Tabled report

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:	31 May 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:

Routine monthly update.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY REPORT

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Where EVERYONE Matters

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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.

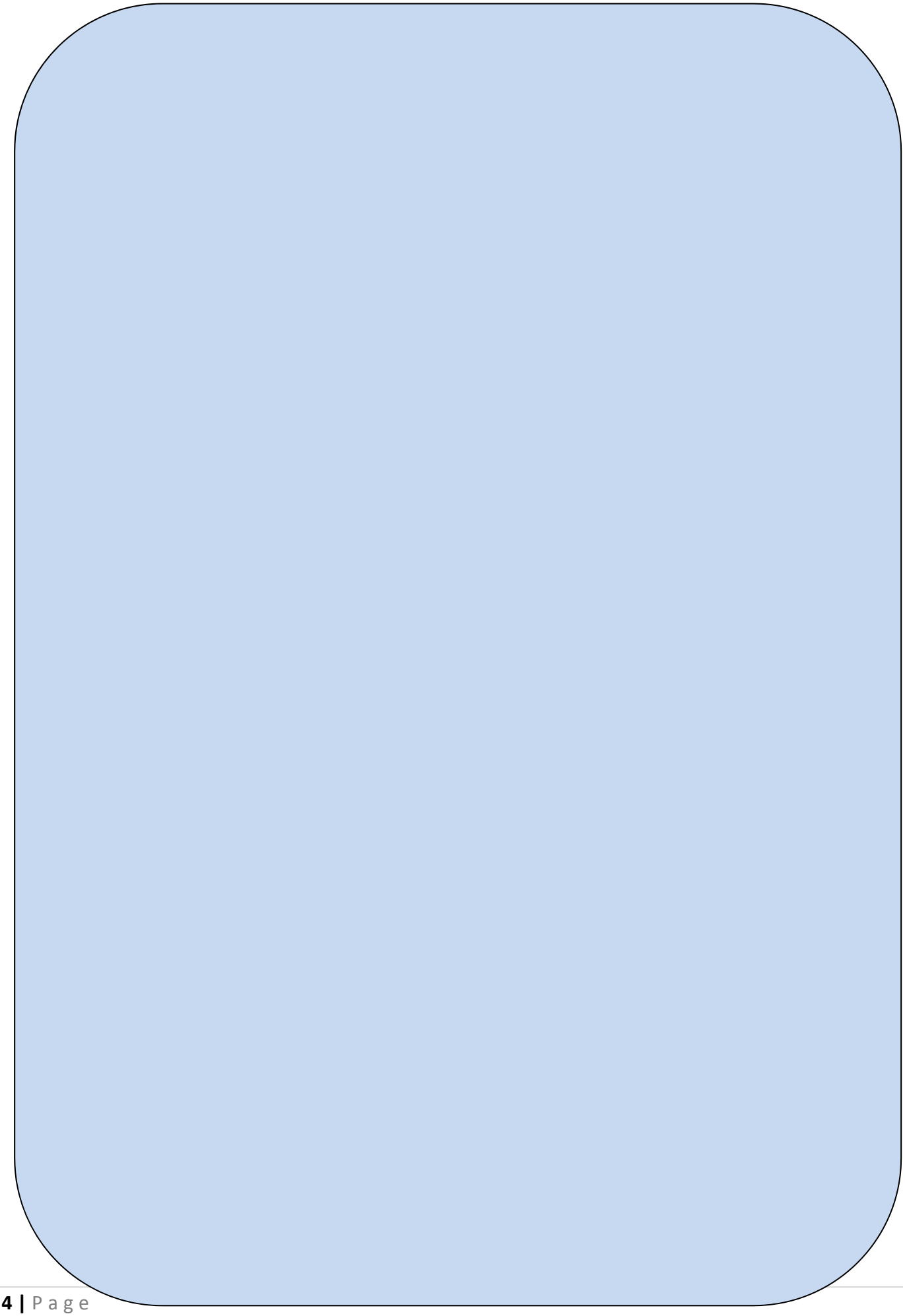
The report has been populated with latest performance information for the period up until this Board meeting, across a range of areas within three domains: patient safety, clinical effectiveness and patient experience.

2 KEY POINTS TO NOTE

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

PATIENT SAFETY

- Safety Thermometer for April – 91% harm free care, May – 94%
- Pressure ulcers – ST results showing Trust performing 'as expected'. Compared to previous years there continues to be a downward trend.
- Falls in February reduced from January position and remains lower than previous years. Sandwell continues to be higher than City.
- Nutrition standards have all been met in month.
- Infection rates are within trajectory but screening rates are lower than the required rate.
- There was a Norovirus outbreak in April on a ward at Sandwell. This was well managed with no cross infection to other areas.
  Water testing for pseudomonas has gone to plan with several actions being taken to ensure safety.
- Maternity – Community midwifery caseloads has for the first time shown some improvement. However, there is a short term issue with recruitment on the labour ward.
- Safeguarding update is included in the report. This is a significant agenda item and only a summary is included within this report. The Trust Board may wish to see more detail at the Quality & Safety Committee. There are no significant risks to note.
- Nurse staffing levels are largely as expected. Sickness rates are down in areas that were showing very high rates before.
- Bank and agency in nursing reduced significantly in April.



3 TARGETED AREAS OF SUPPORT

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

- EAU Sandwell – Special measures
- Lyndon 2/Priory 2 – divisional targeted support

4 EMERGING TRENDS/NOTICEABLE PATTERNS

- Sandwell falls data
- MRSA screening numbers
- Recruitment labour ward

5 PATIENT SAFETY

5.1 Safety Thermometer

CQUiN for 2012/13 – requires introduction of the tool. *CQUiN*

Conducting monthly whole Trust census of patients for 4 harm events (falls, pressure damage, CAUTI and VTE) continues to go well with good engagement of nursing staff. Although an inability to give any ward based data back to teams may start to affect compliance if not sorted soon.

Overall Trust harm free care in: - April = 91%
- May = 94%

The figure continues to vary as definitions and guidance from the SHA is clarified especially around avoidable/non avoidable pressure damage.

In May there were 4.5% of patients with one harm event recorded. There were no patients recorded with more than one harm event. This figure should be taken with significant caution until the data becomes more reliable.

The SHA remain focused purely on the pressure ulcer figures submitted via the ST audit and reported the first results at their April Board. The Trust performed 'as expected' by the SHA and was not alerting any concern. Black Country Trust results are shown below:

	Grade 2	Grade 3/4	Number of patients audited
SWBH	4.4	2.6	1134
Walsall	6.2	3.3	630
Dudley Group	2.6	3.6	467
Wolverhampton	8.0	2.8	763

a) Falls

There are no formal targets set for falls for 2012/13 but we will continue to aim to reduce avoidable falls across the Trust. Our audits will continue to monitor risk assessment compliance, appropriate use of care bundles and numbers of falls. Falls with injury continue to be reported as adverse incidents and TTRs conducted.

The year 2011/12 ended with a 29% reduction in hospital falls compared to the previous year. In District Nursing, falls assessment improved from 9% - 65% by year end.

