AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
FRIDAY 16 NOVEMBER 2012

Title:	**PATIENT CARE QUALITY REPORT**
Responsible Director:	Kay Fawcett, Executive Chief Nurse
Contact:	Michele Owen, Deputy Chief Nurse; Extension 14719

Purpose:	To provide the Board of Directors with an update on care quality improvement within the Trust
Confidentiality Level & Reason:	None
Medium Term Plan Ref:	Aim 1. Always put the needs and care of patients first
Key Issues Summary:	This paper sets out the position for defined aspects of care quality within the Trust and supporting actions to ensure continued improved performance.
Recommendations:	The Council of Governors is asked to receive this report on the progress with Care Quality.

Signed:	**Date:** 7 November 2012

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PATIENT CARE QUALITY REPORT

PRESENTED BY THE EXECUTIVE CHIEF NURSE

1. Introduction and Executive Summary

This paper provides an update of progress with the Trust's Patient Care Quality agenda, including measurement of the patient experience through both internal and external initiatives, and the safeguarding of children and vulnerable adults. It also provides a progress report on the management of falls, eliminating mixed sex accommodation and enhancements in end of life care. Finally, it provides a summary of numbers of complaints received during the previous 2 months.

2. Measuring the Patient Experience

2.1 National Patient Surveys

The Trust recently took part in the National Cancer Patient Experience Survey, as required by the Department of Health. The postal survey was sent to 1122 eligible patients and the response rate was 63%. The National Benchmark results were published by Quality Health, on behalf of the Department of Health, in mid August 2012.

Results were improved overall compared to last year and we are on a par with other trusts.

Specific areas where improvements were seen:

- Information and explanation about tests, care and treatment
- Privacy and dignity
- Care by Clinical Nurse Specialists
- Pain control

Key areas for further improvement:

- Patient offered a written assessment and care plan
- Waiting time in outpatient department
- Information for carers / family
- Information re support e.g. financial, social services

An action plan for improvement is currently being developed by the Cancer Services Team and will be monitored via the Care Quality Group.

2.2 Enhanced Patient Feedback

For the year to date, 18,948 items of feedback from patients, carers and the public have been received. In October there were 2,193 responses to the electronic bedside survey bringing the total so far this year to end of October to 11,530. There is no change to the most positive responses which continue to relate to the cleanliness of wards and bathrooms, overall rating of care, and privacy when being examined, all of which achieved a score above 95%. The least positive responses were for someone to talk about worries, noise at night, rating of hospital food and conflicting information which achieved scores below 75% .

The Patient Experience Team have conducted a three month postal survey trial to obtain feedback from patients about their discharge from hospital. It is hoped this will enable the trust to obtain a higher response rate than was achieved via the telephone survey. The results of this trial will be reported in November and December to the Discharge Quality Group and the Care Quality Group. The Patient Experience Team will be participating in a Task and Finish Group currently being set up by the Outpatient Team to support the development of additional methods of obtaining feedback from patients attending the department. This is due to low response rates to the telephone surveys that focus on these aspects of care.

2.3 Net Promoter Family and Friends Response

As part of the Regional Commissioning Framework 2012/13 from the Strategic Health Authority (SHA) there was a requirement to include the family and friends “net promoter question” for inpatients from 1 April 2012. The question asks patients if they would recommend the service to family and friends. As well as being added to all surveys the patient experience team are currently conducting a trial where they contact patients by telephone the day after discharge to ask the net promoter question and also to ascertain the reason a particular answer has been given.

The net promoter score is identified by subtracting the percentage of detractors from the percentage of promoters. The scores from April to the end of October are detailed below:

Month 2012-13	Score
April	60
May	53
June	62
July	63
August	66
September	63
October	67

3. Falls

3.1 Overview First Quarter April – June 2012

	Q3 11/12	Q4 11/12	Q1 12/13
From bed	103	68	99
From chair (including wheelchair)	52	51	47
From commode	1	7	3
Due to fit/faint	12	23	18
Managed	23	27	27
On mobilising	185	200	176
Toilet/Bathroom	107	88	100
On transferring	17	21	20
Unwitnessed/unknown cause	139	172	148
Totals:	639	657	638

There were a total of 638 patient fall incidents reported Trustwide during the time period. This shows a 2.89% (19) decrease in falls reported compared to the previous quarter when there were 657 falls reported. Patient fall/slips were the second highest reported incident across the Trust in Quarter 1 2012/13; patient falls/slips accounted for 18% of incidents.

3.2 Subcategory of falls

The most common type of fall was on mobilising *(27.6%).* However there is a decrease compared to the 2 previous quarters. The greatest increase of falls numerically is falls from bed. The number is up from 68 to 99 which represents a 45.6% increase, the falls team have been working with the ward teams to ensure that they continue to obtain a hi/lo bed at the appropriate time for the patient to reduce risk of falls from bed.

3.3 Harm from inpatient falls

There were 133 *(21%)* incidents that caused patient harm in Q1 12/13; (Q4 11/12 123 – 19% patients sustained harm from a fall).

