UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 JULY 2013

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 Board of Directors is asked to receive this report on the progress with Care Quality.

Signed: Kay Fawcett	**Date:** 16 July 2013

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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 continued performance against the Safety Thermometer national CQUIN. An update of the position regarding the safeguarding of children and vulnerable adults is provided. It also provides a summary of numbers of complaints received in the previous 3 months progress. Finally there are reports on the management of discharge quality, falls, nutrition and hydration.

2. Measuring the Patient Experience

2.1 Enhanced Patient Feedback

In June there were 2797 responses to the electronic bedside survey, bringing the total for Quarter 1 to 7,813. This is an increase of 22% on Quarter 4, 2012-13. Positive responses achieving above 95% continue to relate to the overall rating of care; privacy when treated; and being treated with respect and dignity. The least positive responses were for noise at night from staff, and conflicting information which achieved scores of 75% and 77% respectively.

2.2 National Patient Surveys

The Trust is currently taking part in three National Cancer Surveys; the National Cancer Survey; the Chemotherapy Survey; and the Cancer Outpatient Survey. The field work has recently concluded. The report of the findings is expected in late August, once it has been agreed by NHS England.

2.3 Net Promoter Family and Friends Response

From the 1 April 2013 the Trust transferred to the new Department of Health Guidance for the Family and Friends Test requirements. This

requires us to report the response rates and scores for each ward, and from May 2013, to publish the information on the Trust website.

The net promoter score is identified by subtracting the percentage of detractors from the percentage of promoters. The Trust started 2012 with a score of 60 and achieved the target score of 72 by year end.

The Emergency Department has now been included in the collection of the Family & Friends Test which creates a challenge in the collection of the responses to the question from the volume of patients that attend the department each day.

The scores and response rates for April were:

Month 2013-14	ED Score	ED Response	Ward Score	Ward Response	Combined Score	Combined Response
April	45	1.91%	80	24.8%	**78**	**12.6%**
May	48	2.55%	78	27.22%	**74**	**11.8%**
June	61	1.88%	79	31.6%	**77**	**11.16%**

As can be seen from the results in the table above, response rates for the Emergency Department have been considerably less than the wards for Q1. Therefore, an alternative methodology, SMS text messaging, has been sourced and will be piloted in Q2. This method has proved successful for other Trusts.

3. Safety Thermometer

The NHS Safety Thermometer 2013/14 is a standardised data collection/ improvement tool that allows NHS organisations to measure patient outcome in three key areas:-

- Pressure Ulcers (both Community and Hospital acquired)
- Falls
- Urine infections and urinary catheter use

The CQUIN scheme will reward submission of data generated through the use of the NHS Safety Thermometer tool which will be published via the NHS Information Centre. It is recognised that nationally pressure ulcers represent the majority of harm reported and therefore the Trust is required to maintain or improve performance in this area, as the source of the harm may occur in both a health or social care setting the concept is to reduce the prevalence of pressure ulcers regardless of their source. Variation in the % of harm is attributed in May 2013 to and increased presence of community acquired pressure ulcers recorded on admission to UHB.

UHB outcomes

Overall	April	May	June						
Total pts surveyed	1050	1051	1059						
All Harm %	1.05	2.0	1.51						
1 Harm	1.05	0	1.51						
2 Harms	0	0	0						
3 Harms	0	0	0						

4. Work on Safeguarding Adults and Children

4.1 Adult Safeguarding

Referrals

Below is a breakdown of safeguarding referrals from April 2013. The numbers of alerts avoided following discussion with Senior Practitioners in Social Services suggests appropriateness of the actual alerts. The source of referrals broadens each month as safeguarding awareness increases.

Number of Referrals

Month	April 2013	May 2013	June 2013
Total Referrals		33	29
Alerts	10	16	5
Cases were alert not completed following discussions with social services	2		3
Advice Calls	10	6	11
Dols	0	2	3
IMCA	0	0	0

Source of Referrals

Source	April 2013	May 2013	June 2013
Ward/ clinical staff	13	24	20
Social services	2	1	1
Therapists	0	0	
Clinical Nurse Specialist	0	1	
Senior Nurse Matron	1	0	
Medical Staff	4	0	1
From Incident report form	1	1	
From a complaint	0	4	1
Health Facilitation Team	1	1	1
West Midlands Ambulance Service		1	

Types of Abuse

Type	April 2013	May 2013	June 2013
Potential Domestic Violence	**2**	**2**	**3**
Potential Financial Abuse	**3**	**2**	
Potential Omission of Care	**5**	**12**	**7**
Potential Physical Abuse	**4**	**4**	**1**
Potential Sexual Abuse	**0**	**3**	**1**
Emotional Abuse			**1**
Self Neglect		**1**	**2**

There were two Domestic Homicide Review requests made to QEHB in the period June 2013 both of which were nil returns.

Training continues to occur for all levels of staff.

4.2 Safeguarding Children

A Named Nurse Children has commenced in post, and is now pulling together a strategy focused on children's care within the Trust.

