Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Quality Report
SPONSOR (EXECUTIVE DIRECTOR):	*Rachel Overfield (Chief Nurse), Dr Deva Situnayake (Acting Medical Director) and Kam Dhami (Director of Governance)*
AUTHOR:	*Various*
DATE OF MEETING:	*26 April 2012*

EXECUTIVE SUMMARY:

The attached report presents a composite picture of performance against a number of key Quality metrics and qualitative information, responsibility for which currently sits within the remits of three members of the Executive Team.

- The Board is invited to accept the report, noting in particular the key points highlighted in Section 2 of the report.

REPORT RECOMMENDATION:

The Board is recommended to ACCEPT the contents of the report.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
✓		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	✓	Patient Experience	✓
Clinical	✓	Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

- Improve and heighten awareness of the need to report and learn from incidents.
- NHSLA Acute and Community risk management standards – 'Learning from experience'
- Includes performance against a number of CQuIN targets and national & local targets and priorities
- Aligned to the priorities set out within the Quality Account

PREVIOUS CONSIDERATION:

Developmental iterations of the report have been considered by the Trust Board previously in its private session.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY REPORT

A monthly report presenting an update on Patient Safety, Clinical Effectiveness and Patient Experience in the Trust

April 2012

Where EVERYONE Matters

CONTENTS

QUALITY REPORT

1 INTRODUCTION

This report presents a composite picture of the performance against the various key Quality metrics to which the Trust works, both in terms of those mandated at a national or regional level and those set by the organisation.

The report has been populated with latest performance information for the period ending 31 March 2012, across a range of areas within three domains: patient safety, clinical effectiveness and patient experience.

2 KEY POINTS TO NOTE

The Trust Board's attention is drawn to the following this month:

PATIENT SAFETY

- Safety Thermometer was completed on 14th March and again 18th April. Results have been accessed via the Quality Observatory for March with headlines as follows:
  - Total patients audited – 1134
  - Overall Trust – 90.3% harm free care across 4 areas: Pressure ulcers, Falls, Catheter associated infections, VTE

  More work is required to further analyse and understand the data.

- Falls – reduction target met at 28% although increase again in January – Sandwell Hospital continue to have a higher rate than City Hospital.
  Incidence by age shows a trend upwards in over 70 year olds whilst in other age groups the trend is down.
  50% of falls with injury are deemed unavoidable at table top review (TTR).

- Nutrition standards have all been met.

- Infection rates are within target trajectory.

- Medicine omissions reduced by 28.6% (target 10%).

- A further 'Never Event' was reported in March in Ophthalmology. At the end of the operation, it was discovered that the wrong lens had been implanted. The patient was advised of the event and agreed to undergo further surgery to implant the correct lens.

  The 'Never Event' investigation process has been instigated and a review meeting took place on 3 April 2012. The findings and lessons learned from this incident will be shared widely.

- Nurse staffing levels – no report this month on ratios. Bank rates increase related to capacity.

CLINICAL EFFECTIVENESS

Performance with the World Health Organisation (WHO) checklist process is high at 98% overall (for completion of the three sections only). The performance with the brief and debrief aspects is less good and with some variability between teams and further work will be undertaken to improve this position.

PATIENT EXPERIENCE

- Survey responses increased in February 2012
- Number of patients describing care as excellent decreased by 2.7%
- Net Promoter (Trust version) reduced by 2%
- New Net Promoter score (1st 2 weeks) – 59.4% overall
  69.4% promoters
  20.5% passive
  10.4% detractors
- As at the time of the preparation of this report, 77 complaints were in breach of the Trust's revised failsafe parameters for response times.
- On 10 April 2012, the Care Quality Commission issued the final report of its review and concluded that the Trust was compliant with Outcome 17, Complaints.

3 TARGETED AREAS OF SUPPORT

The areas of the Trust being provided with targeted support this month are:

- EAU Sandwell continues in special measures with steady progress being made
- Wards D16/D18 showed improvement in month
- Lyndon 5 currently receiving additional support but will close as winter ward shortly
- Review of Newton 1 and Newton 4 by Chief Nurse completed 17th April to assess progress. Good progress has been made although patient perception continues to be more negative than the Trust average on Newton 4. A full condition report has been requested. If satisfactory, all formal targeted support will be gradually withdrawn.

4 EMERGING TRENDS/NOTICEABLE PATTERNS

- Increase in rate of nurse bank staff use
- Falls at Sandwell Hospital are significantly higher than at City Hospital – possibly due to location of trauma and privacy and dignity measures. This is being investigated.

5 PATIENT SAFETY

5.1 Safety Thermometer

This tool has now been mandated as a national CQuIN to be in place by March 2013 but also by the SHA to be in place by March 2012. All in patients (including Maternity, Paediatrics, Neonatal and patients on District Nurse caseload) have been audited using the Safety Thermometer on 14th March and again on 18th April. Results for March:

- Overall Trust 90.3% harm free care
- Acute 92.14% harm free care
- Community 87.47% harm free care

The first report should be available for Mays report and will include data for:

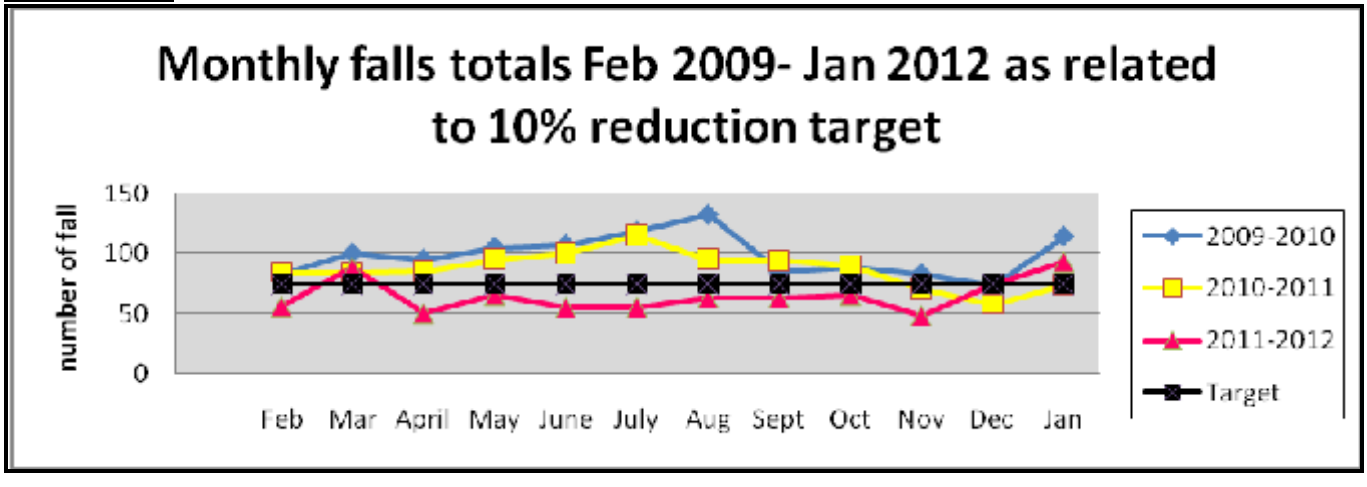
- Pressure damage (avoidable grade 2, 3 and 4)
- VTE assessment and outcome
- Falls with harm
- Catheter associated UTI

