Tabled paper

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

December 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 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 results in November improved to 93.8% (increase of 0.8%) harm free care.
- The number of falls fell in October but those that did happen occurred mainly across a small number of wards.
- Infection control targets continue to be met. MRSA screening in unmatched patients on target.
- There have been a number of D&V outbreaks of the Norovirus type in November and this pattern has increased during the early part of December. Nationally there has been a significant increase in Norovirus cases.
- Nurse staffing levels were discussed in detail at the Q&S Committee and the relationship between a challenging staffing situation and quality standards. The current staffing shortfalls relate to unclosed beds, additional winter beds and the added inflexibility of infection outbreaks. Affects on quality are particularly noticeable on the Sandwell Medical wards.
- Nurse bank/agency rates continue to grow and there remains approximately 15% requested shifts unfilled due to the inability to meet demand.
- Non ward based nurses are working shifts on wards to help fill gaps.

CLINICAL EFFECTIVENESS

- Fractured Neck of Femur operated on within 24 hours of admission is 80.77% demonstrating sustained improvement on previous months performance and exceeding the local target of 70%.
- Compliance with the use of the World Health Organisation (WHO) checklist is 99.86% Work continues on assessing the spirit of the adoption of the checklists as a qualitative evaluation is underway. Performance management arrangements established for non-complaint operators.
- Stroke Care- Some performance indicators dipped during November due to pressure on bed availability. TIA indicators have shown significant improvement through the year with 100% patient with TIAs treated within 7 days compared to only 48% in May.
- VTE performance remains above 90% during November for all admitted patients.
- Mortality Reviews completed within 42 days exceeded the standard and was 68.9% at the end of September, which is the most recent complete month available.
- The Antibiotic CQUIN has been met this month achieving a score of 83points against a target of 80 using the Self-Assessment Toolkit.
- The latest ward reviews and Quality Audits are included in this report. They show some overall deterioration of standards, which reflects the pressure on capacity.

PATIENT EXPERIENCE

- The Net Promoter Score (FFT) in October went up to 64 (target 65). Early results from November suggest the target of 65 has been achieved.
- 79 complaints were received in November and 128 final responses sent out.

3 TARGETED AREAS OF SUPPORT

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

- EAU Sandwell – continues in special measures – will be taken off following completion of closure report this month and incorporation of outstanding actions in ED plans.
- ED, City
- ED, Sandwell

  } Special measures
- L3, P4, P5 and L4 wards – all are struggling as a result of paused bed closures and therefore have staffing issues. Active support is being provided and close monitoring of standards.

4 EMERGING TRENDS/NOTICEABLE PATTERNS

- Increase nursing vacancies/gaps as a result of slippage in bed closure plan and winter capacity open early

5 OF SPECIFIC NOTE

- There is nothing specific to note over and above the other matters highlighted above.

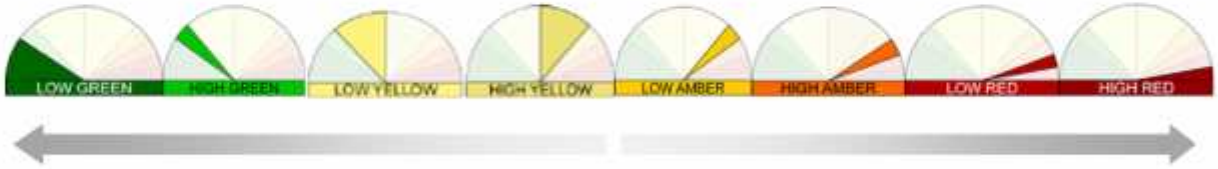
6 KEY CLINICAL RISKS

- Variable standards/leadership EDs
- Staffing levels as a result of 'paused' bed closure plan

7 CARE QUALITY COMMISSION'S QUALITY AND RISK PROFILE

Care Quality Commission (CQC): Quality and Risk Profile (QRP)

The Care Quality Commission (CQC) publishes a QRP for each registered provider which is used to support the day to day work of CQC inspectors. The QRP provides the Trust with a risk estimate for each outcome of the 16 Essential Standards of Quality and Safety. These risk estimates are produced by the CQC using a statistical model that aggregates individual pieces of information which the CQC holds about the Trust. The risk estimates are displayed as dials as shown below:



The current risk estimates for the essential standards for quality and safety for the Trust are:

Risk estimate	Frequency	Outcomes
No Data	-	-
Insufficient data	0	
Low Green	2	21 and 11
High Green	1	14
Low Yellow	11	1, 5, 6, 7, 8, 9, 10, 12, 13, 16, 17
High Yellow	1	2
Low Amber	-	-
High Amber	1	4
Low Red	-	-
High Red	-	-

There are currently no outcome risk estimates Red and one in Amber. This shows the Trust overall as being at a low risk of non-compliance with the CQC's 16 essential standards of quality and safety. Since December 2010, there have been few changes which have not been significant enough to have an effect on the overall RAG status for the Outcomes. It is important to state that low risk estimates in a QRP do not guarantee compliance. On-going monitoring of compliance will take place to ensure that this position is maintained and improved.

8 CQuINs

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - NOVEMBER 2012

Exec Lead				PATIENT SAFETY			July	August	September	October			November			To Date (*=most recent month)	TARGET		Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
RS	A	3		VTE Risk Assessment (Adult IP)	396	%	91.4 ▲	87.5 ■	91.0 ■	→		91.7 ▲	→		91.2 ▼	91.2*	90	90		=>90		<90	●	92.3	92.4
RB	K	20		Appropriate Use of Warfarin	372		→	→		→		→	→		→	Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Safety Thermometer	396	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→		Data Submitted	Data Submitted	Monthly data collection			No variation		Any variation	●		
RB	H	20		Antibiotic Use	743	Score	→	→	83 ▲	→		→	→		→	83	70	80		No variation		Any variation	●		
RO	D	8	Acute CQUIN	Reducing Avoidable Pressure Ulcers	372	No.	Compliant	Compliant	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Nutrition and Weight Management	743		Compliant	Compliant	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit			No variation		Any variation	●		
RS	H	9		Safe Surgery - Operating Theatres	743	%	→	99.7 ■	99.8 ■	→		99.8 ■	→		99.8 ■	99.8	99	100	b	No variation		Any variation	●		
RS	H	9		Safe Surgery - Other Areas		%	→	99.6 ■	100 ▲	→		99.8 ▼	→		99.5 ▼	99.8	98	98		No variation		Any variation	●		
RS	H	10		Stroke Care	743	%	→	→	Met Q2 req's	→		→	→		→	Met Q2 req's	Comply	Comply		No variation		Any variation	●		
RO	H			Safety Thermometer	88	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→			Data Submitted	Monthly data collection			No variation		Any variation	●		
RO	D	11	Community CQUIN	Reducing Avoidable Pressure Ulcers	176		Compliant	Compliant	Compliant	→		Compliant	→			Compliant	Comply with audit			No variation		Any variation	●		
RO	H			Nutrition and Weight Management	176		Compliant	Compliant	Compliant	→		Compliant	→			Compliant	Comply with audit			No variation		Any variation	●		
EFFECTIVENESS OF CARE																									
RO	H	8	Acute CQUIN	Dementia	396	%	Met Q2 req's	Met Q2 req's	Met Q2 req's	→		Meeting Q3 req's	→			Meeting Q3 req's	80	90		No variation		Any variation	●		
RS	H	3		Mortality Review	743	%	63.6 ▼	64.9 ▲	68.9 ▲	→			→			68.9	66	80	b	No variation		Any variation	●		66.9
RO	H	11	Community CQUIN	Dementia	44	%	Met Q2 req's	Met Q2 req's	Met Q2 req's	→		Not Met Q2 req's	→			Not Met Q2 req's	80	90		No variation		Any variation	●		
PATIENT EXPERIENCE																									
RO	H	8		Personal Needs	396	%	→	→	→	→		→	→		→	67.9	67.6	71.6		No variation		Any variation	●		
RO	H	8		Net Promoter	372	No.	58 ■	60 ▲	63 ▲	→		64 ▲	→			64	61	65		No variation		Any variation	●		
RO	H	8	Acute CQUIN	End of Life Care	372	%	55 ▲	57 ▲	60 ▲	→		59 ▼	→			59	49	53		No variation		Any variation	●		
RS	H	10		Every Contact Counts - Alcohol	372	%	→	→	→	→		→	→			55 Base		80					●		
RO	H	12		Every Contact Counts - Smoking	372	%	→	→	Baseline established	→			→			Baseline established							●		
RO	H	11		Pt. (Community) Exp'ce - Personal Needs	44	Score	91 ■	95.5 ▲	91.5 ▼	→			→			91.5	90	90		No variation		Any variation	●		
RO	H	11	Community CQUIN	Net Promoter	88	No	91 (H'son) & 80 (L'wes)	71 ■	81 ■	→			→			81	75	75	b	No variation		Any variation	●		
RO	H	11		Every Contact Counts	132	%	Base data being captured	Base data being captured	Baseline established	→			→			Baseline established							●		
RO	H	11		Smoking Cessation	132	%	Base data being captured	Base data being captured	Baseline established	→			→			Baseline established							●		
RS	H			Clinical Quality Dashboards	49		→	→	Q2 Return Submitted	→		→	→		→	Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	13	Specialised Commissioners	Neonatal - Hypothermia Treatment	73	%	→	→	Q2 Return Submitted	→		→	→		→	Q2 Return Submitted	Derive Base	Derive Base		No variation		Any variation	●		
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	→	Q2 Return Submitted	→		→	→		→	Q2 Return Submitted	Derive Base	Derive Base		Met		Not Met	●		
RS	H	12		HIV - Optmum Therapy	147	%	→	→	Q2 Return Submitted	→		→	→		→	Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		