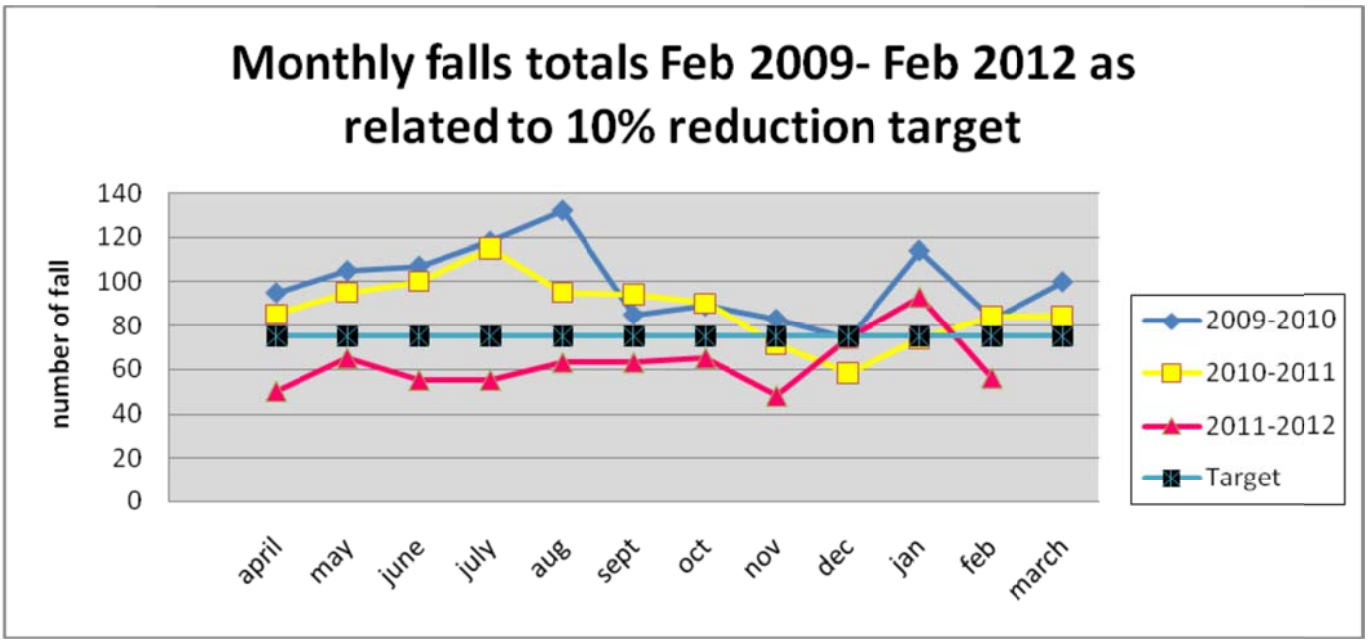


Figure 1: *Trend of falls*

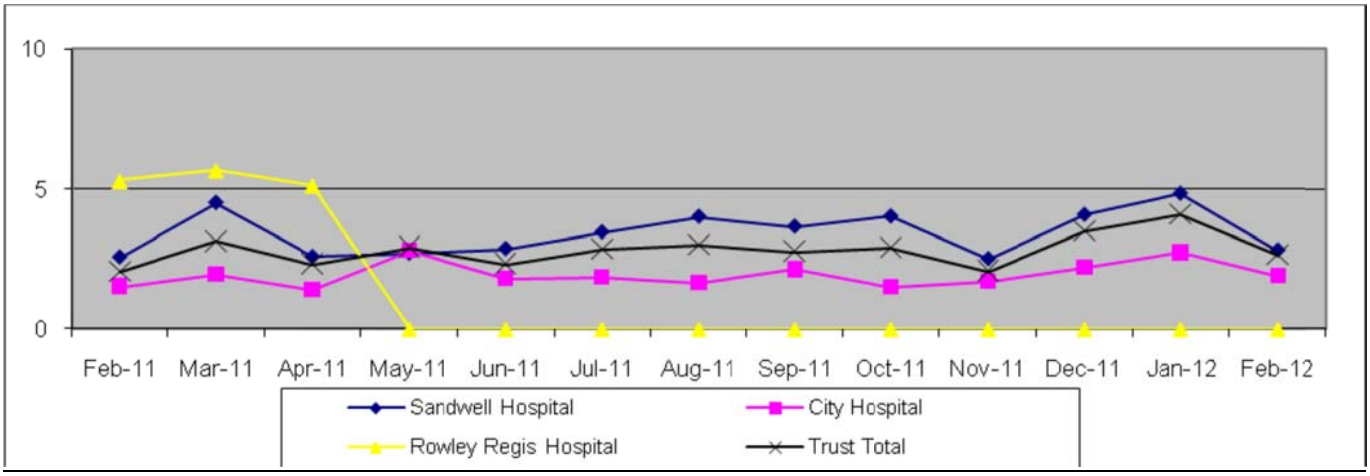


Figure 2: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

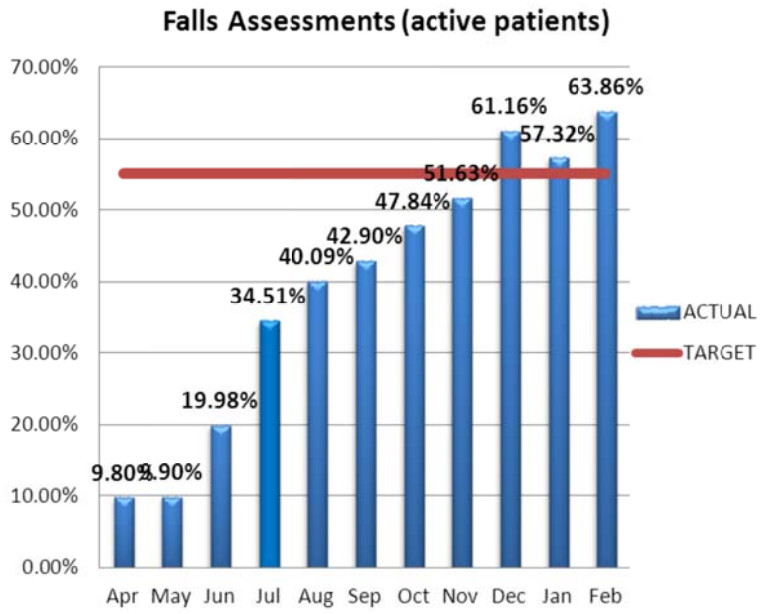


Figure 3: *Community Risk Assessment*

We have investigated the difference in falls rates at Sandwell compared to City and can find no evidence to suggest it is due to trauma being situated at Sandwell. Our conclusion therefore is that the reason for higher rates of falls is due to ward environmental configuration and greater difficulty observing patients. We are therefore considering how this can be improved.

b) Pressure Damage

Target 2012/13: Reduction in pressure damage from baseline (to be agreed) *CQUiN*
Eradication of all avoidable pressure damage *SHA Priority*

The Trust ended 2011/12 with a 41% reduction of pressure damage from the previous year.

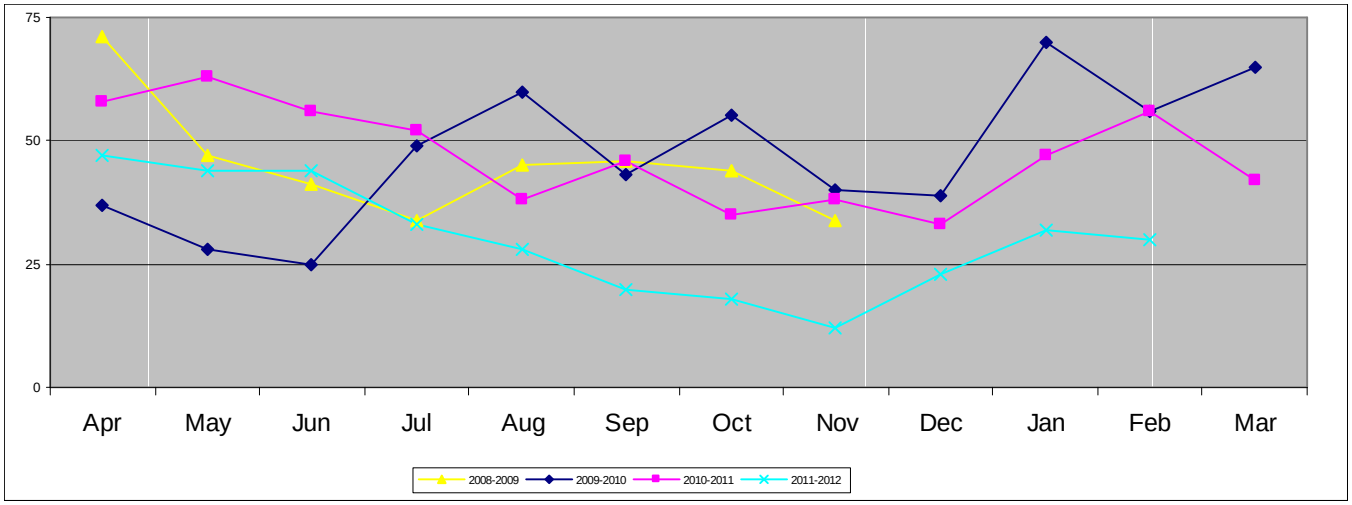


Figure 4: *Number of hospital acquired pressure damage Grade 1, 2, 3 & 4, April2009 - January 2012*

In order to achieve the targets for this year and further improve outcomes for patients we have established a Task and Finish Group to identify further specific actions. Analysis of data suggests the following actions would resolve the majority of the remaining pressure damage we see:

- Focus on heel sores – these account now for most of our grade 3 and 4 sores
- Focus on turns, ie not just checking pressure areas but also taking positive action
- Accountability meetings with the Chief Nurse – focused on 'harm' as a concept and not 'incident'
- Robust application of 'non avoidable' criteria.
- Positively we have presented at several events/conferences in recent months and have been asked to share our positive performance to date with other Trusts.

c) VTE Risk Assessment

The VTE Risk Assessment CQUIN target continued from 2011/12. Performance of at least 90% each month is required to trigger payment. During the month of April 92.2% of patients were assessed. *CQUiN*

5.2 Nutrition/Fluids

Target 2012/13: Reduction of avoidable weight loss in patients on 8 Trust wards where vulnerable adults are nursed. *CQUiN*
95% patients MUST assessed within 12 hours admission *Internal Priority*

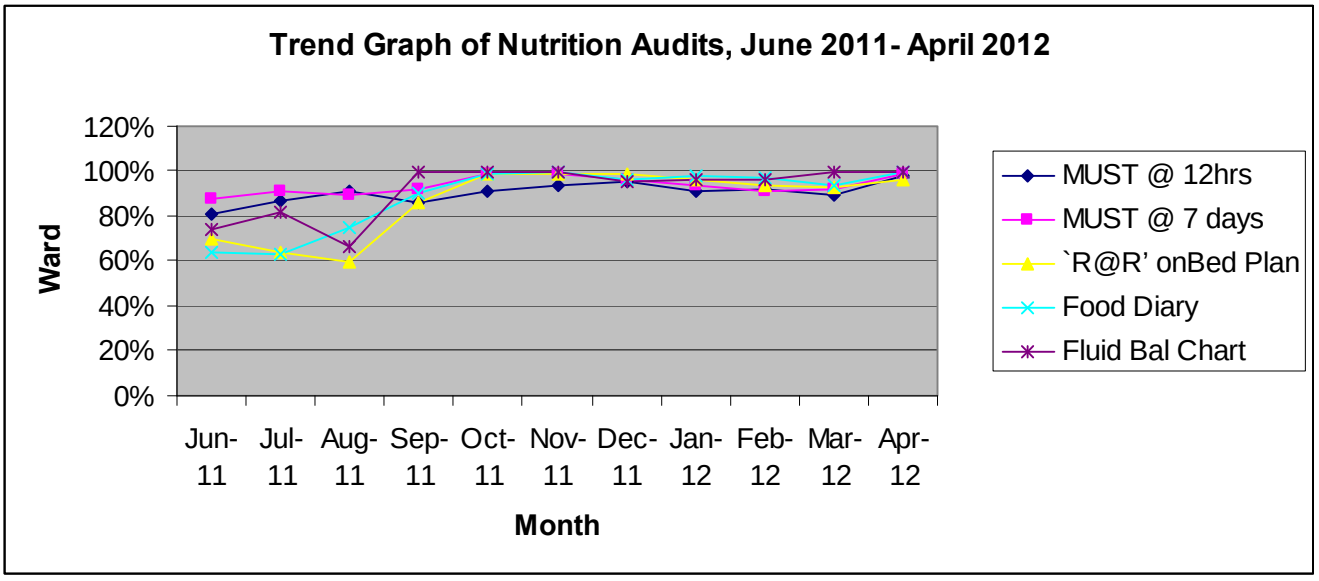


Figure 5: *Nutrition Audit Results*

The majority of our wards now consistently meet nutrition and fluid balance standards on audit. We are changing the audit methodology to include peer audit and also to monitor all patients on the 8 selected wards for avoidable weight loss.

The baseline of avoidable weight loss will be reported in July and a reduction target agreed with commissioners. Non avoidable factors include:

- Gastroenteritis

- Sepsis
- Severe and sudden deterioration in condition
- End of Life
- Lack of Capacity
- (These are similar to determining factors in pressure damage)

5.3 Infection Control

Targets 2012/13:	*C difficile* – 57 cases (post 48 hours, using SHA testing methodology)
(National Priority	MRSA – 2 cases (post 48 hours)
Local contract)	MRSA Screening – 85% eligible patients
	Blood culture contaminants – 3% or less
	E Coli and MSSA – Continue to record and TTR device related infections
	National cleanliness standards – 95%

MRSA

There were no post 48 hour cases of MRSA in April and one pre 48 hour case.