a) Falls

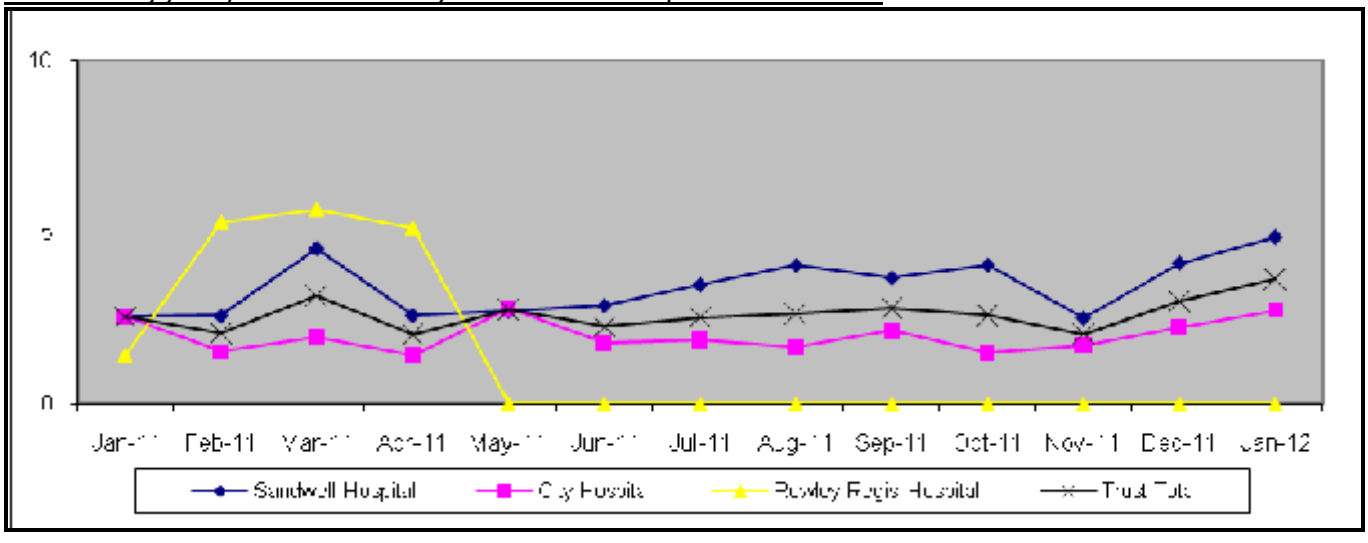
Target:	10% reduction of falls in 2011/12 (acute)	*Internal Priority*
	95% falls risk assessment complete (acute)	*Internal Priority*
	55% falls risk assessment complete (District Nursing)	*CQUiN*

YTD: 28% falls reduction
98.6% risk assessment (acute)
57.32% risk assessment (District Nursing)
Incidence per 1000 bed days = 2.96

Trend of falls

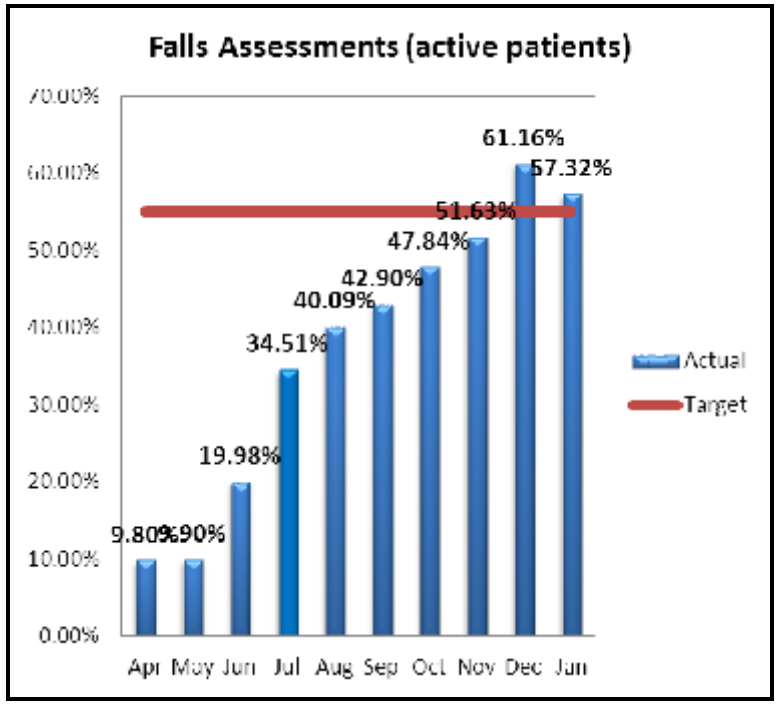


Incidence of falls per 1000 bed days across Acute Inpatient Divisions



	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May - 11	June-11	July-11	Aug-11	Sept - 11	Oct-11	Nov-11	Dec-11	Jan-12	total
Sandwell Hospital	3.86	1.63	2.56	2.57	4.52	2.59	2.71	2.87	3.47	4.02	3.62	4.03	2.51	4.09	4.85	3.65
City Hospital	2.91	2.55	2.55	1.53	1.96	1.42	2.80	1.80	1.87	1.66	2.14	1.52	1.70	2.22	2.73	2.28
Rowley Regis Hospital	0.00	3.00	1.42	5.29	5.60	5.13	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.09
Trust Total	**2.64**	**2.07**	**1.42**	**2.07**	**3.14**	**2.02**	**2.74**	**2.24**	**2.52**	**2.62**	**2.78**	**2.58**	**2.04**	**3.00**	**3.64**	**2.96**

Community Risk Assessment



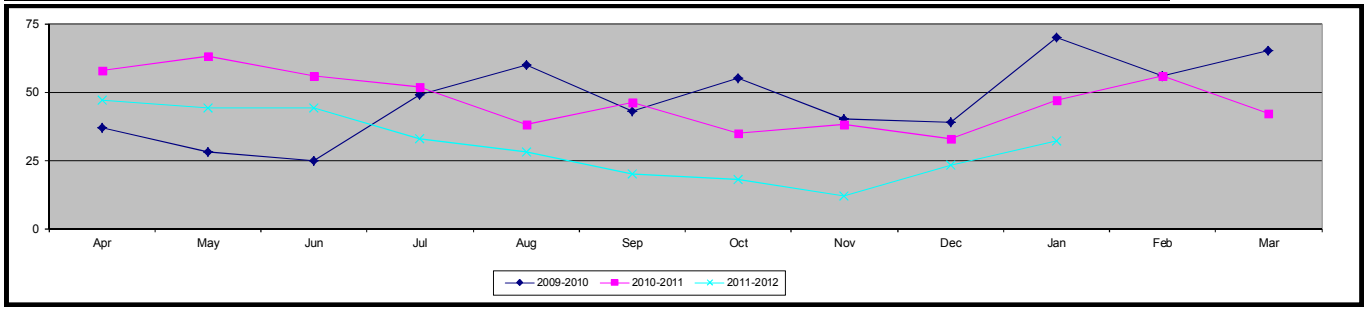
TTRs are completed on all injurious falls and are now significantly advanced to be able to determine whether falls could have been avoided. Of the 24 reported falls with injury in January 10 were considered non avoidable, 12 were avoidable and 2 are still awaiting TTR.

b) Pressure Damage

Target: 10% reduction in hospital acquired grade 2, 3 and 4 sores compared to Q4 2010/11
95% risk assessments completed
} acute only

YTD: Total 39.4% reduction

Number of hospital acquired pressure damage Grade 1, 2, 3 & 4, April2009 - January 2012



The vast majority of pressure sores are at grade 2 (90.7%) with grade 3 accounting for 2.3% and grade 4, 7%.

The most significant reduction in Quarter 3 compared to Quarter 2 has been at grade 2 (40%) suggesting that promotion is occurring earlier. There has been a 27% reduction in grade 3 and a 20% reduction in grade 4.

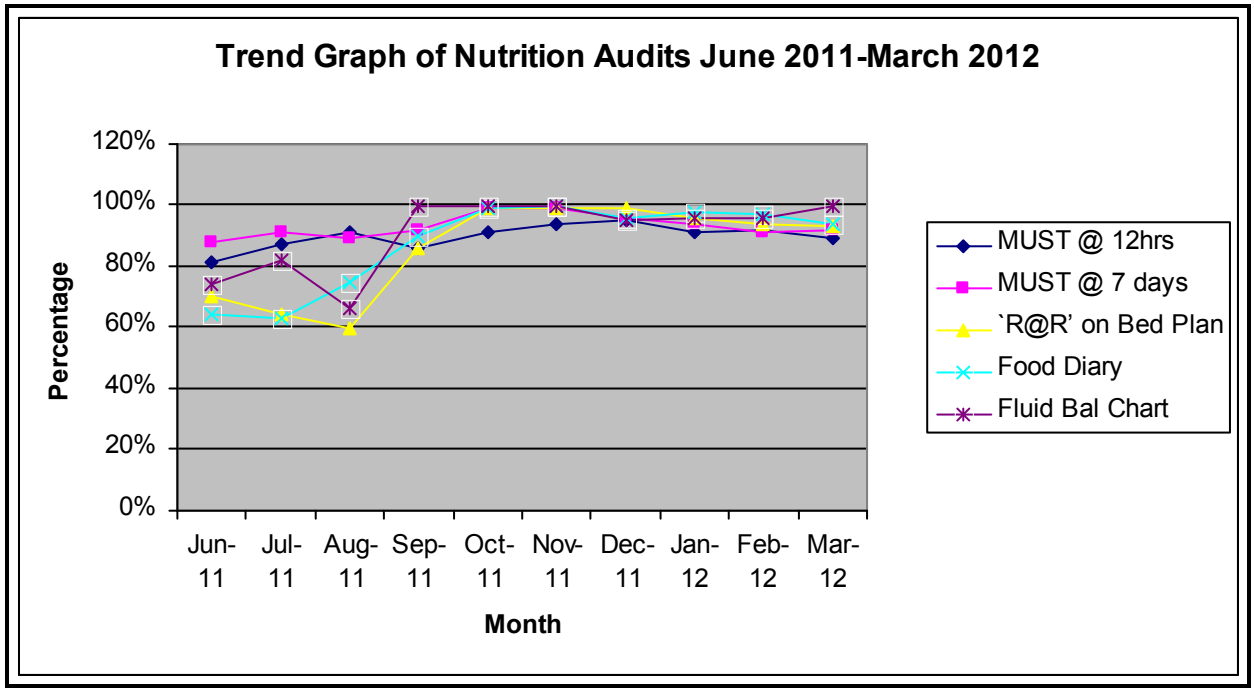
c) VTE Risk Assessment

The VTE Risk Assessment CQUIN target continued from 2010/11. Performance in excess of the 90% threshold has been achieved for each month during the year. *CQUiN*

