Fully Compliant	Not applicable
National Adult Cardiac Surgery Audit 2017/18.	Cardiothoracic Surgery	Fully Compliant	Not applicable
National ATILLA (Administration of Tranexamic acid In Lower Limb Arthroplasty)	Trauma & Orthopaedics	Not Applicable	Not applicable
National audit of breast cancer in older people	General surgery	Not Applicable	Not applicable
National Audit of Cardiac Rehabilitation (2015-2016 data)	Cardiology	Minor Non-Compliance	The uptake of cardiac rehab is in line with national data and it is recognised that female participation could be improved, With continued education, it is hoped that the proportion of attendees will increase.
National Audit of Inpatient Falls - Round Two	Care of the elderly	Fully Compliant	Not applicable
National Audit on Prostate Trans-rectal ultrasound guided biopsy (TRUS) biopsy versus MRI	Urology	Fully Compliant	Not applicable
National Audit: Nephrectomy Audit (2017)	Urology	Fully Compliant	Not applicable
National Audit: BAUS Urology - Cystectomy	Urology	Fully Compliant	Not applicable

National Clinical Audit on Psoriasis 2017/18 and NICE Compliance CG 153	Dermatology	Minor Non-Compliance	To arrange for appointments for patients with psoriasis in nurse led clinic or in clinics run by junior doctors.
National Comparative Re-Audit of Red Cells and Platelets in Adult Haematology Patients	Pathology	Minor Non-Compliance	Pro-active monitoring of requests from the laboratory and challenge of any requests deemed inappropriate or outside of guidelines.
National Falls and Fragility Fractures Audit programme (FFFAP) 2017/18	Rheumatology	Significant Non-Compliance	A business case to address capacity issues in the service provision and data collection.
National ICNARC Case Mix Audit & Research Programme for Critical Care (relates to 2017/18 data cycle).	Critical Care	Not Applicable	Not applicable
National Maternity and Perinatal Audit (NMPA)	Obstetrics	Fully Compliant	Not applicable
National RCR RT Bladder Audit	Oncology & Haematology	Fully Compliant	Not applicable
National Thoracic Surgery Audit 2017/18	Cardiothoracic Surgery	Fully Compliant	Not applicable
National UK Renal Registry	Renal medicine	Fully Compliant	Not applicable
National UK Renal Registry (2017/18)	Renal medicine	Fully Compliant	Not applicable
National: Implant Based reconstruction audit (IBRA) Multicentre National Audit	General surgery	Fully Compliant	Not applicable
NELA - National Emergency Laparotomy Audit (relates to 2016/17 submission of data).	Critical Care	Moderate Non-Compliance	Pre-operative risk scoring needs to be formalised and made mandatory as part of an emergency laparotomy care pathway. Having identified a patient as high risk, they should then be allocated an ICU bed prior to surgery. Post-op review by a Geriatrician for all patients >70 years old.

Neonatal Intensive and Special Care (NNAP)	Neonatal	Minor Non-Compliance	Unit compares favourably with units in Network cohort, however current performance rating and standard compliance percentages shared with all staff in unit - posters displayed in unit as aid memoir.
NHS Benchmarking - Managing Frailty and Delays Transfer of Care	Care of the elderly	Fully Compliant	Not applicable
Pain in Children (Royal College of Emergency Medicine)	Accident & Emergency	Significant Non-Compliance	Audit finding to be shared with all clinical staff in department via teaching and email.
Regional Audit - An audit of performance vs. the Clinical Guidelines for the pre and post-operative physiotherapy management of adults with lower limb amputations. BACPAR 2016.	Maltings	Minor Non-Compliance	Develop a single checklist for the patient record that makes it clear that information/ opportunities have been provided to patients and carers as appropriate.
Regional Audit Project on multiple birth management	Obstetrics	Minor Non-Compliance	Findings to be discussed at Clinical Governance meeting.
Sentinel Stroke National Audit programme (SSNAP)	Stroke	Minor Non-Compliance	Ensure direct admissions from A&E to ASU
Sepsis CQUIN audit 2017/18	Accident & Emergency	Moderate Non-Compliance	Implementation of EWs 2 across the Trust.
Service Evaluation of inpatient care, communication and facilities for children with neuro-disabling conditions	Children's Services - Community	Moderate Non-Compliance	Education of medical and nursing staff to the importance of supporting these complex children and the use of the GMFCS score. Development of a proforma to prompt staff to consider and record their decisions around communication, mobility, feeding, MDT involvement and the use of patient held records. Circulation to nursing staff about the importance of recording up to date weight and height for all admissions. Appropriate use of care plans
Sleep deprived EEG Service evaluation	Neurology	Fully Compliant	Not applicable
Survey of practice of Neurophysiology Departments in the UK for performing evoked potentials	Neurology	Fully Compliant	Not applicable

TARN (Trauma Audit and Research Network) 2017/18	Accident & Emergency	Fully Compliant	Not applicable
TARN (Trauma Audit and Research Network) 2018/19	Accident & Emergency	Fully Compliant	Not applicable
The Management of Iron Deficiency Anaemia in Pregnancy	Obstetrics	Moderate Non-Compliance	Review Management of Anaemia guidelines. Teaching session to all medical staff to emphasize the importance of treating anaemia in pregnancy and the use of IV iron as an alternative to blood transfusion. Liaising with Pharmacy to use Ferrinject instead of Cosmofer to reduce hospital stay (2hrs vs. 8 hours) and improve compliance with IV iron treatment. Develop posters for all antenatal and postnatal areas
Trans Catheter Aortic Valve Implantation (TAVI) - 2017 data	Cardiology	Fully Compliant	Not applicable

Appendix 4 – Local clinical Audits reviewed by RWT in 2018/19 with actions intended to improve the quality of healthcare provided

The following 74 local audits demonstrated moderate or significant non-compliance against the standards audited. The Trust intends to take the following actions to improve the quality of healthcare provided and will be considered for re-audit against these standards once actions have been appropriately embedded.

Directorate	Audit Title	Compliance Rating	Actions identified to improve the quality of healthcare provided
Accident & Emergency	Audit of CG112 on sedation in children in the Emergency Department	Moderate Non-Compliance	To develop a patient information leaflet, guideline and consent form in line with RCEM guidance.
Accident & Emergency	Assessment of children with self-harm presenting to the emergency department (CG16)	Moderate Non-Compliance	To introduce a mental health risk assessment tool for all patients and to develop two stickers for use in patients' medical notes to document room safety and the process to follow if a patient absconds from ED.
Accident & Emergency	Measuring Compliance with the Emergency Department Adult Procedural Sedation Proforma	Moderate Non-Compliance	Directorate will amend the proforma to include tick boxes to encourage full completion.
Accident & Emergency	Audit of DVT pathway	Moderate Non-Compliance	A review of the documentation process and ensure scoring system used will improve sensitivity and specificity. Document the reason why d-dimers are not done. Also will include audit findings in clinical teaching in ED and also to share these findings with all clinical staff via email and presentation in Governance meeting.
Accident & Emergency	Audit to see if all CT scans are reviewed in 1 hour	Audit to see if all CT scans are reviewed in 1 hour Compliance	Liaise with the Radiology department to expedite final radiology reports within 1 hour from time study performed where possible. Continual training and updates and Encourage (Contact via email and teaching sessions in ED) EM consultants & registrars to attend stroke MDTs that are currently run weekly.
Cardiology	Completion of comorbidity form on the Cardiology Ward	Moderate Non-Compliance	Re-education of junior doctors on the ward; audit findings emphasised at induction and junior doctor forums.

Cardiology	Re-audit (2029) - Use of Ticagrelor in diabetic NSTEMI patients undergoing PCI	Significant Non-Compliance	A new prescribing pathway will be introduced where all NSTEMI patients will be prescribed Ticagrelor when diagnosed.
Children's Services - Community	Investigations for developmental delay in CDC clinics at GEM centre.	Moderate Non-Compliance	Make improvements to the documentation to include the presence of dysmorphic features, Neurocutaneous markers and organomegaly. Local guidelines 'developmental delay investigations' to be updated according to clinical practice.
Critical Care	Prophylactic antibiotic prescription	Moderate Non-Compliance	All anaesthetic staff are to receive the audit results via email as well as the speciality leads for them to highlight the findings in their respective Directorate Governance Meetings. The importance of following the Trust antibiotic guidelines will be highlighted to staff.
Critical Care	Provision of water to patients on elective lists	Moderate Non-Compliance	Posters have been put in the operating theatres reminding teams to consider which patients can drink. The issue of being nil by mouth unnecessarily for a long period of time has been discussed at the Directorate Governance Meeting in order to raise staff awareness.
Critical Care	Handover of responsibility for patients in theatre recovery	Moderate Non-Compliance	Key audit conclusions to be shared with Directorate via Theatre team meetings and departmental noticeboards, with relevant reminders. A new recovery document has also been produced and ordered.
Dental	Clinical Record Keeping	Moderate Non-Compliance	Directorate will develop a standardised record keeping template.
Diabetes	Re-Audit Inpatient Management of hypoglycaemia	Moderate Non-Compliance	Implement a new MDT meeting within diabetes to discuss and manage patients with hypoglycaemia.
General surgery	VTE prophylaxis in acute surgical patients.	Moderate Non-Compliance	A VTE patient information leaflet will be added as part of the package of information given to patients at the time of admission. To record the time the patient is reviewed to aid accurate measures of timing of VTE assessments. Ensure VTE assessments are added to the nursing and doctor's handover and to discuss daily on the safety briefs.
General surgery	NICE CG188 Gallstone Disease	Moderate Non-Compliance	To implement a hot gallbladder list in order to reduce the waiting times for acute cases of cholecystitis.

General surgery	Local: Re-audit Are we compliant with NICE Guidelines on extended prophylaxis for patients undergoing lower GI cancer resections	Moderate Non-Compliance	To further educate the junior doctors at their induction and to write clear instructions for the requirement of extended prophylaxis on operation notes.
Neonatal	Donor Breast Milk - Tracking and Tracing Process	Significant Non-Compliance	A proforma is to be designed to capture the recording and processing of donor breast milk in patients' medical records. The directorate will review and update the relevant current local guidelines in line with the new process of recording donor milk.
Neonatal	Resuscitation Equipment Audit	Moderate Non-Compliance	The directorate and pharmacy have discussed the process in order to strengthen the location of drugs and equipment required for resuscitation for new-born in all areas. The directorate have now purchased all necessary medications and equipment.
Neurology	Audit comparing findings of NCS to carpal tunnel decompression findings during operation.	Moderate Non-Compliance	A research study will be proposed to look at the development of using ultrasound as a diagnostic tool in conjunction with nerve conduction studies looking at carpal tunnel post-operative outcomes.
Neurology	Vitamin D Supplement in Epilepsy Patients	Moderate Non-Compliance	During follow up appointments, all patients on the enzyme inducing anti-epileptic drugs and sodium valproate will have a vitamin D screening and appropriate supplementation if necessary. All newly diagnosed patients with epilepsy will have Vitamin D and Bone profile blood tests.
Obstetrics	A NICE-related Audit on Diabetes in Pregnancy	Moderate Non-Compliance	Will communicate out to the community midwives that all diabetic women should be urgently referred to the Diabetic Specialist Midwife allowing a rapid referral to the joint ANC in order for all advice to be appropriately given at the earliest opportunity. Micro albumin screening has been added as a routine test on the Trusts electronic requesting system ICE.
Ophthalmology	Re-audit of referral vetting outcomes	Moderate Non-Compliance	Increase clinic capacity.
Oncology & Haematology	Syringe driver monitoring re-audit	Moderate Non-Compliance	Education of staff on wards to highlight importance of full completion of charts and the audit will also be presented at Matron's group.

Pathology	Audit of Transfusion in Children with Sickle Cell Disease	Moderate Non-Compliance	Paediatric team to inform the CCG of actions required in relation to vaccination in the community. The paediatric team will identify patients for virology screening and phenotyping and submit samples to the laboratory. The consent sticker will be amended to include pre and post transfusion HbS levels.
Pharmacy	Safer use of IV gentamicin in neonates through implementation of the NPSA neonatal gentamicin care bundle	Significant Non-Compliance	Audit findings will be communicated out to the consultant body and senior nursing staff. To ensure the junior doctors are fully aware of the guidelines the correct prescribing protocol will be taught at the junior doctor induction and further emphasised during their teaching sessions. Pharmacy will plan a re-launch of the Gentamicin care bundle at ward level.
Pharmacy	An audit to assess penicillin allergy recording	Moderate Non-Compliance	Findings of audit presented to the antimicrobial stewardship team. A patient information leaflet detailing the difference between penicillin allergy and the side effects and symptoms of true penicillin allergy will be produced. A checklist for diagnosing penicillin allergy will be created.
Primary Care Services (W)	Cervical cytology	Moderate Non-Compliance	Cervical screening uptake is declining nationally however additional recruitment of staff to increase cervical cytology rates is planned. Education for young women, especially those aged 25-29, needs to be improved; an action plan to develop education will be made once additional staff are in post.
Radiology	IPG473 Uterine Artery Embolisation for treating adenomyosis	Moderate Non-Compliance	A business case for the development of a gynae MDT (Multi-disciplinary team) will be created.
Trauma & Orthopaedics	NICE CG 124	Moderate Non-Compliance	Undertaking a re-audit as not all nursing documentation was reviewed in original audit therefore results are not conclusive.
Trauma & Orthopaedics	Management of buckle fractures of the distal radius; a service evaluation.	Moderate Non-Compliance	Current pathway to be amended so consultants can consider discharging patients after their first fracture clinic appointment in either a future splint or removable soft cast with advice to parents to remove splint in 3-4 weeks.
Critical Care	Coagulopathy due to Cholestasis in Obstetric patients undergoing regional technique	Moderate Non-Compliance	Directorate has met with the Obstetric team and they are reviewing new guidelines which have been produced which suggest that coagulation tests to be done on admission to delivery suite if bile acids are more than 40umol/L. A re-audit after implementation of guidelines will be done.

Critical Care	Fasting times in emergency patients	Significant Non-Compliance	Education of the nursing and medical staff on acceptable levels of fasting is required along with better coordination between the specialities on the timing of operations. List orders must be made as far in advance as feasible. These and any changes to list order should be done on a consultant-to consultant level.
Critical Care	Audit on intraoperative use of Entropy/BIS	Significant Non-Compliance	The audit findings are to be presented at the anaesthetic clinical governance meeting to explore the reasons for non-compliance.
General surgery	NICE CG174 IV Fluid Management in Acute Surgical Patients	Moderate Non-Compliance	Ensure all junior doctors have appropriate levels of education on IV fluids management by including the subject in the Junior doctor induction.
Gynaecology	Improving the safety and effectiveness of gynaecology handover: a Quality Improvement Project	Moderate Non-Compliance	Consideration of the timings of handovers and staff involved in this process will be discussed. Measures such as increasing the accuracy of the handover sheet and ensuring there are enough sheets available will also be considered.
Urology	NG002 Bladder cancer: diagnosis and management of bladder cancer	Moderate Non-Compliance	Audit findings will be disseminated to colleagues for further discussions on improving levels of compliance.
Children's Services - Acute	High Hb A1c	Moderate Non-Compliance	Identifying a key worker for each patient. Identifying a consultant for each group of patients. Intensive contact at least 1-2 weeks by the KW. Revisit education and identifying major issues. Review progress 6 weekly by consultant. If no improvement then the patient is to be discussed in the MDT to consider CGM for 2 weeks or other option base on individual needs. Low threshold to admit for stabilization and address Safeguarding/ social issue.
Primary Care Services (VI)	Trust Wide DNA CPR Audit CP 11	Moderate Non-Compliance	Patient MUST be involved in discussions about DNARCPR if having capacity to do so. Involve family members. Perform Mental Capacity 2 stage Test, if clinicians feel the patient may lack capacity. If lacking capacity, all decisions must be done in the best interest and together with the family. Document in the patient notes that DNARCPR has been completed and who was involved (list names) within MDT discussion.

Radiology	IR(ME)R Audit : Compliance of Employers Procedure C. Making Enquiries of Individuals of childbearing potential to establish whether an individual is or may be pregnant or breast feeding (re-audit)	Significant Non-Compliance	Share results of audit with all operators in the department highlighting areas of poor compliance. Bi -monthly audited data to be collated and forwarded to Modality Team Leaders to liaise with individual operators who consistently fail to comply.
Radiology	IR(ME)R Audit : Compliance of Employers Procedure A. Identification (re-audit)	Significant Non-Compliance	Share results of audit with all operators in the department highlighting areas of poor compliance. Conduct a re- audit 2019-2020. Monthly audited data to be collated and forwarded to Modality Team Leaders to liaise with individual operators who consistently fail to comply.
Urology	Active surveillance for prostate cancer: re-audit to assess progress in compliance against national guidelines	Moderate Non-Compliance	Use MDT proforma accept that clinical guideline is obsolete with regards to DRE.
Speech & Language Therapy	Audit of discharge documentation for patients discharged from New Cross Hospital on modified diet/fluids	Significant Non-Compliance	Patients having thickened drinks need to have this added to drug charts to ensure it goes on TTOs. Medics need to record current SALT recommendations on e-Discharge and SLTs to prescribe thickener where appropriate on ePMA.
Oncology & Haematology	Audit of the BSH guideline for the management of acute chest syndrome in sickle cell disease	Moderate Non-Compliance	Teaching to be put in place for nurses on the clinical haematology unit to emphasise requirement of observations to be carried out every four hours and oxygen sats <94% should always trigger a medical review. To be relayed at grand round to all medical staff taking care of SCD patients that these patients should have their chests examined daily and it be noted in the notes. Management checklist template for ACS will be reviewed.
Care of the Elderly	About Me (Spot Audit)	Moderate Non-Compliance	Review the About me doc and re-launch with Care bundle and care plans Recruit more volunteers
Critical Care	Anaesthetic Record-keeping - 2018/19	Moderate Non-Compliance	Distribute individual audit results to respective anaesthetists for discussion at appraisal. Ensure all have an ID stamp and educate that this is a requirement. Clarify where and why ID info needs to be recorded and re-audit annually.

Cardiology	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Directorate to review areas of non-compliance and devise individual action plan.
Cardiothoracic Surgery	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Directorate to review areas of non-compliance and devise individual action plan.
Critical Care	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Directorate to review areas of non-compliance and devise individual action plan.
General Surgery	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Directorate to review areas of non-compliance and devise individual action plan.
Head & Neck	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Directorate to review areas of non-compliance and devise individual action plan.
Ophthalmology	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Directorate to review areas of non-compliance and devise individual action plan.
Trauma & Orthopaedics	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Urology	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Care of the Elderly	Trust Wide OP07 Health Records Documentation audit 2018/19	Significant Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Diabetes	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.

Gastroenterology	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Neurology	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Oncology & Haematology	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Renal	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Respiratory	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Stroke	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Therapy Services	Trust Wide OP07 Health Records Documentation audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Cardiothoracic Surgery	Trust Wide Early Warning Signs Audit 2018/19	Significant Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
General Surgery	Trust Wide Early Warning Signs Audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Head & Neck	Trust Wide Early Warning Signs Audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
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Care of the Elderly	Trust Wide Early Warning Signs Audit 2018/19	Significant Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Diabetes	Trust Wide Early Warning Signs Audit 2018/19	Significant Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
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Renal	Trust Wide Early Warning Signs Audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Respiratory	Trust Wide Early Warning Signs Audit 2018/19	Moderate Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.
Stroke	Trust Wide Early Warning Signs Audit 2018/19	Significant Non-Compliance	Implementation of EWS 2 across the Trust and Directorates to review barriers and identify solutions to these to increase compliance.

Glossary

For those readers who are not familiar with some of the terminology used in this document, the table below offers some explanation of abbreviations that have been used:

A&E	Accident and Emergency Department	MSSA	Methicillin Sensitive Staphylococcus Aureus
ACPs	Advanced Clinical Practitioners	MUST	Malnutrition Universal Screening Tool
CCS	Clinical Classification System	NCDAH	National Care of the Dying Audit – Hospitals
C-Diff	Clostridium Difficile	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
CICT	Community Intermediate Care Team	NCI/NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
CQC	Care Quality Commission	NHS	National Health Service
CQUIN	Commissioning for Quality and Innovation	NHSLA	NHS Litigation Authority
CMACH	Confidential Enquiry into Maternal and Child Health	NICE	National Institute of Clinical Excellence
CNO	Chief Nursing Officer	NIHR	National Institute for Health Research
DNA	Did Not Attend	NPSA	National Patient Safety Agency
DRHABs	Device related hospital acquired bacteraemia (blood infections)	NRLS	National Reporting and Learning Service
EAU	Emergency Assessment Unit	NSSC	Nutrition Support Steering Committee
ED	Emergency Department	ONS	Office for National Statistics
ENT	Ear, Nose & Throat	OSC	Overview & Scrutiny Committee
EOLC	End of Life Care	OWL	Outpatient Waiting List
GP	General Practitioner	PALS	Patient Advice & Liaison Service
GMCRN	Greater Midlands Cancer Research Network	PEAT	Patient Environment Action Team
HCAs	Health Care Assistants	PHSO	Parliamentary and Health Services Ombudsman
HRG	Healthcare Resource Group	PSIs	Patient Safety Incidents
HSMR	Hospital Standardised Mortality Ratio	PCT	Primary Care Trust
IHI	Institute for Healthcare Improvement	RRR	Rapid Response Report
IT	Information Technology	RWT	The Royal Wolverhampton NHS Trust
KITE	Knowledge, Information, Training and Education	SHA	Strategic Health Authority
KPI	Key Performance Indicator	SHMI	Summary Hospital Level Mortality
KSF	Knowledge and Skills Framework	UTI	Urinary Tract Infection
LCP	Liverpool Care Pathway	VTE	Venous Thrombo-embolism
LINk	Local Involvement Network	WHO	World Health Organisation
MLU	Midwifery Led Unit	WMNCLRN	West Midlands (North) Comprehensive Local Research Network
MRSA	Methicillin Resistant Staphylococcus Aureus	WMQRS	West Midlands Quality Review Service

English

If you require this document in an alternative format e.g., larger print, different language etc., please inform one of the healthcare staff.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਰੂਪ ਉਦਾਹਰਨ ਵੱਜੋਂ ਵੱਡੀ ਛਪਾਈ, ਵੱਖਰੀ ਭਾਸ਼ਾ ਆਇਦ ਵਿੱਚ ਚਾਹੀਦਾ ਹੋਵੇ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਸਿਹਤਸੰਭਾਲ ਕਰਮਚਾਰੀ ਨੂੰ ਬੇਨਤੀ ਕਰੋ।

Polish

Aby uzyskać niniejszy dokument w innym języku lub formacie, np. pisany dużą czcionką, itp., prosimy skontaktować się z przedstawicielem personelu medycznego.

Russian

Если данный документ требуется Вам в альтернативном формате, например крупным шрифтом, на другом языке и т.п., просьба сообщить об этом одному из сотрудников здравоохранения.

Lithuanian

Jei pageidaujate šį dokumentą gauti kitu formatu, pvz., padidintu šriftu, išverstą į kitą kalbą ir t. t., praneškite apie tai sveikatos priežiūros darbuotojui.

Kurdish

ئەگەر ئەم بەڵگەنامەیە بە شێوازێکی دیکە دەخوازیت بۆ نموونە چاپی گەورەتر، زمانێکی دیکە هتد. تکایە یەکێك لە کارمەندانی سەرپەرشتی تەندروستی ئاگادار بکەرەوە.

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National Audit of Care at the End of Life

England & Wales
Acute & Community Providers
Bespoke dashboard

April 2019

First round of audit dashboard (2018/19)

NC013 - The Royal Wolverhampton NHS Trust -
The Royal Wolverhampton Hospital NHS Trust

Contents

1. Introduction

The National Audit of Care at the End of Life (NACEL) was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. Delivery of the audit is managed by the NHS Benchmarking Network (NHSBN), supported by a multi-disciplinary Steering Group and Advisory Group. Dr Suzanne Kite, Consultant in Palliative Medicine, and Elizabeth Rees, Lead Nurse for End of Life Care, Leeds Teaching Hospitals NHS Trust, provide joint clinical leadership of the audit.

The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the *five priorities for care* set out in *One Chance To Get It Right* and *NICE Guideline (NG31) and Quality Standards (QS13 and QS144).*

Components of NACEL
The first round of the audit, taking place in 2018/19, included three components:

An organisational level audit, which covered trust/UHB and submission level questions relating to 2017/18 data. Participants were able to set up 'submissions' for separate sites (e.g. hospitals).

A Case Note Review, completed by acute and community providers only, which reviewed all deaths in April 2018 (acute providers) or deaths in April – June 2018 (community providers). The following categories of deaths were included:

> **Category 1:** It was recognised that the patient may die - it had been recognised by the hospital staff that the patient may die imminently (i.e. within hours or days). Life-sustaining treatments may still be being offered in parallel to end of life care.
>
> **Category 2:** The patient was not expected to die - imminent death was not recognised or expected by the hospital staff. However, the patient may have had a life limiting condition or, for example, be frail, so that whilst death wasn't recognised as being imminent, hospital staff were "not surprised" that the patient died.

Deaths which are classed as "sudden deaths" were excluded from the Case Note Review. These were deaths which were sudden and unexpected; this included, but was not limited to, the following:

- all deaths in Accident and Emergency departments
- deaths within 4 hours of admission to hospital
- deaths due to a life-threatening acute condition caused by a sudden catastrophic event, with a full escalation of treatment plan in place. These deaths would not fall into either category 1 or 2 above.

Acute providers were requested to complete up to 80 Case Note Reviews, with participating organisations being asked to ensure the number of case notes reviewed was no less than 5% of the total annual deaths.

A Quality Survey was developed with the assistance of the Patients Association. The survey was designed to gain feedback from relatives, carers and those close to the person who died on their experiences of the care and support received at the end of life. The Quality Survey is linked to the Case Note Review, so that the same deaths were covered.

2. Project outputs

Bespoke dashboard

This bespoke dashboard presents the results for the submission (hospital site) shown in the table below. The table shows the components of the audit in which you participated, together with the number of Case Note Reviews you completed and the number of Quality Surveys that were returned for this submission. A bespoke dashboard is available for each of the submissions registered by your organisation.

Code	Organisation Name	Submission Name	Peer Group	Trust / UHB	Hospital / Site	Case note review	Quality survey
NC013	The Royal Wolverhampton NHS Trust	Whole organisation	Acute	Y	Y	80	-

This dashboard compares the results for your submission to all acute and community hospitals in England and Wales taking part in the first round of NACEL. Results from the three elements of the audit are presented together. The following key is used in the chart titles to show the source of each indicator:

- T/UHB = trust/UHB organisational level audit
- H/S = hospital/submission organisational level audit
- CNR = Case Note Review
- QS = Quality Survey

The information is presented thematically in nine sections, covering the *five priorities for care* and other key issues. The themes are**:**

1. Recognising the possibility of imminent death
2. Communication with the dying person
3. Communication with families and others
4. Involvement in decision making
5. Needs of families and others
6. Individual plan of care
7. Families' and others' experience of care
8. Governance
9. Workforce/specialist palliative care

The full list of indicators shown in this dashboard, the number of responses to each possible answer and the number of responses used in the denominator, for both the whole sample result and for your submission result, are included at Appendix 5.

Additional information, comparing your submission to the national position on patient demographics, characteristics of deaths in hospitals and use of interventions, is provided at Appendices 1 to 3.

In reviewing the results in this dashboard, it should be noted that the total number of Quality Surveys returned was 790, representing 7% of the Case Note Reviews completed (11,034). The Quality Survey results may not therefore, be representative of the whole Case Note Review sample.

Other audit outputs

In addition to this bespoke dashboard, participants will have access to the following outputs for the first round of NACEL:

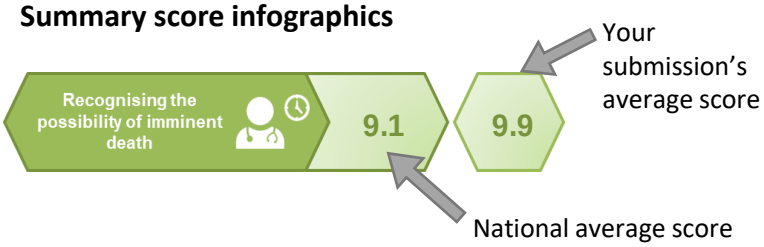
- Online toolkit accessible via the members' area of the NHSBN website. The final version of the toolkit is now available.
- An audit report for the first round of the audit covering England and Wales, acute, community and mental health providers will be published following approval by the audit funders, NHS England and the Welsh Government. This report will include the NACEL recommendations.

The results from the NACEL data reliability study are available via the NACEL webpages.

3. Guidance on using the report

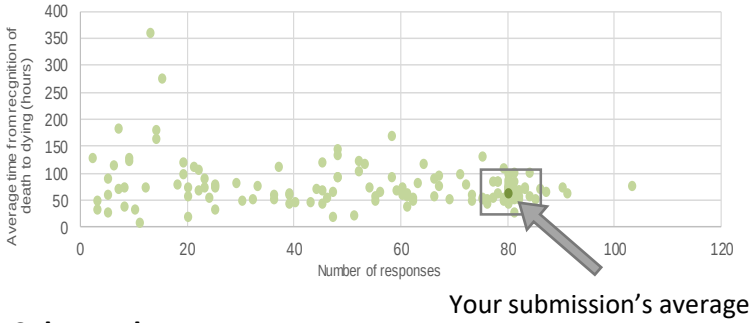
Data within this report is displayed in a number of formats. An example of each format, alongside a brief description is provided below. Please note, the 'national average' is the mean average for all acute/community, English and Welsh NACEL submissions and 'your submission's average/submission's result' relates to the submission shown on the front page of this report. If data for the corresponding metric was not provided during data collection for your submission, then no position will be highlighted or a dash will be displayed.

Summary score infographics



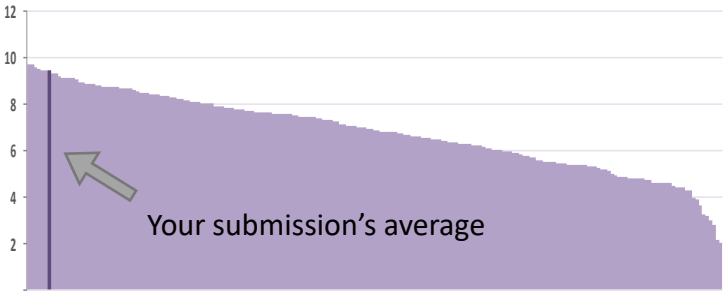
A summary score infographic is provided for each theme within report. The value in the main body of the infographic is the national average score and the value provided in the separate box on the right is the submission's average score.

Scatter chart



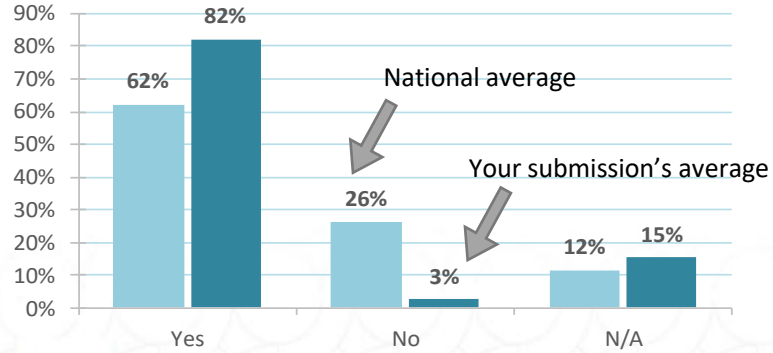
Each point within the scatter chart shows the mean average position for each acute/community, English and Welsh NACEL submission. Your submission's result is highlighted in a darker shade.