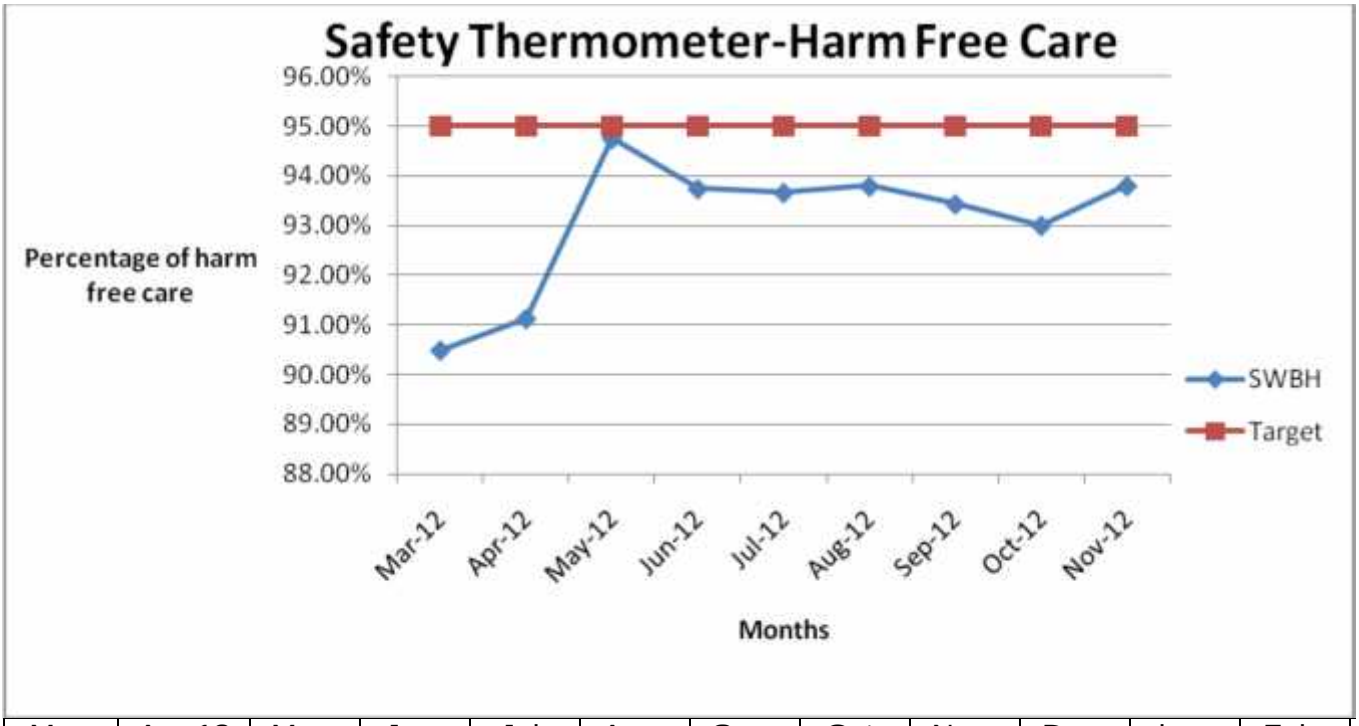
9 PATIENT SAFETY

9.1 Safety Thermometer

CQUiN for 2012/13 – requires introduction of the tool in acute and community in patient areas. *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. Work has commenced to add other harm measures to the tool, eg avoidable weight loss.

The SHA ambition is for Trusts to achieve 95% harm free care.



Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-13	jan-13	Feb-13
90.48 %	91.12% ë	94.75 %ë	93.74 % í	93.55 % í	93.79 %↑	93.43 %↓	93% ↓	93.8 %↑			

Figure 1: *Harm free care trend*

Figures 2 & 3: *Number of patients by type and number of harm incidents*

Acute Divisions **16** patients experienced **1 new harm**. **No** patients experienced **2, 3 or 4 harms**
Community Division **2** patients experienced **1 new harm** and **0** patients experienced **2, 3 or 4 harms**

a) Falls

There are no formal targets set for falls for 2012/13 other than the safety thermometer but we will continue to aim to reduce avoidable falls across the Trust by a further 10%. 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.

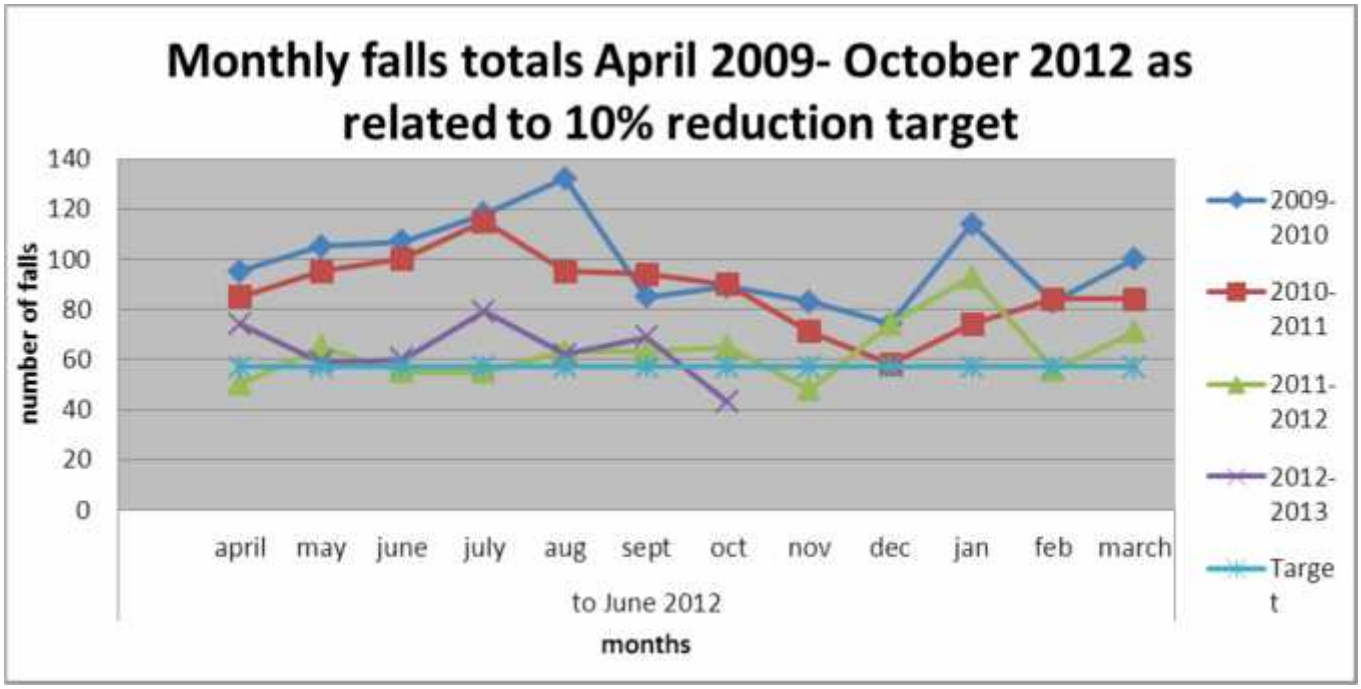


Figure 4: *Trend of falls*

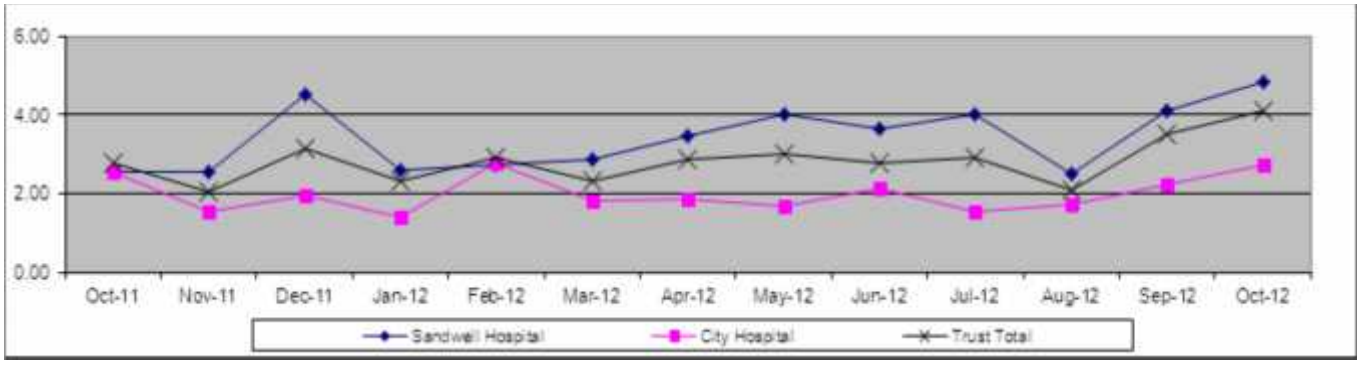


Figure 5: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

Sandwell continues to have a higher number of falls compared to City.

b) Pressure Damage

Target 2012/13: Eradication of all avoidable pressure damage *SHA Priority and CQUiN.*
Target to assess patients for risk, introduce appropriate care bundle and conduct TTRs on all grade 3 and 4 sores.

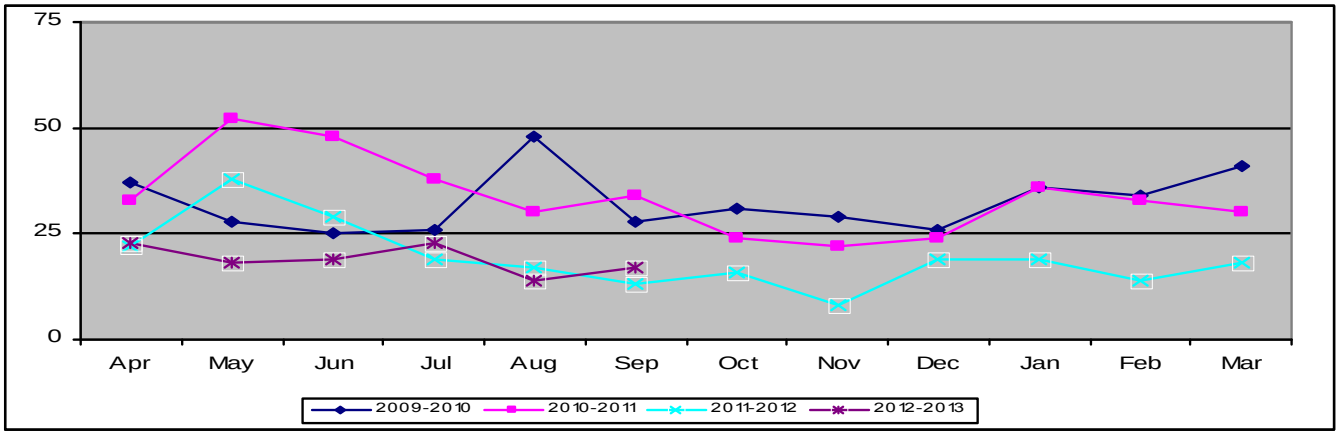


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 - July 2012*

New avoidable pressure ulcers (reported on ST):
October – 5 (4 grade 2, 1 grade 3, 0 grade 4).