MRSA Screening

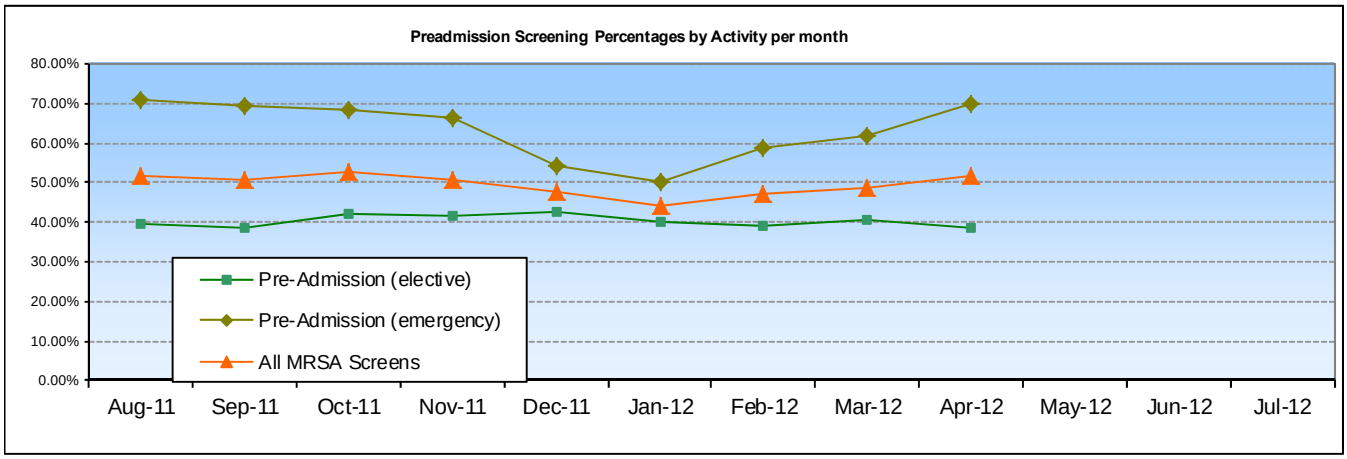


Figure 6: *Percentage of eligible spells screened*

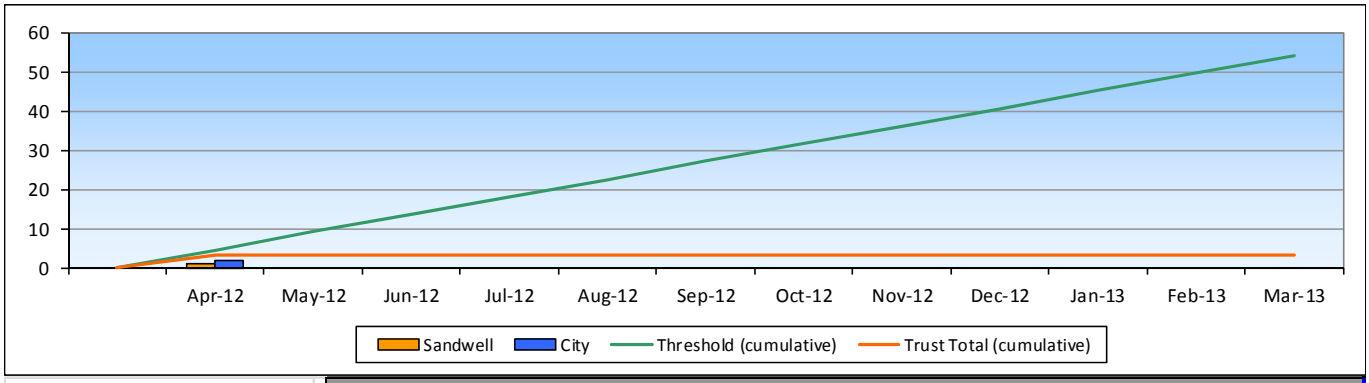
We will be driving screening numbers this year with an aim to achieve 85% by March 2013. This is a simple swabbing procedure that takes less than a minute to perform. The key task is to raise the awareness of staff, especially in medical assessment units and pre operatively, of the importance.

Other key actions for this year to avoid MRSA bacteraemia are:

- Re-emphasise importance on 'line' care, eg cannulae etc. The two cases in 2011/12 were both line related.
- Reduce blood culture contaminants especially in EAU at Sandwell.

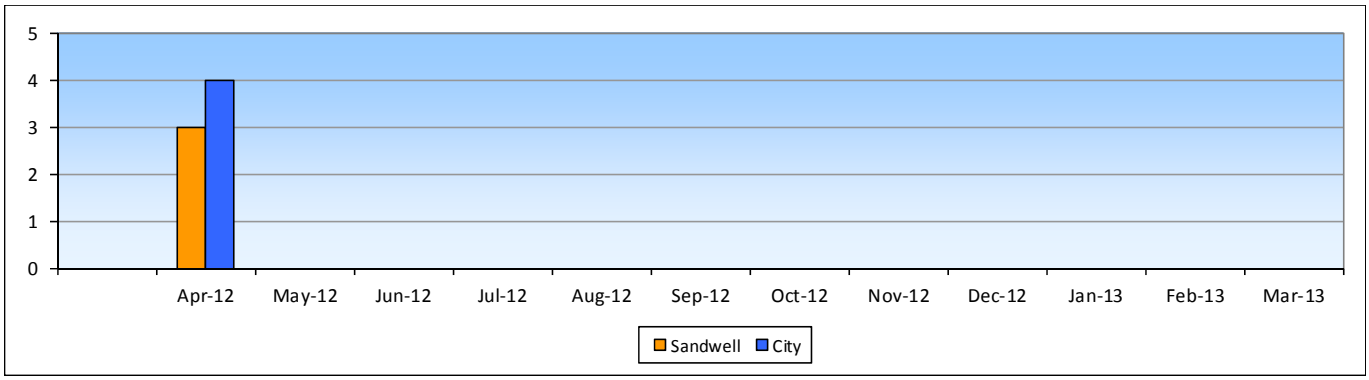
Clostridium difficile

We now report C Diff numbers in two ways; the Department of Health target and our own internal best practice numbers. The SWBH best practice numbers are determined by a combination of clinical assessment and a recognised testing algorithm. By using this reporting mechanism we can ensure that all patients with clinical signs of C diff infections are identified and managed appropriately.



	2012-2013												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Total
Sandwell	1	0	0	0	0	0	0	0	0	0	0	0	**1**
City	2	0	0	0	0	0	0	0	0	0	0	0	**2**
Trust	3	0	0	0	0	0	0	0	0	0	0	0	**3**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DoH Trajectory	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	**54**
Trust Total (cumulative)	3	3	3	3	3	3	3	3	3	3	3	3	-
Threshold (cumulative)	5	9	14	18	23	27	32	36	41	45	50	54	-

Figure 7: *SHA Reportable CDI*



	2012-2013												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Total
Sandwell	3	0	0	0	0	0	0	0	0	0	0	0	**3**
City	4	0	0	0	0	0	0	0	0	0	0	0	**4**
Trust	7	0	0	0	0	0	0	0	0	0	0	0	**7**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Trust Total (cumulative)	7	7	7	7	7	7	7	7	7	7	7	7	-

Figure 8: *Trust Best Practice Data*

Blood Contaminants

We have been monitoring trends for several years (see graph below) and generally the trend is downward. The area with the greatest number of contaminants is EAU at Sandwell and therefore targeted action is happening.

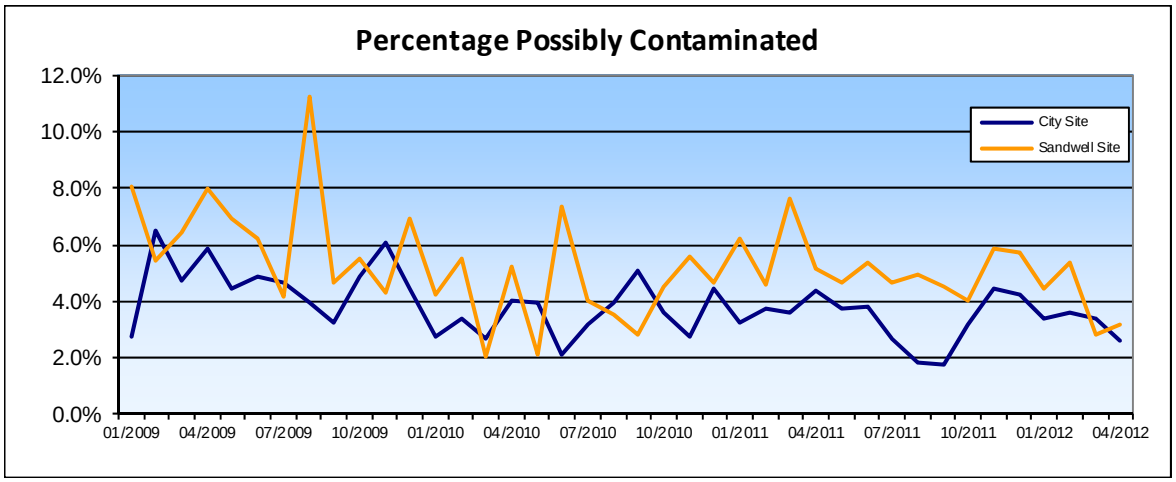


Figure 9: *Blood Contaminants*

E Coli Bacteraemia

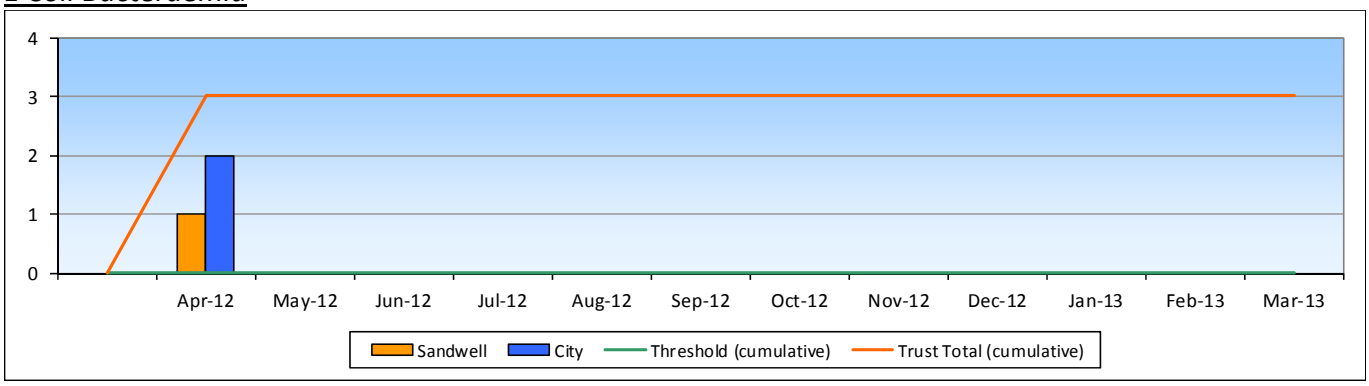


Figure 10: *E Coli Bacteraemia*

MSSA

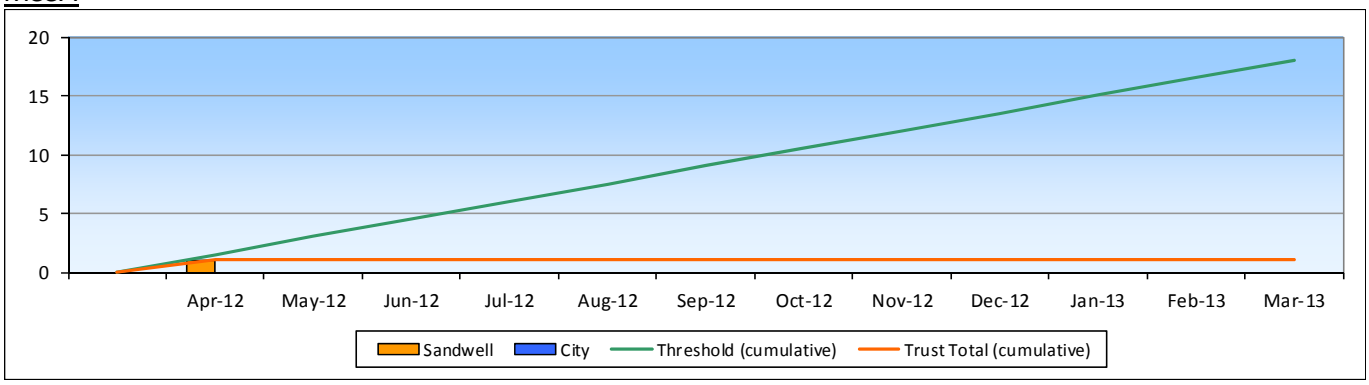


Figure 11: *MSSA*

Surgical Site Surveillance

The Trust continues to participate in surveillance of hip and knee surgical site infection. No concerns have been identified with our practice.

Outbreak and Other Infection Control Activity

Norovirus
There was a Norovirus outbreak on P5 that resulted in the ward being closed to admissions on 23/04/12. The ward was reopened on 05/05/12. 22 patients and 4 staff where affected by confirmed Norovirus. The outbreak was well managed and no spread to other wards occurred. The ward was decanted to L5 at the end of the outbreak in order to deep clean P5.

Water Testing – Pseudomonas
We have been undertaking a programme of water testing in augmented care units (ITU, NNU) as per DH instruction and following the Belfast pseudomonas outbreak on their neonatal unit. We have completed testing in neonatal unit and the ITUs and having found pseudomonas contamination in a number of taps have taken action to resolve by replacing taps or parts of taps where water pooled and introducing flushing regimes (self flush taps). Testing in these areas will continue as part of planned surveillance by Estates and Microbiology.