Column charts



Each column within the column chart shows the average result for each acute/community, English and Welsh NACEL submission. Your submission's result is highlighted in the darker shade.

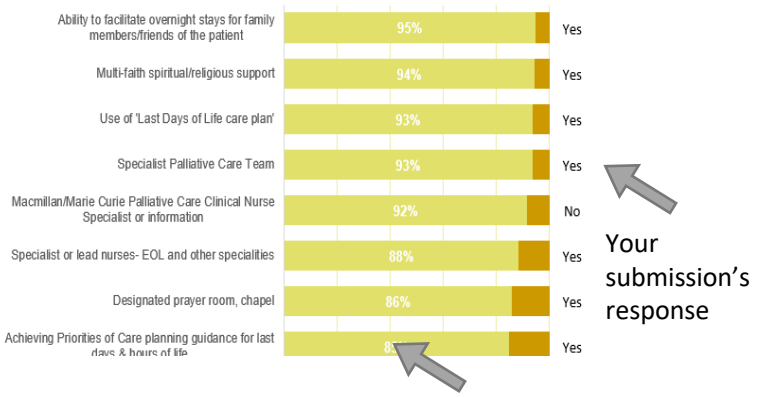
Dual column charts



Within the dual column charts, the lighter shaded column (left) shows the national average and the darker shaded column (right) provides your submission's average.

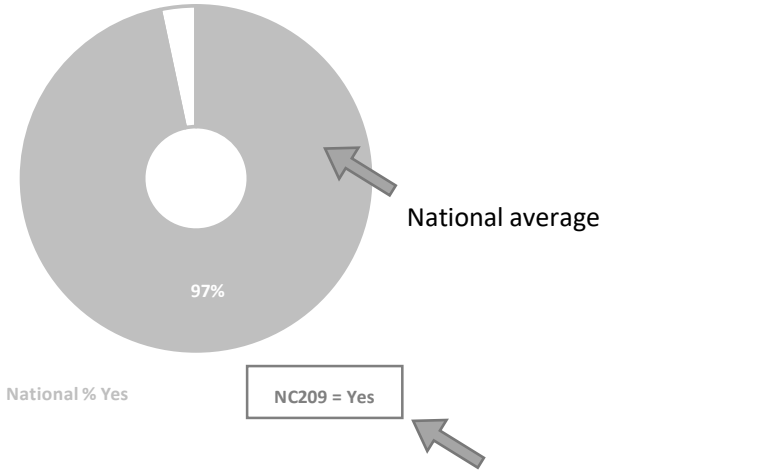
3. Guidance on using the report

Stacked bar chart



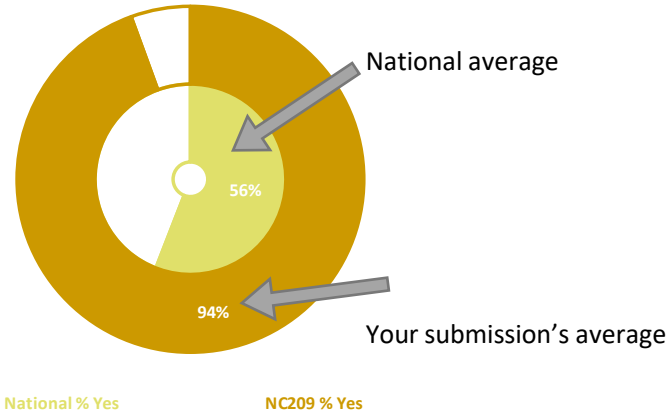
The stacked bar chart shows the national average percentage split for all NACEL participants and your submission's responses are provided in a list next to the chart.

Donut charts



Donut charts are used when the submission's result is a single response, e.g. 'Yes/No' (typically in the organisational level audit). The national average percentage split between the text responses is shown on the chart and your submission's response is shown in the legend below the chart.

Dual donut charts



Dual donut charts are used when the submission's result is a percentage calculated from multiple responses (typically from the Case Note Review). The national average is shown on the inner ring of the chart and your submission's average is shown on the outer ring.

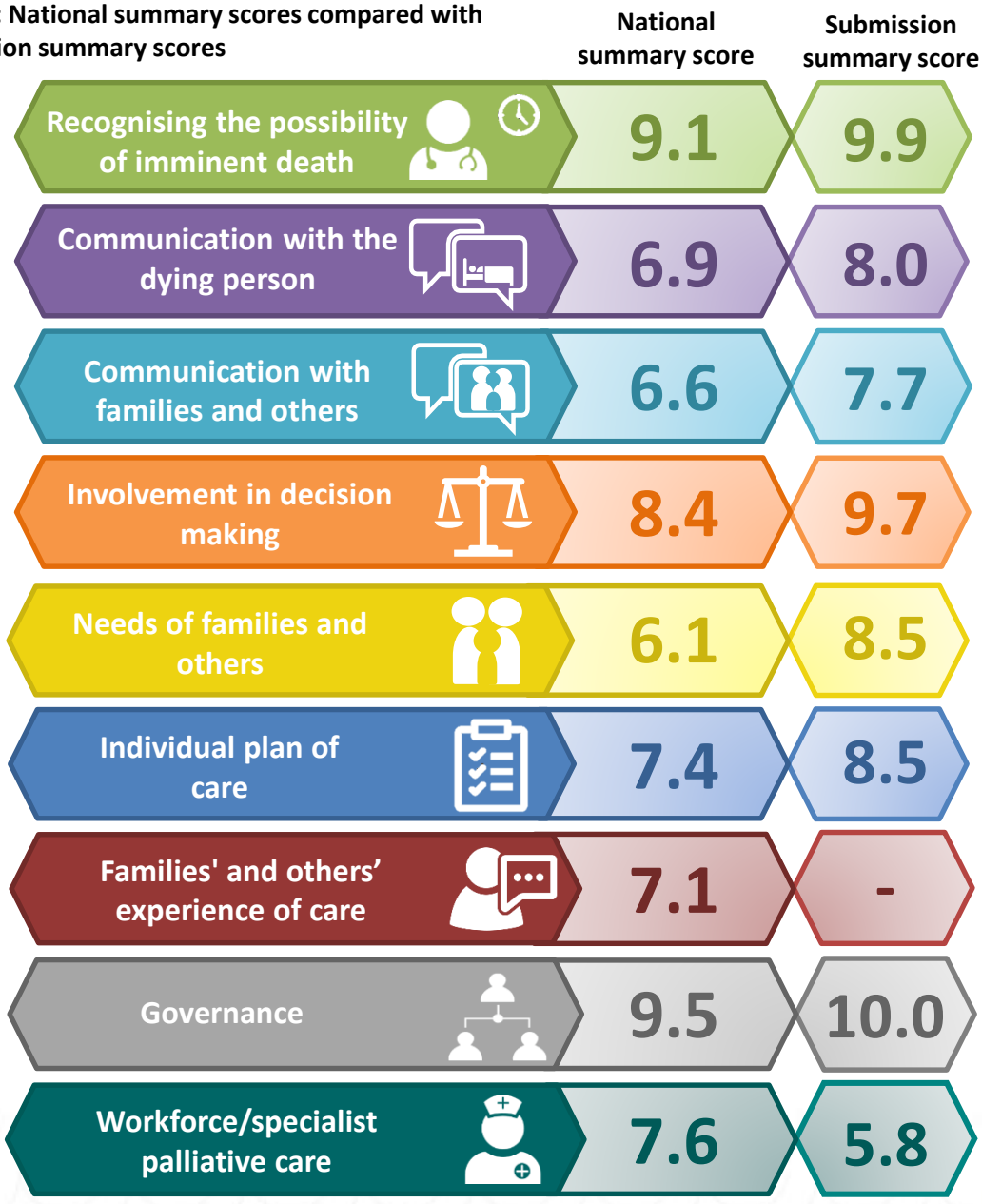
4. Summary scores

For each theme, a summary score has been developed and calculated for each submission/hospital site. The summary scores allow easy comparison between hospitals on the different themes within the audit. Not every hospital submission has received a full set of summary scores. To receive a full set, hospitals were required to provide completed responses for the Governance and Workforce/specialist palliative care summary score component indicators from the organisational level audit, five or more Case Note Review responses for each component indicator and five or more Quality Survey responses.

Note that the mean summary scores for the different themes should not be compared with each other, as they have been calculated from different elements of the audit and are derived by different methods.

Under each theme in this dashboard, the component indicators of the summary score for the theme are shown, together with other relevant indicators from all sections of the audit. Appendix 4 sets out the process undertaken to select the nine key themes and their component indicators, and an explanation of how the scores are calculated. Each summary score can only use indicators from one element of the audit.

Figure 1: National summary scores compared with submission summary scores



5.1 Recognising the possibility of imminent death

The importance of early recognition that a person may be dying imminently is emphasised in *One Chance To Get It Right,* and the *NICE Quality Standard 144.*

Priority 1: This possibility [that a person may die within the next few days or hours] is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly *(One Chance To Get It Right).*

NICE QS144: Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering (*Statement 1, NICE Quality Standard 144).*

Early recognition that a person may be dying enables an individual care plan to be developed, appropriate discussions with the patient and families to take place, treatment decisions to be made and the needs of the family to be considered. It underpins all the priorities for improving people's experience of care in the last few days and hours of life.

Recognising the possibility of imminent death: summary score

The summary score for recognising the possibility of imminent death is calculated using information collected in the Case Note Review:

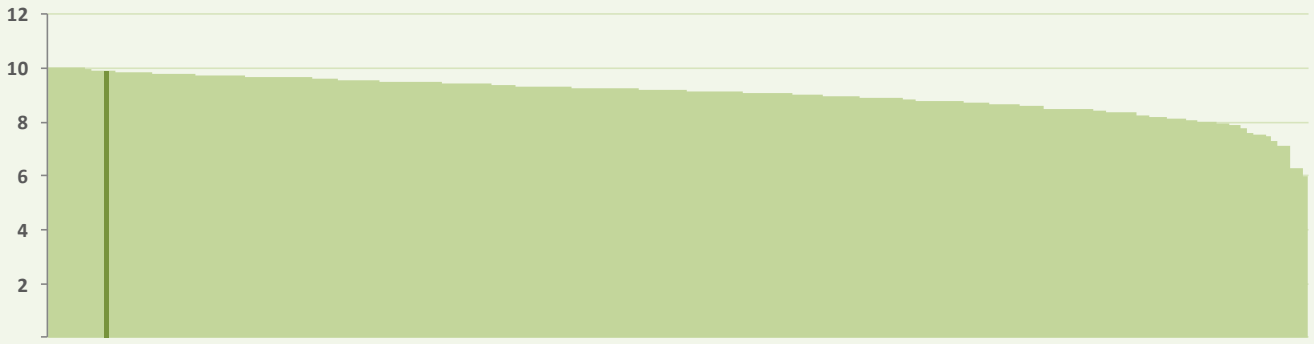
Documented evidence:

- of recognition that the patient may die imminently
- the possibility the patient may die discussed with the patient
- the possibility the patient may die discussed with families/others

The range of hospital mean summary scores for recognising the possibility of imminent death is shown in figure 2. The mean value of the summary score across the whole sample of case notes is 9.1 (n=10,002) and, if available, your submission's value is shown in the infographic above.

It should be noted that the summary score, for technical reasons, does not capture the timeliness of recognition of the possibility that the person may die and may therefore give an overly positive indication of progress on this key priority. Timeliness of recognition is shown in figure 8.

Figure 2: Hospital mean summary score: Recognising the possibility of imminent death

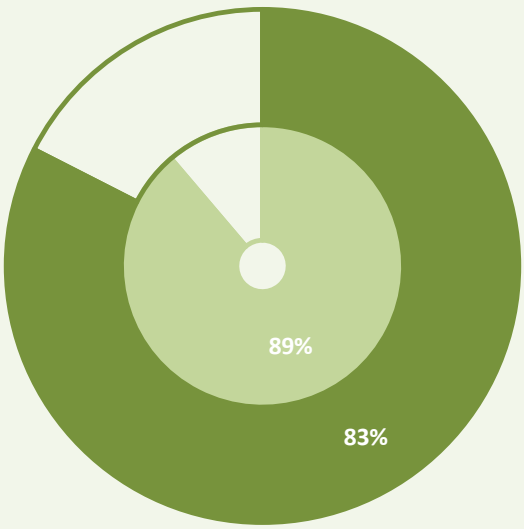


Range 6.0 – 10.0

5.1 Recognising the possibility of imminent death

Summary score component indicators

Figure 3: (CNR) Documented evidence of recognition that the patient may die imminently



National % Yes NC013 % Yes

Figure 4: (CNR) Documented evidence the possibility the patient may die discussed with the patient

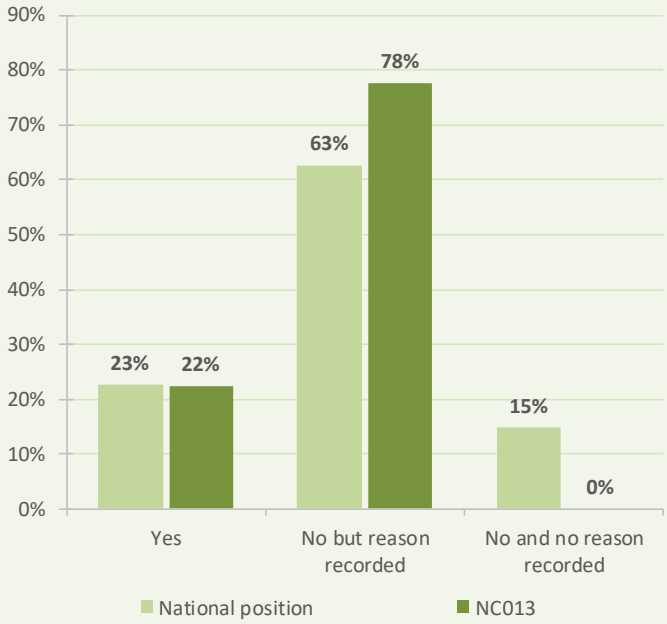
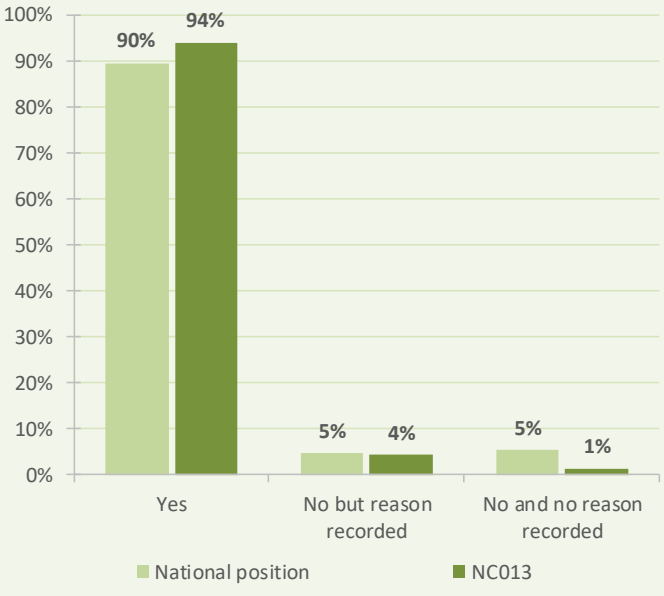


Figure 5: (CNR) Documented evidence the possibility the patient may die discussed with families/others



5.1 Recognising the possibility of imminent death

Additional indicators

Figure 6: (QS) Did a member of staff explain to the patient that they were likely to die?

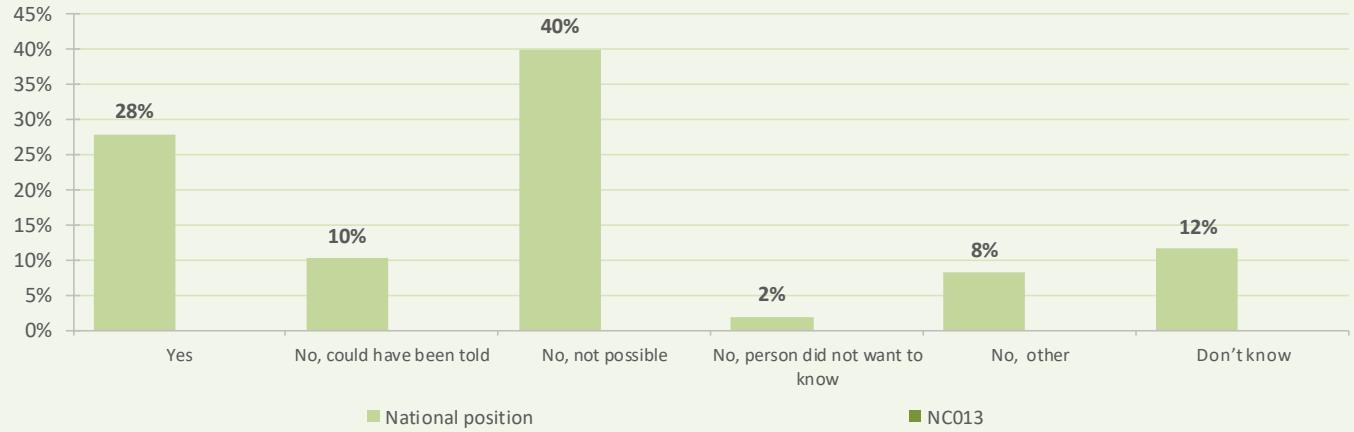


Figure 7: (QS) Did a member of staff explain to you that the patient was likely to die?

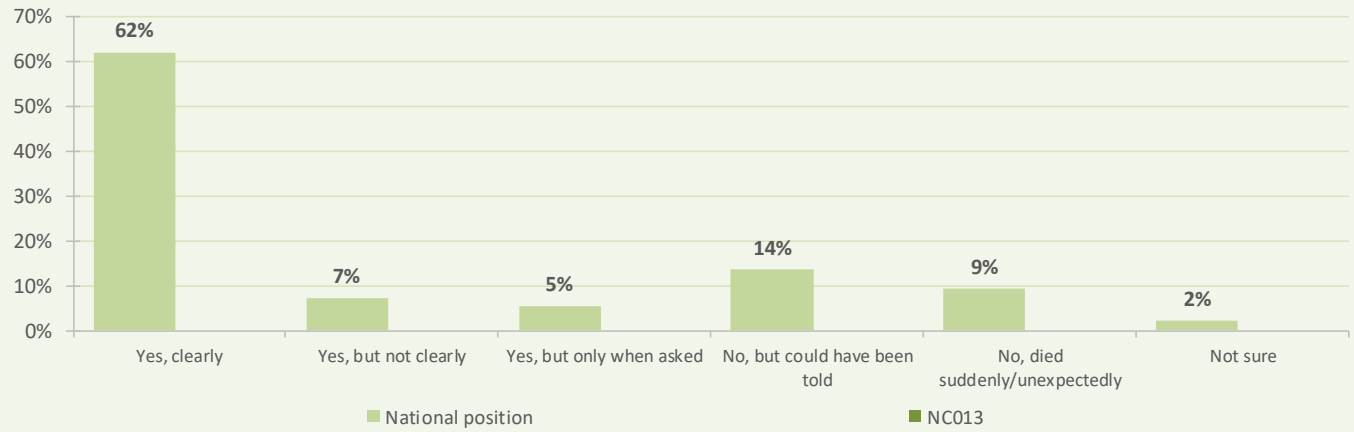
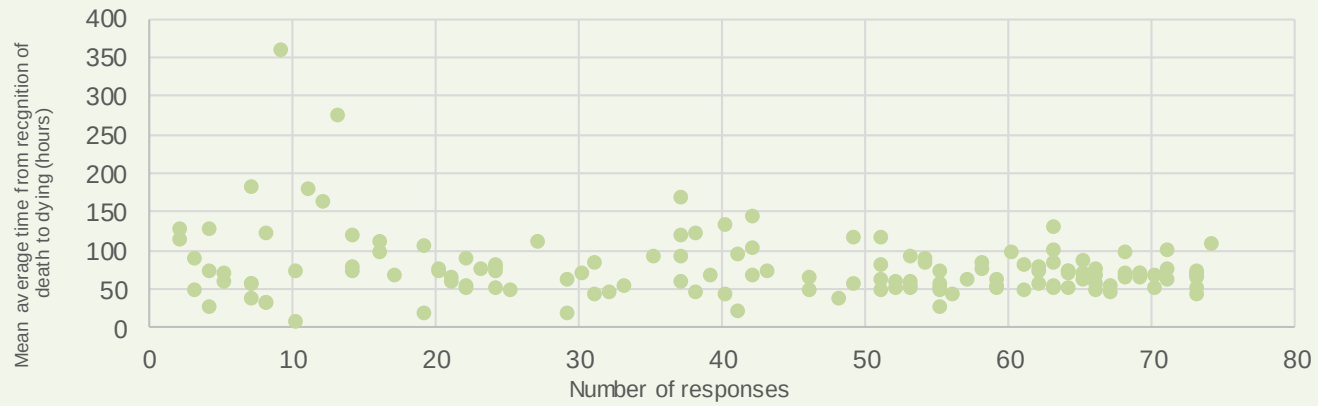


Figure 8: (CNR) Hours from first recognition of dying to death



	Count	Mean average time (hours)
National	8866	74

	Count	Mean average time (hours)
NC013	64	118

5.2 Communication with the dying person

Open and honest communication between staff and the person dying, and those identified as important to them, is critically important to good care. This section presents findings from the Case Note Review and organisational level audit on communication with the dying person. The perspective of those important to the patient on whether communication with the dying person was sensitive was collected in the Quality Survey and is considered in section 5.7, families' and others' experience of care.

Priority 2: Sensitive communication takes place between staff and the dying person, and those identified as important to them *(One Chance To Get It Right).*

NICE QS144: Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan (*Statement 2, NICE Quality Standard 144).*

Notes to Priority 3: The person, and those important to them, must be told who is the senior doctor in the team who has responsibility for their treatment and care, whether in hospital or in the community, and the nurse leading their care *(One Chance To Get It Right).*

In this bespoke dashboard, communication with the dying person and communication with families and others, are reviewed separately, in this and the next section.

Communication with the dying person: summary score

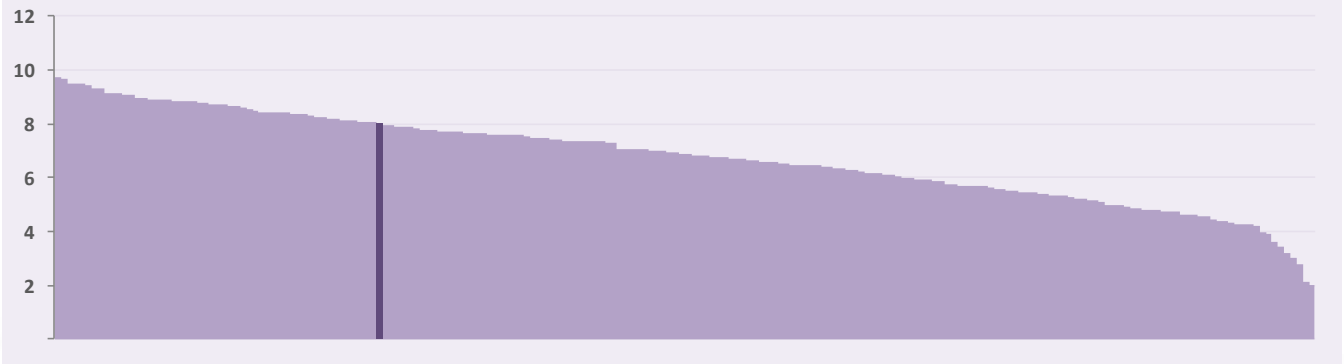
The summary score for communication with the dying person is calculated using information collected in the Case Note Review:

Documented evidence:

- the patient had the opportunity to be involved in discussing their plan of care
- the patient was informed of the professional responsible for their care
- the possibility of side effects of medication was discussed with the patient
- risks and benefits of hydration was discussed with the patient
- risks and benefits of nutrition was discussed with the patient

The range of hospital mean summary scores for communication with the dying person is shown in figure 9. The mean value of the summary score across the whole sample of case notes is 6.9 (n=8,831) and, if available, your submission's value is shown in the infographic above.

Figure 9: Hospital mean summary score: Communication with the dying person



Range 2.0 – 9.7

5.2 Communication with the dying person

Summary score component indicators

Figure 10: (CNR) Documented evidence the patient had the opportunity to be involved in discussing their plan of care

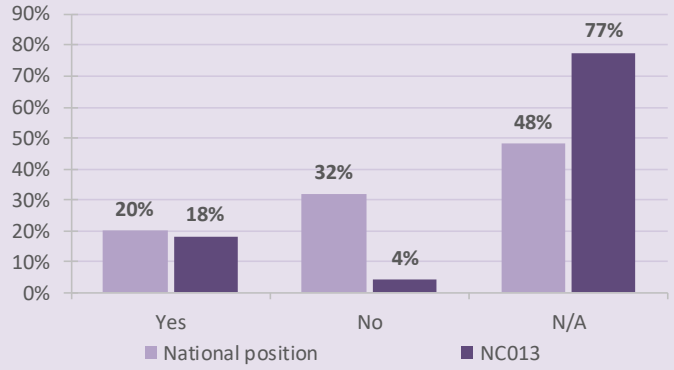


Figure 11: (CNR) Documented evidence the patient was informed of the professional responsible for their care

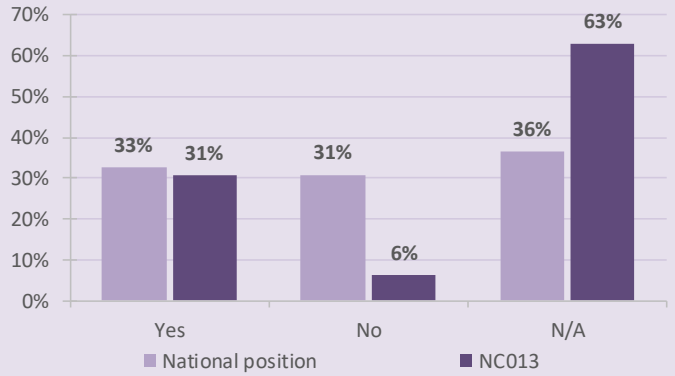


Figure 12: (CNR) Documented evidence the possibility of side effects of medication was discussed with the patient

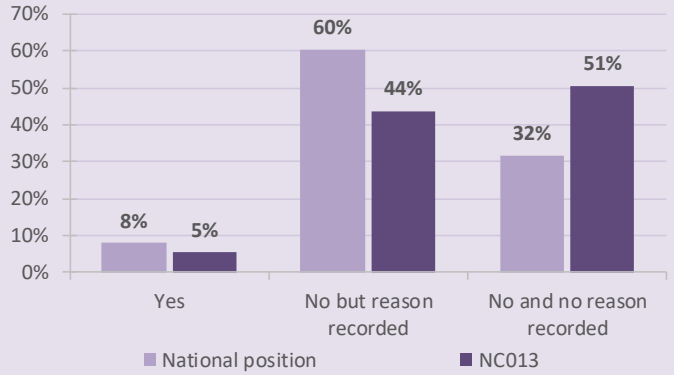


Figure 13: (CNR) Documented evidence risks and benefits of hydration was discussed with the patient

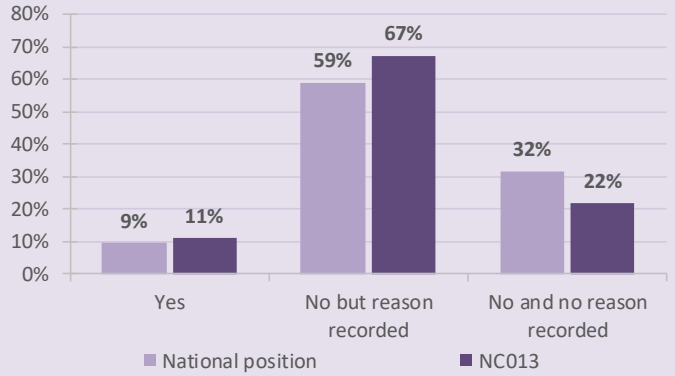
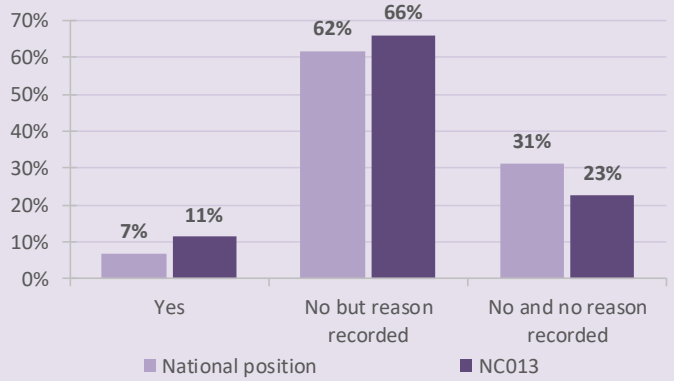


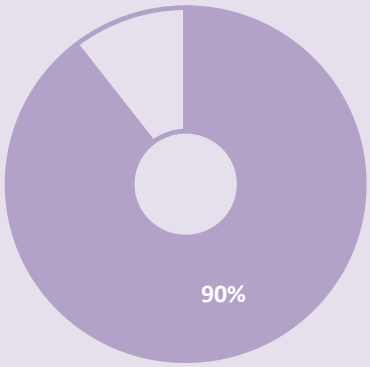
Figure 14: (CNR) Documented evidence risks and benefits of nutrition was discussed with the patient



5.2 Communication with the dying person

Additional indicators

Figure 15: (T/UHB) Guidelines to promote dignity



National % Yes

NC013 = Yes

5.3 Communication with families and others

As noted in section 5.2, open and honest communication between staff and the dying person, and those identified as important to them, is critically important to good care. In this section, findings from the Case Note Review, organisational level audit and Quality Survey, on communication with families and others, are presented.

