AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 25 APRIL 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:	**Date:** 12 April 2013

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 25 APRIL 2013

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 Enhanced Patient Feedback

For the year to date, 34,515 items of feedback from patients, carers and the public have been received. In March there were 2,062 responses to the electronic bedside survey bringing the total so far this year to end of March to 23,950. Positive responses achieving above 95% 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%. In March positive responses to treated with respect and dignity question also achieved 95%. The least positive responses were for noise at night, and conflicting information which achieved scores at 76% and 77% respectively.

2.2 National Patient Surveys

The Care Quality Commission will publish the Benchmark Report of the National Inpatient Survey on 16 April 2013. The findings show that the Trust has improved again this year in many areas and has achieved better than most Trusts in two of the ten sections, the Emergency Department and overall views and experiences. A report of the findings and action plan for improvement will be presented to a future Board meeting.

The Trust is currently taking part in three National Cancer Surveys; the National Cancer Survey; the Chemotherapy Survey; and the Cancer Outpatient Survey.

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.

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 March are detailed below:

Month 2012-13	**Score**
April	60
May	53
June	62
July	63
August	66
September	63
October	67
November	65
December	70
January	72
February	69
March	72

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.

3. **Falls**

3.1 Overview Quarter 4 January – March 2013

There were a total of 798 patient fall incidents reported Trustwide during the time period. This shows a 28% (175) increase in falls reported compared to the previous quarter when there were 623 falls reported. Patient fall/slips were the second highest reported incident across the Trust in Quarter 4 2012/13, patient falls/slips accounted for 21.9% of incidents.

3.2 Subcategory of falls

The most common type of fall was on mobilising with 239 *(29.9%).* There was a 16.6% (34) increase in this type of fall compared the previous quarter when there was 205. Falls from toilet/bathroom saw the biggest increase compared to the previous quarter with 46 more.

3.3 Harm from inpatient falls

There were 136 *(17%)* incidents that caused patient harm in Q4 12/13; (Q3 12/13 122 – 20% patients sustained harm from a fall).

2 (0.38%) patients sustained a fracture as a result of their fall.
There were 46 injuries to the head 1 of these resulted in a Serious Injury Requiring Investigation.
Total of 3 falls in Qtr4 resulted in serious harm.
2 fractured neck of femurs.
1 Subdural haematomas.

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.
- 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**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan 2013**	**Feb**	**March**
Total pts surveyed	983	976	975	961	967	977	985	982	1009	1068	1069	1062
All Harm %	6	5.94	5.23	3.12	3	2.97	3.68	4.07	4.36	2.53	2.71	2.45
1 Harm	5.8	5.94	5.03	3.12	3	2.97	3.45	3.97	4.16	2.53	2.71	2.45
2 Harms	0.2	0	0.21	0	0	0	0.20	0.10	0.20	0	0	0
3 Harms	0	0	0	0	0	0	0	0	0	0	0	0
4 Harms	0	0	0	0	0	0	0	0	0	0	0	0

5. Work on Safeguarding Adults and Children

5.1 Adult Safeguarding

Referrals

Month	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013
Total referrals	26	16	32	26	26
Alerts	2	4	4	4	5
Cases where alert not completed following discussions with Social Service			4	3	3
Advice Calls			24	17	16
DoLS	1	0	3 – all authorised	1 - authorised	2 - authorised
IMCA		1	0	0	0

Below is a breakdown of safeguarding referrals for the period. 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

Source of Referrals

Source	Jan 2013	Feb 2013	March 2013
Ward/clinical staff	19	15	13
Social Services	7	4	3
Therapist	2	2	4
Clinical Nurse Specialist		2	1
Senior nurse/matron	2	1	1
Medical Staff	2		2
From Incident Report Form		1	
From a complaint		1	1
Health Facilitation Team			1

Types of Abuse

Type	Jan 2013	Feb 2013	March 2013
Potential Domestic Violence	2	5	7
Potential Financial Abuse	2	3	3
Potential Omission of Care	16	8	7
Potential Physical Abuse			1
Potential Sexual Abuse			2

There were two Domestic Homicide Review requests, one of which the subject had attended QEHB.

Training

Staff group	Quarter 4
Registered Nurse (level 2)	109
Medical Staff (level 2)	17
All staff (level 1)	603
Safeguarding Children Level 2 - ED	10

5.2 Safeguarding Children

There were no requests from Birmingham Safeguarding Children Board for individual management reviews for Serious Case Reviews during the period. One level 3 MAPPA case is ongoing where an adult poses a significant risk to those under 18 years of age.

A Safeguarding Children Working Group has been set up to provide a forum for all staff working within departments where children are seen to discuss activity, training; governance and compliance/assurance of statutory requirements. The group meets six weekly and reports to the Executive Chief Nurse's Trust Safeguarding Group.

