CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

25 May 2017

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

Venue The Council Room, Wulfruna Building, City Campus, Wulfruna Street, WV1 1LY

Membership

Chair Cllr Jasbir Jaspal (Lab)
Vice-chair Cllr Wendy Thompson (Con)

Labour	**Conservative**
Cllr Greg Brackenridge	Cllr Patricia Patten
Cllr Linda Leach	
Cllr Hazel Malcolm	
Cllr Peter O'Neill	
Cllr Phil Page	
Cllr Martin Waite	

Quorum for this meeting is two Councillors.

Information for the Public

If you have any queries about this meeting, please contact the democratic support team:

Contact Earl Piggott-Smith
Tel/Email Tel: 01902 551251 or earl.piggott-smith@wolverhampton.gov.uk
Address Democratic Support, Civic Centre, 2nd floor, St Peter's Square, Wolverhampton WV1 1RL

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Some items are discussed in private because of their confidential or commercial nature. These reports are not available to the public.

Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of the previous meeting (27 April 2017) (to follow)**
[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 **The Royal Wolverhampton NHS Trust Quality Account 2016/17 (DRAFT)** (Pages 3 - 98)
[Jeremy Vanes, Chairman, The Royal Wolverhampton Hospital NHS Trust,to present draft Quality Account 2016/17 report for comment]

6 **Update on the work of the suicide prevention stakeholder forum** (Pages 99 - 130)
[Neeraj Malhotra, Consultant in Public Health, to present report on work of the suicide prevention stakeholder forum]

INFORMATION

7 **West Midlands Ambulance Service (WMAS) Quality Account - 2016 17** (Pages 131 - 184)
[To comment and agree the draft response to the West Midlands Ambulance Service (WMAS) Quality Account 2016/17]

PRESENTED BY	Jeremy Vanes

Health Scrutiny Panel - 25th May 2017								
Author	Debra Hickman/Alison Dowling							
DATE PREPARED	16 May 2017							
SUBJECT/Title of Report	Quality Account							
PURPOSE/SUMMARY	To provide an overview and seek feedback with regard to the Trust's Quality Account for 2016/17							
ACTION REQUIRED OF GROUP/COMMITTEE	Decision		Approval		Receive for Information	Y	Receive for Assurance	
STRATEGIC OBJECTIVE	Quality Account Details the Trust's position with regard to the objectives set for the previous year and to detail the new objectives for the forthcoming year.							
OVERVIEW OF ASSURANCE THEMES HIGHLIGHTED IN THE REPORT	CQC STANDARDS	√	CLINICAL OUTCOMES	√				
	NHSLA	√	CLINICAL EFFECTIVENESS	√				
	REGULATORY STANDARDS	√	RISK REGISTERS (BAF/TRR/Ops RR)					
	BEST PRACTICE & SHARED LEARNING		POLICY	√				
	EXTERNAL REVIEWS/NATIONAL AUDITS	√	KPI (add PI measure in section 1)					
	INTERNAL REVIEWS	√	Other issues/Report areas					

1. **Executive Summary (summarise/add context to issues/report items below including clinical implications/outcomes , resources required, any proposed risks for escalation, positive/negative impact of assurance given detail below eg CQC, NHSLA, HSE, MHRA, other)**

The annual Quality Report for the year 2016/17 has now been written and will seek final approval at Trust Board on the 26th June 2017.

Priorities to continue for 2017/18 with special focus in Mortality and Sepsis.

The report details the progress made against the previous year's objectives together with details of the key objectives for the forthcoming year. These objectives have been set based on the priorities of the Trust, considering external accreditation, surveys and feedback.

The key priorities are as follows:

(a) Nurse Staffing Levels
(b) Safer Care
(c) Patient Experience

New format – reduce duplication.

New section regards Performance as agreed with Chief Operating Officer.

Some data still outstanding as not all Q4 data has been published.

External stakeholders will also receive copies of the Quality Account in May with the omission of the inpatient survey data that is embargoed till 1st June 2017.

Quality Account 2016/17

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.

Statement on Quality from the Chief Executive

Page 2

Everyone working at RWT has a common goal: to make sure that patients are at the centre of all we do. We want patients to have access to top quality services when they need them; we want our staff to feel valued and supported at all times in a working environment that they can thrive and we want our local community and partner organisations to be confident in The Royal Wolverhampton NHS Trust as provider of excellent care and an employer of choice.

In the current financial climate, all public sector services are grappling with how to meet the increasing and multi complex needs of the population with the limitations of funding. We believe the best way is to secure sustainable, effective and high quality services through our new approach to care with our innovative model. This means significant change in how we deliver care and will take a period of transition in the forthcoming years.

Since June of last year, we have started to put some foundations in place on which our future care model will be based. We have engaged with local GP's, Commissioners and Local authority regards working better together at a local level. As this new model continues to grow and develop we will start to see the benefits of these changes for our communities.

Our greatest challenges over the past 12 months has been our ability to meet the national target of first assessment in our Emergency department within 4 hours, which can at times result in a poor patient experience and we are sorry that this has been the case on some occasions. Recruitment

[1] Quality Account (2009) Health Act

of Nursing and Medical staff has also been a challenge and we are yet to see whether there will be any impact on national issues such as bursary changes. We know our staff are working extremely hard when faced with these real pressures and recognise their dedication during these difficult times.

The Trust are committed to improving patients' experiences and outcomes and many of the initiatives are already now making a difference – our Teletracking 'Safe Hands System' has assisted in improved bed flow. Overseas and local recruitment campaigns have provided nurse staffing for a number of areas optimising staffing ratios.

Following our CQC appeal in November 2015, we finally received an outcome in October 2016, although the changes made to some ratings of services didn't change the overall Trust rating, we were pleased that our appeal had received due consideration.

The Trust's priority remains to ensure patient safety as its overarching principle and we continue to strengthen our learning from incidents, complaints and feedback with a focus on the following priorities:

- Achieving safe nurse staffing levels across the Trust
- Ensuring safer care by reducing the instances of harm caused
- Improving the experience of patients who use our service

This report provides information on progress against the above quality priorities and key performance indicators for the past year and sets out quality improvement priorities and plans for 2017/18.

To the best of my knowledge, the information contained within this Quality account is accurate.

Signed:

David Loughton CBE

Chief Executive

Date:

Looking back 2016/17

Priorities for Improvement

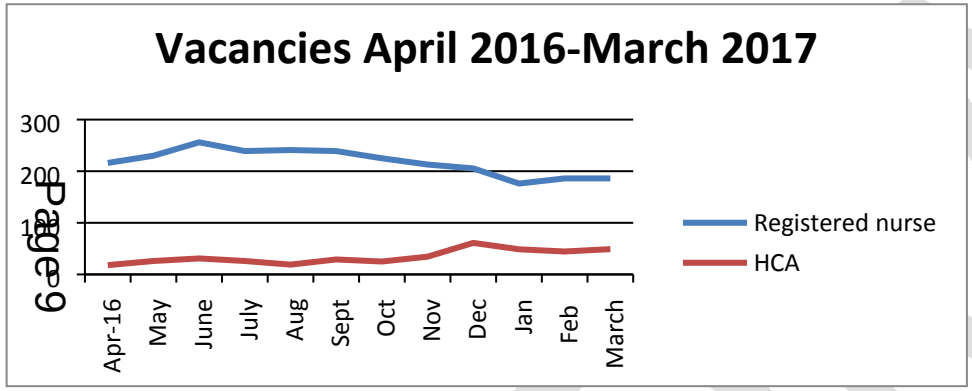
Safe Nurse Staffing Levels	Safer Care	Patient Experience
We aim to deliver safe patient care and good patient experience. Our wards and departments need to have the right levels of staff and skill mix for the acuity of the patients for which they are caring.	We aim to be the safest NHS Trust by "always 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.	We are committed to providing high quality clinical care and aim to provide an excellent experience for patients, their relatives and carers.

Priority 1: Safe Nurse Staffing Levels

The organisation continues to monitor its commitment of ensuring the right staff are in the right place, at the right time.

The Royal Wolverhampton NHS Trust monitors staffing information on a daily basis supported by the innovative technology of Teletracking – 'Safe Hands'.

How have we performed against 2016/17 plans?



The recruitment and retention plans we put in to place last year have yielded a reduction and slowing particularly of the registered nurse vacancies. 28 registered nurses from the Philippines have joined the nursing teams within the Trust during the year and there are a few more in the pipeline to join them. The Trust provided pastoral support to enable the overseas recruits to adapt to their new surroundings. This included:

- Provision of a identified buddy to assist with orientation to the area
- Support with accommodation, registering with health services and financial arrangements
- Each subsequent group received support and contact details of the previous group to aid community development

As part of the implementation of the guidance on the delivery of the 'Hard Truths' commitments (March 2014) associated with publishing nurse staffing data, the Trust reports monthly information on nursing and midwifery staffing this is collated centrally and reported to the Trust Board and posted on the Trust intranet and NHS choices monthly.

Monthly average % Trust fill rate for Registered and Unregistered staff:

	Apr 2016	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan 2017	Feb	March
RN day	**89.5**	**90.4**	**90.0**	**90.4**	**88.2**	**89.1**	**91.9**	**93.9**	**93.9**	**95.5**	**96.5**	**92.5**
RN night	**89.4**	**89.4**	**90.8**	**89.7**	**88.9**	**89.0**	**88.7**	**90.0**	**88.7**	**90.8**	**88.4**	**89.1**
HCA day	**115**	**113.6**	**110.2**	**113.8**	**107.7**	**107.0**	**103.6**	**105.9**	**105.8**	**108.8**	**110.5**	**110.1**
HCA night	**132.8**	**139.1**	**124.4**	**136.2**	**136.7**	**132.2**	**134.3**	**134.6**	**134.1**	**133.6**	**137.1**	**133.5**

The average fill rate for registered nurses particularly on days has seen an improvement this year and we have achieved over 90% for the last 5 months of the year. The overfill rate for unregistered staff helps to offset the deficiency of registered nurses.

What else have we achieved?

The Trust launched its Nurse Recruitment and Retention strategy in early May 2016. Within this strategy we outlined how we would **Enable, Attract** and **Retain**. Within the **Enabling** we developed a micro website; open adverts for online applications; Saturday assessment centres; enhanced our use of social media to promote our services. Within the **Attract** section we reviewed flexible working patterns, established a career pathway, extended our learning and development opportunities and established a staff transfer/rotation programme. Within the **Retain** section we developed a managed progression route and expanded our mentorship programme.

Another strand which we have identified which can make a difference is a positive work environment. The elements that enhance the work environment are - clear leadership, team working, recognition, mentorship and career development. The Trust continues to remodel and design the parts that an efficient and effective team should consist of, this has included the introduction of a trainee Nursing Associate role into the ward teams. We were one of the first wave of 11 Trusts who are piloting the new Trainee Nursing Associate programme. Our first 19 TNAs commenced their training programme in January 2017 and are due to qualify January 2019.

The Nursing and Midwifery Council have confirmed the role will be regulated. This is an innovative approach and role within the workforce.

Care Certificate

The Care Certificate is a nationally recognised programme. At RWT any health care assistant new to the Trust and healthcare commences this programme at the start of their employment. The course is 3 months and contains both theoretical and practice learning which are collated into a portfolio. During 16/17 over 108 have commenced the programme. This course is also open to current staff if they wish to apply.

Overseas recruitment – Attainment of NMC Pathway

Nurse education staff provide an Objective Structured Clinical Examination (OSCE) boot camp to prepare overseas nurses for the NMC examination process at Northampton.

22 staff have completed OSCE boot camp and gained NMC registration
1 candidate completed a university program and gained NMC registration

Timeframe	NMC report Ist attempt pass rate	RWT Ist attempt pass rate	NMC report 2nd attempt pass rate	RWT 2nd attempt pass rate	NMC Combined 1st & 2nd	RWT Combined 1st & 2nd
Aug 16-Oct 16	42%	40%	69%	83%	61%	92%
Nov 16-Jan 17	51%	30%	70%	83%	60.5%	94%

Local passes for second attempts significantly exceed the national average.

Priority 2: Safer Care

Number and Themes of Serious Incidents

The Trust has a robust reporting mechanism communicated through policy, training and management lines. There remains timely reporting and completion of investigations. As at April 2017 there is 1 investigation overdue. In the financial year April 2016 to March 2017 the Trust has reported 124 serious incidents and 263 reportable incidents through the serious and reportable incident system (STEIS), this does not include incidents that have since been agreed for removal.

Accumulated Totals (Acute and Community) Serious Incidents – April 2016 to March 2017	
Confidential Breach	41
C.Diff	9
Delay Diagnosis/Treatment	19
Drug Error	2
Failure to Act	2
Infection	8
MRSA	2
Missed Diagnosis	11
Referral Not Received	1
Radiology	1
Sub Optimal Care	2
Surgical	6
Treatment Given Without Consent	1
Unexpected Death	11
Unexpected Injury	3
VTE	3
Near Miss	2
Total	124

Reportable Incidents April 2016 to March 2017	
Pressure Injuries	208
Maternity	8
Slip/Trip/Fall	47
Total	263

Numbers and Themes of Never Events

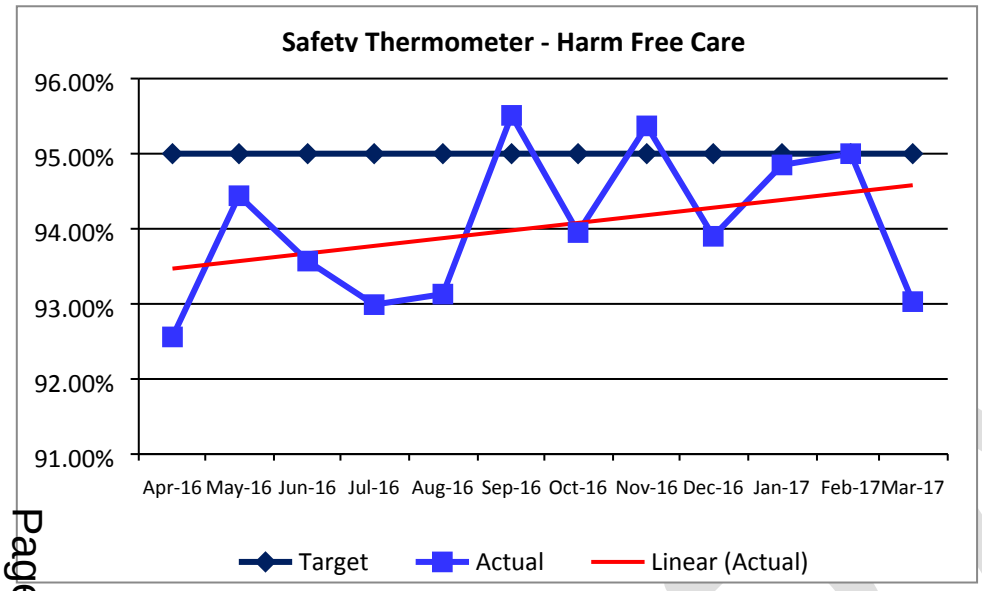
There have been five Never Events reported in the financial year April 2016 to March 2017.

Date	Location	Category
May 2016	Obs & Gynae	Retained Foreign Object
September 2016	Radiology	Wrong Site Surgery
October 2016	Ophthalmology	Wrong Site Surgery
December 2016	Critical Care	Retained Swab
March 2017	T&O	Wrong prosthesis

The Trust reports monthly on the national 'Safety Thermometer' tool, which captures point prevalence data regarding the four harms, which are:

- Falls
- Urine infections in patients with a catheter
- Venous Thromboembolism
- Pressure injuries

It is captured on a given day each month.



(Safety thermometer data 2016/17)

Page 4

How have we performed against 2016/17 plans?

Falls

The Trust continues to see a decline in the number of falls per 1,000 occupied bed days (table 1), however this is beginning to plateau. The Trust has reviewed its falls policy in line with NICE recommendations and this was re-launched late 2016. The Trust requested to take part in the National Falls collaborative led by National Health Service Improvement (NHSI), of which commenced January 2017, to further enhance work already underway, with the aim of further reducing the number of falls occurring.

The Trust continues to work closely with our commissioners and public health on this initiative, with attendance from both at our Falls prevention group and through accountability meetings, whereby our falls with serious harm are reviewed in detail to identify any further learning which may be identified.

The Trust has participated in the National Inpatient falls audit, and awaits the findings to identify any actions that may be indicated, this will further inform the work of the falls prevention group.

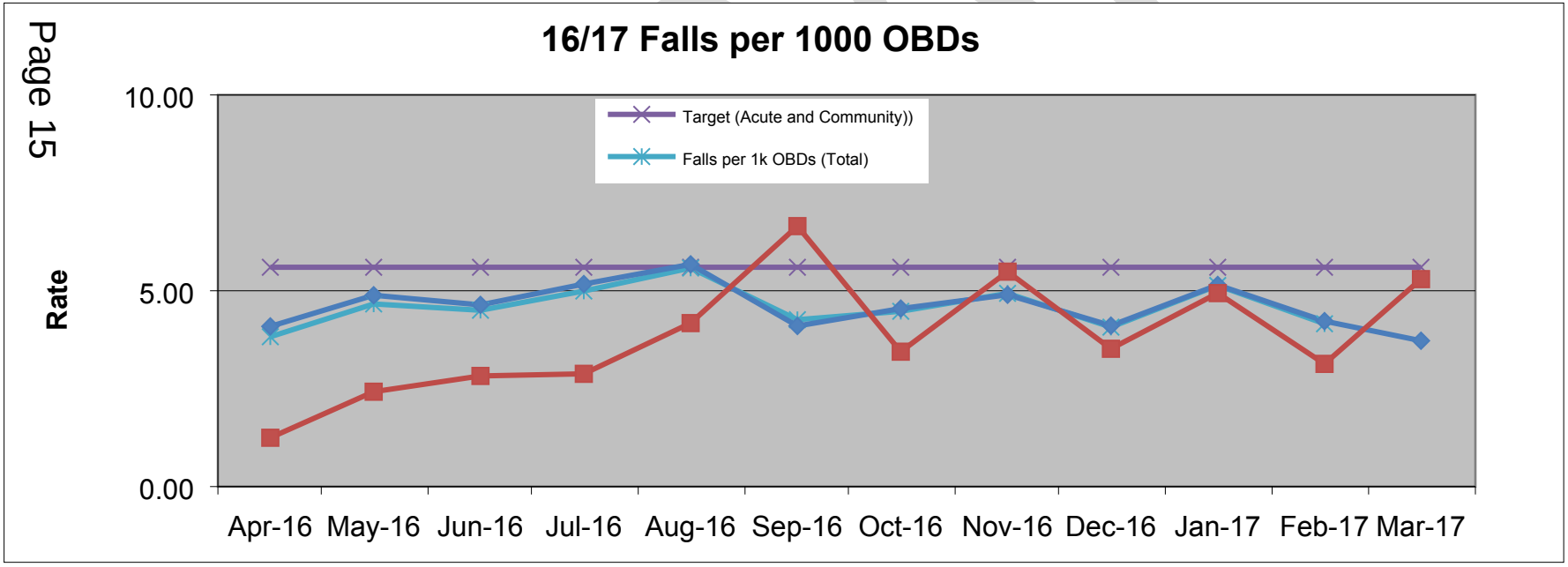


TABLE 1

(Trusts own data – actual falls per 1,000 occupied bed days)

Through the work of the collaborative, the Trust implemented a number of initiatives in 2 pilot areas (see tables 2 & 3) which have included:

- Multidisciplinary presence in the bays at all times to ensure patients are observed
- Fall 'grab bags' placed in toilets to minimise staff having to leave patients unattended
- Toilet signs - 'call before you fall' in situ
- Communication posters which raise awareness of achievements
- Medical assessment of patients in relation to falls' risk
- Staff training

TABLE 2

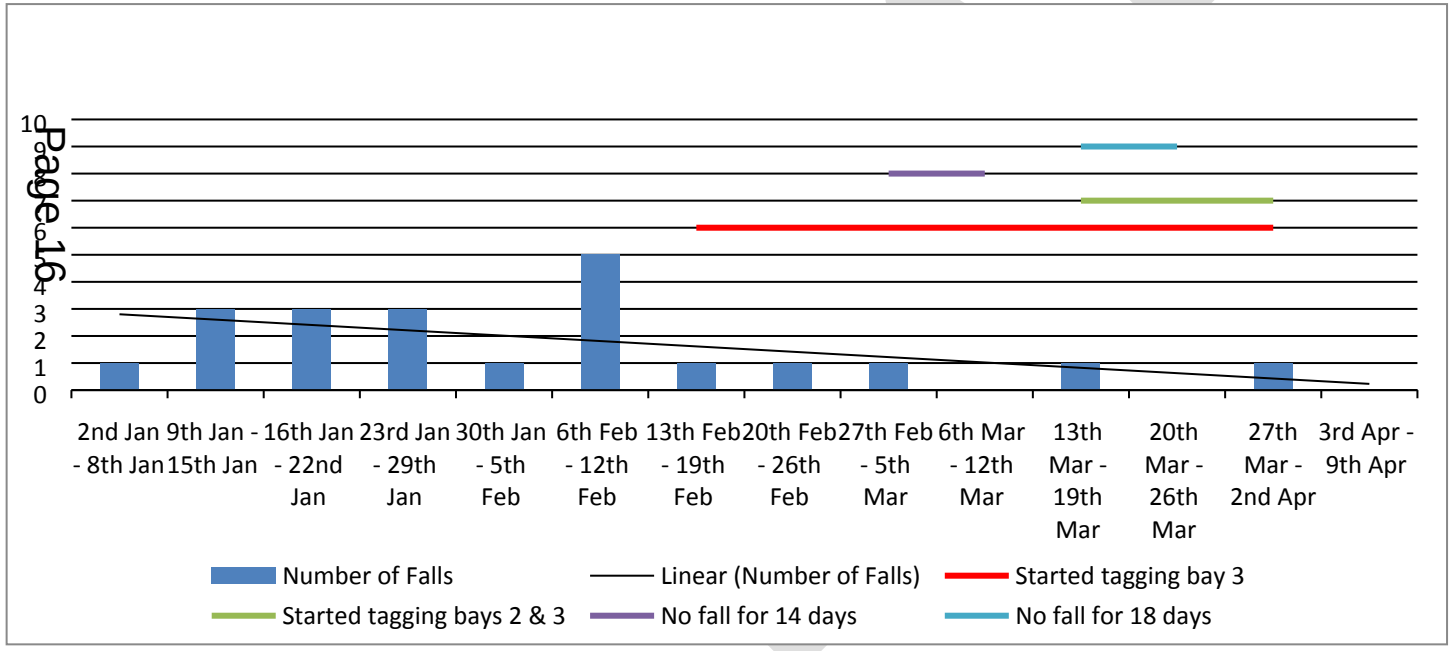
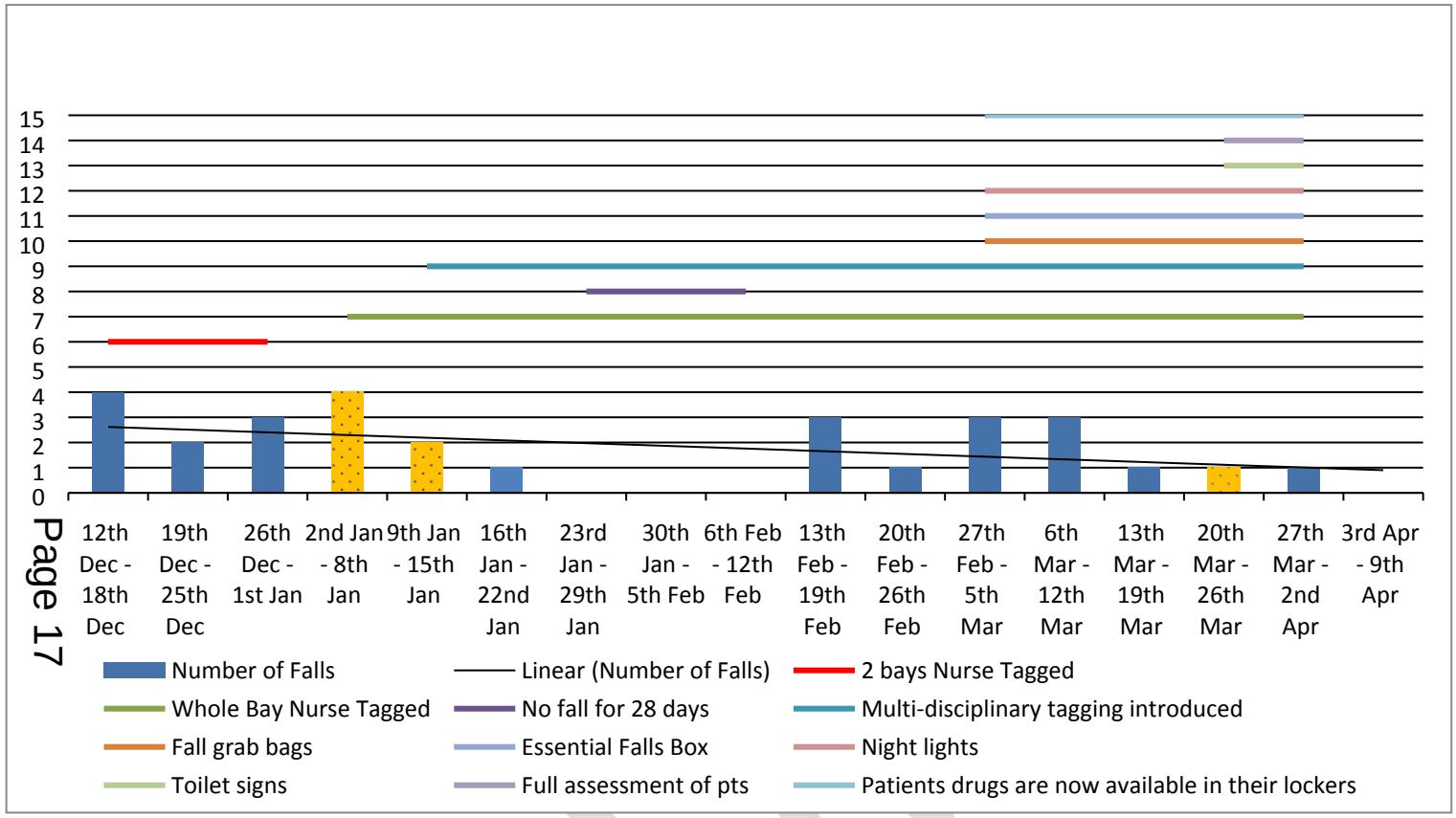


Table 3



Preventing Infection

Infection Prevention remains a high priority for the Trust and this is echoed by Wolverhampton CCG and Wolverhampton City Council Public Health Service which is demonstrated by a continued collaborative working approach throughout 2016/17.

The work of the Infection Prevention Team includes education, research and development, standard and policy setting, establishing assurance processes and, most importantly ensuring patient safety in the prevention of spread and acquisition of new infections across the city.

We have very proudly forged close links with care homes, very sheltered housing accommodations, local authority and independent contractors and we have been working on several projects within these settings to further build on the successes of previous Quality Improvement work undertaken for example:

- A prevalence project commenced in July 2015 to explore the prevalence of infections and antimicrobial use in Wolverhampton Nursing Home beds. The project group continues to meet between the quarterly data collection phases, of which there has been 9 to date. Year 2 of quarterly data collection phases have included a proportion of residential beds
- The Infection Prevention Team has continued the work across the health economy to reduce the MRSA carriage and support patients through the treatment for *Clostridium difficile*
- The project continues to support care homes through the Wolverhampton PREVENT Model, a triad of targeted MRSA screening, education training and auditing of key standards
- During the year 2016 - 17 the Infection Prevention Project team has assisted Wolverhampton care homes with the management of 26 outbreaks; with the aim of preventing admissions and reducing the impact on the acute Trust

Increased risk factors for healthcare acquired infections (HCAI) are acknowledged in the ageing population, alongside the changes in use of health services and the rising threat of highly resistant organisms and this is recognised as part of the strategy for preventing HCAI. 2016/17 has been a productive, yet challenging year, across Wolverhampton in relation to HCAI.

For new organisms such as Carbapenemase Producing Enterbacteriaceae (CPE), antimicrobial stewardship, design innovation regards infection prevention and ensuring clinical practice such as hand hygiene is optimized at all times, is key to the control for both new and familiar organisms alike.

A care home infection prevalence project has been delivered during 16/17 with assurance data held on care home standards for Infection Prevention. GP's have been supported to further improve their environments and practice, again building on improvements that have been achieved over the last 10 years of collaborative working.

What we set out to achieve:

The Trust acknowledges the current challenges surrounding infection prevention. By working in partnership with colleagues across the health economy to deliver nine agreed strategic objectives, delivered through a health economy Infection Prevention 5 year Strategy. Strategic objectives focus on consistent high standards and innovation to sustain and further reduce avoidable infection in healthcare.

The strategic objectives underpin the health economy annual programme of work and the ambition for the year was to fully deliver this programme.

- The challenges with *Clostridium difficile* seen in Q1 and Q2 of 2016/17 were remedied by September, with monthly incidence reduced to just 1 or 2 cases per month. We ended the year just slightly over trajectory.

- An increased focus on Standard Precautions, to include splash and sharps awareness to support a reduction in associated incidents.
- Implementation of the EU legislation surrounding safer sharps across the Organisation to further improve staff safety.
- Implementation of specific risk assessment and screening protocols to detect carriage of Carbapenemase Producing Enterbacteriaceae on admission.
- The Intravenous Resource Team continues to deliver a high standard of line care with increasing numbers of patients discharged on Outpatient Parenteral Antibiotic Therapy. A successful business case was delivered in 2016/17 which allowed the team to expand to further cope with demand on the service.
- Surgical Site Infection (SSI) Surveillance data is shared with Consultant Surgeons via a monthly dashboard. This will continue into 2017/18 to further support with a reduction in SSI. MSSA screening and decolonisation for patients undergoing cardiac surgery was trialled during the year and the benefits to this will be evaluated and considered going forward.
- Lowest year on year record for device related bacteraemia in the Trust and continued communication of community acquired related device related bacteraemia cases.
- Streamlining of catheter usage and care across the city using a standardised agreed formulary
- Delivery of a care home prevalence project.
- Continued 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.
- Introduction of an Infection Prevention Scrutiny process, 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 Trust to develop electronic sharing of infection risks.

The Trust 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.

Venous Thromboembolism (VTE)

2016/2017 saw a number of events to focus attention on ensuring patients are risk assessed correctly and to identify barriers to completing individual risk assessments.

- A process mapping event was held for Junior Doctors and allowed them to feedback directly to VTE group their experiences of completing risk assessments.
- An audit project undertaken by a junior Doctor in gynecology allowed an opportunity to increase VTE risk assessment in that patient group and develop a model that can be used in other struggling areas and ensure changes are sustainable when Doctors rotate.

- Members of the VTE group spoke at a Junior Doctors teaching sessions and an educational day for pre op assessment nurses. Ensuring that patients receive the care indicated in their VTE risk assessment has always been a priority and monitored through the VTE prevention audit and learning outcomes from route cause analysis (RCA's).
- This year with the help of the governance department we have been able to disseminate all ward audit results monthly in full to ward managers, directorates and divisional teams by including VTE on the information governance report (IGR) and developed 4 key questions to be used as a key performance indicator.

Pressure injuries

July 2016 the Trust started to use the new term "pressure injuries" based on the recommended changes reported by National Pressure Ulcer Advisory Panel (NPUAP) 2016. Each grade is now termed as a stage, showing how a pressure injury can evolve, either due to systemic changes and or prolonged pressure. There has been positive feedback from staff, who continue to put in great effort to prevent avoidable pressure injuries on a daily basis. There has been a 16% reduction of total incidents and a reduction of 28% reduction across inpatient areas and community services of avoidable incidents.

Despite some incidents showing omissions in holistic assessment or repositioning on occasions, the reports have shown an impressive leadership approach to drive quality preventative measures. In the adult areas, new documentation has been launched to help record accurate interventions during the patients' journey.

The Trust has a Tissue Viability strategy, which is a 3 year plan to improve prevention of all types of wounds and improved wound healing across the health economy, hospice and local authority. The pathways that have been developed and launched with training are:

- Exudate pathway
- Compression therapy pathway

These pathways have been launched across the Trust, Nursing homes and General Practices to ensure the patients journey is consistent.

Sign up to Safety

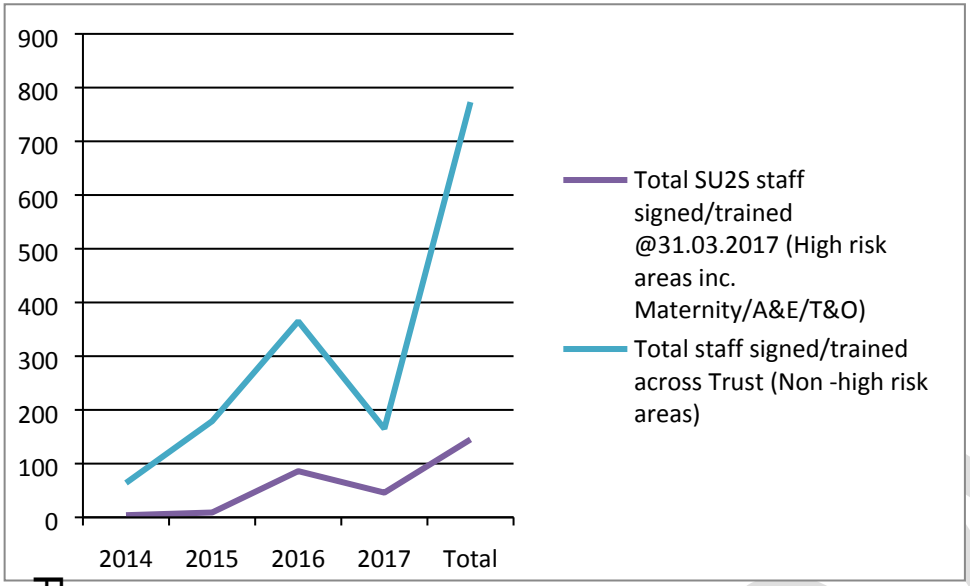
As part of the Sign up to Safety initiative the Trust has committed to improving the safety culture and team effectiveness through a number of complimentary interventions which addressed human factors, staff and team communication, emotional intelligence and wellbeing. The Trust has already invested in related training for Human factors, Clinical Simulations, Emotional intelligence, Process Communication and Leadership and the project funding is used to accelerate training interventions focusing on improving and enhancing communication (PCM) in the 3 prioritised areas i.e. Maternity, ED and Orthopedics.

A Team optimisation model has been in development and will be a key intervention of the Sign up to Safety Project. The intended benefits of the project are expected to include improved patient experience and outcomes as a result of an enhanced safety culture and climate at team level, improved staff wellbeing and morale. For patients there is improved empathy in communication and skills to get the message across and an overall better team environment to receive care.

The Sign up to Safety campaign was launched by the Secretary of State for Health in June 2014. Its intention is to share best practice of project outcomes to improve the safety of care and as a result save 6,000 lives making the NHS the safest healthcare system in the world. The Royal Wolverhampton NHS Trust has made its pledge to join the campaign and has published its improvement plan in support of this goal.

Between 2014 and the end of this financial year (2016/17) 918 staff in total have signed up for the Process Communication Training. This figure includes a total of 145 staff representing the Sign up to Safety 3 priority areas i.e. Maternity, ED and T&O.

PCM Intervention	2014	2015	2016	2017	Total
Total SU2S staff signed/trained @31.03.2017 (High risk areas Inc. Maternity/ED/T&O)	4	9	86	46	145
Total staff signed/trained across Trust (Non -high risk areas)	64	179	365	165	773
Total staff trained Trust wide	68	188	451	211	918



Page 22

Initial diagnostic work covering the review of formal Complaints, PALS data, File closure reports, Quarterly CLIP Reports, Chat back results 2015, FFT data and NHSLA Scorecards has been completed and data packs produced for priority areas to share the key emerging themes.

During 2016/17 staff engagement has continued with the three priority areas to communicate and share the Sign up to Safety plans to encourage support and participation.

Trust wide staff engagement events raising awareness and commitment to the Sign up to Safety Campaign aims of reducing avoidable harm and saving patients' lives by putting patients first, continually learning, being collaborative being honest and being supportive took place in October 2016, jointly with Maternity staff in December 2016 and Trust wide during March 2017.