5.2 Nutrition/Fluids

Target: 75% patients are MUST assessed within 12 hours of admission *CQUiN*
80% compliance protected meal times

Year to Date: D18 was the only ward who failed to achieve in excess of 85% MUST assessment in the March audit.
All wards, except one (Lyndon 2) are achieving at least 80% compliance with protected meal times (based on snap shot audits).



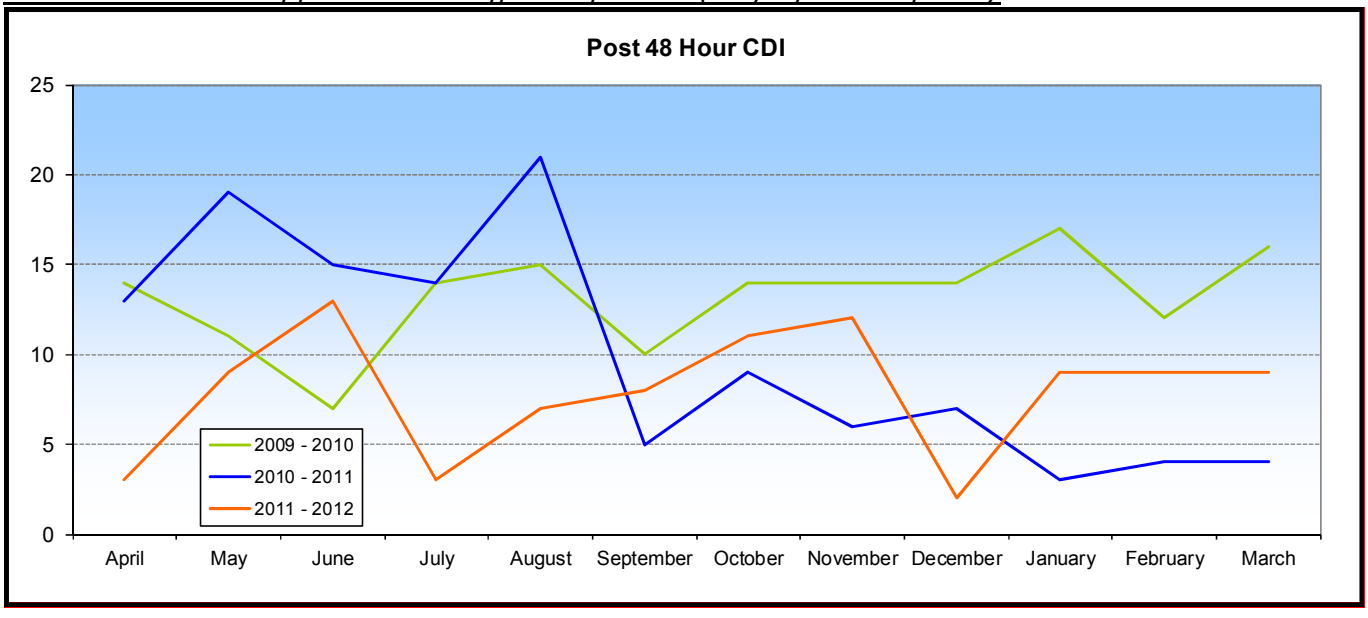
Standard/target	*Trust average*	*Comment*
MUST completed within 12 hours admission (75%)	89%	D18 only ward to fail target
MUST completed within last 7 days	92%	D43 only ward to fail target
Patients identified 'at risk' have a 'Red @ Risk' ID on bed plan	93%	
Completion of food diary in at risk patients	94%	
Completion of fluid balance charts in at risk patients	98%	

5.3 Infection Control

C difficile

There were 9 cases of *C difficile* reported across the Trust during the month of March which is within trajectory for the month. The overall number (95) for the year to date also remains within the trajectory of 100. *National Priority*

Cumulative number of post 48hrs C difficile infections (CDI) against trajectory



MRSA

There were no cases of MRSA Bacteraemia reported in March. The year to date total is 2, compared with a trajectory of 6. *National Priority*

MRSA Screening

Elective – The Trust carried out 3243 MRSA screening tests on elective patients during the month of March and has achieved 35, 879 tests year to date, against a year end target of 30,000.

Non-Elective – The Trust carried out 1687 MRSA screening tests on non-elective patients during the month of March and has achieved 20, 293 tests year to date, against a year end target of 30,000.

Saving Lives

The Trust continues to achieve 100% compliance year to date against a target of 95%.

5.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. Of note:

*Post Partum Haemorrhage (PPH)(>2000ml): t*here was one patient recorded to have had a PPH of >2000ml in February. Year to date, there have been 9 patients reported to have had a PPH.

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for February was 6.4 which was within the trajectory (8) but showed an increase from the previous month (1.9). Perinatal mortality rates must be considered as a 3 year rolling average due to the small numbers involved and the significant variances from month to month.

Caesarean Section Rate: the number of caesarean sections carried out in February was 19%, which is within the trajectory of 25% over the year.

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for February was 20% which was over trajectory (15).

Community Midwife Caseload (bi-monthly): The community midwife caseload in February was 151 which was not within the trajectory of 120. This is due to continued difficulties in recruitment and retention of community midwives and the numbers of midwives being recruited into Health Visitor posts.

5.5 Emergency Department highlights

Performance against a number of key measures is reviewed on monthly basis by the Emergency Department (ED) Action Team. *Quality Account*

Of note:

- Recent assessment of performance against the Clinical Quality Indicators (CQIs) highlights that the four-hour indicator was achieved above 95% in Quarter 4. This represents a significant turnaround in the quarter, which was aided by a series of special measure put into place in February and March 2012.

- The Integrated Development Plan continues to be enhanced and monitored.

- Work will be progressed by the ED Action Team to develop the role of the Acute Medicine Assessment Nurse at Sandwell Hospital.

- The Mental Health Steering group is established and continues to meet on a six weekly basis.

- A four month pilot of the use of a Hospital Admission Avoidance Team and Rapid Therapy Services extended hours pilot has taken place an focussed on discharge intervention and early initiation of therapy to reduce length of stay.

- Spot check proforma audits continue to measure compliance amongst nursing and medical staff. A continued improvement has been seen. A slight dip in compliance with the use of the nursing audit proforma was noted, although this has been determined to be a documentation issue and the importance of completing this is being reinforced.

- The Think Alcohol CQuIN target was achieved un 2011/12 and continues into 2012/13. *CQuIN*

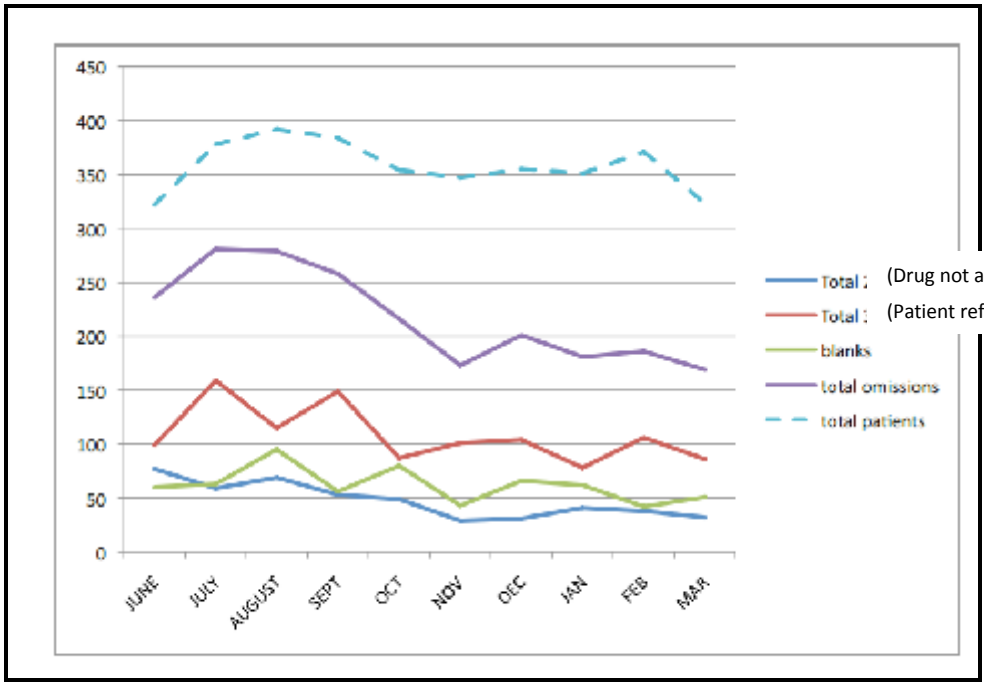
5.6 Safeguarding

An update will be provided on a quarterly basis, following each Safeguarding Committee. The next update will therefore be due in the month of May.

