AGENDA ITEM No:

UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 24 JUNE 2010

Title:	**PATIENT CARE QUALITY REPORT**
Responsible Director:	Kay Fawcett, Executive Chief Nurse
Contact:	Kay Fawcett, Executive Chief Nurse; Extension 2940
Purpose:	To advise the Board of Directors of progress with the work related to care quality within the Trust
Confidentiality Level and Reason :	None
Medium Term Plan Ref:	Aim 1. Always put the needs and care of patients first
Key Issues Summary:	
Recommendations:	The Board of Directors is asked to receive this report on the progress with Care Quality.

Signed: 	**Date:** 15 June 2010

UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 24 JUNE 2010

PATIENT CARE QUALITY REPORT

PRESENTED BY THE CHIEF NURSE

1. Introduction and Executive Summary

This paper provides the quarterly update of work underway with the Trust's Patient Care Quality agenda, including measurement of the patient experience through both internal and external initiatives, safeguarding of children and vulnerable adults including falls, and tissue viability. It also provides progress on eliminating mixed sex accommodation and the focus on improving end of life care.

2. Measuring the Patient Experience

2.1 Enhanced Patient Feedback

Over 3,500 patients responded to the electronic patient survey in April and May. The results continue to be viewed on the Clinical Dashboard, as part of the Back to the Floor visits by the senior nursing team and have contributed to action plans from each visit. The Chief Nurse and Associate Directors of Nursing receive weekly reports alerting them to the excellent and poor responses from patients so that any necessary action can be taken.

It is anticipated that the number of responses will temporarily fall for June as the bedside television units have been removed from many wards at Selly Oak Hospital in readiness for their installation in the new hospital.

An Outpatient Telephone Survey is currently being piloted by the Patient Experience Team. Following the pilot the survey questions will be reviewed and revised. The survey will then commence proper and will aim to capture 50 patients per month.

The benchmark results of the National Inpatient Survey were published by the Care Quality Commission on the 19 May 2010. There was a 50% response rate, which was a slight increase on last year. The overall score card, which provides an overview of the results for NHS Choices website, placed UHB about the same as other NHS Acute Trusts in all sections. The best scores were achieved in questions about doctors, (8.4 out of10), questions about operations and procedures (8.3) and waiting to get a bed on a ward (8.2). The worst scores were for leaving hospital (7.2), overall views and experience

(6.5) and waiting lists and planned admissions (6.4). An action plan is currently being developed by Divisions to address areas for improvement.

3. Falls

For 2010/11 the Trust has a clinical quality measure via a CQUIN ("Commissioning for Quality and Innovation") to improve the quality of care related to falls prevention.

The key measure is related to a 5% reduction in the rate of patients seriously harmed as a result of a fall. This will focus on falls with serious injury where the Trust failed to implement appropriate risk assessments and care plans to prevent a patient from falling. In patients where appropriate measures were taken to prevent the fall and they still fell, these statistics will not be counted within the total figure of falls with serious injury. To assist in measuring the progress with this a number of initiatives have been developed:

- Falls on PICS will go live on 28 July 2010. This will then allow audits of the clinical areas to support the CQUIN and improve compliance to the falls policy.
- The Falls and Fracture Prevention Nurse Specialist has real time alerts from the Datix system and can now monitor patients who fall and patients who are multiple fallers. This system also reinforces the falls policy and improves good practice in the clinical areas.

4. Work on Safeguarding Adults and Children

4.1 Adult Safeguarding

Since April 2010 there have been nine safeguarding adult investigations including strategy meetings and case conferences conducted by the Lead Nurse Safeguarding in line with multi-agency procedures. A Serious Case Review is being conducted on a case involving the Mental Health Trust, SBPCT and UHB. The Coroner's Inquest takes place in July 2010.

The Trust participated in a CQC pilot study on the care of patients with learning disability and mental health disorders (including dementia) being admitted to acute hospital care settings early in the year. The CQC will be launching the national study in two phases commencing with the study on patients with learning disability in July/August 2010. The study on patients with mental health disorders will be conducted in October/November 2010. It will be in the form of an on line questionnaire and there will be questions on whether Trusts have obtained views from carers and on partnership working with other stakeholders. The CQC has indicated that approximately 10% of Trusts will be visited based on results of the study.

4.2 Safeguarding Children

Safeguarding Children and Young People – there were no deficits identified in quarter four for core standard C2. Arrangements are in place for standard 5 (Safeguarding) for the National Service Framework for Children and Young People.

There have been five requests for individual management reviews for Serious Case Reviews since April 2010. In two cases there was a nil return from the Trust. In three cases, adult members of the family had attended A&E, outpatient clinics or were admitted. In two cases the attendances could not be directly linked to the subsequent death of the child; however in both cases, parents/carers had a history of drug and alcohol abuse. In both cases, formal referral of the child/children to Social Services was made at the time of parental attendance or admission and the parents referred to drug and alcohol specialist services. For the remaining case adult members of the family had attended the Trust and records from the archive are being obtained currently.

Ofsted and the CQC are conducting a national review of safeguarding children and looked after children on Government instruction following the murder of Peter Connolly. The CQC are reviewing health service arrangements and the CQC are currently inspecting arrangements in Birmingham. The Trust has participated in a focus group of named professionals. The CQC are not scheduled to visit the Trust as part of their review but will be visiting other Trusts in Birmingham.

Birmingham Safeguarding Children Board has received criticism from Ofsted for the quality of some of its serious case reviews. As a result, all agencies have been asked to revisit and re-present a number of serious case reviews. For UHB no changes to the original independent management reviews were required but the cases have been re-presented into the new format.

5. Single Sex Accomodation

The Department of Health requires our Trust to virtually eliminate mixed sex accommodation for patients and this has presented a challenge in the Trust's old buildings. During June, as the Trust moves 60% of inpatient services into the new hospital, inpatient areas within the new hospital will become single sex compliant, and during phase 2 in November the vast majority of remaining inpatient areas will move into the new hospital and again become compliant. The Trust delivery plan for virtually eliminating mixed sex accommodation is measured monthly and monitored by South Birmingham PCT.

6. End of Life Care

In order to deliver the Trust wide strategy for improving end of life care and choice for patients and their families, a number of task and finish groups have been established. These multidisciplinary groups are led by members of the

End of Life Care Core Steering group. Feedback from these groups so far has shown some consistent themes to be addressed.

- There is a need for advanced communication skills training for nursing and medical staff, particularly in relation to end of life. This has been highlighted by feedback from patients and relatives as well as being identified by groups of nursing staff. This feedback and the data from the questionnaire sent out to all medical staff in the Trust; with regard to end of life care issues and the Supportive Care Pathway; will help to inform the requirements for the training package that will be developed for all staff groups

- There is a lack of side rooms to allow families to have privacy at the end of life. This issue should be addressed by the move to QEHB as 40% of the rooms are for single accommodation. We will, however, continue to monitor feedback through the bereavement questionnaire and Patient Services.

- Further development of relationships with community services to enable patients to be discharged home to die if that is their choice. As a start we are currently working on a project with South Birmingham Community Trust to train unregistered staff in technical aspects of care such as wound drain care in order to facilitate discharge home.

7. Recommendations

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

Kay Fawcett
Chief Nurse
15 June 2010