We debated the requirement to testing N5 Haematology Oncology as it does not fit within the DH requirements and decided to proceed with testing regardless. Pseudomonas contamination in approx. 50% of the taps/showers was found. These were immediately taken out of action and alternatives identified for staff and patients. Patients were fully informed of the issue and advised that they were not at risk due to the measures we were taking. Water testing is now clear, however, N5 needs to be decanted to enable a thorough deep clean and upgrade of kitchen, sink units and taps etc.

PEAT

Please see the below results of externally validated PEAT inspections.

Site Name	Environment Score	Food Score	Privacy & Dignity Score
SANDWELL GENERAL HOSPITAL	4 Good	5 Excellent	4 Good
CITY HOSPITAL	4 Good	5 Excellent	4 Good
BIRMINGHAM & MIDLAND EYE HOSPITAL	4 Good	5 Excellent	4 Good
ROWLEY REGIS HOSPITAL	4 Good	5 Excellent	4 Good

Figure 12: *Results of the PEAT 2012 Programme for each hospital within the Trust*

National Standards of Cleanliness average scores 96 – 97% throughout the year.

5.4 Maternity

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

*Post Partum Haemorrhage (PPH)(>2000ml): t*here were no patients recorded to have had a PPH of >2000ml in March.

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for March was 11.9 which was not over trajectory (8) and showed an increase from the previous month (6.4). 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 March was 20.8%, 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 6% which was within trajectory (15).

Community Midwife Caseload (bi-monthly): The community midwife caseload in February was 139 which was not within the trajectory of 120. However, did indicate an improvement and changed from red to amber.

Vacancies: Vacancy rates remain high, as reported in the divisional review report. A risk assessment has been completed for this. The position is anticipated to improve by May/June.

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.

- Emergency Department and Capacity Management Escalation Plans have been designed to provide a more consistent response to peaks in demand. The plans outline a series of actions for key personnel working in the department and are focussed on responses to deterioration in performance against the Emergency Department clinical quality indicators and ambulance turnaround times.

- Regular meetings have been established with the local commissioning groups and managers of local walk-in centres to increase the number of patients the Trust is able to safely redirect from Emergency Department triage, improve patient experience and ensure referrals from the walk in centres to the Trust are appropriate.

- A review of Standard Operating Procedures (SOPs) has been completed, which hyad identified the need for a clear audit programme to ensure compliance and identify where additional SOPs and or procedures are needed.

- An alert system for frequent attenders to Emergency Department has been introduced

- Two successful candidates have been conditionally offered locum consultant posts to bring numbers in post up to establishment. All speciality doctor vacancies have been appointed to at Sandwell Hospital.

- There has been an increase in the number of amber incidents at City Hospital Emergency Department, with a most notable increase in the number of sharps incidents.

- There remains good performance on compliance with the use of Emergency Department proforma.

5.6 Safeguarding

Target 2012/13: Improve awareness and diagnosis of dementia in acute setting and on District Nurse caseload *CQUiN*
Currently undertaking baseline and developing assessment and audit process

The Safeguarding Adults and Children agenda continues to be challenging, especially around vulnerable adults where considerable attention from the CQC, DH, SHA and Local Authority Safeguarding Boards continues around the whole neglect agenda.

Structurally the Trust continues to operate a Trust Safeguarding Committee with subgroups for Child Safeguarding and the various adult workstreams. The Trust employs the following staff to lead and support this agenda:

- Named Doctor Child Safeguarding
- Named Nurse (Acute) Child Safeguarding – 1.2 WTE
- Named Midwife Child Safeguarding
- HV Liasion Nurse – vacant
- SLA with PCT cluster Community Named Child Safeguarding Team
- 2 Adult Safeguarding Nurses
- Learning Disability Nurse (Sandwell)
- RAID – City
- Mental Health Liaison Team Sandwell

Criminal Records Bureau (CRB) checking

The Trust is fully compliant with requirements around CRB checks. Within the Community these are repeated every 3 years. We have now reduced considerably the number of staff who have never had a CRB (employment predates the requirement) in Women and Children's and the Emergency Department to around 6%.

Safeguarding Training at Level 1 and 2 is compliant but there is a requirement for more staff to undertake Level 3 training. The Divisions are aware of this and taking action when training becomes available.

The Trust has reported non compliance against Learning Disability standards within its monthly performance management report. This will be resolved by the end of June with the following actions:

- Inclusion of a prompt for LD in DN and ED assessment documentation
- Conversion of complaint leaflet to Easy read
- Access to a website for Easy read patient information

Serious Case Reviews (SCR)

Adult

4 domestic homicide reviews in progress

2 potential SCR involving the Trust but at a distance

Maternity

1 domestic homicide review

1 Individual Management Review for a potential SCR

Child

1 Individual Management Review (as per Maternity)

1 Community Child – Individual Management Review submitted

1 case awaiting SCR result and recommendation

There are no issues relating to SCR actions.

5.7 Medicine Management

Target 2012/13: Use of antibiotics – Antimicrobial Stewardship – reduce the incidence of healthcare associated infections *CQUiN*

The baseline work is currently being undertaken and will be reported in June/July.

5.8 'Never Events'

No further never events have been reported in April.

5.9 National Patient Safety Agency (NPSA) alerts

1. Overdue alerts: NPSA 2011/PSA001 – Safer spinal (intrathecal) epidural and regional devices. This alert will continue to remain as "ongoing" on the Central Alert System until all of the components we require to safely convert to the new neuraxial devices are available.

2. New alerts: No new alerts have been received.

3. Completed alerts:

Alert Title	Date for Action
Minimising the risks from spinal devices	31 March 2012
Additional information/actions	
To prevent accidental ordering of new neuraxial devices, these have been "masked" from the NHS catalogue. A trial of the new manometers will take place when available under control of one consultant.	

Figure 13: *Completed NPSA safety alerts*

5.10 Lessons Learned

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

Incident	Extract from Action Plan
Failure to carry out a newborn bloodspot screening test.	• A column has been added to the handover board in the neonatal office to highlight that the NNBS test is required. • When babies admitted to NNU a cot card (with picture for NNBS) is immediately placed on the cot / incubator with date for the NNBS test to be completed, which must not be removed until the test has been undertaken.
Downs screening was missed.	• Additional phlebotomy resources in clinic when dating scans taking place. • Amend process so that those who have consented for the screening, have the blood test first and scan afterwards.
Delay in the provision of replacement potassium.	• Provision of small supply of potassium chloride on coronary care.

Figure 14: *Patient safety lessons learned*

5.11 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.
There were no significant risks presented at RMG in March 2012.

5.12 Listening into Action

A listening into action event was held on Friday 27 April 2012 into patient and staff safety. The event was well attended from staff of all levels and from all divisions. An action plan will be developed from the output of the work everyone contributed to, but two "quick wins" were identified:

Quick win:
To include a session on incident reporting in the Trust's mandatory training programme

Quick win:
To make feedback to staff a mandatory requirement for managers on the incident reporting system

After discussion with Learning & Development, incident reporting is now part of the mandatory training packages. Communications have gone out to all staff advising that from 21 May 2012, the feedback field will be made mandatory.

5.13 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.

	Budgeted Posts & Funded Beds				Actual Bed Usage & Staff Per Bed			Actual In Post				Sickness	SNCT
	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Ward Bed Capacity	Average Bed Usage	Actual Staff: Bed Ratio	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	In Post No. Staff per bed	% (previous Month)	Most Recent SNCT Ratio
D5 (CCU/PCCU)	39.25	92.36	17	2.31	17	17	2.28	38.68	6.2	12.07	2.28	5.95	
CCU Sandwell	19.07	84.27	10	1.91	10	10	1.91	19.11	14.65	4.24	1.91	1.43	
D7	23.04	68.14	16	1.44	25	25	1.23	30.87	23.32	27.58	1.23	6.8	
D11	31.94	59.27	21	1.52	21	21	1.66	34.87	33.04	13.7	1.66	3.96	
D12	16.52	66.1	10	1.65	10	10	1.87	18.71	21.75	14.64	1.87	2.85	
D15	26.35	58.25	24	1.1	24	24	1.15	27.69	36.11	17.3	1.15	2.47	
D16	28.95	56.13	23	1.26	23	23	1.25	28.83	37.54	17.26	1.25	9.11	
D17	28.51	69.8	26	1.1	26	26	1.16	30.09	31.07	13.76	1.16	2.74	
D18	19.61	54.11	16	1.23	16	16	1.64	26.26	30.58	26.66	1.64	0.35	
D41	22.98	75.41	17	1.35	17	17	1.47	25.06	20.75	11.21	1.47	5.36	
D43	31.4	57.36	28	1.12	28	28	0.99	27.81	40.42	12.69	0.99	0.9	
D47	30.47	49.77	22	1.39	22	22	1.52	33.41	32.98	26.64	1.52	9.98	
MAU	65	64.88	28	2.32	28	28	2.25	62.93	25.77	14.02	2.25	5.33	
PRIORY 3	30.5	51.87	29	1.05	29	29	1.05	30.33	46.16	9.03	1.05	6.43	
EAU	45.39	66.45	28	1.62	28	28	1.72	48.37	26.44	19.47	1.72	4.34	
NEWTON 4	26.28	50.57	22	1.19	22	22	1.49	32.68	38.43	26.04	1.49	7.94	
NEWTON 1	20.63	83.57	12	1.72	12	12	1.61	19.37	20.65	5.73	1.61	5.34	
PRIORY 4	35.3	50.71	34	1.04	34	34	1.07	36.25	37.32	15.78	1.07	4.59	
LYNDON 4	28.54	60.44	26	1.1	33	33	0.97	31.94	31.31	15.56	0.97	4.05	
NEWTON 5	23.98	75.81	15	1.6	15	15	1.7	25.51	16.46	10.19	1.7	0.08	
LYNDON 5 (ww)	0	0	12	0	24	24	0.82	19.66	24.42	19.18	0.82	1.49	
D20 (ww)	0	0	0	0	0	closed	0	0	0	20.95	0	n/a	
PRIORY 5	37.2	53.23	34	1.09	34	34	1.04	35.31	35.68	11.75	1.04	8.26	2.4
HENDERSON													1.48
LEASOWES													

Figure 15: *Medicine Nurse Staffing Ratios*

	Budgeted Posts & Funded Beds				Actual Bed Usage & Staff Per Bed			Actual In Post				Sickness	SNCT
	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Ward Bed Capacity	Average Bed Usage	Actual Staff: Bed Ratio	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	In Post No. Staff per bed	% (previous Month)	Most Recent SNCT Ratio
D6 (Pre Assess)	7.95	74.84	27	0.29	27	27	0.26	7.1	25.35	4.93	0.26	6.95	
D21/24	23.21	67.69	15	1.55	15	15	1.49	22.36	31.31	9.08	1.49	10.51	
D25	27.54	60.24	23	1.2	23	23	1.09	25.05	33.81	2.87	1.09	2.05	1.55
D26/28	44.76	59.96	36	1.24	36	36	1.02	36.85	31.07	7.68	1.02	5.38	
D30	19.15	64.49	19	1.01	19	19	1	18.93	32.75	6.44	1	6.55	
SAU/D42	22.34	73.14	17	1.31	19	19	1.18	22.38	26.81	3.44	1.18	5.48	
ASU	26.2	74.05	20	1.31	25	25	1.21	24.12	27.74	0.62	1.21	0	
NEWTON 2	17.85	61.79	18	0.99	24	closed	0	16.95	35.17	4.29	0	6.76	
LYNDON 2	27.73	56.26	26	1.07	20	34	0.85	29.19	38.99	16.67	0.86	11.18	
LYNDON 3	29.37	51.96	28	1.05	28	28	1.05	29.27	43.49	9.36	1.05	9.98	
PRIORY 2	26.67	60.82	26	1.03	26	33	0.9	29.81	34.82	11.83	0.9	6.82	
NEWTON 3	37.1	41.13	33	1.12	33	33	1.16	38.43	41.66	20.43	1.16	9.06	

Figure 16: *Surgery Nurse Staffing Ratios*

The above table demonstrates that on the whole ratios are being maintained.