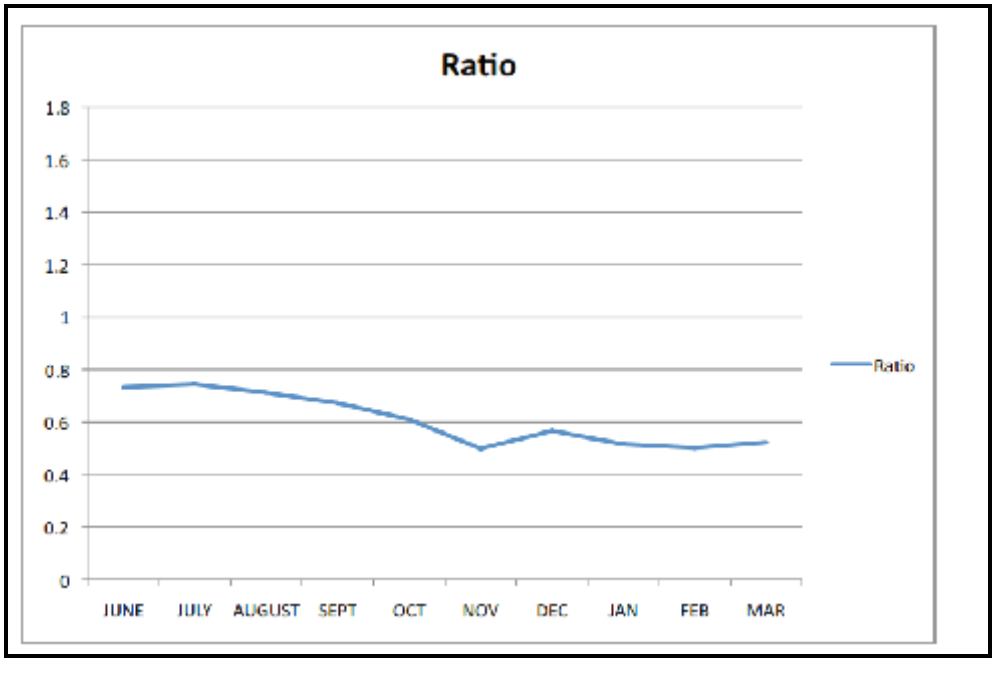
5.7 Medicine Omissions

Target: Reduce the number of avoidable medicine omissions by 10% on Q1 baseline *CQUiN*

YTD: 28.6% reduction



MISSED DOSES PER MONTH 2011



RATIO OF MISSED DOSES PER PATIENT SCREENED

5.8 Health Visitor Screening

The Trust CQUIN target for Health Visiting relates to children on the health visitor case list who have had a full developmental review at 2 years and 6 months. The target is 70% during Quarter 4. Performance during January fell slightly to 69.5% (trajectory 68%), although during the months of February and March has exceeded 70%, ensuring the overall target has been met. *CQUiN*

A full report on Health Visitors will be brought to the Trust Board in May to include progress against the Health Visitors Implementation Plan and also a patient/family experience presentation.

5.9 'Never Events'

A further 'Never Event' was reported in March in Ophthalmology. At the end of the operation, it was discovered that the wrong lens had been implanted. The patient was advised of the event and agreed to undergo further surgery to implant the correct lens.

The 'Never Event' investigation process has been instigated and a review meeting took place on 3 April 2012. The findings and lessons learned from this incident will be shared widely.

5.10 National Patient Safety Agency (NPSA) alerts

1. Overdue alerts: Two alerts in April.

NPSA 2011/PSA001 – Safer spinal (intrathecal) epidural and regional devices. This alert requires a change of spinal needles to those with neuraxial connectors. The Trust has chosen a product but the manufacturer has not yet produced long or paediatric needles. Equally manometers are still awaited. This manufacturing problem was discussed with the Strategic Health Authority and the NPSA. A risk assessment will be undertaken to minimise risks.

NPSA 2011/RRR003 – Minimising the risks from spinal devices. There was a delay in receiving assurance that all areas using spinal needles had advised staff and that no neuraxial needles were within the areas. This alert has now been signed off.

2. New alerts: One new alert has been received.

NPSA 2012/RRR001 – Harm from flushing of nasogastric tubes before confirmation of placement. A gap analysis and action plan is currently being formulated.

5.11 Lessons Learned

The key to a positive safety culture within the organisation is to learn from incidents through sustainable actions. Below are some of the actions taken or being taken following serious incident investigations.

Incident	Extract from Action Plan
Unexpected death with resuscitation issues	• Sheldon block resuscitation equipment under review and each ward to have its own trolley
	• Trust wide audit to take place to review the required daily resuscitation

Incident	Extract from Action Plan
	equipment checks.
Sub optimal care of a deteriorating patient – failure to rescue	• SBAR communication system to be introduced in EAU for safe and effective handover.
	• Development of local ED guideline for use of ambulance sheets as part of the initial assessment
'Never Event' – implantation of wrong lens.	• Revision and implementation of protocol for implantation of Intra Ocular Lenses.
	• Add an additional check to the "time out" section of the WHO cataract checklist to check the lens power against biometry.

5.12 Significant Risks

Significant risks are presented on a monthly basis at the Risk Management Group (RMG). These risks are being proposed for inclusion onto the corporate risk register.
Any new risks presented at the Risk Management Group meeting on 24 April will be reported to the Trust Board for consideration.

5.13 Listening into Action

A corporate 'Listening into Action' event is being held in April to better understand how staff can be supported in undertaking risk management processes such as incident reporting and risk assessments.

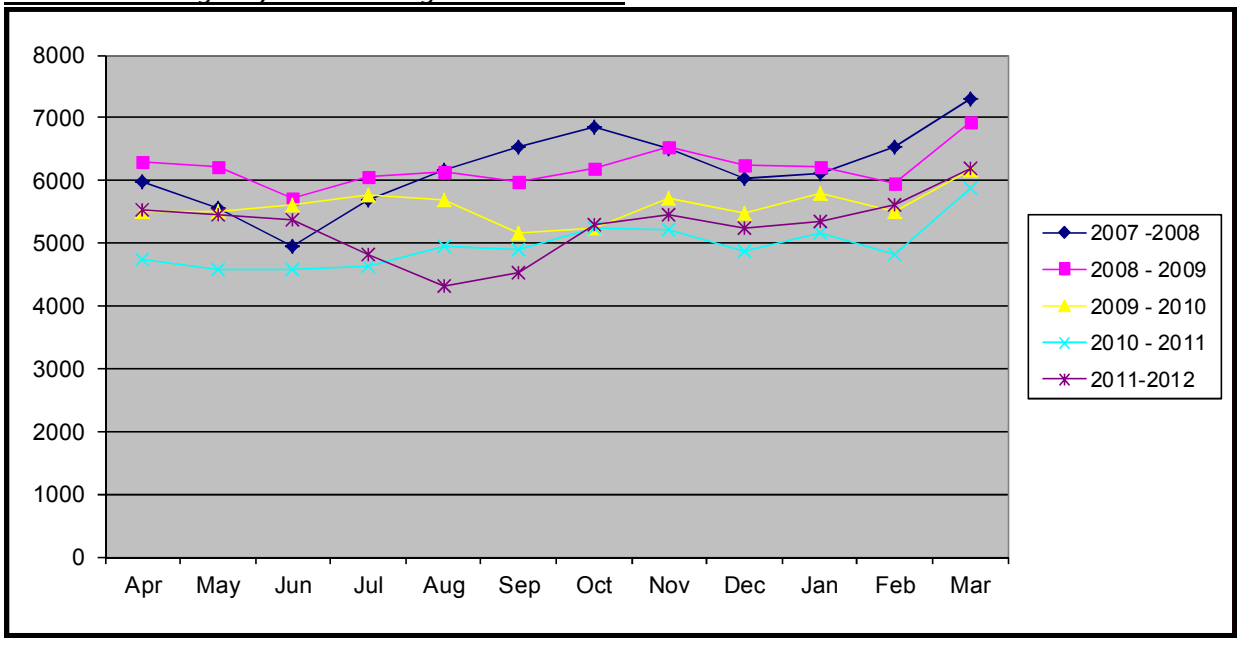
5.14 Nurse Staffing Levels

The Trust aims to have staffing ratios at around 1 WTE:1 bed (unless guidance specifically states otherwise) and a qualified to unqualified ratio of 60:40.