Priority 2: Sensitive communication takes place between staff and the dying person, and those identified as important to them *(One Chance To Get It Right).*

NICE QS144: Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan (*Statement 2, NICE Quality Standards).*

Notes to Priority 3: The person, and those important to them, must be told who is the senior doctor in the team who has responsibility for their treatment and care, whether in hospital or in the community, and the nurse leading their care *(One Chance To Get It Right).*

Communication with families and others: summary score

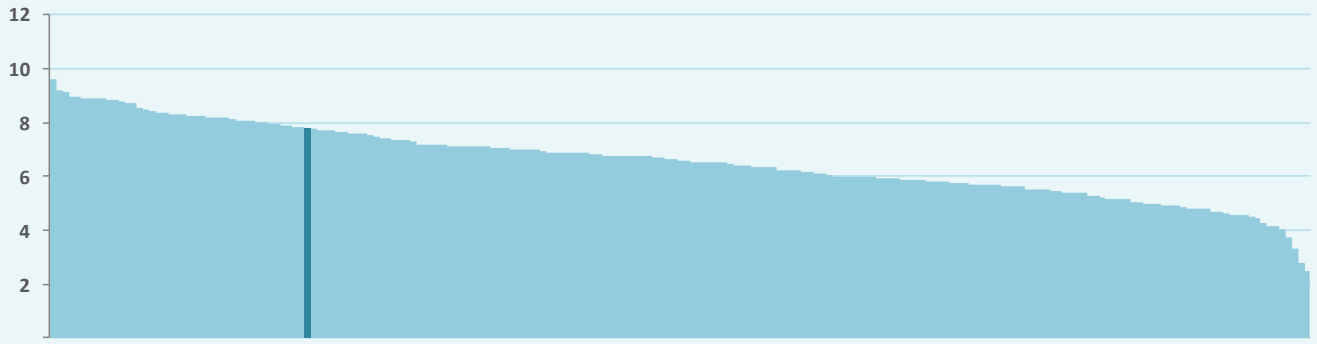
The summary score for communication with families and others is calculated using information collected in the Case Note Review:

Documented evidence:

- families/others had the opportunity to discuss the patient's plan of care
- families/others were notified of the professional responsible for the patient's care
- families/others were notified of the patient's imminent death
- the possibility of side effects of medication was discussed with families/others (weighting 0.33)
- risks and benefits of hydration was discussed with families/others (weighting 0.33)
- risks and benefits of nutrition was discussed with families/others (weighting 0.33)

The range of hospital mean summary scores for communication with families and others is shown in figure 16. The mean value of the summary score across the whole sample of case notes is 6.6 (n=8,622) and, if available, your submission's value is shown in the infographic above.

Figure 16: Hospital mean summary score: Communication with families and others



Range 2.5 – 9.6

5.3 Communication with families and others

Summary score component indicators

Figure 17: (CNR) Documented evidence families/others had the opportunity to discuss the patient's plan of care

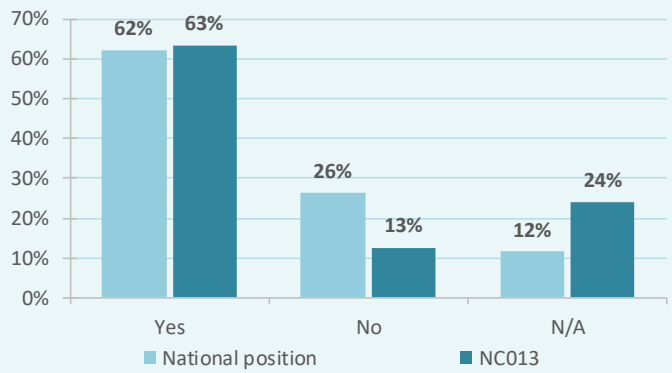


Figure 18: (CNR) Documented evidence families/others were notified of the professional responsible for patient's care

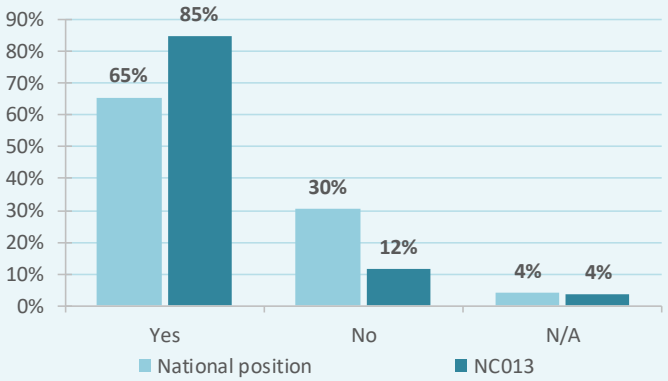


Figure 19: (CNR) Documented evidence families/others were notified of the patient's imminent death

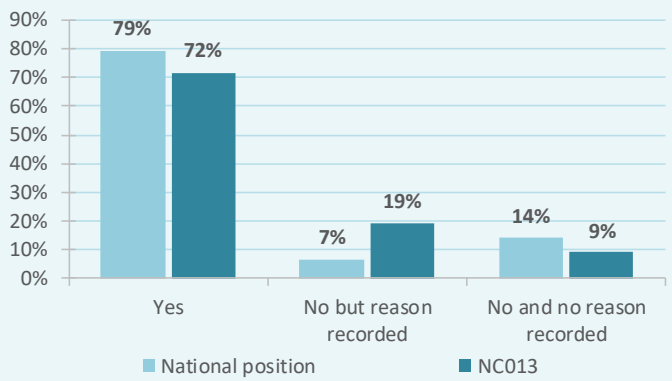


Figure 20: (CNR) Documented evidence the possibility of side effects of medication was discussed with families/others

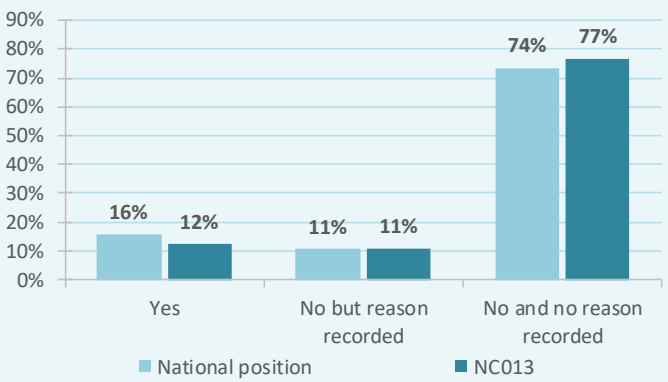


Figure 21: (CNR) Documented evidence risks and benefits of hydration was discussed with families/others

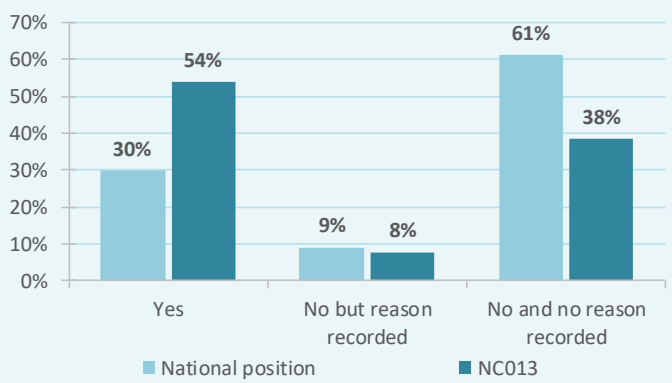
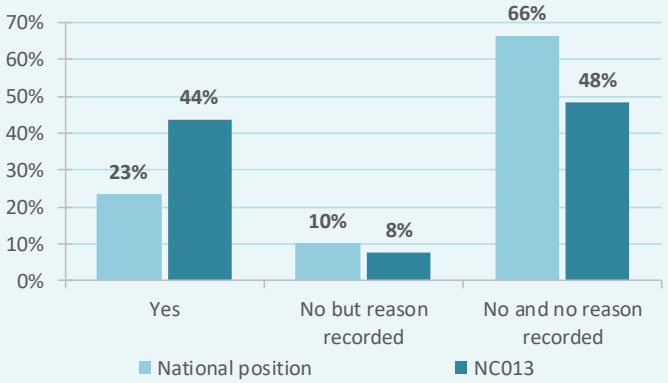


Figure 22: (CNR) Documented evidence risks and benefits of nutrition was discussed with families/others



5.3 Communication with families and others

Additional indicators

Figure 23: (T/UHB) Guidelines for meaningful and compassionate engagement with bereaved families and carers

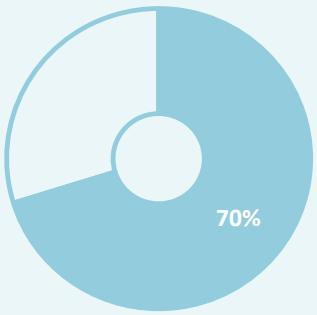


Figure 24: (H/S) Views from bereaved relatives' or friends' views sought during the last two financial years

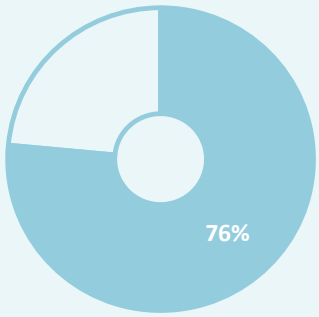


Figure 25: (QS) Did those close to the patient receive clear communication about imminent death soon enough to be there when the patient died?

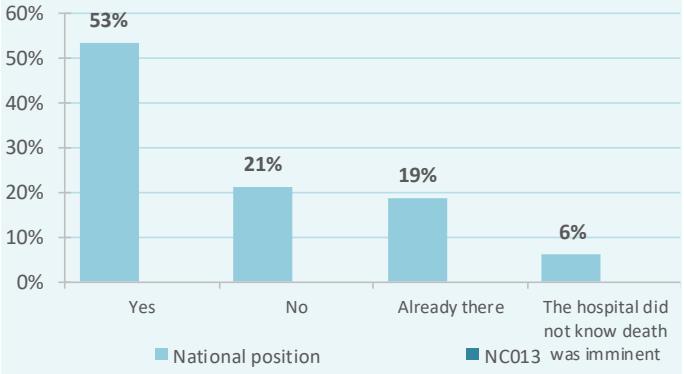


Figure 26: (QS) Were given the name of the doctor and nurse responsible for his/her care?

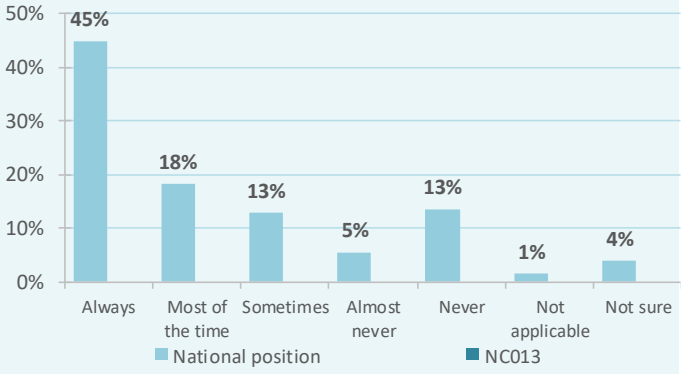


Figure 27: (QS) Did those close to the patient feel that they had enough opportunity to ask questions and discuss patient care?

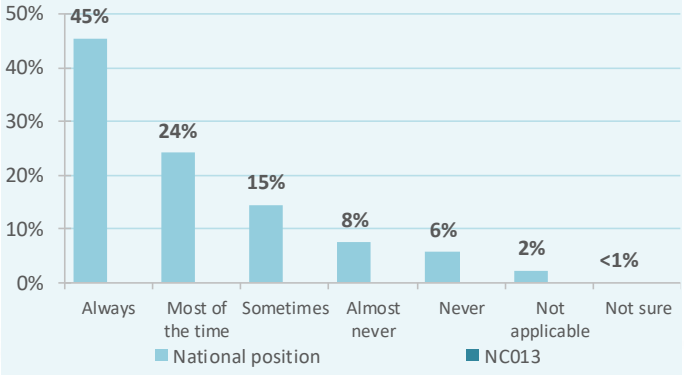
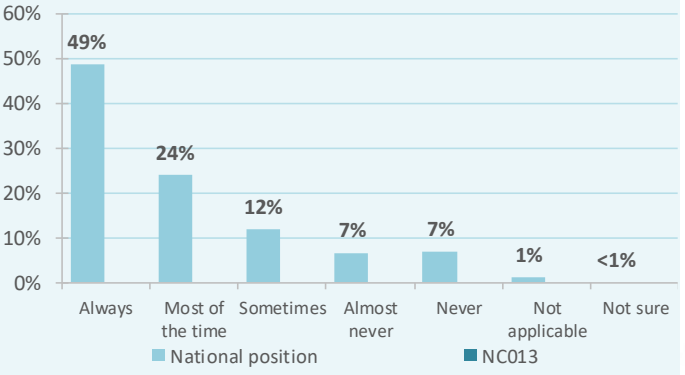


Figure 28: (QS) Did those close to the patient feel that they were kept informed by staff about the patient's condition?



5.4 Involvement in decision making

The right to be involved in decisions about your health and care, including your end of life care, is enshrined in the *NHS Constitution for England*. Where appropriate, this right includes the families and carers. In this section, the findings from the Case Note Review and Quality Survey on involvement in decision making are presented.

Priority 3: The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants (*One Chance To Get It Right*).

Notes to Priority 1: The goals of treatment and care must be discussed and agreed with the dying person, involving those identified as important to them and the multidisciplinary team caring for the person (*One Chance To Get It Right*).

Involvement in decision making: summary score

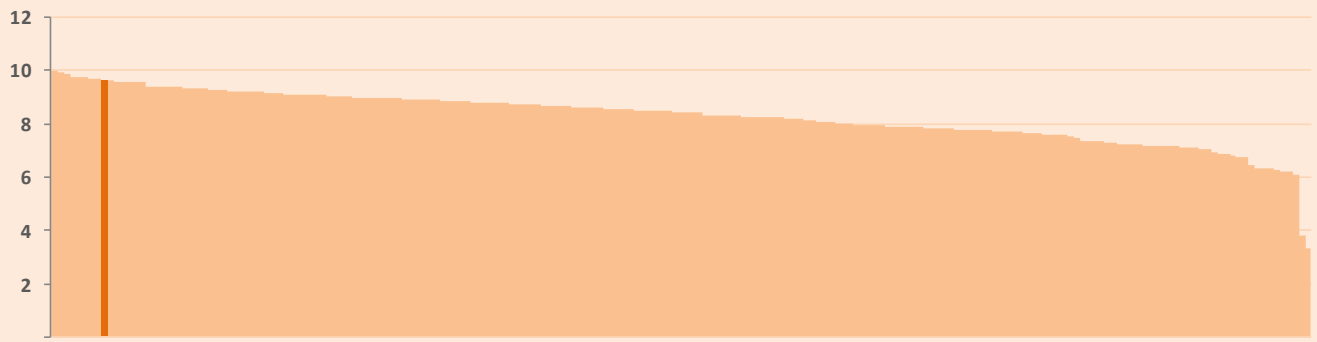
The summary score for involvement in decision making is calculated using information collected in the Case Note Review:

Documented evidence:

- the extent the patient wished to be involved in decisions about care
- the patient had capacity assessed to be involved in care planning
- life-sustaining treatments discussed with the patient
- life-sustaining treatments discussed with families/others
- a clinician discussed CPR with the patient
- a senior clinician discussed CPR with families/others

The range of hospital mean summary scores for involvement in decision making is shown in figure 29. The mean value of the summary score across the whole sample of case notes is 8.4 (n=9,170) and, if available, your submission's value is shown in the infographic above.

Figure 29: Hospital mean summary score: Involvement in decision making



Range 3.3 – 10.0

5.4 Involvement in decision making

Involvement in decision making	8.4	9.7

Summary score component indicators

Figure 30: (CNR) Documented evidence of the extent the patient wished to be involved in decisions about care

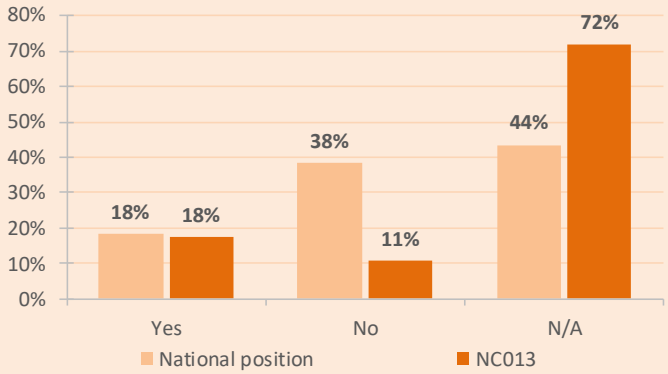


Figure 31: (CNR) Documented evidence the patient had capacity assessed to be involved in care planning

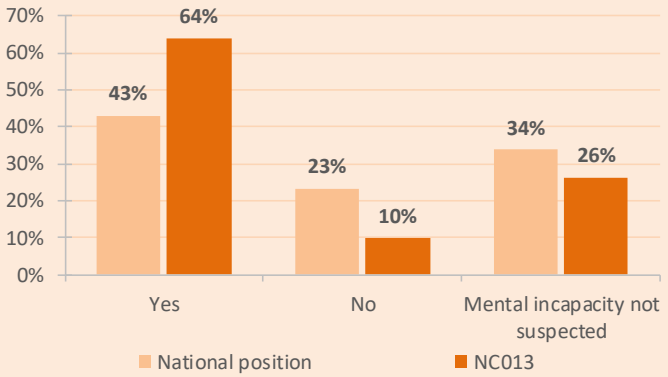


Figure 32: (CNR) Documented evidence life-sustaining treatments discussed with the patient

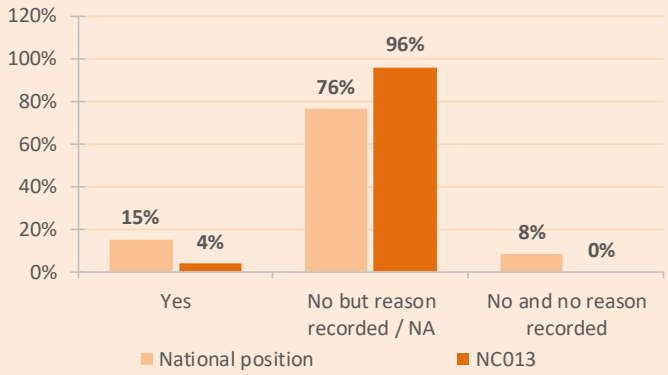


Figure 33: (CNR) Documented evidence life-sustaining treatments discussed with families/others

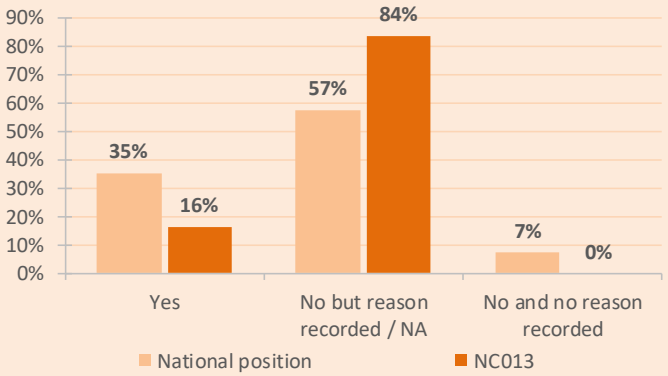


Figure 34: (CNR) Documented evidence a clinician discussed CPR with the patient

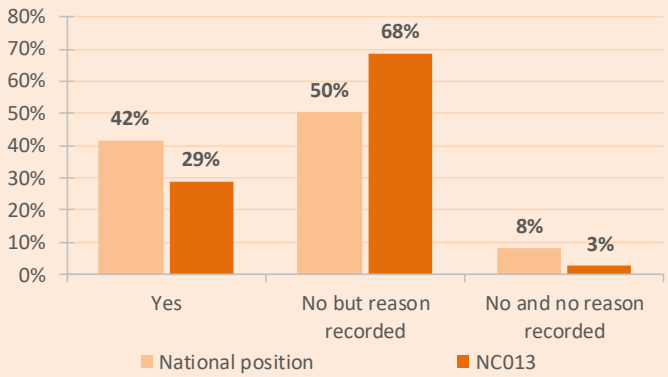
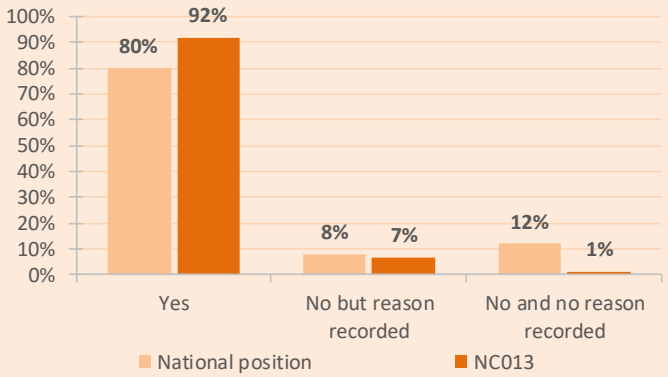


Figure 35: (CNR) Documented evidence a senior clinician discussed CPR with families/others



5.4 Involvement in decision making

Additional indicators

Figure 36: (QS) Did staff involve the patient in decisions about care and treatment?

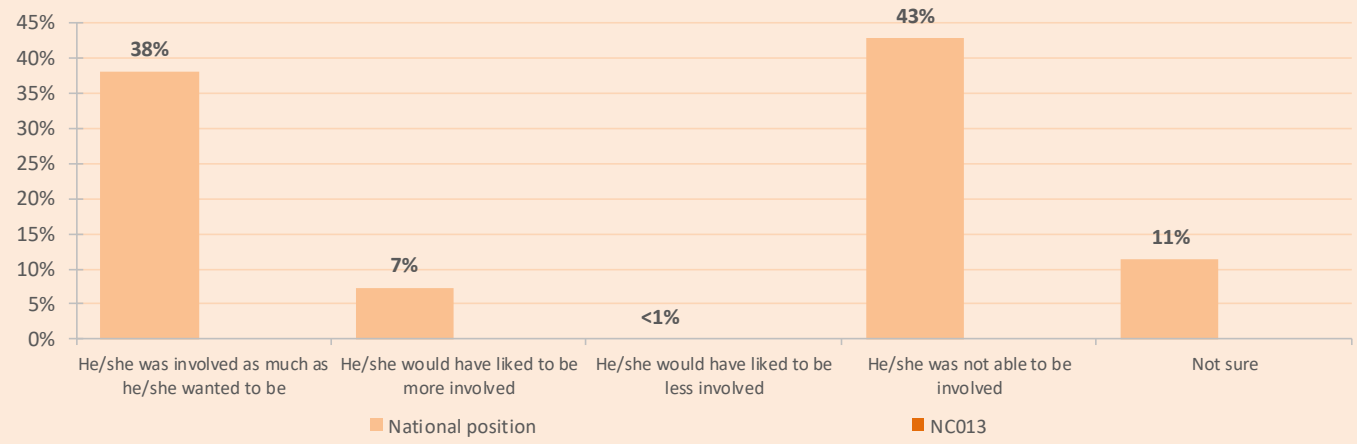
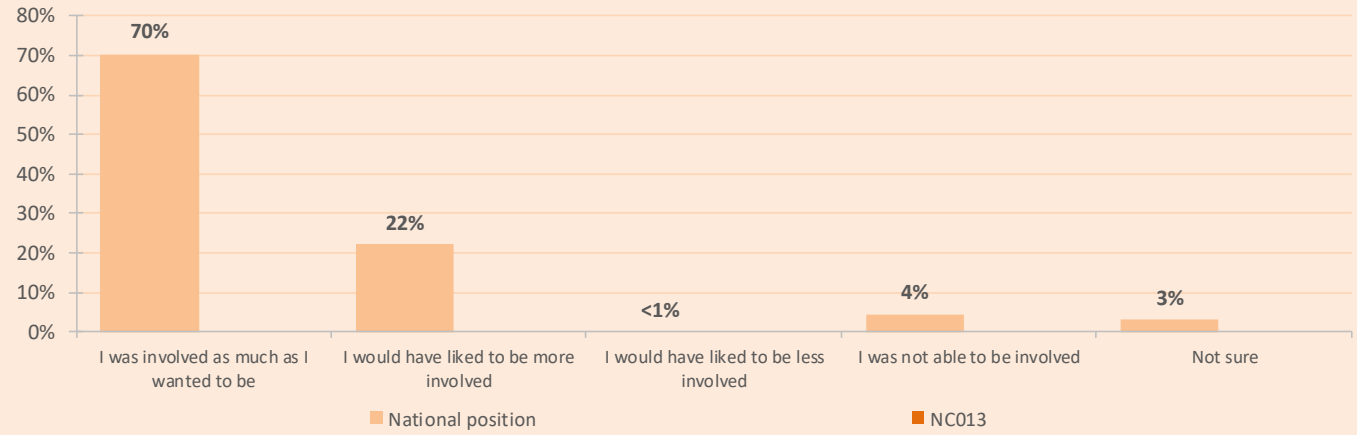


Figure 37: (QS) Did staff involve those close to the patient about care and treatment?



5.5 Needs of families and others

Families and those important to the dying person have their own needs, which they, and others, can overlook in times of distress. In this section, the results from the Case Note Review, organisational level audit and Quality Survey pertaining to the needs of the families and others are presented.

Priority 4: The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible (*One Chance To Get It Right).*

Notes to Priority 4: Where they have particular needs for support or information, these should be met as far as possible. Although it is not always possible to meet the needs or wishes of all family members, listening and acknowledging these can help (*One Chance To Get It Right).*

Needs of families and others: summary score

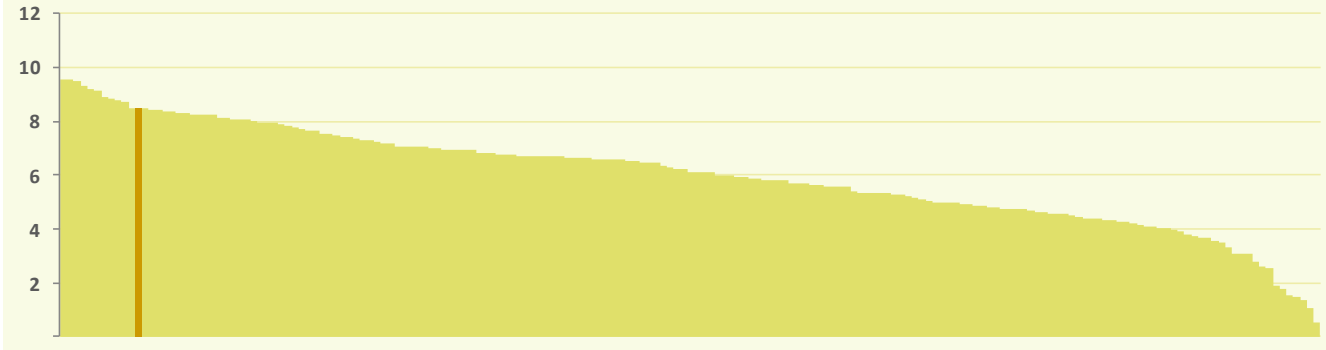
The summary score for the needs of families and others is calculated using information collected in the Case Note Review:

Documented evidence:

- the needs of families/others asked about
- of the care and support provided to families/others at the time of and immediately after death
- needs of families/others were assessed (weighting 0.2 each point):
    - emotional/psychological needs
    - spiritual/religious needs
    - cultural needs
    - social needs
    - practical needs

The range of hospital mean summary scores for needs of families and others is shown in figure 38. The mean value of the summary score across the whole sample of case notes is 6.1 (n=6,108) and, if available, your submission's value is shown in the infographic above.