Sickness absence has reduced on many wards – most notably in Medicine. Wards that failed to maintain ratios:

- D43 – Due to vacancies and inability to fill gaps with bank/agency
- L4 – Due to winter beds still being open during April
- L5 – Now closed completely
- L2 and P2 – Due to additional beds opened to facilitate N2 closing (to enable Trauma & Orthopaedic ward upgrades). N2 staff were deployed to L2 and P2 which is not included in ratios.

Bank & Agency

The Trust's nurse bank/agency rates are detailed in the tables below and show year on year comparison from 2008/9 to date.

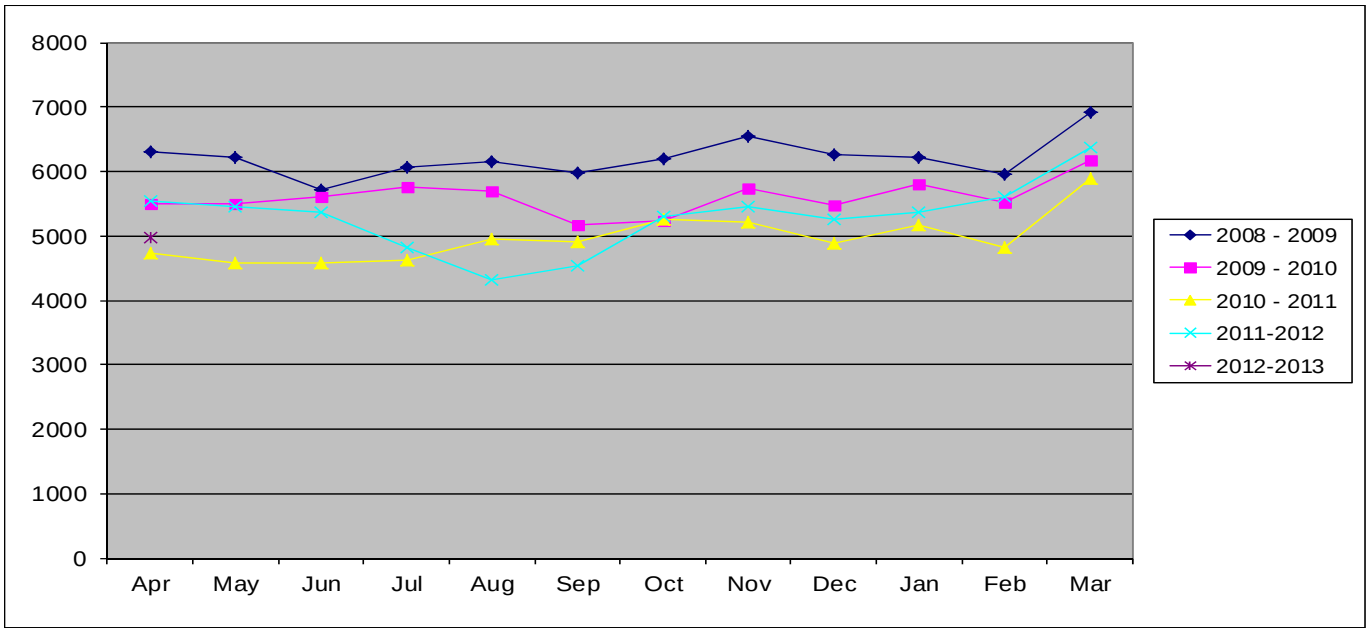


Figure 17: *Total Bank & Agency Use Nursing April 2008 -2012*

Bank and Agency nursing reduced across the Trust in April with the closure of the majority of winter beds.

Relief for wards has been calculated taking into account new Mandatory Training arrangements and a realistic calculation of leave and sickness absence.

Relief is recommended to be set at 22% for Band 6 and above, 21% for Band 5 and 20% for unqualified in all new establishments. It has been further recommended to hold 3% of relief as a flexible staffing line in budgets to allow for unplanned leave.

The e-rostering roll out is going well and we are nearing a point where acuity data can also be included in ward monitoring.

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 period the 12-month cumulative the HSMR for the Trust (93.1) continues to follow a downward trend, similar, but lower than that of the SHA Peer (98.3), with both Trust and SHA (Peer) HSMR beneath the lower (95% statistical confidence) limits. The in-month (January) HSMR for the Trust is 86.6. (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 **99.6**.

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.

Further SHMI data was published on 24/04/12 for the data period October 10 – September 11. This data will be presented to the next meeting of the Mortality and Quality Alerts Committee and an updated position will be included in the next report.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Internal Data:										
Hospital Deaths	140	158	118	130	131	132	146	140	171	172
Dr Foster 56 HSMR Groups:										
Deaths	121	133	102	110	112	116	125	125	152	146
HSMR (Month)	90.1	100.8	81.3	90.7	90.5	92.3	91.1	81.6	89.3	86.6
HSMR (12 month cumulative)	98.4	98.1	103.4	102.9	102.9	101.9	100.6	97.7	95.7	93.1
HSMR (Peer SHA 12 month cumulative)	96.7	97.0	106.4	106.2	105.5	104.5	104.0	102.5	100.7	98.3
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	99.6

Figure 18: *Mortality summary*

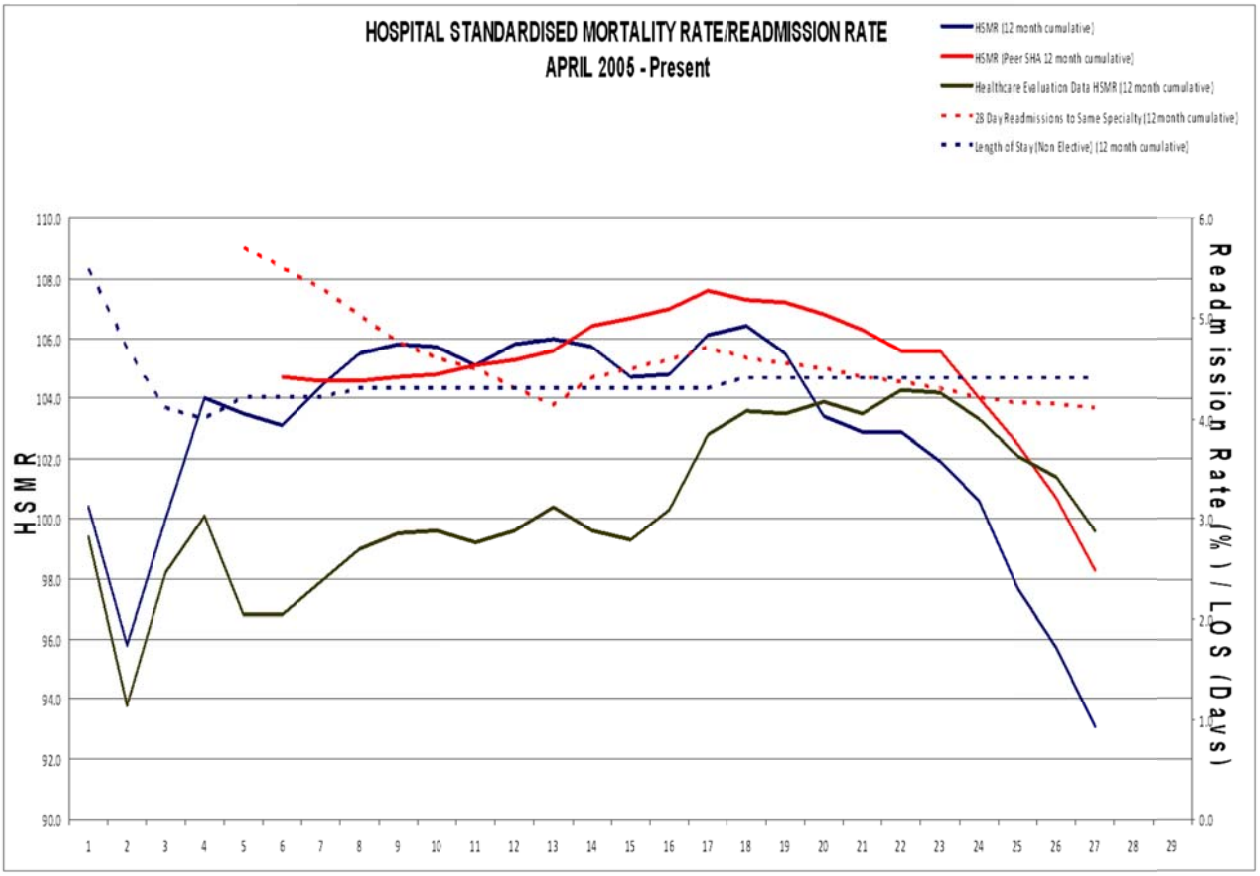


Figure 19: *HSMR/Readmission rate – April 2005 - Present*

CQC Mortality Alerts received in 2012/13

The Trust received notification in April 12 from the Care Quality Commission (CQC) of being an outlier for mortality in the period from Nov10 – Nov11 for patients with a primary diagnosis of biliary tract disease. The review into the deaths that occurred in this period has been completed. It was considered that although none of the deaths were preventable, some aspects of care could be improved. The majority of these are being addressed through existing work streams. The investigation report has been submitted to the Commission and their response is awaited.

Dr Foster generated alerts (RTM)

There were no new diagnoses or procedures alerting with significant variation in terms of mortality when the data period March 2011 – February 2012 is considered (see table below).

Mortality (in-hospital) - Diagnoses										Alert	
Team	Diagnoses	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	HSMR Basket of 56 Diagnosis Groups	39393	1535	3.9%	1663.1	4.2%	92.3	87.7	97.0		9
ALL	Acute bronchitis	1191	32	2.7%	48.0	4.0%	66.6	45.6	94.1		1
ALL	Aspiration pneumonitis, food/vomitus	126	35	27.8%	47.0	37.3%	74.4	51.8	103.5		1
ALL	Biliary tract disease	1049	21	2.0%	13.0	1.2%	160.9	99.6	246.0	1	
ALL	Cancer of prostate	594	6	1.0%	13.3	2.2%	45.0	16.4	98.0		1
ALL	Congestive heart failure, nonhypertensive	710	65	9.2%	89.4	12.6%	72.7	56.1	92.7		2
ALL	Diabetes mellitus with complications	778	10	1.3%	24.2	3.1%	41.3	19.8	76.0		1
ALL	Fracture of neck of femur (hip)	434	42	9.7%	43.0	9.9%	97.7	70.4	132.1	1	
ALL	Leukaemias	934	13	1.4%	8.9	1.0%	146.1	77.7	249.9	1	
ALL	Nonspecific chest pain	3195	0	0.0%	4.6	0.1%	0.0	0.0	79.2		1
ALL	Other upper respiratory disease	996	2	0.2%	6.5	0.7%	30.5	3.4	110.3		1
ALL	Short gestation, low birth weight, and fetal growth retardation	764	6	0.8%	18.2	2.4%	33.0	12.0	71.8		2
Mortality (in-hospital 30 days) - Procedures										**Alert**	
Team	Procedures	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	Reduction of fracture of neck of femur	223	18	8.1%	14.0	6.3%	128.8	76.3	203.5	1	

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

Figure 20: *Dr Foster generated alerts*

6.2 Patient Related Outcome Measures (PROMs)

Further provisional data in the form of experimental statistics were published on 10th May 2012. The provisional data included updated outcome scores for the periods April 10 – March 11 and April 11-December 2011. A summary of this data will be presented to the Governance Board and will be included in the next report

Previously, provisional data for 2010/11 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 a further update on progress to the Governance Board at the meeting to be held in June.