No numbers are reported this month as a result of 'year end' processes. The update will be included in next month's report as routine.

The Trust's nurse bank/agency rates are detailed in the table over and show year on year comparison from 2007/8 to date.

Total Bank & Agency Use Nursing – March 2012



The upward trend in bank use continued in March, thought to be due primarily to capacity demands and therefore additional beds requiring staffing to be open.

6 CLINICAL EFFECTIVENESS

6.1 Mortality

HSMR (Source: Dr Foster)

The Hospital Standardised Mortality Ratio (HSMR) is a standardised measure of hospital mortality and is an expression of the relative risk of mortality. It is the observed number of in- hospital spells resulting in death divided by an expected figure. For the most recent 12 month cumulative period, the HSMR for the Trust stands at **95.7.** This continues to follow a similar downward pattern to that of the SHA Peer which stands at **100.7** (see Mortality table and graph below)

HSMR (Source: Healthcare Evaluation Data (HED))

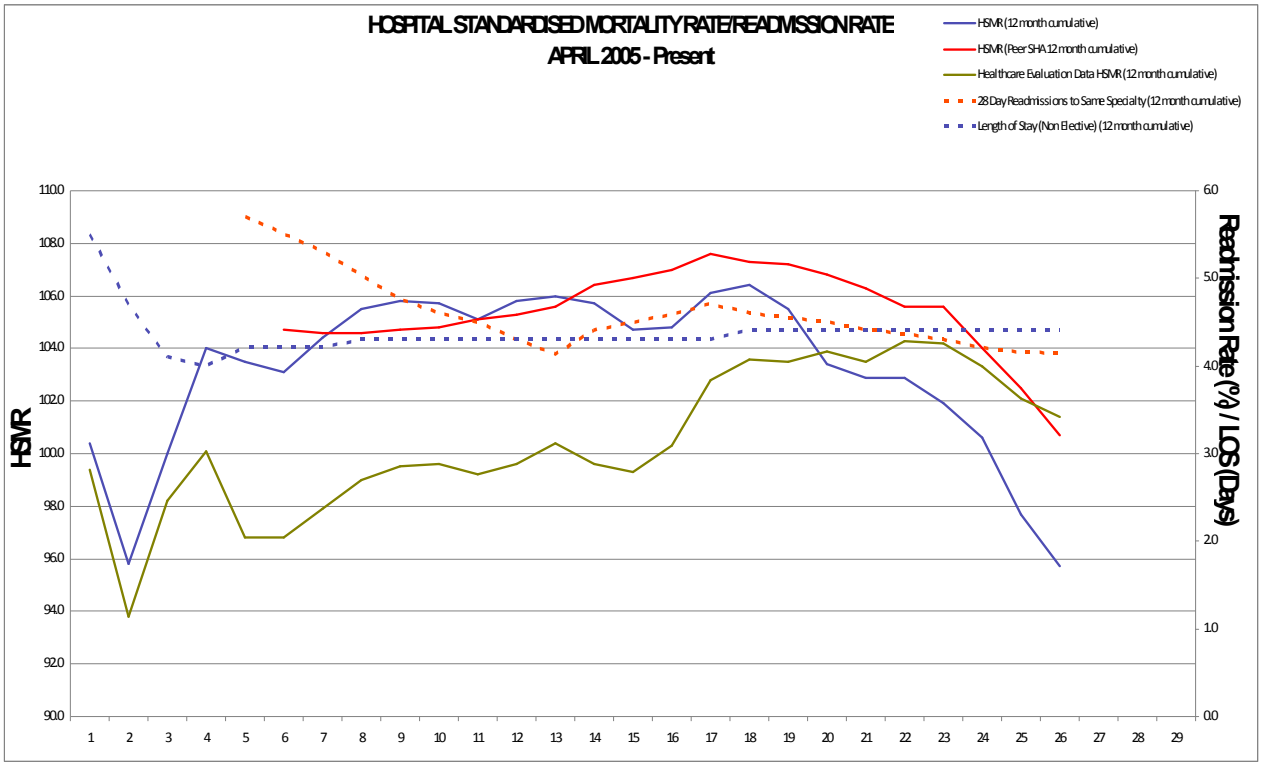
For the most recent 12 month cumulative period, the HSMR for the Trust stands at **101.4**.

Summary Hospital – Level Mortality Indicator (SHMI)

The SHMI is a national mortality indicator launched at the end of October 2011. The intention is that it will complement the HSMR in the monitoring and assessment of Hospital Mortality. The SHMI will be published on a quarterly basis by the Department of Health. An NHS trust with a ratio below 1 had fewer deaths, while trusts with a rate above 1 will have had more deaths than would be expected. The Trust has a SHMI value of **1.01** (as expected) for the data period April 10 – March 11.
No new data has been published.

Mortality table 2011/12

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Internal Data:									
Hospital Deaths	140	158	118	130	131	132	146	140	171
Dr Foster 56 HSMR Groups:									
Deaths	121	133	102	110	112	116	125	125	152
HSMR (Month)	90.1	100.8	81.3	90.7	90.5	92.3	91.1	81.6	89.3
HSMR (12 month cumulative)	98.4	98.1	103.4	102.9	102.9	101.9	100.6	97.7	95.7
HSMR (Peer SHA 12 month cumulative)	96.7	97.0	106.4	106.2	105.5	104.5	104.0	102.5	100.7
HSMR (Peer National 12 month cumulative)	→	→	93.8	→	→	95.7	→	→	92.2
Healthcare Evaluation Data - HSMR (12 month cumulative)	103.6	103.5	103.9	103.5	104.3	104.2	103.3	102.1	101.4



Mortality reviews

There is a CQUIN target to review 60% of all qualifying (adult) deaths within hospital during March 2012. The latest performance for the month of February 12 showed that **68.2%** of deaths had been reviewed.

CQC Mortality Alerts received in 2012/13

The Trust has received notification from the Care Quality Commission (CQC) of being an outlier for mortality in the period from November 10 – November 11 for patients with a primary diagnosis of biliary tract disease. The commission has requested further information from the Trust in order for them to review the matter further. This information is required to be submitted to the Commission by May 9th.

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Dr Foster generated alerts (RTM)

There were no new diagnoses or procedures alerting with significant variation in terms of mortality when the data period February 2011 – January 2012 is considered (see table below). An investigation into the alert generated for the diagnosis group of 'Biliary tract disease' is near completion.

Mortality (in-hospital) - Diagnoses										Alert	
Team	Diagnoses	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	HSMR Basket of 56 Diagnosis Groups	39003	1507	3.9%	1618.8	4.2%	93.1	88.4	97.9		6
All	Acute bronchitis	1152	33	2.9%	45.8	4.0%	71.8	49.5	101.0		1
ALL	Biliary tract disease	1046	19	1.8%	11.8	1.1%	161.5	97.2	252.2	1	
ALL	Cancer of prostate	568	5	0.9%	12.5	2.2%	39.9	12.9	93.2		1
ALL	Congestive heart failure, nonhypertensive	701	63	9.0%	87.4	12.5%	72.1	55.4	92.3		2
All	Diabetes mellitus with complications	787	13	1.7%	24.3	3.1%	53.6	28.5	91.6		1
ALL	Fracture of neck of femur (hip)	416	46	11.1%	42.2	10.1%	109.1	79.8	145.0	1	
ALL	Leukaemias	882	12	1.4%	8.5	1.0%	141.0	72.8	246.3	1	
All	Nonspecific chest pain	3158	0	0.0%	4.5	0.1%	0.0	0.0	81.0		1
All	Other upper respiratory disease	1013	3	0.3%	6.8	0.7%	44.2	8.9	129.2		1
ALL	Short gestation, low birth weight, and fetal growth retardation	746	6	0.8%	17.6	2.4%	34.1	12.5	74.3		1
Mortality (in hospital 30 days) Procedures										**Alert**	
Team	Procedures	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
All	Reduction of fracture of neck of femur	222	21	9.5%	13.8	6.2%	152.3	94.2	232.8	1	

Significantly worse than berchmark
Significantly better than benchmark
No significant variation from benchmark

6.2 Patient Related Outcome Measures (PROMs)

No further Trust level provisional data has been published by the Health and Social Care Information Centre since the last report to the Board in February. The provisional data published in February 2012 for the 2010/11 financial year showed that patient reported outcomes needed to be improved with regard to hip and knee replacement in particular. A number of steps are now being taken to better understand the potential reasons for patients not reporting better outcomes and to enhance the service provided. The Directorate of Trauma & Orthopaedics is due to present an update on progress to the Governance Board at the meeting to be held in May.