Figure 38: Hospital mean summary score: Needs of families and others



Range 0.6 – 9.6

5.5 Needs of families and others

Summary score component indicators

Figure 39: (CNR) Documented evidence the needs of families/others asked about

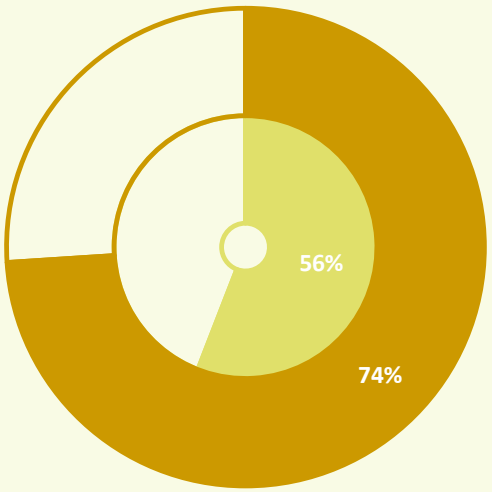


Figure 40: (CNR) Documented evidence of care and support provided to families/others at the time of and immediately after death

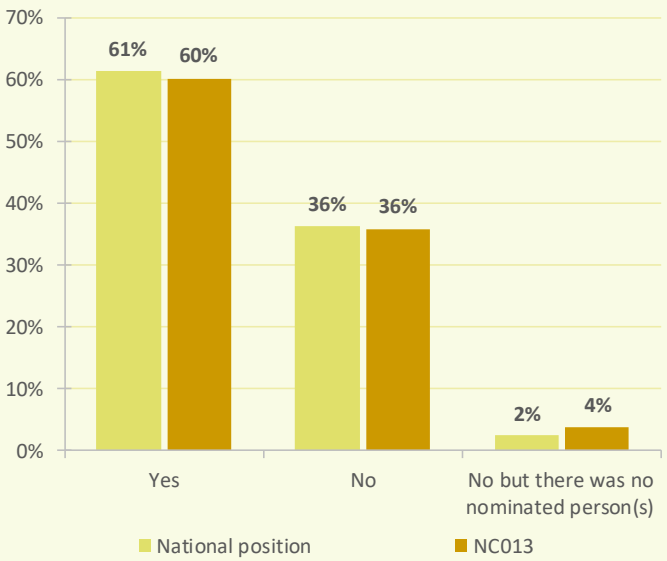


Figure 41: (CNR) Documented evidence the emotional/ psychological needs of families/others were assessed

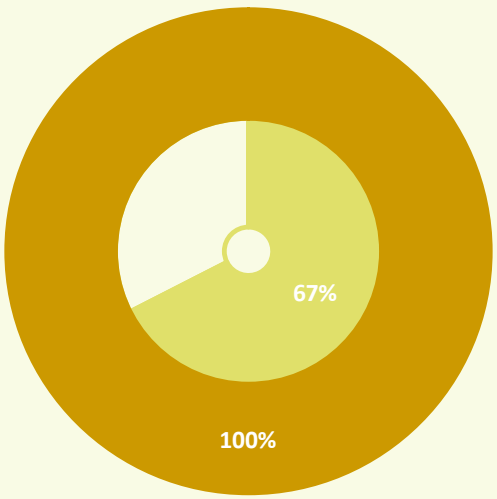
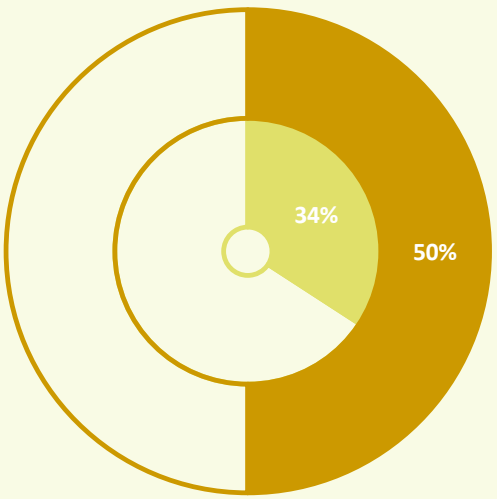


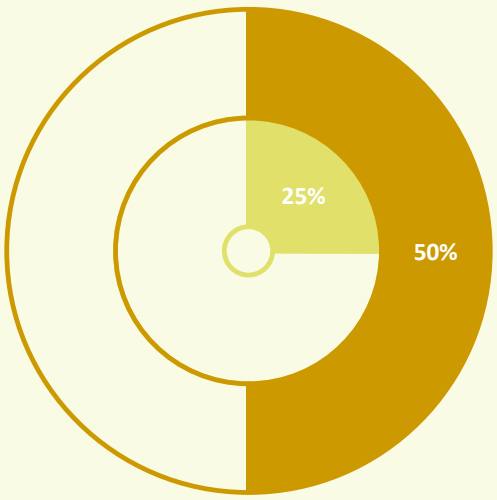
Figure 42: (CNR) Documented evidence the spiritual/religious needs of the families/others were assessed



5.5 Needs of families and others

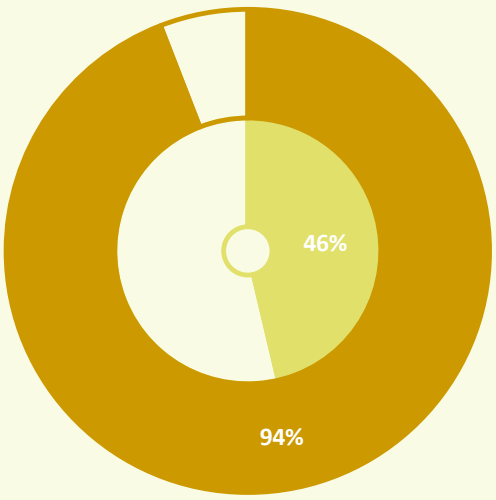
Summary score component indicators

Figure 43: (CNR) Documented evidence the cultural needs of families/others were assessed



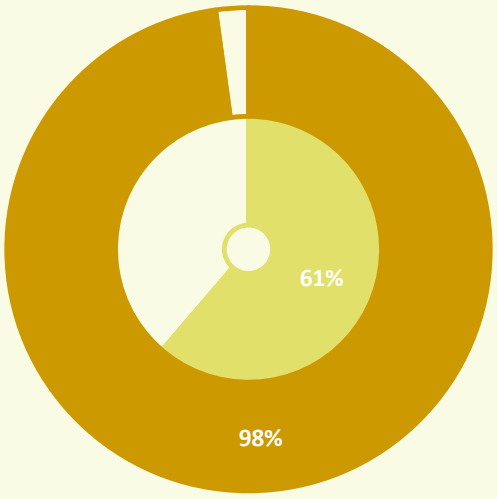
National % Yes NC013 % Yes

Figure 44: (CNR) Documented evidence the social needs of families/others were assessed



National % Yes NC013 % Yes

Figure 45: (CNR) Documented evidence the practical needs of families/others were assessed



National % Yes NC013 % Yes

5.5 Needs of families and others

Additional indicators

Figure 46: (T/UHB) A care after death and bereavement policy

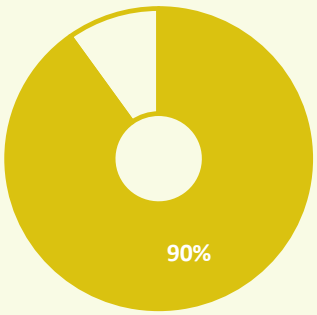


Figure 47: (T/UHB) Guidelines for providing relatives/carers with verification and certification of the death

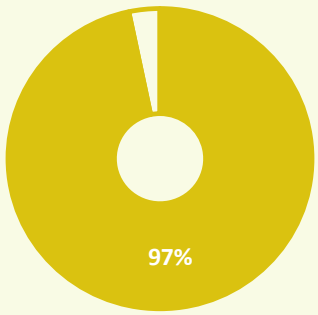


Figure 48: (T/UHB) Guidelines for referral to 'Pastoral care/Chaplaincy team'

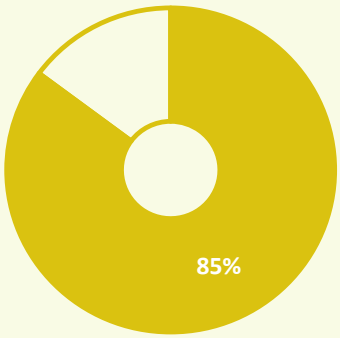


Figure 49: (T/UHB) Guidelines for viewing the body in the immediate time after the death of a patient

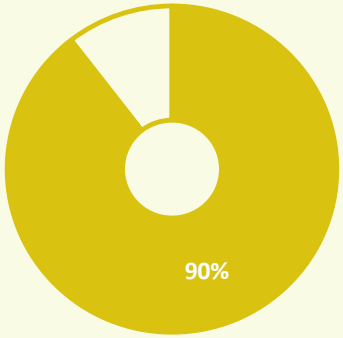


Figure 50: (H/S) Department of Work and Pensions leaflet 'What to Do After a Death in England and Wales' or equivalent provided

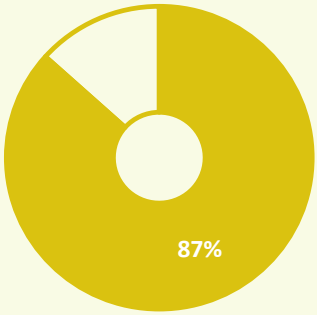
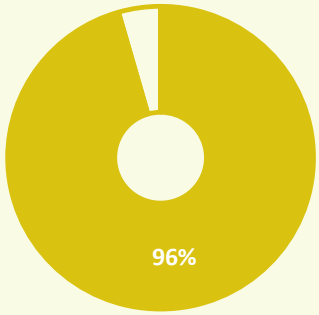


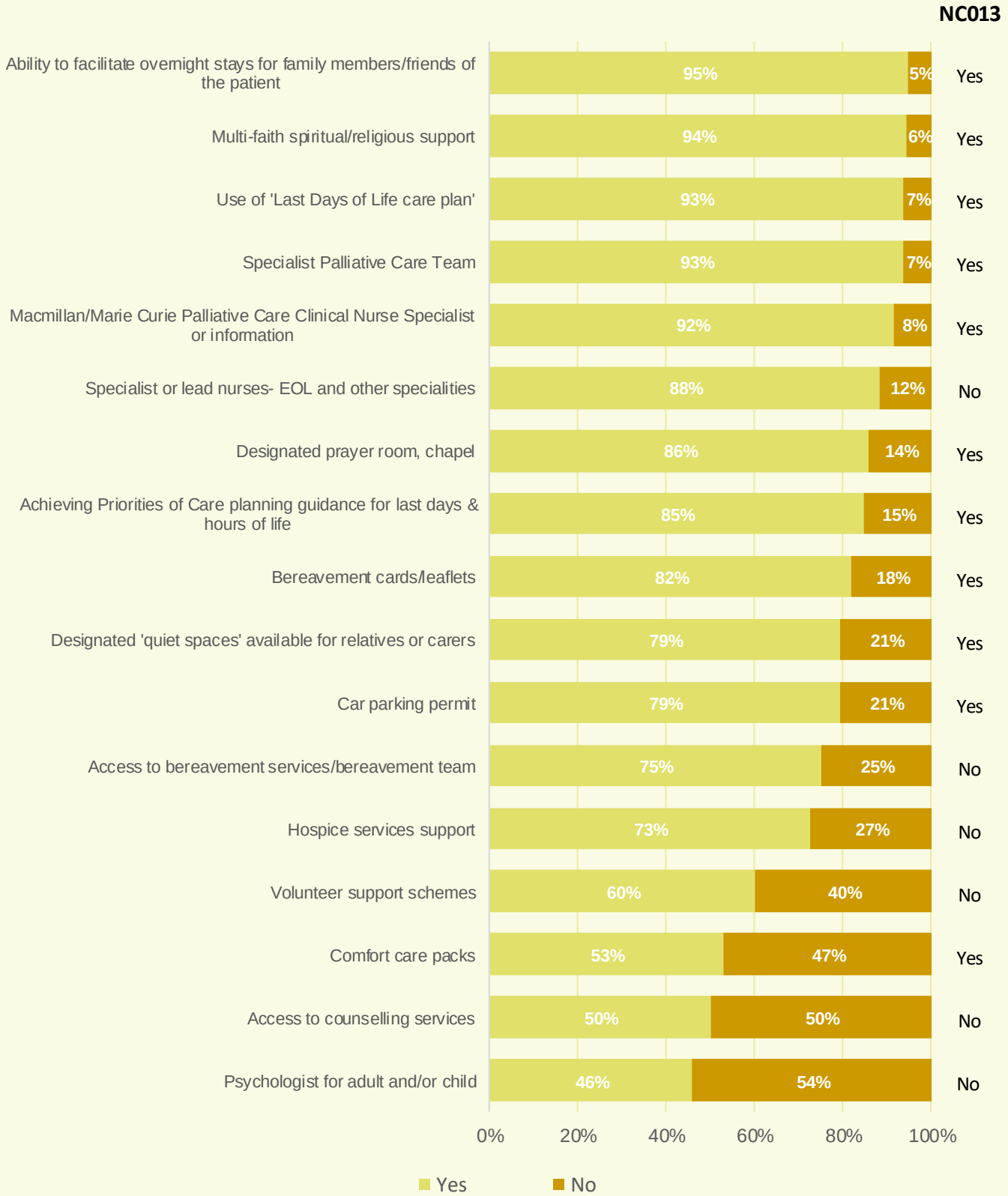
Figure 51: (H/S) A leaflet explaining local procedures to be undertaken after the death of a patient provided



5.5 Needs of families and others

Additional indicators

Figure 52: (H/S) Support processes available in the hospital for people important to the dying person: National



5.5 Needs of families and others

Additional indicators

Figure 53: (QS) Did those close to the patient feel supported by hospital staff after the patient's death?

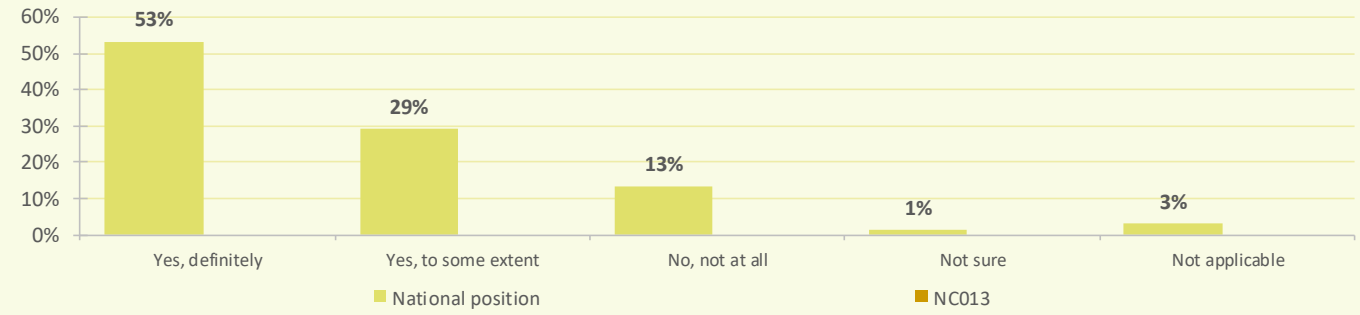


Figure 54: (QS) Did those close to the patient feel they were given enough emotional help and support?

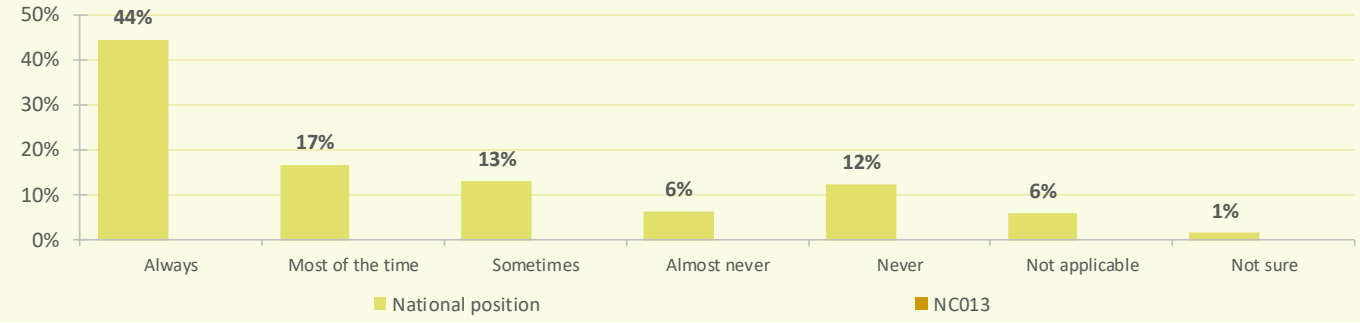


Figure 55: (QS) Did those close to the patient feel they were given enough practical support?

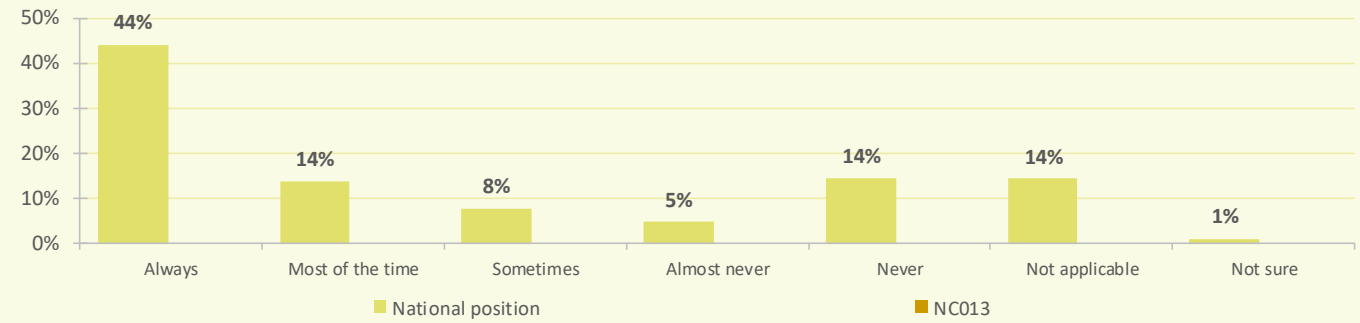
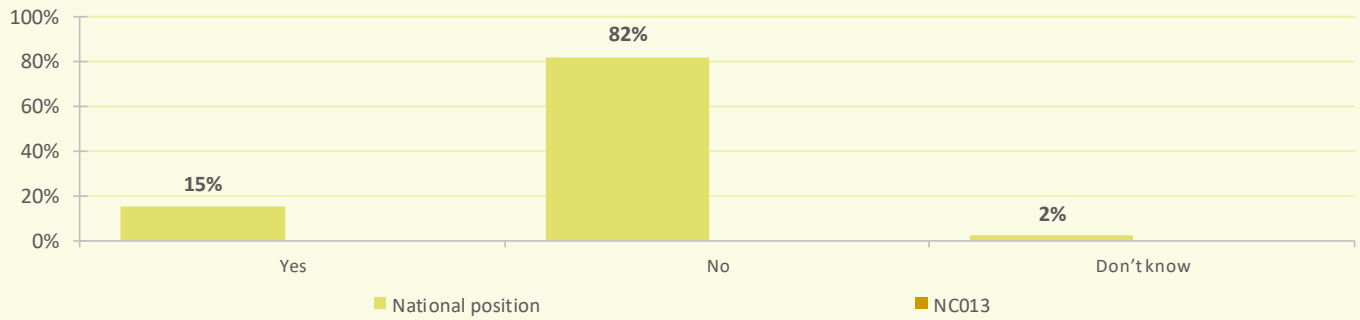


Figure 56: (QS) Were there any unexplained delays in the hospital providing you with certification of death?



5.6 Individual plan of care

The *five priorities for the care* of the dying person (*One Chance To Get It Right*) make clear that there must be an individual plan of care. The plan for end of life care should be documented and should be part of other care planning processes. The dying person and those important to them should have the opportunity to discuss the plan.

In this section, the results from the Case Note Review and the Quality Survey relating to the individual plan of care are presented.

Priority 5: An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion (*One Chance To Get It Right*).

NICE QS144: Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration *(Statement 3, NICE Quality Standard 144).*

NICE QS144: Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options (*Statement 4, NICE Quality Standard 144).*

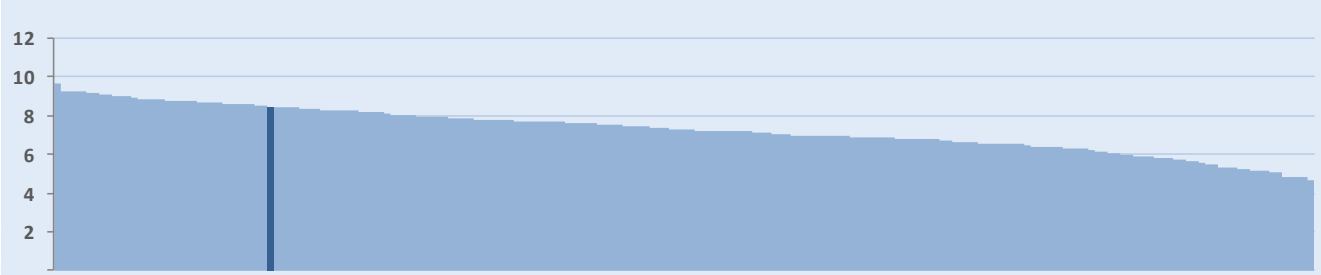
Individual plan of care: summary score

The summary score for the individual plan of care is calculated using information collected in the Case Note Review:

- documented evidence the patient had an individual end of life care plan (weighting 0.5)
- regular review of the patient and their plan of care (weighting 0.5)
- documented evidence of the preferred place of death as indicated by the patient
- documented review of (weighting 0.25 each):
    - routine recording of vital signs
    - blood sugar monitoring
    - administration of oxygen
    - administration of antibiotics
- documented assessment of hydration status between recognition and time of death
- documented assessment of nutrition status between recognition and time of death
- assessment of needs covering 16 domains (weighting 0.25 each)

The range of hospital mean summary scores for the individual plan of care is shown in figure 57. The mean value of the summary score across the whole sample of case notes is 7.4 (n=6,463) and, if available, your submission's value is shown in the infographic above.

Figure 57: Hospital mean summary score: Individual plan of care

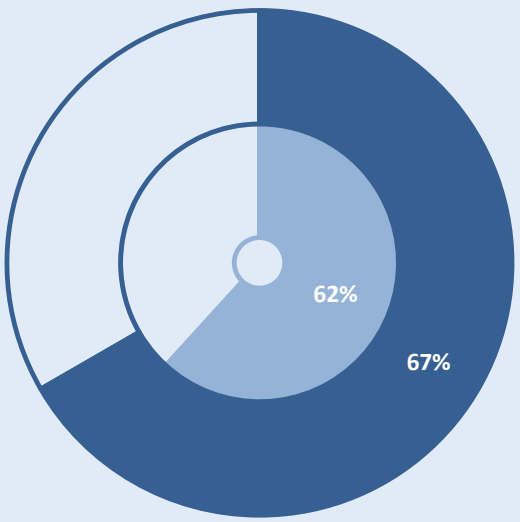


Range 4.7 – 9.7

5.6 Individual plan of care

Summary score component indicators

Figure 58: (CNR) Documented evidence the patient had an individual end of life care plan



National % Yes NC013 % Yes

Figure 59: (CNR) Regular review of the patient and their plan of care

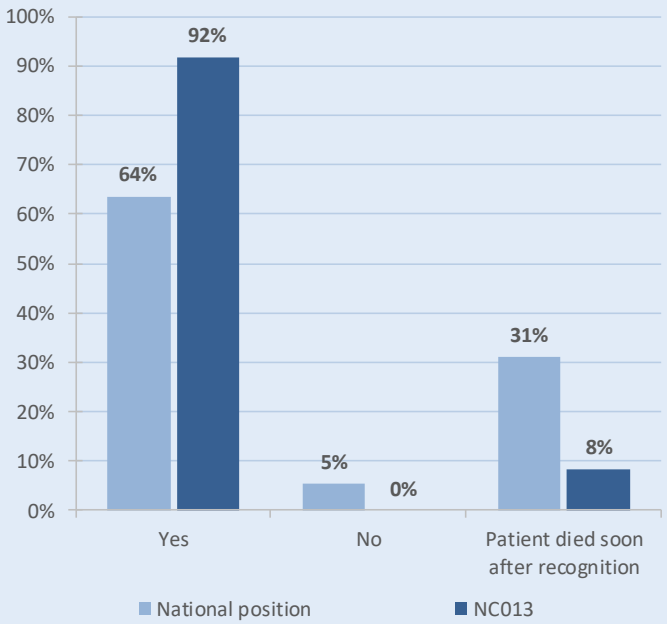
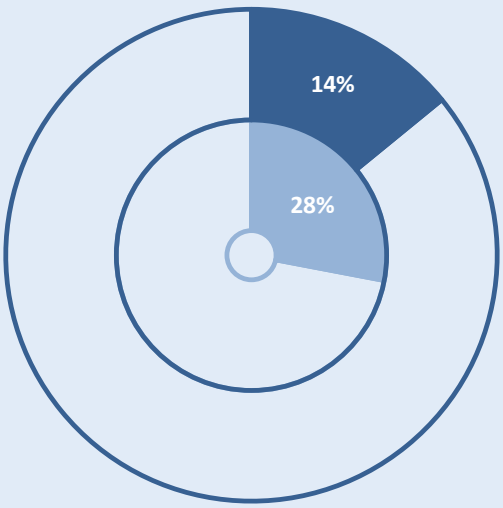
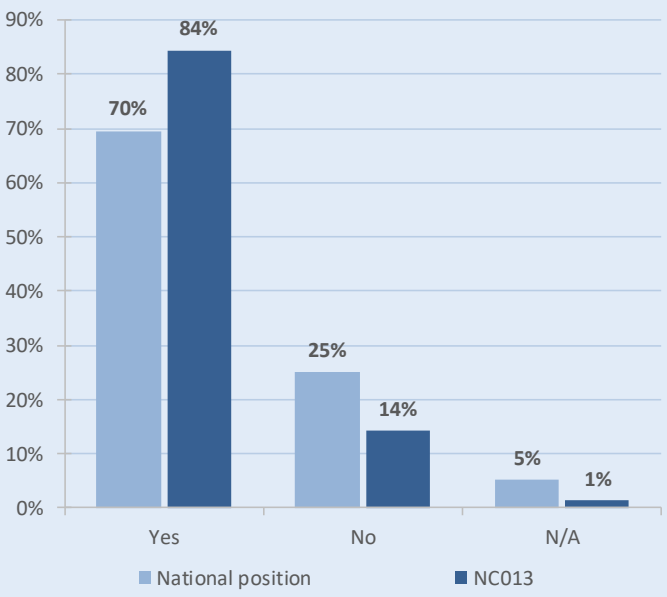


Figure 60: (CNR) Documented evidence of the preferred place of death as indicated by the patient



National % Yes NC013 % Yes

Figure 61: (CNR) Documented review of routine recording of vital signs



5.6 Individual plan of care

Summary score component indicators

Figure 62: (CNR) Documented review of blood sugar monitoring

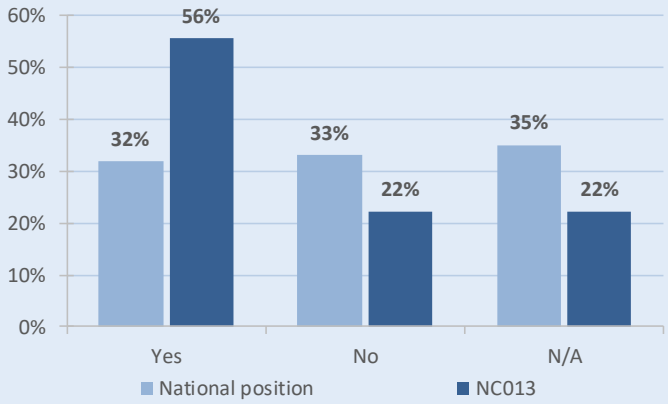


Figure 63: (CNR) Documented review of administration of oxygen

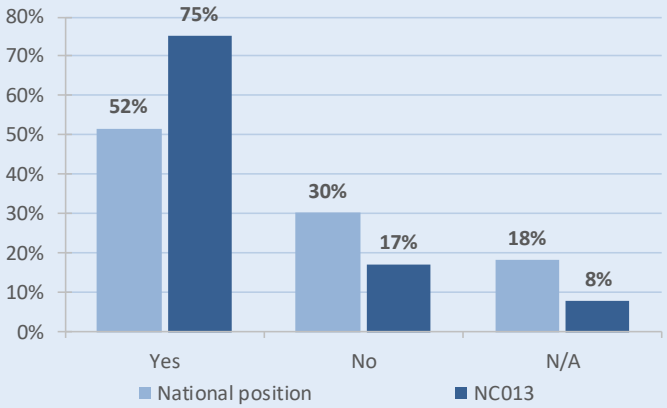


Figure 64: (CNR) Documented review of administration of antibiotics

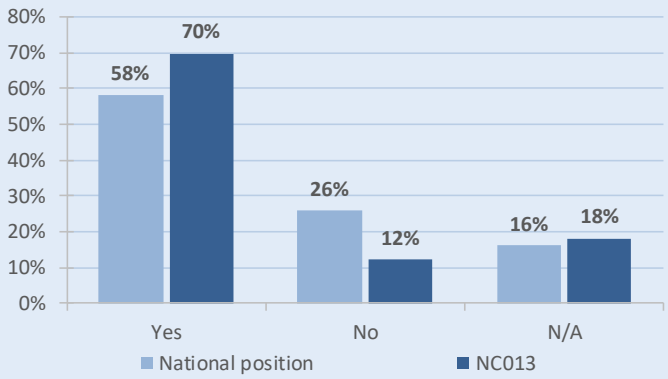


Figure 65: (CNR) Documented assessment of hydration status between recognition and time of death

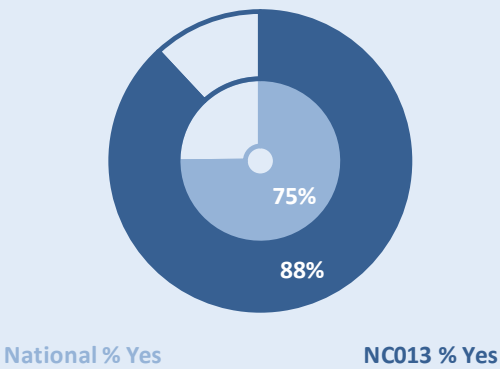
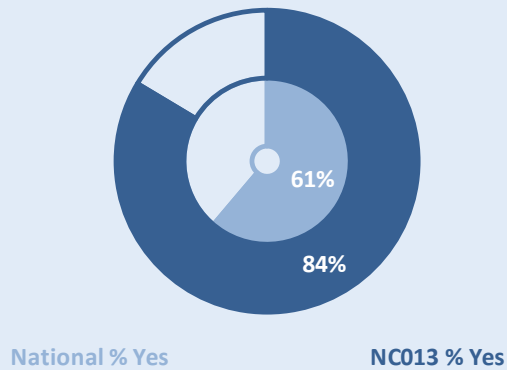


Figure 66: (CNR) Documented assessment of nutrition status between recognition and time of death



5.6 Individual plan of care

Summary score component indicators

Figure 67: (CNR) Assessment of the following needs: national

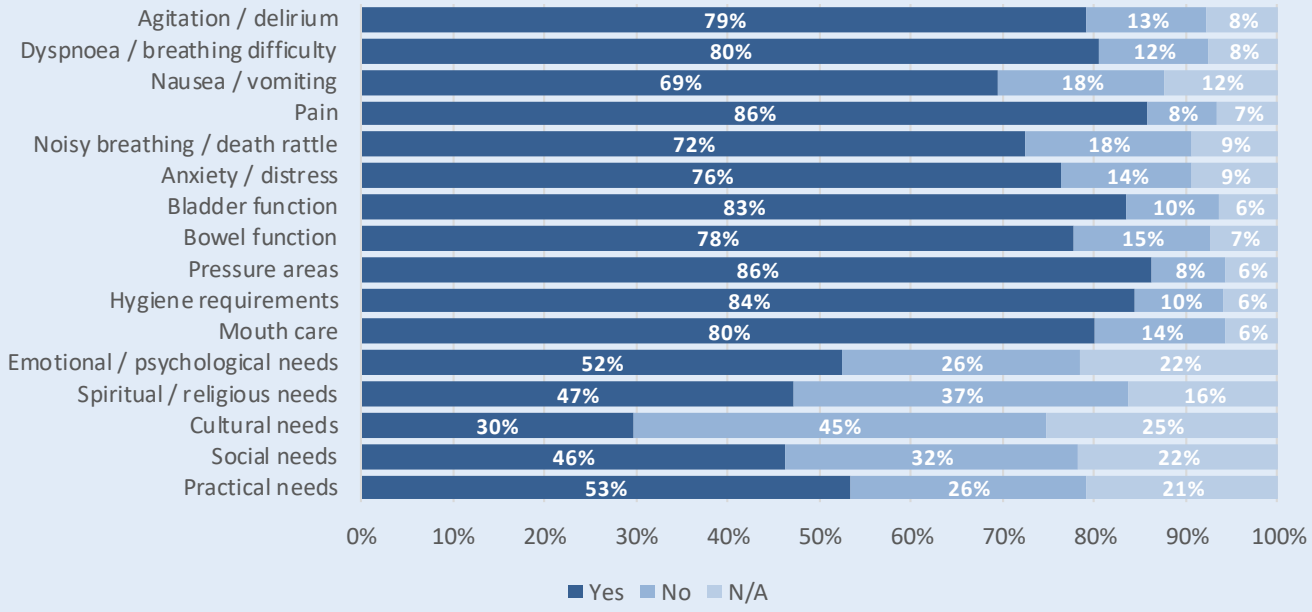
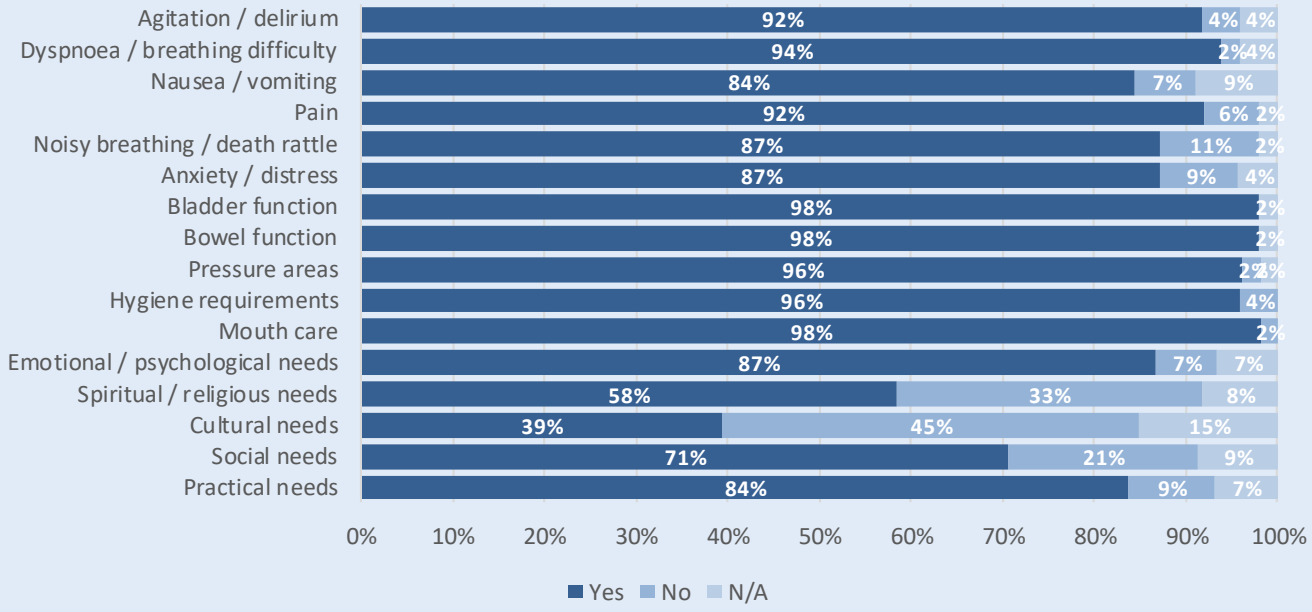


Figure 68: (CNR) Assessment of the following needs: submission



5.6 Individual plan of care

Additional indicators: holistic care

Figure 69: (QS) Do you feel that staff at the hospital took time to explore what was important to him/her in terms of individual requirements and care in the last few days of life?