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. Performance during November has exceeded the required 90%, rising to of 91.49%, *CQUiN*

9.2 Nutrition/Fluids

Target 2012/13: Reduction of avoidable weight loss in patients on 8 Trust wards where vulnerable adults are nursed. *CQUiN*
90% patients MUST assessed within 12 hours admission *Internal Priority*

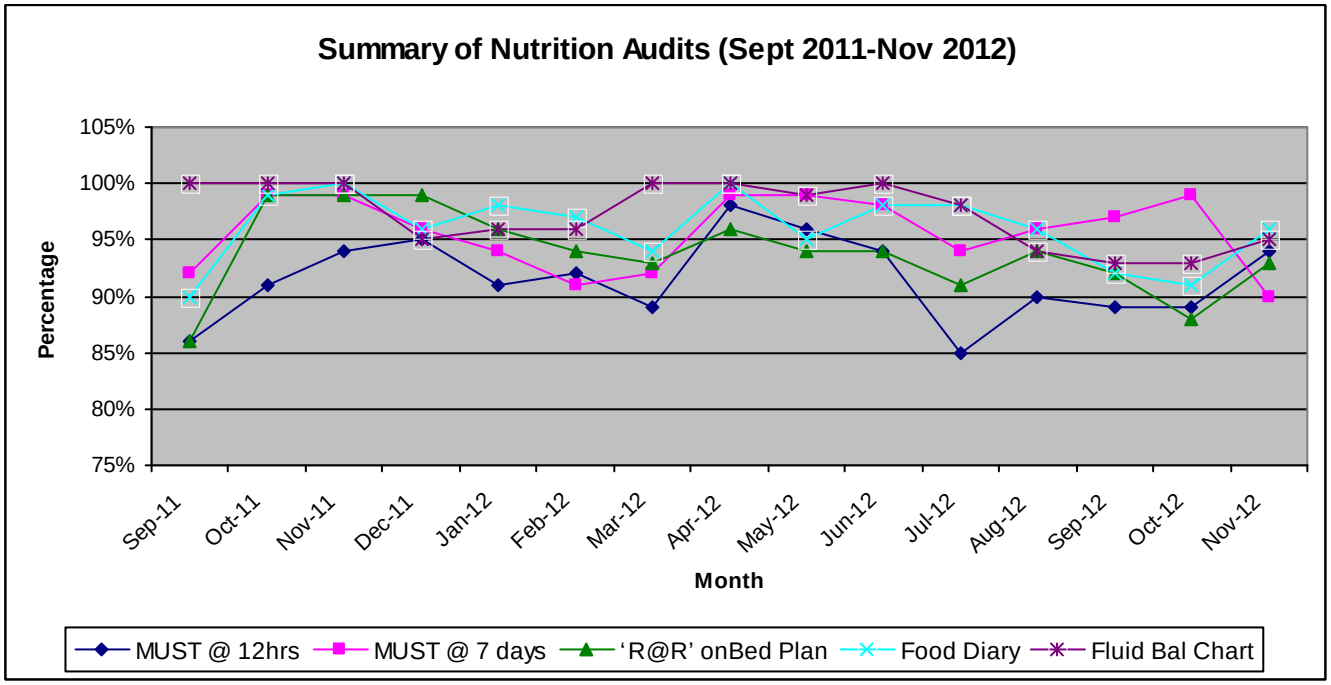


Figure 7: *Nutrition Audit Results*

9.3 Infection Control

Targets 2012/13: (National Priority Local contract)	*C difficile* – 57 cases (post 48 hours, using SHA testing methodology) MRSA – 2 cases (post 48 hours) 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

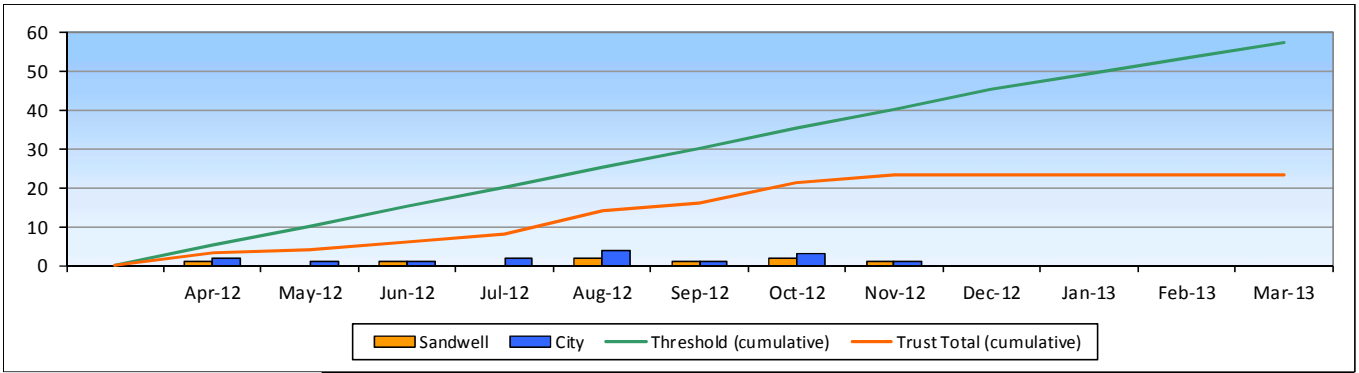
There were no post-48 hour MRSA bacteraemia for November . The total number of MRSA bacteraemias against the Trust target to date is 1.

MRSA Screening

Target: 85% eligible patients by March 2013.

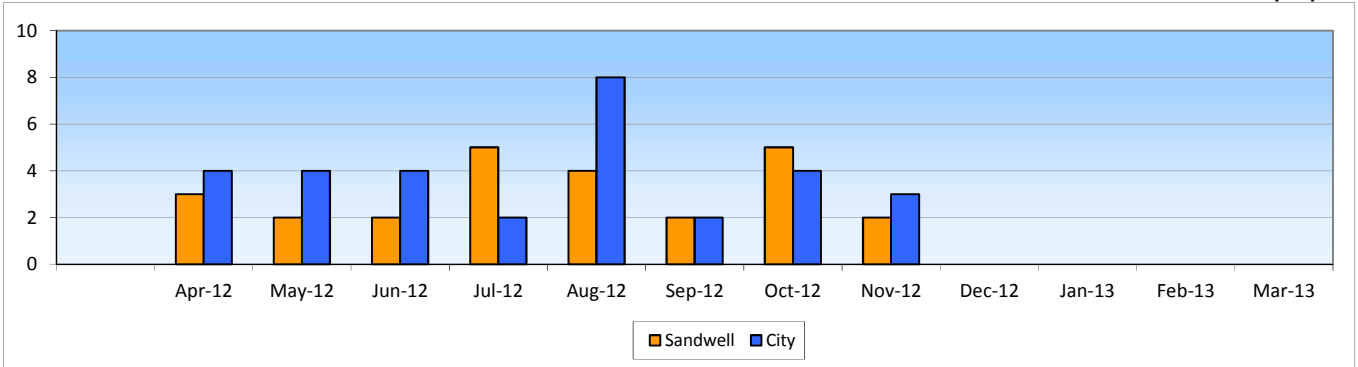
			To Date (*=most recent month)	TARGET	
				YTD	12/13
MRSA Screening - Elective	Patient Not Matched	%	96.2*	65	85
	Best Practice - Patient Matched	%	56.5*	65	85
MRSA Screening - Non elective	Patient Not Matched	%	78.6*	65	85
	Best Practice - Patient Matched	%	66.3*	65	85

Clostridium difficile



	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	1	0	2	1	2	1					**8**
City	2	1	1	2	4	1	3	1					**15**
Trust	3	1	2	2	6	2	5	2	0	0	0	0	**23**
Intermediate Care	0	0	0	0	0	0	0	0					**0**
DoH Trajectory	5	5	5	5	5	5	5	5	5	4	4	4	**57**
Trust Total (cumulative)	3	4	6	8	14	16	21	23	23	23	23	23	-
Threshold (cumulative)	5	10	15	20	25	30	35	40	45	49	53	57	-

Figure 8: *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	2	2	5	4	2	5	2					**25**
City	4	4	4	2	8	2	4	3					**31**
Trust	7	6	6	7	12	4	9	5	0	0	0	0	**56**
Intermediate Care	0	0	0	0	0	0	0	0					**0**
Trust Total (cumulative)	7	13	19	26	38	42	51	56	56	56	56	56	-