6.3 Clinical Audit

Clinical Audit Forward Plan 2012/13

The Clinical Audit Forward Plan for 2012/13 was approved by the Governance Board in April. The plan currently contains 83 audits that cover the key areas recognised as priorities for clinical audit. These include both the 'external must do' audits such as those included in the National Clinical Audit Patient Outcomes Programme (NCAPOP), as well as locally identified priorities or 'internal must do' audits.

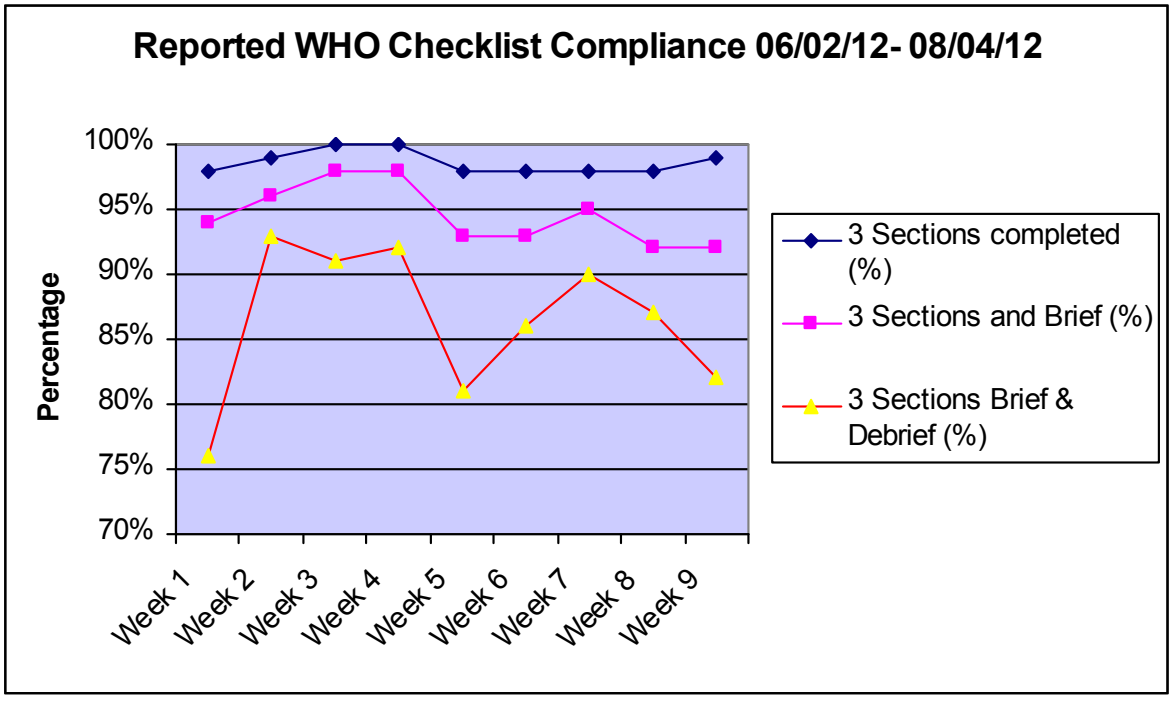
Clinical Audit Forward Plan 2011/12 – Outturn Report

The 2011/12 plan contained 79 audits, 83% of which were considered to be substantially completed by the end of the financial year according to the requirements of the audit. Only 3 audits were not commenced. The Outturn Report identified that clinical staff in a range of specialties participate in clinical audit activity and that the Trust continues to fully participate in a wide range of nationally and regionally organised audits. Although there had been a slight improvement in the number of 'internal must do' audits that were fully completed by the end of the financial year the report identified a number of measures to improve completion rates going forward.

6.4 Compliance with the 'Five Steps for Safer Surgery'

The collection of data on the compliance with the "Five Steps to Safer Surgery" process using the Clinical Systems Reporting Tool (CSRT) commenced on 06/02/12. Compliance data is shown in the table and graph below.

Trust performance from 06/02/12 – 08/04/12 (source CDA)	
Number of list entered	2093
Number of cases	**7921**
"Five Steps to Safer Surgery"	**Reported compliance**
Completion of the 3 sections of the checklist only	98.%
All checklist sections and brief	95.%
All checklist sections completed and brief & debrief	87.%



The above graph indicates that performance with the checklist process itself is high at 98% overall (3 sections only). The performance with the brief and debrief aspects is less good and with some variability between teams. Compliance will continue to be monitored and feedback on performance provided to areas where this needs to be improved.

6.5 Smoking Cessation

Training – Acute Services

The CQUiN target is to train 90% of frontline staff in key specialties (Oral Surgery, Gastroenterology, MAU, Respiratory Medicine, A&E, Cardiology and pre-op assessment to identify smoking and provide brief advice. Final data for the year indicates that 94% of identified staff had been trained. *CQUiN*

Delivery – Acute Services

A CQuIN target of 2000 referrals to the smoking cessation service within the year. This target has been well exceeded with 2890 referrals recorded for the year. *CQUiN*

6.6 Alcohol Cessation

Screening

The CQuIN target is to screen 80% (throughout Q4) of patients (aged 16+) within agreed groups (Emergency Department, EAU, MAU and Gastroenterology OP) to have an alcohol assessment and be offered advice has been revised by agreement with commissioners to exclude patients attending Accident and Emergency. Performance during the defined period of assessment is 88.5%

6.7 Stroke Care

The CQuIN target for stroke discharge is to ensure that 90% of patients discharged meet six set criteria such as discharge information, clinical contact within 48 hours and community contact details throughout Quarter 4. During the period of assessment this target was evidenced to have been met in 90.5% of cases.

Performance against the principal stroke care targets to which the Trust is working in 2011.12 is outlined in the table below.

Work continues through the stroke action team to implement a more efficient 'stroke alert' process to enable more rapid decision making and transfer to the acute stroke units (enabling both CT and ward admission targets to be met more reliably). Work on the efficiency and timeliness of triage and outpatient booking for the high risk and low risk pathways for TIA should also see improved performance in these areas. Pathways for both stroke and TIA will benefit from the Trusts planned service reconfiguration once the options appraisal and approval process is secured.

Indicator	January	February	March	Target	To date (*= most recent month)
Pts spending >90% stay on Acute Stroke Unit	83.6 ▼	86.0 ▲	95.2 ▲	83%	85.9%
Pts admitted to Acute Stroke Unit within 4 hrs	56.1 ▲	75.0 ▲	68.7 ▼	80%	68.7%*
Pts receiving CT Scan within 24 hrs of arrival	97.6 ▲	100 ■	100 ■	100%	100%*
Pts receiving CT Scan within 24 hrs of admission	96.4 ▲	100 ▲	95.7 ▼	90%	95.7%*
Pts receiving CT Scan within 1 hr of arrival	36.6 ▲	55.0 ■	37.5 ■	50%	37.5%*
TIA (High Risk) Treatment <24 h from initial presentation	81.8 ■	73.0 ▼	68.7 ▼	60%	52.8%
TIA (High Risk) Treatment <24 h referral rec'd by Trust	90.9 ■	100 ■	87.5 ▼	60%	71.3%
TIA (Low Risk) Treatment <7 days from initial presentation	15.6 ▼	57.6 ▲	77.8 ■	60%	30.5%
TIA (Low Risk) Treatment <7 days referral rec'd by Trust	31.1 ▲	66.7 ■	88.9 ▲	60%	38.7%

KEY TO PERFORMANCE ASSESSMENT SYMBOLS	
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no sign of improvement