6.3 Clinical Audit

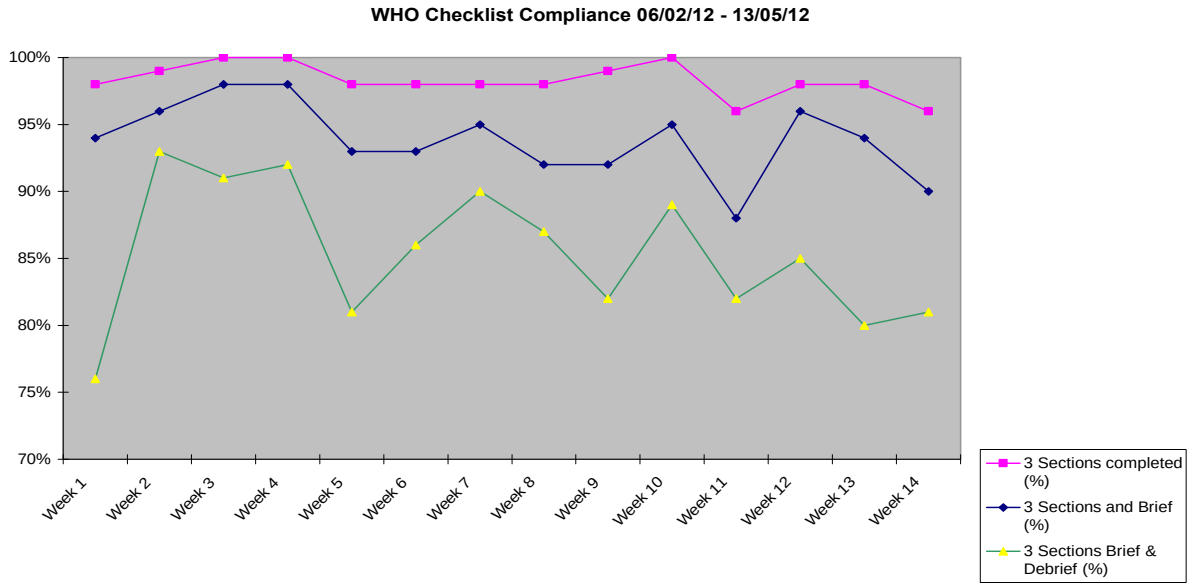
Clinical Audit Forward Plan 2012/13

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.

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 – 13/05/12 (source CDA)	
Number of list entered	3332
Number of cases	**12701**
"Five Steps to Safer Surgery"	**Reported compliance**
Completion of the 3 sections of the checklist only	98.%
All checklist sections and brief	94.%
All checklist sections completed and brief & debrief	86.%



Figures 21 & 22: *Compliance with the use of the WHO checklist*

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 Stroke Care

Performance against the principal stroke care targets to which the Trust is working in 2012/13 is outlined in the table below.

Indicator	April		Target
Pts spending >90% stay on Acute Stroke Unit	**84.4**	▼	**83%**
Pts admitted to Acute Stroke Unit within 4 hrs	**73.3**	▲	**90%**
Pts receiving CT Scan within 24 hrs of arrival	**100**	■	**100%**
Pts receiving CT Scan within 24 hrs of admission	**92.3**	▼	**90%**
Pts receiving CT Scan within 1 hr of arrival	**66.7**	▲	**50%**
TIA (High Risk) Treatment <24 h from initial presentation	**57.1**	■	**60%**
TIA (High Risk) Treatment <24 h referral rec'd by Trust	**57.1**	■	**60%**
TIA (Low Risk) Treatment <7 days from initial presentation	**53.9**	■	**60%**
TIA (Low Risk) Treatment <7 days referral rec'd by Trust	**57.7**	■	**60%**

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

Figure 23: *Stroke care performance*

6.6 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 (April) this was not achieved (66.7%), which also represents the year to date position. *Internal Priority*

6.7 Ward Reviews

The Board will be aware that Ward Performance Reviews are undertaken every quarter. This has now been expanded to include Paediatrics and Critical Care and the tool is now being adapted to include Theatres and Maternity (wards).

Figure 24 shows performance over the year.

Sandwell and West Birmingham Hospitals NHS

All Quarter - Ward Review- 2011/2012

Medicine and Emergency Care	Quarterly Ward Comparison Target Performance																
	Q1- June 2011				Q2- October 2011				Q3- January 2012				Q4- April 2012				
WARD	RED	AMBER	GREEN	N/A		RED	AMBER	GREEN		RED	AMBER	GREEN		RED	AMBER	GREEN	
D5	0	3	5		D5	0	0	7	D5	0	0	7	D5	0	0	7	
D7	0	0	8		D7	0	1	6	D7/D41	0	3	4	D7/D41	0	0	7	
D11	0	3	5		D11	0	2	5	D11	0	2	5	D11	0	2	5	
D12	0	0	8		D12	No	Review	Done	D12	Ward	Has	Merged	D12	Ward	Has	Merged	
D15	0	5	3		D15	0	0	7	D12/D15	0	3	4	D12/D15	0	0	7	
D16/D18	0	3	5		D16/D18	1	1	5	D16/D18	0	5	2	D16/D18	0	2	5	
D17	0	1	7		D17	0	0	7	D17	0	0	7	D17	0	0	7	
D41	0	1	7		D41	0	1	6	D41	Ward	Has	Merged	D41	Ward	Has	Merged	
D43	1	2	5		D43	1	1	5	D43	0	2	5	D43	0	2	5	
D47	0	0	8		D47	0	2	5	D47	0	0	7	D47	0	1	6	
Skin	0	0	8		Skin	0	1	6	Skin	1	6	0	Skin	0	0	7	
MAU	0	1	7		MAU	0	1	6	MAU	0	3	4	MAU	0	2	5	
Endoscopy	0	0	8		Endoscopy	0	0	7	Endoscopy	No	Review	Done	Endoscopy	No	Review	Done	
Priory 3	0	1	7		Priory 3	0	1	6	Priory 3	0	1	6	Priory 3	0	2	5	
Lyndon 4	0	0	8		Lyndon 4	0	2	5	Lyndon 4	0	0	7	Lyndon 4	0	0	7	
Priory 4	0	2	6		Priory 4	1	4	2	Priory 4	0	6	1	Priory 4	0	2	5	
Lyndon 5	0	1	7		Lyndon 5	0	0	7	Lyndon 5	Ward	Has	Closed	Lyndon 5	Ward	Has	Closed	
Newton 4	No	Review	Done		Newton1/4	No	Review	Done	Newton1/4	0	3	4	Newton1/4	0	0	7	
Newton 5	0	0	8		Newton 5	0	0	7	Newton 5	0	0	7	Newton 5	No	Review	Done	
Priory 5	0	6	2		Priory 5	No	Review	Done	Priory 5	0	1	6	Priory 5	0	2	5	
EAU	0	2	6		EAU	2	2	3	EAU	3	1	3	EAU	2	0	5	
CCU	0	0	8		CCU	0	0	7	CCU	0	0	7	CCU	0	0	7	
Medical Day Case	0	1	6	1	Medical Day Case	0	3	4	Medical Day Case	0	3	4	Medical Day Case	No	Review	Done	
A&E- CHT	0	2	6		A&E- CHT	0	1	6	A&E- CHT	0	0	7	A&E- CHT	0	4	3	
A&E- SGH	0	2	6		A&E- SGH	0	0	7	A&E- SGH	1	1	5	A&E- SGH	1	1	5	
Total	1	36	154	1	Total	5	23	126	Total	5	40	102	Total	3	20	110	
WARD	RED	AMBER	GREEN			RED	AMBER	GREEN		RED	AMBER	GREEN		RED	AMBER	GREEN	
Surgery & ACC	Q1- June 2011					Q2- October 2011				Q3- January 2012				Q4- April 2012			
D6	0	0	8		D6	0	2	5	D6	0	1	6	D6	0	1	6	
D21/D24	0	1	7		D21/D24	0	2	5	D21/D24	0	4	3	D21/D24	0	0	7	
D25	0	2	6		D25	0	4	3	D25	1	4	2	D25	0	1	6	
D26	2	5	1		D26	0	3	4	D26	0	4	3	D26	1	3	3	
D30	1	2	5		D30	0	3	4	D30	2	0	5	D30	2	0	5	
D42 [SAU]	0	0	8		D42 [SAU]	0	3	4	D42 [SAU]	1	2	4	D42 [SAU]	1	0	6	
ASU [BTC]	0	3	5		ASU [BTC]	0	3	4	ASU [BTC]	0	3	4	ASU [BTC]	0	5	2	
Eye Ward	0	3	5		Eye Ward	0	3	4	Eye Ward	1	1	5	Eye Ward	1	2	4	
Lyndon 2	2	1	5		Lyndon 2	0	7	0	Lyndon 2	5	1	1	Lyndon 2	4	2	1	
Newton 2	0	2	6		Newton 2	0	2	5	Newton 2	0	1	6	Newton 2	0	1	6	
Priory 2	0	2	6		Priory 2	0	5	2	Priory 2	No	Review	Done	Priory 2	1	5	1	
Lyndon 3	0	2	6		Lyndon 3	0	6	1	Lyndon 3	5	1	1	Lyndon 3	2	1	4	
Newton 3	4	3	1		Newton 3	0	3	4	Newton 3	0	1	6	Newton 3	1	3	3	
SDU	0	1	7		SDU	0	3	4	SDU	0	2	5	SDU	1	0	6	
Critical Care- CHT	No	Review	Done		Critical Care- CHT	No	Review	Done	Critical Care- CHT	No	Review	Done	Critical Care- CHT	0	2	5	
Critical Care- SGH	No	Review	Done		Critical Care- SGH	No	Review	Done	Critical Care- SGH	No	Review	Done	Critical Care- SGH	2	1	4	
Total	9	27	76		Total	0	49	49	Total	15	25	51	Total	0	27	69	
WARD	RED	AMBER	GREEN			RED	AMBER	GREEN		RED	AMBER	GREEN		RED	AMBER	GREEN	
W&CH	Q1- June 2011					Q2- October 2011				Q3- January 2012				Q4- April 2012			
D27	0	0	8		D27	0	1	6	D27	0	1	6	D27	0	0	8	
D19	0	0	5	3	D19	0	2	5	D19	0	4	3	D19	No	Review	Done	
Priory Ground	0	0	5	3	Priory Ground	0	3	4	Priory Ground	0	2	5	Priory Ground	No	Review	Done	
Lyndon Ground	0	0	5	3	Lyndon Ground	0	2	5	Lyndon Ground	0	3	4	Lyndon Ground	No	Review	Done	
Lyndon One	0	0	5	3	Lyndon One	0	3	4	Lyndon One	Ward	has	closed	Lyndon One	No	Review	Done	
OPD	0	0	8		OPD	No	Review	Done	OPD	No	Review	Done	OPD	No	Review	Done	
Total	0	0	36	12	Total	0	11	24	Total	0	10	18	Total	0	0	8	

QUARTERLEY ANALYSIS												
MEDICINE AND EC	RED	AMBER	GREEN	N/A	SURGERY & ACC	RED	AMBER	GREEN	W&CH	RED	AMBER	GREEN
Q1- June 2011 [24 Wards]	1	36	154	1	Q1 June 2011 [14 Wards]	9	27	76	Q1 June 2011 [6 Wards]	0	0	35
Q2- Oct 2011 [22 Wards]	5	23	126	0	Q2- Oct 2011 [14 Wards]	0	49	49	Q2- Oct 2011 [5 Wards]	0	11	24
Q3- Jan 2012 [21 Wards]	5	40	102	147	Q3- Jan 2012 [13 Wards]	15	25	51	Q3- Jan 2012 [4 Wards]	0	10	18
Q4- Jan 2012 [19 Wards]	3	20	110	133	Q4- Jan 2012 [13 Wards]	16	27	69	Q4- Jan 2012 [1 1Wards]	0	0	8

Figure 24: *Ward performance review results for the year*

There are 7 domains assessed and around 50 standards/metrics across the domains.