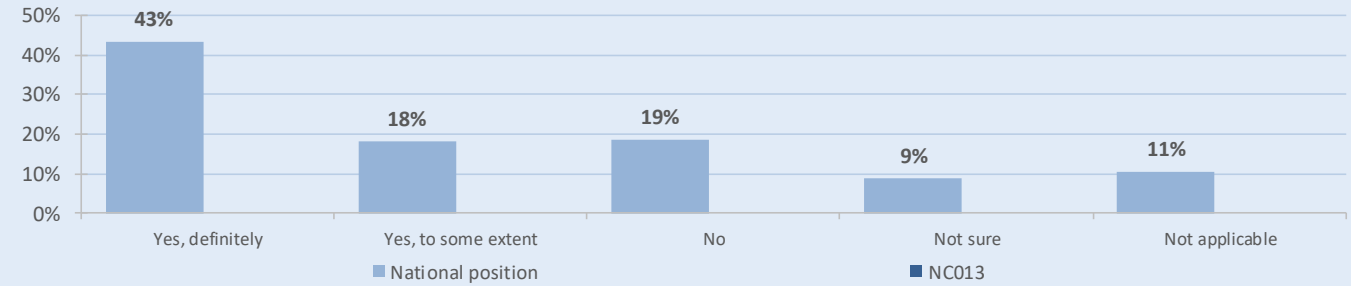


Figure 70: (QS) Do you feel that staff at the hospital made a plan for the person's care which took account of his/her individual requirements and wishes?

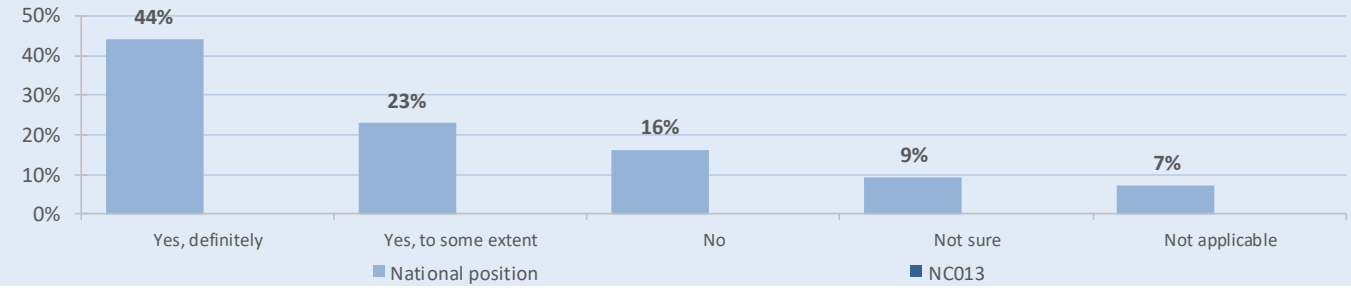


Figure 71: (QS) Had care for emotional needs (e.g. feeling low, feeling worried, feeling anxious) met by staff

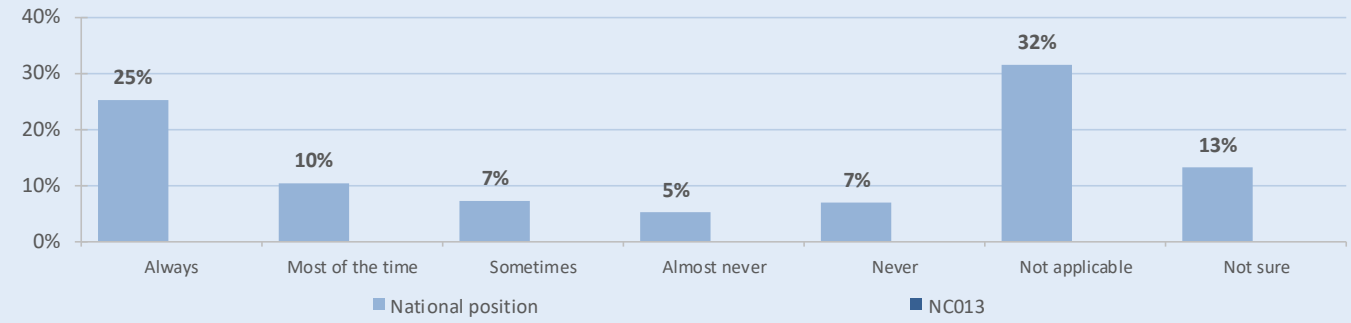
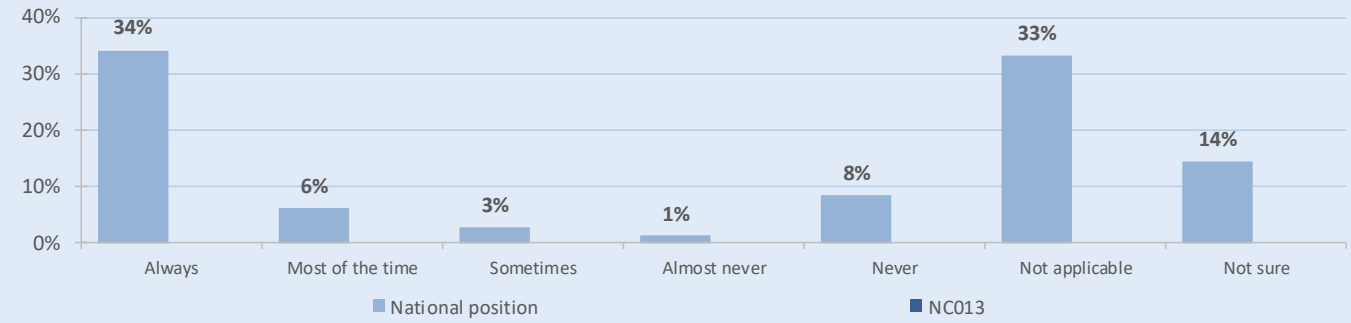


Figure 72: (QS) Staff took into account his/her beliefs, hopes, traditions, religion and spirituality



5.6 Individual plan of care

Additional indicators: physical care

Figure 73: (QS) Was given sufficient pain relief

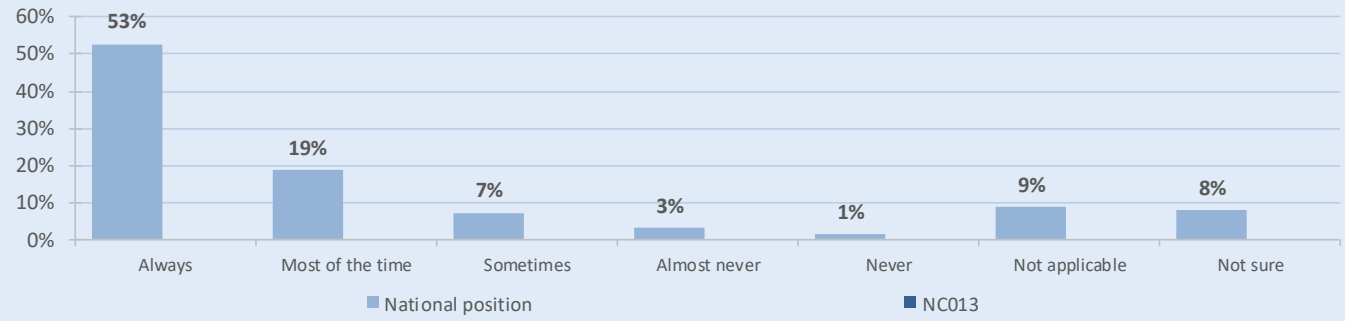


Figure 74: (QS) Had sufficient relief of symptoms other than pain (such as nausea or restlessness)

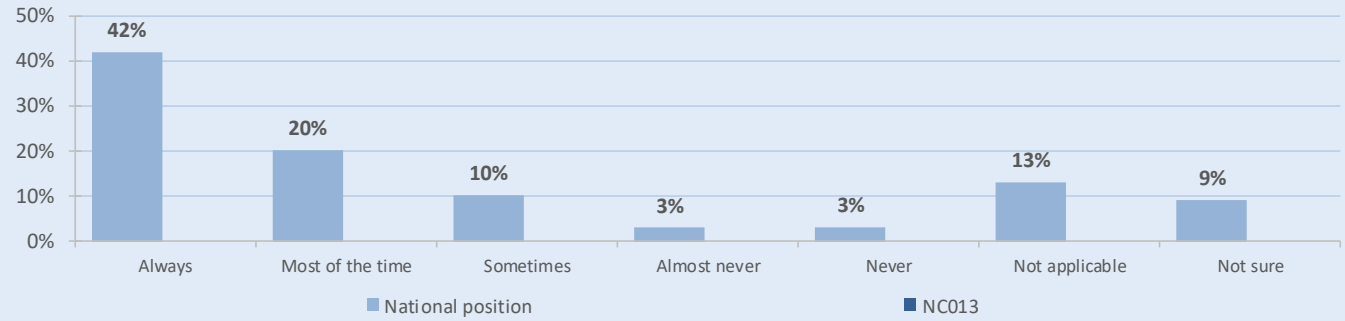


Figure 75: (QS) Had support to drink or receive fluid if he/she wished

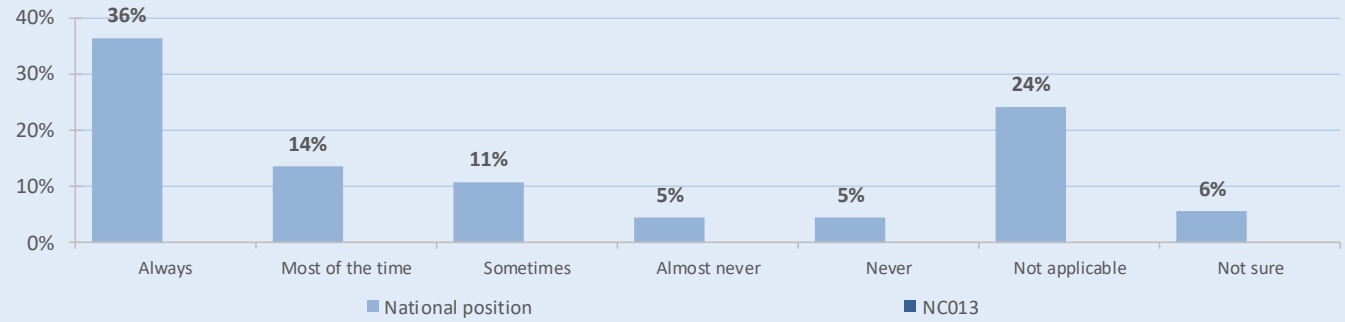
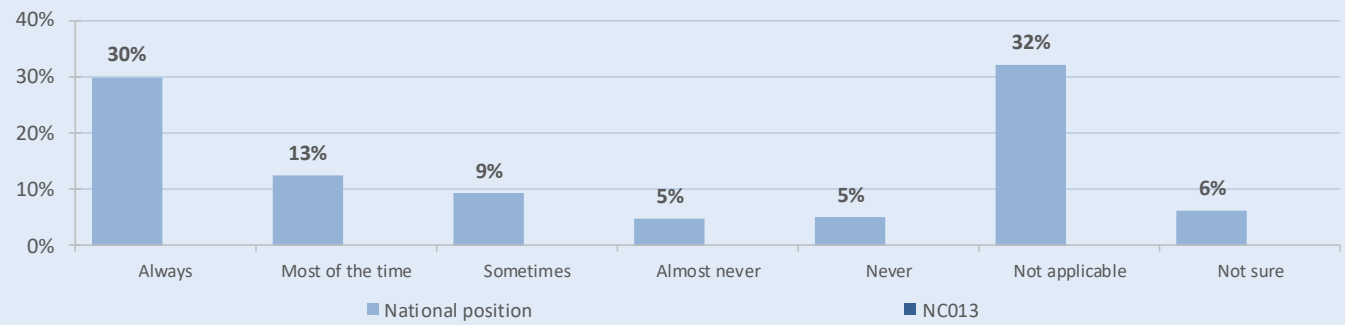


Figure 76: (QS) Had support to eat or receive nutrition if he/she wished



5.6 Individual plan of care

Additional indicators: place of care

Figure 77: (CNR) Attempts made to move the patient home/to a hospice

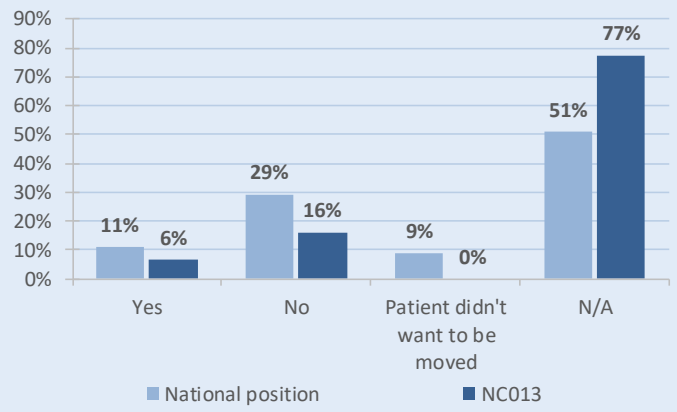


Figure 78: (CNR) Documented that if a side room was requested it wasn't available

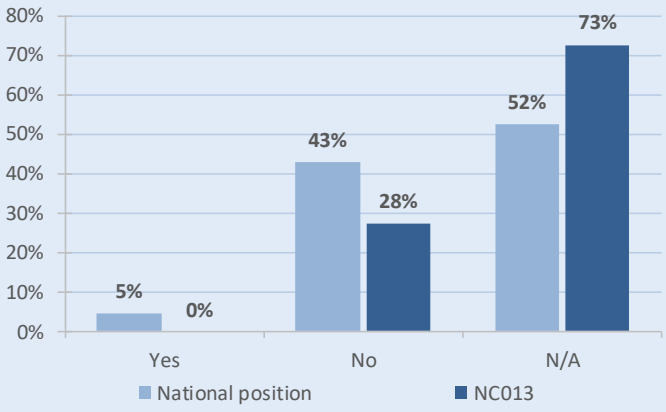


Figure 79: (QS) In the last two to three days of life, were efforts made to transfer the person from hospital if that was his/her wish?

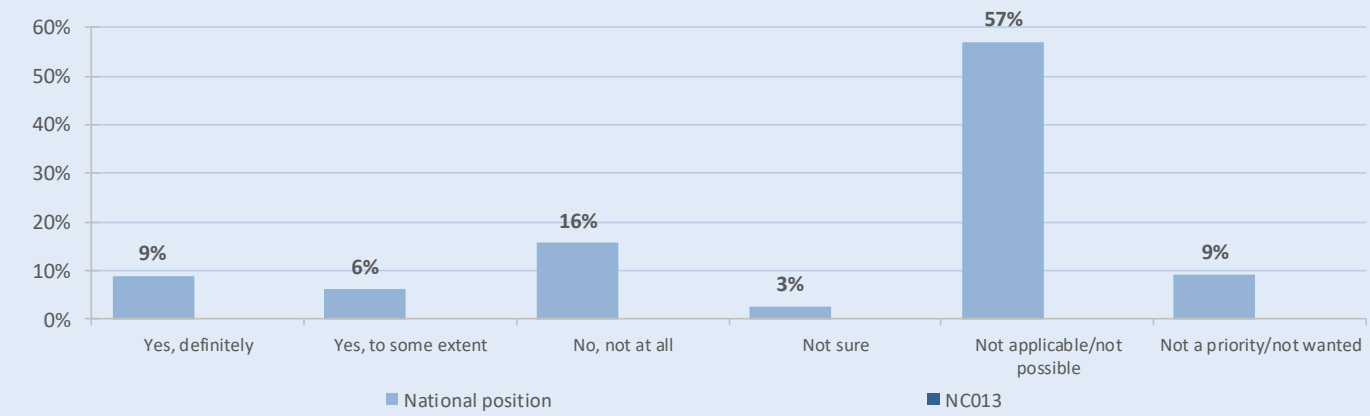
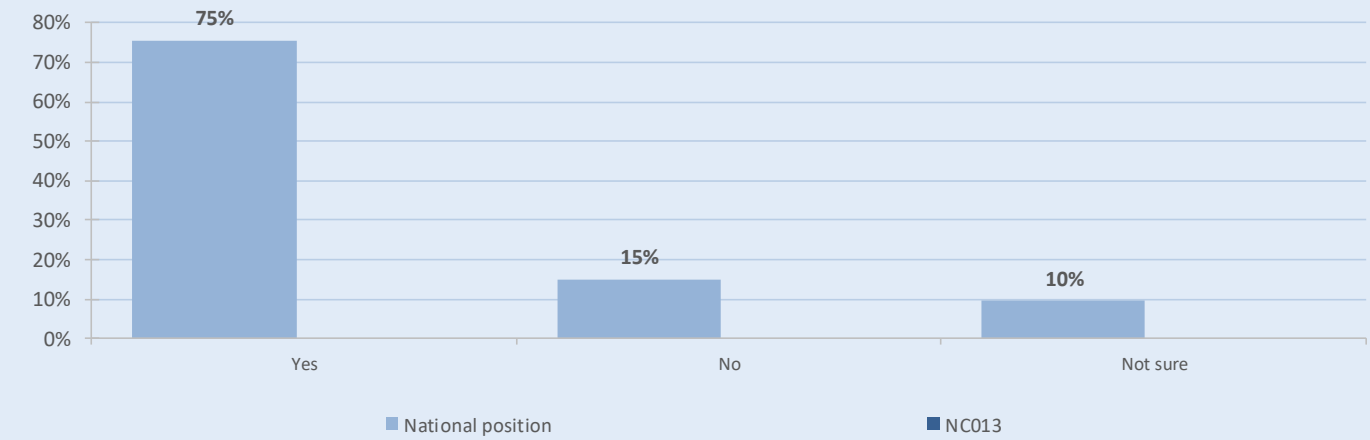


Figure 80: (QS) On balance, do you think that hospital was the right place for him/her to die?



5.6 Individual plan of care

Additional indicators: place of care

Figure 81: (QS) Within the hospital where did the person die?

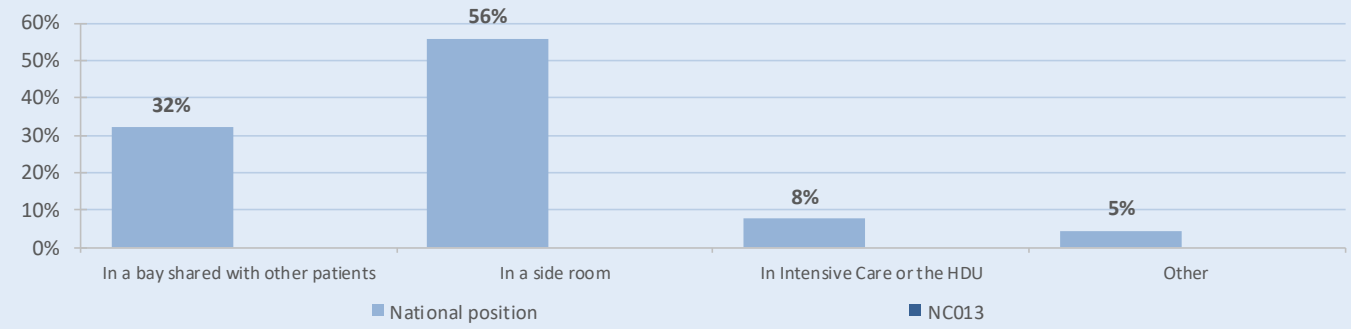


Figure 82: (QS) Were you satisfied that this location within the hospital was appropriate?

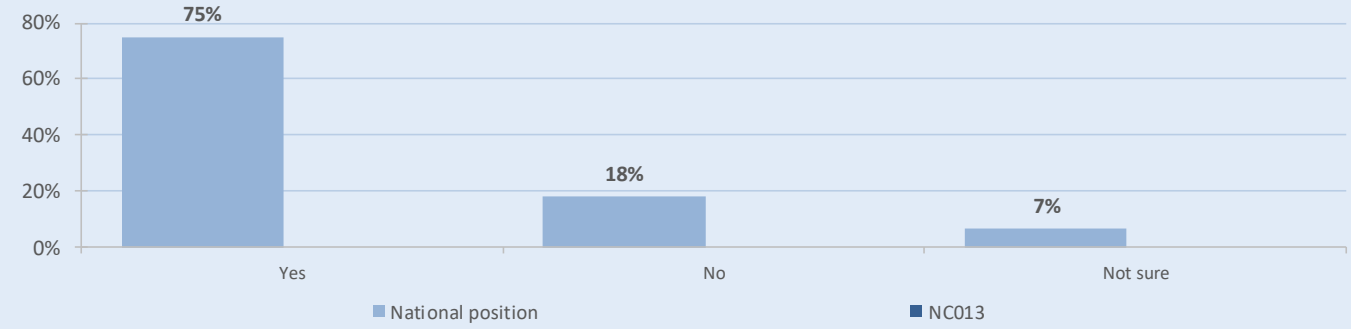


Figure 83: (QS) Had adequate privacy

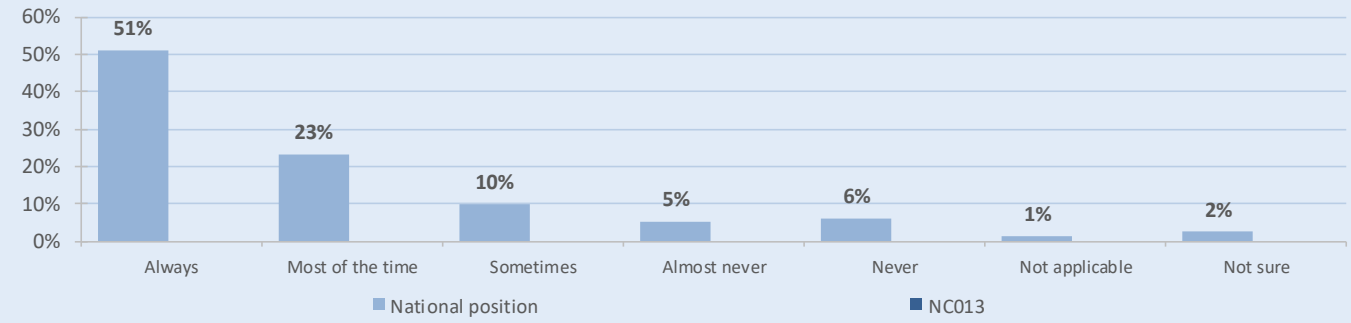
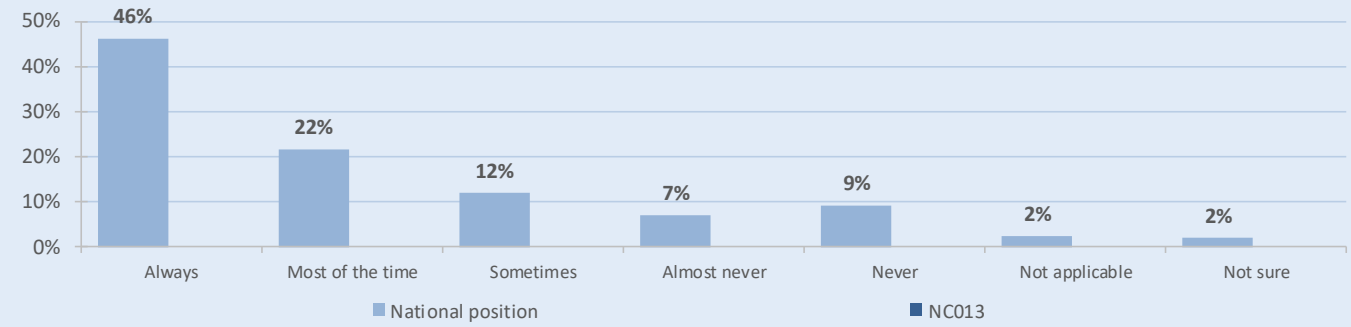


Figure 84: (QS) Had a suitable environment with sufficient peace and quiet



5.7 Families' and others' experience of care

The *NHS Outcomes Framework,* which sets out high level national outcomes for the NHS, has five domains, including ensuring that people have a positive experience of care. When a person has died, those important to the person, be it families, carers, friends or others, are best placed to comment on both the experience of care of the patient and the support they received themselves. In this section, evidence on the experience of care from the Quality Survey is presented.

Families' and others' experience of care: summary score

In reviewing the results for this theme, it should be noted that the total number of Quality Surveys returned was 790, representing 7% of the Case Note Reviews completed (11,034). The Quality Survey results may not, therefore be representative of the whole Case Note Review sample. The number of responses used to calculate each of the summary score component metrics for both national and submission results, is shown at Appendix 5.

The summary score for families' and others' experience of care is calculated using information collected in the Quality Survey:

- overall quality of care provided to the patient
- overall quality of care provided to friends and family of the patient
- staff looking after the patient communicated sensitively
- patient treated with compassion
- family/friends communicated with compassionately

The range of hospital mean summary scores for families' and others' experience of care is shown in figure 85.

The mean value of the summary score across the whole sample of Quality Survey responses is 7.1 (n=682) and, if available, your submission's value is shown in the infographic above.

Figure 85: Hospital mean summary score: Families' and others' experience of care

Range 4.3 – 9.7

5.7 Families' and others' experience of care

Summary score component indicators

Figure 86: (QS) Overall quality of care and support provided to the patient

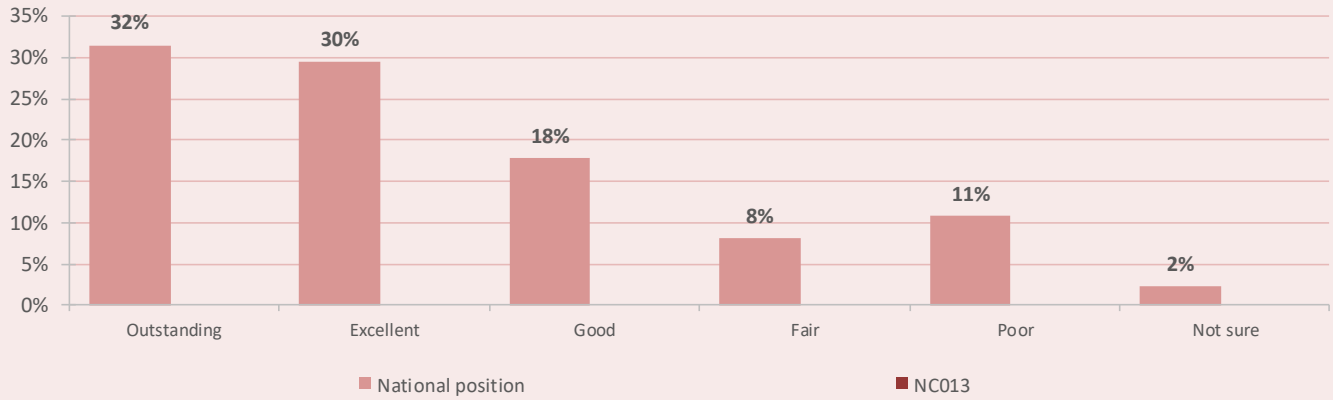


Figure 87: (QS) Overall quality of care and support provided to friends and family of the patient

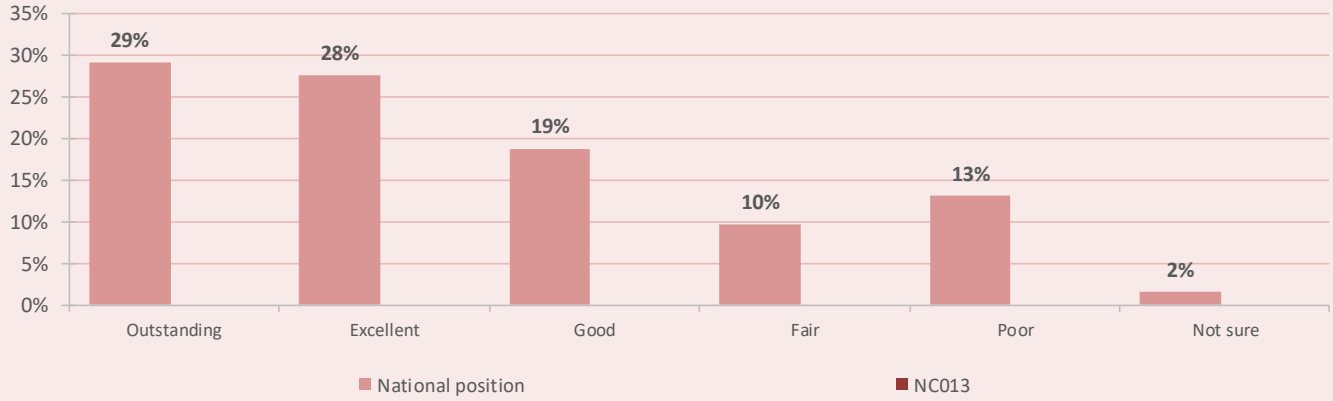
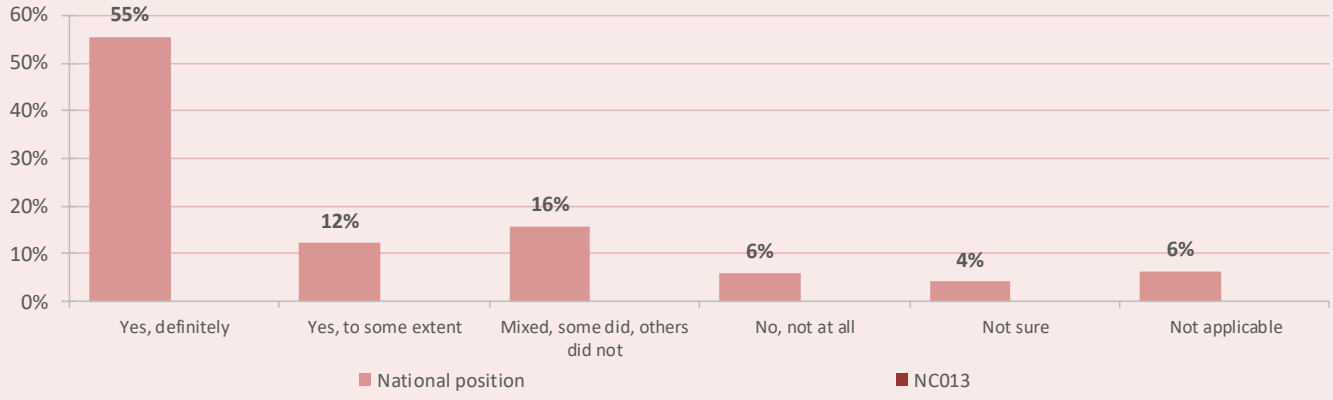


Figure 88: (QS) Staff looking after the patient communicated sensitively



5.7 Families' and others' experience of care

Families' and others' experience of care | **7.1** | **-**

Summary score component indicators

Figure 89: (QS) Patient treated with compassion

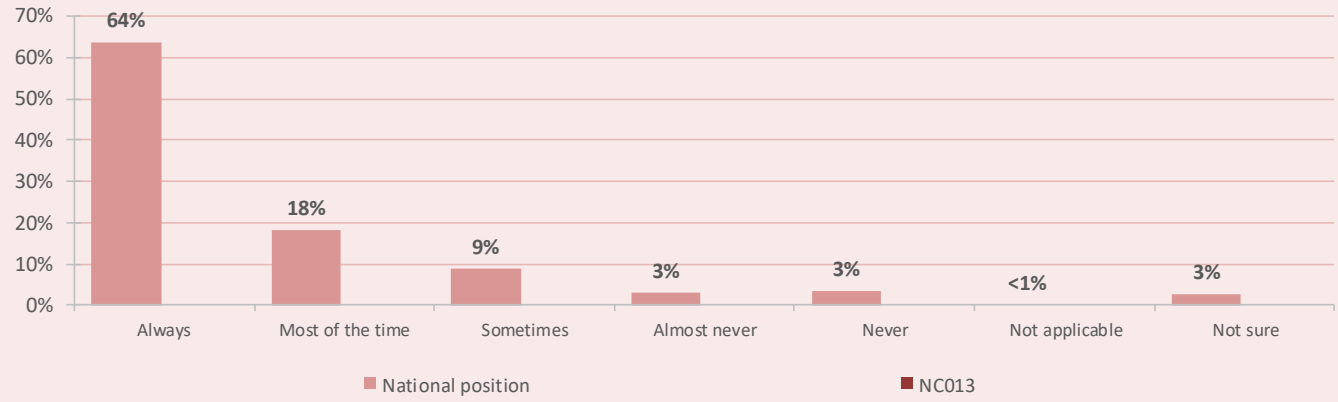
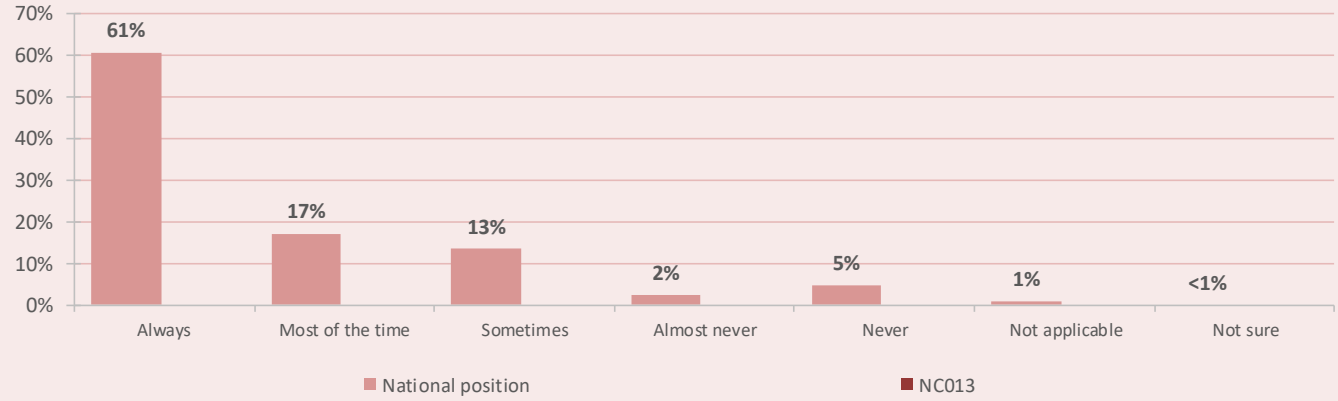


Figure 90: (QS) Family/ friends communicated to compassionately



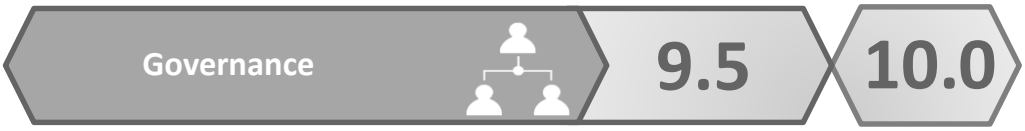
5.8 Governance

Local leadership is essential to securing improvements in the overall care of people in the last few days and hours of life. In this section, evidence on governance arrangements for end of life care from the organisational level audit are presented.

