AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 27 SEPTEMBER 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 Board of Directors is asked to receive this report on the progress with Care Quality.

Signed:	**Date:** 13 September 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, 13,313 items of feedback from patients, carers and the public have been received. In August there were 1,964 responses to the electronic bedside survey bringing the total so far this year to end of August to 9,617. 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, and conflicting information which achieved scores below 75%

The Patient Experience Team is conducting 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 when they become available. The Patient Experience Team are also working with the Outpatient Team to explore 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 August are detailed below:

Month 2012-13	**Score**
April	60
May	53
June	62
July	63
August	66

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; 2 of these incidents resulted in falls related death.
Serious harm:
4 fractured neck of femurs
2 deaths from Subdural haematoma
1 Subdural Haematoma (death unrelated to fall)

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**
Total pts surveyed	983	976	975	961	967
All Harm %	6	5.94	5.23	3.12	3
1 Harm	5.8	5.94	5.03	3.12	3
2 Harms	0.2	0	0.21	0	0
3 Harms	0	0	0	0	0
4 Harms	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

The Birmingham bereavement project has been short listed as a finalist in the category of enhancing patient dignity in the nursing times awards the project demonstrates the importance of working in collaboration and the benefits for the bereaved.

In collaboration with CRUSE the lead nurse has devised a study day for trained nurses to help with there 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 YPU this allows discussion of death, what to expect, any concerns they have can be dealt with immediately. It has evaluated extremely well from the bereaved and the nursing staff have appreciated the support into there 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 following table details the number of Grade 3 &4 pressure ulcers that were recorded during last year and for April and May during Q1 2012/3.

2011/2012	Division A	Division B	Division C	Division D	Total
Q1	4	6	10	5	25
Q2	6	2	8	3	19
Q3	10	5	8	3	26
Q4	14	1	11	5	31

Of the pressure ulcers reported in Q4 25 were classified as avoidable and 6 unavoidable

2012/2013	Division A	Division B	Division C	Division D	Total
Q1	17	7	16	5	45
Q2 (figs to date)	12	2	9	2	25

Of the RCA's completed for Q1 to date 24 were classified as avoidable and 16 unavoidable with 5 RCA's awaiting final verification.

The top 5 areas reporting hospital acquired pressure ulcers from 1 April 2012 split by classification / grade of ulcer are:

	Grade 1	Grade 2	Grade 3	Grade 4	DTI
ICU A	22	63	3	3	15
ICU D	32	40	10	3	8
515	23	27	6	4	3
ICU C	9	37	0	2	13
ICU B	18	28	4	2	7

6.2 Actions Taken

- a monthly pressure ulcer action group (PUAG) the role of the which is to provide advice to the Trust regarding the prevention and management of pressure ulcers and to update the Trust action plan to Eliminate Avoidable Hospital Acquired Pressure Ulcers as well as monitor agreed policies and procedures for all patients, this group reports to the Care Quality Group.

- The Trust will have an external peer review in September 2012 which will provided expert advice on our strategy and appraise the current actions in place.

- Two Wards will commence a regional Pressure Ulcer Prevention collaborative which is being run as part of the NHS Midlands and East ambition programme to eliminate avoidable pressure ulcers.

- A review of the current Tissues Viability service which has identified the need for additional resource to support teams and provide additional education and training. A CEAG paper is being developed which details the requirements and the revised service model developed to improve access, referral times and education.

7. Patient Relations Report

7.1 Number of Formal Complaints by Month: May, June & July 2012

A total of 52 complaints were received in May 2012 and 44 in June 2012, the latter being the lowest monthly figure for more than 2 years. This has reflected the pro-active triaging of complaints to more appropriate avenues of resolution (e.g. PALS, direct Divisional staff contact), which has also enabled the Trust to provide a more responsive service to the complainant.

However, in July 2012 we received 68 complaints, 13 of which related to the postponement, cancellation or waiting time for surgery, which has been highlighted in September's report to the Chief Executive's Advisory Group.

7.2 Complaints Actions

As noted in the last report, a new Patient Relations Department has been created, bringing together the existing PALS and Complaints (Patient Services) teams under one over-arching department.

Office moves have given the opportunity for the Complaints team to be in one larger office, as well as bringing together the existing Complaints Team Leader and the PALS Team leader, which will be recruited to shortly.

Changes have also been made to Complaints template letters to demonstrate greater empathy and relevance.

The team is moving to a revised version of the existing database, Datix, which will enable more streamlined processes and communication with the Divisions, as well as improved reporting, especially of complaints actions. The Head of Patient Relations has met with the senior Divisional management teams to explain the changes and ensure they are kept informed of developments.

7.3 Trust Actions in Response to Complaints

Complaints continue to be reported monthly to the Care Quality Group as part of the wider Patient Experience report. Changes have already been made to the reporting of Complaints to Divisional Clinical Quality Groups, to provide a joint PALS/Complaints/ Compliments report, which gives a more integrated picture of Divisional issues, as well as more focus on actions associated with complaints.

Customer care training sessions continue to be delivered to areas where negative feedback has been received about staff attitude or communication and as part of ongoing staff development programmes and Corporate Trust Induction.

Following an audit of complaints by Deloitte their final report has been delivered, together with an associated action plan, which reflects the changes which are already under way around streamlining processes and gaining greater divisional engagement.

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 2012 Discharge and Transfer of Care Policy and Procedure were approved in January 2012 and a series of communication events were held with key stakeholders.

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

- The Divisions are planning their cycle of audit and the audit tool has been updated to reflect the revised procedure.

- 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 are being explored and discussed and will be agreed during Q2 which will centre around the key themes of assessment and planning, medication to take home and the process of discharge undertaken on the day of discharge.

9. Recommendations

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

Kay Fawcett
Executive Chief Nurse
13 September 2012