The tool has been adapted twice in this year to reflect CQC standards and changes in priorities and therefore comparison over the year is difficult. This is further complicated by changes in ward configuration and specialties.

However, the reviews gives the Heads of Nursing a great opportunity to fully evaluate the performance of their wards and this, along with monthly information about:

- Pressure Damage
- Falls
- Nutrition
- Patient Satisfaction
- Complaints
- Incidents

enables judgements to be made regarding the need for targeted support or special measures conditions.

The intention is for this process to continue and we are working with IT colleagues to convert our monthly data into a real time monitoring/early warning alert system which is long overdue.

The Heads of Nursing report general improvement across their wards with the following areas remaining on the 'concern' lists:

- EAU Sandwell – currently in special measures
- L2
- P2

} Both are receiving targeted support

Other wards failed to produce evidence to support standards and therefore received poorer ratings, eg Sandwell Critical Care.

Trauma & Orthopaedic wards (L3 and N3) were of concern last Summer although not necessarily reflected in the ward review ratings as staffing levels were being managed. Now that staffing is resolved through investment, expectations around systems, process and evidence has increased which is reflected in their scores.

7 PATIENT EXPERIENCE

7.1 Patient Survey Results

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

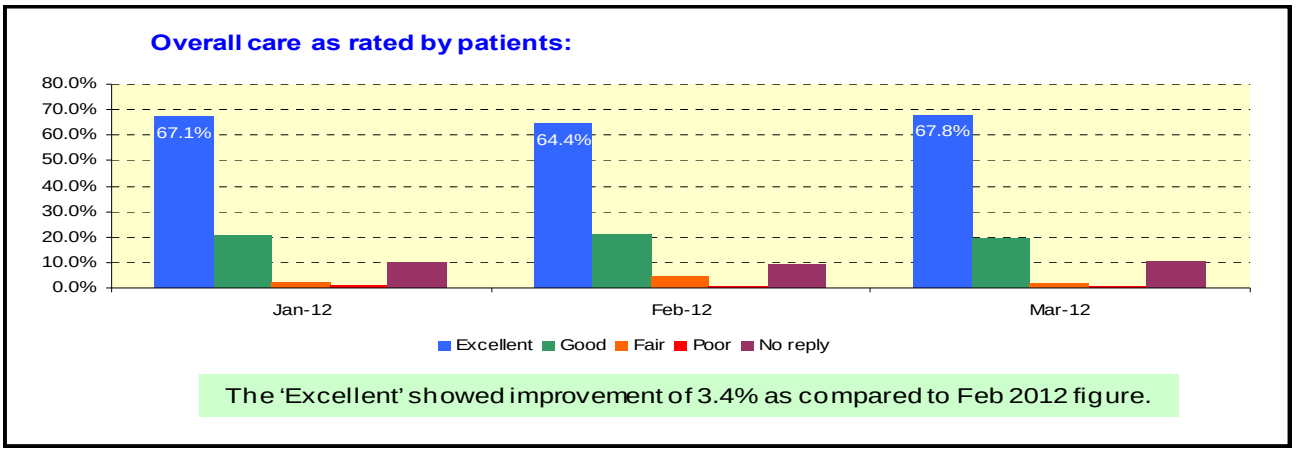


Figure 25: *Graph showing Care as rated by patients*

Net Promoter

This was introduced in April and reported as part of the CQuIN for this year to the PCT cluster. The April net promoter score = 56 (SHA average was 52).

The CQuIN requires a 10% improvement on this baseline. *CQUiN*

The full results of the patient satisfaction survey will go to the next Quality & Safety Committee.

7.2 Complaints/PALS

a) Complaints and PALS data

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

A) Table A: number of complaints received and sent

MONTH	Complaint type: RECEIVED			Complaint type: SENT		
	First contact*	Link*[2]	TOTAL	First contact*	Link*[2]	TOTAL
Jan. 2012	61	4	65	47	7	54
Feb. 2012	69	10	79	49	21	70

MONTH	Complaint type: RECEIVED			Complaint type: SENT		
	First contact*	Link*[2]	TOTAL	First contact*	Link*[2]	TOTAL
Mar.2012	72	7	79	44	12	56
Apr. 2012	60	12	72	43	9	52

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

**[2]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 April 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.	273*[3]	2	21*[4]	57	19	99*[4]
Mar.	288*[3]	1	28	38[4]	10[4]	77
Apr.	299	1	36	38[4]	6[4]	81

*[1]**Total Active Complaints** is the total of 'first contact' and 'link' complaints (see A above) as at the end of the month.*
**[3]Figures adjusted from April 2012 report (February=278 and March=296) to reflect total changes during month to include final day.*

*[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). The figures stated are for the position at the end of the month.*
**[4]Figures adjusted from April 2012 report to deduct 1 case categorised in error as a breach case (amber cases were 22; Total was 100.)*

*[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 the maximum acceptable time 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 (99) of complaints were in breach with about 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 (99); March (77) and April (81) 2012 is unacceptable. The increase in the number of complaints in breach has resulted from the combination of:

- a reduction in the Complaints team staffing level due to a reduction in temporary staffing and unplanned absence;
- disappointing productivity within the complaints team;
- competing priorities e.g. medico legal work and Coroners cases; and
- the impact of the revised (shorter) failsafe parameters.

Urgent action is being taken to reverse the current trend and includes:

- recruiting additional temporary staff;
- prioritising completion of complaints that are in breach of the failsafe target;
- closer monitoring of complaints case management;
- transfer of the investigation and response writing of complaints from the Trust's centralised Complaints team to departmental / ward managers in the source area of the complaint. This will apply to the less serious complaints (graded 'yellow' and 'green') where the required response is usually relatively straightforward;

- Setting a trajectory to accelerate the complaints backlog clearance. On the basis that the average number of complaints received and sent in any one month is about 70, the target for the number of complaints responses to be sent within a 21 working day reporting period (being the average number of working days per calendar month across the year) commencing 1 June 2012 is 95 (i.e. 70 plus 25); this is an ambitious target but has been set with the aim of clearing the complaints backlog as soon as possible;
- a review of the structure of the Complaints Department and a change in senior leadership.

ii) PALS

- **Contacts and general enquiries:** In April 2012 PALS recorded 103 PALS Enquiry contacts and 158 General Enquiries, in comparison to March 2012 PALS recorded 148 PALS enquiry contacts and 171 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 April 2012, these remain unchanged from March 2012. However, the main category reported during the month were issues relating to Clinical Treatment. The most frequent theme and cases concern clinical treatment, these relate to queries, comprising the categories of clinical care, low staffing levels, and medicines. In addition, issues relating to a delay in the following: investigations, results, surgery, treatment and x-ray/scan.

- During April 2012, there has been a reduction in appointment related queries from 22 being reported in March and 15 during April. In addition formal complaint issues which comprise the categories of handling, advice, process, referral and response time reduced significantly from 34 reported in March and 15 during April 2012.

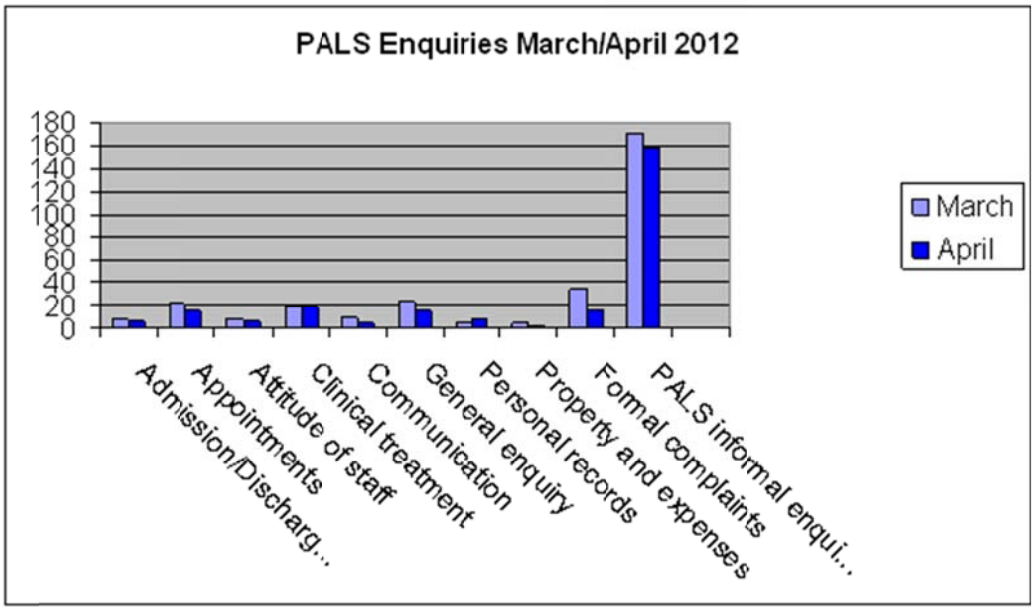


Figure 26: *Breakdown of top 10 PALS issues*

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 May 2012, the Trust had 14 open cases that complainants had referred to the PHSO. Of these, there were 2 new cases received since April 2012; 12 cases were under PHSO review or had been referred back to the Trust and 2 were to be closed.

National Priority

7.3 End of Life

CQuIN 2011/12 was achieved.

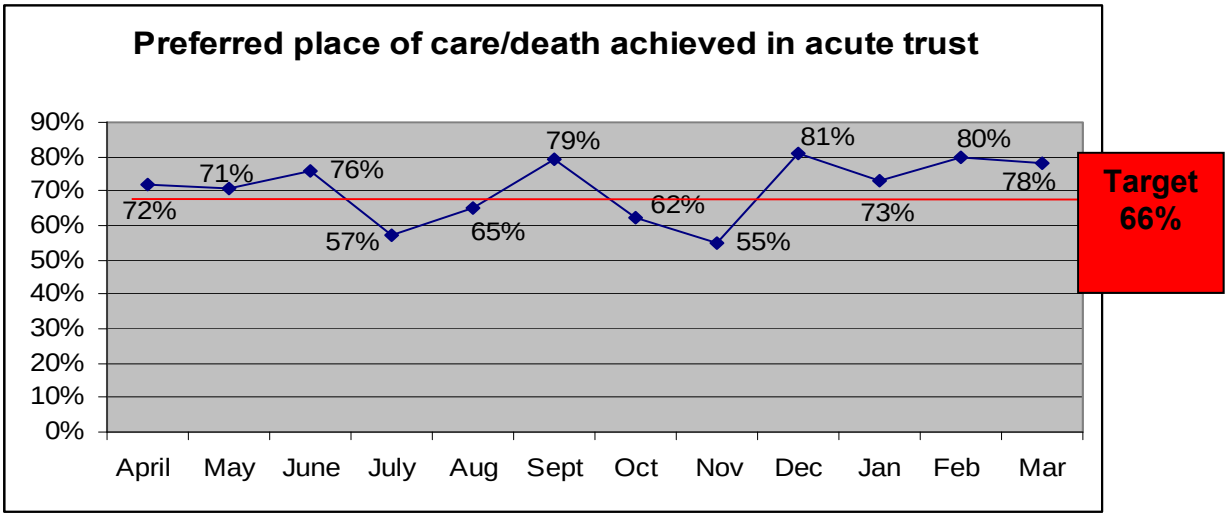


Figure 27: *Graph presenting the % of preferred place of death achieved*

Target 2012/13: To increase the % patients receiving effective end of life care including dying in their place of choice and reduce the variation in use by ward of the supportive care pathway by patients known to palliative care. Q1 baseline and improvement trajectory required. *CQUiN*

A more detailed report for End of Life Care will come to the next Trust Board.