6 (0.94%) patients sustained a fracture as a result of their fall. There were 58 injuries to the head 17 of these were lacerations Total of 7 falls in Qtr1 resulted in serious harm and each has been reported and reviewed as a serious incident to ensure that lessons are learned from them.

4. Safety Thermometer

The NHS Safety Thermometer is a standardised data collection/ improvement tool that allows NHS organisations to measure patient outcome

in four key areas:-

- Pressure Ulcers
- Falls
- Urine infections and urinary catheter use
- VTE (Venous Thromboembolisim)

Key Points arising from the Audit

- The data set is based on the number of patients surveyed each month which will vary. The first survey was completed in April 2012
- There the outcome measures will be displayed as a % of the total number of patients surveyed each month against a pre set criteria

UHB outcomes

Overall	**April 2012**	**May**	**June**	**July**	**August**	**Sept**	**Oct**
Total pts surveyed	983	976	975	961	967	977	985
All Harm %	6	5.94	5.23	3.12	3	2.97	3.68
1 Harm	5.8	5.94	5.03	3.12	3	2.97	3.45
2 Harms	0.2	0	0.21	0	0	0	0.20
3 Harms	0	0	0	0	0	0	0
4 Harms	0	0	0	0	0	0	0

4.1 Work on Safeguarding Adults and Children

4.1.1 Adult Safeguarding

During the period there have been forty four new safeguarding adult investigations. Of these, nine were formal multi-agency alerts. The remainder comprised of enquiries related to complex care arrangements. Two patients without family or close friends required independent mental capacity advocates for changes to accommodation after discharges for patients lacking the mental capacity to make such decisions. Two DoLS assessments were made and both proceeded to the authorisation of deprivation of liberty for one month and three months respectively. There were two requests for domestic homicide reviews and in one case both adults identified had attended the Trust.

4.1.2 Safeguarding Children

There were no requests from Birmingham Safeguarding Children Board for individual management reviews for Serious Case Reviews during the period. Four referrals were made to the integrated access teams where adults presented to ED and had the responsibility for the care of children. One level 3 MAPPA case is ongoing where an adult poses a significant risk to those under 18 years of age.

5. **Bereavement**

In collaboration with CRUSE the Lead Nurse for bereavement has devised a study day for trained nurses to help with their understanding of loss/ bereavement in an acute setting. The aim is to pilot the training and the benefits to staff – 4 days are planned with 50 nurses to complete the training.

Pre bereavement work with families has commenced on the young persons unit. This allows discussion of death, what to expect, and any concerns they have can be dealt with immediately. It has evaluated extremely well, and the bereaved and nursing staff have appreciated the support into their ward.

6. **Pressure Ulcer Prevention / Management**

6.1 Background

From April 2011 the Trust adopted the European Pressure Ulcer Advisory Panel classification system which is widely used across the United Kingdom prior to this a different classification system was in place. From April 2012 we will be able to undertake a month by month comparison which will allow us to analyse data collated from the previous year.

All Grade 3&4 Hospital acquired Pressure Ulcers are subject to a root cause analysis investigation which investigates all the clinical areas / wards where the patient was cared for. The outcome of the RCA is to determine if the pressure ulcer was avoidable or unavoidable, action plans are developed to address any areas where improvement in practice is required.

The table overleaf details the number of Grade 3 &4 hospital acquired pressure ulcers that were recorded during the stated periods

2012 / Month	Total Number	Avoidable	Unavoidable
April	13	7	6
May	18	12	6
June	14	8	6
July	14	11	3
August	10	7	3
Sept	6	TBC	TBC
October	5	TBC	TBC

During September 2012 the Trust underwent an external peer review which was to give the Trust Board, assurance that all actions that can be taken to reduce pressure ulcers are being taken and to understand what further action was required to continue to reduce the number of hospital acquired avoidable pressure ulcers.

Following the review a number of recommendations were considered and a revised action plan has been developed which includes

additional resources to provide education in practice and enable the Tissue Viability Nursing Team to review Grade 2 pressure ulcers.

Two clinical teams are currently participating in a regional wide collaborative programme and have both demonstrated improvement and engagement across the whole multidisciplinary team with this approach. The Trust has been able to secure bespoke training from the collaborative facilitator in January 2013 to enable further teams to participate in the programme.

7. Patient Relations Report

7.1 Number of Formal Complaints by Month: August, September, October 2012

A total of 64 complaints were received in August 2012, 47 in September 2012 and 60 in October 2012. The fluctuation in monthly totals reflects the unpredictability of the overall number of complaints being received.

7.2 Complaints Actions and Trust Actions in Response to Complaints

Changes continue to be made to systems and processes within the Patient Relations Department to ensure we are delivering the best possible service to staff and patients.

Both Complaints and PALS were recently inspected by the CQC as part of their recent unannounced visit to the Trust. The feedback was largely positive, although a few minor issues were highlighted as areas for improvement, including arranging safeguarding training for PALS staff and ensuring complainants always receive an interim letter on a timely basis, where we are unable to meet our original response deadline.