6.8 Treatment of Fractured Neck of Femur within 48 hours

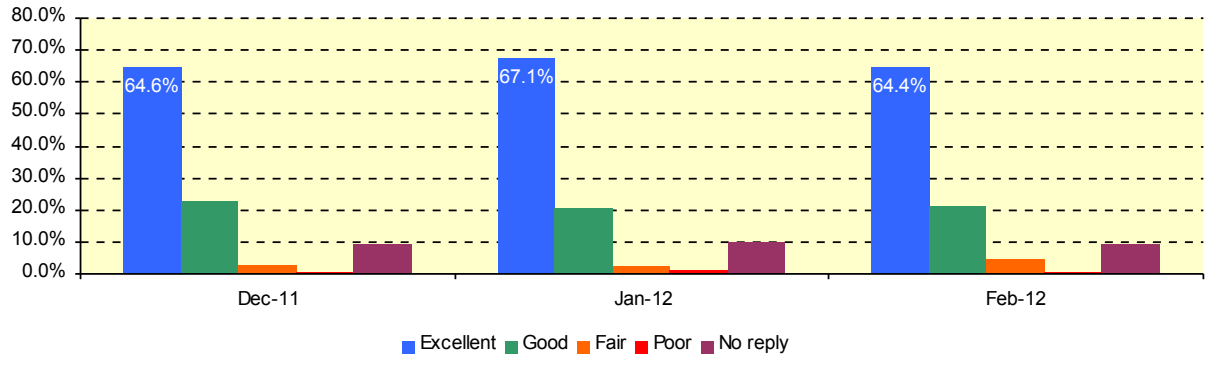
The Trust had an internal Clinical Quality target whereby 70% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. For the most recent month (March) this was not achieved (58.8.1%), which reduced the compliance rate for the year to 65.9%. *Internal Priority*

7 PATIENT EXPERIENCE

7.1 Patient Survey Results

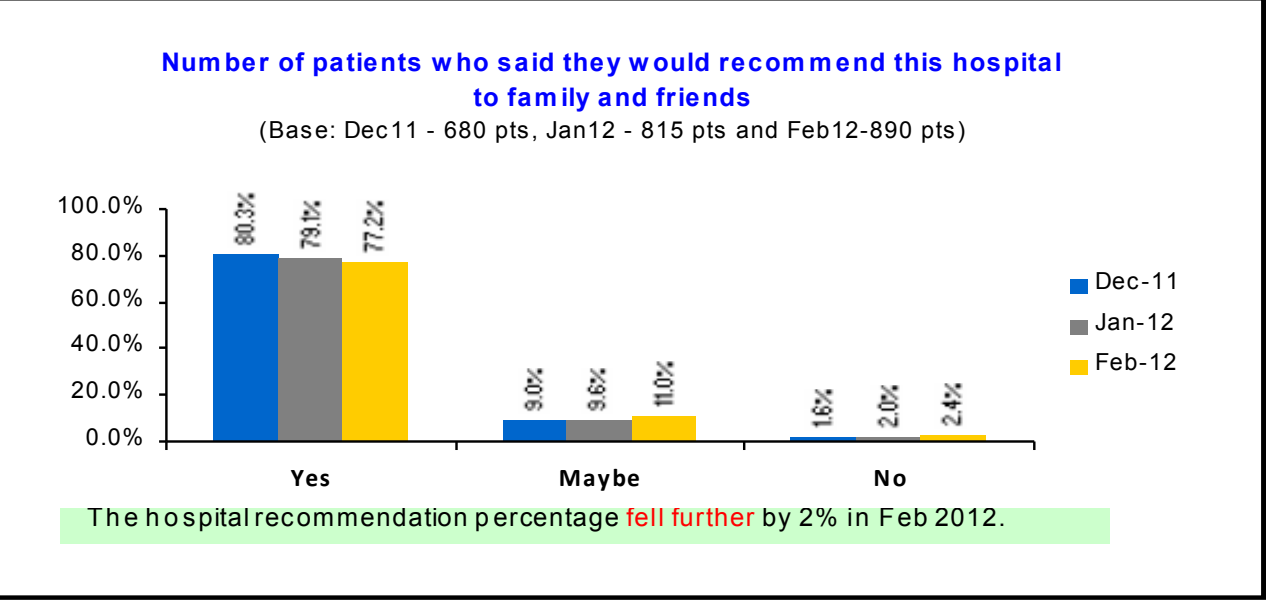
The results of the surveys received back from the wards for the months December 2011 – February 2012 are presented in the graph below. 'No replies' are not displayed in the results figures below.

Care as rated by patients:



The 'Excellent' dipped by 2.7% as compared to Jan 2012 figure.

Increasing the percentage of patients who would recommend the Trust to family and friends is one of the top three Quality and Safety related priorities for the Trust. To reflect this, the following question has now been included in the new version of the survey.



The hospital recommendation percentage fell further by 2% in Feb 2012.

The full Net Promoter Score will be introduced into the Trust in April 2012 and the first report will be available in May 2012. (This is a CQuIN and SHA requirement for next year). *CQUiN*

7.2 Complaints/PALS

a) Complaints and PALS data

i) Complaints: Tables A and B set out the complaints data for March 2012 with reference to previous months where relevant.

A) Table A: number of complaints received and sent

MONTH	Complaint type: RECEIVED		TOTAL	Complaint type: SENT		TOTAL
	First contact*	Link**		First contact*	Link**	
Jan. 2012	61	4	65	47	7	54
Feb. 2012	69	10	79	49	21	70
Mar.2012	72	7	79	44	12	56

***First Contact complaint**: where the Trust's substantive (i.e. initial) response has not yet been made.

****Link complaint**: the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.

It is acknowledged that complaints handling activity during March 2012 was disappointing. The action taken in response is detailed below.

B) Table B: Total Active Complaints[1] and cases outside the failsafe parameters

MONTH 2012	TOTAL ACTIVE COMPLAINTS [1]	NO. of COMPLAINTS OUTSIDE REVISED FAILSAFE PARAMETERS from 01 Feb. 2012 WITHIN RISK GRADE[2]				TOTAL
		Red[2] (60 days)	Amber[2] (70 days)	Yellow[2]	Green[2]	
				20 days (fast track[3]) 60 days (standard)		
Feb.	278	2	22	57	19	100
Mar.	296	1	28	38[4]	10[4]	77[3]

[1]**Total Active Complaints** is the total of 'first contact' and 'link' complaints (see A above).

[2]**Risk grade:** On receipt, each complaint is categorised according to its severity within one of four risk grades; red (most serious); amber; yellow; green (least serious).

[3]**Fast track**: for straightforward complaints (e.g. minimal no. of issues/areas) where a response can be made within 20 days.

[4]The figures stated for 'yellow' and green grade complaints are calculated using a failsafe parameter of 90 days (rather than 60 days) for the reasons stated below.

Failsafe parameters

The failsafe parameters identify those complaints which breach a prescribed period of days considered reasonable for the Trust to respond in the context of the risk grade of the complaint (see **Risk Grade**[2] above).

The utilisation of 'failsafe parameters' has been a fundamental tool in the Trust's management of its complaints workload and specifically its complaints backlog during 2011. The failsafe parameters have remained in place as an ongoing management tool with the aim of preventing a recurrence of the complaints backlog.

The 'initial' failsafe parameters were in place until 31 January 2012 and comprised 75 days for red; 90 days for amber and 120 days for yellow and green grade complaints.

From 01 February 2012, 'revised' failsafe parameters in place comprised 60 days for red; 70 days for amber and 20 days (fast track) or 60 days for yellow and green grade complaints (see **Table B** above).

At the end of the first month (i.e. February 2012) of the 'revised' failsafe parameters, a significant number (100) of complaints were in breach with 76% being either yellow or green grade complaints. Of the four risk grades, the failsafe parameters for the yellow and green grades had been reduced most acutely (i.e. from 120 days to 60 days). In light of this and the context of other changes occurring simultaneously (as referred to below), it was considered that the yellow-green failsafe parameter reduction had been too acute. Accordingly, from 01 March 2012, the yellow-green failsafe parameter was amended to 90 days on the premise that, in due course, this will revert to 60 days.

It is acknowledged that the number of complaints in breach in February (100) and March (77) 2012 is unacceptable. However it has been concluded that the increase in the number of complaints in breach has resulted from the combination of a reduction in the Complaints team staffing level, an increase in Total Active Complaints, disappointing complaints handling activity and reduction in the revised failsafe parameters.

The Trust is in the course of implementing a strategy focussed on reversing the current trend to include additional staffing resources; increased priority on resolving complaints that are in breach; closer tracking of complaints cases and delegation of investigation and responses from the Trust's centralised Complaints team to senior managers in the areas of the complaint's origin. A review of the structure of the Complaints team/Department is also under consideration.