The initial deep dive review of T&O clinical negligence claims data has been completed and shared with T&O for review, discussion and targeted action to improve the quality of care.

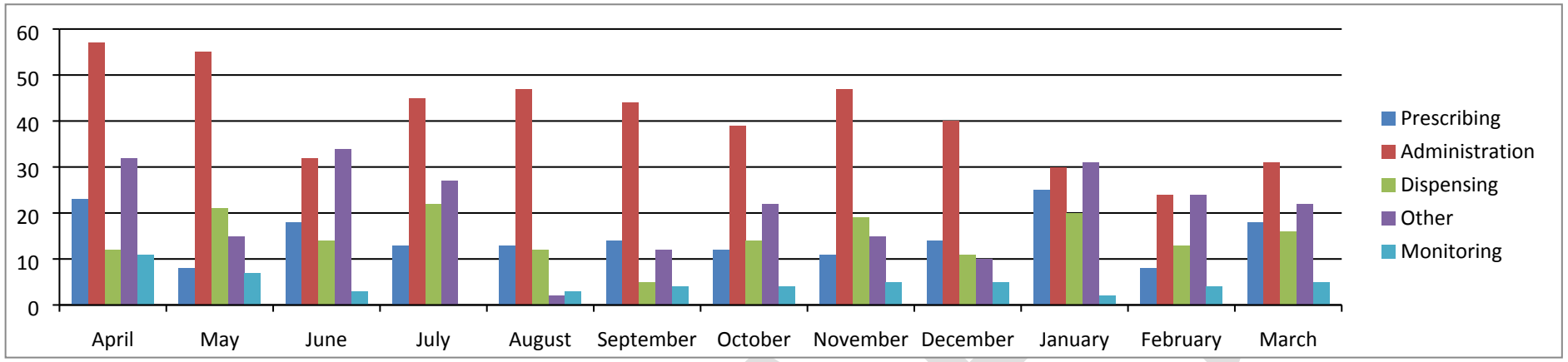
The project team conducted during 2016/17 the Sign up to Safety Team and Safety Climate Survey with each of the three priority areas and received 116 returns from Maternity, 117 staff returns from Orthopaedics and 59 completed surveys from ED.

The survey findings have been shared with each of the areas to review and take action to continually monitor and improve the team and safety culture within their areas.

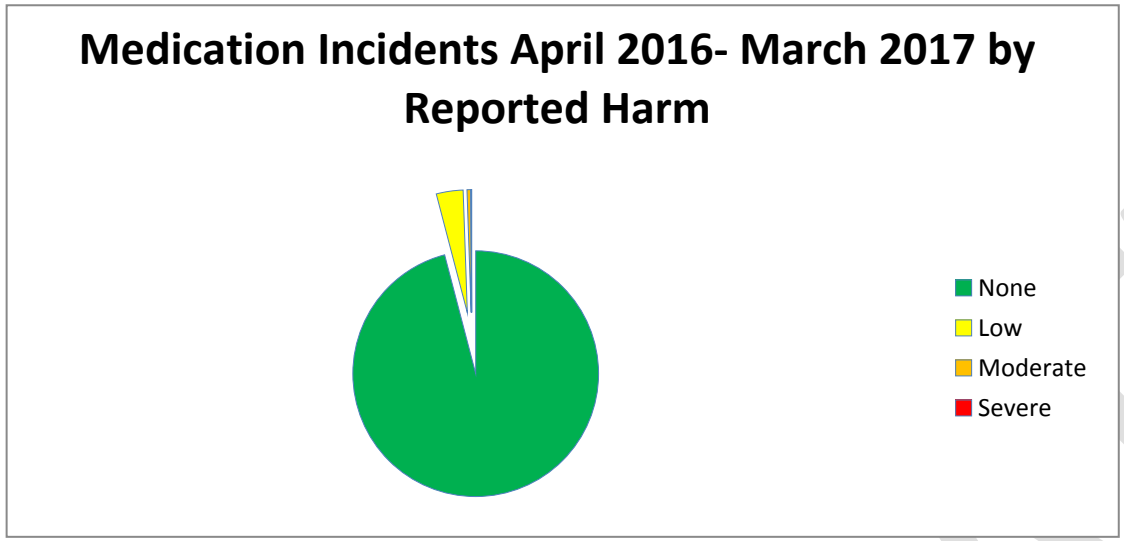
Medication errors

The Trust continues to encourage incident reporting across all services, driving a culture of openness and honesty. This allows us to further understand incidents and how they occur, thus allowing us to learn from them and further improve safety and outcomes for our patients.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Medication Incidents Reported in line with Trust Policy (i.e. within 5 days)	137	108	94	107	78	79	91	97	80	108	73	92
Medication Incidents Reported/Approved outside of Trust Policy	-	-	-	2	17	13	18	18	40	19	10	
Level of Harm Caused	130	102	90	107	81	87	104	110	117	125	80	92
	5	5	4	2	8	3	5	3	3	2	2	3
	2	1	0	0	0	1	0	1	0		1	0
	0	0	0	0	0	0	0	1	0	0	0	0
Number of Admissions	13268	13940	13979	13561	13218	13365	13333	13741	13201	13690	12566	14187
Rate of Medication Error (%)	1.03	0.77	0.67	0.80	0.72	0.69	0.82	0.84	0.91	0.93	0.58	0.65



- We have increased the number of technicians onto wards to undertake medicines' reconciliation when patients are admitted.
- The pharmacist leading on antimicrobial resistance has led teaching sessions for a range of clinicians on improving antibiotic prescribing.
- The Medication Safety Officer has established the Medicines' Safety Group to provide leadership and a multidisciplinary view on medicines' safety.
- The hospital pharmacy team and the Primary Care Management Team are working together to exchange information about patients to improve medicines use in both primary and secondary care.



Sepsis

As part of the Trust's overarching 'Sign up to Safety' plan, the Trust has committed to further improve how we diagnose and treat patients with serious infections (sepsis) at an earlier stage in their illness is cited as a further priority. The Deteriorating Patient Group has focused on 'big data' and analytics to improve data visualisation, more reliably measure quality and outcomes, and to utilise this information for further improvements which include the following elements of work:

- Refining and drawing upon sources of data from the electronic patient observation system (VitalPAC) database, Early Warning Score (EWS) audit and interaction between the Resuscitation group and Mortality Review group
- Trust wide re-launch of sepsis awareness promoting Sepsis week
- Launch of community care bundles for the recognition of sepsis
- Continued Trust wide Sepsis study days with excellent attendance and feedback.
- Implementation of Sepsis awareness session provided within Nurse Induction and HCA training
- Currently reviewing the Trusts sepsis screening tool to incorporate new evidence base guidance.
- The Trust education department has purchased the Sepsis movie "Starfish" for promoting the awareness of sepsis. This will be launched by Dr Ron Daniels Chief Executive of The UK Sepsis Trust and CEO of the Global Sepsis Alliance

Responding to Safety Alerts

The Trust is moving towards the Health Assure Central Alert System to better manage safety alerts.

Safety alerts continue to be monitored by external bodies and the Trust works to ensure compliance within the tight timeframes. Although at the time of writing there were no alerts outstanding, throughout the year 2016/17 two alerts were late in being responded to, 1 Medical Device Alert and 1 EFN both due to administrative oversight.

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

Stage 1 = Warning

Stage 2 = Requires Resource

Stage 3 = Directive giving instruction on implementation of protocols

In the main the alerts require an action plan for implementation of the alerts 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.

Health & Safety Steering Group also monitor the alerts and response times and this is reported to the Quality Standards Action Group.

2016/17 has been a busy year particularly for Estates Facilities alerts, however many of them are for information enabling a swift response.

The Trust continues to work towards full and prompt compliance.

12 months April to March 2016/17:

To Date received (financial year)	
MDA's	23
EFN's	76
NHS/PSA/	10
EFA	6
DH	0
SDA	0
Total	115

Year To Date Closed	
MDA's	23
EFN's	76
NHS/PSA/	7
EFA	6
DH	0
SDA	0
Total	112

Year To Date Open	
MDA's	0
EFN's	0
NHS/PSA/	3
EFA	0
DH	0
SDA	0
Total	3

Open (Year To Date & Previous years still open)	
MDA's	0
EFN's	0
NHS/PSA/	3
EFA	0
DH	0
SDA	0
Total	7

Overdue Alerts x NHS PSA	0
Overdue MDA alert	0

***Key

MDA's	Medical Device Alerts
EFN's	Estates Facilities Notices
NHS/PSA/	NHS Patient Safety Alert
EFA	Estates Facilities Alert
DH	Dept Health
SDA	Supply Disruption Alert

Priority 3: Patient Experience

The Trust measures patient experience via feedback in a variety of ways. This includes local and national survey's, Friends and Family Tests, PALS concerns, formal complaints, compliments and social media forums such as Patient Opinions and NHS Direct.

By effective analysis and use of patient and family feedback we will improve our services to ensure we meet their needs.

We know that the patients' experience 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 us provide the kind of care that we all want to deliver and would like to receive.

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

How have we performed in 2016/17?

This year, as was the previous year, has been a period of transformation for patient experience at the Trust. This is on-going into 2017/18.

Following last year's full review of the Trust's policies and strategies in relation to patient experience, this year has primarily focused on ensuring that those policies and strategies have been embedded into everything the Trust does to improve the patient experience.

This has included:

- An external full complaints audit
- Internal quarterly complaints compliancy audit
- A full analysis of the breach
- Setting up of an Equality, Diversity and Inclusion Group
- Focus on the gathering of patient stories used as a learning tool
- Increased level of engagement with our stakeholders including quarterly meetings between CCG, Healthwatch, RWT and the Black Country Partnership Foundation Trust
- Support and promote a series of engagement workshops with stakeholders

- Publication of the Trust's Equality, Diversity and Inclusion report. [2]

The Patient Experience Team continues to provide supportive and informative measures to assist the directorates. This includes the design and implementation of the Divisional dashboards, which also includes information in relation to a variety of patient feedback metrics including complaints and the Friends and Family Test. The information provided on the dashboards will help to identify and triangulate key themes.

Complaints' Management

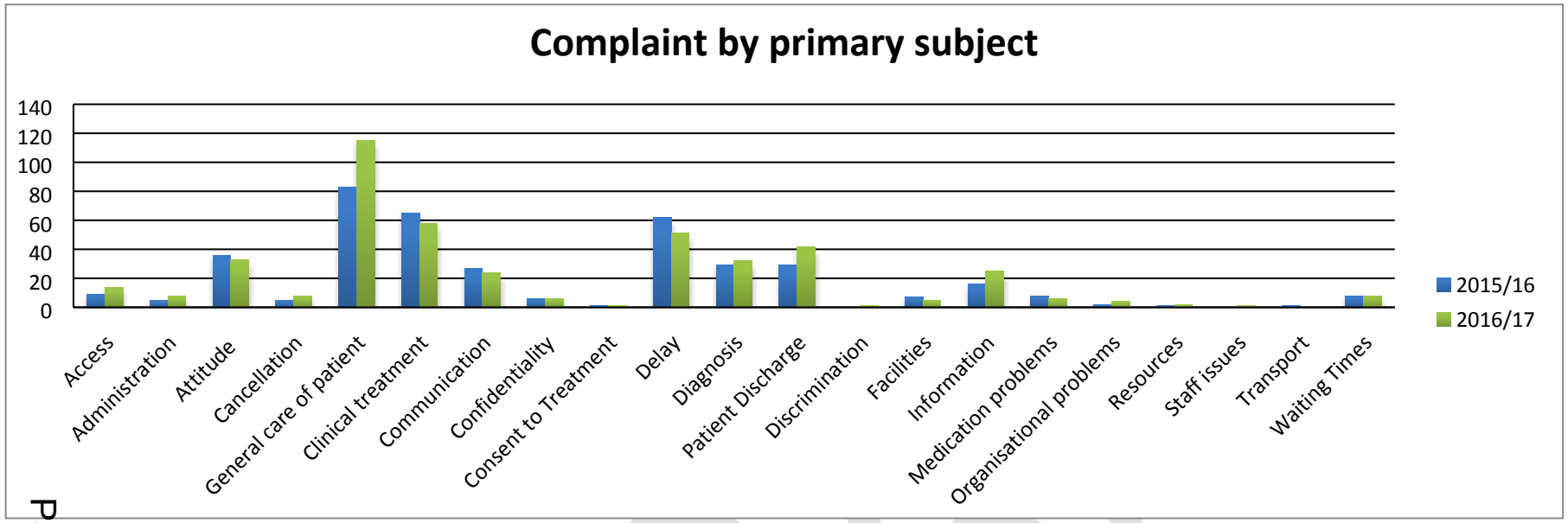
Formal complaints are managed in accordance with the relevant statutory regulations.[3] With the amendments made to the Complaints' Management Policy in March 2016, and following bespoke training, we have seen a dramatic improvement in the timeliness of complaint handling and informing the complainants of the progress of their complaint.

Prior to the amendments to the policy in March 2016, statistics show that in Q4 2015/16 that overall 67% of complaints were closed either within the organisational timeframe of 25 working days or were given consent to breach due to extenuating circumstances or complexity. This has now increased to 92% (as at Q4 2016/17) and measured on the amended timescale of 30 working days.

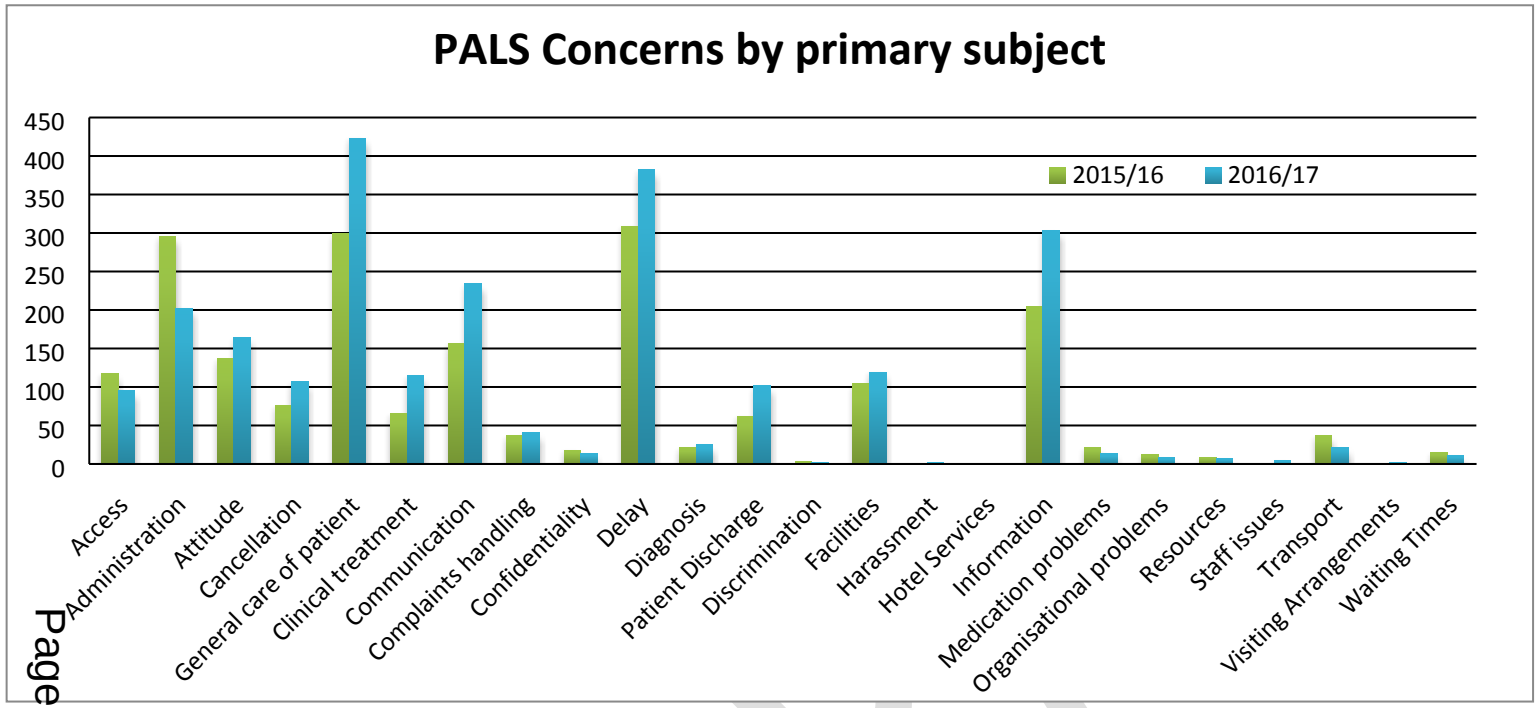
In terms of volume, 2016/17 has seen an 11% increase in comparison to the previous year for formal complaints made through the statutory process, and 24% increase in the volume of PALS concerns raised.

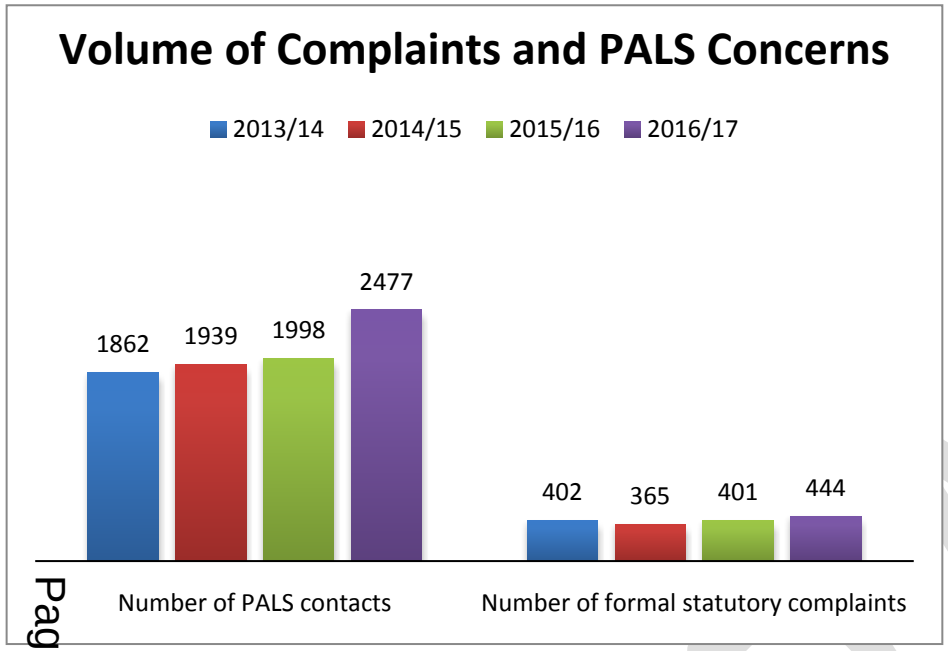
[2] http://www.royalwolverhampton.nhs.uk/patients-and-visitors/patient-experience-team/equality-diversity-and-inclusion/equalities-information/

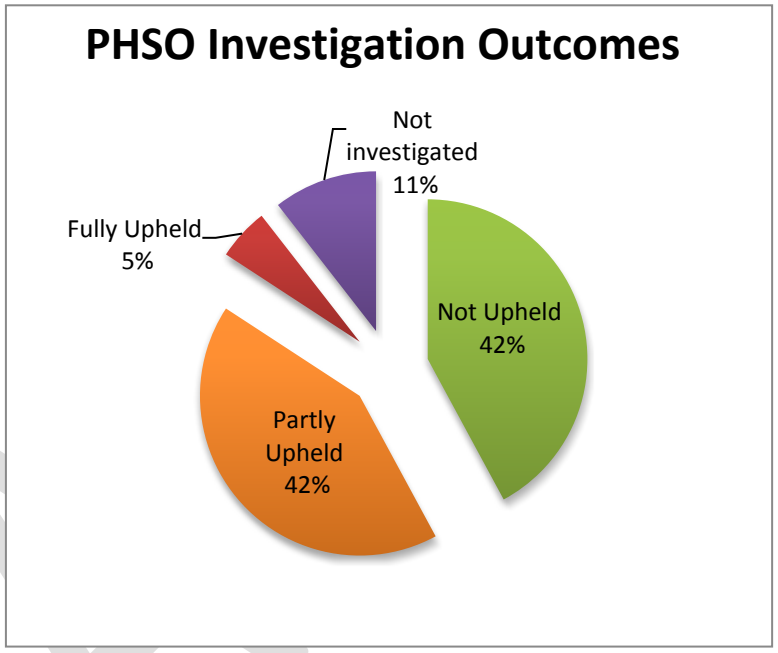
[3] http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf



During 2016/17, 18 complainants referred their complaints to the Parliamentary Health Service Ombudsman (PHSO) for their consideration. This represents 4% 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 by directorates to bring complaints to a resolution satisfactory.

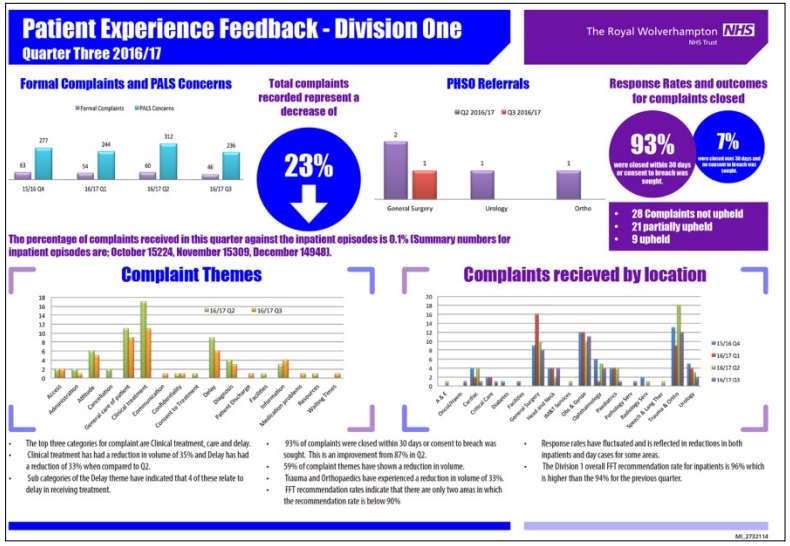

PALS Concerns by primary subject
450
400
350
300
250
200
150
100
50
0
2015/16
2016/17
Access
Administration
Attitude
Cancellation
General care of patient
Clinical treatment
Communication
Complaints handling
Confidentiality
Delay
Diagnosis
Patient Discharge
Discrimination
Facilities
Harassment
Hotel Services
Information
Medication problems
Organisational problems
Resources
Staff issues
Transport
Visiting Arrangements
Waiting Times

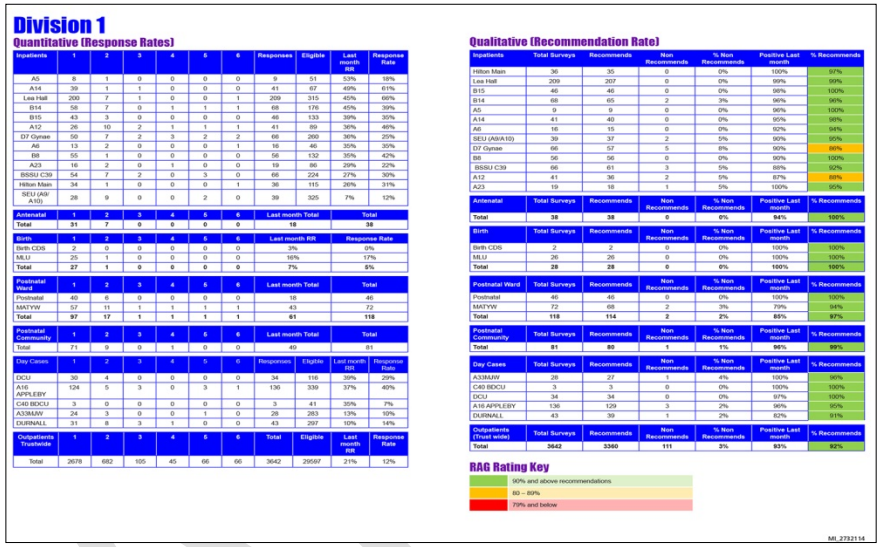




The volume of complaints received for the year (444) represent 0.02% of the total volume of admissions, emergency activity, outpatient attendances and community contacts for the year of 2,058,106.

The PHSO took the decision not to investigate two of the eighteen cases as it would not achieve the remedy the complainant was seeking.





The Friends and Family Test

As the FFT has activity formed the basis of the commissioning for quality and innovation national goals (CQUIN) for this year, work has focused on ensuring that the test is inclusive and provides information to ensure an improved patient experience. Key principles given by NHS England on making the test inclusive have been adopted.[4]

Improvements have included:

- A comprehensive review and analysis of 2015/16 scores and additional patient feedback provided on the FFT.
- Ensuring FFT inclusivity across ED, Inpatient, Outpatient, Day Case, Community Services and Maternity. This includes implementation for Children and Young People, Learning Disabilities, Dementia, Deaf, Blind or vision loss and People with little or no English.
- Hand held devices used to capture FFT responses in real time on wards.
- Monthly metrics are analysed and the lowest five performing areas for response and recommendation rate are targeted with direct work for improvement.

[4] https://www.england.nhs.uk/ourwork/pe/fft/fft-inclusive/

Patient and Public Engagement

Patient and public engagement (or involvement) is a continual process of working with patients, carers and other stakeholders (including relatives and advocates) to design, shape and develop services to improve services for its patients and their representatives. The Trust has a rolling 3 year strategy for Patient and Public Engagement which identifies the benefits of local engagement, and provides us with a framework to achieve our objectives.

Initiatives for the year have included:

- Bi - monthly Patient Experience Forum, which is open to patients and public members to seek their views on our services, and help us shape future developments.
- The creation of an Equality and Diversity Steering Group, run with significant input from the Patient Experience Team. This group considers matters important in the Trust from an Equality Diversity and Inclusion perspective, in which we encourage participation from local stakeholders, to ensure voices of marginalised groups are listened to and understood in our service delivery and policies.
- Representatives from the Trust, including from the Patient Experience Department attends regular meetings with the Vertical Engagement Patient Participation Group to extend our engagement with GP surgery patients.
- The Patient Experience Team have been pro- active in attending local events to publicise the work of the Patient Experience service and seek local views on the way Trust delivers care.
- We encourage patients and carers to share their 'Patient Stories' with us by recording their experience of care and allowing us to share these recordings at Trust Board and Senior Management Forums, as both a staff learning tool, and opportunity for patients to express how it feels to receive care from RWT.

Volunteering

The last year has again been a busy year for Volunteer Services and has provided many new developments and opportunities in extending the support we offer to patients and staff. Across RWT, volunteers help hospital cafés run, run hospital radio, fundraise, help visitors find their way, provide information and emotional support, run a mobility scooter service, help patients at meal times, support patients who have dementia and their carers, and the list goes on.

In addition to their regular roles volunteers also help out in emergencies and on short term projects such as assistance with ward cleanliness audits. Volunteers are located across all our sites including New Cross, Cannock, West Park, and other community buildings.

In the last year new roles we have placed volunteers into include:

- Further expanding 'Play Assistant' volunteers on the Children's ward, Paediatric Assessment Unit and Children's Outpatients
- At Cannock Chase Hospital- placing volunteers within Cancer services, Outpatients, and Rheumatology

- Pathology at New Cross Hospital- placing 'Meet and Greet' volunteers at the building entrance to act as a visitor guide
- At West Park Hospital- developing ward based Patient Activity volunteers who provide a range of activities from a games group to gentle art and reminiscence activities

We currently have 450 active volunteers with up to a further 75 on a waiting list. In the last 12 months combined volunteer hours across the Trust was approximately 129,600 hours. The Trust is very thankful for all the help the volunteers give, we do hope that they help us give that 'little bit extra' in the services we offer to our patients and hospital visitors.

In November 2016 a joint event was held between volunteer services and the Trust Charity. The two services are linked quite closely due to the Trust Charity funding volunteer activity, for example, volunteer travel expenses and support with our volunteer's patient buggy service at New Cross.

Both Volunteering and The Trust Charity celebrated milestones in 2016- 20 years of the Trust Charity being in existence, and 10 years of Volunteer Awards ceremonies being held in the Trust.

The joint event was held at the Molineux Stadium, Wolverhampton, in the presence of the Mayor of Wolverhampton, Councillor Barry Findlay, and Executives of RWT.

148 Volunteers attended the event which provided thank you speeches, lunch, and an awards presentation, and 10 lucky individual volunteers/ volunteer teams were selected to receive awards on the day.

Equality, Diversity and Inclusion

The Trust has a genuine commitment to equality, diversity and inclusion. We understand that our diverse workforce is our greatest asset, so we strive to create working environments in which people are valued, able to reach their full potential and flourish, this in turn will help us deliver high quality accessible services that are truly inclusive.

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.

Previously in the Quality Accounts the Trust has included progress on actions contained within its Equality Objectives, however, a range of equality information is available within various reports which are published on the Trust's website (Equality, Diversity and Inclusion page). The Trust is moving towards a 'one stop shop' showing its equality information in one place, to make access, comparisons and analysis easier.

The new Annual Equality, Diversity and Inclusion Report contains a plethora of information which has been broken down into protected characteristics (as per the Equality Act 2010) as far as possible, including information such as; workforce, access to services and complaints data.

A range of actions have been pulled from this report and will form part of the Trust's Equality Objectives. The report also contains summary information on the:-

- Workforce Race Equality Standard.
- Inclusivity of the national Friends and Family Test.
- Service user engagement activities.
- Accessible Information Standard.
- Equality Delivery system.
- Equality Objectives.
- Interpreting and translation services.
- Meeting religious and cultural needs of service users.
- Equality analysis.
- Learning disability.

The Trust realises it has some challenges ahead on its journey towards inclusion, but is totally committed to making a difference to our workforce and to the people we serve.

Equality is not just about our legal obligations, we have moral and social responsibilities, treating people fairly is the right thing to do

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 5 broad categories:

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

The details for the inspection process were as follows;

	Date	No of Patients Assessors	No of Staff	No of Wards inspected	No of Outpatients inspected	No of food tastings
New Cross	7.4.16	15	8	10	10	5
West Park	2.3.16	6	3	4	2	3
CCH	12.4.16	7	4	2	6	1

In addition all sites had an external and internal inspection of general areas. 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.

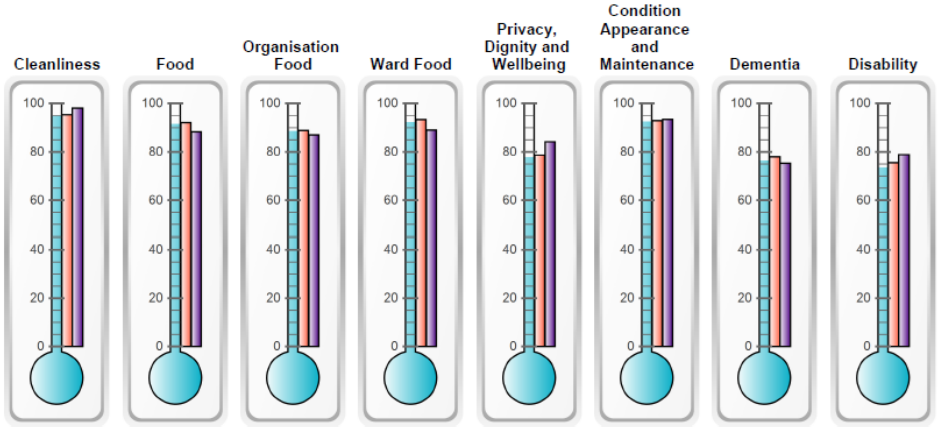
The inspection process was not a technical audit; this is the patient's perception of the environment based on the training given to them.

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

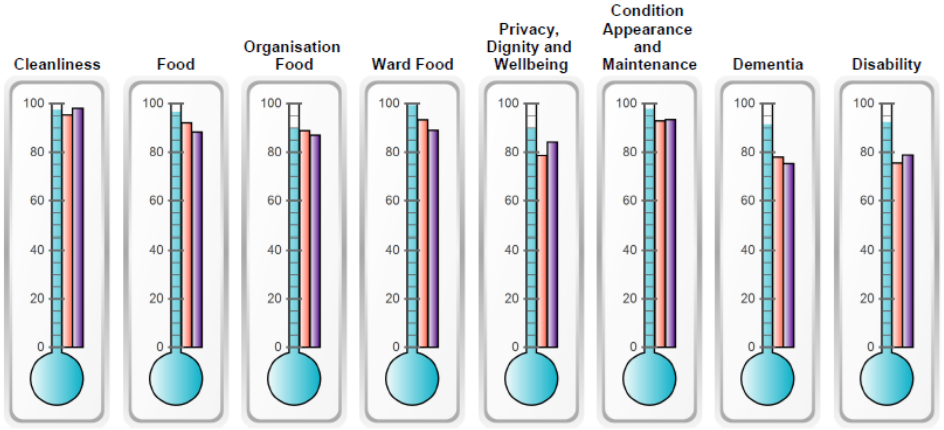
NEW CROSS HOSPITAL (WOLVERHAMPTON)- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2966.0000	508.1930	101.5124	406.6806	396.6666	1629.0000	896.3991	545.4243
Available Score (Actual)	3120.0000	554.9409	114.5880	440.3529	510.0000	1760.0000	1172.8571	740.3697
Site Score	95.06%	91.58%	88.59%	92.35%	77.78%	92.56%	76.43%	73.67%
Organisation Average	95.36%	92.11%	88.77%	93.30%	78.66%	92.88%	77.91%	75.52%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

RESULTS – WEST PARK

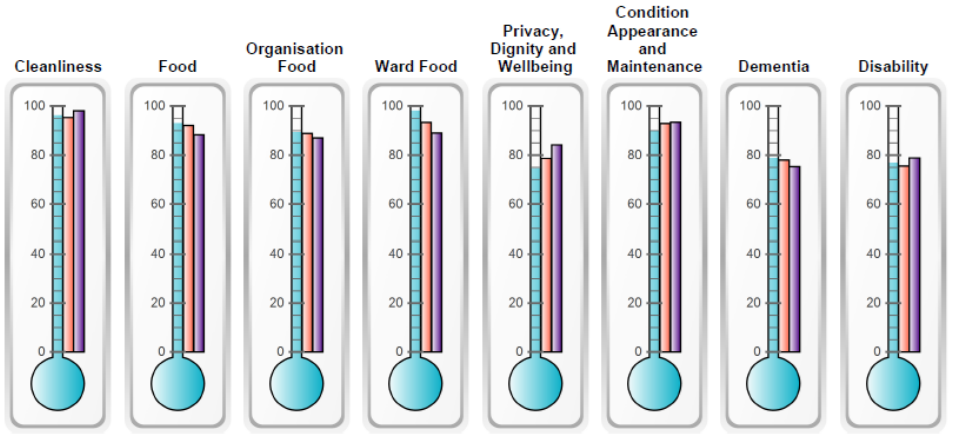
WEST PARK HOSPITAL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1128.0000	380.6510	103.3485	277.3025	177.6666	648.0000	458.3991	281.4243
Available Score (Actual)	1156.0000	393.7812	114.5880	279.1932	198.0000	662.0000	500.8571	304.3697
Site Score	97.58%	96.67%	90.19%	99.32%	89.73%	97.89%	91.52%	92.46%
Organisation Average	95.36%	92.11%	88.77%	93.30%	78.66%	92.88%	77.91%	75.52%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

RESULTS – CANNOCK CHASE HOSPITAL

CANNOCK CHASE HOSPITAL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1108.0000	183.5923	102.4032	81.1891	159.6666	676.0000	404.8991	267.9243
Available Score (Actual)	1150.0000	197.2771	114.5880	82.6891	214.0000	752.0000	512.8571	348.3697
Site Score	96.35%	93.06%	89.37%	98.19%	74.61%	89.89%	78.95%	76.91%
Organisation Average	95.36%	92.11%	88.77%	93.30%	78.66%	92.88%	77.91%	75.52%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

Of the 24 assessment scores carried out across all three hospital sites, 15 (62%) achieved above the national average score.