Figure 9: *Trust Best Practice Data*

Blood Contaminants

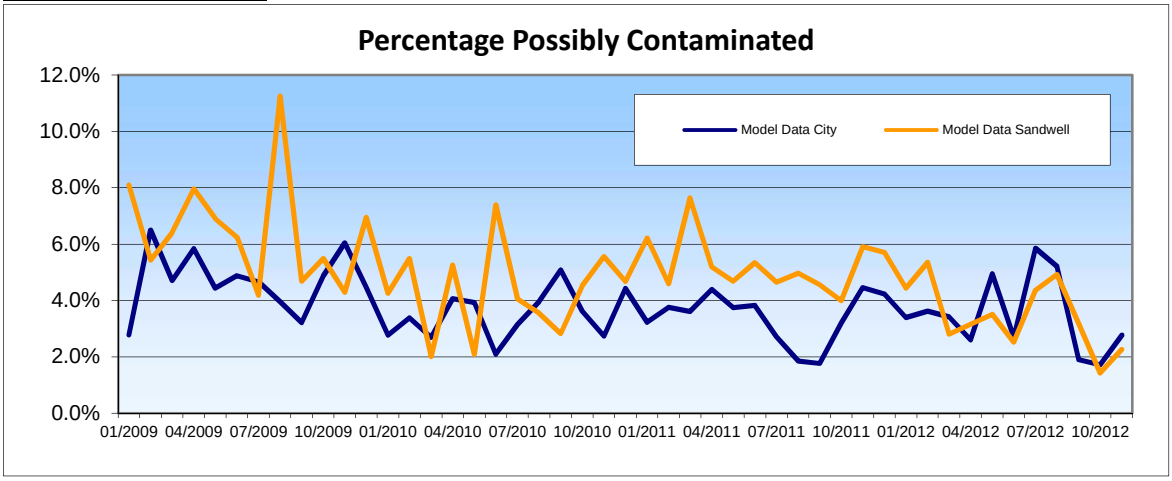


Figure 10: *Blood Contaminants*

E Coli Bacteraemia

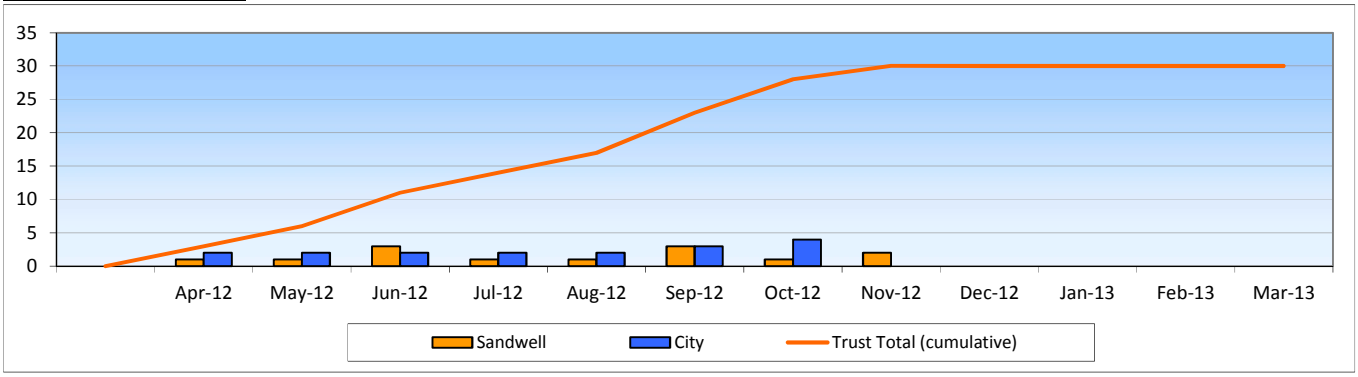


Figure 11: *E Coli Bacteraemia*

MSSA

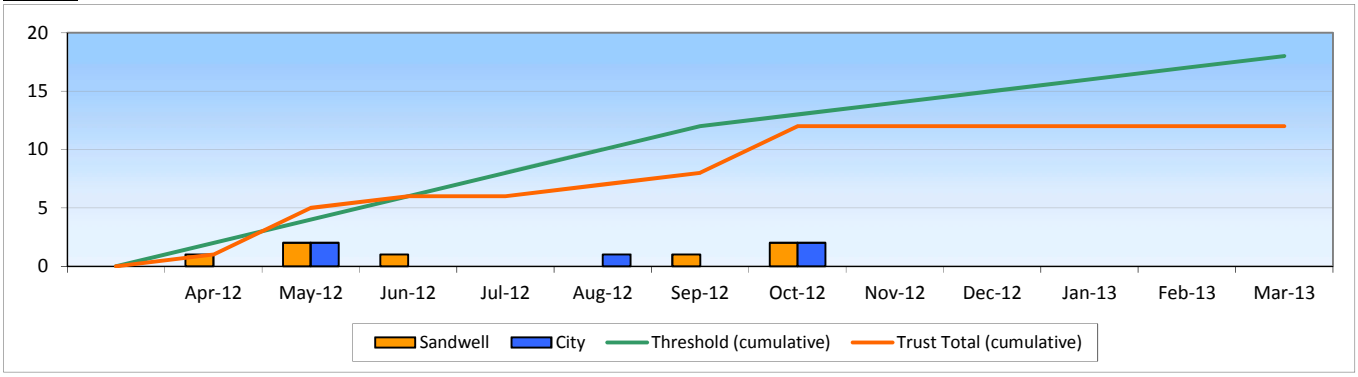


Figure 12: *MSSA*

Outbreak and Other Infection Control Activity

- During November, 3 babies on the NNU were found to have an ESBL producing *Klebsiella pneumoniae* on routine faecal screens. No baby showed any signs of infection. Typing showed that two babies had the same strain of this organism, reclassifying this incident as an outbreak. Environmental screening was negative for this organism, and infection control on the unit reviewed and no major concerns found. Outbreak meetings have been held and the incident closed; there have been no further cases to date. The unit remained open during this period.
- A patient was transferred to Henderson unit from a local residential facility and found to be positive for Norovirus. The unit was closed for 48 hours for observation, but no other patients or members of staff developed any symptoms of diarrhoea and/or vomiting attributable to Norovirus following his admission and the unit was re-opened.
- D17 was temporarily closed because of diarrhoea and vomiting. The cause for the outbreak has not been confirmed.
- Leasowes was temporarily closed because of symptoms of diarrhoea and vomiting. No infectious cause has been detected.
- Newton 3 was temporarily closed as 9 patients exhibited symptoms of diarrhoea and vomiting. No infectious cause has been detected.
- Priory 3 was closed because of confirmed Norovirus which affected 16 patients and 9 members of staff. It re-opened at the end of November.
- Priory 5 was closed on 28th November because of confirmed Norovirus. It re-opened in December.
- Because of concerns about transmission of VRE, Sandwell ITU was decanted to theatres to allow a deep clean and application of hydrogen peroxide vapour. Further work is ongoing to resolve the issue.
- A healthcare worker was found to be positive for Bordatella pertussis, the organism which causes whooping cough. Incident meetings have been held and patients and staff who may have been in contact with the member of staff contacted and offered prophylaxis where appropriate.
- During December so far the Trust is experiencing a significant increase in diarrhoea and vomiting outbreaks, mostly confirmed as Norovirus. At the time of writing this report 7 wards across the Trust had been affected in the first two weeks of December.

PEAT

National Standards of Cleanliness average scores 96%.

9.4 Maternity

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

*Post Partum Haemorrhage (PPH)(>2000ml): t*here were 3 patients recorded to have had a PPH of >2000ml in October.

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for October was 3.8 which was under the trajectory (8) and was lower than the previous month. 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 October was 22.6%, which is below the trajectory of 25% over the year but slightly higher than the previous month.

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for October was 8% which is below the trajectory (15).

Community Midwife Caseload (bi-monthly): The community midwife caseload in October decreased to 138 from 139 in the previous month, which is just below the trajectory of 140.

Vacancies: Vacancy rates remained high in October (10.5) but had improved slightly from the previous month (11.6).

9.5 Emergency Department highlights

A separate report is provided for the Trust Board this month.

9.6 Safeguarding

A Safeguarding Update was provided in last month's report.

9.7 Medicine Management

Antibiotic CQUIN.

Self-Assessment Toolkit score of 83 points has been achieved (target 80).

Drug Storage Audits

Drug storage audits have been carried out in November and the early results are summarised below.

General Drugs:
Compliance of 90-100% was seen across 70% standards (compared to 65% in October)
Compliance of 70% or higher was seen across 100% standards (compared to 95% in October)

Controlled Drugs:
Compliance of 90-100% was seen across 75% standards (compared to 67% in October)
Compliance of 70% or higher was seen across 85% standards (compared to 81% in October)

9.8 Never Events

There were no Never Events reported in November 2012.

9.9 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.

9.10 Lessons Learned

The key to a positive safety culture within the organisation is to learn from incidents through sustainable actions.
During November there were no new incident reviews completed.

9.11 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.
Existing risks on the Corporate Risk Register are currently being reviewed and an updated Corporate risk register and update on existing risks will be presented to the Quality & Safety Committee in January 2013.
No new risks were presented at Risk Management for inclusion.

9.12 Listening into Action

- Plan for transition to Safeguard Risk management system ahead of schedule.
- Further Risk management Forum planned for December 2012
- Risk Management website in development.

9.13 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.

Nov-12

	Budgeted Posts & Funded Beds				Actual Bed Usage		Actual In Post				Sickness	SNCT	Bed Occupancy	Vacancies	IRI's	Complaint	Falls	Pressure sores	MUST	ST (Target 95%)	FFT (Target 65)
	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Average Actual Bed Usage	Budgeted Staff: Actual Bed Ratio	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	Actual Staff:Bed Ratio	% (previous Month)	Most Recent SNCT Ratio	%		Number	Number	Number	Number	%	%	Score
D5 (CCU/PCCU)	39.65	92.43%	17	2.33	17	2.33	37.1	84.95%	12.36%	2.18	5.62%	46.4	98	1	1🡅	0➲	0🡅	2🡇	100🡅	100🡅	73🡅
CCU Sandwell	19.07	86.21%	10	1.91	10	1.91	18.75	73.97%	10.03%	1.88	2.99%	18.43	93	2.5	8🡇	0➲	3🡇	0➲	71🡇	100🡅	86🡅
D7 (13base/12 ww)	42.66	49.81%	25	1.71	25	1.71	42.43	48.69%	17.82%	1.70	4.46%	42.81	88	2	19🡇	0🡅	0➲	0➲	92🡇	100➲	47🡇
D11	32.14	59.52%	21	1.53	21	1.53	32.58	50.96%	19.82%	1.55	3.60%	27.43	94	2.13	22🡇	1🡇	3🡅	0➲	100➲	100➲	55🡇
D12	17.12	64.95%	10	1.71	10	1.71	16.54	59.87%	11.11%	1.65	11.26%	11.76	85	0	3🡅	2🡇	0➲	0➲	100➲	100🡅	100➲
D15	26.45	58.41%	24	1.10	24	1.10	28.37	48.82%	22.97%	1.18	5.64%	29.09	95	3	4🡅	0🡅	0➲	0➲	100➲	100➲	76🡅
D16	29.46	46.57%	23	1.28	23	1.28	35.44	37.02%	29.04%	1.54	9.06%	18.62	92	0	9🡅	0🡅	0🡅	1🡇	96➲	82.61➲	70🡇
D17	29.01	65.84%	26	1.12	26	1.12	27.24	61.68%	9.94%	1.05	8.89%	19.62	70	0.6	6🡅	0🡅	0➲	1➲	100➲	100🡅	50🡇
D18	20.48	53.13%	16	1.28	16	1.28	28.44	36.89%	33.96%	1.78	5.06%	21.07	100	0	31🡇	0➲	2🡅	1🡅	100➲	93.75🡅	87🡅
D41	29.32	76.53%	19	1.54	19	1.54	22.46	64.20%	18.03%	1.18	2.25%	29.99	91	3	57🡇	1🡇	4🡇	0➲	100➲	100🡅	44🡇
D43	31.6	57.63%	28	1.13	20	1.58	26.43	41.78%	18.72%	1.32	0.53%	34.98	93	1.74	2🡅	0➲	0🡅	0➲	100➲	94.44🡇	100🡅
MAU	65.2	64.98%	28	2.33	28	2.33	64.45	54.50%	20.81%	2.30	9.10%	NA	NA	3	46🡅	2🡇	1🡇	NA	60🡅	100🡅	40🡅
PRIORY 3	30.7	52.18%	29	1.06	29	1.06	31.62	44.27%	11.49%	1.09	6.97%	27.83	87	0	11🡇	0🡅	8🡇	0🡇	73🡇	76.92🡅	17🡅
EAU	63.44	47.86%	28	2.27	28	2.27	64.08	45.71%	35.26%	2.29	4.44%	NA	NA	12	7🡅	8🡇	0🡅	NA	80🡇	100➲	61🡅
NEWTON 4	26.38	50.76%	22	1.20	22	1.20	36.19	34.21%	32.71%	1.65	8.61%	42.97	100	1.8	9🡇	0➲	5🡅	0➲	100➲	90.91🡇	93🡇
NEWTON 1	20.73	83.65%	12	1.73	12	1.73	21.01	71.30%	15.33%	1.75	1.53%	19.15	89	2	16🡅	0➲	3🡇	0➲	100➲	100🡅	55🡇
PRIORY 4 (base)	15.64	58.25%	14	1.12	14	1.12	17.3	11.97%	50.40%	1.24	3.36%	40.95	99	10	50🡇	1🡇	5🡇	2🡇	97➲	84.85🡇	29🡇
LYN4(13 base,20ww	37.99	58.25%	33	1.15	33	1.15	31.88	50.63%	24.52%	0.97	8.15%	NA	NA	11	-	0➲	3🡅	0🡅	87🡅	81.82🡅	80🡅
NEWTON 5	22.43	69.73%	15	1.50	15	1.50	23.25	66.80%	15.14%	1.55	1.07%	15.37	91		9🡇	0🡅	2🡇	0➲	100➲	100➲	-
Priory 4 (winter)	22.35	58.26%	20	1.12	20	1.12	22.44	68.32%	7.98%	1.12	no data	40.95			-	-				-	-
D30 (winter)	14.9	61.88%	12	1.24	16	0.93	22.78	52.46%	14.18%	1.42	12.15%					-	0➲	NA		75🡇	-
PRIORY 5	35.31	54.52%	34	1.04	34	1.04	39.73	43.97%	16.58%	1.17	7.33%	68.99	99	1.6	13🡅	2🡇	2🡅	3🡇	100🡅	85.29🡇	0🡇