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
CAUTI	Catheter Associated Urinary Tract Infection
C Diff	Clostridium Difficile
CRB	Criminal Records Bureau
CSRT	Clinical Systems Reporting Tool
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
ED	Emergency Department
DH	Department of Health
DN	District Nursing
HED	Healthcare Evaluation Data
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
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
RAID	Rapid Assessment Interface and Discharge
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
ITU	Intensive Therapy Unity
NNU	Neonatal Unit

WHO	World Health Organisation
WTE	Whole time equivalent
YTD	Year to date

Appendix 1

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST - CQUIN SCHEMES 2012 / 2013

	ACUTE	VALUE (£000s)	DESCRIPTION OF GOAL	SUMMARY	EXECUTIVE LEAD	OPERATIONAL LEAD
1	VTE Risk Assessment (nationally mandated)	392	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE).	This CQUIN continues from 2011 / 2012. Performance of at least 90% each month is required to trigger payment.	MD	CDs
1b	Appropriate use of Warfarin Treatment	392	Audit the number of patients admitted taking warfarin with INR >5.0 whose dosage has been adjusted or reviewed prior to the next warfarin dose.	Requires a quarterly audit of patients admitted taking warfarin with an International Normalised Ratio (INR) above 5.0 whose dosage has been adjusted or reviewed prior to the next warfarin dose.	RB	Pharmacy
2	Personal Needs (nationally mandated)	392	Improve responsiveness to personal needs of patients	This CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The average composite score during the period September - November (66.6%) defines the baseline, against which an improvement of 5% is required during Quarter 4.	RO	Debbie Talbot
3	Dementia (nationally mandated)	392	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	Comprises 3 elements, a) Assessment (by screening question) of all emergency admissions aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories.	RO	Dr Stuart Hutchinson / Debbie Talbot
4	Safety Thermometer (nationally mandated)	392	Improve collection of data in relation to pressure ulcers, falls, UTI infection in those with a catheter and VTE	Requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre on a quarterly basis. Submission of data for 3 consecutive months within the quarter triggers payment for the period Quarters 2 - 4 inclusive.	RO	Debbie Talbot
5	Net Promoter (SHA mandated)	392	Patient Experience	The target is to deliver a 10 point improvement (by Q4) in the Net Promoter Score from a minimum survey size of 10% of inpatients. During Q1 the baseline and process is to be established.	RO	Debbie Talbot
6	Antibiotic Use	784	Use of antibiotics - Antimicrobial Stewardship - Reduce the incidence of healthcare-associated infections.	Although exact details of this CQUIN are yet to be determined, it will require a quarterly self-assessment audit of prescribing of antibiotics in agreed specialities. A baseline will be determined during Quarter 1 which will inform an improvement trajectory.	RB	Pharmacy
7	Reducing avoidable pressure ulcers (SHA Mandated)	392	Reduction of avoidable PUs for all in-patients	Comprises 3 elements, a) Percentage of all inpatients with documented assessment of risk of developing a pressure ulceration, b) Percentage of patients identified as at risk who have an action plan to prevent / treat ulceration, c) Evidence of quarterly reduction in avoidable pressure ulcers. Requires a Q1 baseline and improvement trajectory.	RO	Debbie Talbot
8	Mortality Review	784	Every death that occurs within the hospital will be subject to a mortality review involving senior medical staff. Root causes will be identified and avoidable deaths will be identified and learning propagated to the rest of the hospital teams	Mortality Review - target to review 60% of all qualifying (adult) deaths within hospital within 42 days of death each month.	MD	CDs
9	Nutrition & Weight Management	784	Reducing avoidable hospital acquired weight loss.	This CQUIN is to reduce avoidable hospital acquired weight loss in elderly care and stroke patients. A comprehensive definition is required and baseline assessment during Q1, upon which an improvement trajectory will be determined.	RO	Fiona Shorney
10	EOL Care	392	Improve percentage of patients receiving effective EOL care from integrated SWBH palliative care team.	To increase the percentage of patients receiving effective EOL care from the integrated SWBH NHST palliative care team including dying in their place of choice, and reduce the variation in use by ward of the supportive care pathway by patients known to palliative care. Q1 baseline and improvement trajectory required.	RO	Kate Hall
11	Safe Surgery	784	To take measures to ensure zero Never Events for wrong site surgery and retained foreign object post-op to include policy, process, audit and reporting	To take measures to ensure 100% compliance with SHA defined areas (effective April 2012) and improvement trajectory for other (non-SHA defined) areas following Q1 baseline assessment.	MD	Dr Zoe Huish
12	Every Contact Counts - Alcohol	392	To improve the health of the population by ensuring that all patients who drink at harmful levels are identified and provided with brief advice by trained staff	Screen all defined (EAU, MAU and Cardiology, Diabetic Medicine and Gastroenterology Outpatients) patients aged 16 and over and offer brief intervention. Q1 baseline and improvement trajectory to 80% to be determined.	RB	Dr Ed Fogden
12b	Every Contact Counts - Smoking Pregnancy	392	To improve the health of the population by ensuring that all expectant mothers are provided with brief advice by trained staff and offered help and support.	Comprises 2 elements, a) 80% eligible maternity staff to complete locally agreed training in delivering brief stop smoking advice by Q4 and improvement trajectory following Q1 baseline assessment of patient smoking status checking and recording at booking or first midwife contact.	RO	Elaine Newell
13	Stroke - Driving Stroke Improvements	784	To ensure rapid access to diagnostics, swallow screens are undertaken in a timely manner, antiplatelets and anticoagulants are prescribed.	Comprises 4 components, a) CT Scan within 24 hours of arrival (95%), b) Swallow Screen completed within 4 hours of presentation (70%), c) Prescription / Administration to eligible patients within 24 hours of presentation of anti-platelet agents (90%), d) Commencement of anti-coagulation / Management Plan in place on discharge (60%). a) is assessed quarterly. b), c) and d) require Q1 baseline assessment and improvement trajectory.	MD	Anne O'Leary
		7840				

	COMMUNITY	VALUE (£000s)	DESCRIPTION OF GOAL	SUMMARY	EXECUTIVE LEAD	OPERATIONAL LEAD
1	Composite Indicator on Responsiveness to Personal Needs	45	Improve responsiveness to personal needs of patients (patient satisfaction survey) - Community IP Services (Henderson and Leasowes)	This CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The baseline score is to be assessed during Q1, which will then determine an improvement trajectory.	RO	Debbie Talbot
2	Dementia (nationally mandated)	45	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	Comprises 3 elements, a) Assessment (by screening question) of all new patients to District Nursing caseload (wef April 2012) aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories.	RO	Dr Stuart Hutchinson / Debbie Talbot
3	Safety Thermometer (nationally mandated)	90	Improve collection of data in relation to pressure ulcers, falls, UTI infection in those with a catheter and VTE - Community IP Services (Henderson and Leasowes)	Requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre on a quarterly basis. Submission of data for 3 consecutive months within the quarter triggers payment for the period Quarters 2 - 4 inclusive.	RO	Debbie Talbot
4	Net Promoter (SHA mandated)	90	Patient Experience - Community IP Services (Henderson and Leasowes)	Target is to deliver a 10 point improvement (by Q4) in the Net Promoter Score from a minimum survey size of 10% of inpatients. During Q1 the baseline and process is to be established.	RO	Debbie Talbot
5	Reducing avoidable pressure ulcers (SHA Mandated)	180	Reduction of avoidable PUs for all in-patients - Community IP Services (Henderson and Leasowes)	Comprises 3 elements, a) Percentage of all inpatients with documented assessment of risk of developing a pressure ulceration, b) Percentage of patients identified as at risk who have an action plan to prevent / treat ulceration, c) A process for the effective review and elimination of all Grade 3 and 4 pressure ulcers . Requires a Q1 baseline and improvement trajectory.	RO	Debbie Talbot
6	Nutrition and weight management	180	Reducing avoidable hospital acquired weight loss in elderly and stroke patients - Community IP Services (Henderson and Leasowes)	This CQUIN is to reduce avoidable hospital acquired weight loss in elderly care (aged 65+) and all stroke patients. A comprehensive definition is required and baseline assessment during Q1, upon which an improvement trajectory will be determined.	RO	Fiona Shorney
7	Every Contact Counts	135	Number of Community staff delivering brief advice required to implement Every Contact Counts. All (new) patients on DN caseload (wef April 2012).	Comprises 3 elements, a) Staff completing locally agreed training in delivering brief advice as required to implement the Making Every Contact Count (MECC) ambition, b) Delivery of advice, c) Referrals to any lifestyle service from contacts. Requires a Q1 baseline and improvement trajectory.	RO	
8	Smoking	135	Referral to NHS Stop Smoking Support and Brief Advice Delivery. All (new) patients on DN caseload (wef April 2012)	Comprises 3 elements, a) Number of patients with smoking status recorded, b) Number of patients given brief stop smoking advice, c) Number of patients referred to the Stop Smoking Service. Requires a Q1 baseline and improvement trajectory.	RO	
		900				

	SPECIALISED	VALUE (£000s)	DESCRIPTION OF GOAL	SUMMARY	EXECUTIVE LEAD	OPERATIONAL LEAD
1	VTE Risk Assessment (nationally mandated)	26	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE).	As per Acute Scheme	MD	CDs
2	Personal Needs (nationally mandated)	26	Improve responsiveness to personal needs of patients (National Patient Survey Results)	As per Acute Scheme	RO	Debbie Talbot
3	Dementia (nationally mandated)	26	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	As per Acute Scheme	RO	Dr Stuart Hutchinson / Debbie Talbot
4	Safety Thermometer (nationally mandated)	26	Improve collection of data in relation to pressure ulcers, falls, UTI infection in those with a catheter and VTE	As per Acute Scheme	RO	Debbie Talbot
5	Clinical Quality Dashboard	53	Implement & Routinely use the required clinical quality dashboards.	CQUIN is to implement and demonstrate routine use of clinical quality dashboard for specialised services (Cardiology, Paediatric Intensive Care and Neonatal Services).	MD	Dily Sadhra, Janka Webb & Cheryl Walne
6	Neonatal - Increase effectiveness of hypothermia treatment	79	To increase the effective use of hypothermia treatment.	CQUIN is for pathway for therapeutic hypothermia to be utilised for all babies meeting criteria (excluding those born at home).	MD	Cheryl Walne
7	Neonatal - Discharge Planning / Family Experience and Confidence	131	Discharge Planning / Family Experience and Confidence.	CQUIN is for 95% of babies transitioned / discharged from neonatal care by 44 weeks corrected gestation.	MD	Cheryl Walne
8	HIV	158	Ensure therapy is optimised.	The number of patients failing therapy (as measured by a detectable viral load) who are stabilised quickly and regain an undetectable viral load.	MD	Amanda Geary
		525.0				
	OVERALL	9265				