On the New Cross Hospital site Dementia, and Condition Appearance and Maintenance, have seen a marked increase from the previous year. This is a clear reflection of the Estates work that has been undertaken over the last year.

The Trust average score for Cleanliness was 95.36% against the national average of 98.06%, which was a disappointing result. However having reviewed the cleanliness scores nationally, 23%(299) of all organisations assessed (1291), returned a cleanliness score of 100%, which will of significantly impacted on the average score.

All three of the food assessment across all sites achieved above the national average.

West Park Hospital has achieved above the national average in 7 or their 8 areas of assessment.

Vertical Integration

Awaiting information

Continuous Quality Improvement 2016/17

Use of the CQUIN payment framework

A proportion of the Trust's income is conditional on achieving quality improvement and innovation goals through the CQUIN Payment Framework.

CQUINs enable the organisation to look at the quality of the services delivered, ensuring that we continuously improve and drive transformational change with the creation of new, improved patterns of care. These will impact on reducing inequalities in access to services, improve the experiences of the patients using them and the outcomes achieved. CQUIN initiatives are owned by identified service leads who develop SMART action plans to ensure the required changes are delivered.

CQUINs are agreed during the contract negotiation rounds with input from Clinical leads 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.

Priority 1 – Patient Safety

The CQUINs agreed for 2016/17 are detailed below:

Commissioner	Priority	CQUIN Title	Purpose of CQUIN	Outcome
CCG	Patient Safety	Care of Patients with Acute Kidney Injury	Focused on the diagnosis of Acute Kidney Injury, treatment in hospital and the development of a care plan to monitor kidney function after discharge from hospital.	achieved
CCG	Patient Safety	Sepsis Screening	Focused on the early identification of patients with sepsis and treatment in line with local clinical protocols.	achieved
CCG	Patient Safety	Sepsis Antibiotic Administration	Safely reducing the amount of antibiotics prescribed to patients is an important part of work to tackle antimicrobial resistance.	achieved
CCG	Patient Safety	Dementia and Delirium	To improve care for patients with dementia or delirium during episodes of emergency unplanned care including provision of training for staff.	achieved

CCG	Patient Experience	Reducing the Proportion of Avoidable Emergency Admissions to Hospital	Development of services to ensure patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time.	achieved
CCG	Patient Experience	Improving Diagnoses of Patients with Mental Health Needs at ED	The focus was to improve data recording and encourage improved, timely communication between acute Trusts and mental health providers to improve outcomes for those with MH conditions seeking urgent and emergency care.	achieved
CCG	Patient Experience	Best practice in Day Surgery - outpatient procedures	Provide assurance that the Trust processes reflect Best Practice Guidance as defined by the British Association of Day case Surgeons	achieved
CCG	Patient Experience	Optimising Outpatient Follow-Ups	Redesign of outpatient services in order to reduce attendances at hospital by providing alternative locations and methods of reviewing patients.	achieved
CCG	Patient Experience	Complaints Management	To ensure good quality complaints handling which is vital to continuous improvement in the quality and safety of care at provider organisations	achieved
Specialised Services	Patient Safety and Patient Experience	eGFR - Chronic Kidney Disease	Preventing or delaying the need for patients to start dialysis through laboratory monitoring of eGFR being flagged to Primary Care providers.	achieved
Specialised Services	Patient Experience	Right Care Right Place	Redesign of outpatient services in order to reduce attendances at hospital by providing alternative locations and methods of reviewing patients such as community clinics and telephone follow up clinics.	achieved
Specialised Services	Patient Experience	NICE DG10 (Oncotype DX)	Improving quality of patient care through consistent and accelerated adoption of non-binding NICE guidance. To help patients, who cannot be categorised as low or high risk by existing clinical practice, make more informed choices about	achieved

			whether to undergo chemotherapy through greater insight into their likelihood to benefit from the treatment.	
Specialised Services	Patient Experience	Haemoglobinopathies Networks	Support specialist haemoglobinopathy centres to work with commissioners and the wider haemoglobinopathy community to define and develop networks of care for patients with haemoglobin disorders	achieved
NHSE PH	Safe Staffing	Integrated Working Maternity and Health Visiting Services	Develop and implement an integrated shared assessment framework to ensure robust and appropriate procedures for information sharing between Maternity and Health Visiting Services and so enable continuous high quality care.	achieved
NHSE PH	Patient Experience	Bowel Screening	Improve uptake of bowel screening, targeting specific population demographic groups and GP practice registered populations of low uptake.	achieved

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 also monitored via the Finance and Performance Committee.

Each of the Service Leads is required to submit a quarterly report via the Contracts Team providing relevant data and any additional evidence which provides assurance that the goals outlined within the CQUIN have been achieved.

These reports are collated and submitted to each of the three Commissioning bodies. These reports are scrutinised and where needed additional clarification is requested from the Trust before the Commissioners provide feedback as to levels of achievement.

Looking forward 2017/18
Priorities for Improvement

Safe Nurse Staffing

Patient Safety

Patient Experience

Priority 1 – Safe Nurse Staffing

Nationally there is a shortage of nurses and applications to nurse training are not going up. With the withdrawal of bursary from September 2017 it is essential the Trust works 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 skills within the Trust to provide safe and effective care to patients.

Ensuring the pipe line of students from all professions is essential for the future workforce, however it is essential to focus on maximising our workforce. The Trust needs to be flexible and innovative to enable staff to have work life balance, a focus on wellness and manage the impact of having four different generations, with different expectations and needs, working side by side within a work force. [5]

With considerations given to the above the Nurse Recruitment and Retention Strategy (2016-2020) embraces the concepts of 'Enable', 'Attract' and 'Retain'. Below is a snap shot overview of actions:-

Enabling staff:

- Design Career Pathways
- Review skill mix and future roles
- Design an outreach programme for school college and university leavers to take the step into health care / nursing profession.
- Review opportunities for sponsorship and scholarship into the profession for the local area
- Align with the apprentice strategy
- Work with Higher Educational establishments to design higher level apprenticeships within the nursing career path
- Review and invest in the graduate curriculum to support roles for the future.

Attract staff

- 'The Grass is Greener'- demonstrating the opportunities, benefits and investment in staff provided by the Trust.
- 'The Sky is the limit' – investing in education and career paths within the Trust

[5] Jones, A. Warren, A. Davies, A (2015) Mind the Gap - Exploring the needs of early career nurses and midwives in the workplace. NHS HEE.

- ‘The Future is Rosy’ - promoting a positive working and learning environment, for all ,where care is delivered safe and effectively, demonstrating a kind and caring attitude which enables a culture of support, personal growth and promotes care delivery which exceeds expectations.
- Engage with national incentives i.e. Return to Practice.
- Bespoke education and training
- Streamline recruitment processes and internal transfers
- National and International campaign.

Retain

- Internal work force investment
- Review leadership and team work, provide a frame work to support excellence and recognise effective team.
- Analyse workforce data and anticipate projections for retirement
- Offer coaching mentoring and support / clinical supervision
- Focus on workplace wellbeing
- Review exit interviews
- Review structures of working weeks and flexibility
- Review employee benefits and wellbeing offers

Although the above are not exhaustive, the Trust, with partners, are committed to ensuring safe staffing levels which, through education, training and new role development, deliver effective care. Promoting a culture of wellbeing, work life balance and recruiting staff with the right attitudes and behaviours, will enable the Trust to provide services which demonstrate a kind and caring environment, where patients experience and expectations are be exceeded.

Priority 2 – Safer Care

The Trust will continue to identify learning from incidents following robust investigation processes and disseminate this learning through tried and tested measures throughout the organisation.

The mortality review group will look to develop processes to ensure that structured judgement reviews are carried out for deaths within the organisation as part of its mortality review process and publish this data in line with national guidance recently issued. [6]

Falls

The Trust will continue to engage with the National Falls Collaborative, sharing best practice and embedding learning/innovation obtained through this route to continue to reduce not only the incidence of falls with harm but the overall number of falls deemed avoidable within the Trust. The Trust is committed to:

- Roll out of positive learning from the National falls collaborative
- Introduce mandatory training re: falls prevention for medical staff
- Review of nurse staffing in relation to period of high falls incidence
- Continue to up skill volunteers to engage with patient activities
- Embed the newly revised policy & practice in line with national guidance with regards to falls prevention to identify omissions and best practice
- Continue to utilise a recognised improvement methodology to inform falls prevention, thus positively impacting the number of falls that incur serious harm
- Embed falls prevention knowledge to develop a culture of falls prevention approaches across the Trust.

Preventing Infection

[6] National Quality Board (2016) National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. London: HMSO.

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 values of the Trust and our CCG.

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

- Increased awareness of antimicrobial resistance through delivery of an Antimicrobial Stewardship Programme.
- A strategy for reduction in gram negative bacteraemias (in particular *E.coli*) through a range of measures.
- Robust prevention and management of Carbapenemase Producing Enterbacteriaceae.
- Renewed focus on the environment and sustaining improvements made during 16/17.
- Influenza preparedness and prevention for patients and staff.
- Launch new annual training and recognition events for care homes and primary care providers.
- Development of the Surgical Site Infection Surveillance Team to include assurance of adherence to NICE guidance and evaluation of the MSSA screening programme in Cardiac Services.
- Strengthened education delivery to include forging links with the University of Wolverhampton
- Sustain *Clostridium difficile* reduction with a lower tolerance of individual cases.
- Review of the city wide strategy for Infection Prevention by September 2017.
- Evaluation of the IV Resource Team impact.

Goals:

- Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data
- Develop an infection prevention system in the wider healthcare community setting, to include care agencies and hospice settings
- Zero tolerance to avoidable health care associated infection
- Expand research activity of the Infection Prevention Team
- Sustain the Trusts' good reputation for Infection Prevention through team members participation in national groups and projects

Venous Thromboembolism (VTE)

Building on last year's work maintaining patient safety through accurate and timely VTE risk assessment will continue. A review of systems and processes used for the data collection to calculate the number of VTE risk assessments undertaken and a process of internally validating that data will devised.

The forthcoming year will see a continuation on the focus of the quality VTE prevention via the following workstreams:

- A key area requiring attention is to reduce the number of patients who miss doses of prescribed thromboprohylaxis. This will be continued to be monitored though weekly VTE prevention audit.
- New educational programmes for medical and nursing staff are in development and will be implemented over the year.
- A larger scale audit is again planned for May.
- VTE group will continue to update patient pathways and protocols adapting to new ways of working and opportunities to integrate more widely with the community teams.

Pressure Injuries

The Trust has a Tissue Viability strategy, which is a 3 year plan to improve prevention of all types of wounds and improved wound healing across the health economy, hospice and local authority. The Trust is working on a number of priorties including:

- Reviewing the wound formulary, a pathway at a time. This will then have quality outcomes to measure against.
- Wound product orders are being monitored on a weekly basis to ensure changes are made to comply with the formulary and pathways. The CCG also submits drug tariff reports to be analysed to have a consistent approach across the city
- Many other pathways will be launched in 17/18 including:
- Venous, arterial and lymphoedema pathway, which has been designed in collaboration with the Vascular, Dermatology and Wolverhampton Lymphoedema service. The assessment document has been redesigned to support the pathway and will be launched along with the new wound assessment process for the Adult Community services.
- Moisture associated dermatitis prevention pathway
- Debridement and biofilm prevention pathway
- Managing and infected wound pathway
- Wound exit site pathway
- Post operation wound pathway
- Perianal abscess and pilonidal sinus pathway
- Burns pathway

The Trust is working collaboratively with the CCG to design education pathways for the local authority, with an aim to prevent some of the inherited pressure injury incidence. There is also a working group looking at the patients journey for wound care with an aim to have a wound care centre of excellence process within the community setting.

Sign up to Safety

As we enter 2017/18 our actions are to work more closely with Maternity, ED and Orthopaedics to roll out the Team optimisation model in addition to increasing the participation of staff from the high risk areas in the current intervention PCM. The intended benefits of the Project are expected to include improved patient experience and outcomes as a result of an enhanced safety culture and climate at team level, improved staff wellbeing and morale. For patients there is improved empathy in communication and skills to communicate the message across and overall better team environment to receive care.

Medication Errors

The Trust will continue to embed the role of the recently appointed Medication Safety Officer who will support the following initiatives:

- The Medicines Safety Group will run campaigns across the year on missed doses and allergy status.
- Pharmaceutical input to all wards is being reviewed to increase the clinical input in line with the Carter report recommendation (80% of pharmacist time on clinical duties)[7]
- The Controlled Drug Accountable Officer will deliver a report on controlled drug usage from safe storage to effective prescribing following full Trust audit.
- The number of trained independent prescribers will be increased and utilised in clinics
- New model of medicines supply closer to patients being tested using satellite dispensing on wards
- Medication error categories will be updated on Datix to allow more targeted analysis and increase shared learning.

Sepsis

The Trust has recently appointed two members of the medical team to lead the workstreams to increase timely identification of sepsis within patients and ensuring that the necessary interventions are timely, they will also lead and support the following initiatives:

- Involvement in the Deteriorating Patient Group with a clear remit of sepsis focus
- Review of Case Studies/RCA's/Audits to identify key learning regarding sepsis management
- The continuation of Trust wide Sepsis study days

[7] Lord Carter (2016) Operational productivity and performance in English acute hospitals: Unwarranted variations. London: HMSO.

- Trust wide launch of the new sepsis screening tool
- A Trust premier of the “Starfish” movie launched by Dr Ron Daniels Chief Executive of The UK Sepsis Trust and CEO of the Global Sepsis Alliance to raise awareness
- The launch of a bespoke e-learning package and educational programmes for all practitioners

This is one of the key areas that the Trust will focus on as part of the patient safety agenda in the forthcoming year, recognising that there is important work to be done.

Priority 3 – Patient Experience

1. **Increased Patient and User Engagement (carried forward from last year and will include building on current links within the community in particular the marginalised groups and embedding the patient voice at strategic level).**

Whilst the Trust has made some significant improvements with increasing patient and user engagement, in particular the setting up of an Equality, Diversity and Steering Group, it is felt that there is still room for improvement.

Finding ways to improve meaningful patient involvement and engagement with patients at the centre of the services we provide is paramount, and we wish to explore how we can improve their involvement and have meaningful engagement with our patients.

To achieve this we will implement a broad range of initiatives to encourage patient involvement. These will include reviewing how we can make it easier for our patients to feedback on their experience, improving patient information, including them in relevant working groups with our staff and inviting them to participate in the design, planning and delivery of any new services.

Our aim during 2017/18 is to increase public and patient engagement, in particular to create a Council of Members in replace of its current Patient Experience Forum which will ensure that the voice of the patient is embedded throughout the organisation at a strategic level.

The suggestion of a Council of Members is being proposed to drive forward and actively contribute to:

- Providing a patient and carer perspective on Trust patient related strategies and initiatives
- Reviewing performance monitoring data with regards to patient safety, quality and experience issues
- Reviewing and commenting on the Trust’s compliance with the Care Quality Commission’s (CQC) five quality domains and responsibilities
- Reviewing the implementation of the patient experience and engagement strategies for effectiveness
- Advising the organisation on how patient experience could be improved

- Engaging with the organisation where required in terms of providing membership views on identified projects and work streams
- Representation at internal forums such as the Leadership Council and PSIG

The benefits of using a Council of Members to help us achieve these objectives, are they are patients and members of our local community who have an outsider view of the organisation and can act as our 'critical friend'. It is felt that with their support and input, throughout the organisation, the strategic objectives can be achieved and our relationship with those we engage with will be broadened. It is hoped that by applying a targeted recruitment and selection process to membership, this will differ to PEF as appointed members will need to demonstrate key skills and attributes relevant to the remodelled role.

In particular we will be focusing on improving patient involvement and user engagement through the creation of a Council of Members

2. **To review the PALS and Complaints services**

This will include:

- Refining the complaints policy further to enhance how the Trust responds to complaints and other forms of patient feedback.
- Review how the Trust supports the organisation on how it handles complaints and other forms of patient feedback effectively and efficiently whilst ensuring that the volume of complaints escalated to the Parliamentary Health Service Ombudsman remains low.
- Implementing an additional level of scrutiny for cases where complainants remain dissatisfied, and incorporating this into the complaints management process

3. **Continue to introduce and enable technology to support the overall patient experience feedback mechanism.**

    - Introduce an effective and timely telephony system for the public to have direct access to the complaints and PALS team
    - Explore different software packages to assist in the administration of recording of patient feedback

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 38 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 Royal Wolverhampton NHS Trust has reviewed all the data available to them on the quality of care 38 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 83% of the total income generated from the provision of relevant health services by The Royal Wolverhampton NHS Trust for 2016/17.

The Trust has reviewed the data against the three dimensions of quality; 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.

Participation in Clinical Audits

During 2016/17 there were 61 applicable national clinical audit projects (and their respective work streams) and 3 National Confidential Enquiries covering relevant health services that The Royal Wolverhampton NHS Trust provides.

During 2016/17 The Royal Wolverhampton NHS Trust participated in 89% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Royal Wolverhampton NHS Trust were eligible to participate in, and for which data collection was completed during 2016/17 are shown in the tables below

The Trust has submitted 100% of the required number of cases for all national audit projects. Please note that 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 National Confidential Enquiries that The Royal Wolverhampton NHS Trust participated in during 2016/17 are as follows:

National Confidential Enquiries	Participated
Chronic Neurodisability (2967)	Yes – In Progress
Young People's Mental Health (2968)	Yes – In Progress
Non-invasive ventilation (2993)	Yes – Awaiting Report

The 7 national clinical audits that The Royal Wolverhampton NHS Trust did not participate in during 2016/17 are as follows including rationale as to why the Trust did not participate:

National Clinical Audit, Enquiry or Programme	Workstream/ Component	Directorate	Rationale
Child Death Database	Database Development - Feasibility Study	Paediatrics	The Trust has not been invited to participate in this audit by the provider. Project is Database development only.
Endocrine and Thyroid National Audit		Head & Neck	MDT lead for Thyroid Cancer reported that the Trust had not been invited to participate in this audit.
National Cardiac Arrest Audit (NCAA)		Resuscitation Team	Resuscitation Team advised that data captured would be of extremely limited value to the Trust and that assurance is evidenced via local audit.
National Complicated Diverticulitis Audit (CAD)	Acute surgical services	General Surgery	The Trust was unable to participate in this audit due to its complexity and the time commitment involved.
National Diabetes Audit - Adults	National Pregnancy in Diabetes Audit	Obstetrics	The Trust was unable to participate in this audit due to limited resources.

National Ophthalmology Audit	Adult Cataract surgery	Ophthalmology	New electronic system installed so currently insufficient data available. A minimum of 6-12 months data would be required for a meaningful audit.
Stress Urinary Incontinence Audit		Gynaecology	The Trust did not participate due to the complexity and expense of subscribing to this audit, due to individual medics having to purchase their own licence to input their own data onto the database. The relevant assurance on stress incontinence is determined locally.

The national clinical audits that The Royal Wolverhampton NHS Trust did participate in during 2016/17 are shown in Appendix 1.

The national clinical audits that The Royal Wolverhampton NHS Trust continues to participate in since 2016/17 (remain in progress) are shown in Appendix 2.

The reports of 20 completed National clinical audits projects that were reviewed by the provider in 2016/17 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 438 clinical audits were conducted across the Trust, 84% of which were completed by the end of the financial year. The adjusted completion rate for 2016/17 (excluding national audits) was 92%.

Clinical Audit Outcomes

The reports of 369 clinical audits (completed to date) are shown in Appendix 4 were reviewed by the provider and a compliance rating against the standards audited agreed. The following 59(16%) audits demonstrated **moderate or significant non-compliance** against the standards audited. The Royal Wolverhampton NHS Trust intends to take the following actions to improve the quality of healthcare provided and will re-audit against these standards in 2017-18.

Participation in Clinical Research

National studies have shown that patients cared for in research active acute NHS Trusts have better clinical outcomes. The availability of research across clinical services at RWT 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 Trusts' 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, has continued to be developed during the year.

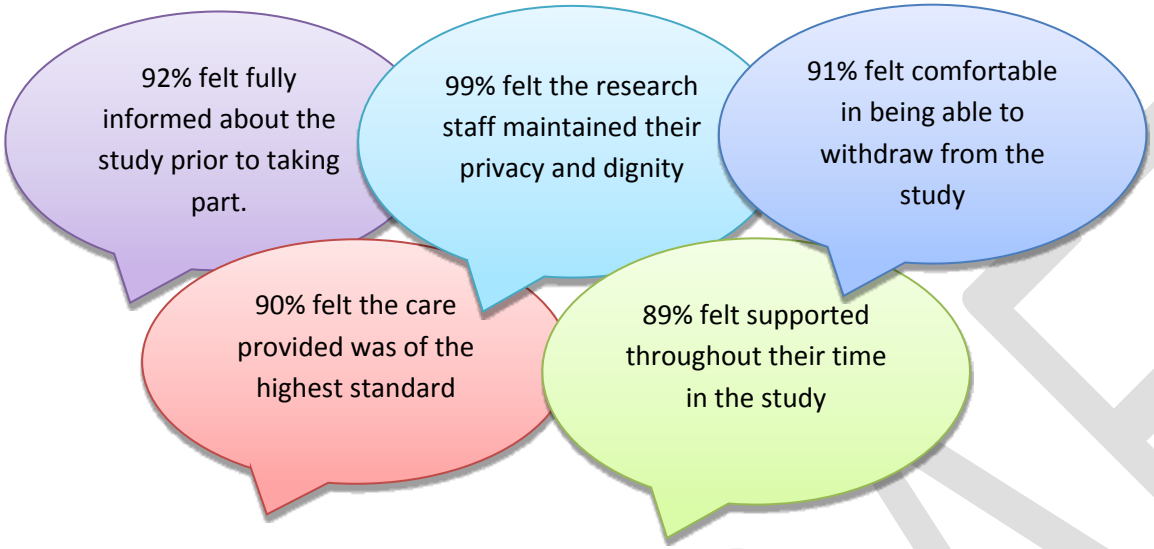
The Trust is measured against a range of national performance indicators covering recruitment into studies, increasing access to commercially sponsored research and reducing the time to set-up studies. The Trust has worked hard to improve its performance in these key areas, whilst ensuring that the high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

The number of patients receiving health services provided or sub-contracted by The Royal Wolverhampton NHS Trust in 2016/17 recruited to participate in research approved by a research ethics committee was in excess of 2,600. Over 260 studies have been active during the past year. Of these participants, more than 2,300 were recruited into studies adopted onto the National Institute of Health Research (NIHR) Clinical Research Network Portfolio, exceeding the target of 2000 set at the beginning of the year. This represents a 19% increase in recruits compared to 2015/16.

There was also an increase in the number of NIHR adopted industry sponsored clinical research studies opened at RWT during 2016/17 – 42 compared to 39 in 2015/16.

The Trust research teams have this year received national recognition for their recruitment into studies within a number of clinical areas including Cardiology, Rheumatology and Dermatology. In addition, two staff members have received Clinical Research Network (CRN) and Trust awards respectively in recognition of their achievements and exceeding expectations in supporting research at RWT.

The R&D Directorate at RWT activity seeks feedback from research participants on their experiences of research activity at the Trust. Our most recent patient experience questionnaire, including 512 participants of research during 2016/17, showed the following levels of satisfaction:



97% of participants felt research is important to improve healthcare services.
74% would consider participating in research again.
87% would recommend participating in research to a friend or family member.

Statements from the Care Quality Commission

The Royal Wolverhampton NHS Trust is required to register with the Care Quality Commission and its current registration status is registered with no conditions.

The Care Quality Commission has not taken enforcement action against The Royal Wolverhampton NHS Trust during 2016/17.

The Royal Wolverhampton NHS Trust has participated in an announced review of the Walk-In Centre based at the Phoenix Site. The report is currently in draft, undergoing factual accuracy however, overall the feedback appears to be extremely positive.

The Trust received a:

- Notice of Contravention issued on the 28th April 2016 to Nuclear Medicine for a contravention of :

the Management of Health & Safety at Work Regulations 1999 Regulation 3 risk assessment,
Ionising Radiation Regulations 1999 Regulations (7), prior risk assessment, (14) Information, instruction & training, (17) Local Rules & Radiation Supervisors, (32) equipment used

- An Advisory visit for Pathology for the Brucella incident, no formal notice received at the time of this document being produced.

The Royal Wolverhampton NHS Trust last participated in an announced hospital inspection in June 2015. This resulted in an appeal being submitted in October 2015, disappointingly the outcome of this appeal was not received until October 2016. Within the outcome findings there was acknowledgement from the Care Quality Commission of process errors were made in the original review findings.

The following ratings were amended as follows:

New Cross Hospital

Children and Young People - Safe and Well Led both changed from Requires Improvement to Good. Changing the overall service rating of Requires Improvement to Good.

Cannock Chase Hospital

Urgent and Emergency Care – Safe and Well Led changed from Requires Improvement to Good. Increasing the overall rating from Requires Improvement to Good.

Community Services

Children and Young People Services – Changed the rating for Caring and Well Led from Good to Outstanding. Changing the overall service rating from Good to Outstanding

The overall rating for this Trust remains ‘Requires improvement’.

The detailed action plan which was subsequently developed to address concerns raised has subsequently been closed with some of the more substantive actions being monitored through other routes. For example safer staffing levels being actioned through the recently launched Nursing Recruitment and Retention Strategy.

	Safe	Effective	Caring	Responsive	Well Led	Overall
Urgent and Emergency Services	Requires Improvements	Good	Good	Good	Good	Good
Medical Care	Inadequate	Good	Requires Improvements	Good	Requires Improvements	Requires Improvements
Surgery	Good	Good	Good	Good	Good	Good
Critical Care	Requires Improvements	Good	Good	Good	Requires Improvements	Requires Improvements
Maternity and Gynecology	Requires Improvements	Good	Good	Good	Good	Good
Children and Young People	Good	Good	Good	Good	Good	Good
End of Life Care	Requires Improvements	Good	Good	Good	Good	Good
Outpatients and Diagnostic Imaging	Requires Improvements	Inspected but not rated	Good	Requires Improvements	Requires Improvements	Requires Improvements
Overall	Requires Improvements	Good	Good	Good	Requires Improvements	Requires Improvements

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

The Royal Wolverhampton NHS Trust will be 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

- Use external/internal data quality reports
- Use standardised and itemised data quality processes in SUS data submissions monthly
- Hold bi-monthly meetings with Commissioners with a set agenda to discuss data quality items
- Hold bi-monthly Trust Data Quality Meetings to manage / review practices and standards

NHS Number and General Medical Practice Code Validity

Clinical Coding Error Rate

The Royal Wolverhampton NHS 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 Information Governance Standards Level 3. The area Audited for this was Admitted Patient Care for General Surgery and General Medicine.

The error rates reported in the latest audit for that period are detailed below and were based on a small sample of 200 Finished Consultant Episodes.

General Surgery Admitted Patient Care diagnoses and procedure coding (clinical coding) were:
Primary Diagnoses Incorrect 2%
Primary Procedures Incorrect 4%

General Medicine Admitted Patient Care diagnoses and procedures coding (clinical coding) were:
Primary Diagnoses Incorrect 1%
Primary Procedures Incorrect 1%

The overall Healthcare Resource Group error rate for the audit was 1.5% of the total number of episodes, which is a change of 0.6% absolute and -0.2% net.

All recommendations following the audit have been completed.

NHS Number and General Medical Practice Code Validity Updated as per Month 10 2016/17

The Royal Wolverhampton NHS Trust submitted records during 2016/17 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 2015/16 submission, which included the patient's valid NHS number:

- 99.9% for admitted patient care;
- 99.9% for outpatient care; and
- 98.2% for accident and emergency care.

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

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and ED

Information Governance Toolkit

Information Governance Toolkit Return 2016/ 2017

The annual self-assessment submission (V14) on the Information Governance Toolkit to the Department of Health for 2016/17, the overall scores are as follows:

- RL4 - The Royal Wolverhampton NHS Trust – 79% Satisfactory (45 requirements)
- M92654 - MGS Medical Practice – 100% Satisfactory (13 requirements)
- M92007 - Lea Road Practice - 100% Satisfactory (13 requirements)
- M92002 - Alfred Squire Practice - 100% Satisfactory (13 requirements)
- M92640 - Tettenhall Road Practice - 100% Satisfactory (13 requirements)

Looking forward to 2017/18 for Information Governance

The Trust are continuing to monitor patterns and trends of Information Governance incidents and implementing measures to reduce these to the lowest level practicable, in line with the Trusts Information Governance Strategy 2016-18. An IG risk profile is also being developed in order for the Trust to identify and manage IG risk.

The Trust has started a programme of work to ensure compliance with the new General Data protection regulation 2016 (GDPR) in readiness for May 2018 when the regulation comes into force. The Trust is also working closely with GP Partnerships that have joined the organisation to align practices and share good practice.

Core Quality Indicators

The data made available to the Trust by the Information Centre with regard to-

(a) The value and branding of the Summary Hospital-Level Mortality Indicator ("SHMI") for the Trust for the reporting period 2016/17;

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

The Royal Wolverhampton NHS Trust (RWT) has a robust mortality governance system and is continuously striving to improve processes to help minimise avoidable in-hospital mortality. The Trust uses a variety of mortality monitoring measures such as unadjusted mortality rates, standardised mortality rates (Summary Hospital Level Mortality Indicator – SHMI*) and qualitative information from deceased patient case note reviews.

We benchmark our performance using the information published by the Health & Social Care Information Centre (HSCIC) and more sophisticated analysis provided by the Healthcare Evaluation Data (HED**).

**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 on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge.*

***The HED analytics system developed by the University Hospitals Birmingham NHS Foundation Trust is widely used across the West Midlands and nationally as a comprehensive surveillance tool for clinical outcomes as well as effectiveness.*

For 2013-2015 the SHMI for RWT has been lower than or equal to the England average and banded "as expected". For the past 18 months the SHMI for RWT has increased at decimal level and was banded "as expected" (Fig. 1).

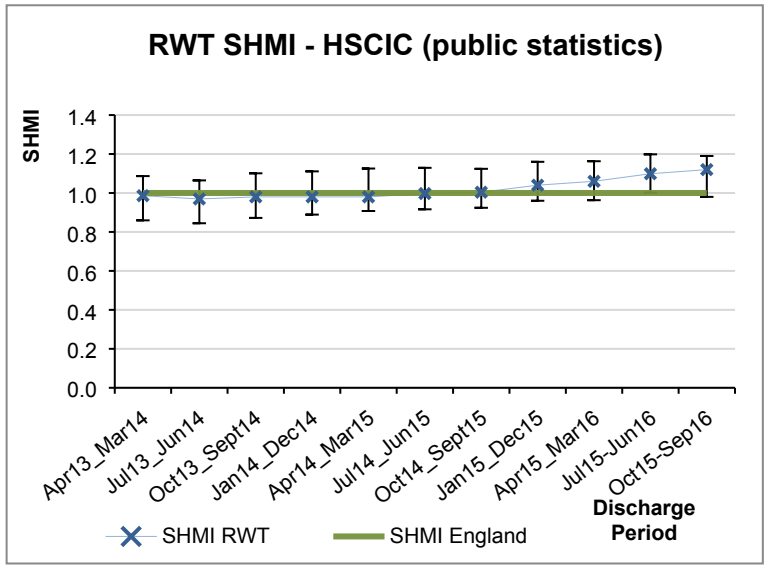


Fig. 1 RWT's SHMI by publication period

For the latest publication (October 2015 to September 2016) the SHMI for the Trust is 1.1, and banded "as expected". Fig. 2 shows the SHMI for RWT in the national context for the latest publication.

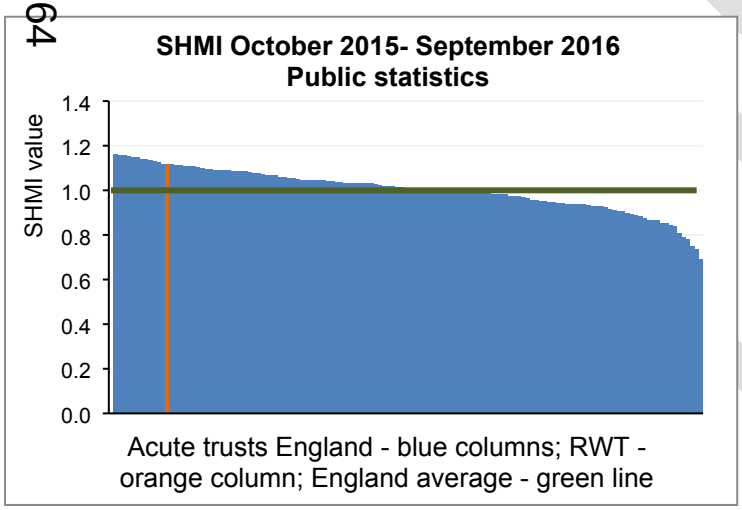


Fig. 2 RWT's SHMI for the latest 12 months

The table below shows RWT's SHMI for the last two publication periods, together with the highest and lowest SHMI values recorded in England and their banding.

	Reporting Period	
Indicator	October 2015 - September 2016	July 2015 - June 2016
RWT SHMI	**1.1**	**1.1**
Banding	as expected	as expected
England Average	1	1
Highest SHMI value in England	1.2	1.2
Banding	higher than expected	higher than expected
Lowest SHMI value in England	0.7	0.7
Banding	lower than expected	lower than expected

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

The Trust has implemented its own methodology for retrospective case note reviews of deceased patients, drawing on national research conducted in England. Following the publication of the new national guidance on learning from deaths in late March 2017, the Trust is in the process of reviewing its internal processes in order to align them with the newly released guidance. The plan and revised mortality review policy will be published in due course. The Trust has opted to be an early adopter, together with other 39 acute Trusts in England, of the structured mortality review methodology developed by the Royal College of Physicians.

Clinical and executive committees continue to regularly monitor and review the mortality information, statistics and other available relevant information, to provide oversight of Trust and directorates' outcomes and performance. The Trust is in the process of commissioning external reviews of clinical pathways and mortality case note reviews for additional assurance in relation to clinical care.

Data quality and accuracy of clinical coding can affect to a very high degree the mortality statistics. The Trust has made sustained efforts to improve quality and accuracy of data so that the statistics reflect a true picture. A program of external reviews is currently being rolled out to provide additional assurance in relation to data quality.

(b) The data made 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 deaths reported in the SHMI dataset, where the patients received specialist palliative care as identified by the clinical coding. This is an indicator designed to accompany the SHMI. The SHMI makes no adjustments for palliative care because there is considerable variation between Trusts in the coding of palliative care, which will have an impact on the national average. The Trust has seen a decline in the overall palliative care rate when compared to the national rate following the introduction of the new end of life care pathway. The variation could be explained by different recording and coding practices for specialist palliative care employed across England.

Indicator	Reporting Period	
	October 2015 - September 2016	July 2015 - June 2016
Percentage of spells reported in the SHMI with palliative care coding at either diagnosis or specialty level - RWT	1.25	1.28
Percentage of spells reported in the SHMI with palliative care coding at either diagnosis or specialty level - England	1.53	1.51
Percentage of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level - RWT	22.8	22.8
Percentage of deaths reported in the SHMI with palliative care coding at either diagnosis or specialty level - England	29.7	29.2

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

- The Trust is currently reviewing the processes of palliative care coding with regards to a multidisciplinary approach
- Each case that receives treatment from the principal management team will be cross referenced with the Somerset database for accuracy
- Each member of the multidisciplinary team that provides specialist palliative care will record, with the use of a stamp in patient's notes, to aid

the coding process
- Those end of life patients who require additional support from the specialist palliative nursing team will have activity coded at source

(c) 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 four surgical interventions using pre and post-operative survey questionnaires:

- Groin Hernia surgery
- Varicose vein surgery
- Hip replacement surgery
- Knee replacement surgery

The questionnaire doesn't differentiate between first time intervention or repeat surgery for the same procedure.

	April 13 - March 14	April 14 - March 15	National Average	Lowest Reported Trust	Highest Reported Trust
(i) Groin Hernia Surgery	0.84	0.86	0.085	0.015	0.979
(ii) Varicose Vein Surgery	0.84	0.84	0.093	0.023	0.99
(iii) Hip Replacement Surgery	0.76	0.74	0.438	0.319	0.991
(iv) Knee Replacement Surgery	0.67	0.69	0.319	0.187	0.974

Awaiting publication of recent data

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

For hip replacement there were 449 eligible hospital episodes with, 374 patients completed the questionnaire - a participation rate of 83.3% (higher than the 75.6% national average). Of the 374 post-operative questionnaires sent out 267 were returned, a response rate of 71.4% (marginally lower than the 73% average).