There were no requests from Birmingham Safeguarding Children Board for individual management reviews for Serious Case Reviews during June 2013.

Number of Referrals

Referrals	April 2013	May 2013	June 2013
Concerns about at risk dependents of adult patients	12	15	30
Patients under 16 years of age	2 (to HV)	0	
Patients 16-19yrs	1 (from CDU – patient already known to Social Services)	0	

5. Patient Relations Report

5.1 Number of Formal Complaints by Month by Division

Division	Number of Complaints Apr 13	Number of Complaints May 13	Number of Complaints June 13	Total Complaints
Division A	**4**	**2**	**8**	**14**
Division B	**16**	**14**	**10**	**40**
Division C	**25**	**14**	**13**	**52**
Division D	**22**	**17**	**13**	**52**
Corp Services	**1**	**1**	**2**	**4**
Total Complaints	**68**	**48**	**46**	**162**

There was another decrease in the level of complaints received in June 2013, continuing the downward trend after the peaks in January and February 2013. Whilst all Divisions saw low levels of complaints in June 13, Division A received 8 complaints, which is unusually high for that Division – 3 of which related to Ambulatory care. This has been highlighted to the Divisional Associate Director of Nursing.

5.2 Complaints Issues

The total number of issues highlighted remained static (169 in June, 166 in May) given the similarity in the overall complaints numbers (46 in June, 18 in May).

The ratio of issues around clinical treatment rose slightly from 29% in May to 31% in June. In contrast, the ratio of complaints highlighting communication issues fell from 24% in May to 18% in June 13. Issues around privacy and dignity contributed 8% of the total issues highlighted in June13, compared to 4% in May.

The other main issues were constant in terms of actual number and ratio of the total issues.

6. 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.

The monthly Discharge Quality Meeting agrees monitors processes around discharges and length of stay in order to maintain best practice. Core members of the group now attend the Discharge CQUIN meeting which is chaired by the Chief Operating Officer.

- Monthly audit of discharge quality is reported by Ward / Division as part of a series of key performance indicators to the Discharge Quality Group. This demonstrates where compliance with the procedures associated with Discharge may require attention, review or amendment.

- 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. The group agrees where focus and review is required in response to patient experience and amend the procedures associated with discharge to ensure that practice is dynamic and safe and has encompassed patient experience feedback.

- The Self Discharge Section of the Discharge and Transfer of Care Procedure has been amended and will be published and widely communicated during July / August 2013.

- Key performance indicators for Discharge d 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).

7. Falls

7.1 Falls for Quarter 1 - April to June 2013

The table 1 details the number of falls for quarter 1, in total there were 737 falls recorded during the quarter, this was 63 less than in quarter 4. The consequence of the fall is detailed in regards to level of harm as insignificant, minor, moderate, severe and catastrophic. There were no catastrophic events related to a fall; severe harm there were 10 incidents and moderate 7, the majority of incidents were minor in nature with 719 incidences. The falls team review all reported falls within the Trust and ensure that the patient received optimum care post and that there is consideration made to any other interventions that would reduce the risk of further falls.

Table 1

	No harm/ Near miss	Patient harmed	Total
Insignificant	1	0	1
Minor	605	114	719
Moderate	0	7	7
Severe	0	10	10
Catastrophic	0	0	0
Totals:	604	131	737

Table 2 demonstrates the Quality indicators set for falls in regards to key performance indicators; falls assessments are to be completed within the first 4 hours of admission, Urinalysis will help to indicate potential cause of patients confusion, night sedation is to only be prescribed when all other enabling sleep has been explored and the requirement to inform next of kin are considered as key areas to see an consistent improvement target. Work is underway to focus upon the areas that need support to make the necessary improvements generally monthly on month improvement is being made.

Table 2

Specialty	Ind key	Indicator	Latest Month	Latest Month Figure	Previous Month Figure	Average 6 Months	Goal	Result Flag
Nursing	689	Patients with a falls assessment within 4 hours of admission	May	64.0 %	61.8 %	60.7 %	90%	Figures are better from last month
Nursing	940	Urinalysis within 24 hours of admission for patients at risk of falls	May	21.4 %	20.8 %	19.4 %	90%	Figures are better from last month
Nursing	957	Next of kin informed of fall in hospital	May	54.3 %	47.9 %	46.7 %	90%	Figures are better from last month
Nursing	675	Reduction of night sedation prescribed for patients at risk of falls	May	16.9 %	16.9 %	17.6 %	10%	Same performance

8. Nutrition

8.1 Nutrition and Hydration Steering Group

The Trust has a Nutrition and Hydration Steering group which review and directs all aspects of Nutrition and hydration for the Trust The membership includes Nursing, Nutrition and Dietetics, Medical, Divisional Reps and Catering. Each Division has also set up local groups that include patient reps to ensure that relevant topics are addressed at a local level. The Steering Group reviews aspects such as national guidance, targets, compliments & complaints, incidents and education.