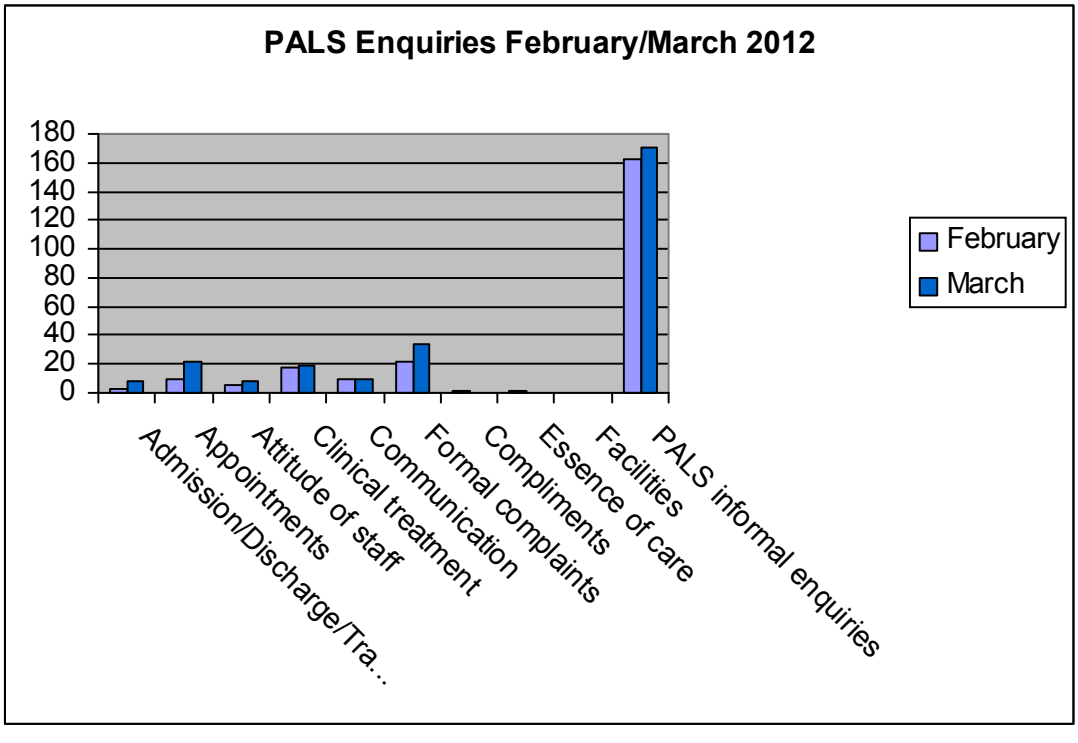
ii) PALS

- **Contacts and general enquiries:** In March 2012 PALS recorded 148 PALS enquiry contacts and 171 general informal enquiries, in comparison to February 2012 where PALS recorded 119 PALS enquiry contacts, and 163 general informal enquiries. The general informal enquiries are not captured on the PALS database but relate to enquiries taken at the PALS reception desk.

- **Chart A** provides a breakdown of the themes identified via PALS contacts in March 2012, these remain unchanged from February 2012, with the addition of communication issues reported, with the following noted:
  - The most frequent theme and cases concern appointment related queries, comprising the categories of appointment cancellation, notification, delay and appointment time.
  - Clinical treatment related enquiries comprise the categories of clinical care, treatment, delay in results, delay in treatment, information on condition, low staffing levels and waiting times.
  - Formal complaint related enquiries comprise the categories of formal complaint advice, process, complaint handling, referral and response time
  - Communication related enquiries compromise the categories of verbal and written communication.

In addition, during March 2012, there was a significant increase in general enquiry contacts, these enquires comprise the categories of general advice, information and support.

CHART A – Breakdown of top 10 issues for February/March 2012



b) Parliamentary and Health Service Ombudsman (PHSO) cases

- The NHS Complaints Procedure comprises 2 stages. The first or 'local resolution' stage involves the Trust investigating the complaint and providing a substantive response to the complainant. Where the complainant remains dissatisfied with the Trust's response given at the local resolution stage, the complainant can progress their complaint to the second stage, that is, referral to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO provides a service to the public by undertaking independent investigations into complaints that the NHS has not acted properly fairly or has provided a poor service.

- As at April 2012, the Trust had 12 open cases that complainants had referred to the PHSO. Of these, there were no new cases received since the March 2012; 11 cases were under PHSO review or had been referred back to the Trust and 1 was to be closed.

c) Care Quality Commission draft report

- On 14 March 2012, the Care Quality Commission (CQC) issued its draft report into its review of the Trust's compliance with Outcome 17 – Complaints. The CQC's review was to check whether the Trust had made improvements into Outcome 17 – Complaints since the CQC's review in July 2011.
- On 10 April 2012, the CQC issued the final report of its review and concluded that the Trust was compliant with Outcome 17.

7.3 Privacy and Dignity

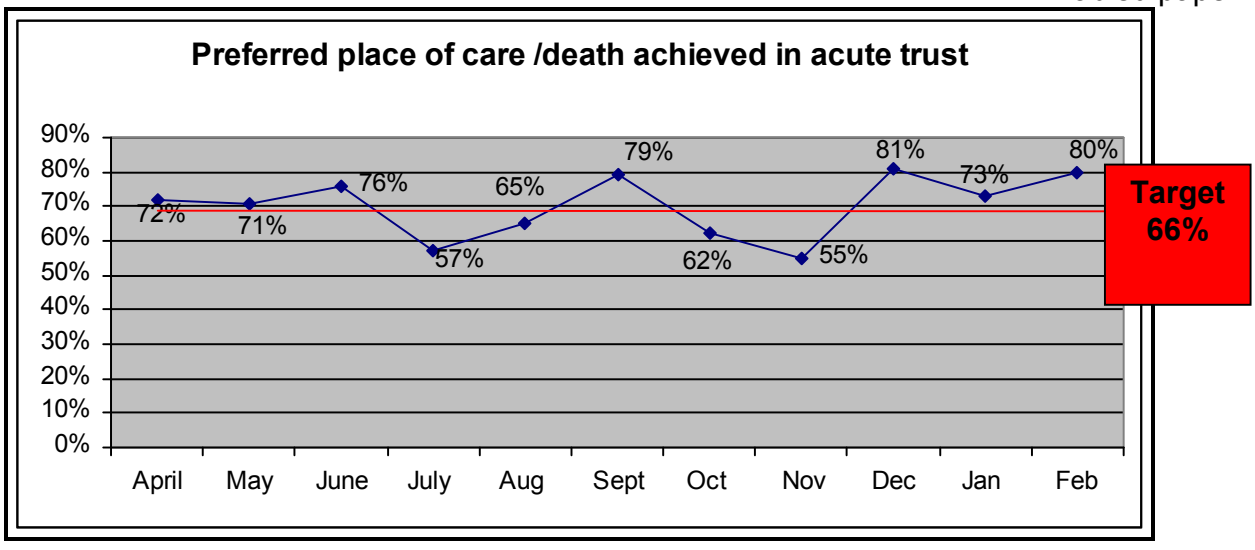
Same Sex Accommodation

There were 0 breaches of same sex accommodation reported during the month of March 2012.
National Priority

7.4 End of Life

Target: 10% increase in patients achieving preferred place of death (acute and community). Measured against Q4 baseline = 66% acute and 38% Sandwell Community *CQUiN*
10% reduction in emergency admissions.

YTD: 80% (acute) achieved preferred place of death.
82% (community) achieved preferred place of death.



7.5 Pain Control

Information not yet available.

8 RECOMMENDATION

The Trust Board is asked to:

- **NOTE** in particular the key points highlighted in Section 2 of the report and **DISCUSS** the contents of the remainder of the report.

APPENDIX 1

Glossary of Acronyms

Acronym	Explanation
CSRT	Clinical Systems Reporting Tool
CQuIN	Commissioning for Quality and Innovation
ED	Emergency Department
HED	Healthcare Evaluation Data
HSMR	Hospital Standardised Mortality Ratio
ID	Identification
LOS	Length of Stay
MRSA	Methicillin-Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NPSA	National Patient Safety Agency
OP	Outpatients
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
Pts	Patients
RTM	Real Time Monitoring
SHA	Strategic Health Authority
SHMI	Summary Hospital-level Mortality Indicator
TIA	Transient Ischaemic Attack (‘mini’ stroke)
TTR	Table top review
UTI	Urinary tract infection
VTE	Venous thromboembolism
Wards:	
EAU	Emergency Assessment Unit
MAU	Medical Assessment Unit
D	Dudley
L	Lyndon
N	Newton
P	Priory
A&E	Accident & Emergency
WHO	World Health Organisation
WTE	Whole time equivalent
YTD	Year to date