Organisational leadership and governance: Each [organisation] needs to have leadership that is committed to ensuring that those people to whom it provides services who are dying receive high-quality, compassionate care, focused on the needs of the dying person and their family (*One Chance To Get It Right*).

Education, training and professional development: Individual providers of health and care are responsible for ensuring their staff have the experience and competence they need to do their jobs well. This includes making time and other resources available for staff to undergo professional development *(One Chance To Get It Right).*

Governance: summary score

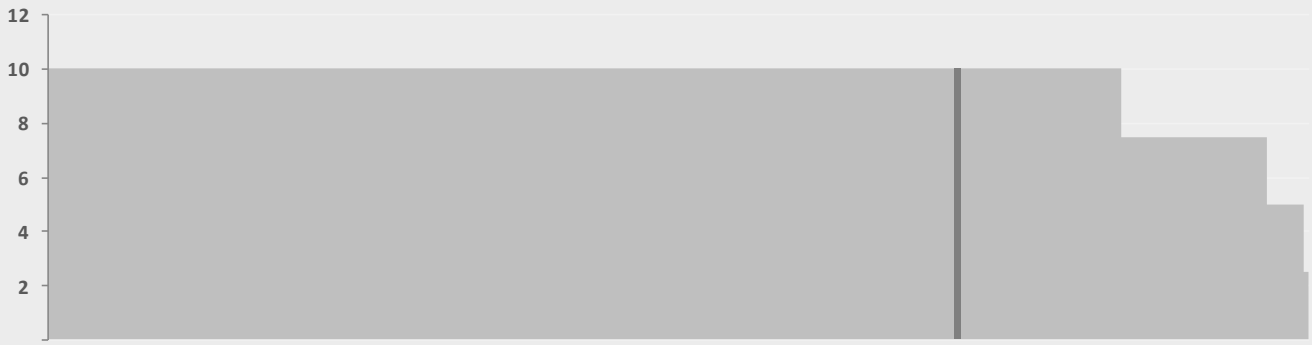


The summary score for Governance is calculated using information collected in the trust/UHB level audit:

- an identified member of the trust/UHB board with a responsibility for end of life care
- a policy on how to respond to and learn from the death of patients under the organisation's management and care
- specific care arrangements to enable rapid discharge home to die, if this is the person's preference
- a care plan to support the *five priorities for care* for the dying person (*One Chance To Get It Right*)

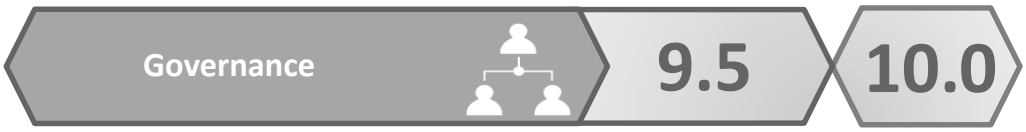
The range of hospital mean summary scores for governance is shown in figure 91. The mean value of the summary score across the participating hospitals is 9.5 (n=177) and, if available, your submission's value is shown in the infographic above.

Figure 91: Hospital mean summary score: Governance



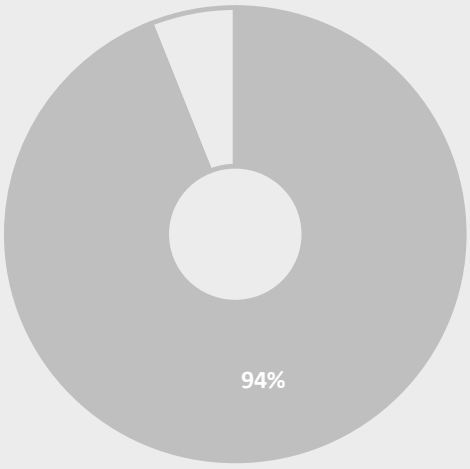
Range 2.5 – 10.0

5.8 Governance



Summary score component indicators

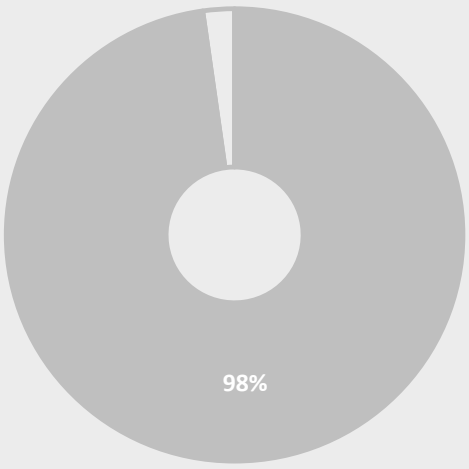
Figure 92: (T/UHB) An identified member of the trust/UHB board with a responsibility for end of life care



National % Yes

NC013 = Yes

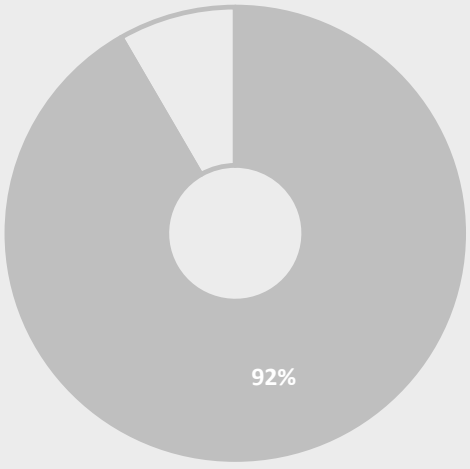
Figure 93: (T/UHB) Policy on how to respond to and learn from the death of patients under the organisation's management and care



National % Yes

NC013 = Yes

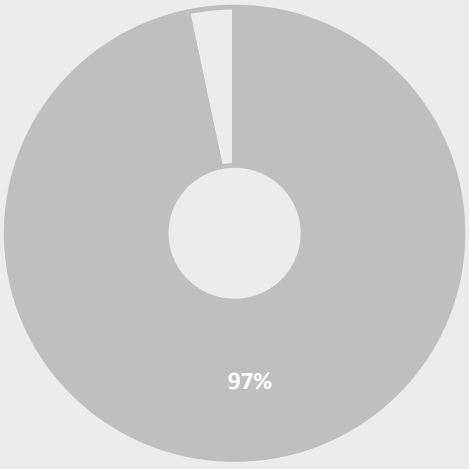
Figure 94: (T/UHB) Specific care arrangements to enable rapid discharge home to die, if this is the person's preference



National % Yes

NC013 = Yes

Figure 95: (T/UHB) A care plan to support the *five priorities of care* for the dying person



National % Yes

NC013 = Yes

5.8 Governance

Additional indicators

Figure 96: (H/S) Formal process for discussing and reporting on the *five priorities for care* within your trust/UHB quality governance structure

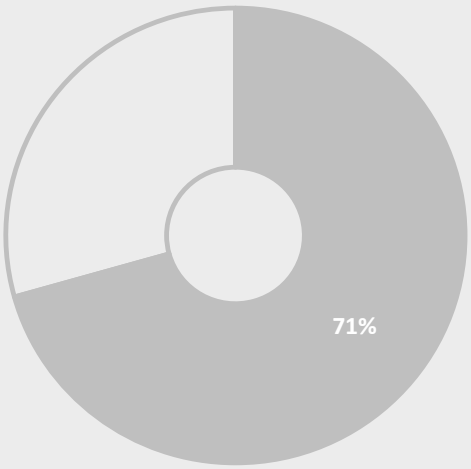


Figure 97: (H/S) Action plan produced in the last financial year to promote improvement in end of life care

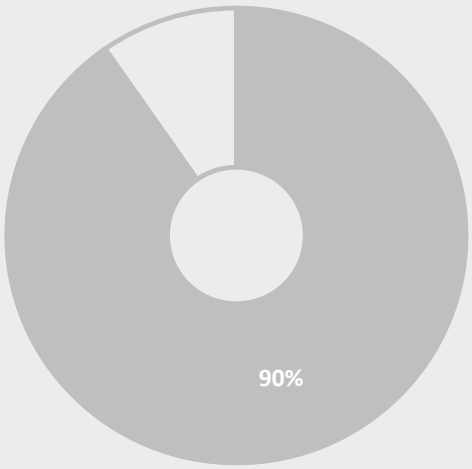


Figure 98: (T/UHB) A non-executive director responsible for the oversight of the national guidance on *learning from deaths* agenda progress

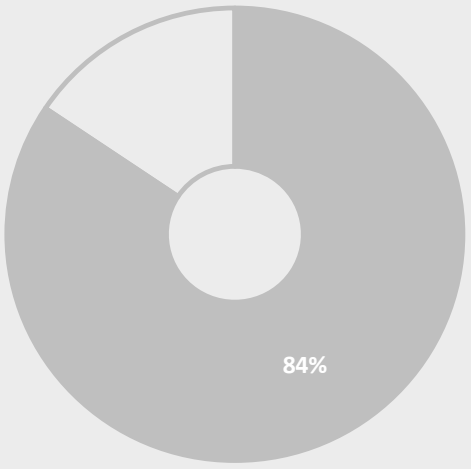
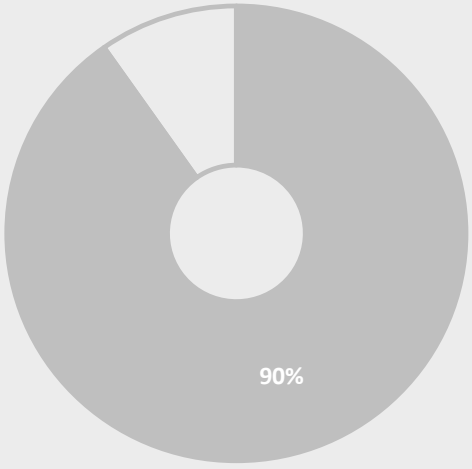


Figure 99: (H/S) Mechanism for flagging complaints that relate to end of life care



5.9 Workforce/specialist palliative care

National guidance recognises the need for providers to work with commissioners to ensure access to an adequately resourced specialist palliative care (SPC) workforce to provide leadership, education and training, including for pre-qualifying education, and support to non-specialist front-line health and care workers. In this section, findings for the organisational level audit and Quality Survey regarding the specialist and non-specialist workforce are presented.

Notes to Priority 5: There must be prompt referral to, and input from, specialist palliative care for any patient and situation that requires this (*One Chance To Get It Right*).

Notes to Priority 5: [service providers must] work with commissioners and specialist palliative care professionals to ensure adequate access to specialist assessment, advice and active management. 'Adequate' means that service providers and commissioners are expected to ensure provision for specialist palliative medical and nursing cover routinely 9am - 5pm seven days a week and a 24 hour telephone advice service (*One Chance To Get It Right*).

Ongoing education and training for all health and care staff: [..all] staff who have contact with dying people must have the skills to do this effectively and compassionately. This includes clinical and support staff (e.g. porters, reception staff and ward clerks.) Those organisations that deliver such care have the prime responsibility for ensuring that the people they employ are competent to carry out their roles effectively, including facilitating and funding ongoing professional development, where this is appropriate (*One Chance To Get It Right*).

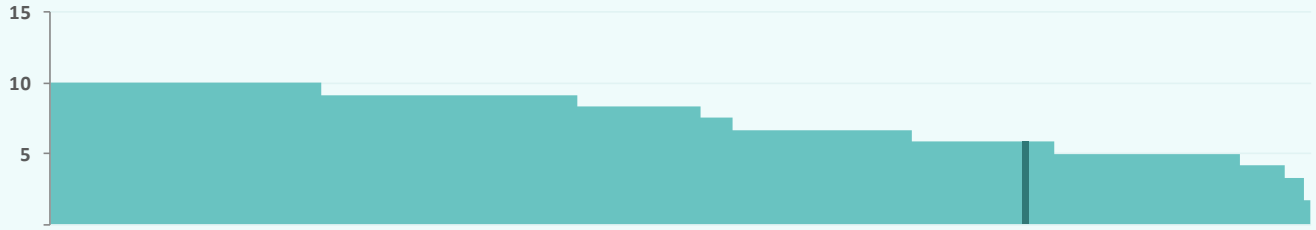
Workforce/specialist palliative care: summary score

The summary score for workforce/specialist palliative care is calculated using information collected in the organisational level audit:

- does the hospital provide/have access to a specialist palliative care service
- nurses in SPC team available 9am-5pm, 7 days a week, face-to-face (or better/equivalent)
- training (weighting 0.25 each)
  - end of life care training included in induction programme
  - end of life care training included in mandatory/priority training
  - training to improve the culture, behaviours, attitudes around communication skills
  - other training in relation to end of life care

The range of hospital mean summary scores for workforce/specialist palliative care is shown in figure 100. The mean value of the summary score across participating hospitals is 7.6 (n=196) and, if available, your submission's value is shown in the infographic above.

Figure 100: Hospital mean summary score: Workforce/specialist palliative care

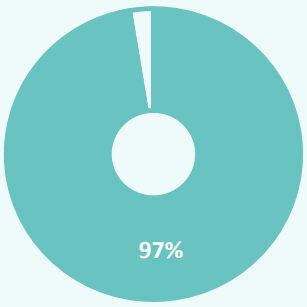


Range 1.7 – 10.0

5.9 Workforce/specialist palliative care

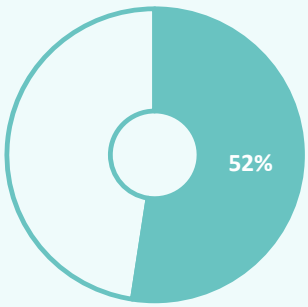
Summary score component indicators

Figure 101: (H/S) Does the hospital provide/have access to a specialist palliative care service?



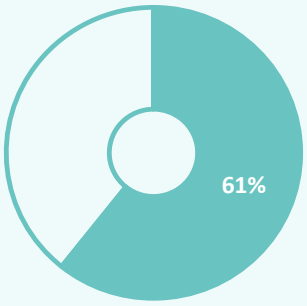
National % Yes NC013 = Yes

Figure 102: (H/S) Nurses in SPC team available 9am-5pm, 7 days a week, face-to-face (or better/equivalent)



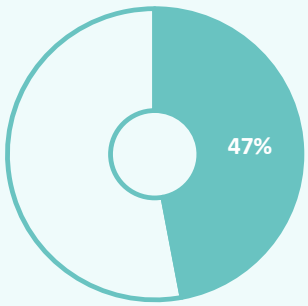
National % Yes NC013 = No

Figure 103: (H/S) End of life care training included in induction programme



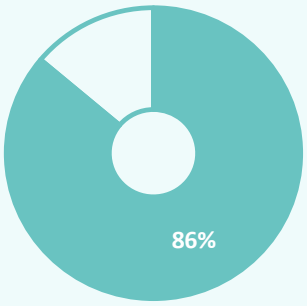
National % Yes NC013 = Yes

Figure 104: (H/S) End of life care training included in mandatory/priority training



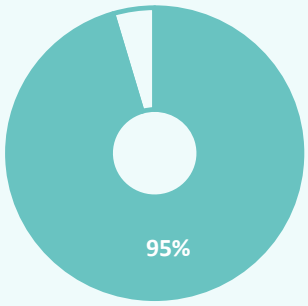
National % Yes NC013 = No

Figure 105: (H/S) Training to improve the culture, behaviours, attitudes around communication skills



National % Yes NC013 = Yes

Figure 106: (H/S) Other training in relation to end of life care

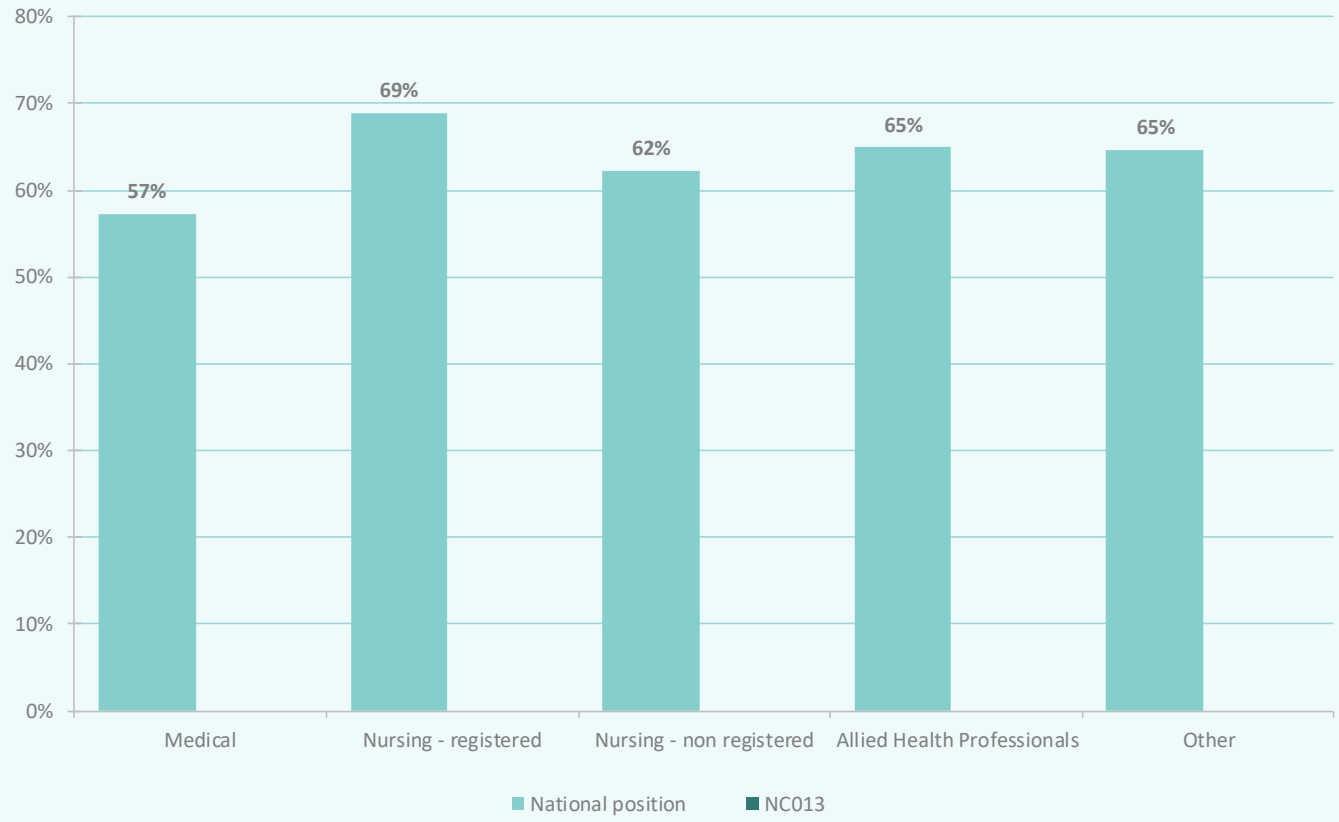


National % Yes NC013 = Yes

5.9 Workforce/specialist palliative care

Additional indicators

Figure 107: (H/S) Percentage of staff who have received mandatory/priority end of life care training



5.9 Workforce/specialist palliative care

Additional indicators

Figure 108: (T/UHB) Opportunities for staff to reflect on the emotional aspects of their work

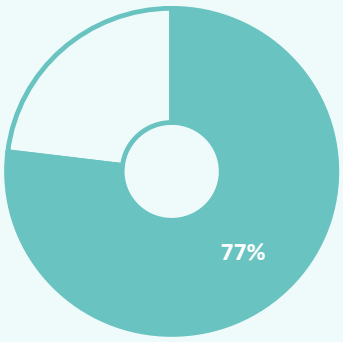


Figure 109: (CNR) Patient reviewed by the specialist palliative care team during final admission

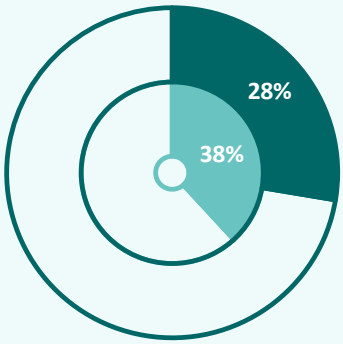


Figure 110: (QS) Were you confident that healthcare staff looking after him/her had enough skill and experience to care for someone at the end of their life?

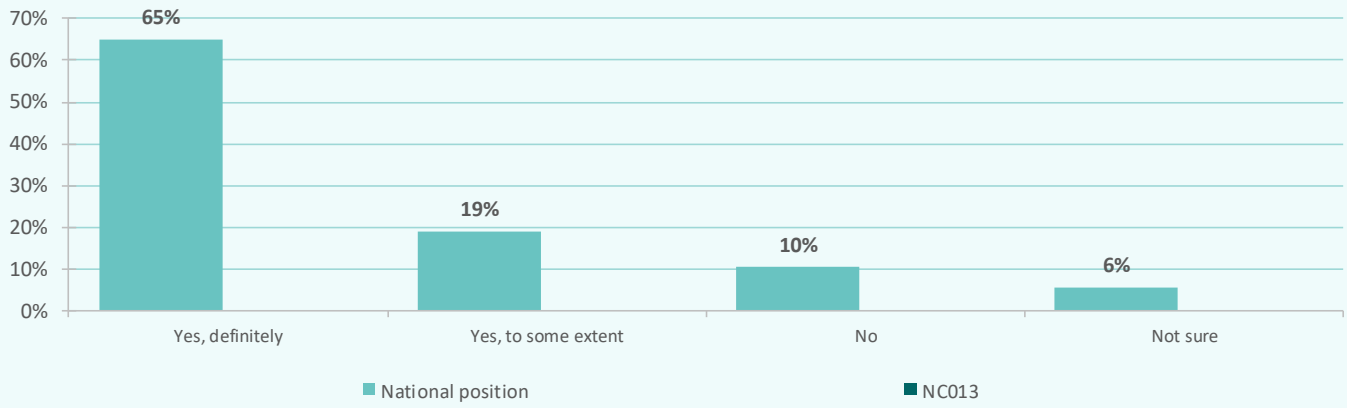
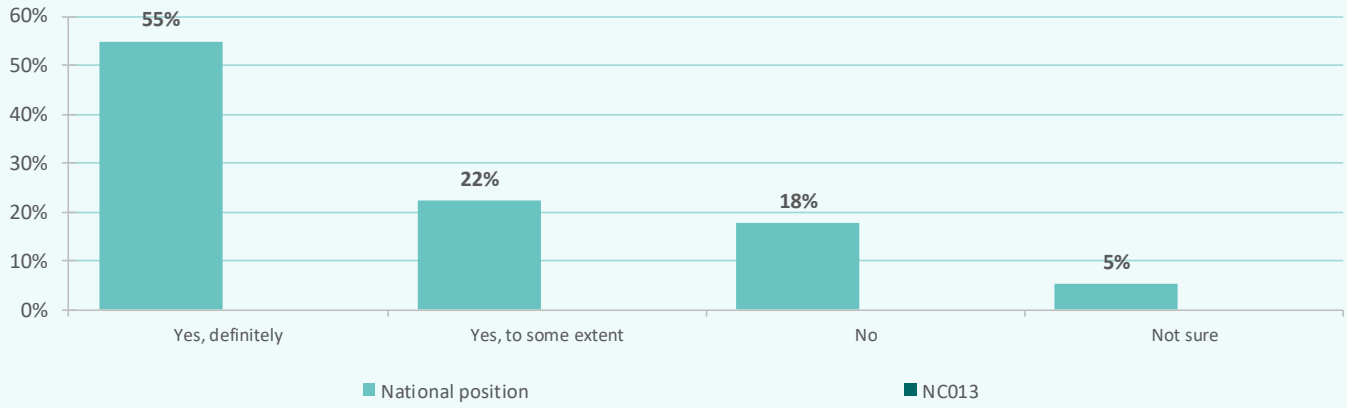


Figure 111: (QS) Did you feel that there was a consistent team approach and good coordination between different members of staff?



6. Next steps

This bespoke dashboard summaries the results of the first round of NACEL for your submission (hospital site) under nine key themes. The report includes your summary scores for each of the key themes, compared to the whole sample results. The component indicators for the summary scores are included, together with additional relevant metrics for these themes. The summary scores for each theme should not be compared to each other.

The full results for all of the indicators included in the first round of NACEL can be found in the NACEL online toolkit accessible in the members' area of the Network website. If you require a log-in for the members' area, or any other assistance, please contact nhsbn.nacelsupport@nhs.net.

The audit report for the first round of the audit covering England and Wales will be published following approval by the audit funders, NHS England and the Welsh Government. This report will include the NACEL recommendations.

Ahead of the publication of the national report and recommendations, participants are encouraged to review their local results as set out in this dashboard, and in the online toolkit, and develop a local action plan.

Second round of the audit (NACEL 2019)

The second round of the audit will take place in 2019. As in 2018, the audit will include an organisational level audit, Case Note Review and Quality Survey. The scope and content of each of the components is under discussion with the Steering Group, however, it is likely that:

- The definition of deaths will be as for the first round of NACEL, to ensure comparability.
- The content of the organisational level and Case Note Review will be reduced substantially to reduce the data burden for participants.
- The number of case notes to be reviewed will be reduced.
- The timescales will be as for the first round of NACEL, with minor amendments to allow a greater number of Quality Surveys to be collected.

References

The Leadership Alliance for the Care of Dying People. *One Chance to Get it Right. Improving people's experience of care in the last few days and hours of life*. June 2014. (This document includes the *five priorities for care* of the dying person.)