8.2 Pressure Ulcer Prevention / Management

The role of nutrition in pressure ulcer prevention and management is essential. Current work in being undertaken to review evidence based recommendations for both macronutrient as well as micronutrient advice, once developed this will give clear guidance for staff on nutritional recommendations for patients with grade 1 grade 2 grade 3 and above pressure ulcers in terms of menu choice, oral diet, oral nutritional supplements and artificial feeding.

8.3 Nutritional Screening

The Trust undertakes nutritional screening and uses MUST (Malnutrition Universal Screening Tool). The aim is for all patients (where appropriate) admitted have a nutritional screening undertaken on admission and then on a weekly basis and that this is followed up by an appropriate nutritional care plan.

The activities that the Trust is undertaking regarding MUST were discussed with the CCG at the June 2013 meeting. Following the achievement of 85% assessment for MUST across inpatient clinical areas during 2012/13 the Trust is seeking to improve in all elements of patient assessment on admission. To ensure continuous improvement the Nutrition and Hydration Steering Group audited all appropriate areas to identify where improvements were required; the majority of areas were achieving the standard, with measures for improvement initiated in areas of non compliance. The Trust recognises that a significant number of ward areas will need to improve in the nutritional assessment of patients and appropriate action plans are in place to address this.

8.4 Menu Systems

The Trust has undertaken an extensive review of meal providers and is due to move to a new provider over the summer. The review has taken into consideration, nutritional value, costs, variety and range, a taste review was undertaken by patients and staff. The Trust continues to monitor patient satisfaction of food.

8.5 Supported Mealtimes

The Trust has launched the Supported Mealtimes. This is to enable ward areas to prepare the environment and patients for meal times. While non essential activities are requested to be deferred till after the mealtime relatives that are helping patients are actively encouraged to attend.

9 . **Recommendations**

The Board of Directors is asked to receive this report on the progress with Care Quality.

Kay Fawcett
Executive Chief Nurse
16 July 2013

Discharge Performance Indicators - Trustwide

KPIs 1-9 exclude Ambulatory Care/Short Stay Surgery and Clinical Decision Unit as they use tailored audit tools

Ref	Indicator	Data Source	Data Provider	Target	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
1	Number of cases audited	Discharge Notes Audit	Samantha Baker	N/A	269	269	234	233	236	273	280	302	293
2	Simple	Discharge Notes Audit	Samantha Baker	N/A	92.6 %	91%	86%	92%	94%	86%	85%	85%	88%
3	Complex	Discharge Notes Audit	Samantha Baker	N/A	7%	7%	13%	8%	5%	14%	13%	13%	11%
4	Blank	Discharge Notes Audit	Samantha Baker	N/A	0.4%	2%	0.4%	0%	1.3%	0.4%	2.5%	1.3%	1.1%
5	Nurse discharge letter printed from PICS	PICS	Samantha Baker	90%+ green 70%-79% amber <70% red	88%	87%	92%	93%	94%	96%	93%	92%	95%
6	Medical discharge letter printed from PICS	PICS	Samantha Baker	90%+ green 70%-79% amber <70% red	99.6 %	99%	98%	99%	99.6 %	96%	100.0 %	99.7 %	99.6 %
7	Nursing discharge letter fully completed	Discharge Notes Audit	Samantha Baker	90%+ green 70%-79% amber <70% red	87%	84%	90%	85%	88%	88%	89%	89%	93%
8	Nursing discharge letter present in the notes	Discharge Notes Audit	Samantha Baker	90%+ green 70%-79% amber <70% red	77%	81%	88%	83%	89%	87%	86%	86%	91%
9	Nursing discharge letter includes name/signature/designation of nurse who discharged the patient/time and date	Discharge Notes Audit	Samantha Baker	90%+ green 70%-79% amber <70% red	60%	66%	70%	71%	80%	76%	79%	78%	79%

10	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	124	103	117	154	163	144	155	143	148
11	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	90	80	94	106	140	131	169	161	147
12	Dispensing incidents (internal)	Datix Incident Data	Jessica Richardson*	TBC	7	6	7	3	2	1	4	5	0
13	Dispensing incidents (external)	Datix Incident Data	Matt Onions*	TBC	0	0	0	0	0	0	0	0	0
14	Number of items dispensed	Pharmacy System	Jessica Richardson (figures sent from Pharmacy)	n/a	33299	34512	32959	35927	33950	36099	36974	38092	34914
15	Dispensing error rate per 100,000 items (also a QuORU indicator)	Calculated from KPIs 13 & 15	Jessica Richardson	TBC	21	17	21	8	6	3	11	13	0
16	Dispensing complaints	Datix Incident Data	Derek Ball*	TBC	1	0	0	3	0	0	0	0	2
17	Dispensing PALS contacts	Datix Incident Data	Derek Ball*	TBC	0	2	1	0	0	0	1	1	0
18	Transport incidents relating to discharge	Datix Incident Data	Matt Onions^	TBC	1	0	0	0	1	1	0	0	0

* = validated by Inderjit Singh

^ = validated by Carolyn Pitt