For knee replacement there were 637 eligible hospital episodes with, 589 patients completed the questionnaire - a participation rate of 92.5% (higher than the 75.6% national average). Of the 587 post-operative questionnaires sent out 415 were returned, a response rate of 70.7% (marginally lower than the 73% average).

For both hip and knee surgery the data demonstrates the RWT score to be above the national average with a slight reduction in performance for hip replacement and a slight improvement for knee surgery.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

PROMs data is reviewed at the Trauma and Orthopaedic governance meetings with the following actions identified:

- 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

(d) The data made to the Trust by the information centre with regard to Re-admission Rates

Emergency readmissions within 28 days

Readmissions			Grand Total
Age	2015/16	2016/17	
Aged 4-14	405	463	868
15yrs and over	5971	5466	11437
Grand Total	6376	5929	12305

Total Admissions			Grand Total
Age	2015/16	2016/17	
Aged 4-14	4945	5025	9970
15yrs and over	115631	118992	234623
Grand Total	120576	124017	244593

Percentage Readmissions			Grand Total
Age	2015/16	2016/17	
Aged 4-14	8%	9%	9%

15yrs and over	5%	5%	5%
Grand Total	5%	5%	5%

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

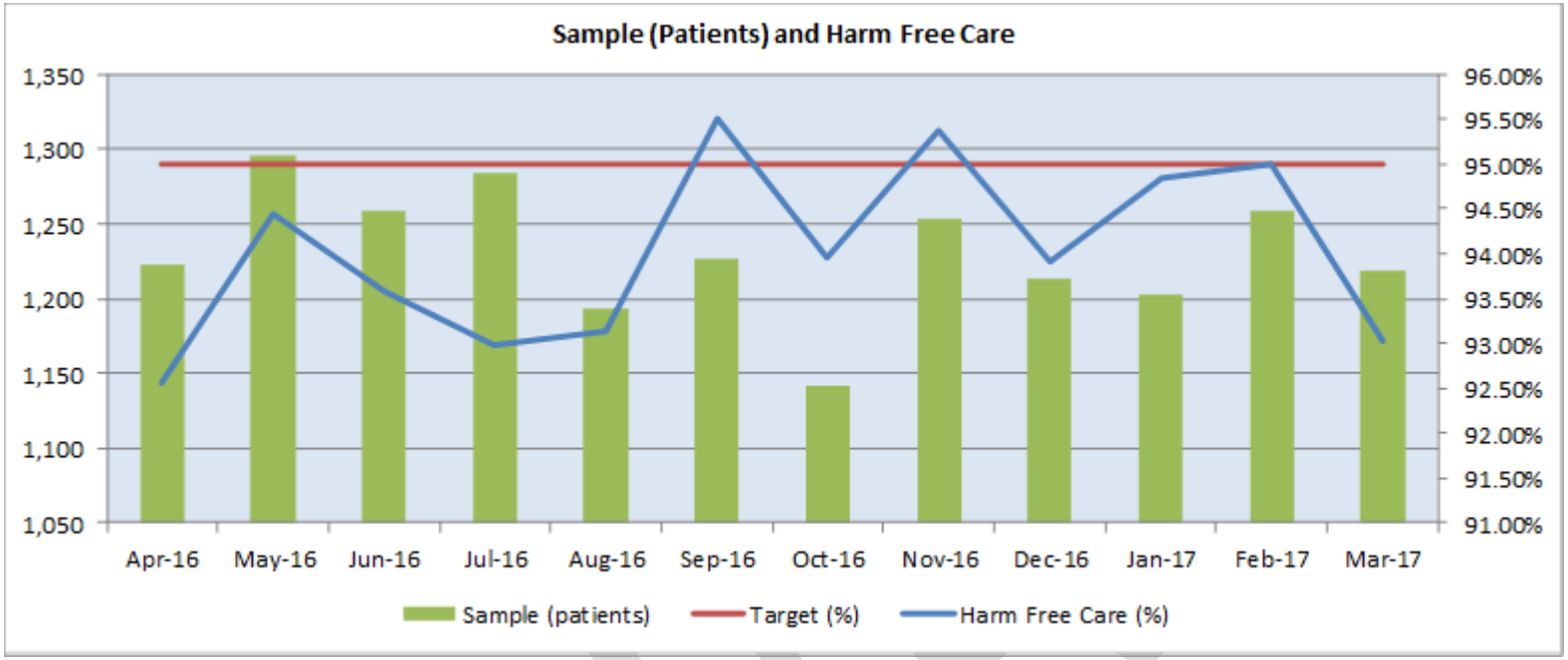
HSCIC no longer publish readmission data and therefore the Trust's internal data has been used, however this does not provide opportunities to allow benchmarking.

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 2017/18 by:

- Reviewing its discharge information provided to patients and relatives
- Ensuring that full and accurate details are included in the discharge summary
- Reviewing the discharge checklist
- Reviewing the current standardised letter templates
- Undertake regular conversations with patients and/or significant others regards discharge planning

(e) 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 Trust to analyse and triangulate performance.
- Data for each of the 4 harms is triangulated with that of internal incidence data reported via the Trust's datix system.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

- The Senior Nurses reenergised the Safety Thermometer collection tool in autumn 2016, to promote awareness of the prevalence of harm and associated learning in the Trust.
- Pressure injuries and falls are scrutinised using an accountability model, whereby root cause analyses are reviewed together with our commissioners for those with serious harm, this thereby ensures root causes are evidenced and lessons learnt explicit for communicating in to the Trust.

- Training regarding specific developments and learning for the 4 individual harms will be delivered through a range of forums and methods to ensure current evidence is used in practice
- The Trust will continue to work with its stakeholders to ensure that a city wide approach is taken.

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

(f) The data made to the Trust by the information centre with regard to VTE Prevention

	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
RWT	96.69%	96.82%	95.49%	95.90%	95.54%	95.29%	96.73%	96.60%
National Average	96.05%	95.86%	95.48%	95.53%	95.73%	95.51%	95.57%	
Trust with Highest Score	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Trust with Lowest Score	86.08%	75.04%	61.47%	78.06%	80.61%	72.14%	76.48%	

Awaiting publication of current data

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); and
- The denominator is the number of adult inpatients (including surgical, acute medical illness, trauma, long term rehabilitation and day case etc).

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

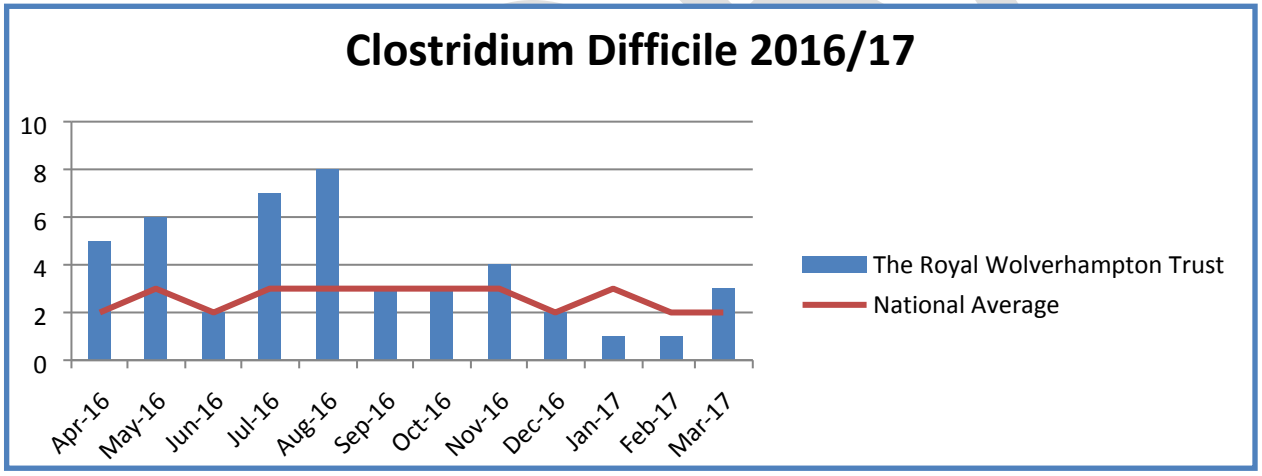
The VTE leads have the support of the Executive team to assist in promoting the importance of undertaking VTE assessments across the organization. The Trust is consistently meeting national targets and exceeding previous figures.

Multiple measures have been put in place to increase awareness of VTE prevention and management amongst all healthcare staff and some of the measures include-

- Creation of a bespoke intranet webpage to house all VTE and anti-coagulation related information in one place.
- Process mapping exercise to identify hurdles to better performance
- Building up links to individual directorates to better understand local issues which act as barriers. For example, this led to a local audit in Gynaecology and underpinned consistent improvements in VTE assessments achieved by this directorate.
- Trust-wide audits for a minimum of twice a year are now in place in addition to the focused rolling monthly audits both of which serve to inform and assure the Trust regarding not only completion of VTE assessments but the actual care provided at individual patient level with respect to VTE management.
- Rolling RCA process to identify errors and disseminate the learning derived to the Trust.

The Royal Wolverhampton NHS Trust intends to continue its efforts to become a VTE exemplar site and to maintain its percentage as close to 100% and seek on-going assurance not only regarding completed VTE assessments but also appropriate prescribing and use of VTE prevention measures and to reduce patient harm. Measures are currently underway to improve clinical pathways and guidance and tighten up on other aspects of VTE prevention and anti-coagulation including the use of newer oral anti-coagulants.

(g) The data made to the Trust by the information centre with regard to C Difficile



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Totals

The Royal Wolverhampton Trust	5	6	2	7	8	3	3	4	2	1	1	3	45
National Average	2	3	2	3	3	3	3	3	2	3	2	2	31

	2014/15	2015/16	2016/17
RWT	17.6	24.9	15.5
National Average	14.6	14.8	13.3
Trust with highest score	62.3	64.4	77.8
Trust with lowest score	0.00	0.00	0.00

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 annual programme of work, and this is supported by surveillance and indicator data, to include:

- NHS 'Safety Thermometer'
- Nursing quality metrics
- Laboratory data
- Domestic monitoring
- Mortality information
- National HCAI data capture system Monitoring
- Trust Infection Prevention and Control Group
- Environment Group
- Health and Safety Steering Group
- Clinical Quality Review Meetings
- Contract Monitoring Meetings

The Infection Prevention Team feed data, assurance and risks into various reporting structures, to include but is not limited to; Patient Safety Improvement Group, Quality Standards Action Group, Environment Group, Health and Safety Steering Group, Decontamination Committee, Trust

Management Committee and Trust Board.

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

The challenge of acute and community incidence of *Clostridium difficile* meant that new approaches were required in order to improve patient safety. These included:

- Novel treatment therapies; Fidaxomicin, a new antibiotic choice for *Clostridium difficile*
- Human Probiotic Infusion (HPI) have been used more frequently during the year. These have been incorporated into the treatment algorithm which ensures they are used more often with recurrent disease for improved outcomes.
- Environmental controls have been a top priority in our approach in tackling *Clostridium difficile;* the deep clean schedule has been completed with great effect, disposable mop heads have been introduced in the last year and a new wipe for decontamination of the environment and equipment was introduced within inpatient and health centre settings.

d)The data made to the Trust by the information centre with regard to Incident Reporting

2015/16 (Full Year Data)			2016/17 (April – September)		
Incidents	% resulting in death	% resulting in severe harm	Incidents	% resulting in death	% resulting in severe harm
10407	0.2% (19)	0.2% (16)	4571	0.3% (12)	0.1% (3)

Data source – Trust Data at present

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 and healthy 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 to the National Patient Safety Agency.
- The Royal Wolverhampton NHS Trust has taken the following actions to improve risk management and reporting and so the quality of its services
- The Trust has reviewed its policy and training to facilitate swift reporting and management review of incidents (including serious incidents)

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

- Trust will continue to communicate lessons learnt via risky business newsletter
- Governance officers will continue to share Route Cause Analysis summaries across all directorate governance meetings where applicable

(I) The data made to the Trust by the information centre with regard to National Inpatient Survey regards the Trusts' responsiveness to the personal needs of its patients

The National Inpatient Survey for 2016 surveyed patients who were discharged from hospital during July 2016.

The results of the Trust's National Inpatient Survey is not expected to be publically released until 31 May 2017 and final results will be put in the final draft of the document before publication.

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

Please note that 2016/17 figures shown are yet to be confirmed by NHS England and are based on the survey provider results only, however full details are publicised nationally 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 2017/18 by:

- An action plan is currently being developed to address the key findings of the report which are yet to be agreed. This will be reported on in due course and monitored through the Trust's governance arrangements to ensure that appropriate improvements are made.

(j) The data made 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 forms part of nursing metrics
- Analysis undertaken regards low performing areas and improvement plans implemented

Survey Response Rate

	Q1 2016/17				Q2 2016/17				Q3 2016/17				Q4 2016/17				2016/17 Average				2015/16 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	18%	13%	44.4%	0.4%	19%	13%	43.6%	0.5%	19%	12%	43.3%	0.3%	14%				17%				21%	14%	44.7%	0.3%
Inpatients	25%	25%	91.9%	4.8%	28%	24%	81.8%	6.0%	30%	24%	96.7%	4.9%	26%				27%				28%	25%	100%	6.3%
Maternity	14%	25%	72.2%	0.7%	12%	23%	59.8%	0.3%	15%	24%	81.7%	0.0%	11%				13%				18%	23%	73.7%	0.7%
Outpatients	21%	6%	90.0%	0.1%	18%	6%	48.3%	0.2%	19%	9%	56.3%	0.1%	19%				19%				19%	6%	78.2%	0.1%

Percentage of Patients who would recommend the Trust

	Q1 2016/17				Q2 2016/17				Q3 2016/17				Q4 2016/17				2016/17 Average				2015/16 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	80%	86%	98.7%	42.8%	82%	86%	98.0%	45.0%	84%	86%	98.0%	58.0%	85%				83%				82%	87%	99.9%	47%
Inpatients	92%	96%	99.7%	71.3%	93%	95%	99.0%	77.0%	94%	95%	99.0%	76.0%	96%				94%				91%	95%	100%	75%
Maternity	94%	96%	99.5%	87.0%	94%	95%	99.0%	71.0%	97%	96%	100%	82.0%	96%				95%				95%	95%	100%	77%
Outpatients	93%	93%	99.8%	77.5%	93%	93%	100%	67.0%	93%	93%	100%	74.0%	93%				93%				92%	92%	100%	51%

Percentage of Patients who would not recommend the Trust

	Q1 2016/17				Q2 2016/17				Q3 2016/17				Q4 2016/17				2016/17 Average				2015/16 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	12%	8%	37.7%	0.7%	11%	8%	33.0%	1.0%	10%	8%	33.0%	0.0%	9%				10%				9%	6%	29%	0.4%
Inpatients	4%	2%	10.6%	0.1%	3%	2%	10.0%	0.0%	3%	2%	7.0%	0.0%	2%				3%				5%	2%	11%	0%
Maternity	2%	1%	10.0%	0.3%	3%	2%	14.0%	0.0%	2%	1%	12.0%	0.0%	2%				2%				4%	2%	12%	0%
Outpatients	3%	3%	14.3%	0.1%	3%	3%	26.2%	0.3%	3%	3%	26.0%	0.0%	3%				3%				3%	3%	29%	0%

Page 78

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

- **Continue with work to ensure that the test is inclusive to all**

(k) The data made to the Trust by the information centre with regard to Supporting Our Staff
(Staff FFT, National NHS Survey and Chatback)

The Trust is one of the largest employers in its local community, employing over 8000 people. The detailed workforce profile is shown in section 1 of the Annual Report.

The Trust follows a number of established ways of engaging with staff in order to improve employee engagement and to support staff to continuously strive for excellence in patient care. These include the annual national NHS Staff Survey and the quarterly national Friends and Family Test. In addition, the Trust conducts an annual local staff survey called Chatback.

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 Q 1 2015/16 to Q 4 2016/17.

(a) Staff Friends and Family Test

Recommendation Rates - Work

	Q1 2015/16	Q2 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q4 2016/17
RWT	70%	70%	68%	70%	72%	
England	62%	62%	61%	64%	63%	
Highest	90%	90%	87%	89%	97%	
Lowest	22%	21%	27%	30%	29%	

Recommendation Rates - Care

	Q1 2015/16	Q2 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q4 2016/17
RWT	79%	80%	83%	79%	86%	
England	79%	79%	78%	80%	80%	
Highest	100%	100%	100%	100%	100%	
Lowest	44%	48%	51%	50%	44%	

Not Recommended - Work

	Q1 2015/16	Q2 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q4 2016/17
RWT	12%	14%	16%	13%	12%	
England	18%	19%	19%	18%	18%	
Highest	66%	61%	60%	57%	57%	
Lowest	4%	3%	4%	1%	0%	

Not Recommended - Care

	Q1 2015/16	Q2 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q4 2016/17

RWT	5%	7%	4%	5%	5%	
England	7%	7%	7%	6%	6%	
Highest	32%	27%	27%	28%	41%	
Lowest	0%	0%	0%	1%	0%	

(b) National NHS Survey
(c) Chatback

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

The Royal Wolverhampton Trust intends to take/ has taken the following actions to improve this, and so the quality of its services in 2017/18 by:

- Continuing to provide a supportive framework for staff to help staff continuously improve patient experience of care within the Trust.
- Ensure the following standards are in place: The Workplace Wellbeing Charter, The Workforce Race Equality Standards, The Equality and Delivery Scheme 2 and the Trust is working on The Workforce Disability Equality Standard. The Trust has also been recognised for the following Charters which demonstrate commitment to developing the workforce, thus ensuring that staff work within and experience a positive, caring environment in line with the Trust vision and values.

Our performance in 2016/17

Quality of care based on Trust performance – overview

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 2016/17	Performance 2016/17	2015/16	2014/15
*Cancer two week wait from referral to first seen date	93%	**93.62%**	94.71%	93.61%
*Cancer two week wait for symptomatic breast patients	93%	**95.34%**	95.77%	80.84%
*Cancer 31 day wait for first treatment	96%	**96.47%**	96.75%	97.15%
*Cancer 31 day wait for second or subsequent treatment - Surgery	94%	**86.51%**	92.80%	91.05%
*Cancer 31 day wait for second or subsequent treatment - Anti cancer drug	98%	**99.72%**	99.85%	99.89%
*Cancer 31 day wait for second or subsequent treatment - Radiotherapy	94%	**98.03%**	99.76%	99.89%
*Cancer 62 day wait for first treatment	85%	**77.47%**	75.89%	84.07%
*Cancer 62 day wait for first treatment from Consultant screening service	90%	**86.97%**	86.45%	90.20%
*62 Day Wait - Consultant Upgrade (Local target)	88%	**91.03%**	91.50%	92.73%
Emergency Department - total time in ED	95%	**90.66%**	91.76%	93.27%
Referral to treatment - incomplete pathways	92%	**90.89%**	93.07%	93.87%
Cancelled operations on the day of surgery as a % of electives	<0.8%	**0.42%**	0.69%	0.91%
Mixed Sex accommodation breaches	0	**1**	0	0
Diagnostic tests longer than 6 weeks	<1%	**1.10%**	0.0%	1.6%

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

Cancer Performance

The Trust managed to hit six of the nine (including one local) cancer standards during 2016/17.
The single biggest issue affecting the trust performance is late tertiary referrals. The operational protocol states that external providers must refer into the Trust by day 42 of the pathway. Evidence suggests that this is not happening frequently enough and leads to a number of breaches for the 62-day standard. Capacity issues impacted upon the Urology department which has led to problems seeing all patients within standard. However, this has been resolved towards the back end of the year.
The Trust has also hosted a review by the national intensive support team to identify areas for improvement and is currently partnering with Leeds Teaching Hospitals NHS Trust to identify other areas of good practice and learning.

Emergency Care

A new Urgent Care Centre opened within the ED department at the start of the 2016/17. This is managed by a private provider and saw the introduction of revised clinical pathways and new ways of working around triage and assessment. The benefits of this new approach took a while to embed and it was not until September 2016, following the implementation of the joint clinical triage process, that the full benefits of this have been felt.
There has been a 16% increase in attendances compared to the contracted activity across the quarter. This has led to operational pressures and is the primary reason for the Trust not being able to achieve the overall standard.

The Trust is committed to the "Physician A" model which has demonstrated reduced emergency admissions. This has enabled the Trust to maintain the number of beds it has open across the year and has resulted in significantly less pressure on bed stock across the winter period as a whole.

The Trust has already asked the Intensive Support Team (IST) to undertake a review and offer support and advice for improvement in 2016. The action plan developed a result of this is now fully embedded. To further support this, the Trust commissioned a "Human Factors" report to identify additional actions that could be taken to improve performance and are currently looking to implement these findings.

RTT Performance

The pressure on the Trust has grown again during 2016/17 with referrals 6% above planned levels. This has given rise to a number of specialties facing difficulties in achieving the 92% threshold. This is combined with a capacity issues with some specialties unable to recruit, despite repeatedly advertising and exploring networks and contacts. For RWT the capacity issue is most strongly felt in General Surgery and Urology.

Recovery Action Plans (RAPS) have been developed for a number of specialties and shared with commissioners for monitoring purposes and support for demand management.
The Trust has also invested in a capacity management tool that will provide more detailed support to operational teams in managing the workflow across the year.

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	Performance		
	2016/17	2016/17	2015/16	2014/15
Clostridium Difficile	35	**45**	73	51
MRSA	0	**0**	0	2
Referral to treatment - no one waiting longer than 52 weeks	0	**10**	0	0
Trolley waits in A&E not longer than 12 hours	0	**0**	1	0
VTE Risk Assessment	95%	**96.00%**	96.20%	96.90%
Duty of Candour - failure to notify the relevant person of a suspected or actual harm	0	**3**	1	1
Stroke - 90% of time spent on stroke ward	80%	**89.16%**	84.0%	86.0%
Maternity - bookings by 12 weeks 6 days	>90%	**90.40%**	89.1%	87.0%
Maternity - Breastfeeding initiated	>64%	**65.20%**	64.6%	63.8%

Healthcare-Associated Infection (HCAI)

The Trust has a well-established reputation for high standards in relation to HCAI. This can be evidenced with the second consecutive year of zero MRSA infections. Whilst not quite achieving the target for Clostridium Difficile, the Trust managed to reduce the number of cases by nearly 40% and had the best performance in any of the last three years.

Duty of Candour (DoC)

The Duty of Candour is a legal duty placed on a hospital to inform and apologise to patients if there have been mistakes in their care that have led to harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.

The Trust reported three incidents across the year where a breach occurred. In all three cases the DoC was applied and patients were informed of a lapse in care, however, the breach was reportable as we were no able to complete this task within the 10day time period required. A full analysis is done after each incident to determine where lessons could be learnt and to establish how to improve the standards of care provided.

Referral to Treatment (RTT) Performance

During 2016/17 the trust identified a reporting issue within Orthodontics. A full investigation was conducted that was able to provide assurance that no harm had come to any patients. However, whilst patients were being monitored and treated, not all of these were included within the reported numbers. As a result of this the Trust reported a number of breaches against the over 52 week RTT target during the year.

A robust recovery plan has been implemented which has seen this number managed and the plan is to have no patients waiting greater than 52 weeks by June 2017.

Appendix 1 – National Clinical Audits that RWT participated during 2016/17

National Clinical Audit, Enquiry or Programme	Workstream/ Component	Lead Directorate	Status of Audit
6th National Audit Project of the Royal College of Anaesthetists	Perioperative Anaphylaxis in the UK	Critical Care	Completed
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		Cardiothoracic Services	Completed
Adult Asthma		Respiratory	Awaiting Report
Adult Cardiac Surgery		Cardiothoracic Services	Completed
Asthma (paediatric and adult) care in emergency departments		Emergency Department	Awaiting Report
Cardiac Rhythm Management (CRM)		Cardiothoracic Services	Completed
Case Mix Programme (CMP)		Critical Care	Completed
Congenital Heart Disease (CHD)	Adult	Cardiothoracic Services	Completed
Consultant Sign-off (Emergency Departments)		ED	Awaiting Report
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		Cardiothoracic Services	Completed
Cystectomy Audit		Urology	Completed
Diabetes (Paediatric) (NPDA)		Paediatrics	Completed
Elective Surgery (National PROMs Programme)		Trauma & Orthopaedics/ General Surgery	Completed
Falls and Fragility Fractures Audit programme (FFFAP)	National Hip Fracture Database	Trauma and Orthopaedics	Completed
Medical and Surgical Clinical Outcome Review Programme	Non-invasive ventilation	Respiratory	Awaiting Report

National Audit of Dementia	Care in general hospitals	Care of the Elderly	Awaiting Report
National Comparative Audit of Blood Transfusion programme	Audit of Patient Blood Management in Scheduled Surgery	Pathology	Completed
National Comparative Audit of Blood Transfusion programme	Use of blood in Haematology	Pathology	Completed
National Comparative Audit of Blood Transfusion programme	Audit of Patient Blood Management in Scheduled Surgery	Pathology	Awaiting Report
National Emergency Laparotomy Audit (NELA)		Critical Care	Completed
National Heart Failure Audit		Cardiothoracic Services	Awaiting Report
National Joint Registry (NJR)	Hip replacement	Trauma and Orthopaedics	Completed
National Joint Registry (NJR)	Knee replacement	Trauma and Orthopaedics	Completed
National Lung Cancer Audit (NLCA)	Lung Cancer Consultant Outcomes Publication	Respiratory	Awaiting Report
National Prostate Cancer Audit		Urology	Completed
Nephrectomy audit		Urology	Completed
Radical Prostatectomy Audit		Urology	Completed
Sentinel Stroke National Audit programme (SSNAP)		Stroke	Awaiting Report
Smoking Cessation		Respiratory	Completed
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Acute Internal Medicine / General Internal Medicine	AMU	Completed
UK Cystic Fibrosis Registry	Adult	Respiratory	Awaiting Report

Appendix 2 – National clinical Audits that RWT continues to participate in and which remain in progress since 2016/17

National Clinical Audit, Enquiry or Programme	Workstream/ Component	Directorate	Status of audit
Bowel Cancer (NBOCAP)		Cancer Services	In Progress
Child Health Clinical Outcome Review Programme	Chronic Neurodisability	Paediatrics	In Progress
Child Health Clinical Outcome Review Programme	Young People's Mental Health	Paediatrics	In Progress
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	Rheumatology	In Progress
Head and Neck Cancer Audit		Cancer Services	In Progress
Inflammatory Bowel Disease (IBD) programme		Gastroenterology	In Progress
Major Trauma Audit		Emergency Department	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal morbidity and mortality confidential enquiries (cardiac, plus cardiac morbidity, early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	Obstetrics	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance	Obstetrics	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Obstetrics	In Progress
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance	Obstetrics	In Progress

National Audit of Management of Intra-abdominal sepsis	Acute surgical services	General Surgery	In Progress
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Pulmonary rehabilitation	Respiratory	In Progress
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Secondary Care	Respiratory	In Progress
National Diabetes Audit - Adults	National Core	Diabetes	In Progress
National Diabetes Audit - Adults	National Footcare Audit	Diabetes	In Progress
National Diabetes Audit - Adults	National Inpatient Audit	Diabetes	In Progress
Neonatal Intensive and Special Care (NNAP)		Neonates	In Progress
Oesophago-gastric Cancer (NAOGC)		Cancer Services	In Progress
Paediatric Pneumonia		Paediatrics	In Progress
Percutaneous Nephrolithotomy (PCNL)		Urology	In Progress
Renal Replacement Therapy (Renal Registry)		Renal	In Progress
Severe Sepsis and Septic Shock - care in emergency departments		ED	In Progress
UK Cystic Fibrosis Registry	Paediatric	Paediatric	In Progress

Appendix 3 – National clinical Audits reviewed by RWT in 2016/17 with actions intended to improve the quality of healthcare provided

Audit Title	Directorate	Compliance Rating	Actions identified to improve the quality of healthcare provided
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Cardiology	Moderate Non-Compliance	Meetings to be held with ED teams both here and Walsall Manor Hospital and Russell's Hall Hospital to facilitate a quicker patient pathway.
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	Critical Care	Not Applicable	No actions required. Purpose of audit was to inform development of new national standards.
Case Mix Programme (CMP)	Critical Care	Fully Compliant	Not applicable as results indicate that the ICU has performed above average for the past 5 years. ICU will continue to participate in ICNARC in order to maintain standards and provide the key quality benchmarking indicators.
Adult Cardiac Surgery	Cardiothoracic Surgery	Fully Compliant	No actions required. Cardiac surgery is well within safe practice in comparison with other units in the UK.
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions	Cardiology	Fully Compliant	No actions required. Meeting standards stipulated by BCIS.
Radical Prostatectomy Audit	Urology	Fully Compliant	No actions required. Meeting standards stipulated by BCIS.
Cystectomy Audit	Urology	Fully Compliant	No actions required. Satisfactory Trust performance against national figures. Detailed local audits also undertaken, particularly with respect to robotic cystectomy, to provide further assurance.
Cardiac Rhythm Management (CRM)	Cardiology	Fully Compliant	No actions required. Audit demonstrated complication rates are low with no mortality for this period and a good patient service.
Nephrectomy audit	Urology	Fully Compliant	No actions required. Results demonstrated efficient and a safe service.
National Joint Registry (NJR) **- Hip Replacement** **- Knee Replacement**	Trauma & Orthopaedics	Fully Compliant	No actions required. Data reviewed to ensure all surgeons are performing to appropriate standards.
Elective Surgery (National PROMs	Trauma & Orthopaedics	Fully Compliant	No actions required. Satisfactory Trust performance against

Programme)			national figures.
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Trauma & Orthopaedics	Moderate Non-Compliance	Junior Doctors to be made aware of the importance of good practice for hip fracture patients and mandatory tasks/data that has to be collated for all hip fracture patients in a timely fashion. This is done at junior doctor induction. Results to be reviewed monthly at Directorate Governance Meeting via the live NHFD website.
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Acute medicine	Minor Non-Compliance	No actions agreed. Demonstrated significant improvements in compliance.
National Comparative Audit of Blood Transfusion programme - Use of blood in Haematology	Pathology	Significant Non-Compliance	Implementation of audit and monitoring of transfusion requests and challenging requests which are deemed inappropriate.
Diabetes (Paediatric) (NPDA)	Paediatrics Acute	Minor Non-Compliance	Increased educational input required from Diabetes Team. Need for database to collect data has been escalated to Divisional Management.
National Prostate Cancer Audit	Urology	Fully Compliant	Missing datasets have been identified and addressed with the relevant Departments.
National Emergency Laparotomy Audit (NELA)	Critical Care	Minor Non-Compliance	Reminder of importance of the NELA suggested standard of care to all those involved in care of patients undergoing emergency laparotomy. Dr Claxton is to present findings to a wider audience including general surgeons to further raise awareness. Anaesthetic chart may be altered to reflect the p-possum documentation.
Congenital Heart Disease (CHD)	Cardiology	Fully Compliant	No actions required. Excellent patient outcomes for PFO closure with procedural success at 100% and 30 day mortality at 0% demonstrating excellent patient care.
Smoking Cessation	Respiratory medicine	Minor Non-Compliance	Implementing a smoking cessation unit into the mandatory electronic induction, targeting teaching sessions to all Junior Doctors, nominating "Stop Smoking" champions within AMU and SAU with the aim of increasing awareness. Offer the use of Nicotine replacement therapy to current smokers by Introducing a ward supply of Nicotine replacement therapy on wards such as AMU and SAU to reduce delay due to orders from pharmacy. Refer those identified as smokers to the Healthy Living Team and develop a smoke free environment in and around the hospital.

Appendix 4 – Local clinical Audits reviewed by RWT in 2016/17 with actions intended to improve the quality of healthcare provided

Directorate	Audit Title	Compliance Rating	Actions identified to improve the quality of healthcare provided
ED	Trust Wide OP07 Documentation Audit 16/17	Moderate Non-Compliance	The requirement for improved Documentation will be raised with staff via the Consultants meeting and also discussed at the Junior Doctors education sessions and local induction.
ED	Does the prescribing of Co-amoxiclav in the Emergency department follow Trust guidelines on prescribing?	Moderate Non-Compliance	Actions have been put in place to improve the availability of prescribing guidance and also to educate new doctors as they commence in ED re: which antibiotics to prescribe.
ED	Is the Emergency Department at New Cross Hospital following the Trust's neutropenia sepsis management protocol	Moderate Non-Compliance	Audit results to be presented to Junior Doctors and email to be circulated to all staff reminding them of the antibiotic requirements.
ED	Assessment of children with self-harm presenting to the emergency department (NICE CG16)	Moderate Non-Compliance	Email circulation to all ED staff the requirement to discuss with young people where they would prefer to be admitted
Acute medicine	Heart Failure	Moderate Non-Compliance	Inclusion in Junior Doctors training to reinforce the importance of undertaking BNP and also the importance of daily weights and fluid restriction in heart failure patients.
Acute medicine	Atrial Fibrillation	Moderate Non-Compliance	AMU consultants to counsel all patients around need for anti-coagulation if appropriate after assessment and offer choice of agent. If NOAC chosen, to initiate immediately. To liaise with the cardiology team about guideline update. Improve availability of informative leaflet about Atrial fibrillation and risk of stroke, NOAC.
Acute medicine	The initial assessment of delirium on AMU	Significant Non-Compliance	Delirium guidelines are currently in development for use across the Trust and the Acute Medical Units clerking booklet is currently being reviewed to incorporate a delirium stamp/ prompt to remind staff to undertake an assessment.
Cardiology	ECG Training and standards at RWT	Significant Non-Compliance	Access to training e-learning provided intranet site. Risk assessment to be undertaken. Liaise with medical Equipment Team particularly regarding the status of training. Increase awareness of the appropriate stock that the ECG Trolley should contain.