Complaints continue to be reported monthly to the Care Quality Group as part of the wider Patient Experience report, as well as the Chief Executive's Advisory Group and as part of the Aggregated Governance Report provided to the Audit Committee and the Primary Care Trust. The revised Patient Relations Report to the Divisional Clinical Quality Group meetings, incorporating PALS and Complaints data, has now been delivered to all Clinical Divisions. The response has been positive from the Divisional Management Teams, who have found the report helpful to them in identifying key areas and issues for attention and ensuring actions are followed up.

Customer care training sessions continue to be delivered to areas where themes around staff attitude or communication have been identified and as part of ongoing staff development programmes and Corporate Trust Induction. Recent areas where such training has been delivered has been the 7th floor wards and the Private Patients ward (519).

8. Discharge Quality

The Trust Policy stipulates that our overall aim is to provide a framework that delivers safe, effective and timely discharge or care transfer for all patients, with appropriate support to enable them and their families and carers to be fully involved in the process.

- A Trust wide action plan for improvement has been developed and is being monitored at the Discharge Quality Meetings chaired by the Executive Chief Nurse.

- The Divisional report on their action plans specific to their services which are to be tabled at the Discharge Quality Group.

- Monthly audit of discharge quality is reported by Ward / Division as part of a series of key performance indicators to the Discharge Quality Group.

- There is an agreed cycle of reporting to the Discharge which ensures reports are received in a timely manner ie: patient experience / self discharge / incidents and procedural updates.

- Key performance indicators for Discharge have been agreed and are reported monthly at the meeting which include the adherence to process described in the procedure, the dispensing of medication to take home and the process of discharge undertaken on the day of discharge. (Appendix 1)

9. Recommendations

The Council of Governors is asked to receive this report on the progress with Care Quality.

Kay Fawcett
Executive Chief Nurse

16 November 2012

Discharge Performance Indicators - Trustwide

(KPIs 1-10 exclude Ambulatory Care/Short Stay Surgery and Clinical Decision Unit as they use tailored audit tools)

Ref.	Indicator	Data Source	Data Provider	Target	Oct 11	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
1	Number of cases audited	Discharge Notes Audit	Samantha Baker	N/A	560	-	-	-	293	277	294						
2	Simple	Discharge Notes Audit	Samantha Baker	N/A	88%	-	-	-	88%	92%	94%						
3	Complex	Discharge Notes Audit	Samantha Baker	N/A	11%	-	-	-	11%	8%	6%						
4	Blank	Discharge Notes Audit	Samantha Baker	N/A	1%	-	-	-	1%	0%	0%						
5	Nurse discharge letter completed on PICS	PICS	Samantha Baker	80%+ green 70%-79% amber <70% red	93%	-	-	-	93%	92%	95%						
6	Nurse discharge letter printed from PICS	PICS	Samantha Baker	80%+ green 70%-79% amber <70% red	90%	-	-	-	87%	87%	90%						
7	Medical discharge letter printed from PICS	PICS	Samantha Baker	80%+ green 70%-79% amber <70% red	100%	-	-	-	100%	100%	100%						
8	Nursing discharge letter fully completed	Discharge Notes Audit	Samantha Baker	80%+ green 70%-79% amber <70% red	85%	-	-	-	89%	86%	88%						
9	Nursing discharge letter present in the notes	Discharge Notes Audit	Samantha Baker	80%+ green 70%-79% amber <70% red	79%	-	-	-	77%	75%	76%						
10	Nursing discharge letter includes name/signature/designation of nurse who discharged the patient/time and date	Discharge Notes Audit	Samantha Baker	80%+ green 70%-79% amber <70% red	56%	-	-	-	64%	58%	54%						

11	Minutes between TTOs being sent to print to Pharmacy and being listed on tracker as complete (median) WEEKDAY	PICS and Pharmacy Tracker data	Vijay Dabhi*	120 minutes	-	-	-	-	180	130	126						
12	Minutes between TTOs being sent to print to Pharmacy and being listed on tracker as complete (median) WEEKEND	PICS and Pharmacy Tracker data	Vijay Dabhi*	120 minutes	-	-	-	-	123	97	92						
13	Dispensing incidents (internal)	Datix Incident Data	Matt Onions*	TBC	5	7	10	13	10	4	4						
14	Dispensing incidents (external)	Datix Incident Data	Matt Onions*	TBC	-	-	1	-	-	-	-						
15	Number of items dispensed	Pharmacy System	Inderjit Singh	n/a	25142	22871	25038	24080	27283	25827	27854						
16	Error rate per 100,000 items (also a QUORU indicator)	n/a	Automatic Calculation	TBC	to be provided by Informatics (QUORU)												
17	Dispensing complaints	Datix Incident Data	Derek Ball*	TBC	5	0	2	1	2	0	1						
18	Dispensing PALS contacts	Datix Incident Data	Derek Ball*	TBC	-	4	4	2	2	3	0						

* = validated by Inderjit Singh