▯	No previous score available
➲	Stayed the same
🡅	Improved
🡇	Deteriorated
	Off Plan
	Significantly off plan
Data in blue	Indicates previous months data
Red text	Of concern

Figure 13: *Medicine*

Surgery A - Bed Ratio Report

Sandwell and West Birmingham Hospitals NHS

Nov-12

	Budgeted Posts & Funded Beds				Actual Bed Usage		Actual In Post				Sickness
	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Average Actual Bed Usage	Budgeted Staff: Actual Bed Ratio	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	Actual Staff:Bed Ratio	% (previous Month)
D6 (Pre Assess)	8.15	75.46%	27	0.30	27	0.30	9.99	79.28%	2.70%	0.37	0.82%
D21(was D30)	28.84	56.80%	23	1.25	23	1.25	33.62	49.11%	15.88%	1.46	6.27%
D25	28.28	60.04%	19	1.49	19	1.49	24.96	57.17%	4.53%	1.31	6.32%
SAU/D42	22.54	73.38%	14	1.61	14	1.61	23.62	68.64%	5.95%	1.69	13.94%
ASU	24.6	72.36%	20	1.23	26	0.95	22.67	68.02%	1.99%	0.87	6.99%
NEWTON 2	18.05	62.22%	24	0.75	28	0.64	17.86	57.27%	6.00%	0.64	8.45%
LYNDON 2	27.93	56.57%	26	1.07	26	1.07	31.32	46.29%	23.08%	1.20	12.61%
LYNDON 3	39.8	58.27%	33	1.21	33	1.21	41.6	46.71%	11.97%	1.26	5.99%
PRIORY 2	26.87	61.11%	26	1.03	22	1.22	31.26	47.09%	18.46%	1.42	14.07%
NEWTON 3	41.27	57.98%	33	1.25	33	1.25	39.95	53.71%	4.76%	1.21	3.84%

Figure 14*: Surgery A*

Community - Bed Ratio Report

Nov-12

	Budgeted Posts & Funded Beds				Actual Bed Usage		Actual In Post				Sickness
	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Average Actual Bed Usage	Budgeted Staff: Actual Bed Ratio	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	Actual Staff:Bed Ratio	% (previous Month)
HENDERSON	28.67	49%	22	1.30	22	1.30	20.93	55%	33.00%	0.95	8.06%
LEASOWES	25.58	40%	20	1.28	20	1.28	21.55	41%	16.00%	1.08	8.09%

NB It is acceptable to have a lower ratio of registered:unregistered staff in Community Rehabilitiation facilities

Figure 15: *Community*

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. Notably we are now using more nurse bank/agency than we have for the past 4 years.

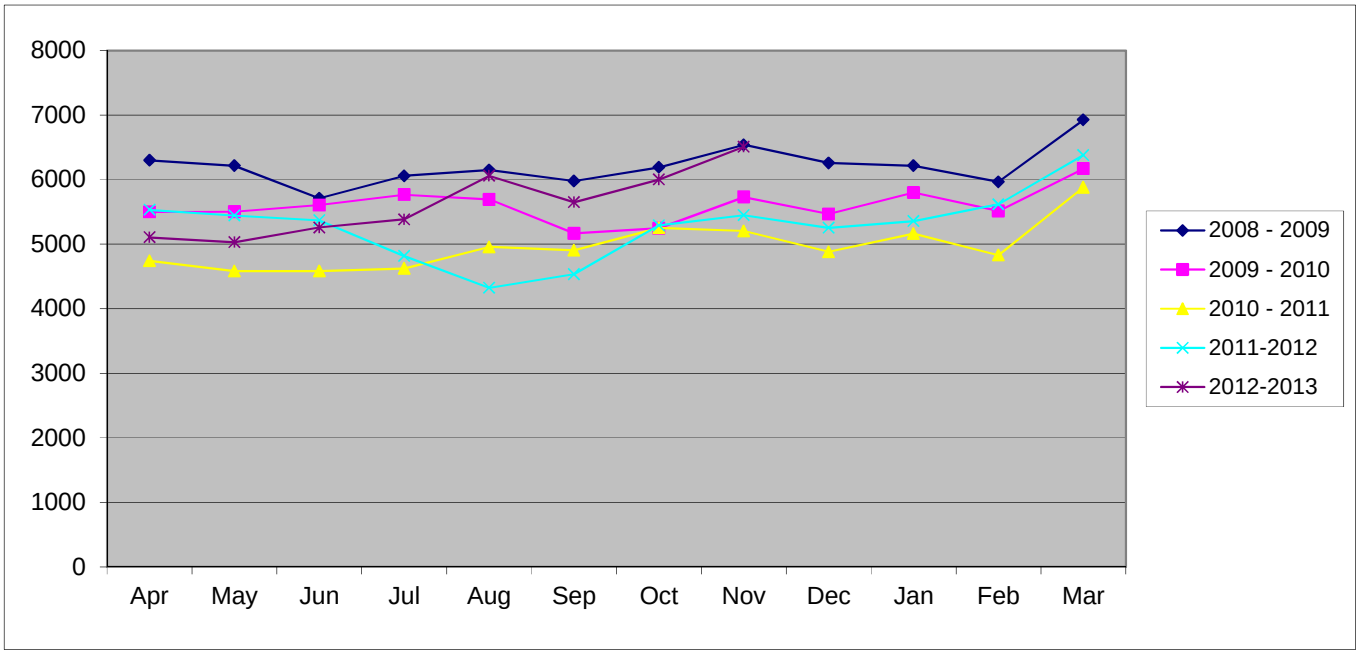


Figure 16: *Total Bank & Agency Use Nursing April 2008 –date.*

10 CLINICAL EFFECTIVENESS

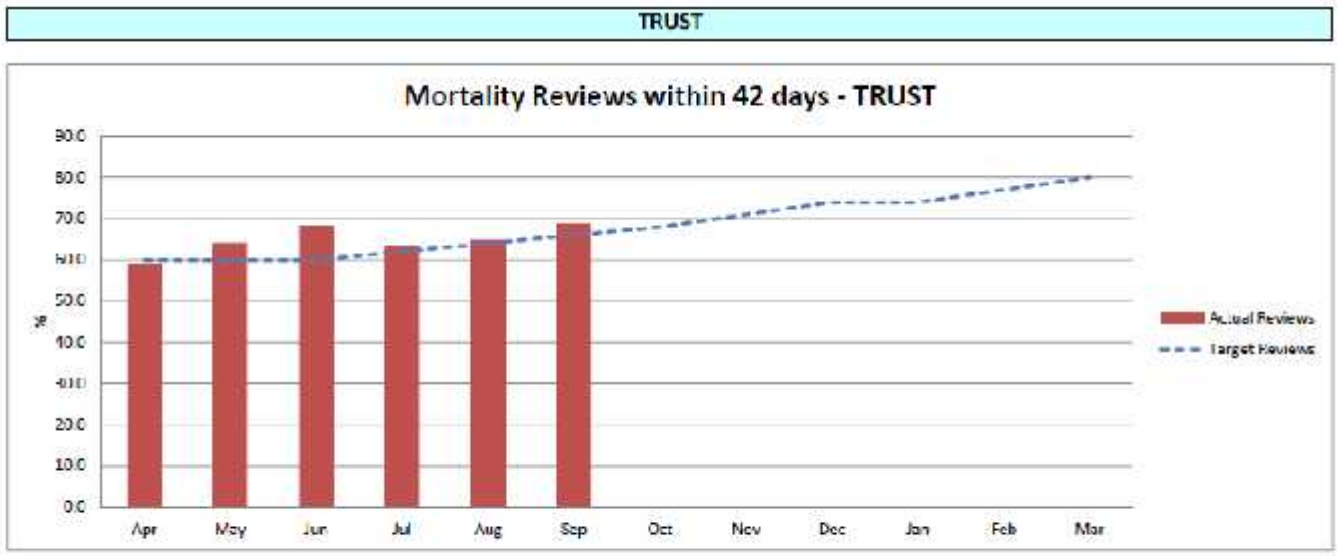
10.1 Mortality

CQUIN Target

As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme with an end year target to review 80% of hospital deaths within 42 working days.

During the most recent month for which complete data is available (September) the Trust reviewed 66.9% of deaths compared with a target trajectory for the period of 66.0%.

The value of this CQUIN for 2012 / 2013 is approximately £743K.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
All Reviews within 42 days (%)	59.1	64.1	68.3	63.6	64.9	68.9						
Target Reviews within 42 days (%)	60.0	60.0	60.0	62.0	64.0	66.0	68.0	71.0	74.0	74.0	77.0	80.0
DEATHS (ALL TRUST)	133	146	126	121	132	138						

Figure 17: *Mortality review results*

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.

The Trusts 12-month cumulative HSMR (93.1) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (97.8). The in-month (September) HSMR for the Trust has increased slightly to 84.8 and this remains within statistical confidence limits (Figures 17& 18).