Cardiology	National Heart failure (HF) Audit - 2014/15 data	Moderate Non-Compliance	Additional Heart Failure Cardiologists employed.
Cardiology	National Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) Audit - 2014/15 data	Moderate Non-Compliance	Meetings to be held with ED teams both here and Walsall Manor Hospital and Russell's Hall Hospital to facilitate a quicker patient pathway.
Cardiology	Weekend discharges: a look at delays in the pathway on the cardiology ward	Moderate Non-Compliance	Directorate to discuss if use of expedited (abridged) e-discharge would see a decrease in time from decision to actual discharge. All clinicians would be able to access and complete this when there are no medication changes.
Cardiothoracic Surgery	Compliance with IRMER regulations for CXR review on CICU (Previous audit ID 2426)	Moderate Non-Compliance	Do not report from the X ray machine due to poor resolution. Aim to report within an hour
Care of the elderly	Falls Assessment recording in West Park Hospital	Moderate Non-Compliance	Addition of Falls documentation training to locum induction; Medical staff reminded of their responsibilities in CP42
Care of the elderly	In-hospital prescribing of anti-psychotics and benzodiazepines to patients with dementia	Significant Non-Compliance	The Audit Convenor is going to share the findings with a Trust wide multidisciplinary group of staff (Clinical Audit Group). Delirium protocol to be developed and published. Consultant Nurse in Dementia to audit the utilisation of the 'About Me' document, presenting the findings on a regular basis and encouraging increased use of the document as a support to clinical care
Care of the elderly	Utilisation of the About Me document across the Trust	Moderate Non-Compliance	Documented reminder in clinical notes by Dementia Outreach Service Dementia Outreach Service to begin to provide carers with information pack and check 'About Me' compliance Dementia Outreach Service led spot compliance audits to be reinstated on a quarterly basis.
Care of the elderly	Trust wide OP07 Documentation Audit	Moderate Non-Compliance	Documentation is being flagged up in a number of situations, consequently the ward managers and matrons are dealing with omissions immediately when they are identified..
Critical Care	Adherence to recommended cuff pressure guidance - a snapshot audit	Significant Non-Compliance	Invest in manometers and test regularly and modify practice.
Critical Care	Audit of anaesthetic record keeping	Moderate Non-Compliance	Deficiencies in completing anaesthetic chart have been highlighted to staff. To improve/ modify anaesthetic chart to include prompts for: temperature, GMC number/ stamp and

			ventilator parameters.
Critical Care	Audit of unscheduled patient transfers from Cannock to New Cross Hospital	Moderate Non-Compliance	To present audit to the Board and medical division to highlight the deficiencies in the system. T&O CD to review documentation of decision-making for transferred patients.
Critical Care	Availability of emergency guideline folders in anaesthetic rooms and theatres	Moderate Non-Compliance	We have agreed that despite the plethora of apps available, it is still a good idea to have a paper copy of emergency procedures easily accessible wherever anaesthesia is performed.
Critical Care	Awareness of the location of the difficult airway trolley, resuscitation trolley, Dantrolene and Intralipid.	Moderate Non-Compliance	Clinical Director has written to the Anaesthetic faculty and Matron has communicated to ODP staff to increase awareness of the location of emergency trolleys and drugs prior to the start of the list. WHO Surgical brief includes verbal confirmation that staff are aware of the locations of the Difficult Airway trolley, the Resuscitation trolley and the location of emergency drugs.
Critical Care	NICE CG83 - Rehabilitation after critical illness in adults	Moderate Non-Compliance	The rehabilitation group is an evolving service which has only relatively recently received funding. The future plan is to apply for charitable status and develop it further. Data collection for new patients entering the service is likely to be increased.
Critical Care	Obtaining informed consent for elective orthopaedic procedures utilizing patient information leaflets.	Moderate Non-Compliance	Pre-assessment teams across both hospital sites to ensure patients are given procedure-specific leaflets at pre-assessment stage.
Critical Care	Perioperative Management of Diabetes in Elective Surgery	Moderate Non-Compliance	New guidelines developed. Audit author to convene with CD to determine if 2 hourly or 1 hourly blood sugar monitoring is required intra-operatively and reinforce this message within the department.
Critical Care	Safe extubation - are we following guidelines?	Significant Non-Compliance	Incorporate extubation teaching and utility of neuromuscular monitors in induction for junior staff and Airway days. Consideration of trainees raising awareness of use of nerve stimulators.
Critical Care	VTE prophylaxis for patients undergoing elective caesarean section	Moderate Non-Compliance	Obstetric Department have made appropriate changes to risk assessment forms and obstetricians have been reminded to use it.
Dental	Case Mix Audit	Moderate Non-Compliance	To set standards on how to be scoring in order to achieve more coherent scores. Undertake assessment of patients scoring 15-20 and the reasoning for this.
Diabetes	Inpatient management of	Significant Non-	Place hypoglycaemia guidelines on all medical and surgical

	hypoglycaemia	Compliance	wards and nursing staff rooms / notice boards. Since some hypo-boxes have no guidelines in place, place a laminated copy within or near the range of the hypo box to provide easy access for staff to refer to.
Gastroenterology	Confirming correct placement of nasogastric feeding tubes	Significant Non-Compliance	Specific chart for on-going confirmation of nasogastric and naso-jejunal tubes. Mandatory use of Nasogastric Feeding Tube Insertion Confirmation sticker and further training to be provided to ward staff to improve compliance with the use, care and documentation of Nasogastric tubes.
Gastroenterology	Management of upper gastrointestinal bleeding secondary to peptic ulcer disease	Moderate Non-Compliance	Endoscopists to comment on antithrombotic resumption on endoscopy report.
General surgery	Medical And Surgical Clinical Outcome Review Programme National: Sepsis in emergency general surgery admission: A multi-centre audit	Moderate Non-Compliance	Create a sepsis proforma to use in the notes. On-line module on sepsis/ group training sessions for staff in triage and SAU.
Gynaecology	A Service Evaluation: Standard of Clerking of Emergency Admissions (EGAU Documentation Audit)	Moderate Non-Compliance	A new clerking proforma that is comprehensive and user-friendly has been introduced.
Head & Neck	Fractured Mandible Time To Theatre	Moderate Non-Compliance	We as a team have requested an extra list for our speciality which is currently under review.
Head & Neck	Patient Medical Record Documentation	Significant Non-Compliance	Distribution of OP 07 Health Records Policy Increase availability of patient sticker in records Ensure all members have a working identification stamp Re-audit in the next quarter
Head & Neck	Seven day working: Review of acute ENT patient admissions.	Moderate Non-Compliance	Seven day working being implemented in April 2017
Head & Neck	Surgical Intervention in Otitis Media with Effusion: Adherence to NICE Guidance	Significant Non-Compliance	Reminder to staff to provide written documentation to patients and their parents/carers and document this in the notes. Cover all aspects of the history especially behavioural problems, hearing fluctuations and balance problems. Clinicians need to be aware that a bilateral hearing loss of over 25-30dB needs to be present to indicate surgery. Education of all staff relating to the relevant NICE guidance. Ensuring clinicians complete a guidance checklist before requesting a ventilation tube

			insertion.
Oncology & Haematology	Audit of Neutropenic sepsis	Moderate Non-Compliance	Meeting with ED team. Increase Education. Care bundle to be completed and filed in notes
Oncology & Haematology	Neutropenia care	Moderate Non-Compliance	Staff training in ED to be rolled out again Guidelines to be updated to a simpler format for easier use and understanding.
Paediatrics Acute	A National Audit: Facing the Future	Moderate Non-Compliance	The directorate is implementing new Ward Round arrangements and have submitted a Business Case for extending Consultant presence on the ward.
Pathology	National Comparative Audit of Red Cells and Platelet use in Haematology Patients	Significant Non-Compliance	Training on pre-transfusion Hb and adverse events. Clinicians have been advised of the requirement of adequate documentation on the reason for transfusion if outside the standard. National Blood transfusion committee (NBTC) indicator codes have been added to the intranet.
Pharmacy	An audit investigating the prescribing patterns of Triple Therapy within the Wolverhampton region assessing compliance against national NICE recommendations.	Significant Non-Compliance	To present audit findings at pharmacy meetings stipulating the key areas for improvement. Also, to encourage members of pharmacy team to educate medical staff on wards making them aware of the importance of stating duration of therapy on discharge. Team to create a Triple Therapy guideline accessible to both medical and pharmacy teams.
Pharmacy	An audit of the level of compliance to the local surgical prophylaxis antimicrobial guideline	Moderate Non-Compliance	Antimicrobial guidelines to be reviewed on a regular basis and local education /training is required by the directorate to help improve compliance against the guidelines.
Pharmacy	An audit to assess whether doctors are prescribing oxygen therapy correctly and whether nurses are completing their required documentation on the drug chart.	Significant Non-Compliance	Local discussions at clinical pharmacy meetings have been used to raise awareness of this audit. The Respiratory Pharmacist Lead, Pharmacists and Ward Doctors have been informed of the keeping accurate oxygen prescribing and monitoring on the ward.
Pharmacy	Evaluate prescribers' compliance with Antimicrobial guidelines in surgical prophylaxis for hysterectomy patients; and evaluate compliance with World Health Organization Surgical Checklist and NICE guidelines	Significant Non-Compliance	Team will feedback to colleagues regarding the outcomes highlighted in this report. Further awareness for antimicrobial pharmacist and antimicrobial consultants is planned. This interaction will be used to highlight the importance of prescribing prophylactic antibiotics as per RWH antimicrobial guidelines.

	[CG74] Surgical site infections: prevention and treatment		
Radiology	Consent for tissue retention	Significant Non-Compliance	Communicate to consultant team the requirement to complete the section on the tissue removal on the consent form. Directorate are considering introducing a specific consent form for biopsy patients.
Radiology	IR(ME)R Audit : Compliance of Employers Procedure A. Identification	Significant Non-Compliance	All IR(ME)R operators have been presented with the results highlighting the areas of poor compliance. They have been provided with step by step instructions reminding them on how to complete patient identification.
Radiology	IR(ME)R Audit : Compliance of Employers Procedure D. Making Enquires of females of childbearing age to establish whether an individual is or may be pregnant	Significant Non-Compliance	All IR(ME)R operators have been presented with the results highlighting the areas of poor compliance. They have been provided with instructions on the six point check to remind them of the IR(ME)R Employers Procedure D regulation.
Radiology	Percutaneous nephrostomy salvage and tube exchange - are we following guidelines?	Significant Non-Compliance	Database has been set up to monitor appointments. Urologists have been informed that the Radiology Department need to be aware of patients with long term nephrostomies. Warning label in notes of all nephrostomies in use.
Radiology	To assess the number of patients presenting to New Cross with an acute deep vein leg thrombosis who should be considered for thrombolysis	Significant Non-Compliance	Consultant Radiologist has proposed writing a business case to offer catheter-directed thrombolysis therapy.
Rheumatology	An audit of management of osteoarthritis in adults (NICE CG177)	Moderate Non-Compliance	To record BMI. To make specific recommendations for analgesia and communicate that to GP. To document exercise advise given to patients. To consider use of questionnaires.
Rheumatology	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Moderate Non-Compliance	Identify a robust process for capturing 3 months of data on enrolled patients.
Sexual Health	2015-16: NICE Audit - Audit of PH33 NICE Guidelines Increasing the uptake of HIV testing in Black Africans (carried over to 2016-17)	Significant Non-Compliance	Further actions are required to review barriers around testing in Secondary Care and improve education to staff working in medical unit of the Trust.
Trauma & Orthopaedics	An audit of trauma theatre	Moderate Non-	Consider feasibility of implementing the 'Golden Patient'

	utilisation at New Cross Hospital	Compliance	principle. Present findings in Anaesthetic directory meeting in order to maximise improvements to help with delays.
Trauma & Orthopaedics	National Hip Fracture Audit- 2014 data	Moderate Non-Compliance	Detailed action plan has been drawn up by directorate including; on-going recruitment and further teaching for Junior Doctors at induction.
Trauma & Orthopaedics	National Hip Fracture Audit 2015 data	Moderate Non-Compliance	Junior Doctors to be made aware of the importance of good practice for hip fracture patients and mandatory tasks/data that has to be collated for all hip fracture patients in a timely fashion. This is done at junior doctor induction. Results to be reviewed monthly at Directorate Governance Meeting via the live NHFD website.
Trauma & Orthopaedics	Reasons for Delays & average waiting times for ORIF of wrist & Ankle fractures	Moderate Non-Compliance	Introduction of ice packs to ward. Discuss amongst consultant body possibility of transferring and operating on more wrist fractures at Cannock Hospital.
Trauma & Orthopaedics	Referral time from ED to fracture clinic	Moderate Non-Compliance	ED are now reviewing soft tissue injuries reducing the amount of referrals therefore this may already have had an impact on results. A re-audit is going to be conducted.
Trauma & Orthopaedics	VTE Assessments: A Punctuality Audit	Moderate Non-Compliance	To include VTE check part of routine observations. Raise awareness. Directorate Governance Lead has spoken to VTE Lead Nurse regarding the issues with VitalPac in ED. At induction juniors are informed of the VTE requirements.
Trauma & Orthopaedics	VTE assessments: a punctuality audit	Moderate Non-Compliance	Increase awareness of guidelines to new junior doctor's cohort.

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Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

25 May 2017

Report title	Update on the work of the suicide prevention stakeholder forum
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and wellbeing
Wards affected	All
Accountable director	Ros Jervis, Service Director Public Health and Wellbeing
Originating service	Public Health and Wellbeing
Accountable employee(s)	Neeraj Malhotra — Consultant in Public Health Tel — 01902 558667 Email — neeraj.malhotra@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Senior Management Team — 4 May 2017 People's Leadership Team — 8 May 2017

Recommendation(s) for action or decision:

The Panel is recommended to:

1. Provide feedback on the work of the suicide prevention stakeholder forum

Recommendations for noting:

The Panel is asked to note:

1. Note the suicide prevention needs assessment, strategy and action plan
2. Note what has been undertaken in 2016
3. Note the 'benchmarking' assessment that has been completed, comparing the forum, strategy and action plan against the Parliamentary Health Committee recommendations

1.0 Purpose

1.1 To inform members of the Health Scrutiny Panel of the city-wide work that is going on to reduce the risk of suicides in the City of Wolverhampton.

2.0 Background

2.1 Between 2013-2015, there were 66 suicides in Wolverhampton i.e. roughly 22 per year. At a meeting with the coroner in January 2017, he reported that in 2016 there were 14 suicides. Whilst the decline is welcome, one suicide is too many and these numbers are subject to fluctuation.

2.2 A suicide prevention needs assessment was undertaken in 2015. This was a collaborative effort by Public Health and wellbeing and the Samaritans. More than 20 local organisations were consulted as part of this needs assessment. Key findings can be found in the executive summary attached to this briefing report (appendix 1).

2.2 Following completion of the needs assessment, the suicide prevention stakeholder forum was established. Members of the forum include:
A range of Council services including Public Health and Wellbeing, Educational Psychology, Adult Services, HeadStart, the Clinical Commissioning Group, mental health trust, acute trust, prison service, the police, Network Rail, university, college, Papyrus, Samaritans, and a wide range of voluntary sector organisations: Refugee and Migrant Centre, P3, Voiceability, Changing lives, Wolverhampton Voluntary Sector Council, Heantun and Midland Heart. The forum is chaired by the Samaritans. The Lesbian and Gay forum did initially attend but that forum has since folded.

2.3 This forum has overseen the development of a strategy and action plan. Progress against this plan is monitored on a quarterly basis. The latest version of the strategy and action plan is attached to this report (Appendix 2).

3.0 Progress against the plan

As a result of the strategy, action plan and forum being in place, progress is being made to take a city-wide approach to reducing the risk of suicides occurring. Key headlines include:

3.1 In 2016, 70 people have received basic suicide prevention awareness training. In partnership with the Clinical Commissioning Group, plans are now afoot to deliver suicide prevention awareness training to GPs.

3.2 Suicide prevention awareness week 2016: a range of activities took place: a summary document is attached (Appendix 3). In addition, the Council needed to respond to a ‘campaign’ led by the national Samaritans team. The Council’s response is attached (Appendix 4).

3.3 Meeting with coroner: a meeting took place with the Director of Public Health and Wellbeing and the coroner. The coroner has agreed to inform the Council when suicide inquests are occurring so that representatives can attend. Additionally, he has indicated support for an audit of suicides to be undertaken in the future.

3.4 The forum oversees the information that is available to the public via the Wolverhampton Information Network and checks that it is up to date on a regular basis.

3.5 In December 2016, The Parliamentary Health Committee produced a report on suicide prevention which included a series of recommendations. The forum has reviewed how Wolverhampton is progressing against this set of recommendations. The full benchmarking report is available as an attachment to this report (Appendix 5).

4.0 Next steps

4.1 Roll out suicide prevention training to primary care practitioners.

4.2 Suicide prevention work for younger people: a programme of work in partnership with educational psychology to reduce the risk of suicide in young people has commenced.

4.3 Suicide prevention work with older people's services: a set of actions has been identified in partnership with adult services including training and embedding suicide prevention approaches into practice. Age UK will also be involved in this work.

4.3 Wolves in wolves: the arts project which will see 30 wolf sculptures placed around the city will include one that promotes mental wellbeing and seeks to reduce the stigma around mental ill-health including suicide. Members of the forum and their service users have been very involved in the design of this wolf.

4.4 Progress work to understand what is on offer for those bereaved by suicide and where possible and appropriate, involve those bereaved by suicide in the work of the forum.

4.5 Develop a stronger mechanism for the surveillance of suicides and self-harm by obtaining data on a routine basis such as self-harm admissions to hospital, mental health triage data, suicide information from the coroner.

5.0 Financial implications

5.1 £5,000 is available from the Public Health budget for 2017-18 to support both suicide prevention training and other general mental wellbeing activities.
[GS/04052017/X]

6.0 Legal implications

6.1 There are no immediate legal implications arising from this report.
[RB/17052017/S]

7.0 Equalities implications

7.1 Nationally, suicide is much more prevalent in males and there is a peak in the 30-34 years' age group. Stakeholder consultation identified migrants, men and deprived communities as being at the greatest risk of mental health problems locally. Sexual orientation is also a risk factor with the greatest risk being in gay men due to the discrimination that these groups may experience

8.0 Environmental implications

8.1 None

9.0 Human resources implications

9.1 None

10.0 Corporate landlord implications

10.1 None

11.0 Schedule of attached papers/documents

Appendix 1 Needs assessment executive summary
Appendix 2 Strategy and action plan
Appendix 3 Summary of suicide prevention awareness week activities
Appendix 4 Response to the national Samaritans 'campaign'
Appendix 5 Benchmarking the strategy and action plan against the Health Committee recommendations

Mental Illness and Suicide Prevention: Wolverhampton Needs Assessment 2015

A collaborative project between Wolverhampton City Council Public Health and Wellbeing Team and Wolverhampton Samaritans

Sarah Wilkinson [1], Foundation Year 2 Doctor in Public Health

July 2015

[1] *Contact for enquiries:* Neeraj.Malhotra@wolverhampton.gov.uk

Acknowledgements

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Executive Summary

This needs assessment is a collaborative project between the Wolverhampton Public Health Department and the Wolverhampton Samaritans, and has been based on consultation with local stakeholders working with the wider determinants of mental health. It profiles those adults at high risk of developing mental health disorders, with a particular emphasis on suicide; and maps which services are available to support these high risk groups in Wolverhampton. This will guide focussed outreach by the Wolverhampton Samaritans, inform local commissioning and highlight future areas for study.

Mental, emotional and psychological problems account for more disability than all physical health problems combined in the UK; and mental health problems are estimated to cost £105 billion annually in England. Suicide is the leading cause of death for 20-34 year olds in the UK and each completed suicide during working age costs £1.67 million in England.

90% of people who commit suicide had evidence of a mental illness prior to their death, but only 29.5% had been in contact with secondary statutory mental health services in the preceding 12 months. To reduce suicide at a population level, there should be both suicide-specific interventions and general measures to improve population mental wellbeing and engagement with services, with a view to helping the 60% who go on to complete suicide without being known to formal services.

Key Findings

Suicide is four times more common in men than women and this gap is widening nationally. The highest rates of suicide are in those aged 30 to 59 years – it has been high in the 30 to 44 age group for many years, but there is an upward trend in the 45 to 59 age group that doesn't yet show signs of plateauing. Ethnicity data is not formally collected by coroners. Globally, suicide rates are highest in Eastern Europe, and many Wolverhampton migrants originate from this area. Non-heterosexual sexual orientation is also a risk factor for suicide, with the greatest risk being in homosexual men.

Areas of deprivation are associated with increased suicide rates, and over half of Wolverhampton residents are in the most deprived 20% of the country. The recent recession may exacerbate this. Homelessness is higher in Wolverhampton than nationally, and multiplies the risk of suicide by nine.

Isolation increases the risk of suicide, whereas marriage confers protection against suicide. The risk of suicide is increased by bereavement – especially when a male partner loses their spouse. The risk of suicide in men is four times greater when their partner dies by suicide than by any other cause.

Risk of suicide risk increases with depression severity, and in Wolverhampton the incidence and prevalence of depression is higher than nationally. Mood disorder is the most common psychiatric diagnosis in inpatient suicide. Wolverhampton has a higher alcohol related hospital admission rate than nationally, and heavy drinking confers a three-fold increase in suicide risk. Physical illness also raises suicide risk, particularly in terminal and chronic conditions.

Local stakeholders were consulted through interviews with local organisation working with the wider determinants of mental health and through an online survey distributed to local primary care. This consultation showed that migrants, men and deprived communities were thought to be at the greatest risk of mental health problems locally. In contrast, women are more likely to approach their

GP for mental health support. The most commonly reported triggers for mental health crisis were (1) relationships, (2) employment, (3) housing and (4) drugs/alcohol.

The most common concerns with mental health support provision in Wolverhampton currently are (1) waiting times, (2) needing to be referred via GPs, (3) the system being too complicated (particularly with regards to dual diagnosis patients) and (4) language barriers. Waiting times were mentioned by more than 60% of community groups. Although the referral rate is lower for Wolverhampton IAPT than the national average, the waiting times are longer. Although almost half of stakeholders reported needing to be referred by a GP as a barrier to access, Healthy Minds introduced self-referral in late May during the writing of this project.

The greatest supply of services locally is for women and the Asian community. This is in contrast to the areas of need identified by both data and stakeholder consultation. Therefore, the biggest gaps in provision are for men and for migrants. When considering geography, there is a paucity of mental wellbeing support in Bilston, and a lack of third sector mental health support in Whitmore Reans (both of which being highly deprived areas and therefore likely in great need of support).

Key Recommendations

These recommendations have been formulated based on the findings of the report as well as comments from the confirm and challenge workshop of key local mental health stakeholders.

- The mental health service directory should be redesigned to become more easily accessible and to facilitate it being kept up-to-date. It should be well-advertised to the local population.
- Access to low-tier statutory services should not be limited to referral via GPs alone.
  NB. This is currently being superseded by self-referrals for Healthy Minds
- Ways to limit mental health deterioration while awaiting treatment should be explored and the Healthy Minds waiting lists should be monitored during the transition to self-referrals.
- Frontline staff, in health and non health occupations, for example the police, fire and rescue, and those who come into contact with people who are homeless, unemployed, on benefits, socially isolated or otherwise vulnerable should be confident and competent in recognising signs of mental distress and how to support people appropriately and know where to refer onwards if necessary.
- The need for similar training in the voluntary sector should be assessed, especially amongst those groups providing practical support in those areas and with groups that are at higher risk. Training for frontline staff and others can be provided by the Samaritans, or, if focussing on young adults, by Papyrus. Training packages includes ASSIST, Mental Health First Aid, and STORM.
- How to provide more joined-up support for dual diagnosis patients should be considered.
- Men should be encouraged to engage with mental health support and the provision of male-specific services should be increased.
- More should be done to support the mental health of the migrant community.
- Future commissioning should address geographic imbalances – there is a sparsity of mental wellbeing services in Bilston and of third sector mental health support in Whitmore Reans.
- Local communications teams should ensure that when reporting cases of suicide, local media have access to appropriate guidelines, for example, those produced by the Samaritans, and should work with their media contacts should an incident occur.

- Local authority planning teams should consider suicide prevention by ensuring that new developments and plans do not increase access to the means of suicide and also by designing and maintaining suicide prevention signage. Local authorities could also consider working with other transport partners to identify ways to reduce means of suicide on the transport network. Examples include installation of barriers on bridges, erecting signs, and providing access to telephone hotlines.
- Local pharmacies should be engaged in campaigns, for example to support safe medicine management.
- A campaign to raise awareness of suicide prevention amongst the general public and promote suicide prevention guidance, for example by using MIND's 'supporting someone who feels suicidal' and raising awareness by supporting World Suicide Prevention Day should be considered.
- Wolverhampton organisations should consider signing up to campaigns that challenge mental health stigma, such as 'Time to Change'. http://www.time-to-change.org.uk/
- Workplaces should be encouraged to sign up to policies that support positive mental health, as outlined in NICE guidance 'promoting mental wellbeing at work' (NICE Guidance PH 22) http://www.mind.org.uk/information-support/types-of-mental-health-problems/suicide-supporting-someone-else/#.Vfl5GxFViko
- The emerging issue with new psychoactive substances ('legal highs') should be investigated.
- How best to manage data sharing appropriately between organisations should be investigated, in order to try to allow improved joined up working across the city.

> *"The best results for mental health promotion, mental illness prevention, and suicide prevention have been achieved by initiatives that […] address a combination of known risk and protective factors, set clear goals, support communities to take action, and are sustained over a long period of time."*
>
> Changing Directions, Changing Lives: The Mental Health Strategy for Canada (121)

Making Wolverhampton a Suicide Safer Community

Wolverhampton Suicide Prevention Strategy 2016 - 2020

Wolverhampton Suicide Prevention Stakeholder Forum
Updated April 2017

Suicides in Wolverhampton – What do we know?

Suicide is a potentially preventable cause of death and is a significant cause of death in young adults. When someone takes their own life, the effect on their family and friends is devastating and many others involved in providing support and care will also feel the impact. In England, one person dies every two hours as a result of suicide and at least 10 times that number attempt suicide. The highest rates of suicide in the UK are amongst people aged over 75, and it is a common cause of death in men under the age of 35[i].

Suicide rates

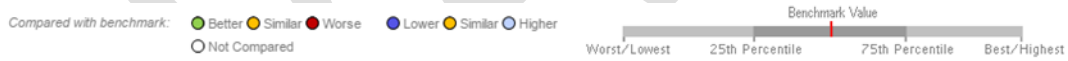
Table 1 shows the overall numbers and rates per 100,000 populations for suicides and injury undetermined over a three year period from 2012 to 2014. Over this period, there were 64 deaths registered in Wolverhampton (aged 15 and over), the majority (89%) being males.

Reporting of suicides in young children

In the UK, a coroner is able to give a verdict of suicide for those as young as 10 years old. However, the Office for National Statistics (ONS) does not include the under 15s in suicide figures due to the difficulty in determining the cause of death in young people This is because of the known subjectivity between coroners with regards to classifying children's deaths as suicide, and because the number in those aged under 15 tends to be low and their inclusion may reduce the overall rates[1].

The overall (persons) suicide rate in Wolverhampton is at the England average and lower than the West Midlands average. However, this latest data now shows that the rate for males is higher (but not statistically significantly higher) at 15.9 per 100,000 compared to 14.1 per 100,000 for England.

Table 1 Suicide rates in Wolverhampton



Indicator	Period	Wolves		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
4.10 - Suicide rate (Persons)	2012 - 14	64	8.8	9.1	8.9	15.7		4.5
4.10 - Suicide rate (Male)	2012 - 14	57	15.9	14.8	14.1	25.3		7.2
4.10 - Suicide rate (Female)	2012 - 14	7	*	3.7	4.0	-	*Insufficient number of values for a spine chart*	-

Source: Public Health Outcomes Framework (downloaded 5 April 2016)

This increase is reflected in the trend data shown in Figure 1 where it can be seen that Wolverhampton rates have been decreasing since 2003 and were lower than the England average but recent trends suggest an increase, closing the gap. However, we know that suicide rates can be volatile as new risks emerge. Previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide. Evidence is emerging of an impact of the current recession on suicides. Therefore an increase in suicide rates in the coming years would not be unexpected[ii].

Suicide is much more prevalent in males and there is a peak in the 30-34 years age group as shown in Figure 2.

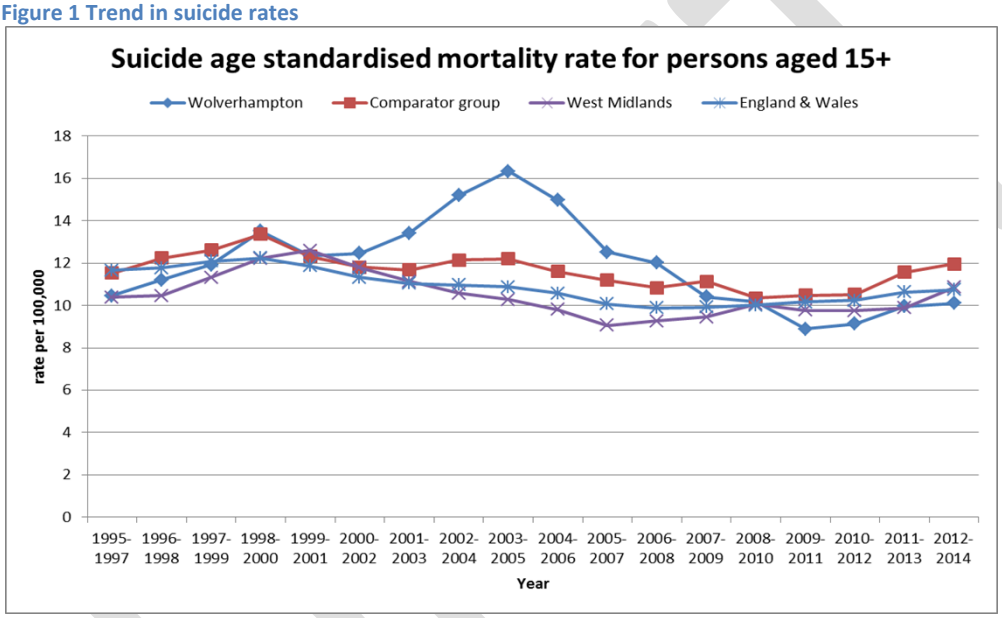
[1] http://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/Suicide_statistics_report_2015.pdf

This mirrors national trends. As stated above, there are no recorded suicides in the under 15 year age group as ONS has taken the decision to exclude under 15s from suicide figures as it cannot be determined whether these deaths are as a result of suicide or due to ill treatment.

Suicide rates are highest in our most deprived areas (Figure 3). In the most deprived parts of the city, the suicide rate is higher than the national average and higher than our comparator group average.

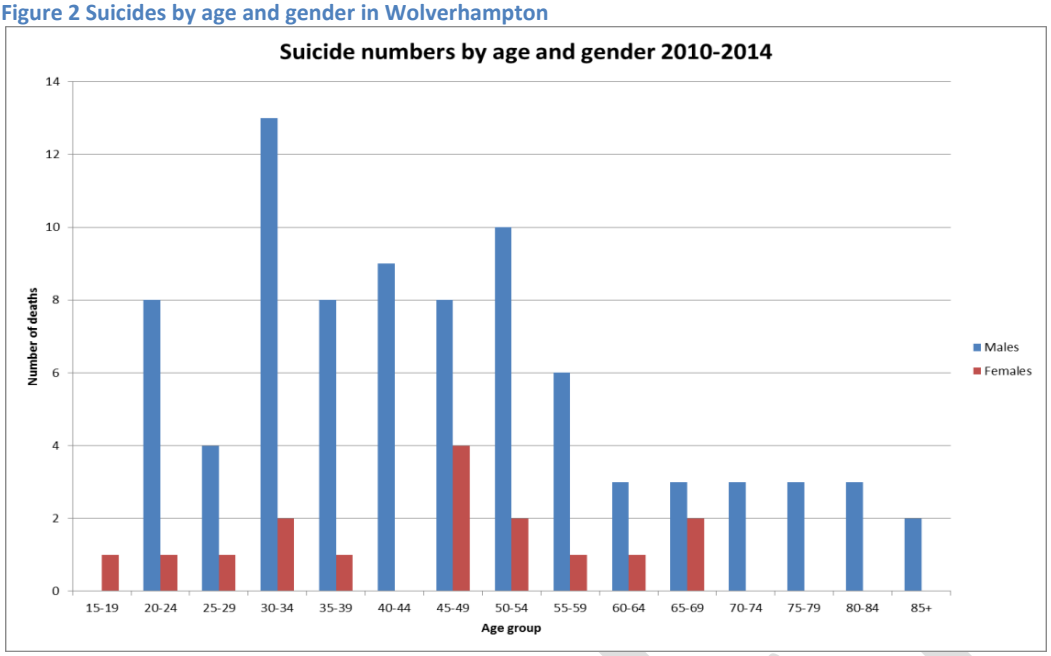
It is not possible to accurately analyse suicides by ethnic grouping as ethnicity is not available as part of the national mortality data set. The only data we have is available from a local audit of suicide cases between 2004 and 2008. This study highlighted that ethnicity is poorly recorded as it was not available in 20% of cases. In cases where ethnicity was recorded suicides amongst the Asian population appeared to be slightly over represented compared to the general population, however, these findings must be interpreted with caution due to the incompleteness of the data (Figure 4).

Figure 1 Trend in suicide rates



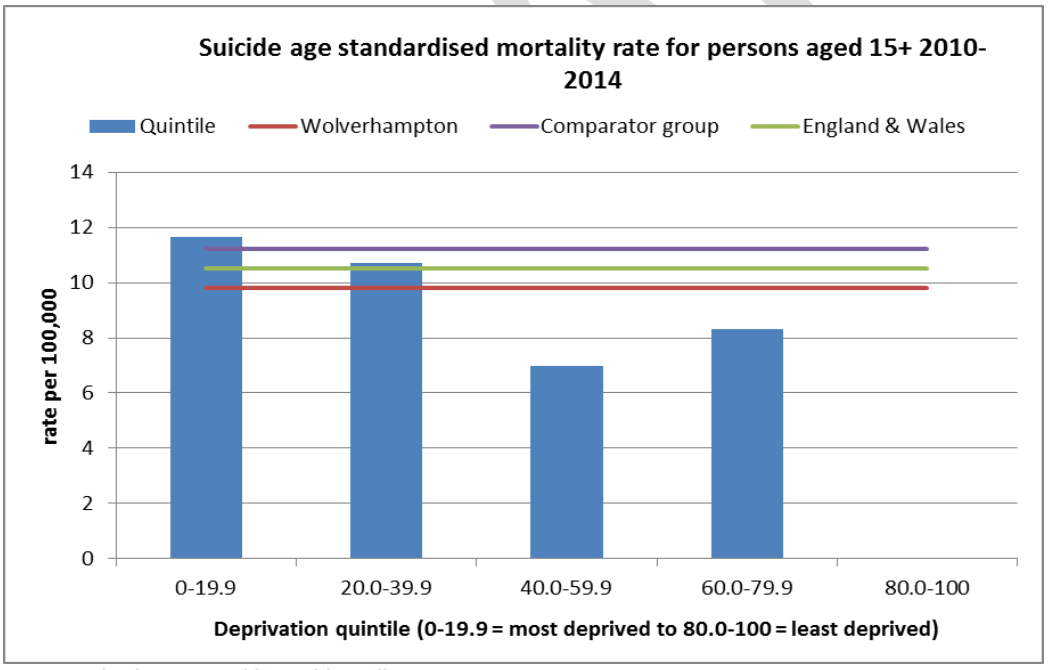
Source: Wolverhampton Public Health Intelligence Team

Figure 2 Suicides by age and gender in Wolverhampton



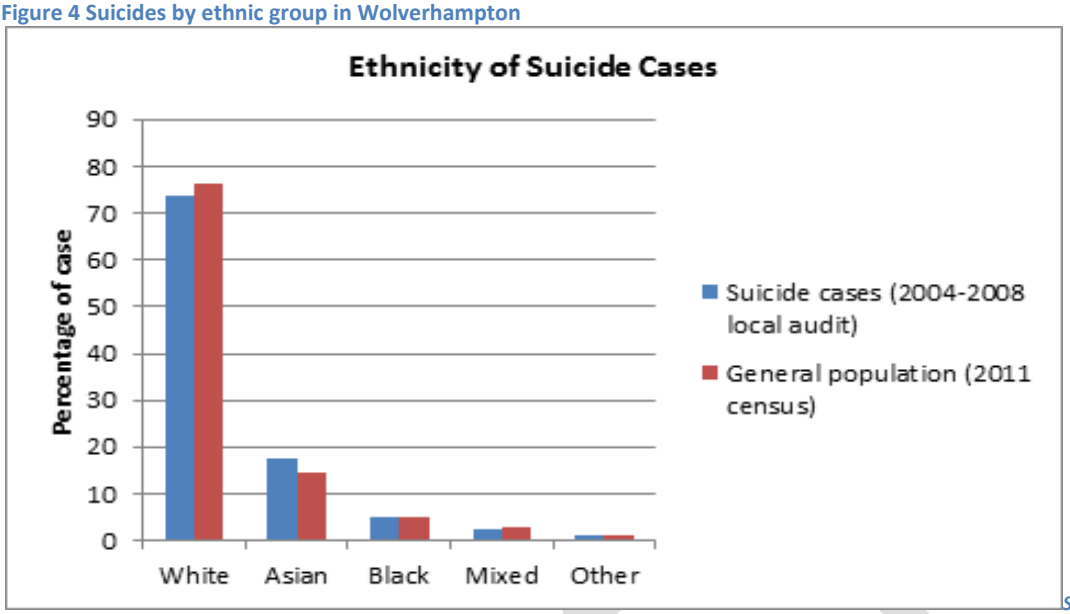
Source: Wolverhampton Public Health Intelligence Team

Figure 3 Suicides in Wolverhampton by deprivation quintile



Source: Wolverhampton Public Health Intelligence Team

Figure 4 Suicides by ethnic group in Wolverhampton



Source: Wolverhampton Public Health Intelligence Team

Suicide prevention needs assessment

In addition to ONS data, a comprehensive mental health and suicide prevention needs assessment has been undertaken co-produced between Wolverhampton Public Health and Wellbeing and Wolverhampton Samaritans in 2015. Over 20 organisations were involved in the needs assessment, which included an online survey distributed to local primary care. Risk factors and key findings identified were:

- Non-heterosexual sexual orientation with the greatest risk being in homosexual men due to the discrimination that these groups may experience.
- Areas of deprivation are associated with increased suicide rates, and over half of Wolverhampton residents are in the most deprived 20% of the country. Homelessness is higher in Wolverhampton than nationally, and multiplies the risk of suicide by nine.
- Isolation increases the risk of suicide, whereas marriage confers protection against suicide. The risk of suicide is increased by bereavement – especially when a male partner loses their spouse. The risk of suicide in men is four times greater when their partner dies by suicide than by any other cause.
- Risk of suicide risk increases with depression severity, and in Wolverhampton the incidence and prevalence of depression is higher than nationally. Wolverhampton has a higher alcohol related hospital admission rate than nationally, and heavy drinking confers a three-fold increase in suicide risk. Physical illness also raises suicide risk, particularly in terminal and chronic conditions.
- Stakeholder consultation identified migrants, men and deprived communities as being at the greatest risk of mental health problems locally. In contrast, women are more likely to approach their GP for mental health support. The most commonly reported triggers for mental health crisis were (1) relationships, (2) employment, (3) housing and (4) drugs/alcohol.
- The biggest gaps in provision were for men and for migrants.