Below is a breakdown of referrals to Children's Services

Referrals	Jan 2013	Feb 2013	March 2013
Concerns about at risk dependants of adult patients	10	7	11
Patients under 16 yrs of age	1	2 (to HV or School Nurse)	1
Patients 16 – 18yrs		1 (from Amb Care)	

6. End of Life Care and Bereavement

6.1 Committing to the 'Priorities of Care' for the dying patient and their families

SAGE and THYME Advanced care planning workshops are taking place on Thursday 11 April 2013 and teach:

- How to open a conversation about advance care planning/end of life
- How to structure and close the conversation

The format of the workshop is a combination of a lecture, several pieces of small group work and a couple of interactive rehearsals. Currently we have 60 staff booked to attend including not only UHB staff but also staff from community services such as Heart Failure nurses and consultants from neighbouring Trusts.

6.2 End of Life and Bereavement Champions

As part of our strategy for improving the care that is delivered to dying patients and their families we are conducting workshops for 40 champions from across the Trust. The champions will be attending for the whole day and will be taking part in a SAGE and TYHME advanced care planning workshop as well as a workshop utilising the end of life care training resources, which also focus on bereavement care and last offices.

Each champion will be given, for their clinical area, a training pack and copies of ‘Information for you when your loved one is dying’ leaflets as well as a laminated sheet with the latest update for last offices. Each champion will also receive a credit card size ‘prompt’ care which has reminders of the priorities which they can store with their Trust ID badge.

These cards can also be used as a discreet sign, which can be put into the window of rooms where patients are dying to let domestics and housekeepers know, so that extra refreshments can be offered to families.

The training for the champions will also be supported by the leads for End of Life, Bereavement and Palliative Care undertaking training sessions for staff in the clinical areas.

7. Pressure Ulcer Prevention / Management

7.1 Background

All pressure ulcers are classified using the European Pressure Ulcer Advisory Panel classification system. 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 Trust Wide action plan details a number of educational and training actions and resources and Divisions report on progress by a cycle of reporting to the PUAG.

The Tissue Viability team has 2.6 wte Band 6 Nurses on a one year secondment, all of whom will have taken up their position by May 2013. The band 6 Tissue Viability Nurses will focus on education in practice and support service expansion.

The following table 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	5	3	2
October	5	5	0
Nov	3	3	0
December	4	3	1
January 2013	7	5	2
February	8	TBC	TBC
March	9	TBC	TBC

8. Patient Relations Report

8.1 Number of Formal Complaints by Month by Division

Division	Number of Complaints Dec 12	Number of Complaints Jan 13	Number of Complaints Feb 13	Total Complaints
Division A	0	4	3	7
Division B	10	27	25	62
Division C	13	37	36	86
Division D	18	29	23	70
Corp Services	2	0	7	9
Total Complaints	43	97	94	234

There has been a significant increase in the level of complaints received in January and February 2013, after the low number in December 2012. The highest levels have been seen in Division C, where the complaints around A&E and CDU accounted for half of the complaints in both January and February, in part reflecting increased activity through those areas.

8.2 Complaints by Top 5 Issues by Division (all issues raised in complaint)

Issues about clinical treatment and communication are consistently the categories receiving the highest level of complaints issues. Some of the issues highlighted around aspects of clinical treatment could have been avoided with improved communication both between different members of staff and communication between staff and patients and their relatives and carers.

A significant step in addressing communication issues and improving the skill levels of staff in this respect has been the creation of a multi-disciplinary communication skills training and development review task and finish group by the Education Manager. An initial meeting has been held which has begin the process of scoping existing training delivered in this area around the Trust, with a view to reviewing existing training and determining the shape and nature of communication skills training going forward for all staff groups.

The relatively high level of issues raised around privacy and dignity will be highlighted in more detail at other Trust forums including Divisional Clinical Quality Group meetings and individual meetings between the Head of Patient Relations and Matrons. The Head of Patient Relations also highlights issues raised around dignity at training sessions on complaints and customer care.

The other significant issue raised in the complaints received since the start of the year has been delays with and cancellation of elective surgery.

8.3 QUORU Indicators

Two new indicators around complaints have been agreed to be shared at QuORU. These relate to acknowledgement of the complaint within 3 working days, for which the target is 100% of cases being acknowledged within 3 working days. There had been issues with aspects of the data quality, which has now been resolved, and reports from April onwards should be an accurate reflection and will be shared in future reports.

The second indicator relates to the ratio of follow up complaints. This has been selected as an indicator of the quality of the initial response to the complaint. The reporting of this indicator will be 3 moths in arrears to allow time for the complainant to receive and digest the response and determine how satisfied they are with the response. It should be borne in mind that a number of complainants will send a follow up complaint regardless of the quality of the original response. The agreed target is no more than 5% of the complaints for the month receiving a follow-up. The initial results are shown in the table below.