NICE. Quality Standard 13, *End of life care for adults*. November 2011

NICE. Quality Standard 144, *Care of dying adults in the last days of life*. March 2017

NICE. Guideline NG31, *Care of dying adults in the last days of life*. 2015

NHS Constitution (p17)

NHS Outcomes Framework (p34)

Appendix 1: Patient demographics

Age range	National %	National N =	NC013 %	NC013 N =
18-64	12%	1308	19%	15
65-74	17%	1827	15%	12
75-84	31%	3339	28%	22
85-94	34%	3733	36%	29
95+	6%	666	3%	2
Total		**10873**		**80**

Age	National	NC013
Range	18 - 110	35 - 101
Mean	79	76
Median	82	79

Gender	National %	National N =	NC013 %	NC013 N =
Male	49.3%	5391	64%	51
Female	50.6%	5535	36%	29
Other	0.1%	9	0.0%	0
Total		**10935**		**80**

Ethnicity profile	National %	National N =	NC013 %	NC013 N =
White	81.39%	8649	81%	65
Mixed	0.47%	50	0%	0
Asian or Asian British	2.20%	234	13%	10
Black or Black British	1.27%	135	5%	4
Other Ethnic Groups	0.77%	82	0%	0
Not stated	13.90%	1477	1%	1
Total		**10627**		**80**

Religious affiliation	National %	National N =	NC013 %	NC013 N =
Baha'i	0.01%	1	0%	0
Buddhist	0.10%	11	0%	0
Christian	50.26%	5332	63%	50
Hindu	0.42%	45	1%	1
Jain	0.02%	2	0%	0
Jewish	0.37%	39	0%	0
Muslim	1.23%	131	4%	3
Pagan	0.00%	0	0%	0
Sikh	0.37%	39	6%	5
Zoroastrian	0.00%	0	0%	0
Other	2.82%	299	3%	2
None	7.94%	842	14%	11
Declined to disclose	0.56%	59	3%	2
Unknown	35.90%	3809	8%	6
Total		**10609**		**80**

Appendix 1: Patient demographics

Primary cause of death	National %	National N =	NC013 %	NC013 N =
Cancer	17.7%	1922	20%	16
Chronic respiratory disease	5.0%	541	5%	4
Dementia	2.2%	240	5%	4
Heart failure	7.6%	822	1%	1
Neurological conditions	0.9%	101	1%	1
Pneumonia	26.8%	2905	33%	26
Renal failure	1.8%	198	3%	2
Stroke	4.8%	516	8%	6
Other	23.8%	2575	19%	15
No access to death certificate	9.4%	1013	5%	4
Total		**10833**		**79**

Documented co-morbidities	National %	National N =	NC013 %	NC013 N =
Cardiovascular	25%	3720	30%	40
Central nervous system	5%	782	5%	7
Dementia	8%	1128	10%	13
Endocrine	8%	1253	10%	14
Frailty	10%	1469	11%	15
Genitourinary	6%	921	9%	12
Malignancy	7%	1066	9%	12
Musculoskeletal	3%	487	2%	3
Respiratory	14%	2044	9%	12
Other	14%	2072	4%	6
Total		**14942**		**134**

Appendix 2: Characteristics of deaths in hospitals

Day of death	National %	National N =	NC013 %	NC013 N =
Monday	15.66%	1703	12%	9
Tuesday	14.48%	1575	18%	14
Wednesday	13.96%	1518	14%	11
Thursday	13.77%	1498	22%	17
Friday	13.77%	1498	6%	5
Saturday	12.70%	1381	15%	12
Sunday	15.67%	1704	13%	10
Total		**10877**		**78**

Time of death	National %	National N =	NC013 %	NC013 N =
00:00 - 06:00	24%	2552	21%	16
06:01 - 12:00	25%	2738	30%	23
12:01 - 18:00	27%	2917	29%	22
18:01 - 23:59	24%	2543	21%	16
Total		**10750**		**77**

Hospital department	National %	National N =	NC013 %	NC013 N =
Care of the Elderly	21.92%	2378	8%	6
Cardiology	3.12%	339	3%	2
Respiratory	10.36%	1124	9%	7
Oncology	4.02%	436	6%	5
Medical	19.01%	2062	38%	30
Neurology	0.47%	51	0%	0
Stroke	4.77%	518	8%	6
Surgical	5.12%	556	8%	6
Trauma	0.26%	28	0%	0
Orthopaedics	1.65%	179	1%	1
Urology	0.41%	45	0%	0
Renal	1.00%	109	4%	3
Critical Care Level 2 (HDU)	1.54%	167	0%	0
Critical Care Level 3 (ICU)	7.12%	772	9%	7
Acute assessment / admissions	7.82%	848	5%	4
Specialist palliative care unit	1.99%	216	0%	0
Rehabilitation unit	1.70%	184	0%	0
Other	7.71%	837	1%	1
Total		**10849**		**78**

Appendix 2: Characteristics of deaths in hospitals

Length of stay profile	National %	National N =	NC013 %	NC013 N =
0-1 days	7.0%	741	4%	3
2-10 days	46.9%	4946	46%	35
11-20 days	22.9%	2419	33%	25
21-30 days	10.6%	1114	7%	5
31-40 days	5.6%	593	7%	5
41-50 days	2.9%	309	1%	1
51-60 days	1.5%	160	1%	1
61-70 days	0.9%	91	0%	0
71-80 days	0.7%	69	1%	1
81-90	0.3%	28	0%	0
90 +	0.7%	79	0%	0
Total		**10549**		**76**

Appendix 3: Use of interventions

DNACPR in place	National %	National N =	NC013 %	NC013 N =
Yes	97%	10349	96%	76
No	3%	347	4%	3
Total		**10696**		**79**

Medication prescribed subcutaneously	National %	National N =	NC013 %	NC013 N =
Pain				
Yes	80%	8322	66%	53
No	20%	2062	34%	27
Total		**10384**		**80**
Agitation				
Yes	79%	8182	64%	51
No	21%	2236	36%	29
Total		**10418**		**80**
Dyspnoea				
Yes	73%	7598	64%	51
No	27%	2779	36%	29
Total		**10377**		**80**
Nausea				
Yes	74%	7722	65%	52
No	26%	2656	35%	28
Total		**10378**		**80**
Noisy breathing				
Yes	75%	7791	64%	51
No	25%	2582	36%	29
Total		**10373**		**80**

Nil by Mouth order in place	National %	National N =	NC013 %	NC013 N =
Yes	10%	981	9%	6
No	90%	8633	91%	61
Total		**9614**		**67**

Appendix 3: Use of interventions

Use of clinically assisted hydration	National %	National N =	NC013 %	NC013 N =
Yes	31%	3073	56%	37
No	69%	6745	44%	29
Total		**9818**		**66**

Route of clinically assisted hydration	National %	National N =	NC013 %	NC013 N =
SC	9%	269	11%	4
NG	4%	120	11%	4
PEG	1%	39	5%	2
IV	82%	2505	73%	27
N/A	4%	117	0%	0
Total		**3050**		**37**

Use of clinically assisted nutrition	National %	National N =	NC013 %	NC013 N =
Yes	7%	689	14%	9
No	93%	9010	86%	57
Total		**9699**		**66**

Route of clinically assisted nutrition	National %	National N =	NC013 %	NC013 N =
NG	64%	469	67%	6
PEG	8%	60	22%	2
IV	15%	112	11%	1
N/A	13%	95	0%	0
Total		**736**		**9**

Appendix 4: Method for scoring

A scoring system has been devised to summarise the results of the audit under nine key themes.

This appendix sets out the process undertaken to select the nine key themes and their component indicators, and an explanation of how the scores were calculated.

Selection and content of the nine key themes

The NACEL key themes were developed by the NACEL Steering Group and discussed with the wider Advisory Group. The starting point was the *five priorities for care* from *One Chance To Get It Right* as follows:

1. Recognition of dying
2. Sensitive communication
3. Involvement in decision making
4. Needs of families and others
5. Individual plan of care

Priority 2, concerning sensitive communication, was split into two themes; communication with the dying person and communication with families and others, as the Steering Group felt it was important to distinguish these linked, but different, aspects of communication. In addition, a theme on the overall rating of experience by the bereaved from the Quality Survey was included as an overarching measure of the quality of care. Finally, two further themes on governance and workforce/specialist palliative care were added to cover key aspects of the infrastructure that trusts/UHBs need to put in place to ensure good end of life care.

The component indicators for the summary scores are drawn from all three elements of the audit, including measures from the Case Note Review, the organisational level audit (trust and hospital level responses) and the Quality Survey, which provides the perspective of bereaved families and carers. However, in order to create a summary score, only indicators from one element of the audit were used for each theme. At least three indicators were used for each summary score, to provide granularity in the results. The themes and component indicators are summarised as follows:

Key theme	Source of component indicators (audit element)	Component indicators
Recognising the possibility of imminent death	Case Note Review	3 questions on recognition of death and related discussions with dying and nominated person
Communication with the dying person	Case Note Review	5 questions on discussions with the dying person on plan of care, senior clinician, side effects of medications, hydration and nutrition
Communication with families and others	Case Note Review	6 questions on discussions with nominated person on plan of care, notification of imminent death, senior clinician, side effects of medication, hydration, nutrition
Involvement in decision making	Case Note Review	6 questions on decision making including involvement, capacity, stopping life-sustaining treatments and CPR
Needs of families and other	Case Note Review	3 questions on asking about needs, needs assessed and care and support at time of death
Individual plan of care	Case Note Review	7 questions on having a care plan, reviewing the plan, holistic assessment (4 points in total), review of 4 interventions (1 point in total), review of hydration and nutrition status and preferred place of death
Families' and others' experience of care	Quality Survey	5 questions covering care and support, sensitive communication and compassionate treatment
Governance	Organisational level audit	4 questions on responsibility for end of life care, policy on learning from deaths, policy for discharge home, care plan to support 5 Priorities of Care
Workforce/ specialist palliative care	Organisational level audit	3 questions on specialist palliative care access, seven day availability and training

Appendix 4: Method for scoring

Methods of scoring

The basic principle for scoring for each audit element is outlined below.

Audit element	Scoring for each component indicator	Total score for theme
Case Note Review	Yes = 1* No, but reason recorded or N/A = 1 No and no reason recorded = 0 *Please note, a number of metrics are weighted as detailed in the tables below	• Each component indicator scored for each case note • Total score for each case note calculated by summing indicator scores • Case note scores averaged (over whole sample or hospital) • Shown as score out of 10 (equating to maximum available score)
Organisational level	Yes = 1 No = 0	• Each component indicator scored for each hospital • Total score for each hospital calculated by summing indictor scores • Hospital scores averaged • Shown as score out of 10 (equating to maximum available score)
Quality Survey	Outstanding/ Yes definitely/Always = 4 Excellent/Most of the time = 3 Good/yes to some extent/Sometimes = 2 Fair/Mixed/Almost never = 1 Poor/No not at all/ Never = 0	• Each component indicator scored for each Quality Survey • Total score for each Quality Survey calculated by summing indictors • Quality Survey scores averaged (over whole sample or hospital) • Shown as score out of 10 (equating to maximum available score)

Recognising the possibility of imminent death						
Source: Case Note Review					**EXAMPLE SCORING**	
Section		**Scoring per question**			**Response**	**Score**
	Question	**Yes**	**No but reason recorded or N/A**	**No and no reason recorded**		
Recognition of death	Is there documented evidence within the final episode of care that it was recognised that the patient might die imminently i.e. within a few hours or days?	1	-	0	Yes	1
Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the patient?	1	1	0	Yes	1
Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the nominated person(s)?	1	1	0	No and no reason recorded	0
	Total possible	**3.00**			**Total score this patient**	**2.00**
					Out of 10	**6.67**

Appendix 4: Method for scoring

Communication with the dying person						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the patient had the opportunity to be involved in discussing the plan of care?	1	1	0	No and no reason recorded	0
Individualised EoL care planning	Is there documented evidence that the patient had been informed about the senior doctor/nurse in the team who has professional responsibility for their care and treatment?	1	1	0	No and no reason recorded	0
Physical care	Is there documented evidence that the possibility of side effects of medications such as drowsiness were discussed with the patient?	1	1	0	No and no reason recorded	0
Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the patient once death was recognised as a possibility?	1	1	0	Yes	1
Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the patient?	1	1	0	Yes	1
	Total possible	**5.00**			**Total score this patient**	**2.00**
					Out of 10	**4.00**

Communication with families and others						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the nominated person(s) had the opportunity to develop and discuss an individualised plan of care for the patient?	1	1	0	No and no reason recorded	0
Individualised EoL care planning	Is there documented evidence that the nominated person(s) had been informed about the senior doctor/nurse in the team who has professional responsibility for care and treatment?	1	1	0	N/A	1
Immediately prior to and after death	Is there documented evidence that the nominated person(s) were notified of the patient's imminent death?	1	1	0	Yes	1
Physical care	Is there evidence that the possibility of side effects of medications such as drowsiness were discussed with the nominated person(s)?	0.33	0.33	0	No and no reason recorded	0
Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the nominated person(s)?	0.33	0.33	0	No but reason recorded	0.33
Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the nominated person(s)?	0.33	0.33	0	No and no reason recorded	0
	Total possible	**4.00**			**Total score this patient**	**2.33**
					Out of 10	**5.83**

Appendix 4: Method for scoring

Involvement in decision making						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence about the extent to which the patient wished to be involved in decisions about their care?	1	1	0	Yes	1
Treatment decisions	Is there documented evidence in the notes that the dying person had their capacity assessed to be involved in their end of life care planning?	1	1	0	No and no reason recorded	0
Treatment decisions	Is there documented evidence within the final admission of a discussion with the patient by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	1	1	0	No but reason recorded	1
Treatment decisions	Is there documented evidence within the final admission of a discussion with the nominated person(s) by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	1	1	0	No but reason recorded	1
Treatment decisions	Is there documented evidence that a discussion with the patient regarding Cardiopulmonary Resuscitation (CPR) was undertaken by a clinician?	1	1	0	Yes	1
Treatment decisions	Is there documented evidence that the Cardiopulmonary Resuscitation (CPR) decision was discussed with the nominated person(s) by a senior clinician?	1	1	0	No but reason recorded	1
	Total possible	**6.00**			**Total score this patient**	**5.00**
					Out of 10	**8.33**

Needs of families and others						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the needs of the nominated person(s) were asked about?	1	-	0	Yes	1
Individualised EoL care planning	Of which of the following needs of the nominated person(s) is there documented evidence that they were assessed and addressed?					
Individualised EoL care planning	emotional/psychological needs	0.2	-	0	Yes	0.2
Individualised EoL care planning	spiritual/religious needs	0.2	-	0	Yes	0.2
Individualised EoL care planning	cultural needs	0.2	-	0	No	0
Individualised EoL care planning	social needs	0.2	-	0	No	0
Individualised EoL care planning	practical needs	0.2	-	0	Yes	0.2
Immediately prior to and after death	Is there documented evidence of the care and support provided to the nominated person(s) at the time of and immediately after death?	1	1	0	No and no reason recorded	0
	Total possible	**3.00**			**Total score this patient**	**1.60**
					Out of 10	**5.33**

Appendix 4: Method for scoring

Individual plan of care						
Source: Case Note Review					**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**			**Response**	**Score**
		Yes	**No but reason recorded or N/A**	**No and no reason recorded**		
Individualised EoL care planning	Is there documented evidence that the patient who was dying had an individualised end of life care plan?	0.5	-	0	Yes	0.5
Individualised EoL care planning	If there was a care plan, was the patient and their plan of care reviewed regularly?	0.5	0.5	0	Yes	0.5
Immediately prior to and after death	Was there documented evidence in the case notes of the preferred place of death as indicated by the patient?	1	-	0	Yes	1
Treatment decisions	In the period between the recognition that the patient might die and death, were any of the following interventions documented as being reviewed in the patient's plan of care?					
	routine recording of vital signs	0.25	0.25	0	Yes	0.25
	blood sugar monitoring	0.25	0.25	0	No	0
	the administration of oxygen	0.25	0.25	0	Yes	0.25
	the administration of antibiotics	0.25	0.25	0	No	0
Physical care	Is there a documented assessment of the patient's hydration status in the time between when death was recognised and time of death?	1	-	0	Yes	1
Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented assessment of the patient's nutrition status?	1	-	0	Yes	1
Individualised EoL care planning	Is there documented evidence within the individualised end of life care plan of an holistic assessment of the patient's needs? - If yes, does this include an assessment of the following					
	agitation/delirium	0.25	0.25	0	No	0
	dyspnoea/breathing difficulty	0.25	0.25	0	Yes	0.25
	nausea/vomiting	0.25	0.25	0	Yes	0.25
	pain	0.25	0.25	0	Yes	0.25
	noisy breathing/death rattle	0.25	0.25	0	Yes	0.25
	anxiety/distress	0.25	0.25	0	No	0
	bladder function	0.25	0.25	0	No	0
	bowel function	0.25	0.25	0	No	0
	pressure areas	0.25	0.25	0	No	0
	hygiene requirements	0.25	0.25	0	No	0
	mouth care	0.25	0.25	0	Yes	0.25
	emotional/psychological needs	0.25	0.25	0	Yes	0.25
	spiritual/religious needs	0.25	0.25	0	Yes	0.25
	cultural needs	0.25	0.25	0	No	0
	social needs	0.25	0.25	0	No	0
	practical needs	0.25	0.25	0	No	0
	Total possible	**9.00**			**Total score this patient**	**6.25**
					Out of 10	**6.94**

Appendix 4: Method for scoring

Families' and others' experience of care									
Source: Quality Survey								**EXAMPLE SCORING**	
Question	**Question**	**Scoring per question**						**Response**	**Score**
		Outstanding	**Excellent**	**Good**	**Fair**	**Poor**	**Not sure**		
Q15	Overall, how would you rate the care and support given to the person who died by the hospital in the last two to three days of life?	4	3	2	1	0	0	Excellent	3
Q23	Overall, how would you rate the care and support given to you and other close relatives or friends by the hospital in the last two to three days of his/her life?	4	3	2	1	0	0	Good	2
		Yes definitely	**Yes to some extent**	**Mixed**	**No not at all**	**Not sure**	**N/A**		
Q8	Did you feel that members of healthcare staff looking after him/her communicated sensitively during the last two to three days of life?	4	2	1	0	0	0	Yes to some extent	2
		Always	**Most of the time**	**Sometimes**	**Almost never**	**Never**	**Not sure & N/A**		
Q19d	During the last two to three days of his/her life, did you feel that he/she was treated with compassion?	4	3	2	1	0	0	Most of the time	3
Q14g	During the last two to three days of his/her life, did you feel that you were communicated to by staff in a sensitive and compassionate way?	4	3	2	1	0	0	Sometimes	2
	Total possible	**20.00**						**Total score this Quality Survey**	**12.00**
								Out of 10	**6.00**

Governance					
Source: Organisational level				**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**		**Response**	**Score**
		Yes	**No**		
Trust/UHB overview	Does your trust/UHB have an identified member of the trust/UHB board with a responsibility/role for End of Life Care?	1	0	Yes	1
Trust/UHB overview	Does your trust/UHB have policies in place which include how it responds to and learns from, deaths of patients who die under its management and care?	1	0	Yes	1
Trust/UHB overview	Which of the following are used within your trust/UHB: Specific care arrangements to enable rapid discharge home to die, if this is the person's preference?	1	0	No	0
Trust/UHB overview	Which of the following are used within your trust/UHB: A care plan to support the *five priorities for care for the dying person*?	1	0	Yes	1
		4.00		**Total score this hospital**	**3.00**
				Out of 10	**7.50**

Appendix 4: Method for scoring

Workforce/specialist palliative care					
Source: Organisational level				**EXAMPLE SCORING**	
Section	**Question**	**Scoring per question**		**Response**	**Score**
		Yes	**No**		
Hospital/ site overview	Is there a Specialist Palliative Care service provided by the hospital, or does your hospital have access to a Specialist Palliative Care service funded and/or based outside of the hospital/site?	1	0	Yes	1
Hospital/ site overview	Is the Specialist Palliative Care team commissioned to provide: Nurses available 9-5, 7 days a week, face-to-face (better/equivalent)	1	0	No	0
Hospital/ site overview	In the period between 1st April 2017 and 31st March 2018 what continuing End of Life education and training was available:				
Hospital/ site overview	induction Programme	0.25	0	Yes	0.25
Hospital/site overview	mandatory/ Priority Training	0.25	0	Yes	0.25
Hospital/site overview	other training in relation to End of Life Care	0.25	0	No	0
Hospital/site overview	Does your hospital provide training to help improve the culture, behaviours, attitudes around communication skills?	0.25	0	No	0
	Total possible	**3.00**		**Total score this hospital**	**1.50**
				Out of 10	**5.00**

Appendix 5: Indicators in the bespoke dashboard

Recognising the possibility of imminent death							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p9,3	Case Note Review - Recognition of death	Is there documented evidence within the final episode of care that it was recognised that the patient might die imminently i.e. within a few hours or days?	Yes	89%	9538	83%	66
			No	11%	1206	18%	14
			Total		**10744**		**80**
p9,4	Case Note Review - Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the patient?	Yes	22.59%	2284	22%	15
			No but reason	62.55%	6324	78%	52
			No and no reason recorded	14.86%	1502	0%	0
			Total		**10110**		**67**
pg9,5	Case Note Review - Recognition of death	Is there documented evidence that the possibility that the patient may die had been discussed with the nominated person(s)?	Yes	90%	9038	94%	63
			No but reason	5%	492	4%	3
			No and no reason recorded	5%	551	1%	1
			Total		**10081**		**67**
p10,6	Quality Survey	Did a member of healthcare staff at the hospital explain to the person that he/she was likely to die in the next few days?	Yes	28%	215	-	-
			No could have been told	10%	79	-	-
			No not possible	40%	308	-	-
			No person did not want to know	2%	15	-	-
			No other	8%	63	-	-
			Don't know	12%	89	-	-
			Total		**769**		**-**
p10,7	Quality Survey	Did a member of healthcare staff at the hospital explain to you that the person was likely to die in the next few days?	Yes clearly	62.08%	465	-	-
			Yes but not clearly	7.21%	54	-	-
			Yes but only when asked	5.47%	41	-	-
			No but could have been told	13.62%	102	-	-
			No died suddenly	9.35%	70	-	-
			Not sure	2.27%	17	-	-
			Total		**749**		**-**
p10,8	Case Note Review - Recognition of death	Date and time of first recognition of death & Date and time of death	Mean time from first recognition of death to death (hours)	74	8866	118	64

Appendix 5: Indicators in the bespoke dashboard

Communication with the dying person							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p12, 10	Case Note Review - Individualised EOL care planning	Is there documented evidence that the patient had the opportunity to be involved in discussing the plan of care?	Yes	20%	2002	18%	13
			No	32%	3211	4%	3
			N/A	48%	4816	77%	55
			Total		**10029**		**71**
p12, 11	Case Note Review - Individualised EOL care planning	Is there documented evidence that the patient had been informed about the senior doctor/nurse in the team who has professional responsibility for their care and treatment?	Yes	33%	3271	31%	24
			No	31%	3087	6%	5
			N/A	36%	3653	63%	49
			Total		**10011**		**78**
p12, 12	Case Note Review - Physical care	Is there documented evidence that the possibility of side effects of medications such as drowsiness were discussed with the patient?	Yes	8%	789	5%	4
			No but reason recorded	60%	6035	44%	32
			No and no reason recorded	32%	3160	51%	37
			Total		**9984**		**73**
p12, 13	Case Note Review - Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the patient once death was recognised as a possibility ?	Yes	9%	919	11%	7
			No but reason recorded	59%	5792	67%	43
			No and no reason recorded	32%	3092	22%	14
			Total		**9803**		**64**
p12, 14	Case Note Review - Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the patient?	Yes	7%	661	11%	7
			No but reason recorded	62%	5967	66%	41
			No and no reason recorded	31%	3036	23%	14
			Total		**9664**		**62**
p13, 15	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include - guidelines to promote dignity?	Yes	90%	162	-	1
			No	10%	19	-	0
			Total		**181**		**1**

Appendix 5: Indicators in the bespoke dashboard

Communication with families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p15, 17	Case Note Review - Individualised EOL care planning	Is there documented evidence that the nominated person(s) had the opportunity to develop and discuss an individualised plan of care for the patient?	Yes	62%	6205	63%	45
			No	26%	2626	13%	9
			N/A	12%	1162	24%	17
			Total		**9993**		**71**
p15, 18	Case Note Review - Individualised EOL care planning	Is there documented evidence that the nominated person(s) had been informed about the senior doctor/nurse in the team who has professional responsibility for care and treatment?	Yes	65.48%	6552	85%	66
			No but reason recorded	30.33%	3035	12%	9
			No and no reason recorded	4.19%	419	4%	3
			Total		**10006**		**78**
p15, 19	Case Note Review - Immediately prior to and after death	Is there documented evidence that the nominated person(s) were notified of the patient's imminent death?	Yes	79%	8446	72%	56
			No but reason recorded	7%	698	19%	15
			No and no reason recorded	14%	1506	9%	7
			Total		**10650**		**78**
p15, 20	Case Note Review - Physical care	Is there evidence that the possibility of side effects of medications such as drowsiness were discussed with the nominated person(s)?	Yes	15.7%	1538	12%	9
			No but reason recorded	10.8%	1055	11%	8
			No and no reason recorded	73.5%	7199	77%	56
			Total		**9792**		73
p15, 21	Case Note Review - Physical care	Is there documented evidence that a discussion about the risks and benefits of hydration options was undertaken with the nominated person(s)?	Yes	30%	2918	54%	35
			No but reason recorded	9%	890	8%	5
			No and no reason recorded	61%	5983	38%	25
			Total		**9791**		**65**
p15, 22	Case Note Review - Physical care	Is there documented evidence that a discussion about the risks and benefits of nutrition options was undertaken with the nominated person(s)?	Yes	23.4%	2264	44%	28
			No but reason recorded	10.2%	981	8%	5
			No and no reason recorded	66.4%	6410	48%	31
			Total		**9655**		**64**

Appendix 5: Indicators in the bespoke dashboard

Communication with families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p16, 23	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include: guidelines for meaningful and compassionate engagement with bereaved families and carers?	Yes	70%	125	-	0
			No	30%	53	-	1
			Total		**178**		**1**
p16, 24	Hospital/ Site overview - Quality and outcomes	Did your hospital/ site seek bereaved relatives' or friends' views during the last two financial years? (i.e. from 1st April 2016 and 31st March 2018)	Yes	76.5%	169	-	1
			No	23.5%	52	-	0
			Total		**221**		**1**
p16, 25	Quality Survey	Did you and/ or others close to the patient receive clear communication about the patient's imminent death soon enough to be with the person when he/she died?	Yes	53.48%	400	-	-
			No	21.39%	160	-	-
			Already there	18.85%	141	-	-
			The hospital did not know the death was imminent	6.28%	47	-	-
			Total		**748**		**-**
p16, 26	Quality Survey	Were given the name of the doctor and nurse responsible for his/her care?	Always	44.73%	335	-	-
			Most of the time	18.16%	136	-	-
			Sometimes	12.82%	96	-	-
			Almost never	5.47%	41	-	-
			Never	13.48%	101	-	-
			N/A	1.47%	11	-	-
			Not sure	3.87%	29	-	-
			Total		**749**		**-**
p16, 27	Quality Survey	During the last two to three days of his/her life, did you feel that you were given enough opportunity to ask questions and discuss his/her condition and care with staff?	Always	45.35%	346	-	-
			Most of the time	24.12%	184	-	-
			Sometimes	14.55%	111	-	-
			Almost never	7.60%	58	-	-
			Never	5.64%	43	-	-
			N/A	2.23%	17	-	-
			Not sure	0.52%	4	-	-
			Total		**763**		**-**
p16, 28	Quality Survey	During the last two to three days of his/her life, did you feel that you were kept informed by healthcare staff about his/her condition and treatment in a way which was easy to understand?	Always	48.75%	371	-	-
			Most of the time	23.92%	182	-	-
			Sometimes	11.96%	91	-	-
			Almost never	6.70%	51	-	-
			Never	6.96%	53	-	-
			N/A	1.18%	9	-	-
			Not sure	0.53%	4	-	-
			Total		**761**		**-**

Appendix 5: Indicators in the bespoke dashboard

Involvement in decision making							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p18, 30	Case Note Review - Individualised EOL care planning	Is there documented evidence about the extent to which the patient wished to be involved in decisions about their care?	Yes	18%	1795	18%	13
			No	38%	3772	11%	8
			N/A	44%	4288	72%	53
			Total		**9855**		**74**
p18, 31	Case Note Review - Treatment decisions	Is there documented evidence in the notes that the dying person had their capacity assessed to be involved in their end of life care planning?	Yes	43%	4584	64%	51
			No	23%	2492	10%	8
			N/A	34%	3597	26%	21
			Total		**10673**		**80**
p18, 32	Case Note Review - Treatment decisions	Is there documented evidence within the final admission of a discussion with the patient by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	Yes	15.36%	1631	4%	3
			No but reason recorded	76.37%	8107	96%	76
			No and no reason recorded	8.27%	878	0%	0
			Total		**10616**		**79**
p18, 33	Case Note Review - Treatment decisions	Is there documented evidence within the final admission of a discussion with the nominated person by a senior clinician regarding whether to continue or stop life-sustaining treatment offering organ support such as assisted ventilation, implanted defibrillator, renal dialysis?	Yes	35.3%	3702	16%	13
			No but reason recorded	57.3%	6009	84%	66
			No and no reason recorded	7.4%	776	0%	0
			Total		**10487**		**79**

Appendix 5: Indicators in the bespoke dashboard

Involvement in decision making							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p18, 34	Case Note Review - Treatment decisions	Is there documented evidence that a discussion with the patient regarding Cardiopulmonary Resuscitation (CPR) was undertaken by a clinician?	Yes	42%	4408	29%	22
			No but reason recorded	50%	5332	68%	52
			No and no reason recorded	8%	868	3%	2
			Total		**10608**		**76**
p18, 35	Case Note Review - Treatment decisions	Is there documented evidence that the Cardiopulmonary Resuscitation (CPR) decision was discussed with the nominated person(s) by a senior clinician ?	Yes	80%	8239	92%	68
			No but reason recorded	8%	830	7%	5
			No and no reason recorded	12%	1224	1%	1
			Total		**10293**		**74**
p19, 36	Quality Survey	Did staff at the hospital involve the person in decisions about care and treatment as much as he/she would have wanted in the last two to three days of life?	He/ she was involved as much as he/she wanted to be	38.0%	294	-	-
			He/she would have liked to be more involved	7.4%	57	-	-
			He/she would have liked to be less involved	0.4%	3	-	-
			He/she was not able to be involved	42.8%	331	-	-
			Not sure	11.4%	88	-	-
			Total		**773**		**-**
p19, 37	Quality Survey	Did staff at the hospital involve you in decisions about his/her care and treatment as much as you wanted in the last two to three days of life?	I was involved as much as I wanted to be	70.3%	526	-	-
			I would have liked to be more involved	22.1%	165	-	-
			I would have liked to be less involved	0.1%	1	-	-
			I was not able to be involved	4.4%	33	-	-
			Not sure	3.1%	23	-	-
			Total		**748**		**-**

Appendix 5: Indicators in the bespoke dashboard

Needs of families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p21, 39	Case Note Review - Individualised EOL care planning	Is there documented evidence that the needs of the nominated person(s) were asked about?	Yes	56%	5534	74%	54
			No	44%	4367	26%	19
			Total		**9901**		**73**
p21, 40	Case Note Review - Immediately prior to and after death	Is there documented evidence of the care and support provided to the nominated person(s) at the time of and immediately after death?	Yes	61.3%	6425	60%	47
			No	36.3%	3801	36%	28
			No but there was no nominated persons	2.4%	252	4%	3
			Total		**10478**		**78**
	Case Note Review - Individualised EOL care planning	Of which of the following needs of the nominated person(s) is there documented evidence that they were assessed and addressed?					
p21, 41		Emotional/psychological needs	Yes	67%	4951	100%	50
			No	33%	2386	0%	0
			Total		**7337**		**50**
p21, 42		Spiritual/religious needs	Yes	34%	2309	50%	7
			No	66%	4450	50%	7
			Total		**6759**		**14**
p21, 43		Cultural needs	Yes	25%	1622	50%	7
			No	75%	4854	50%	7
			Total		**6476**		**14**
p21, 44		Social needs	Yes	46%	3160	94%	32
			No	54%	3663	6%	2
			Total		**6823**		**34**
p21, 45		Practical needs	Yes	61%	4356	98%	45
			No	39%	2754	2%	1
			Total		**7110**		**46**
p23, 46	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include : a care after death and bereavement policy?	Yes	90%	164	-	1
			No	10%	18	-	0
			Total		**182**		**1**
p23, 47	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include : guidelines for providing relatives/carers with verification and certification of the death?	Yes	97%	176	-	1
			No	3%	6	-	0
			Total		**182**		**1**
p23, 48	Trust/ UHB overview	Does your Trust/ UHB have policies in place which include: guidelines for referral to 'Pastoral care/Chaplaincy team?	Yes	85%	155	-	1
			No	15%	27	-	0
			Total		**182**		**1**