Vision – A Suicide Safer Community in Wolverhampton

What is a Suicide Safer Community

The previous section reported the numbers of death due to suicide in Wolverhampton, but suicides are not inevitable. Suicide attempts are up to 20 times more frequent than completed suicides [iii] and many people can have thoughts about suicide – for example one in four (26%) of young people in the UK experience suicidal thoughts[iv]. But most do not act on these thoughts. Most want help to stay alive. A Suicide Safer Community[v] is a concept in which people are supported to stay alive with organisations and stakeholders coming together to:

- Prevent suicides
- Promote public education and awareness
- Provide support to people bereaved by suicide and promote healing and recovery
- Promote the mental health and wellbeing of all its citizens

In addition, suicide prevention should be set into the context of the fact that:

- Nationally in England and Wales **only 28%** of suicides occur in people who are in contact with services
- This means that **72%** of those who died by suicide were **NOT** in touch with secondary mental health services within one year prior to death.

Therefore, most people who commit suicide are not known to mental health services, or had not had recent contact with services, highlighting the need for a public health approach to suicide prevention.

Vision

To make our community 'suicide safer' our vision is that Wolverhampton:

- is a place where mental wellbeing and good mental health is seen as important as good physical health, at all ages from childhood to older ages
- people are supported during difficult times and try not to think of suicide as an action
- And that professionals and the wider community feel confident to provide that support.

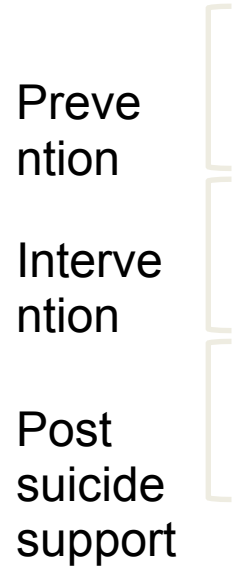
How are we going to make Wolverhampton a Suicide Safer Community

Many factors can contribute to someone thinking about taking their own life and while these factors can be intertwined and complex, they are amenable to change. However, preventing suicide has to address this complexity which is why organisations, communities, individuals and society as a whole need to work together to make suicide safer places. No one organisation can address this complexity alone.

The evidence suggests that there is a sliding scale of opportunities to intervene to prevent a suicide - based on prevention, intervention and post suicide support. In particular we need to have a wider programme of work to reach the 72% of those who are not in contact with specialist mental health services, while ensuring that all opportunities to prevent suicides within mental health settings are taken. Post suicide, we know that family and friends are up to 3 times more at risk of taking their own lives. Therefore, our approach is to:

1. become a suicide safer community
2. push for Zero suicide approach in local NHS care – both primary and secondary
3. Establish post suicide support.

Figure 5 Opportunities to intervene



Source: Public Health England

Why do we need a strategy?

In 2012 the government published *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives*. The national strategy has two overall objectives

- A reduction in the suicide rate in the general population in England
- Better support for those bereaved or affected by suicide

It identifies 6 key areas of action to support these objectives. These are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behavior
6. Support research and data collection.

The strategy recommends that local authorities conduct a suicide audit, produce a suicide prevention action plan and set up a multi-agency suicide prevention group and Wolverhampton has achieved these requirements. This strategy brings these elements together so that all agencies are working towards the same goal and can see what they can contribute to suicide prevention locally.

Suicide prevention audit

The mental health and suicide prevention needs assessment, referred to above provides robust evidence base for our suicide prevention work and informs the suicide prevention action plan.

Suicide prevention stakeholder forum

A multi-agency Suicide Prevention Stakeholder Forum has been established to oversee the delivery of the Wolverhampton Suicide Prevention Action Plan 2015. The forum will take a public health approach to suicide prevention and brings together key stakeholders in the city to focus action on

suicide prevention (for both children and adults), address the national strategy and develop and deliver the Wolverhampton Suicide Prevention Action Plan.

Membership of the forum includes organisations/networks likely to have the greatest impact on reducing suicides in Wolverhampton and includes representatives from Wolverhampton Samaritans, Black Country Partnership Foundation Trust, CCG, Police, local authority adult, children's and public health teams, Network Rail, PAPYRUS, British Waterways and a wide range of voluntary sector organisations.

The group reports to Wolverhampton Health and Wellbeing Board.

Suicide prevention action plan

The suicide prevention needs assessment and additional stakeholder views from the Wolverhampton Mental Health Stakeholder Forum form the basis of the draft Suicide Prevention Action Plan (Table 2)

Outcomes

The success of the strategy will be judged through progress towards, or achievement of, the actions identified in Table 2 which will mark progress towards making Wolverhampton a suicide safer community. The action plan will be reviewed and updated annually to take into account new guidance and evidence on suicide trends in Wolverhampton. The action plan will be monitored by the Suicide Prevention Stakeholder Forum at its quarterly meetings.

Table 2 Wolverhampton suicide prevention action plan

Key area for Action	*Priority Actions:*		*Rationale*	*Proposed Lead*	*Timescale*
Raising awareness of the risk of suicide	1.	Focus on Gatekeeper Training and awareness raising among frontline staff • Conduct an audit who has already been trained in ASIST and SafeTALK in Wolverhampton • Assess training gap and develop plan for gatekeeper training and awareness raising in Wolverhampton to include public sector organizations, mental health trust, GPs /primary care; voluntary sector, businesses. • Also awareness raising of medical students i.e. embed into medical training or at least for GP registrars • Scope training providers and cost to provide.	Frontline staff, in health and non-health occupations who come into contact with people who are homeless, unemployed, on benefits, socially isolated or otherwise vulnerable should be confident and competent in recognizing the signs of mental distress and how to support people appropriately and where to refer to if necessary Some SafeTALK training has already been undertaken (March 2016) but more is needed	PH lead to produce a plan Sign up from partner organisations to training	What do we need for the new financial year?
	2.	Update service directory • Update and sustain Web based resource Wolverhampton Information Network (WIN) to become a useful resource • Update suicide resource list update – SPSF to send out quarterly and members update	Individuals, the public and those seeking to help those needing support need a reliable source of where to get help	All	Immediate/ ongoing
	3.	Reduce stigma around mental health and suicide • Organisations sign up to campaigns that challenge mental health stigma, such as Time to Change http://www.time-to-change.org.uk/ • Participate in mental health promotion campaigns e.g. mental health awareness week, suicide prevention awareness raising events	Reducing stigma is important because it means that people can talk about mental health issues and the problems they are facing and more people can feel that it is okay to ask someone about their feelings, especially about their suicidal feelings and more people feeling suicidal can feel they can talk about it	All	Is there more we can do to make this more systematic and measure the

Key area for Action	*Priority Actions:*		*Rationale*	*Proposed Lead*	*Timescale*
					impact?
	4.	Workplaces encouraged to sign up to policies and guidance that support positive mental health as outlined in NICE PH22 guidance 'promoting mental wellbeing at work'			Workplace wellbeing charter
	5.	Organize a community suicide awareness event to link in with World Suicide Prevention Day in September.		PH and voluntary sector	Completed September 2016
Tailor approaches to improve mental health in specific groups	6.	Ensure that suicide prevention is an additional work stream within the crisis concordat programme	Inclusion within the crisis concordat program as an additional work stream will strengthen the work of the suicide prevention stakeholder forum	CCG	
	7.	Develop a work stream that addresses suicide prevention issues for children and young people - Policy/Guidance document for schools to respond to self-harm incidents and concerns around suicide: to work alongside critical incident and child death policy documents - Understand what schools procure regarding social and emotional wellbeing training for staff and if it includes self-harm and suicide - Headstart officers to be trained in recognising risk that is higher than 'low to moderate' - Obtain numbers on a routine basis for children and young people who have been admitted to hospital for self-harm and/or suicide	The strategy is an all age strategy, however suicide prevention amongst young people needs a particular focus and specific actions	Ed Psychol Ed pscyh Headstart Ed Pscyh and Hospital Youth Team	Review October 2017 August 2017? Review July 2017
	8.	Ensure that suicide prevention is included in LGBT, migrants, older people's strategies and work streams and programmes covering adult men.	The needs assessment highlighted specific groups as being at higher risk and therefore requiring specific attention	Leads for: LGBT Migrants	For discussion

Key area for Action	*Priority Actions:*		*Rationale*	*Proposed Lead*	*Timescale*
				Older people Men's health	
	9.	Engage local pharmacies in campaigns, for example to support safe medicine management, through Healthy Pharmacies initiative	The Healthy Pharmacies initiative is a programme to improve health and raise awareness in local communities. It is important to embed mental wellbeing and suicide prevention in general health improvement campaigns that are targeting the general population.	Pharmacy leads PH and CCG	Verbal update
	10.	Improve pathways between secondary and acute and specialist services	Psychiatric liaison service for adults within acute trust is good however this is not replicated for younger adults, this shortfall needs to be addressed through the CCG. Communication between secondary and primary care is limited and needs to improve, this could be facilitated through GP training.	TBC	
Reduce access to the means of suicide	11.	Link suicide prevention to planning • Work across the West Midlands to include suicide prevention in the Regional toolkit being developed See : *Preventing suicides in public places –a practical resource https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf*	Local authority planning teams can influence suicide prevention by ensuring that new developments and plans do not increase access to the means of suicide and also by designing and maintaining suicide prevention signage	PH	Verbal update
	12.	Continue to monitor for hotspots (through	We need to remain vigilant to the	Coroner	Verbal

Key area for Action	*Priority Actions:*		*Rationale*	*Proposed Lead*	*Timescale*
		development of real time suicide surveillance – action 17 below)	emergence of any suicide 'hotspots' and take appropriate action.		update
	13.	SPSF include other transport partners to identify and reduce the means of suicide on the transport network	We need to continue to monitor the methods used and to work with appropriate organizations to minimize the risk of suicide.	BTP/Railway mission	
Provide better information and support to those bereaved or affected by suicide	14.	Promote Help Is At Hand and other post suicide support • Members of the Suicide Prevention Stakeholder Forum should promote Help is at Hand across their organisations • Specific distribution to first responders, police and paramedics; coroners' officers, bereavement support organizations; public libraries, advice centers, health centers, promote online	Those bereaved or affected by suicide are also at risk. This is an under developed area of suicide prevention in Wolverhampton .	All	For discussion
	15.	Scope the availability of post suicide bereavement support	Meeting arranged with bereavement services.		
Support the media in delivering sensitive approaches to suicide and suicidal behavior	16.	Local communications teams should ensure that when reporting cases of suicide, local media have access to appropriate guidelines, for example those produced by the Samaritans, and should work with their media contacts should an incident occur http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide	Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behavior, but when handled responsibly the media can play an important role in helping people understand some of the complex issues surrounding suicide. For example, the sign which may indicate a person is at risk, the kinds of problems that can lead to a person feeling suicidal, and encourage those who are struggling to reach out for help.	Local Comms and Samaritans	
	17.	Press Responsibility – work with local media on reporting of suicides.			
Support research	18.	Work with partners to investigate real time suicide	Nationally reported suicide data has a time	Police?	

Key area for Action	*Priority Actions:*		*Rationale*	*Proposed Lead*	*Timescale*
and data collection.		surveillance and other sources of intelligence (e.g. police data) (Awaiting PHE guidance)	lag in release by PHE.	Subject to PHE report	
	19.	Work with the coroner to explore the practicality of routine collection of ethnicity data and other important information e.g location/hotspots	Currently ethnicity is not routinely collected This (and other protected characteristics) data will help understanding of suicide risk in Wolverhampton and guide future service provision in an evidence based manner.		
	20..	Annual update of suicide outcome briefing /suicide needs assessment	There is a need to continue to monitor trends in order to react to new issues emerging	PH Intel team	Provide update from ONS
Partnerships	21.	Maintain a strong suicide prevention partnership with close links to the West Midlands combined authority	Tackling suicide is only effective through a strong partnership.	All	
	22.	Ensure synergy with Black Country Partnership Foundation Trust's suicide group	This action plan and strategy needs to feed into the work of the internal BCPFT group and vica versa	BCPFT/PH	

References

[i] https://www.mentalhealth.org.uk/a-to-z/s/suicide
[ii] http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf
[iii] http://forwardforlife.org/wp-content/uploads/2013/11/The_Biggest_Elephant_In_The_Room.pdf
[iv] The Princes' Trust Macquarie Youth Index 2014 http://bit.ly/12j0uGT cited in http://www.youngminds.org.uk/about/whats_the_problem/mental_health_statistics
[v] Developed by The Canadian Association for Suicide Prevention and Living Works.

Further reading/resources

Preventing suicides in public places A practice resource
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/481224/Preventing_suicides_in_public_places.pdf

Suicide prevention: identifying and responding to suicide clusters. A practical resource
https://www.gov.uk/government/publications/suicide-prevention-identifying-and-responding-to-suicide-clusters

Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359993/Guidance_for_developing_a_local_suicide_prevention_action_plan__2_.pdf

Preventing suicide among lesbian, gay and bisexual young people: a toolkit for nurses
https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

Preventing suicide among Trans young people: a toolkit for nurses
https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

Suicide Prevention Profile
http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

Headlines of Wolverhampton Suicide Prevention Week (5th -11th September 2016)

- **Launch of the Week** with releasing balloons and photo at Samaritans with Mayor, Mayoress, Director of Wolverhampton Samaritans and Councillor Sweet
- **2 sessions of PAPYRUS Suicide Awareness** with a total of 50 individuals from council and voluntary sector organisations. Feedback included, *'informative and beneficial session' 'Fantastic training'*
- **Fundraised £265.81 for PAPYRUS by selling orange and yellow ribbons which we ran out of!** Ros Jervis and Councillor Sweet Cabinet member of Public Health and Wellbeing presented the cheque to Louise from PAPYRUS

- **Great turnout for the Public and Employee Wellbeing Walk** with Councillor Darke attending the public walk.
- **Health and Emotional checks by Wolverhampton Healthy Minds were very well received.**
- **Information stands at Epic Café were well received for the individuals who turned up.**
- **Support for the week by Wolves FC:**

RESPONSE TO NATIONAL CAMPAIGN BY THE SAMARITANS

Dear Ollie

Thank you for your email to the Leader. As the Vice-Chair of the Suicide Prevention Stakeholder Forum, I would like to respond to the points you raised in your email.

We believe that every local authority should:
- Have a clear suicide prevention plan, supported by a suicide prevention group which includes representatives from all the relevant local organisations, including the voluntary sector

A suicide prevention strategy and action plan is in place and it is overseen by a suicide prevention stakeholder forum with wide, multi-agency representation from across the city. This is chaired by the local Samaritans. Representation includes: a wide range of voluntary sector organisations, Black country partnership mental health foundation trust, Wolverhampton university, Wolverhampton college, Papyrus, Wolverhampton clinical commissioning group, LGBT community, educational psychology, mental health social work, police, network rail, refugee and migrant centre, Head Start (mental health programme for 10-16 year olds), Wolverhampton homes, Recovery near you (substance misuse service) and mental health commissioners.

The strategy is available here http://www.wolverhampton.gov.uk/stress

- Have cabinet level leadership to ensure suicide prevention is a top priority and that the plan leads to real action

Councillor Paul Sweet, cabinet member for Public health and well-being, is a key sponsor of this work, as is Councillor Roger Lawrence, the leader of the council, who chairs the Health and Well-Being Board. When the suicide prevention strategy and action plan was presented to the Health and Well-being board in April 2016, it was highly commended by the Board. Since then Councillor Sweet and the Mayor have championed the activities that were organised for Suicide Prevention Week in September 2016 (see attached briefing paper detailing the activities from that week).

- Identify the most at-risk groups and ensure that its approach is tailored towards them

At risk groups have been identified by the suicide prevention needs assessment that was undertaken in 2015.

Each plan must respond to local need, but all local authorities will need to:
- ensure that the help and support which is available in the local area is promoted effectively so that all who require it are aware of it and able to access it when in need. One good way to do this is through community programmes aimed at those least likely to seek help.

The action plan includes the systematic updating of organisations that can offer support on the 'Wolverhampton Information Network' http://win.wolverhampton.gov.uk/kb5/wolverhampton/directory/home.page

Checks are made regularly that the information is up to date. This directory has been regularly disseminated across the network and has been distributed at suicide prevention training events that have been held in March and September 2016.

- work in partnership with hospital trusts in order to ensure that people who attend A&E and are at risk of suicide are always provided with follow-up support

This is an area that was identified at the last meeting as needing more attention and the action plan is in the process of being updated accordingly.

- ensure that services are available to support everyone bereaved by suicide – a particularly high risk group

This is part of the action plan.

You can read more about Samaritans' policy calls here: www.samaritans.org/localaction

As a constituent and member of the local community, I hope that you will ensure that the local suicide prevention plan in our area addresses all of these points, and is championed at the highest level in the council, in order to reduce the number of people taking their own lives.

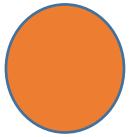
I trust that you can see that the Council takes the issue of suicide prevention very seriously. We are proud of the joint work we are doing with the Samaritans and other organisations.

Regards
Neeraj

--
Neeraj Malhotra
Consultant in Public Health
Wolverhampton City Council
01902 558667

Suicide Prevention Guidance Benchmarking (Public Health and WellBeing Wolverhampton)

Local Suicide Prevention Planning: A practice resource (October 2016)		
Guidance set out in the Local Suicide Prevention Planning document	**Wolverhampton's position**	**Red/Amber/Green**
Building a Partnership Approach: 1. Establishing a formal multi-agency suicide prevention group 2. Building a wider partnership approach 3. Working with elected members 4. Involving health and wellbeing boards 5. Working with Crisis Care Concordat networks 6. Working with primary care 7. Involving people affected by suicide 8. Working with the community and voluntary sector 9. The role of suicide prevention champions 10. Working with other partners	Wolverhampton established the Suicide Prevention Stakeholder Forum in 2015 which consists of a number of partners across various organisations within the public and voluntary and community sector. The group has an agreed terms of reference and meet on a quarterly basis. The strategy and action plan take a partnership approach with agreed aims and objectives cutting across various services. As per guidelines the forum has representation from CCG, Public Health, secondary mental health care, voluntary sector, and criminal justice service (prisons). **Primary care providers to be approached.** The elected member who holds the portfolio for Public Health and Wellbeing is regularly updated on the work of the forum. A scrutiny panel around mental wellbeing is also kept informed on progress of the forum and how this links into mental wellbeing, the scrutiny panel consists of elected members with officer support. The Health and Wellbeing Board has been provided with presentations at appropriate intervals around suicide prevention and support the work of the forum. The Mental Illness and Suicide Prevention Needs Assessment consulted with a number of organisations who work directly with family and friends bereaved by suicide. More could be done to involve people affected by suicide. Approaches have been made to the CCG to embed suicide prevention into the crisis concordat; this needs to progressed.	
	Areas for development: - Form closer links with primary care (GP training) - Explore idea of suicide champions, possibly through working those affected by suicide - Engage primary care providers - Embed suicide prevention work within the crisis concordat programme	
Making sense of national and local data: 1. How data support effective suicide prevention work 2. Suicide data collection in practice 3. Nationally available data 4. Locally sourced data	The Mental Illness and Suicide Prevention Needs Assessment forms the basis for Wolverhampton's strategy and action plan. The need assessment used national and local data to gain an understanding of Wolverhampton's position around suicide prevalence. The main source of data for suicide is via ONS. Discussions have recently taken place with the coroner on sharing of real time data and this has been agreed in principle: inquests are in public approximately 8 weeks after a person has died and the coroner's office can inform Public Health of when these inquests are taking place. Operational processes to share this data will be developed.	

Local Suicide Prevention Planning: A practice resource (October 2016)		
Guidance set out in the Local Suicide Prevention Planning document	**Wolverhampton's position**	**Red/Amber/Green**
5. Real-time suicide surveillance 6. Data sharing agreements 7. Building a suicide prevention database	The Forum is in the process of routinely obtaining data relating to self-harm admissions to hospital. Discussion has been had about identifying recurring themes relating to these admissions to identify where effective, earlier interventions can be put in place.	
	Areas for development: - Agree process for sharing of real time information on suicides - Explore idea of creating a suicide database to add further value to understanding trends and causes - Identify new sources of data to obtain a **richer picture of suicide prevalence, for example, data from primary and secondary services, criminal justice system and social care.**	

Local Suicide Prevention Planning: A practice resource (October 2016)		
Guidance set out in the Local Suicide Prevention Planning document	**Wolverhampton's position**	**Red/Amber/Green**
Developing a suicide prevention strategy and action plan: 1. What to include in a suicide prevention strategy 2. Building the case for suicide prevention work 3. Mapping the strategy to the wider health and wellbeing agenda 4. Accountability 5. Local approaches for suicide prevention 6. Priority areas for all local suicide prevention plans 7. Developing a multi-agency action plan 8. Monitoring and evaluating progress	Wolverhampton produced a suicide prevention needs assessment in 2015, jointly with the Samaritans. The needs assessment underpins the strategy and action plan. All the relevant sections recommended by the guidelines are included within Wolverhampton's strategy (see next section). The multi-agency action plan sits alongside other plans to improve mental well-being as well as plans to reduce the harm from alcohol. Priority groups have been identified. The needs assessment has been shared with the JSNA group for wider partners to gain a better understanding of suicide prevention and how this connects to their respective area of work and organisation. Updates are provided to the Health and Wellbeing board on a 12-18 month basis. Wolverhampton's suicide prevention strategy is largely in line with the key areas identified in the national strategy with some additionality around maintaining a strong suicide prevention partnership with close links to the West Midlands combined authority and the actions derived from the 'Thrive West Midlands' report. Wolverhampton's action plan sets out key objectives, rationale, leads and timescales which are in line with the guidelines. Steps are being taken to monitor self-harm admissions and suicides on a routine basis. Evaluations of training are captured at each event. Progress on the action plan is reviewed by the forum on a quarterly basis.	

Local Suicide Prevention Planning: A practice resource (October 2016)		
Guidance set out in the Local Suicide Prevention Planning document	**Wolverhampton's position**	**Red/Amber/Green**
Ideas for action: 1. Reduce the risk of suicide in key high-risk groups 2. Tailor approaches to improve mental health in specific groups 3. Reduce access to the means of suicide 4. Provide better information and support to those bereaved or affected by suicide 5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour 6. Support research, data collection and monitoring	**Reduce the risk of suicide in key high-risk groups** Wolverhampton's suicide prevention action plan is in line with the 6 areas of action set out in the national strategy. The action plan recognises the enhanced risk of suicide for some sections of the community. The action plan highlights heightened vulnerability in LGBT, older people, young people, men, migrant communities and those people in the care of mental health services. However there is a gap in terms of working with those in the criminal justice system and recognising specific occupational high-risk groups for example, doctors, nurses and veterinary workers. Wolverhampton has recently secured representation from HM Prison Service which will enable development within the criminal justice system and the acute trust and the mental health trust. **Tailor approaches to improve mental health in specific groups** Much of what is recommended within the guidance document is included within Wolverhampton's priority of raising awareness, for example, training and community based campaigns. The national guidance does include further specific groups such as survivors of abuse, including sexual abuse, pregnant women or those recently given birth, those with history of self harm and veterans which are not explicitly referenced within the Wolverhampton's plan. **Action plan to be amended.** **Reduce access to the means of suicide** Wolverhampton's action plan is robust in this area and includes working at regional level to ensure planning toolkits consider suicide prevention. Working with public health colleagues who work closely with planning to ensure suicide prevention is embedded within the planning process. Although transport industry has provided input to the forum this needs to be strengthened. **Network rail have been members but representation has lapsed.** **Provide better information and support to those bereaved or affected by suicide** Whilst the local action plan has a section around this priority further work is needed to understand and develop postvention services. **Support the media in delivering sensitive approaches to suicide and suicidal behaviour** Work is developing under this priority and is adequately reflected within the local plan. **Support research, data collection and monitoring** Local plan is in line with what is set out in the national strategy under this theme. The forum is improving monitoring by looking at attempts amongst young people and real time collection of information from the coroner.	

Local Suicide Prevention Planning: A practice resource (October 2016)		
Guidance set out in the Local Suicide Prevention Planning document	**Wolverhampton's position**	**Red/Amber/Green**
	Areas for development: - Develop work with criminal justice services, for example, police custody, probation for post release - Explore risk for specific occupational groups in the city for example nurses - Consider including survivors of abuse, pregnant women and those recently gave birth as specific groups at high risk - Include action around targeting and supporting individuals with history of self harm - Re-engage with transport industry i.e. Network Rail and strengthen work with planning department	

Three main elements of the All-Party Parliamentary Group on Suicide and Self-harm Prevention recommends as essential to successful local implementation of the national strategy		
Guidance set out in the Local Suicide Prevention Planning document	**Wolverhampton's position**	**Red/Amber/Green**
1. Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations	Covered above and meeting standard	
2. Completing a suicide audit	A needs assessment was completed in 2015 which included an audit **but this could be updated**	
3. Developing a suicide prevention strategy and/or action plan that is based on the national strategy and the local data	Covered above and achieved	

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Quality Account 2016-17

Contents

Please note that information regarding each area of the Trust as described in the 2015/16 Quality Account will be available on the Trust website

Part 1
Statement on Quality from the Chief Executive

We are pleased to present the West Midlands Ambulance Service NHS Foundation Trust's Quality Report which reviews 2016-17 and sets out our priorities for 2017-18.

This quality account is designed to assure our local population, our patients and our commissioners that we provide high-quality clinical care. It also shows what we are doing to improve.

As an organisation, we always strive to be the best that we can be. Not only does this mean that staff are able to provide an excellent service, it also ensures patients get the highest standard of care possible. Whilst we might think that we are doing an excellent job, it is extremely pleasing when external scrutiny shows that those outside the organisation agree.

During 2016-17 we received two tremendous pieces of news: we were rated 'Outstanding' by the Care Quality Commission and were placed in 'Segmentation One' by NHS Improvement. To receive such ratings means that we are providing the highest standards of care, have excellent finances and good use of resources, high operational performance, excellent strategic leadership and an ability to constantly improve our capability.

Whilst I am only too aware of just how hard our staff and volunteers work, day in, day out, often in very difficult circumstances I would like to take this opportunity to formally place on record my thanks to everyone associated with the Trust for everything they do to ensure we provide the highest quality of patient care. I am sure there are many grateful patients, families and friends who will join me in thanking them for their superb efforts over the past year. This is echoed by the number of 'thank you' letters, emails, tweets and Facebook posts that we have received. We are very grateful for the time taken by those who wrote them.

Once again, we have been able to maintain our position as the only ambulance service with no frontline vacancies and no use of either the private or voluntary sector. Over 300 new members of staff joined us last year increasing the level of clinical care provided to patients. Our detailed plans and not inconsiderable investment mean the future looks very bright for our organisation. I look forward to working with colleagues, our staff and volunteers to ensure the Trust continues to provide the very best patient care in the future.

To the best of my knowledge the information contained in this report is an accurate account.

a.c.marsh.

Anthony C. Marsh
Chief Executive Officer

Introduction

We have a vision to deliver the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies. Put simply, patients must be central to all that we do. This means a relentless focus on patient safety, experience and clinical outcomes.

At West Midlands Ambulance Service NHS Foundation Trust, we place quality at the very centre of everything that we do. We work closely with partners in other emergency services, different sections of the NHS and community groups. These include general practitioners, mental health workers and local community groups. Together we ensure that patients remain at the forefront of service provision through uncompromising focus on improving patient experience, safety and clinical quality.

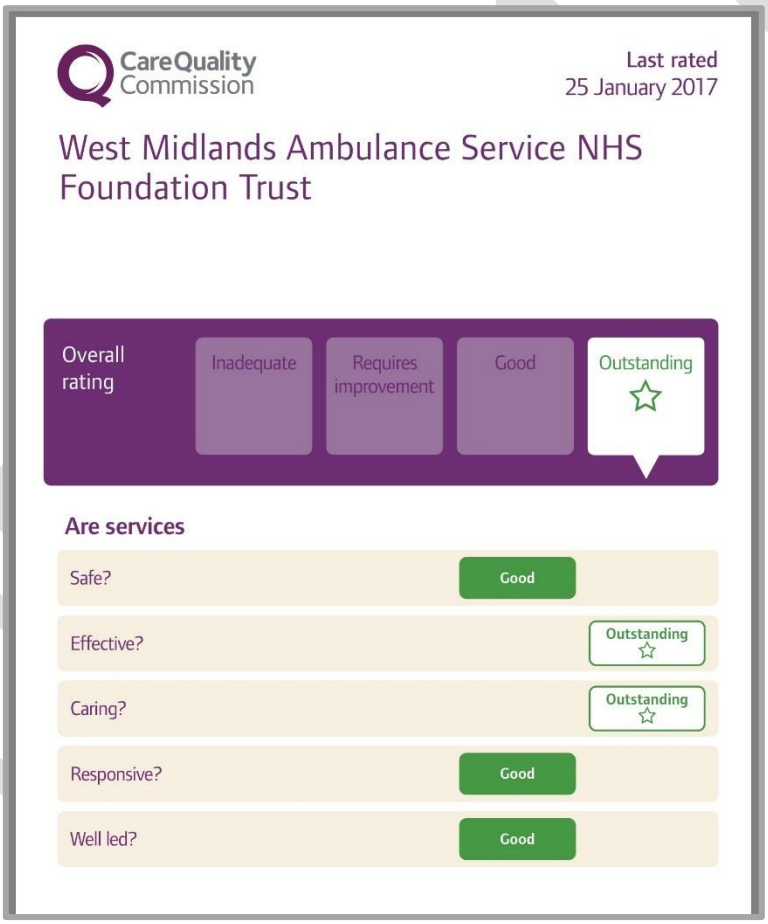
The Quality Account is a yearly report that highlights the Trusts progress against quality initiatives and improvements made over the previous year and looks forward to prioritising our ambitions for the year ahead. We understand as a provider organisation that to continue to improve quality it is essential that our patients and staff are fully engaged with the quality agenda. We continue to reinforce these through our current values.

Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status is Outstanding. WMAS has no conditions attached to its registration.

The Trust has been registered with the Care Quality Commission (CQC) without conditions since 2010. WMAS has not participated in any special reviews or investigations by the Care Quality Commission during 2016/17 and CQC has not taken enforcement action against West Midlands Ambulance Service during 2016/17.

The Trust was inspected by the CQC in June 2016. The final report available from www.cqc.org.uk or the Trust website confirms the Trust achieved an overall rating of Outstanding.



Whilst we have been rated as Outstanding by the CQC they did identify areas for improvement mainly related to our non-emergency Patient Transport Service. The following page provides an overview of our plans that have either been implemented or are in the process of being implemented to ensure all the services we provide aim for an outstanding rating and reach a minimum level of good.

CQC planning to improve further

What the CQC said required improving	Actions taken
The trust did not always keep proper and safe storage of medicines across PTS services.	• Safe rectified on the one vehicle of concern next day • Signs on all vehicles advising keep locked and regular compliance checks initiated • All staff written to and no agency staff utilised
The Trust must improve staff attendance at mandatory training ensuring it is monitored and actively supported.	• The Trust exceeded its targets for attendance at mandatory training • Early implementation of 2017/18, aiming to complete by 30 Sept 2017
Challenges around management of Prescription Only Medicines (POM's) needed to be addressed consistently across the Trust.	• Restricted swipe access on all POMS stores • Audit improved from 91 - 96% in 3 months
In PTS, CQC saw that staff did not always carry out equipment checks and sterile environments were not always maintained.	• High Dependency now going through Make Ready • Formal load lists now in place for all vehicles • Announced and unannounced compliance visits
PTS staff did not consistently lock ambulances when parked	• Vehicle security has been improved and is monitored to ensure that vehicles are always locked securely.
On one hub CQC saw dirty equipment within the sluice area	• Improved cleaning schedules with regular check implemented
Operational Performance varied across the Trust	• Ambulance Response Programme to improve response based on clinical priorities
PTS staff needed more mental health and bariatric training	• Mental Health sessions delivered within the weeks following the inspection. • Mandatory training scheduled for 2017/18 changed to address areas identified by CQC
Bariatric equipment was not always available when required	• Bariatric vehicle and equipment increased
Incident reporting, learning from incidents, risk awareness and management of risk was not consistent across the Trust	• Increased management training and inclusion on 2017/18 mandatory training • Increased sharing of learning via publications, station meetings, plasma screens etc.
Resilience and availability of operational middle management was a concern	• Changes to the Trust management structure to include an increase in middle management and increased education and support to ensure clarity of role requirements.

Part 2
Priorities for 2017/18

In deciding our quality priorities for 2017-18 for improving patient experience, patient safety and clinical quality. We have listened to what our patients and staff are telling us through engagement events, surveys, compliments, complaints and incident reporting. We have assessed our progress during the year against last year's priorities and have agreed where priorities need to continue to ensure a high-quality service is maintained and continues to improve.

The Trust Priorities for 2017/18 are summarised below.