HSMR (Source: Healthcare Evaluation Data (HED))

For comparison the Trust HSMR for corresponding 12-month cumulative periods, derived from the UHBT *Healthcare Evaluation Data (HED) Tool* is included. The HSMR for the most recent 12-month cumulative period remains stable at 95.6. *HED* data is subject to continued rebasing.

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. One SHMI value is calculated for each trust. The baseline value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment was exactly the same as the number expected using the SHMI methodology. SHMI values have also been categorised into the following bandings.

1	where the Trust's mortality rate is 'higher than expected'
2	where the trust's mortality rate is 'as expected'
3	where the trust's mortality rate is 'lower than expected'

Further SHMI data was published on 23/10/12 for the period April 11 – March 12. For this period the Trust has a SHMI value of 0.97 and was categorised in band 2.

- 10 trusts had a SHMI value categorised as 'higher than expected'
- 16 trusts had a SHMI value categorised as 'lower than expected'
- 116 trusts had a SHMI value categorised as 'as expected'

In addition**,** the UHBT *Healthcare Evaluation Data (HED) tool provides data in month based on the SHMI criteria. The Trust SHMI for the most recent period (September 11- August 12) is 94.2*

	Apr	May	June	July	Aug	Sept
Internal Data:						
Hospital Deaths		146	126	121	132	121
Dr Foster 56 HSMR Groups:						
Deaths		129	111	100	113	101
HSMR (Month)		89.2	89.7	85.5	83.9	84.8
HSMR (12 month cumulative)		88.3	96.4	95.5	94.2	93.1
HSMR (Peer SHA 12 month cumulative)		93.3	101.3	100.2	98.7	97.8
Healthcare Evaluation Data - HSMR (12 month cumulative)		96.8	97.0	96.5	95.6	95.7

Figure 18: *Mortality statistics*

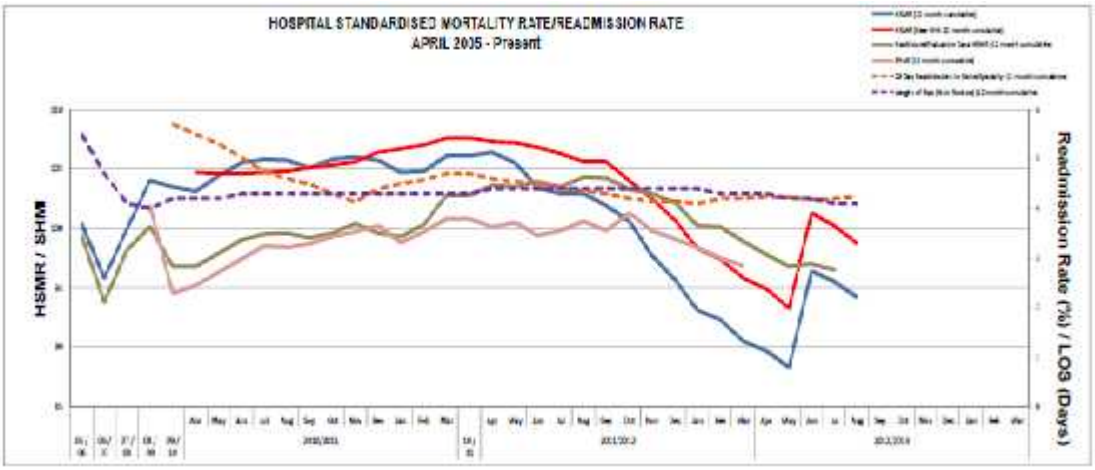


Figure 19: *HSMR/Readmission rate*

Note In the graph above it should be noted that the sharp rise shown both for our Trust and also for our SHA peers is because the scores have been rebased and does not indicate deterioration in performance.

CQC Mortality Alerts received in 2012/13

A new CQC Alert has been received by the Trust relating to higher rates of perinatal mortality following birth at the Trust. This will be investigated and reported to the Mortality, Quality & Alerts Committee. The findings will be reported in January 2013.

Dr Foster generated alerts (RTM)

In the data period Oct 2011 -Sept 2012 there were no new alerts generated from RTM

Mortality (in-hospital) - Diagnoses										Alert	
Team	Diagnoses	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	HSMR Basket of 56 Diagnosis Groups	40155	1503	3.7%	1613.9	4.0%	93.1	88.5	98.0		4
ALL	Acute bronchitis	1257	32	2.5%	39.2	3.1%	81.7	55.9	115.4		1
ALL	Acute cerebrovascular disease	604	100	16.6%	112.4	18.6%	89.0	72.4	108.2		1
ALL	Aspiration pneumonitis, food/vomitus	161	40	24.8%	56.3	35.0%	71.1	50.8	96.8		1
ALL	Biliary tract disease	1095	18	1.6%	15.9	1.5%	113.3	67.1	179.1	1	
ALL	Cancer of prostate	705	7	1.0%	10.5	1.5%	66.8	26.8	137.7		1
ALL	Congestive heart failure, nonhypertensive	793	80	10.1%	95.6	12.1%	83.6	66.3	104.1		1
ALL	Diabetes mellitus with complications	507	11	2.2%	17.3	3.4%	63.5	31.6	113.6		2
ALL	Other psychoses	166	9	5.4%	4.8	2.9%	188.9	86.2	358.6	1	
ALL	Pulmonary heart disease	243	22	9.1%	12.5	5.1%	176.2	110.4	266.8	1	
ALL	Septicemia (except in labour)	97	11	11.3%	20.2	20.8%	54.5	27.2	97.6		1
ALL	Short gestation, low birth weight, and fetal growth retardation	779	7	0.9%	18.1	2.3%	38.6	15.5	79.6		1
Mortality (in-hospital 30 days) - Procedures										**Alert**	
Team	Procedures	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	Reduction of fracture of bone (upper/lower limb)	833	0	0.0%	3.5	0.4%	0.0	0.0	103.4		1
ALL	Reduction of fracture of neck of femur	210	13	6.2%	11.7	5.6%	111.0	59.1	189.8	1	

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

Figure 20: *Mortality in hospital diagnoses*

National Clinical Audit Supplier – Potential Outlier Alerts
The Trust has not been notified of any new outlier alerts.

10.2 Patient Related Outcome Measures (PROMs)

Provisional data in the form of experimental statistics was published on 13/11/12 for the 2011/12 financial year and also for the period April 12 to June 12 for the current financial year. Patient level data is currently being analysed and is being forwarded to the relevant specialties for them to review.

10.3 Clinical Audit

Clinical Audit Forward Plan 2012/13
The Clinical Audit Forward Plan for 2012/13 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.

Status	Total
0 - Information requested	3
1 - Audit not yet due to start	7
2- Significant delay	2
3- Some delay - expected to be completed as planned	5
4- On track - Audit proceeding as planned	50
5- Data collection complete	9
6- Finding presented and action plan being developed	2
7- Action plan developed	2
A - Abandoned	3
Grand Total	83

The status of the audits that have been included in the plan as at the end of November is shown in the table above.

10.4 Compliance with the 'Five Steps for safer surgery'

Compliance with the "Five Steps to Safer Surgery" process is reported using the Clinical Systems Reporting Tool (CSRT).

The reported compliance with the 3 sections in the checklist for November 2012 is shown in the table below (data source CDA) .

2012		July	August	Sept	October	Nov	YTD performance
WHO Checklist Safer Surgery Audit - 3 Sections (All areas)	%	99.45%■	99.65%▲	99.83%▲	99.46%▼	99.86%▲	99.64%
WHO Checklist Safer Surgery Audit - 3 Sections and Brief	%	92.89%■	93.90%▲	93.50%▼	93.55%▲	94.17%▲	93.59%
WHO Checklist Safer Surgery Audit - 3 Sections, Brief and Debrief	%	80.61%■	80.67%▲	76.33%▼	81.71%▲	81.61%▼	80.25%

Figure 21: *WHO checklist compliance*

The WHO Checklist Steering Group continues to meet monthly. Work is in progress to carry out qualitative reviews focussing on the culture of patient safety in areas where interventions take place. A communication plan has been drawn up and in under constant updating. Focus is on improving completion of the debrief section of the 5 steps. The group also looks at if there are lessons to be learned where any incidents have occurred where a WHOCL could be used.

For lists that are identified as not being compliant with the WHOCL, the consultant in charge of the list is identified and the Clinical Director for the speciality informed. The CDs are advised to speak with the consultants concerned. The CDs are also advised to remind all their consultants to use the WHOCL for all interventional lists and include briefing and debriefing. Nursing staff are reporting feeling more empowered to ensure that the WHOCL is taking place.

10.5 Stroke care

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

Stroke Care- Source- CDA Dashboard 18/12/12	April	May	June	July	Aug	Sept	Oct	Nov	YTD
% Spending >= 90% of stay on stroke unit	91.18% ▼	93.88% ▲	94.12% ▲	85.11% ▼	85.19% ▲	86.96% ▲	84.91% ▼	86.79% ▲	88.37%
Admitted to stroke unit within 4 hrs of arrival at hospital	76.67% ▲	72.22% ▼	72.55% ▲	65.31% ▼	68.75% ▲	67.44% ▼	52.08% ▼	52.50% ▲	65.35%
CQUIN: % pts receiving brain imaging in 24 hrs of admission	94.74% ■	98.11% ▲	98.33% ▲	95.00% ▼	88.37% ▼	96.23% ▲	100.00 %▲	87.23% ▼	95.16%
Pts scanned within 24 hrs of hospital arrival	96.67% ▲	100.00 %▲	92.16% ▼	93.88% ▲	93.75% ▼	100.00 %▲	91.67% ▼	95.00% ▲	95.14%
Pts scanned within 1 hr of arrival to hospital	70.00% ▲	61.11% ▼	58.33% ▼	52.63% ▼	53.13% ▲	58.97% ▲	45.45% ▼	55.26% ▲	56.23%
TIA - ABCD2 >= 4 treated within 24 hours	61.54% ▼	50.00% ▼	100.00 %▲	66.67% ▼	80.00% ▲	60.00% ▼	84.62% ▲	76.47% ▼	71.17%
TIA - ABCD2 < 4 treated within 7 days	57.14% ▼	48.15% ▼	68.42% ▲	66.67% ▼	88.37% ▲	96.77% ▲	86.49% ▼	100.00 %▲	78.30%

Figure 22: *Performance against stroke care targets*

Some performance indicators have suffered during November because of pressure on bed capacity. It should be noted that, for the first time this year, 100% of patients with TIAs have been treated within 7 days.
The Clinical Implementation Group continues to meet twice a month to continue with the agreed action plan. Stroke outreach nurses at both City and Sandwell on all shifts are now becoming more effective at pulling patients into the acute wards from ED following an automated stroke alert.