Appendix 5: Indicators in the bespoke dashboard

Needs of families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p23, 49	Trust/ UHB overview	Does your Trust/ UHB have polices in place which include: guidelines for viewing the body in the immediate time after the death of a patient?	Yes	90%	162	-	1
			No	10%	19	-	0
			Total		**181**		**1**
p23, 50	Hospital/ site overview - Quality and Outcomes	Does your hospital/site give the following written information to families and those people that are important to the patient during the patients admission and when the patient has died: DWP leaflet 1027, 'What to do after death in England and Wales' or equivalent ?	Yes	87%	188	-	1
			No	13%	29	-	0
			Total		**217**		**1**
p23, 51	Hospital/ site overview - Quality and Outcomes	Does your hospital/site give the following written information to families and those people that are important to the patient during the patients admission and when the patient has died: A leaflet explaining procedures to be undertaken after the death of a patient?	Yes	96%	215	-	1
			No	4%	10	-	0
			Total		**225**		**1**
p24, 52	Hospital/site - Quality and outcomes	Support process available in the hospital/ site for people important to the dying patient -					
		Ability to facilitate overnight stays for family members/friends of the patient	Yes	95%	213	-	1
			No	5%	12	-	0
			Total		**225**		**1**
		Multi-faith spiritual/religious support	Yes	94%	214	-	1
			No	6%	13	-	0
			Total		**227**		**1**
		Use of 'Last Days of Life care plan'	Yes	93%	213	-	1
			No	7%	15	-	0
			Total		**228**		**1**
		Specialist Palliative Care Team	Yes	93%	213	-	1
			No	7%	15	-	0
			Total		**228**		**1**
		Macmillan/Marie Curie Palliative Care Clinical Nurse Specialist or information	Yes	92%	207	-	1
			No	8%	19	-	0
			Total		**226**		**1**
		Specialist or lead nurses- EOL and other specialities	Yes	88%	198	-	0
			No	12%	26	-	1
			Total		**224**		**1**
		Designated prayer room, chapel	Yes	86%	195	-	1
			No	14%	32	-	0
			Total		**227**		**1**
		Achieving Priorities of Care planning guidance for last days & hours of life	Yes	85%	187	-	1
			No	15%	34	-	0
			Total		**221**		**1**
		Bereavement cards/leaflets	Yes	82%	186	-	1
			No	18%	41	-	0
			Total		**227**		**1**

Appendix 5: Indicators in the bespoke dashboard

Needs of families and others							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p24, 52	Hospital/site - Quality and outcomes	Designated 'quiet spaces' available for relatives or carers	Yes	79%	180	-	1
			No	21%	47	-	0
			Total		**227**		**1**
		Car parking permit	Yes	79%	168	-	1
			No	21%	44	-	0
			Total		**212**		**1**
		Access to bereavement services/bereavement team	Yes	75%	170	-	0
			No	25%	57	-	1
			Total		**227**		**1**
		Hospice services support	Yes	73%	161	-	0
			No	27%	61	-	1
			Total		**222**		**1**
		Volunteer support schemes	Yes	60%	131	-	0
			No	40%	87	-	1
			Total		**218**		**1**
		Comfort care packs	Yes	53%	118	-	1
			No	47%	105	-	0
			Total		**223**		**1**
		Access to counselling services	Yes	50%	113	-	0
			No	50%	113	-	1
			Total		**226**		**1**
		Psychologist for adult and/or child	Yes	46%	102	-	0
			No	54%	120	-	1
			Total		**222**		**1**
p25, 53	Quality Survey	Did you feel supported by hospital staff after he/she had died?	Yes, definitely	53.03%	402	-	-
			Yes, to some extent	29.16%	221	-	-
			No , not at all	13.32%	101	-	-
			Not sure	1.45%	11	-	-
			N/A	3.03%	23	-	-
			Total		**758**		**-**
p25, 54	Quality Survey	During the last two to three days of his/her life, did you feel that you were given enough emotional help and support by staff?	Always	44.4%	338	-	-
			Most of the time	16.7%	127	-	-
			Sometimes	13.0%	99	-	-
			Almost never	6.3%	48	-	-
			Never	12.3%	94	-	-
			N/A	5.9%	45	-	-
			Not sure	1.4%	11	-	-
			Total		**762**		**-**
p25, 55	Quality Survey	During the last two to three days of his/her life, did you feel that you were given enough practical support (e.g. finding refreshments and parking arrangements)?	Always	44%	333	-	-
			Most of the time	14%	104	-	-
			Sometimes	8%	59	-	-
			Almost never	5%	36	-	-
			Never	14%	109	-	-
			N/A	14%	108	-	-
			Not sure	1%	8	-	-
			Total		**757**		**-**
p25, 56	Quality Survey	Were there any unexplained delays in the hospital providing you with certification of death?	Yes	15.4%	117	-	-
			No	82.4%	626	-	-
			Don't know	2.2%	17	-	-
			Total		**760**		**-**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p27, 58	Case Note Review-Individualised EOL care planning	Is there documented evidence that the patient who was dying had an individualised end of life care plan?	Yes	62%	6527	67%	52
			No	38%	4042	33%	26
			Total		**10569**		**78**
p27, 29	Case Note Review-Individualised EOL care planning	If there was a care plan, was the patient and their plan of care reviewed regularly?	Yes	64%	4760	92%	44
			No	5%	406	0%	0
			Patient died soon after recognition	31%	2322	8%	4
			Total		**7488**		**48**
p27, 60	Case Note Review-Immediately prior to and after death	Was there documented evidence in the case notes of the preferred place of death as indicated by the patient?	Yes	28%	2880	14%	11
			No	72%	7409	86%	67
			Total		**10289**		**78**
p27, 61	Case Note Review-Treatment decisions	In the period between the recognition that the patient might die and death, was routine recording of vital signs documented as being reviewed in the patient's plan of care?	Yes	70%	7088	84%	59
			No	25%	2562	14%	10
			N/A	5%	539	1%	1
			Total		**10189**		**70**
p28, 62	Case Note Review-Treatment decisions	In the period between the recognition that the patient might die and death, was blood sugar monitoring documented as being reviewed in the patient's plan of care?	Yes	32%	3163	56%	35
			No	33%	3279	22%	14
			N/A	35%	3489	22%	14
			Total		**9931**		**63**
p28, 63	Case Note Review-Treatment decisions	In the period between the recognition that the patient might die and death, was administration of oxygen documented as being reviewed in the patient's plan of care?	Yes	52%	5185	75%	48
			No	30%	3031	17%	11
			N/A	18%	1825	8%	5
			Total		**10041**		**64**
p28, 64	Case Note Review-Treatment decisions	In the period between the recognition that the patient might die and death, was administration of antibiotics documented as being reviewed in the patient's plan of care?	Yes	58%	5856	70%	46
			No	26%	2605	12%	8
			N/A	16%	1626	18%	12
			Total		**10087**		**66**
p28, 65	Case Note Review-Physical care	Is there a documented assessment of the patient's hydration status in the time between when death was recognised and time of death?	Yes	75%	7493	88%	59
			No	25%	2518	12%	8
			Total		**10011**		**67**
p28, 66	Case Note Review-Physical care	Once it was recognised that the patient may die within the next few days and hours, was there documented assessment of the patient's nutrition status?	Yes	61%	6007	84%	56
			No	39%	3813	16%	11
			Total		**9820**		**67**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p29, 67,68	Case Note Review- Individualised EOL care planning	Is there documented evidence within the individualised end of life care plan of an holistic assessment of the patient's needs? - If yes, does this include an assessment of the following					
		Agitation / delirium	Yes	79%	6191	92%	45
			No	13%	1019	4%	2
			N/A	8%	609	4%	2
			Total		**7819**		**49**
		Dyspnoea / breathing difficulty	Yes	80%	6284	94%	46
			No	12%	932	2%	1
			N/A	8%	595	4%	2
			Total		**7811**		**49**
		Nausea / vomiting	Yes	69.49%	5382	84%	38
			No	18.13%	1404	7%	3
			N/A	12.38%	959	9%	4
			Total		**7745**		**45**
		Pain	Yes	85.7%	6719	92%	46
			No	7.7%	603	6%	3
			N/A	6.6%	519	2%	1
			Total		**7841**		**50**
		Noisy breathing / death rattle	Yes	72.42%	5625	87%	41
			No	18.12%	1407	11%	5
			N/A	9.46%	735	2%	1
			Total		**7767**		**47**
		Anxiety / distress	Yes	76.46%	5949	87%	41
			No	14.06%	1094	9%	4
			N/A	9.48%	738	4%	2
			Total		**7781**		**47**
		Bladder function	Yes	83.4%	6487	98%	49
			No	10.2%	794	0%	0
			N/A	6.4%	496	2%	1
			Total		**7777**		**50**
		Bowel function	Yes	78%	6013	98%	47
			No	15%	1158	0%	0
			N/A	7%	573	2%	1
			Total		**7744**		**48**
		Pressure areas	Yes	86%	6729	96%	51
			No	8%	619	2%	1
			N/A	6%	447	2%	1
			Total		**7795**		**53**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p29, 67,68	Case Note Review-Individualised EOL care planning	Hygiene requirements	Yes	84%	6567	96%	47
			No	10%	751	4%	2
			N/A	6%	454	0%	0
			Total		**7772**		**49**
		Mouth care	Yes	80%	6223	98%	51
			No	14%	1101	2%	1
			N/A	6%	441	0%	0
			Total		**7765**		**52**
		Emotional / psychological needs	Yes	52%	4026	87%	39
			No	26%	1998	7%	3
			N/A	22%	1656	7%	3
			Total		**7680**		**45**
		Spiritual / religious needs	Yes	47%	3606	58%	21
			No	37%	2804	33%	12
			N/A	16%	1243	8%	3
			Total		**7653**		**36**
		Cultural needs	Yes	30%	2238	39%	13
			No	45%	3406	45%	15
			N/A	25%	1917	15%	5
			Total		**7561**		**33**
		Social needs	Yes	46%	3508	71%	24
			No	32%	2421	21%	7
			N/A	22%	1661	9%	3
			Total		**7590**		**34**
		Practical needs	Yes	53%	4008	84%	36
			No	26%	1942	9%	4
			N/A	21%	1574	7%	3
			Total		**7524**		**43**
p30, 69	Quality Survey	Do you feel that staff at the hospital took time to explore what was important to him/her in terms of individual requirements and care in the last few days of life?	Yes, definitely	43%	336	-	-
			Yes, to some extent	18%	142	-	-
			No	19%	145	-	-
			Not sure	9%	70	-	-
			N/A	11%	83	-	-
			Total		**776**		**-**
p30, 70	Quality Survey	Do you feel that staff at the hospital made a plan for the person's care which took account of his/her individual requirements and wishes?	Yes, definitely	44.0%	341	-	-
			Yes, to some extent	23.0%	178	-	-
			No	16.4%	127	-	-
			Not sure	9.4%	73	-	-
			N/A	7.2%	56	-	-
			Total		**775**		**-**
p30, 71	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had care for emotional needs (e.g. feeling low, feeling worried, feeling anxious) met by staff?	Always	25.30%	191	-	-
			Most of the time	10.46%	79	-	-
			Sometimes	7.28%	55	-	-
			Almost never	5.17%	39	-	-
			Never	7.02%	53	-	-
			N/A	31.52%	238	-	-
			Not sure	13.25%	100	-	-
			Total		**755**		**-**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p30, 72	Quality Survey	During the last two to three days of his/her life, did you feel that staff took into account his/her beliefs, hopes, traditions, religion and spirituality?	Always	34.14%	254	-	-
			Most of the time	6.05%	45	-	-
			Sometimes	2.69%	20	-	-
			Almost never	1.21%	9	-	-
			Never	8.47%	63	-	-
			N/A	33.06%	246	-	-
			Not sure	14.38%	107	-	-
			Total		**744**		**-**
p31, 73	Quality Survey	During the last two to three days of his/her life, did you feel that he/she was given sufficient pain relief?	Always	53%	401	-	-
			Most of the time	19%	142	-	-
			Sometimes	7%	55	-	-
			Almost never	3%	23	-	-
			Never	1%	11	-	-
			N/A	9%	67	-	-
			Not sure	8%	61	-	-
			Total		**760**		**-**
p31, 74	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had sufficient relief of symptoms other than pain (such as nausea or restlessness)?	Always	42%	315	-	-
			Most of the time	20%	151	-	-
			Sometimes	10%	76	-	-
			Almost never	3%	22	-	-
			Never	3%	24	-	-
			N/A	13%	99	-	-
			Not sure	9%	68	-	-
			Total		**755**		**-**
p31, 75	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had support to drink or receive fluid if he/she wished?	Always	36.47%	275	-	-
			Most of the time	13.66%	103	-	-
			Sometimes	10.88%	82	-	-
			Almost never	4.64%	35	-	-
			Never	4.51%	34	-	-
			N/A	24.14%	182	-	-
			Not sure	5.70%	43	-	-
			Total		**754**		**-**
p31, 76	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had support to eat or receive nutrition if he/she wished?	Always	30%	227	-	-
			Most of the time	13%	95	-	-
			Sometimes	9%	70	-	-
			Almost never	5%	37	-	-
			Never	5%	38	-	-
			N/A	32%	244	-	-
			Not sure	6%	48	-	-
			Total		**759**		**-**
p32, 77	Case Note Review - Immediately prior to and after death	Was any attempt made to move the patient home / to a hospice if that was their preferred place of death?	Yes	11%	923	6%	4
			No	29%	2473	16%	10
			Patient didn't want to be moved	9%	757	0%	0
			N/A	51%	4293	77%	48
			Total		**8446**		**62**

Appendix 5: Indicators in the bespoke dashboard

Individual plan of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p32, 78	Case Note Review - Other	Is there documented evidence that if a side room had been requested for this patient, that it wasn't available?	Yes	5%	431	0%	0
			No	43%	3987	28%	22
			N/A	52%	4868	73%	58
			Total		**9286**		**80**
p32, 79	Quality Survey	In the last two to three days of life were efforts made to transfer the person from hospital if that was his/her wish?	Yes, definitely	9%	70	-	-
			Yes, to some extent	6%	48	-	-
			No, not at all	16%	122	-	-
			Not sure	3%	21	-	-
			N/A / not possible	57%	442	-	-
			Not a priority/ not wanted	9%	72	-	-
			Total		**775**		**-**
p32, 80	Quality Survey	On balance, do you think that hospital was the right place for him/her to die?	Yes	75%	583	-	-
			No	15%	116	-	-
			Not sure	10%	74	-	-
			Total		**773**		**-**
p33, 81	Quality Survey	Within the hospital where did the person die?	In a bay shared with other patients	32.07%	246	-	-
			In a side room	55.67%	427	-	-
			In Intensive Care or the HDU	7.69%	59	-	-
			Other	4.56%	35	-	-
			Total		**767**		**-**
p33, 82	Quality Survey	Were you satisfied that this location within the hospital was appropriate?	Yes	75%	580	-	-
			No	18%	142	-	-
			Not sure	7%	52	-	-
			Total		**774**		**-**
p33, 83	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had adequate privacy?	Always	51.02%	376	-	-
			Most of the time	23.34%	172	-	-
			Sometimes	10.04%	74	-	-
			Almost never	5.43%	40	-	-
			Never	6.24%	46	-	-
			N/A	1.49%	11	-	-
			Not sure	2.44%	18	-	-
			Total		**737**		**-**
p33, 84	Quality Survey	During the last two to three days of his/her life, did you feel that he/she had a suitable environment with sufficient peace and quiet?	Always	46%	341	-	-
			Most of the time	22%	160	-	-
			Sometimes	12%	88	-	-
			Almost never	7%	52	-	-
			Never	9%	67	-	-
			N/A	2%	17	-	-
			Not sure	2%	14	-	-
			Total		**739**		**-**

Appendix 5: Indicators in the bespoke dashboard

Families and others' experience of care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p35, 86	Quality Survey	Overall, how would you rate the care and support given to the person who died by the hospital in the last two to three days of life?	Outstanding	31.5%	237	-	-
			Excellent	29.5%	222	-	-
			Good	17.8%	134	-	-
			Fair	8.1%	61	-	-
			Poor	10.8%	81	-	-
			Not sure	2.3%	17	-	-
			Total		**752**		**-**
p35, 87	Quality Survey	Overall, how would you rate the care and support given to you and other close relatives or friends by the hospital in the last two to three days of his/her life?	Outstanding	29.15%	209	-	-
			Excellent	27.62%	198	-	-
			Good	18.83%	135	-	-
			Fair	9.76%	70	-	-
			Poor	13.11%	94	-	-
			Not sure	1.53%	11	-	-
			Total		**717**		**-**
p35, 88	Quality Survey	Did you feel that members of healthcare staff looking after him/her communicated sensitively during the last two to three days of life?	Yes, definitely	55.47%	431	-	-
			Yes, to some extent	12.23%	95	-	-
			Mixed, some did, others did not	15.83%	123	-	-
			No, not at all	6.05%	47	-	-
			Not sure	4.12%	32	-	-
			N/A	6.31%	49	-	-
			Total		**777**		**-**
p36, 89	Quality Survey	During the last two to three days of his/her life, did you feel that he/she was treated with compassion?	Always	63.6%	475	-	-
			Most of the time	18.1%	135	-	-
			Sometimes	8.7%	65	-	-
			Almost never	2.9%	22	-	-
			Never	3.3%	25	-	-
			N/A	0.7%	5	-	-
			Not sure	2.7%	20	-	-
			Total		**747**		**-**
p36, 90	Quality Survey	During the last two to three days of his/her life, did you feel that you were communicated to by staff in a sensitive and compassionate way?	Always	60.5%	460	-	-
			Most of the time	17.2%	131	-	-
			Sometimes	13.4%	102	-	-
			Almost never	2.4%	18	-	-
			Never	4.9%	37	-	-
			N/A	1.1%	8	-	-
			Not sure	0.5%	4	-	-
			Total		**760**		**-**

Appendix 5: Indicators in the bespoke dashboard

Governance							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p38, 92	Trust/ UHB overview	Does your trust/UHB have an identified member of the trust/UHB board with a responsibility/role for End of Life Care?	Yes	94%	172	-	1
			No	6%	11	-	0
			Total		**183**		**1**
p38, 93	Trust/ UHB overview	Does your trust / UHB have policies in place which include how it responds to and learns from, deaths of patients who die under its management and care?	Yes	98%	175	-	1
			No	2%	4	-	0
			Total		**179**		**1**
p38, 94	Trust/ UHB overview	Which of the following are used within your trust/UHB: Specific care arrangements to enable rapid discharge home to die, if this is the person's preference?	Yes	92%	165	-	1
			No	8%	15	-	0
			Total		**180**		**1**
p38, 95	Trust/ UHB overview	Which of the following are used within your trust/UHB: A care plan to support the Five Priorities of Care for the Dying Person?	Yes	97%	176	-	1
			No	3%	6	-	0
			Total		**182**		**1**
p39, 96	Hospital/Site - Quality and outcomes	Within your trust/UHB quality governance structure was there a formal process for discussing and reporting on the fire priorities of care, between 1st April 2017 and 31st March 2018?	Yes	71%	154	-	1
			No	29%	64	-	0
			Total		**218**		**1**
p39, 97	Hospital/Site - Quality and outcomes	Was an action plan produced in the financial year (i.e. between 1st April 2017 and 31st March 2018 to promote improvement in end of life care in your trust/UHB?	Yes	90%	205	-	1
			No	10%	22	-	0
			Total		**227**		**1**
p39, 98	Trust/ UHB overview	Does your trust/UHB have a non executive director responsible for the oversight of the national guidance on learning from deaths agenda progress?	Yes	84%	146	-	1
			No	16%	27	-	0
			Total		**173**		**1**
p39, 99	Hospital/Site - Quality and outcomes	Does your hospital/site have a mechanism for flagging complaints that relate to end of life care?	Yes	90%	203	-	0
			No	10%	22	-	1
			Total		**225**		**1**

Appendix 5: Indicators in the bespoke dashboard

Workforce/specialist palliative care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p41, 101	Hospital/ Site - Specialist palliative care workforce	Is there a Specialist Palliative Care service provided by the hospital? Or does your hospital have access to a SPC service funded and/or based outside of the hospital/site?	Yes	97%	225	-	1
			No	3%	6	-	0
			Total		**231**		**1**
p41, 102	Hospital/ Site - Specialist palliative care workforce	Is the Specialist Palliative Care team commissioned to provide: Nurses available 9-5, 7 days a week (face-to-face) (or better/equivalent)	Yes	52%	108	-	0
			No	48%	100	-	1
			Total		**208**		**1**
p41, 103	Hospital/ Site - Staff training	EoLC training included in induction programme	Yes	61%	136	-	1
			No	39%	88	-	0
			Total		**224**		**1**
p41, 104	Hospital/ Site - Staff training	EoLC training included in mandatory/priority training	Yes	47%	103	-	0
			No	53%	116	-	1
			Total		**219**		**1**
p41, 105	Hospital/ Site - Staff training	Training to improve the culture, behaviours, attitudes around communication skills	Yes	86%	192	-	1
			No	14%	31	-	0
			Total		**223**		**1**
p41, 106	Hospital/ Site - Staff training	Other training in relation to end of life care	Yes	95%	208	-	1
			No	5%	10	-	0
			Total		**218**		**1**
p42, 107	Hospital/ Site - Staff training	Percentage of staff who have received mandatory / priority EOL care training					
		Medical	%	57%	53	-	-
		Registered	%	69%	67	-	-
		Non-registered	%	62%	52	-	-
		AHPs	%	65%	44	-	-
		Other	%	65%	27	-	-
p43, 108	Trust/ UHB overview	Which of the following are used within your Trust/UHB : Opportunities for staff to reflect on the emotional aspects of their work (e.g. Schwartz rounds)?	Yes	77%	140	-	1
			No	23%	42	-	0
			Total		**182**		**1**

Appendix 5: Indicators in the bespoke dashboard

Workforce/specialist palliative care							
Page / Figure	Data collection element	Chart Title	Response	National	National N =	NC013	NC013 N =
p43, 109	Case Note Review - Final admission	Was the patient reviewed by a member of the specialist palliative care team during their final admission?	Yes	38%	4068	28%	21
			No	62%	6594	72%	55
			Total		**10662**		**76**
p43, 110	Quality Survey	Were you confident that healthcare staff looking after him/her had the skills and experience to care for someone at the end of their life?	Yes, definitely	65%	495	-	-
			Yes, to some extent	19%	145	-	-
			No	10%	79	-	-
			Not sure	6%	43	-	-
			Total		**762**		**-**
p43, 111	Quality Survey	Did you feel that there was a consistent team approach and good coordination between different members of staff?	Yes, definitely	55%	418	-	-
			Yes, to some extent	22%	170	-	-
			No	18%	136	-	-
			Not sure	5%	40	-	-
			Total		**764**		**-**

Appendix 6: Submission's summary scores

	Recognising the possibility of imminent death	Communication with the dying person	Communication with the families and others	Involvement in decision making	Needs of families and others	Individual plan of care	Families and others' experience of care
	9.900497512	8.0	7.7	9.7	8.5	8.5	
0094-012018-001702	10.0	8.0	5.8	10.0	8.7		
0094-012018-001703				10.0			
0094-012018-001704							
0094-012018-001705	10.0	10.0	8.3	10.0	8.7	7.8	
0094-012018-001706							
0094-012018-001707	10.0	10.0	9.2	10.0	8.7	8.3	
0094-012018-001708	10.0	8.0	2.5	10.0		7.5	
0094-012018-001709	10.0	10.0	10.0	10.0			
0094-012018-001710	10.0	8.0	7.5	8.3	5.3	8.1	
0094-012018-001711	10.0	10.0	5.0	10.0	4.0		
0094-012018-001712	10.0	8.0	8.3	10.0	8.7	9.4	
0094-012018-001713							
0094-012018-001714	10.0	10.0	8.3	10.0	10.0	10.0	
0094-012018-001715	10.0	10.0	2.5	6.7			
0094-012018-001716	10.0	10.0	9.2	10.0	5.3	8.3	
0094-012018-001717		10.0	10.0	10.0			
0094-012018-001718							
0094-012018-001719							
0094-012018-001720	10.0	8.0	8.3	10.0	9.3	8.9	
0094-012018-001721	10.0	10.0	2.5	10.0			
0094-012018-001722	10.0	6.0	8.3	10.0			
0094-012018-001723	10.0	10.0	7.5	6.7			
0094-012018-001724	10.0	4.0	7.5	10.0			
0094-012018-001725	6.7	10.0	0.0	10.0			
0094-012018-001726				10.0			
0094-012018-001727	10.0	6.0	5.0	10.0			
0094-012018-001728	10.0	4.0	9.2	10.0			
0094-012018-001729	10.0	8.0	9.2				
0094-012018-001730	10.0	4.0	7.5	10.0			
0094-012018-001731	10.0	10.0		10.0			
0094-012018-001732	10.0	4.0	8.3	10.0		8.9	
0094-012018-001733	10.0	10.0					
0094-012018-001734	10.0		8.3	8.3			
0094-012018-001735	10.0	4.0	7.5	10.0		8.9	
0094-012018-001736	10.0	4.0	7.5				
0094-012018-001737	10.0	8.0	9.2	10.0			
0094-012018-001738	10.0	6.0	9.2	10.0	10.0	8.9	
0094-012018-001739	10.0	10.0	10.0	10.0		8.3	
0094-012018-001740	10.0	10.0	10.0	10.0	10.0	8.9	
0094-012018-001741	10.0	10.0	10.0	10.0		8.1	
0094-012018-001742	10.0	8.0	9.2	10.0			
0094-012018-001743	10.0	10.0	2.5	8.3			
0094-012018-001744	10.0	8.0	9.2	10.0		7.2	
0094-012018-001745	10.0	10.0	9.2	10.0			
0094-012018-001746	10.0	8.0	9.2	10.0		6.9	
0094-012018-001747	10.0						
0094-012018-001748	10.0						
0094-012018-001749	10.0	10.0	7.5	10.0		8.9	
0094-012018-001750	10.0	4.0	7.5	10.0			
0094-012018-001751				8.3			
0094-012018-001752	10.0	4.0	7.5	10.0		7.8	
0094-012018-001753							
0094-012018-001754	10.0	10.0	10.0	10.0	10.0	8.9	
0094-012018-001755	10.0	10.0	10.0	10.0		10.0	
0094-012018-001756	10.0	4.0	7.5	10.0			
0094-012018-001757	10.0	8.0	9.2	10.0			
0094-012018-001758				10.0			
0094-012018-001759	10.0	4.0	5.0	10.0			
0094-012018-001760				8.3			
0094-012018-001761	10.0	10.0	10.0	10.0		9.4	
0094-012018-001762	10.0			10.0			
0094-012018-001763	10.0	10.0	9.2	8.3			
0094-012018-001764	10.0	10.0	7.5	10.0			
0094-012018-001765	10.0	10.0	7.5	8.3			
0094-012018-001766	10.0		0.0	10.0		6.1	
0094-012018-001767	10.0	10.0	5.8	8.3			
0094-012018-001768	10.0	10.0	9.2	10.0		5.3	
0094-012018-001769	10.0						
0094-012018-001770	10.0	4.0	10.0	8.3		8.3	
0094-012018-001771	10.0	8.0	9.2	10.0	10.0	8.9	
0094-012018-001772	10.0	8.0	9.2	10.0			
0094-012018-001773	10.0	8.0	8.3	10.0		7.8	
0094-012018-001774	10.0	8.0	8.3	10.0			
0094-012018-001775	10.0	8.0	8.3	10.0		8.9	
0094-012018-001776				10.0			
0094-012018-001777	10.0	8.0	9.2	8.3			
0094-012018-001778	10.0	8.0	9.2	10.0	10.0	8.9	
0094-012018-001779	6.7			10.0			
0094-012018-001780	10.0	6.0	7.5	10.0		10.0	
0094-012018-001781	10.0	8.0	9.2	10.0		10.0	

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Health Scrutiny Panel

The Panel will have responsibility for Scrutiny functions as they relate to: -

- All health-related issues, including liaison with NHS Trusts, Clinical Commissioning Groups, Health and Wellbeing Board and Healthwatch.
- All functions of the Council contained in the National Health Service Act 2006, to all regulations and directions made under the Health and Social Care Act 2001, the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002,
- The Health and Social Care Act 2012 and related regulations.
- Reports and recommendations to relevant NHS bodies, relevant health service providers, the Secretary of State or Regulators.
- Initiating the response to any formal consultation undertaken by relevant NHS Trusts and Clinical Commissioning Groups or other health providers or commissioners on any substantial development or variation in services.
- Participating with other relevant neighbouring local authorities in any joint scrutiny arrangements of NHS Trusts providing cross border services.
- Decisions made by or actions of the Health and Wellbeing Board.
- Public Health – Intelligence and Evidence
- Public Health – Health Protection and NHS Facing
- Public Health - Transformation
- Public Health – Commissioning
- Healthier City
- Mental Health
- Commissioning Mental Health and Disability
- HeadStart Programme

Date of Meeting	Item Description	Lead Report Author	Notes
12 September 2019	• Tettenhall Wood GP Surgery Consultation	CCG	
	• The Royal Wolverhampton NHS Trust - Quality Accounts– September 2019	RWT – Alison Dowling	In the Quality Accounts, the National Audits showed significant non-compliance by RWT in a few areas, the Panel wishes to look at progress in these areas.
	• National Audit of Care at the End of Life	RWT	
	• Verbal Update on Brexit Preparations	All present	
7 November 2019	• GP appointment waiting times – involve Wolverhampton Healthwatch	CCG – Helen Hibbs	
	• CCG Annual Report	Steven Marshall	

	• Draft Budget • Public Health Annual Report • Healthwatch Annual Report	Public Health – John Denley Tracey Cresswell	
16 January 2020	• Reconfiguration of hyper acute and acute stroke services • Review of the impact of the new Medical Examiner Role and the Registrar's Office at New cross Hospital • Cancer Screening • Accident and Emergency • STP (Sustainability and Transformation Plans) • Minutes and Report from the Adults and Sifter City Scrutiny Panel on Alcohol and Drugs Strategy	CCG / Royal Wolverhampton NHS Trust Royal Wolverhampton NHS Trust Royal Wolverhampton NHS Trust / Public Health Royal Wolverhampton NHS Trust / CCG Earl Piggott-Smith	

5 March 2020	• Mortality Statistics • Patient Participation Groups • Pharmaceutical Ordering (Provisional) • West Midlands Ambulance • Maternity Services – Quality Assurance	RWT Royal Wolverhampton NHS Trust	To address priorities identified in the Quality accounts and in particularly those on Maternity Care in the pre-hospital environment.

Potential Future Items: -

1. Black Country Partnership NHS Foundation Trust Merger – Possible an informal meeting will be arranged
2. West Park Hospital (Suggested by Chair of Healthwatch) – Will be a site visit
3. June 2020 – Review of the new Patient Experience, Engagement and Public Involvement Strategy.
4. Primary Care – CCG
5. Healthy Child Programme