Patient Experience

- Educate Trust clinicans and implement the ReSPECT form in order to improve understanding and treatment of patients with specific care plans such as those people at the end of their life
- Work with partner agencies to provide improved care pathways for patients i.e. mental health and end of life
- Increase Friends and Family Test feedback

Patient Safety

- Improve timeliness of response based on clinical need
- Reduce the risk of harm to patients whilst in our care
- Deliver the objectives set within our 'Sign up to Safety' pledge (specific to top 5 risks identified through learning)

Clinical Effectiveness

- Improve the level of care delivered as measured by national Ambulance Quality Indicators
- Use the learning from external regulator reports to improve further
- Ensure 'Learning from Deaths' through mortality reviews takes place

Patient Experience

Patient Experience	Priority	WHY WE HAVE CHOSEN THIS priority	WHAT WE ARE TRYING TO IMPROVE	WHAT SUCCESS WILL LOOK LIKE
	1. ReSPECT education and implementation	This is a new initiative being trialled and is likely to be rolled out across the NHS	The care and treatment of patients with complex needs and end of life plans.	Staff will take part in the trial proactively and feedback from WMAS will influence the national introduction of the tool.
	2. Work with partner agencies to provide improved care pathways for patients i.e. mental health and end of life	The Health & Social care system is complicated for patients to understand and navigate. We hope to make the transfer of care easier and more effective for patients at their most vulnerable times.	To ensure initiatives to improve patient care across organisations is seamless.	The Trust can evidence support for cross agency working. Patients are positive in their feedback.
	3. Increase Friends and Family Test (FFT) feedback	The Trust has experienced difficulty in obtaining high numbers of FFT feedback.	Learning from patients on what works well and what doesn't is crucial to improving the service.	Improved FFT feedback
	How we will monitor progress: 1. Training will be monitored through quarterly reports 2. Clinical Quality Commissioning meetings (minutes) will reflect WMAS proposals and engagement 3. FFT reports to internal meetings up to and including Trust Board and for website publication via Learning Review quarterly reports.			
	Responsible Lead: 1. Head of Education & Training and Consultant Paramedic (Vulnerable People) 2. Medical Director and Consultant Paramedics 3. Deputy Director of Nursing & Quality and Head of Patient Experience			
	Date of completion: March 2018			

Patient Safety

	PRIORITY	WHY WE HAVE CHOSEN THIS PRIORITY	WHAT WE ARE TRYING TO IMPROVE	WHAT SUCCESS WILL LOOK LIKE
PATIENT SAFETY	1. Improve timeliness of response based on clinical need	The Trust is part of the Ambulance Response Programme (ARP) trials.	Sending the right response first time based on clinical need will ensure patients receive an appropriate response within a timeframe to meet their specific needs.	Performance indicators are currently being agreed with the Department of Health – once agreed the Trust will demonstrate improved patient outcomes.
	2. Reduce the incidence of harm to patients whilst in our care	Harm whilst rare and usually low, does remain a theme particularly during moving and handling	The moving and handling of patients will not cause harm	Reduced number of harm to patients whilst in our care.
	3. Deliver the objectives set within our 'Sign up to Safety' pledge (specific to top 5 risks identified through learning)	During the year, we identify various risks that could result in harm to patients. We don't routinely publish the learning for all risks managed.	Improved shared learning	The Trust Website and Quality Accounts will contain more 'you said, we did' relating to our top Patient Safety risks.
	How we will monitor progress: 1. ARP is monitored by the Trust Board of Directors and Commissioners – reports included in Board papers 2. The Learning Review Group (LRG) monitors incidence of patient harm in its quarterly reports – published internally and on our website 3. The LRG quarterly reports will include reference to top risks and their management – published internally and on our website			
	Responsible Lead: 1. Emergency Services Director 2. Deputy Director of Nursing & Quality and Head of Patient Safety & Safeguarding 3. Deputy Director of Nursing & Quality and Head of Patient Safety & Safeguarding			
	Date of completion: March 2018			

Clinical Effectiveness

	Priority	WHY WE HAVE CHOSEN THIS PRIORITY	WHAT WE ARE TRYING TO IMPROVE	WHAT SUCCESS WILL LOOK LIKE
CLINICAL OUTCOMES	1. Improve the level of care delivered as measure by national Ambulance Quality Indicators (AQI)	We nationally measure quality of clinical care and always strive for improvements	Care of patients within all areas is improved.	Quality Indicators evidence improvement
	2. Use the learning from external regulator reports to improve our performance further	Learning from our own CQC report and other regulator reports will help us to identify where we could improve	Learning will not be missed and patients harmed.	Action is taken to improve the care of patients
	3. Ensure 'Learning from Deaths' through mortality reviews takes place	Mortality reviews in Acute Trusts have identified where care is not to required standards. Ambulance services are not required to report on mortality.	We aim to identify and develop a method for performing mortality reviews so that we can ensure the best care.	A method for mortality reviews is identified, and commenced so that learning takes place.
	How we will monitor progress: 1. AQI is monitored through the Trust Governance system up to and including Trust Board of Directors – reports included in Board papers 2. The Quality Governance Committee will monitor this via Compliance Assurance presented by senior managers/directors 3. The Mortality review is proposed for August 2017 and is scheduled to be presented to QGC and Commissioners in September			
	Responsible Lead: 1. Medical Director and Consultant Paramedic (Emergency Care) 2. Deputy Director of Nursing and Consultant Paramedics 3. Deputy Director of Nursing and Consultant Paramedics			
	Date for Completion: March 2018			

Our Services

The Trust serves a population of 5.6 million who live in Shropshire, Herefordshire, Worcestershire, Coventry and Warwickshire, Staffordshire and the Birmingham and Black Country conurbation. The West Midlands sits in the heart of England, covering an area of over 5,000 square miles, over 80% of which is rural landscape.

The Trust has a budget of over £200 million per annum. It employs almost 5,000 staff and operates from 15 Operational Hubs and a variety of Community Ambulance Stations together with other bases across the Region. In total the Trust uses over 800 vehicles including Ambulances, Response Cars, Non-Emergency Ambulances and Specialist Resources such as Motorbikes and Helicopters.

There are two Emergency Operations Centres, located at Tollgate in Stafford and Brierley Hill in Dudley, taking around 3,000 to 3,500 emergency '999' calls each day.

During 2016 -17 West Midlands Ambulance Services Foundation Trust provided the following three core services:

1. **Emergency and Urgent** (E&U)
   This is the best-known part of the Trust and deals with the emergency and urgent patients. Initially, the Emergency Operations Centres (EOC) answers and assesses 999 calls. EOC will then send the most appropriate ambulance crew or responder to the patient or reroute the call to a Clinical Support Desk staffed by experienced paramedics who will be able to clinically assess and give appropriate advice. Where necessary, patients will be taken by ambulance to an Accident and Emergency Department or other NHS facility such as a Walk-in Centre or Minor Injuries Unit for further assessment and treatment. Alternatively, they can refer the patient to their GP.

2. **Patient Transport Services** (PTS)
   In many respects, this part of the organisation deals with some of the most seriously and chronically ill patients. They transfer and transport patients for reasons such as hospital appointments, transfer between care sites, routine admissions and discharges and transport for continuing treatments such as renal dialysis. The Patient Transport Service has its own dedicated control rooms to deal with the 1,000,000 patient journeys it undertakes annually, crews are trained as patient carers. The Trust has contracts in Birmingham, Worcestershire, Coventry & Warwickshire, North Staffordshire, Cheshire, Dudley and Wolverhampton.

3. **Emergency Preparedness:**
   This is a small but vitally important section of the organisation which deals with the Trust's planning and response to significant and major incidents within the region as well as co-ordinating a response to large gatherings such as football matches and festivals. It also aligns all the Trust's Specialist assets and Operations into a single structure. Such assets include the staff, equipment and vehicles from the Hazardous Area Response Team (HART), Air Operations, Decontamination staff and the Mobile Emergency Response Incident Team (MERIT). The department constantly arranges training for staff and ensures the Trust understands and acts upon intelligence and identified risk to ensure we keep the public safe in terms of major incidents.

The West Midlands Ambulance Service NHS Foundation Trust has reviewed all the data available to them on the quality of care for these three relevant health services.

The Trust is supported by a network of volunteers. More than 800 people from all walks of life give up their time to be community first responders (CFRs). CFRs are always backed up by the Ambulance Service but there is no doubt that their early intervention has saved the lives of many people in our communities. WMAS is also assisted by voluntary organisations such as BASICS doctors, water-based Rescue Teams and 4x4 organisations.

The Trust does not sub-contract to Private of Voluntary Ambulance services for provision of its E&U services.

To ensure excellent business continuity in support of major incidents the Trust has agreements in place to request support from other NHS Ambulance Services.

The Trust has utilised the services of private providers during 2016/17 to support Patient Transport Services particularly during the introduction of new contracts. Sub-contractors are subjected to a robust governance review before they are utilised.

The total service income received in 2016/17 from NHS sources represents 98.35% of the total service income for the Trust. More detail relating to the financial position of the Trust is available in the Trust's 2016/17 Annual Report.

Performance

Emergency and Urgent Service

The Trust is measured nationally against **operational standards for the E&U Service**. Prior to 8 June 2016 the Trust was measured against the national standards as follows:

- ### Red 1 performance

  A Red 1 priority is assigned to patients in cardiac arrest. A cardiac arrest happens when your heart stops pumping blood around your body. If someone has collapsed, is not breathing normally and is unresponsive, they are in cardiac arrest. This is a time critical priority. Ambulance services are expected to reach 75% of Red 1 calls within 8 minutes.

- ### Red 2 performance

  A Red 2 priority is assigned to other types of potentially life-threatening incidents. These include stroke, difficulty breathing, major loss of blood and heart attack. A heart attack differs from cardiac arrest because the supply of blood to the heart is suddenly blocked, usually by a blood clot. These cases are serious but less immediately time critical. Ambulance services are expected to reach 75% of Red 2 calls within 8 minutes.

- ### Red 19 performance

  This target relates to how quickly ambulance services get a vehicle to the scene able to transport a patient. Trusts are expected to get a patient-carrying vehicle to Red 1 and Red 2 incidents within 19 minutes in 95% of the time.

Ambulance Response Programme

NHS England has been leading a workstream since late 2015, known as the Ambulance Response Programme (ARP). It aims to increase operational efficiency whilst maintaining a clear focus on the clinical need of patients, particularly those with life threatening illness and injury.

In November 2015 WMAS moved onto phase 1 of the trial, which allowed more triage time within the call process for less urgent emergency calls. This additional time enables the Trust to allocate the most appropriate resource to each emergency call. It also introduced additional early questioning within the 999 system to help identify the most critically ill patients more quickly.

On 8 June 2016 WMAS moved to phase 2 of the trial, along with two other ambulance Trusts, which introduced new clinically based call priorities, based on the patients' clinical need. These new categories, along with the benefits of Phase 1, support the dispatching of the right vehicle to provide appropriate clinical care for the patient.

The trial is subject to independent evaluation and is due for publication in summer 2017

Whilst an 8-minute target for our most critically ill patients is in place it does not directly correlate with the previous Red1 category as the patient group has changed considerably. As a result, the Trust does not publish performance against the national target and the focus of the external audit as part of the Quality Account has shifted to two other indicatorsNo other measures are being reported by the trial sites.

For the evaluation of the trial and the possible outcome proposals going forward not to be prejudiced prior to publication, the trial Trusts are unable to share performance data externally during the trial period, apart from the 8-minute performance target. One of the outcomes of the evaluation will be around how ambulance services should measure and report performance going forward.

Clinical Audit

WMAS recognise the importance of ongoing evaluation of the quality of care provided against key indicators. As a member of the National Ambulance Service Clinical Quality Group (which develops National Clinical Performance Indicators and National Clinical Audits), we actively partake in both national and local audits to identify improvement opportunities. As a result, the Trust has a comprehensive Clinical Audit Programme which is monitored via our Clinical Audit & Research Programme Group. The Trust has participated in 100% of national audits and has not been required to participate in any national confidential enquiries.

The National Audits that WMAS was eligible for and participated in during 2016/17.

Audit	WMAS Eligible	WMAS Participation	*Number of Cases Submitted	Annual Number of Cases Submitted
Ambulance Quality Indicators (Clinical)	✓	100%	11847	The AQIs run 2-3 months behind for submission to the DH End of year data will be available June 2017.
Myocardial Infarction National Audit Programme (MINAP)	✓	100%	N/A – Hospitals enter data onto national database	

Local Trust Audits

	Local Audit
The Trust produces Local Performance indicators to support local improvements. The Trust is committed to developing links with Hospitals to access patient outcomes.	Examining the Delivery of Mental Health Care
	PGD Medication Audit (previously done Medicines Management)
	Clinical Records Documentation Audit
	Care of Patients Discharged at Scene
	Management of Deliberate Self Harm
	Management of Head Injury
	Management of Obstetric Emergencies
	Management of Peri-Arrests
	Management of Paediatric Pain
	Paediatric Medicine Management
	Paediatric Patients Discharged at Scene
	Administration of Morphine Audit
	Management of Asthma in Paediatric Patients

Learning from Audit

National Audits

Ambulance Services are not included in the formal National Clinical Audit programme however during 2016/2017, WMAS participated in the following four National Clinical Audits.

Ambulance Quality Indicators

1. **Care of ST Elevation Myocardial Infarction (STEMI)**
   Percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction (type of heart attack) who received an appropriate care bundle from the trust during the reporting period.
2. **Care of Stroke Patients**
   Percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.
3. **Care of Patients in Cardiac Arrest**
   In patients who suffer an out of hospital cardiac arrest the delivery of early access, early CPR, early defibrillation and early advanced cardiac life support is vital to reduce the proportion of patients who die from out of hospital cardiac arrest.

Plus the following National Clinical Audit included within STEMI above.

4. **Myocardial Infarction National Audit Programme (MINAP)**

The reports of the four National Clinical Audits were reviewed by the Trust in 2016/17 and the WMAS intends to take the following actions to improve the quality of healthcare provided for patients

- Review and feedback of delays to patients arriving at a Hyper Acute Centre
- Development of performance reports from the Electronic Patient Record
- Development and introduction of individual staff performance from the Electronic Patient Record
- Communication through Trust Weekly Briefing and Clinical Times
- Documentation guidance produced

Local Audits

Three local audit reports were reviewed by the Trust and the Trust intends on taking the following actions to improve the quality of healthcare provided.

Examining the Management and Treatment of Feverish Illness

This latest audit has shown a significant improvement in compliance with appropriate advice documented and patients being discharged in accordance with the NICE traffic light system. There are some areas for improvement that could be included with a wider sepsis audit. The recommended actions are:

- Display posters on Hubs to highlight audit findings.
- Consider discontinuing this audit or combining it with a sepsis* audit.

Clinical Records Documentation audit

The clinical documentation report has highlighted an improvement in standards however there are areas that continue to require improvement. The recommended actions are:

- Expand work on the documentation for onset of symptoms time to all patient groups
- Ensure staff are aware of the rationale and importance of documenting the hospital staff member that accepted the care of the patient.
- Expand work on the documentation of pain assessment to all patient groups
- Raise awareness of the rationale for crossing through mistake through any amendments to paper records with a single line and initials.

Paediatric Asthma Patients Discharged at Scene

This audit demonstrated a significant improvement in the appropriateness of discharging the paediatric asthma patient on scene, however there are some areas that still require improvement; these being:

- Re-issue appropriate Clinical Notices
- Publish audit results via Clinical Times and Intranet to highlight areas of poor compliance and offer guidance on how to comply with guidelines.
- Re-audit of a 100% sample of patients.

***Sepsis is a rare but serious complication of an infection

Participation in Research

The Trust continues to be committed to supporting research within pre-hospital care, thus providing evidence to support improved patient care, treatment and outcomes. To achieve this, we work with universities within the West Midlands and further afield as well as acute hospitals, pharmaceutical companies etc. We also work with the Clinical Research Network West Midlands to ensure all research we take part in complies with the Research Governance Framework to safeguard participants.

During 2016-17 the number of patients receiving relevant health services provided or sub-contracted by WMAS in 2016-17 that were recruited during that period to participate in research approved by a research ethics committee was 643.

During this time period WMAS has supported 10 portfolio studies examples of which are shown below:

The following studies have continued during 2016-17

Epidemiology and Outcomes from Out Of Hospital Cardiac Arrest (OHCA)

Sponsored by Warwick University and funded by the Resuscitation Council (UK) and British Heart Foundation, this project aims to establish the reasons behind such big differences nationally in outcome from cardiac arrest. It will develop a standardised approach to collecting information about OHCA and for finding out if a resuscitation attempt was successful. The project will use statistics to explain the reasons why survival rates vary between regions.

Brain Biomarkers after Trauma

Traumatic Brain Injury is a major cause of illness, disability and death and disproportionally affects otherwise young and healthy individuals. Biomarkers are any characteristic which may be used to gain insight into the person either when normal or following injury or disease. The study will look at biomarkers taken from blood, from fluid in the brain tissue and from new types of brain scans and investigate whether any biomarkers can give us insight into novel therapeutic strategies. WMAS and Midlands Air Ambulance are working with the University of Birmingham to support this study.

PARAMEDIC 2

This trial, sponsored by Warwick University is looking at whether adrenaline is helpful or harmful in the treatment of a cardiac arrest that occurs outside of a hospital setting. Answering this question will help to improve the treatment of people who have a cardiac arrest.

Adrenaline was introduced as a treatment for cardiac arrest before clinical trials were common. Adrenaline has not been fully tested to find out if it is helpful or harmful for patients who have a cardiac arrest outside of hospital. The International Liaison Committee for Resuscitation (ILCOR) has called for a definitive clinical trial to assess the role of adrenaline.

Many research studies suggest that, while adrenaline may restart the heart initially, it may lower overall survival rates and increase brain damage and there are real concerns in the clinical and research community that current practice may be harming patients. However, the evidence is not strong enough to change current practice.

The following studies began during 2016-17

RIGHT-2

It is thought that lowering blood pressure quickly after a stroke could have a beneficial effect on a patient's recovery. Therefore, this study aims to find out whether giving patients who are suspected of having a stroke, a 5mg transdermal glyceryl trinitrate (GTN) patch (a commonly used drug in patients with heart disease) as soon as possible after stroke, and then daily for the next three days, improves outcome.

This is a British Heart Foundation funded study, sponsored by University of Nottingham.

RePHILL

WMAS and Midlands Air Ambulance are working with University Hospitals Birmingham to investigate whether giving blood products (red blood cells and freeze-dried plasma) to badly injured adult patients, before reaching hospital improves their clinical condition and survival. Patients with major bleeding are currently given clear fluids but military and civilian research suggests that survival increases if hospital patients receive blood products instead.

Sustainability

The Trust has an important responsibility to minimise its impact on the environment, ensure efficient use of resources and maximise funds available for patient care

Embedding sustainable development into the Trust's management and governance processes is essential for the Trust to continue to deliver high quality healthcare.

The Trust Senior Efficiency Group chaired by the Chief Executive Officer meets every other month. In line with Lord Carter (2015) recommendations the group ensures that action is taken to find new ways of improving efficiency and productivity whilst ensuring high quality clinical care continues to be delivered across the organisation.

The Trust is proud of the new initiatives it has introduced to improve our buildings, fleet and equipment with energy saving technology which we envisage will produce many cost savings in the future allowing us to support the environment and provide cost savings.

The Trust has continued to see a rise in requests for services and responses to 999 calls which, coupled with the need to travel greater distances to specialist units, has resulted in an increase in our carbon footprint. We will continue to develop improvements to reduce our effect on carbon emissions whilst also maintaining a responsive and effective service.

For more information on our performance last year and how we intend to progress our full sustainability programme during 2017/18 please see our Sustainability Report 2017/18 in Trust publications on our website.

Goals Agreed with Commissioners CQUIN Indicators

Commissioning for Quality and Innovation (CQUIN) is a payment framework that enables commissioners to agree a proportion of the Trust's income to be paid on achievement of quality and innovative work to improve the quality of the Service. The Trust achieved 100% against CQUIN criteria.

A proportion of the WMAS income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between [name of provider] and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.
Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at www.wmas.nhs.uk

2016/17 CQUIN Indicators

Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected Financial Value of Indicator	Achieved (Qtr1-4)
1. National CQUIN - Introduction of Health and Well Being (Option B)	10.02%	£450,542	Yes
2. National CQUIN - Healthy Foods for NHS Staff and Visitors	10.02%	£450,542	Yes
3. National CQUIN - Increasing the Uptake of Staff Flu Vaccinations	10.02%	£450,542	Yes
4. Local CQUIN – Utilization of the Electronic Record	23.45%	£1,054,268	Yes
5. Local CQUIN – Paramedic Skill Mix	23.25%	£1,045,527	Yes
6. Local CQUIN –Locality Planning	23.25%	£1,045,527	Yes

The Trust CQUIN total for 2016/17 is set at 2.5% of the Trust income and equates to £4,496,948.

2017/18 CQUIN Indicators

Indicator Name	Value(% of CQUIN scheme available)	Expected Financial Value of Indicator
1. National CQUIN – NHS Staff Health and Wellbeing – Staff survey improvement	0.500%	£929,359.00
2. National CQUIN – NHS Staff Health and Wellbeing – Flu vaccinations	0.500%	£929,359.00
3. National CQUIN – Reducing 999 Conveyance	0.750%	£1,394,038.50
4. Meeting the Control Total	0.375%	£697,019.25
5. STP Engagement	0.375%	£697,019.25
Total	2.5%	£4,646,795

A full CQUIN report will be published as part of the July 2017 Board Papers on our Trust Website.

Data Quality

West Midlands Ambulance Service takes the following actions to assure and improve data quality for the clinical indicators while the Clinical Audit Department completes the data collection and reports. The patient group is identified using standard queries based on both the paper Patient Report Forms and the Electronic Patient Record. These clinical records are then audited manually by the Clinical Audit Team using set guidance. The data is also clinically validated and then analysed following an office procedure that is available to the Clinical Audit Team and is held on the central Clinical & Quality network drive. The process is summarised as:

- For the clinical indicators, the Clinical Audit Team completes the data collection and reports.
- The Patient Report Forms/Electronic Patient Records are audited manually by the Clinical Audit Team.
- A process for the completion of the indicators is held within the Clinical Audit Department on the central network drive.
- A Clinician then reviews the data collected by the Clinical Audit Team.
- The data is then analysed and reports generated following a standard office procedure. A second person within the Clinical Audit Team checks for any anomalies in the data.
- The results are checked for trends and consistency against the previous month's data.
- The Clinical Indicators are reported through the Trust Clinical Performance Scorecard.

The reports are then shared via the Trust governance structure to the Board, of Directors, Commissioners and Service Delivery meetings.

NHS Number and General Medical Practice Code Validity

The Trust was not required to and therefore did not submit records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics to be included in the latest published data.

Information Governance Toolkit Attainment Levels

West Midlands Ambulance Service Information Governance Assessment Report overall score for 2016/2017 was 84.7% and was satisfactory from IGT Grading

Clinical Coding Error Rate

West Midlands Ambulance Service was not subject to the Audit Commissions Payment by Results Clinical Coding Audit during 2016/2017

West Midlands Ambulance Service was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

NICE Guidance

The Trust monitors NICE guidance to ensure relevance to the services we provide is identified. A report of relevant guidance and actions taken to ensure compliance with best practice will be available of the Trust website in July 2017.

Performance against Quality indicators

To ensure patients of the West Midlands receive quality care from their Ambulance Service a set of national Ambulance Quality Indicators have been set. These help set our policies and guidelines and develop our organisational culture that places quality at the top of the Trust agenda. The following details the figures for each and highlights the national mean percentage and the position of WMAS against other Trusts.

All Ambulance Trusts are required to report these mandatory quality indicators:

Operational Performance

Ambulance Services nationally have again struggled to meet both national performance targets and efficiency targets in 2016/17 but West Midlands Ambulance Service NHS Foundation Trust has continued to perform well.

The Trust is one of three ambulance Trusts that has participated in a national trial "Ambulance Response Programme". The purpose of the trial is to determine the future of ambulance performance standards by testing the clinical viability of a set of new standards that are proposed for future roll out. Since the trial commenced on 8 June 2016, the Trust has not been subject to existing standards other than Category 1. The selection of incidents in each category within the trial differs from previous categorisation. Therefore, whilst category 1 performance is reportable, the volume and type of incidents is not comparable to the Red 1 Category reported in previous years. As a rough guide, Category 1 encompasses about twice as many calls as Red 1.

The Trust 2016-17 performance against the Category 1 standard is 66.5%. However, as a result of the changes implemented for the trial, the volume of resources that are allocated to each incident has reduced because patients are receiving the right response first time, this has impacted positively upon efficiency measures.

We continue to work with our Commissioners and other Providers such as Acute Hospital colleagues to ensure improvements in the provision of healthcare for the people of the West Midlands. WMAS continues to employ the highest paramedic skill mix in the country with a paramedic present in over 95% of crews attending patients every day.

Ambulance Quality Indicators

1. **Care of ST Elevation Myocardial Infarction (STEMI)**
   Percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction (type of heart attack) who received an appropriate care bundle from the trust during the reporting period.
2. **Care of Stroke Patients**
   Percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.
3. **Care of Patients in Cardiac Arrest**
   In patients who suffer an out of hospital cardiac arrest the delivery of early access, early CPR, early defibrillation and early advanced cardiac life support is vital to reduce the proportion of patients who die from out of hospital cardiac arrest.

STEMI (ST- elevation myocardial infarction)
This is a type of heart attack. It is important that these patients receive:

- Aspirin - this is important as it can help reduce blood clots forming.
- GTN – this is a drug that increases blood flow through the blood vessels within the heart. (Improving the oxygen supply to the heart muscle and also reducing pain).
- Pain scores – so that we can assess whether the pain killers given have reduced the pain.
- Morphine – a strong pain killer which would usually be the drug of choice for heart attack patients.
- Analgesia – Sometimes if morphine cannot be given Entonox, a type of gas often given in childbirth, is used.

The Care Bundle requires each patient to receive each of the above.

In addition, the below is monitored for patients eligible for Primary Percutaneous Coronary Intervention (PPCI):

- Call to Balloon - 75% of patients that have PPCI should do so within 150 minutes of the initial call. This treatment is provided at a specialist heart attack centre.

Stroke Care Bundle

A stroke care bundle includes early recognition of onset of stroke symptoms and application of the care bundle to ensure timely transfer to a Specialist Stroke Centre.

The Stroke Care Bundle requires each patient to receive each of the detailed interventions below:

- FAST assessment - A FAST test consists of three assessments; has the patient got Facial weakness, or Arm weakness or is their Speech slurred.
- Blood glucose - In order to rule out the presence of hypoglycaemia patients suspected of having suffered a stroke should have their blood glucose measured
- Blood pressure measurement documented - Raised blood pressure is associated with increased risk of stroke so patients suspected of having suffered a stroke should have their blood pressure assessed

Where a patient is eligible for thrombolysis, they should be taken to a Hyper-Acute Stroke Unit within 60 minutes

Cardiac Arrest

A cardiac arrest happens when your heart stops pumping blood around your body. If someone suddenly collapses, is not breathing normally and is unresponsive, they are in cardiac arrest.

The AQI includes:

- ROSC (return of spontaneous circulation) on arrival at Hospital
- Survival to discharge from hospital

The above are reported within two different groups as follows:

- Overall Group
  - Resuscitation has commenced in cardiac arrest patients
- Comparator Group
  - Resuscitation has commenced in cardiac arrest patients AND
  - The initial rhythm that is recorded is VF / VT i.e. the rhythm is shockable AND
  - The cardiac arrest has been witnessed by a bystander AND
  - The reason for the cardiac arrest is of cardiac origin i.e. it is not a drowning or trauma cause.

In this element, we would expect a higher performance than the first group.

Care bundles include a collection of interventions that when applied together can help to improve the outcome for the patient.

Year-to-date Clinical Performance AQI's

Mean (YTD)							
Ambulance Quality Indicators	**WMAS (14-15)**	**WMAS (15-16)**	***WMAS (16-17)**		**National Average** (Apr-Sept 16)	**Highest** (Apr-Sept 16)	**Lowest** (Apr-Sept 16)
			Apr-Sept 16	Apr-Dec 16			
STEMI Care Bundle	72.49%	77.99%	80.29%	80.48%	79.58%	84.21%	73.68%
STEMI Call to Balloon within 150 minutes	88.14%	87.52%	87.00%	87.03%	86.33%	91.95%	77.04%
Stroke Care Bundle	94.00%	98.19%	97.46%	97.42%	97.62%	98.77%	96.36%
Stroke FAST + patients transported to Hyper Acute Centre <60 mins	46.93%	58.83%	57.50%	56.85%	54.53%	60.38%	52.91%
Cardiac Arrest - ROSC At Hospital (Overall Group)	28.71%	30.17%	31.94%	30.62%	28.98%	34.30%	29.93%
Cardiac Arrest - ROSC At Hospital (Comparator)	45.57%	50.61%	49.54%	46.25%	52.51%	64.71%	35.71%
Cardiac Arrest - Survival to Hospital Discharge (Overall Group)	8.29%	8.66%	9.56%	9.19%	8.98%	10.90%	8.64%
Cardiac Arrest - Survival to Hospital Discharge (Comparator Group)	20.62%	24.69%	26.15%	25.00%	27.12%	36.11%	19.44%

**The Trust is permitted to re-submit nationally reported clinical data to NHS England twice a year. This re-submission is to allow for data to be accessed from hospitals for outcome data and to ensure a continual validation of data can be completed. The above table shows April – September 2016 data submitted to NHS England and the focus of external audit and a further column which includes more recent data, however this has not yet been validated. The final submission of 2016-2017 data will be in July 2017.*

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What our Staff Say

As in previous years, the National Staff Survey was conducted for WMAS by Quality Health. Unlike previous years, the Board of Directors took the decision to run a census for the 2016 survey, rather than using a randomised selection of staff. Furthermore, the survey was conducted electronically and to maintain confidentiality and anonymity, the questionnaire was distributed via an email link to all 4350 staff in the Trust.
The Survey opened on 12 September 2016 and closed on the 2 December 2016.
1332 staff took part. This is a response rate of 31% an increase from 26% in 2015.

The average for ambulance trusts in England was 38%. The overall national response rate for all organisations in England was 44%.

The top 5 Scores for WMAS were:

- 92% of staff appraised in last 12 months (76%*)
- 3.24 Staff satisfaction with resourcing and support (3.12*)
- 83% of staff working extra hours (85%*)
- 71% of staff / colleagues reporting most recent experience of violence (64%*)
- 37% of staff satisfied with the opportunities for flexible working patterns (34%*)

The bottom 5 Scores for WMAS were:

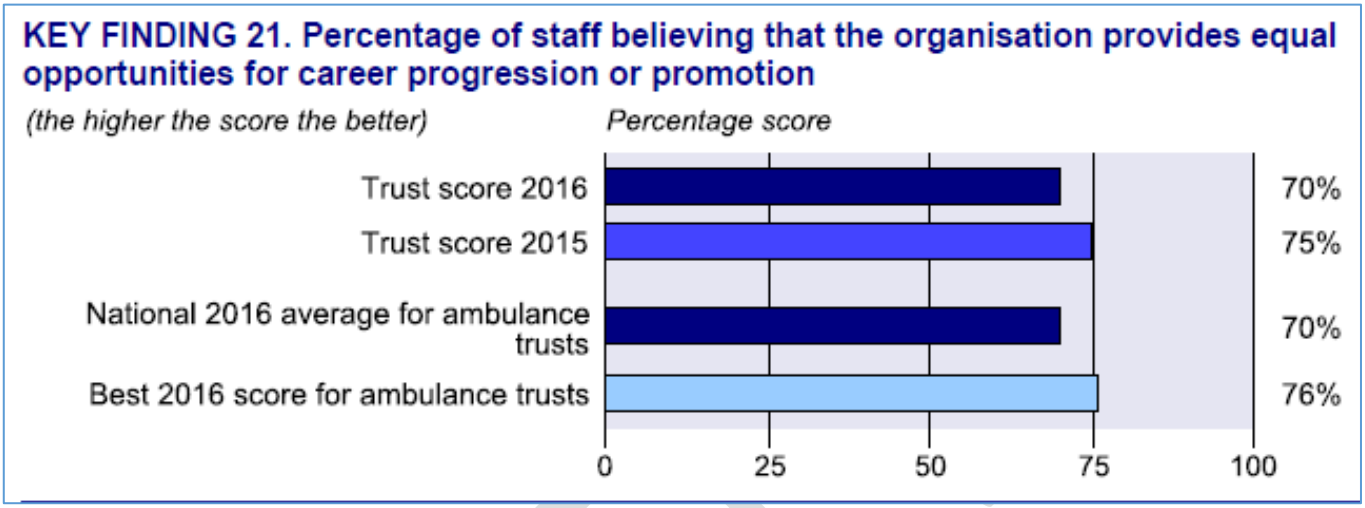
- 3% of staff experiencing physical violence from staff in last 12 months (2%*)
- 2.33 Quality of appraisals (2.69*)
- 33% of staff experiencing harassment, bullying or abuse from staff in last 12 months (28%*)
- 2.87 Recognition and value of staff by managers and the organisation (3.02*)
- 3.30 Support from immediate managers (3.44)

* 2016 Average for Ambulance Trusts

As in previous years, there are two types of Key Finding:

- **percentage scores**, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
- **scale summary scores**, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

The findings of the staff survey questionnaire have been summarised and presented in the form of 32 Key Findings and these have been structured into nine themes. Under Equality and Diversity theme, KF21 refers to the percentage of staff who took part in the survey believing the organisation provides equal opportunities for career progression or promotion.



The Staff Survey Response Action Group has analysed the results in detail and classified them into “Pleasing Results” and “Areas for inquiry and discussion”.

It has been agreed that the results will be communicated to staff through roadshows at different locations. The roadshows will give the group an opportunity to get qualitative feedback from staff.

The group has identified the following three potential areas so far which it is proposed may form the basis for the Staff Survey Action Plan.

1. Question 9g – Have you put yourself under pressure to come to work?
2. Question 15b – How many times have you experienced bullying, harassment or abuse at work from your manager?
3. Question17c – On what grounds have you experienced discrimination?

West Midlands Ambulance Service has reviewed the data made available by the Health and Social Care Information Centre with regard to percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. WMAS considers that this data is as described as it has been cross checked with Trust database systems.

The full Survey results are published on the NHS Employers website- http://www.nhsstaffsurveys.com/Page/1006/Latest-Results

Equality and Diversity

Equality & Diversity is at the core of everything the Trust does from dignity & respect through to providing equality of opportunity for all.

EDS2 [Equality Delivery System 2]

The Trust has embraced EDS2 by hosting events internally with our staff and externally with our communities and other organisations we work with. The aim of EDS2 is to grade the Trust against 18 outcomes and publish the grading and provide a report on the feedback from our consultations which have been constructive and enlightening in the development of action plans. The Trust achieved a grade of good in fourteen outcomes and developing in the remaining categories. www.wmas.nhs.uk/Pages/Equality-and-Diversity.aspx

Recruitment

The Trust endeavors to recruit a workforce that is representative of the communities we serve by the use of Positive Action on all advertised jobs. A more diverse workforce enables us to deliver a more inclusive service and improve patient care.

The Trust has enhanced recruitment through the following measures:

- Positive Action Statement on every job advert for BME & Disability applicants
- Marketing through positive imagery leaflets and brochures
- Community engagement
- Stringent auditing to ensure fairness and equity
- Recruitment training for interviewers to ensure all interviews are fair and provide an equality of opportunity.
- WMAS has produced a DVD to particularly encourage applicants from a BME background to apply for the post of Student Paramedic. The first draft is expected May 2017 and after editing will be offered in different languages and placed on You Tube, the Trust web site and Trust Facebook page. It is also being shared with other ambulance services.

Future initiatives for Recruiting:

- New recruitment web site May 2017
- You Tube package of interviews for different roles with BME staff volunteering to take part in the use of positive imagery.
- Marketing materials that reflect the diversity of the workforce for WMAS will be distributed at events.
- Community engagement targeting areas of high BME demographics and engagement at young people level. Particularly when young people are deciding on a career.
- WRES action plan to incorporate recruitment measures and encourage development and progression.

www.wmas.nhs.uk/Pages/Job-Opportunities.aspx

Public Sector Equality Duty [Equality Act 2010]

The Trust meets the requirements of the Public-Sector duty [Equality Act 2010] and has produced an annual report for the Board and for public dissemination.

General Public Sector Duty

The Trust has evidenced how it has achieved the aims of the General Duty i.e.

- *To eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.*
- *Advance equality of opportunity between people who share a protected characteristic and those who do not.*
- *Foster good relations between people who share a protected characteristic and those who do not.*

This has been achieved through our work on key areas including a positive and supportive approach to recruitment and actions taken relating to our Equality Delivery System 2 and Workforce Race Equality Standard plans.

Specific Duties

The Specific Duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives. The Trust publishes this information annually on our website.

Equality Objectives

The Trust is required under the "Specific Duties" to prepare and publish equality objectives which help to further the aims of our Equality Duty. WMAS objectives are

Equality Objective One
Increase recruitment applications from BME [Black Minority Ethnicity] and Disabled candidates to the Trust to ensure that Trust staff are representative of the communities we serve. Encourage current members of staff who are BME or Disabled to develop and flourish to their full potential.
Equality Objective Two
Build trust and confidence with our communities, patients, carers and their families through effective communication, engagement and partnership working.
Equality Objective Three
Create a culture where all staff, patients, carers and their families and other agencies the Trust works with are treated with Dignity and Respect
Equality Objective Four
Continue to develop the working environment, were all staff are encouraged to develop as individuals, so they will provide high quality patient care and enhance the reputation of the Trust in doing so will feel valued for their contribution.
Equality Objective Five
All staff are to foster working relationships that eliminate Bullying, Harassment, Discrimination and other unwanted behaviours that do not reflect Trust values.

www.wmas.nhs.uk/Pages/Equality-and-Diversity.aspx

Workforce Race Equality Standard [WRES]

The Trust supports and promotes the WRES, encouraging BME staff to reach their full potential through equality of opportunity. The Trust aims to recruit a workforce that is diverse and representative of our communities. The WRES is a set of metrics which annually is published in conjunction with an Action plan. This is due to be published in May 2017 and will incorporate a new Action plan to reflect the progress the Trust has achieved over the last year.