The Stroke service achieved top quartile performance for Stroke SINAP audit at City and narrowly missed it at Sandwell, but the performance overall is certainly moving in the right direction and the service for high risk TIA has dramatically improved.

10.6 Treatment of Fractured Neck of Femur within 48 hours

The Trust has an internal Clinical Quality target whereby 70% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. Provisional data for November (Source CDA –QMF Dashboard18/12/12) indicates 80.77% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission, resulting in a year to date performance of 65.87%. Performance has improved significantly throughout the year from 45.83% in April 2012. *Internal Priority*

10.7 Ward Reviews

Medicine and Emergency Care					increase or decrease against key performance targets				
	Q1- July 2012				Q2- Oct 2012				
WARD	RED	AMBER	GREEN	WARD	RED	AMBER	GREEN	▲ or ▼	High to Low Ranking
D5	0	0	7	D5	0	0	7	▬	D5
D7/ D41	1	0	6	D7	0	3	4	▼	D15
D11	1	0	6	D11	1	0	6	▬	D43
D12	1	0	6	D12	1	0	6	▬	Newton 5
D15	1	0	6	D15	0	0	7	▲	CCU
D16/D18	0	1	6	D16/D18	0	1	6	▬	D16/D18
D17	0	0	7	D17	1	0	6	▼	Lyndon 4
D41	2	1	4	D41	1	0	6	▲	D11
D43	0	0	7	D43	0	0	7	▬	D12
D47	Tool	Under	Review	D47	Tool	Under	Review		D17
Skin	Tool	Under	Review	Skin	Tool	Under	Review		D41
MAU	0	5	2	MAU	1	0	6	▲	MAU
Endoscopy	Tool	Under	Review	Endoscopy	Tool	Under	Review		Newton1/4
Priory 3	1	0	6	Priory 3	1	2	4		Priory 4
Lyndon 4	1	0	6	Lyndon 4	0	1	6	▲	D7
Priory 4	1	1	5	Priory 4	0	2	5	▲	Priory 3
Newton 1/4	1	2	4	Newton1/4	1	0	6	▲	EAU
Newton 5	0	0	7	Newton 5	0	0	7		Priory 5
Priory 5	1	3	3	Priory 5	1	5	1	▼	A&E CHT
EAU	Tool	Under	Review	EAU	1	3	3		
CCU	0	1	6	CCU	0	0	7	▲	
Medical Day Case Unit	Tool	Under	Review	Medical Day Case Unit	Tool	Under	Review		
A&E- CHT	Special	Measures		A&E- CHT	3	4	0		
A&E- SDGH	Special	Measures		A&E- SDGH	Special	Measures			
Total	11	14	94	Total	12	21	100		

Figure 23: *Medicine ward review comparison results*

Ward Review Quarterly comparison performance Scorecard - Surgery A&B, and Anaesthetics and Critical Care

Sandwell And West Birmingham Hospitals NHS Trust

Surgery A/B & Anaesthetics — Ward Comparison indicating movement in terms of increase or decrease against key performance areas

WARD	Q1 - July 2012 RED	AMBER	GREEN		Q2 - Oct 2012 RED	AMBER	GREEN	▲or▼	HIGH TO LOW RANKING
D6	0	1	6	D6	0	0	7	▲	
D21/D24	0	0	7	D21/D24	Ward	is	closed		
D25	1	2	4	D25	2	3	2	▼	
D26/D28	0	3	4	D26/D28	Ward	is	closed		
D30	1	1	5	D30 [D21]	0	0	7	▲	
SAU	0	1	6	SAU	0	2	5	▼	
ASU-BTC	0	2	5	ASU-BTC	0	3	4	▼	
Eye	0	3	4	Eye					
Lyndon 2	1	3	3	Lyndon 2	0	5	2	▲	
Newton 2	0	1	6	Newton 2	0	2	4		
Priory 2	4	1	2	Priory 2	0	4	3	▲	
Newton 3	0	3	4	Newton 3	2	4	1		
Lyndon 3	0	2	5	Lyndon 3	1	5	1		
SDU	0	2	5	SDU					
Critical Care-CHT	0	1	6	Critical Care-CHT	0	3	4	▼	
Critical Care-SGH	2	0	5	Critical Care-SGH		1	5		
				Theatres City	0	6	1		
				Theatres SGH	0	6	1		
Total	9	26	77						

Figure 24: *Surgery ward review comparison results*

10.8 Quality Audits

These audits include:

- Essence of care standards (DoH)
- Same sex standards
- Observations of care
- Patient ID and uniform audits

Audits are conducted twice yearly in all adult in patient areas.

Comparison of Trust Wide Data from the audits undertaken in June 2012 and November 2012 Part A: General and Observation of Care	June 2012 (Base: 48 wards/units)			November 2012 (Base: 45 wards/units)		
	Yes	No	Not observed removed	Yes	No	Not Observed removed
Generic	95%	5%	-	88%	12%	-
Observations of Care	98%	2%	-	91%	9%	-
Promoting health and well being	83%	17%	-	78%	22%	-
Bladder and Bowel care (HIA-8)	98%	2%	-	84%	16%	-
Environment and staff	96%	4%	-	86%	14%	-
Individualised care/ Self care	97%	3%	-	87%	13%	-
Eating and drinking (HIA-3)	98%	2%	-	85%	15%	-
Safety (HIA-2)	96%	4%	-	92%	8%	-
Privacy and Dignity	88%	12%	-	90%	10%	-
Pressure area (number of patients with Waterlow score >10)	-	-	-	45%	55%	-
Orientation and Bed Board Information	-	-	-	88%	12%	-

Figure 25: *Observation of Care Trust Wide data comparison from June 2012 to November 2012*

Comparison of Trust Wide Data from the audits undertaken in June 2012 and November 2012 Part B: Patients being risk assessed against prescribed benchmarks						
	June 2012 (Base:622 patients)			November 2012 (Base:522 patients)		
	Yes	No	Spoilt	Yes	No	Spoilt
Tissue viability	97%	3%	-	97%	3%	-
Safety(falls)	98%	2%	-	97%	3%	-
Bladder & Bowel Care	96%	4%	-	94%	6%	-
Communications	96%	4%	-	96%	4%	-
Personal Hygiene/Self care	96%	4%	-	97%	3%	-
Manual Handling	97%	3%	-	96%	4%	-
Pain	96%	4%	-	95%	5%	-
Oral Hygiene	94%	6%	-	97%	3%	-
Record Keeping (mean value)	89%	11%	-	86%	4%	-
Mental Health	95%	5%	-	92%	8%	-
Nutrition	93%	7%	-	92%	8%	-
Infection prevention and control	-	-	-	30%	70%	-

Figure 26: *Patients being risk assessed against prescribed benchmarks: comparison of Trust wide data*

Comparison of benchmark compliance from June 2012 to November 2012 (best to worst)					
June 2012			November 2012		
1.	Falls	98%	1.	Falls	97%
2.	Pressure ulcers	97.3%	2.	Pressure ulcers	97%
3.	Manual Handling	97%	3.	Personal hygiene/ self care	97%
4.	Communication	97%	4.	Oral hygiene	97%
5.	Bladder and Bowel care	96%	5.	Manual Handling	96%
6.	Personal hygiene/ self care	96%	6.	Communication	96%
7.	Pain	96%	7.	Pain	95%
8.	Environment	96%	8.	Bladder and Bowel care	94%
9.	Mental Health	95%	9.	Mental Health	92%
10.	Generic	95%	10.	Hydration/ nutrition	92%
11.	Oral hygiene	94%	11.	Observations of care	91%
12.	Privacy and Dignity	93%	12.	Privacy and dignity	90%
13.	Record keeping	89%	13.	Generic	88%
14.	Patient ID compliance	89%	14.	Uniform compliance	88%
15.	Promoting health and wellbeing	83%	15.	Orientation/ bed Board	88%
16.	Uniform compliance	77%	16.	Environment	86%
			17.	Record keeping	86%
			18.	Patient ID	86%
			19.	Promoting health and wellbeing	78%

Figure 27: *Comparison of benchmark compliance (December 2011 and June 2012)*

11 PATIENT EXPERIENCE

11.1 Net Promoter

The Trust overall Net Promoter Score (NPS) increased by 1 to 64 making progress towards the SHA target of 65 - the CQuIN requires a 10 point improvement on the baseline of 55 by March 2013. *CQUiN* % returns have increased with the use of iPADS – weekly reports to the SHA has commenced.

SHA ambition requires both the improvement on score plus weekly reporting.