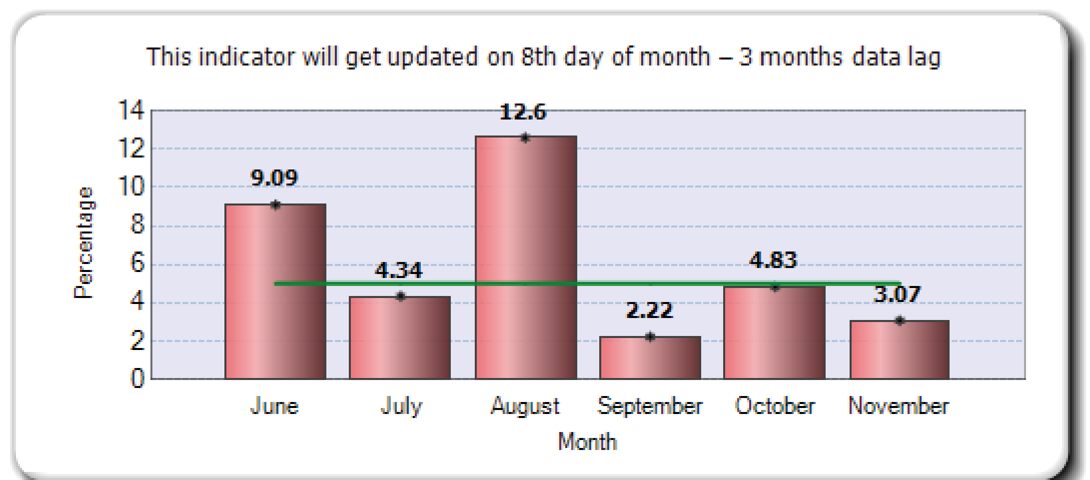

Table showing ratio of follow up complaints received

9. 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.

The Group will work closely with key individuals involved in the discharge process for example, the Divisional Directors of Operations, the Divisional

Directors, senior medical, nursing and allied Health Professionals, Group managers and Health Informatics staff.

- 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. 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 group has identified quality improvement areas and is focused on self discharge and patients who leave before being medically discharged.
- 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).

10. Francis Report

Following the release of the Francis report on 6 February 2013 a full gap analysis is being undertaken by the Trusts Governance team with input from all relevant groups.

11. Compassion in Practise

The Chief Nurse of England has launched a Nursing strategy based upon 6 key components, Care, Compassion, Competence, Communication, Courage and Commitment the 6 C’s, these will be incorporated into all elements of care quality, and measurement.

12. Recommendations

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

Kay Fawcett
Executive Chief Nurse
12 April 2013

Appendix 1

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
Number of cases audited	Discharge Notes Audit	Samantha Baker	N/A	560	-	-	-	293	277	294	269	269	234	233
Simple	Discharge Notes Audit	Samantha Baker	N/A	88%	-	-	-	88%	92%	94%	92.6%	91%	86%	92%
Complex	Discharge Notes Audit	Samantha Baker	N/A	11%	-	-	-	11%	8%	6%	7%	7%	13%	8%
Blank	Discharge Notes Audit	Samantha Baker	N/A	1%	-	-	-	1%	0%	0%	0.4%	2%	0.4%	0%
Nurse discharge letter completed on PICS	PICS	Samantha Baker	80%+ green 70%-79% amber <70% red	93%	-	-	-	93%	92%	95%	89%	92%	94%	93%
Nurse discharge letter printed from PICS	PICS	Samantha Baker	80%+ green 70%-79% amber <70% red	90%	-	-	-	87%	87%	90%	88%	87%	92%	93%
Medical discharge letter printed from PICS	PICS	Samantha Baker	80%+ green 70%-79% amber <70% red	100%	-	-	-	100%	100%	100%	100%	99%	98%	99%
Nursing discharge letter fully completed	Discharge Notes Audit	Samantha Baker	80%+ green 70%-79% amber <70% red	85%	-	-	-	89%	86%	88%	87%	84%	90%	85%
Nursing discharge letter present in the notes	Discharge Notes Audit	Samantha Baker	80%+ green 70%-79% amber <70% red	79%	-	-	-	77%	75%	76%	77%	81%	88%	83%

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%	60%	66%	70%	71%
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	124	103	117	154
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	90	80	94	106
Dispensing incidents (internal)	Datix Incident Data	Jessica Richardson*	TBC	5	6	8	10	13	3	3	7	6	7	3
Dispensing incidents (external)	Datix Incident Data	Matt Onions*	TBC	-	0	1	0	0	0	0	0	0	0	0
Number of items dispensed	Pharmacy System	Jessica Richardson (figures sent from Pharmacy)	n/a	-	30064	35382	33161	36098	35096	31936	33299	34512	32959	35927
Dispensing error rate per 100,000 items (also a QUORU indicator - but yet to be signed off by QuORU board)	Calculated from KPIs 13 & 15	Jessica Richardson	TBC	-	20	23	30	33	9	9	18	14	21	8
Dispensing complaints	Datix Incident Data	Derek Ball*	TBC	5	0	2	1	2	0	1	1	0	0	2
Dispensing PALS contacts	Datix Incident Data	Derek Ball*	TBC	-	4	4	2	2	3	0	0	1	1	0
Transport incidents relating to discharge	Datix Incident Data	Matt Onions^	TBC	-	-	-	0	1	0	1	1	0	0	0