EDHR Group [Equality, Diversity & Human Rights}

The Trust supports an EDHR group with representation from a diverse range of staff from across the Trust who are representative of the various roles and departments within the Trust, this group is chaired by the CEO. The EDHR group meets every three months to consult and drive the Equality & Diversity agenda forward.

Staff Networks

The Trust currently has two staff networks which are both supported:

1. The Pride Network:
   This network is for Lesbian, Gay, Bisexual & Transgendered staff and is supported by “Straight Ally’s” which is a concept developed by Stonewall. The Network is represented at Pride marches and the Trust is a member of the Ambulance Sector National LGBT group.

2. The BME Group
   The group is a new development within the Trust and is currently looking at Terms of Reference and electing a staff committee. The group when formalized will have representation on the national forum.

NADG (National Ambulance Diversity Group)

The Trust is represented on the national group and attends the meetings regularly. It is a forum of shared knowledge and expertise which drives the Equality & Diversity agenda at a national level.

Health and Wellbeing

Working in partnership with union colleagues the Trust has developed a Health and Wellbeing Strategy and 12-month implementation plan to ensure that health and well-being of staff is supported.

Health & Wellbeing is embracing the whole person's physical and mental health both inside and outside of the workplace. It is a feeling of physical, emotional and psychological wellness rather than absence of ill health and disease.

Last year the Trust improved on the NHS target set at 75% by achieving 76.2% of staff that accepted the flu vaccination during winter 2016. WMAS is the first Ambulance Service to achieve the 75% target.

The Trust has been part of the national pilot group of 11 Trusts for Health & Wellbeing under the remit of NHS England. WMAS this year has been proactive across three key areas;

- Mental Health
- Musculoskeletal
- Weight Management

Staff Mental Health

Staff have been helped through a variety of interventions to support their Mental Health and Wellbeing for example:

- Working conditions: The Trust provides state of the art vehicles and equipment to enable staff to provide the best possible service and care.
- Bullying & Harassment: The Trust has a 'zero tolerance' position statement issued via the CEO and E Learning training packages for staff and Managers in the management of any Bullying, Harassment and Discrimination.
- Information: Mental Health information is provided via the mental health yammer group, regular articles about Mental health in the Weekly Brief, raising awareness on key dates on the HWB calendar, Time to Talk and the Trust have signed the Blue Light Pledge.
- Mental Health Training: Managers have under gone mental health training and stress risk assessments
- Listening Centre: The Listening Centre is an external counselling service through which the Trust provides support for staff.
- SALS Staff Advice & Liaison Service; This service is a 24/7 service provided by staff for staff in supporting and signposting staff to the most appropriate services
- Absence Management Training; All managers and supervisors undergo this training so that they have an awareness of protocols and how they can support staff when they are absent due to illness.

Future Initiatives

- Mental Health First Aid training [MHFA] for managers
- LITE Training via Mind for staff
- Mind your Mate Training
- Mental Health Checks
- TRiM Training [Trauma Resilience Management]

Musculoskeletal

Last year the Trust was funded by NHS England for the provision of an in-house physiotherapist who is a specialist in musculoskeletal injuries and ailments. This service started in July 2016 and is proving to be very popular and successful with a drop of 2% in absence for musculoskeletal related injuries.

Future Initiatives

The way forward will be to adopt a more pro-active approach with prevention being better than cure. This could be achieved by physical fitness programmes and exercise.

Weight Management

The Trust successfully launched a weight management programme in conjunction with Slimming World. The Trust has supported staff by providing free membership and 12 weeks attendance at Slimming World free of charge. So far over 400 staff have taken part losing 3,552lbs between them.

Future Initiatives

The Trust will provide the opportunity in May for another 200 staff to avail themselves of the Slimming World vouchers to commence their weight loss journey. It is planned to use members of staff who have already been successful through SW to act as buddies to the new applicants.

2016/17		
	Target	Achievement
Appraisals	85%	97%
Mandatory Training – A&E day 1	85%	110%*
Mandatory Training – A&E day 2	85%	102%*
Mandatory Training - PTS	85%	88.5%
Sickness Absence	Less than 4%	3.27%

*Changes in workforce and clinical managers also included.

Part 3
Review of Performance against 2016-17 Priorities

	Priority	Progress	How we did
Patient Experience	**Deliver Making Every Contact Count (Public Health) Education**	The Trust is limited in the time that clinicians have with patients and for them to promote health and wellbeing effectively it was agreed that during 2016/17 the Trust would provide suitable education. The Trust was supported in the provision of MECC education through funding from PHE. Education was provided to all Clinical Team Mentors who then provided 96% of clinical staff with a supervision shift where MECC was addressed.	Achieved
	Continue to work with Public Health to reduce health inequalities	The Trust now provides non-patient identifiable data to Public Health England daily which is assisting them to determine planning and priorities for the future. Once PHE have fully analysed and reported on this data it is expected they will work with other ambulance services to progress this work nationally.	Achieved
	Engage with Rural Communities	The Trust engagement vehicle and team has visited all counties within the Trust to attend local events and talk with public. The CEO and Director of Nursing have met with local community representatives from rural areas of Staffordshire. Community First Responders have agreed to speak with their local communities and have been provided with feedback documentation. Work with Healthwatch has not been progressed as much as the Trust hoped and therefore work will continue in this area as part of the Trusts Engagement Plans for 2017/18	Partly achieved and Ongoing

Patient Safety	**Reduce the risk of falls that result in harm when assisting with mobilising patients in our care**	The Trust committed to reducing the risk of harm to patients specifically moderate and above through education and a raising of awareness campaign. During 2016/17, the Trust provided training to 88.5% of Patient Transport Staff as part of their mandatory training. A Trust wide raising of awareness and a promotion of the need to report near miss and low harm incidents to facilitate learning has resulted in a 70% increase in reporting of patient safety incidents and no increase in moderate and above harm. During 2015/16 there were 17 moderate and above incidents reported and in 2016/17 there were 16.	Achieved
	Reduce the risk of harm that occurs to patients in wheelchairs (skin tears, bruises etc)	Training and education provided as above and Trust wheelchair provision has been reviewed and improved. There has been an increase in patient safety reporting of low harm and near miss since the introduction of an electronic reporting system. Both the number of near misses and low harm have increased and therefore this priority will be carried forward as part of reducing all patient harm during 2017/18. There has been no increase in moderate and above harm.	Partly achieved
	Reduce the risk of harm by utilizing the most appropriate safety restraints	The Trust has worked with providers of child safety restraints to ensure a more appropriate system for babies under 5kg in weight. New restraints have now been purchased to ensure restraints are now available for under 5kg to adult. The Trust has introduced new signage for ambulances that reminds staff and parents that child restraints need to be used.	Achieved

Clinical Outcomes	**Deliver an Improved Model of Clinical Supervision**	The Trust recognised that the changing workforce and increased skills of their clinicians meant a greater focus was required for Clinical Supervision. The model introduced during 2016/17 increased opportunities for reflective practice through • Part of group sessions during mandatory training – 100% completed • Part of Personal Development Review with manager – 97% completed • A full supervision shift with a Clinical Team Mentor – 96% completed We expect our new model of Clinical Supervision to embed fully over the next year which will continue to help our clinicians provide the very best care available.	Achieved
	Safe on scene project is completed.	Reviews / case studies have taken place to ensure the most appropriate time on scene. Information has been shared with staff via Trust publications. With an ever-increasing pressure on the NHS the time our crews spend with patients is crucial to ensure they receive a timely transfer to hospital or appropriate care in their home to enable safe discharges and effective transfers of care to suitable care pathways. Reviewing time on scene will continue as routine work for the Trust.	Achieved
	Improve Clinical Performance - specifically those areas reported on nationally to include management of single limb fractures	The Trust agreed this clinical priority based on nationally agreed indicators which have since ceased due to variances in the original nationally agreed reporting criteria. As part of the work reviewing the indicators the Trust identified a need for changes in equipment to ensure the most appropriate care was delivered to patients with leg fractures and this has now been agreed and new equipment purchased.	Achieved

Patient Safety

Reporting, monitoring, taking action and learning from patient safety incidents is a key responsibility of any NHS provider. At WMAS, we actively encourage all our staff to report patient safety incidents so that we can learn when things go wrong and make improvements.

A positive safety culture is indicated by high overall incident reporting with few serious incidents which we continue to achieve. Encouraging staff to report near misses allows us the opportunity to learn lessons before harm occurs.

Analysis of all incidents takes place and is supported by triangulation with other information such as complaints, claims, coroners' inquiries, clinical audit findings and safeguarding cases. These are discussed monthly at the Learning Review Group (LRG). The meeting is chaired by the Deputy Director of Nursing & Quality and attended by clinicians from across the organisation. Themes and trends are reported quarterly to the Quality Governance Committee and the Trust Board of Directors.

West Midlands Ambulance Service has reviewed the data made available by the Health and Social Care Information Centre (HSCIC) with regard to the number and, where available, rate of patient safety incidents reported within the trust during 2016/17, and the number and percentage of such patient safety incidents that resulted in severe harm or death. WMAS considers that this data is as described for the following reasons: it has been cross checked with Trust database system and is consistent with reports made to NRLS during this period.

Incidents reported to the NRLS between 1st April 2016 and 30th September 2016						
Level of Harm			Severe		Death	
Ambulance Service	Days between incident date and report to NRLS	Number of incidents	N	%	N	%
LAS	122 (109)	294 (1,187)	10 (3)	3.4 (0.3)	2 (3)	0.7 (0.3)
NEAS	28 (102)	680 (1,059)	2 (1)	0.3 (0.1)	11	1.6 (1.5)
NWAS	10 (9)	650 (570)	0 (3)	0 (0.5)	3	0.5 (0.7)
YAS	13 (16)	944 (848)	23 (21)	2.4 (2.5)	0	0 (2)
EMAS	7 (34)	419 (362)	3 (11)	0.7 (3)	5	1.2 (5)
WMAS	22 (35)	563 (314)	5 (3)	0.9 (1)	0	0 (0.6)
EoE	69 (90)	727 (1,016)	0 (0)	0 (0)	0	0 (0)
SECAMB	77 (40)	159 (267)	7 (9)	4.4 (3.4)	1	0.6 (1.9)
SCAS	13 (5)	80 (415)	6 (6)	7.5 (1.4)	0	0 (0)
SWAST	131 (180)	1,070 (1,530)	6 (20)	0.6 (1.3)	0	0 (0)
Total		5,586 (8,082)	62 (77)	1.1 (1)	22 (69)	0.4 (0.9)

( ) Data relates to 1st Oct 2015 to 31 March 2016 earlier reports are not available in this format.

The WMAS has taken the following actions to improve this percentage of harm, and so the quality of its services, by ensuring robust review of incidents and identification of priority actions as identified within this quality account.

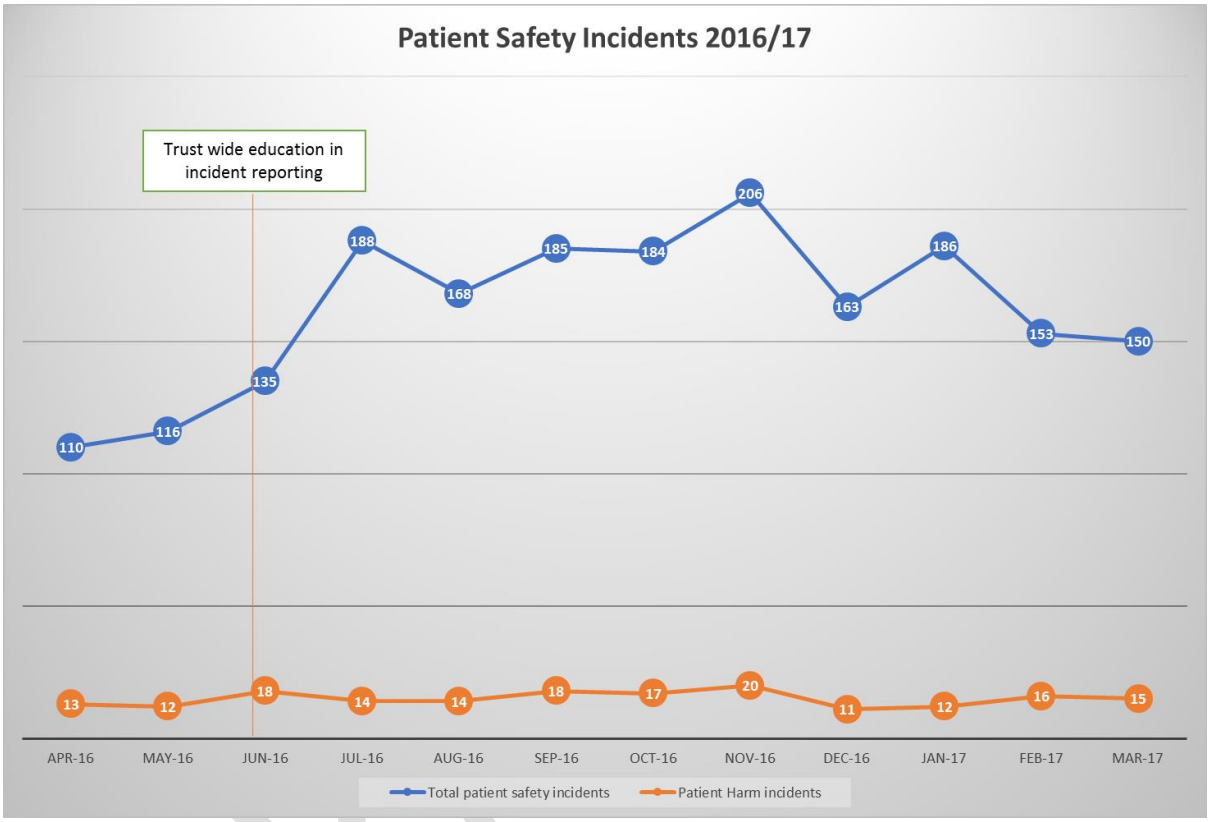
Total Number of Patient Safety Incidents reported by Month

	April 16	May 16	June 16	July 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	March 17	Total
Birmingham	20	19	22	30	19	26	22	22	20	28	20	23	271
Black Country	19	14	25	34	24	39	27	23	34	20	19	16	294
Coventry & Warwickshire	11	15	17	23	20	20	20	25	15	17	20	23	226
West Mercia	15	27	25	29	36	41	29	29	27	44	29	25	356
Staffordshire	7	10	9	23	20	22	19	18	17	21	16	10	192
PTS	24	16	21	27	34	19	43	64	37	34	37	38	394
EOC	14	14	14	17	15	17	23	24	12	16	9	14	189
Air Ambulance	0	1	1	4	0	2	2	2	3	4	0	1	20
HART			1					1	1	2	3	1	
Other (Corporate)				1									
Total	**110**	**116**	**135**	**188**	**168**	**186**	**185**	**208**	**166**	**186**	**153**	**151**	**1952**

Total Number of Harm Incidents	**13**	**12**	**18**	**14**	**14**	**18**	**17**	**21**	**12**	**12**	**16**	**15**	**182**

This demonstrates a 76% increase on incident reporting compared to last financial year. Patient harm events accounted for 8% of those incidents reported during 2015/16 and 9% for 2016/17.

Following on from the introduction of the electronic incident reporting system in February 2016, a programme of Trust wide education relating to the importance of incident reporting with emphasis on the reporting of near miss/no harm incidents took place throughout June 2016. This saw a positive impact on the reporting of incidents for no harm and/or near miss incidents whilst patient harm incidents increased by 1%.



Themes

Patient Safety/Patient Experience/Clinical Audit

- Harm Incidents: Continue to be associated with slips, trips and falls and collision/contact with objects with a concern noted about patients in wheelchairs experiencing minor harm such as grazes and bruising. Mainly in our Patient Transport Service (PTS) – the PTS training programme for 2016/17 included a refresher on assessment of patients and risk of harm from Slip, Trip, Fall and wheelchair use.

- Equipment: Failure of the air cushion used to lift patients from the floor resulted in a review being completed by the patient safety and risk teams which highlighted several actions. A robust device management plan which included infection control, battery management and servicing has been implemented following which incidents relating to the device will continue to be monitored.

- Monitoring: Failure to utilise waveform capnography a device used to ensure a patient airway is being maintained correctly continues to be a focus of the Trust.

- Make Ready – Missing equipment or out of date drugs on vehicles that have been through the make ready system. Although a reduction in the number of incidents reported has been seen since the filling of Ambulance Fleet Assistant vacancies it continues to be a leading trend.

- Delays - PTS delays in attendance continue to be a theme – contractual issues have been a main cause due to roll over of under commissioned contracts – concerns have been highlighted to commissioners of services. New contracts have been introduced which we hope will support us to deliver a more responsive service during 2017/18.

Serious Incidents

All serious incidents are investigated using Root Cause Analysis methodology to determine failures in systems and processes. This methodology is used to steer away from blaming operational staff at the sharp end of the error, to ensure the organisation learns from mistakes and that systems are reinforced to create a robustness that prevents future reoccurrence.

Between April 2016 and March 2017, the Trust registered 32 cases as serious incidents. Of those 32 cases registered, 7 were stood down following investigation as it was established they did not meet the threshold as a serious incident. Further information on our Serious Incidents is provided within our Learning Review Reports published on our website within the Patient Safety section.

Following investigations into serious incidents the Trust identified the following key areas for improvement.

Increased education specific to:

- Use of the waveform capnography
- ECG interpretation
- Crew Resource Management
- Identification of acute stroke
- Identification of sepsis
- Use of early warning scores

The Trust has not had cause to report any Never Event incidents

Sign up to Safety

In March 2015 the Trust formally signed up to the NHS Sign up to Safety (Listen Learn Act) Campaign. The Trust five pledges are listed below and further information on our plans is available via the Patient Safety section of our website.

1. **Put Safety First - We will continue to;**
   - Promote the quality and safety agenda and provide positive leadership through clinical champions across all areas of the Trust and from Board of Directors to front line staff
   - Ensure that staff are given the education and tools to continue to provide high quality care
   - Improve seamless handover of care through utilization of formally agreed communication tools and standards developed in partnership with Acute colleagues.
   - Ensure that our top 5 patient safety risks have action plans to reduce the risk of harm and that these plans are shared with all staff.

2. **Continually Learn - We will continue to;**
   - Provide full support to the Learning Review Group (LRG) by ensuring full commitment to the membership by all directorates and in depth review of LRG reports throughout the committee structure up to and including the Trust Board of Directors.
   - Ensure a series of Patient Safety 'walk-a-rounds' to allow staff and patients to raise issues that can be addressed and shared in a timely manner.
   - Utilize Root Cause Analysis (RCA) methodologies for reviewing and investigating trends where low to moderate harm has occurred rather than just RCA serious and high risk incidents.
   - Continue to share learning with other organisations and key stakeholders to improve practice and encourage a culture of openness.
   - Evaluate organizational understanding of quality and safety and provide a forum for staff to make suggestions for improvements.

3. **Honesty - We will continue to;**
   - Always tell our patients and their families/carers if there has been an error or omission resulting in harm.
   - Undertake an awareness raising campaign to support our staff in the being open process and incorporate this further into Patient Safety Training.
   - Publish outcomes of incident investigations and trends/themes on our website/ intranet.
   - Publish our top 5 Patient Safety Risks, explain what our plans are for reducing the risk of harm and then ensure we publish progress reports at least quarterly.

4. **Collaborate - We will;**
   - Work in partnership with local Health and Social Care organisations to explore new models of care delivery in order to maintain a safe and high quality service for all patients
   - Scrutinize our quality and safety systems to assess the effectiveness of assurance gathering processes to evidence our service is operating effectively.
   - Develop and improve our service through benchmarking and standardization with other Ambulance Services via membership of national expert groups within the Association of Ambulance Chief Executives network.

5. **Support - We will continue to;**
   - Continually review our methods of Education and Training to ensure our staff are kept well informed
   - Ensure staff are given the opportunity for reflective practice through a robust clinical supervision model.
   - Promote safety and best practice through Trust Communications and the Ambulance National Patient Safety Conference hosted by this Trust.
   - Reward and publish good practice via Trust Communications, the Patient Safety Conference and Award Ceremonies

Top Patient Safety Risks

Missing equipment/drugs and/or out of date drugs on vehicles that have been through the make ready system.

Failure to appropriately utilise waveform capnography following intubation.

Incidents when transferring/moving patients during transport.

Failure to interpret clinical findings and act on appropriately.

Failure of the electronic patient Lifting Cushion.

You said – We did'

To encourage staff and to provide them with assurance that incident reporting does improve patient safety and care we regularly publicize 'you said – we did' articles within the Weekly Briefing. Examples of this include:

- Staff reported concerns over the provision of the size and gauge of the IM safety needle introduced by the Trust particularly in relation to paediatric patients. Following review a smaller size needle was quickly agreed and made available to staff
- The review and improvements in the management of the patient lifting cushion device

Duty of Candour

The Trust promotes a culture of openness to ensure it is open and honest when things go wrong and a patient is harmed. Being open is enacted in all incidents where harm is caused no matter the severity to ensure this culture is carried out.

NHS providers registered with the Care Quality Commission (CQC) are required to comply with a new statutory Duty of Candour, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 Duty of Candour which relates to patient harm events considered to have caused moderate harm or above. This regulation requires a more formal process of ensuring that incidents are investigated at an appropriate level and that being open and honest with the patient and/or their families is completed.

The introduction of a Patient Safety section of the Trust website supports the Trust Duty of Candour requirements and allows greater openness and sharing about when things have gone wrong and what the Trust has learnt and is doing to put things right and improve.

The Trust Duty of Candour/Being Open policy is available via the Trust website or directly from the Freedom of Information officer.

The policy details the arrangements the Trust has in place for staff and managers and the Trust Learning Review Reports published on the Trust Website and presented to the Board of Directors each quarter identifies compliance with our statutory duties.

The Trust has recognised that it needs to pay greater attention to all moderate harm (seven reported during 2016/17) to ensure full compliance is included in the reports shared with the Board of Directors.

Safeguarding

Safeguarding for Adults and Children is embedded in WMAS throughout Policies, Procedures, education and literature. All staff within WMAS are educated to report safeguarding concerns to the single point of access Safeguarding Referral Line.

Safeguarding Referral Numbers

Adult Safeguarding Referrals

	Total
April 2015 - March 2016	19604
April 2016 – March 2017	21386
% variance	**9%**

Child Safeguarding Referrals (Under 18's)

	Total
April 2015 - March 2016	3498
April 2016 – March 2017	4534
% variance	**30%**

In April 2015, some aspects of the Care Act 2014 were introduced resulting in a significant change in adult safeguarding. This presented a key challenge to ensure staff were aware of the changes. A bespoke WMAS adult safeguarding pocket book was created and made available to all staff to assist in this transition.

Currently there are 28 Safeguarding Boards across the West Midlands and engagement continues to develop with WMAS.

Patient Experience

Complaints and Contacts

Key themes for PALS and formal complaints relate to

- **Timeliness of 999 ambulance and Patient Transport Service Vehicles**–that there is a delay or perceived delay in the arrival of a 999 ambulance or response vehicle or there is a delay in the arrival of a Non-Emergency Ambulance to take a patient to and from their hospital appointment.
- **Professional Conduct** - that the patient or a family relatives feels that the attitude of conduct of the attending ambulance staff or call taker was not to the standard that they would expect.
- **Clinical Treatment complaints**- that the patient or a family relative feels that the treatment or advice received is not appropriate. Examples being a patient is left at home and not conveyed to hospital, as a GP appointment has been arranged.

Complaints

The Trust has received *377 complaints compared to *354 in 2015/16. Equating to 1 complaint in every 4607 patients. The main reason relates to care provided.

Breakdown of Complaints by Service Type YTD:

	2015-2016	2016-2017	Variance 15/16 – 16/17
EOC	94	73	-23.4
EU	196	193	-0.5
PTS	59	102	78
OOH	0	0	0
Other	5	9	28.6
Total	**354**	**377**	**6%**

Upheld Complaints

The table below indicates that of the *377 closed complaints, 138 were upheld. If a complaint is upheld, learning will be noted and actioned locally and will also be fed into the Learning Review Group for regional learning to be identified and taken forward.

	Justified	Non Justified	Part Justified	Total
Call Management	8	9	9	26
Attitude and Conduct	28	28	25	81
Clinical	24	55	31	110
Driving and Sirens	2	3	1	6
Response	69	24	30	123
Information Request	5	8	3	16
Other	2	8	5	15
Total	**138**	**135**	**104**	**377**

*(Data verified 15 May 2017)

PALS

Concerns have increased year on year with *1625 concerns raised in 2016/17 compared to *1142 in 2015/16, an increase of 42%. The main reason for a concern is 'response' including emergency and non-emergency patient transport arrangements.

It should be noted that the Trust acquired two new PTS Contracts one in July and the other in October 2017 which would have contributed to the increase.

Ombudsman Requests

Most complaints were resolved through local resolution and therefore did not proceed to an independent review with the Parliamentary and Health Service Ombudsman. During 2016/17 - 9 independent reviews were carried out compared to 8 in 2015/16 of these two were closed with no further action and four remain under investigation by the Ombudsman.

Patient Feedback/ Surveys

The Trust received 45 completed surveys via our website relating to Emergency Services and 8 relating to the Patient Transport Service. A targeted survey has also been undertaken of patients that use the non-emergency patient transport service.

The Friends and Family Test (FFT) was official launched on 1 April 2015. The FFT is offered to patients that dial 999, receive an emergency response but are not conveyed to hospital and patients that use the Non-Emergency Patient Transport Service. Patients are offered a freepost leaflet to return to regional HQ or they can complete the return on online through the Trust website. To date we have received the following responses:

- Patient Transport Service - 34
  31 were extremely likely or likely to recommend the service and 3 were unlikely or extremely unlikely. *
- Emergency Services – 40
  32 were extremely likely or likely to recommend the service and 7 were unlikely or extremely unlikely. Other responses were neutral

Compliments

The Trust has received *1328 compliments in 2016/17 compared to *1279 in 2015/16. It is pleasing to note that the Trust has seen an increase of 4% in Compliments received. The Trust has a dedicated compliment email address: compliments@wmas.nhs.uk which is available to members of public via the Trust website and PALS leaflets.

*Data verified 4 April 2017 -further analysis and final report will be available June 2017

You said	We did
Non-emergency ambulance staff were parking inappropriately.	We sent a reminder to all staff through the weekly briefing that they should be mindful when parking.
There was a lack of updates and openness when hospital appointments are cancelled due to Patient Transport Services delay.	Staff managing calls have been reminded to communicate with patients about delays. To be honest about the reasons why the appointment has been cancelled e.g. the hospital has cancelled the appointment because we could not get the patient to their appointment on time
A few non-emergency patients raised concerns information they wanted sharing with crews wasn't readily available when required	We added those notes to the master computer system to assist with future bookings.
Crews needed a better explanation of Pseudo-seizures	An article was published in the weekly briefing explaining non-epileptic seizures, treatment and a medical reference for crews to be able to update their knowledge base.
Key safe details were not available to 999 crews resulting in delays getting to patients.	Key safe details shared with us are saved to the Computer Aided Dispatch (CAD) System for future information for crews.
Crews were not always clear regarding 'do not attempt CPR forms and whether photocopies were acceptable.	Information was shared with all staff via an article in our weekly publication. The article explained that whilst the photocopying of DNACPR forms is not ideal, on occasions it is necessitated and legal.

Annex 1: Statement from the Lead Commissioning Group

Lead Commissioner Comments – WMAS Quality Account

This Quality Account, prepared by West Midlands Ambulance Service (WMAS), is a true reflection of the work undertaken by the trust during the 2016/17 contract year.

WMAS engages fully and openly with its CCG commissioners, providing opportunity for dialogue at both a contract and locality level, via CQRM, CRM and Local Level meetings.

WMAS has demonstrated a dedicated focus to quality which should not be confused with performance and has performed well against national and local quality targets throughout the year. In addition, WMAS has achieved 100% of its milestone targets in relation to its performance against National and Local CQUIN schemes.

Furthermore, commissioners welcome WMAS participation in the Ambulance Response Pilot study, which aims to ensure that the most effective resources are dispatched to patients based on their need. WMAS has also continued development of an Electronic Patient Record system, which allows for better data sharing within the wider health economy.

Commissioners also wish to acknowledge and congratulate WMAS on achieving a CQC rating of Outstanding in June 2016.

Looking forward, commissioners support and welcome the Trust's improvement priorities for 2017/18, which include: Implementation of the ReSPECT form for EOLC, Improving working relationships with partner agencies, Increasing FFT feedback, Improving timeliness of responses (based on need), reducing risk of harm to patients, delivering against 'Sign up to Safety' objectives, Improving performance against national Ambulance Quality Indicators, utilising and embedding learning from external regulator reports, and ensuring that 'Learning from Deaths' occurs via mortality reviews.

Commissioners are encouraged to continue working with WMAS, respecting the trusts approach to delivering a first class service, and supporting its approach to addressing workforce issues at an organisation level.

Finally, West Midlands commissioners aspiration is to continue to develop WMAS as an integrated part of the urgent and emergency care system; fully developing the system to be greater than the sum of its parts.

Tom Richards
Chair of the Commissioners Clinical & Quality Review Meeting
Received 16 May 2017
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Annex 2: Statement from the Council of Governors

Governors welcomed the opportunity to comment on this Quality Account which provides an account of the Trust over the last year. Comments received back from the Governors include:

"This year's Quality account again demonstrates the excellent work undertaken by Trust staff. Patient's care and their expectations are always the priority. This report both demonstrates and provides confidence to patients and Governors alike" Steve Elliker, Staff Governor – Support Staff

"The Council of Governors welcome the opportunity to have an input into the Quality Account which provides a comprehensive account of the Trust over the last year.

"Whilst we are aware that WMAS is a high performing ambulance trust, we are not complacent by this and the Council of Governors robustly challenge to ensure the Trust responds and adapts to the problems it faces on a daily basis and in addition looks ahead to see what can be improved. Whilst Governors recognise that there are small variations across the region, the Council are particularly pleased to note how well the Trust has done in overall performance achievement over the year both in timeliness of arrival of ambulances and the high standards of care.

"Governors note the ambitious plans the Trust has embarked on to ensuring paramedic recruitment has been consistent over a number of years now ensuring the Trust paramedic skill mix remains high. We welcome the introduction of and commitment to a new model of clinical supervision and will watch closely to see how this is delivered and what benefits for patients it achieves. The Council of Governors are extremely proud of the Trust to be awarded 'Outstanding' status by the Care Quality Commission and continue to be financially stable.

"This was a very robust and detailed Quality Account document and its work and time taken to prepare it should be commended." Adam Williams, Public Governor, Birmingham.

"I really enjoyed reading the 2017 Quality Account Review and as a Governor learnt a lot more about what WMAS has done over the last year than when at Governor Meetings - pretty amazing! If anyone reads the Review they have a complete picture of what the Trust is doing and my hope would be for more members of the public to become Members". Elizabeth Dixon, Public Governor - Coventry and Warwickshire

"The Quality Account 2016/17 clearly indicates the Trust's determination to strive to continue to provide the best possible patient care. It is a fact that this can only be achieved by having the best Leadership team, which WMAS has in place, and the CQC rating of "outstanding" and Segmentation 1 by NHS Improvement is an acknowledgement of the efforts of everyone - staff and volunteers alike whose common goal is patient care. The Trust is not complacent and where improvement has shown to be necessary in the PTS service, it is admirable that immediate effective action has been taken.

"All aspects of good management are shown to be in place and with such a huge budget to be controlled this is yet another area where the right people are in place. It is clear that staff care is also a priority with the encouragement of physical and mental wellbeing. Equality and Diversity are very important to the Trust evidenced by the recruitment processes. By setting out its "vision, strategic objectives resulting in the highest values", the patients of WMAS can feel assured that all means are in place to give them the best results as regards their care.

"As for 2017/18 by setting out the Trust's priorities the intention of maintaining the highest standards of care are underlined which does give confidence to all who are involved with the Trust and the fact that there are no paramedic vacancies shows that WMAS is the Trust to work for." Eileen Cox, Lead Governor and Public Governor – Staffordshire

Received 16 May 2017

Annex 3: Local Healthwatch and Overview & Scrutiny Committees

Statement from Worcestershire Health Overview and Scrutiny Committee
'Worcestershire Health Overview and Scrutiny Committee regrets that it is unable to provide commentary on the 2016/17 Quality Account. This is due to the imminent county council elections in May, which will mean changes in the Committee's membership during the period for finalising the Accounts.'
Received 15 March 2017

Statement from Shropshire Council Health and Adult Social Care Scrutiny Committee,
Shropshire Council's Health and Adult Care Scrutiny Committee is unable to provide comments on the 2016/17 Quality Account due to the fact that the national timetable for Scrutiny Committees to comment on Quality Accounts coincides with the pre-election period of Shropshire Council's elections and the appointment of the new Scrutiny Committee at Annual Council.
Received 9 May 2017

Annex 4 - Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to 25 May 2017
    - papers relating to quality reported to the board over the period April 2016 to 25 May 2017
    - feedback from commissioners dated TBC
    - feedback from governors dated TBC
    - feedback from local Healthwatch organisations dated TBC
    - feedback from Overview and Scrutiny Committee dated TBC
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15 May 2017
    - the [latest] national staff survey published March 2017
    - the Head of Internal Audit's annual opinion of the trust's control environment dated TBC
    - CQC inspection report dated 25/01/2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- As the trust is currently not reporting performance against all operational performance indicators due to the Ambulance Response Programme trial the directors have a plan in place to remedy this and return to full reporting once the outcome of the trial and subsequent guidance from NHS England is published
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

.....Date.....Chairman

.....Date.....Chief Executive

Annex 5: The External Audit limited assurance report

Annex 6: Glossary of Terms

Glossary of Terms

Abbreviation	Full Description
A&E	Accident and Emergency
AFA	Ambulance Fleet Assistant
ARP	Ambulance Response Programme
AQI	Ambulance Quality Indicators
BASICs	British Association of Immediate Care Doctors
CCGs	Clinical Commission Groups
CFR	Community First Responder
CPO	Community Paramedic Officer
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSD	Clinical Support Desk
DCA	Double Crewed Ambulance
E&U	Emergency & Urgent
EMB	Executive Management Board
EOC	Emergency Operations Centre
FAST	Face, Arm, Speech Test
GP	General Practitioner
HALO	Hospital Ambulance Liaison Officer
HART	Hazardous Area Response Team
HCAI	Healthcare Acquired Infections
HCRT	Healthcare Referral Team
IGT	Information Governance Toolkit
IM&T	Information Management and Technology
IPC	Infection Prevention and Control
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
KPIs	Key Performance Indicators
MERIT	Medical Emergency Response Incident Team
MINAP	Myocardial Infarction Audit Project
NED	Non-Executive Director
NHSP	National Health Service Pathways
NICE	National Institute for Health and Clinical Excellence
NRLS	National Reporting & Learning System
OOH	Out of Hours
PALS	Patient Advice and Liaison Service
PDR	Personal Development Review
PRF	Patient Report Form
PTS	Patient Transport Service
QIA	Quality Impact Assessment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSC	Return of Spontaneous Circulation
RRV	Rapid Response Vehicle
SI	Serious Incident
STEMI	ST Elevation Myocardial Infarction
STP	Sustainability and Transformational Partnerships
VAS	Voluntary Aid Services
WMAS	West Midlands Ambulance Service NHS Foundation Trust
YTD	Year to Date

Further Information

Further information and action plans on all projects can be obtained by contacting the lead clinician named on the project.

Further information on performance for local areas is available as an Information Request from our Freedom of Information Officer or from the leads for the individual projects.

Progress reports will be available within the Trust Board papers every three months with the end of year progress being given in the Quality Report to be published in June.

If you require a copy in another language, or in a format such as large print, Braille or audio tape, please call West Midlands Ambulance Service on 01384 215 555 or write to:

West Midlands Ambulance Service NHS Foundation Trust
Regional Headquarters
Millennium Point
Waterfront Business Park
Brierley Hill
West Midlands
DY5 1LX

You can also find out more information by visiting our website: **www.wmas.nhs.uk**

If you have any comments, feedback or complaints about the service you have received from the Trust, please contact the **Patient Advice and Liaison Service (PALS)** in the first instance; **01384 246370.**

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