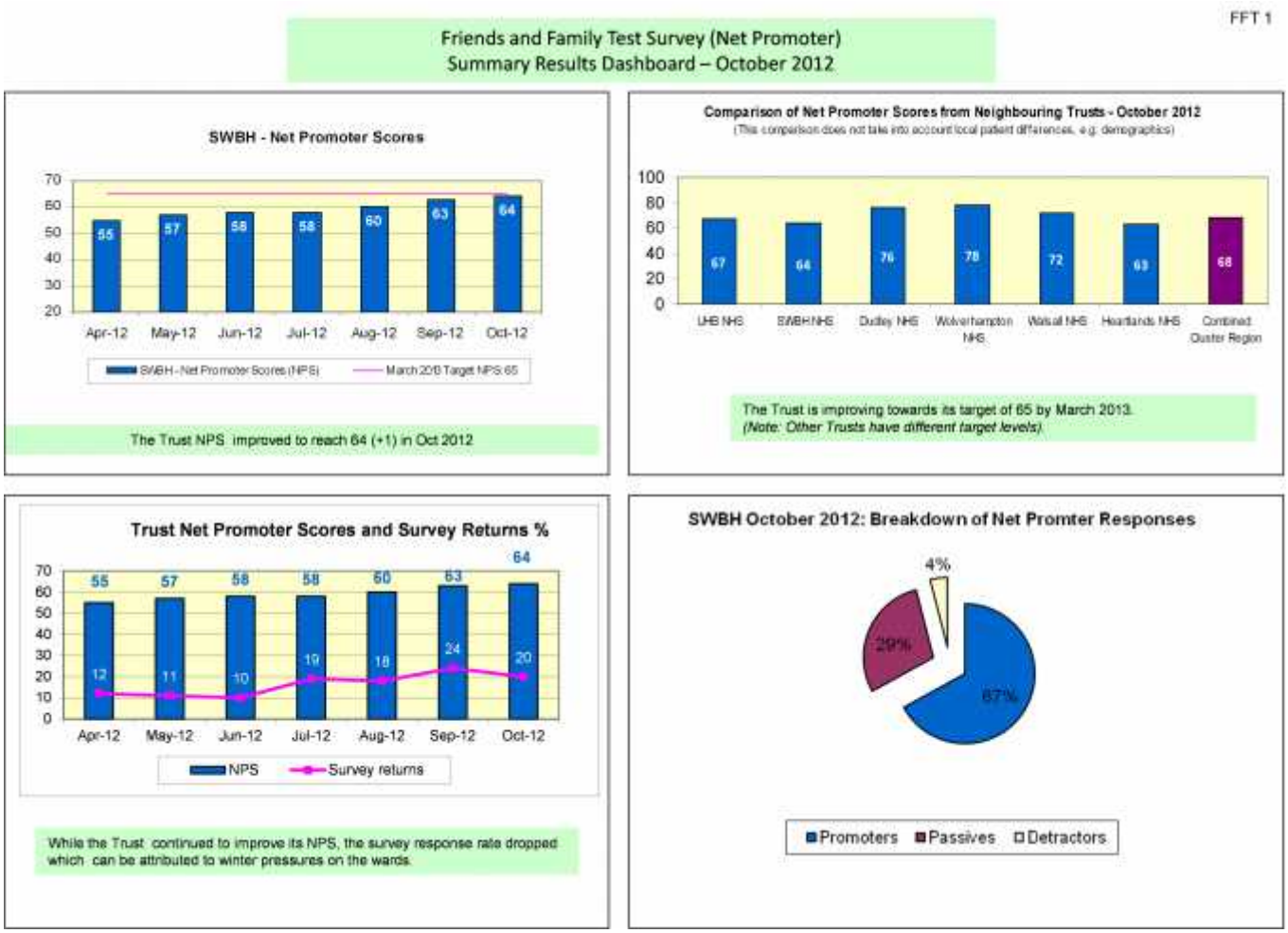


Figure 28: *Net Promoter position*

Resources have now been identified to expand the Patient Experience Team which will enable a more robust and co-ordinated approach to improvements in patient experience and bringing patient experience to the Trust Board.

11.2 Complaints and PALS

a) Complaints data

i) Complaints: Tables A and B set out the complaints data for November 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
Aug 2012	77	10	87	58	3	61
Sept 2012	55	5	60	81	11	92
Oct 2012	62	12	74	97	19	116
Nov 2012	68	11	79	113	15	128

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.*

As at the 3 December a total of 79 complaints had been received and 128 responses sent during November 2012.

Verita, a company specialising in complaints management commenced their review and undertook to complete cases that had serious breach implications. They were active from mid-July and until the end of November. Verita completed a total of 135 backlog cases on behalf of the Trust.

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

MONTH 2012	TOTAL ACTIVE COMPLAINTS [1]	NO. of COMPLAINTS OUTSIDE FAILSAFE PARAMETERS WITHIN RISK GRADE[2]				TOTAL
		Red[2] (60 days)	Amber[2] (70 days)	Yellow[2]	Green[2]	
				90 days (standard)		
Aug	364	4	42	65	19	130
Sept	335	4	33	50	15	102
Oct	290	3	25	31	13	72
Nov	258	1	3	6	2	12

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

[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 as at the end of month.*

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 failsafe parameters for 1 April 2012 onwards comprise: 60 days for red; 70 days for amber and 90 days for yellow and green grade complaints (see **Table B** above).

Of the 12 complaint responses in breach of the failsafe parameters (held over at November 2012):

- 3 have not been sent at the request of the complaints who want to have a meeting first. The meetings have been / are being arranged.
- 5 have been investigated, the response completed and are going through the final stages of the Complaints process.
- 2 cases were the response is near completion
- 2 cases were the investigation is on-going

b) PALS data

ii) PALS

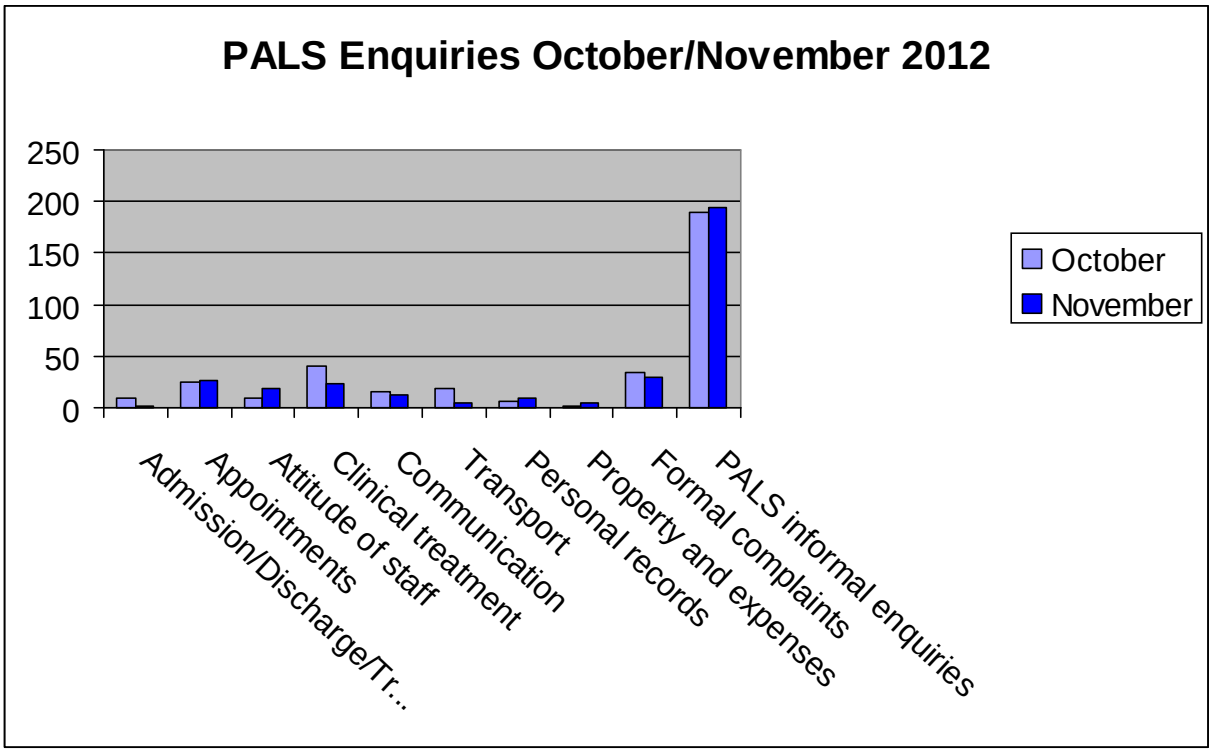
- **Contacts and general enquiries:** In November 2012 PALS recorded 169 PALS enquiry contacts and 194 general enquiry contacts in comparison to October 2012 PALS recorded 188 PALS enquiry contacts and 189 general enquiry contacts. The general informal enquiries are not captured on the PALS database but relate to enquiries taken at the PALS reception desk.

- Chart A provides a breakdown of the themes identified via PALS contacts in November 2012. The main categories reported during the month of November 2012, were issues relating to Clinical Treatment. PALS received 24 this month in comparison to 40 reported during October 2012. 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 November 2012 the number of appointment enquiries remained the same where 26 were reported this month, in comparison to October 2012, where there 25 enquiries. Appointment enquires relate to appointments cancelled, delay, notification and time.

- There has been slight reduction in the number of formal complaint issues which comprise the categories of handling, advice, process, referral and response time from 30 enquiries received this month in comparison to 34 enquiries reported during October 2012.

CHART A – Breakdown of top 10 issues



a) Parliamentary and Health Service Ombudsman (PHSO) cases

õ 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.

õ The Trust currently has 7 active cases with the PHSO.

11.3 End of Life

End of Life Report

Targets/Metrics: *CQuIN* 10% increase in number of patients achieving preferred place of death who are on a supportive care pathway – Acute and Community. This is also a national nursing high impact action and nurse sensitive indicator. The target for this year is 53%.

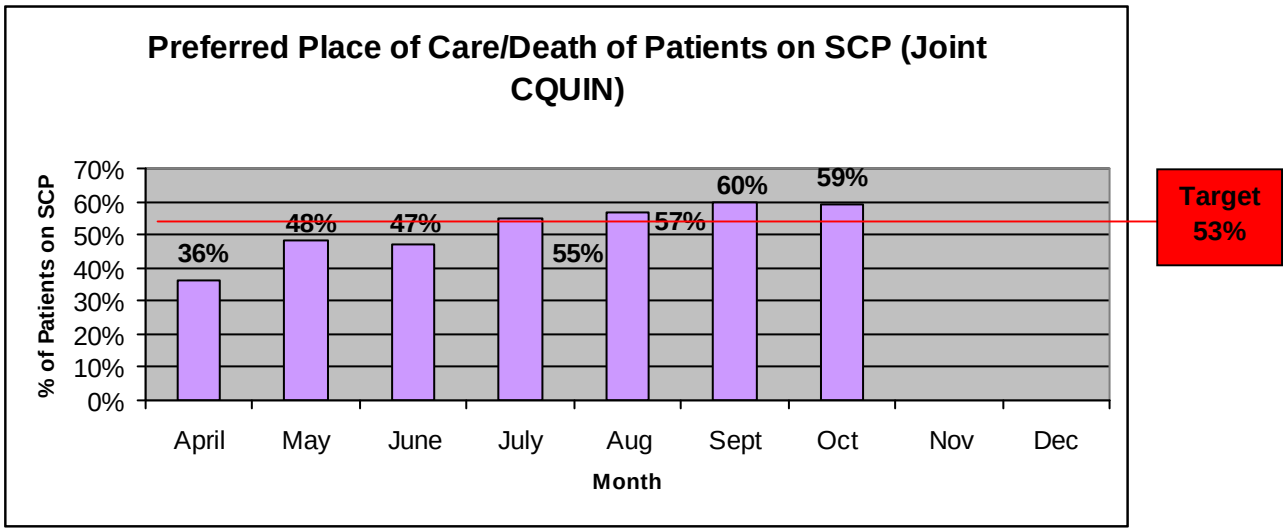


Figure 29: *Preferred place of death/death of patients on SCP*

12 WORKFORCE QUALITY

The Board is asked to note key headlines from the workforce dashboard for November 2012.

	% Trust
Mandatory Training	86.88% (85%)
PDR	69.31% (85%)
Turnover (leavers)	9.77%
Sickness absence	4.39% (3.5%)

13 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
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
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