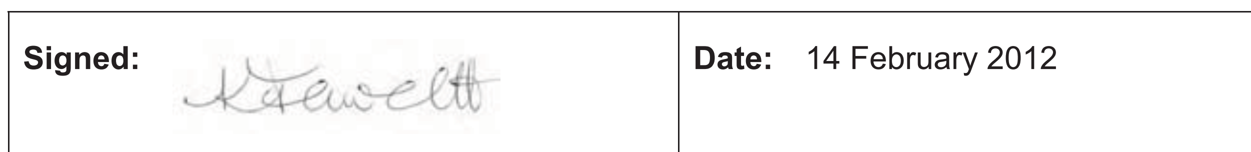
AGENDA ITEM NO: 12

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 23 FEBRUARY 2012

Title:	**PATIENT CARE QUALITY REPORT**
Responsible Director:	Kay Fawcett, Executive Chief Nurse
Contact:	Michele Morris, 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:	• To indicate any implications, eg Clinical, Financial, Human Resources • To report any benefits, risks or costs associated with the decision
Recommendations:	The Board of Directors is asked to receive this report on the progress with Care Quality.



Signed:	**Date:** 14 February 2012

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
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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 Inpatient Survey

The Trust is currently taking part in the National Inpatient Survey, as required by the Care Quality Commission (CQC). The postal survey has been sent to 850 patients who were inpatients for one night or more in June 2011. The fieldwork completed in November. The National Benchmark results will be published by the Care Quality Commission in May 2012

2.2 Enhanced Patient Feedback

For the period ending 31 December, 23,774 items of feedback from patients, carers and the public has been received. This figure includes all the different methods of feedback including patient surveys, compliments, PALS contacts, complaints, and NHS Choices. This information forms the basis of a report to the Care Quality Group and is used to inform the actions taken by each Division to improve the experience of patients, carers and visitors.

In December there were 1667 responses to the electronic bedside survey bringing the total for the year to date to 16,519. The most positive responses 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 90 (out of 100). The least positive responses were for someone to talk about worries, noise at night, and conflicting information, and food which achieved scores below 80.

An action plan for improvement in 2011/12 has been agreed and

progress is monitored by the Care Quality Group and through the Back to the Floor programme.

The electronic Patient Experience surveys have been formulated for use on the trust internet site and will go live in February.

As part of the Regional Commissioning Framework 2012 / 13 from the Strategic Health Authority (SHA) there will be a requirement to include the “net promoter question” for inpatients from 1 April 2012. The question asks patients if they would recommend the service to family and friends, and will be used as a temperature gauge of patient satisfaction. Work is underway to facilitate the use of the question just prior to discharge and a reminder will be added to the discharge checklist.

2.3 Support for Carers

Following feedback from carers a task and finish group was set up to develop some key principles for supporting carers. This work recently won the runner up award at the National Patient Experience Network Awards held in Birmingham. The principles will be launched Trust-wide on 24 February.

3. Falls

3.1 Falls Assessment on PICS

The monitoring of the falls assessments on PICS continues and areas are targeted by the falls team to improve their compliance to assessment.

Month	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total	2359	2919	2909	2986	2984	2892	2851	3580	3564
% Assess-ments	67.8%	75.31%	80.25%	80.62%	79.81%	80.51%	78.52%	81.2%	81.82%
Total falls	213	225	193	235	216	195	198	236	204
Patient harm	34	34	39	41	51	35	49	50	35

The ongoing audit monitoring compliance with completing a falls assessment on PICS on admission continues. The areas not achieving 70% or who have a reduction in the % risk assessment from the month previous are contacted by the team and action plans for improvement are requested and monitored.

The Admissions lounge will be live on PICS from February and assessments completed in the area before theatre. Also the team are working with the informatics team to look at the rules around episode data on PICS to ensure all assessments are being added appropriately.

3.2 Harm from inpatient falls

There were 4 incidents in Q3 - 2011 that caused serious harm to patients. This is a 43% reduction from 7 to 4 falls compared with Q3-2010. These incidents will all be investigated to identify if they could have been prevented and what learning outcomes need to be achieved.

3.3 AHP collaborative work streams for Falls Prevention

The PICS group has agreed that the Ward Pharmacists will receive an alert when a patient in their area has been assessed at risk of falls. This will ensure that medication is reviewed along with the rest of the care.

3.4 Senior Nurse Forum

The Falls and Fracture Prevention Nurse Specialist attended the Senior Nurse Forum on the 2 February 2012 to update the senior nurses on the falls prevention service.

4. Care Rounds

In March 2011 "Care Rounds "were introduced to all inpatient wards across UHB with the aims of improving the quality, consistency and reliability of essential care elements, reducing patient harm and improving experience.

At the beginning of the project a set of metrics was agreed to be monitored monthly. The outcome measures that are associated with the implementation of care rounds are shown in the table below.

	2011											
Metric	**Jan** % Shown as a % of total number of patients admitted	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
4 hr Patient risk assessment on PICS , Falls	47%	51%	52%	68%	75%	80%	81%	79%	80%	78%	81%	82%
6 hr Patient risk assessment on PICS , Waterlow	46%	48%	48%	61%	70%	75%	76%	74%	76%	75%	78%	79%
0 > 24 hour Patient risk assessment on PICS , MUST	37%	40%	42%	50%	56%	62%	64%	62%	61%	64%	69%	72%
No of falls	236	229	230	212	224	192	234	215	196	198	236	204
Harm from fall reported	48	40	44	34	34	39	41	51	35	49	50	35
Referral to dietician	357	324	378	341	370	390	412	451	422	438	414	449
Grade 2 Pressure Ulcer **	32	36	37	42	48	40	44	46	45	68	72	61

** The pressure ulcer metric is complicated by the need to review and compare like for like data at the same time of year, direct comparison of ward size and case mix is not possible until each ward has been in place in QEHB for 1 year and this is further affected by classification and grading of pressure Ulcers which was changed on 1 April 2011.

5. Work on Safeguarding Adults and Children

5.1 Adult Safeguarding

During the period there have been thirty five new safeguarding adult investigations. Of these, twenty five were formal multi-agency alerts. The remainder comprised enquiries related to complex discharge arrangements. Four patients required independent mental capacity advocates to be appointed for changes to accommodation after discharge for patients lacking mental capacity to make such a decision. One deprivation of liberty authorisation has been given and two extensions of the same deprivation have been authorised. The reason for the two extensions relate to funding delays from Social Services for a specific care home and in order to seek a Guardianship order for the patient. There has been one serious case review request involving UHB which was downgraded to a detailed case review to be monitored by BSAB.

5.2 Safeguarding Children

There have been two requests from Birmingham Safeguarding Children Board for individual management reviews for Serious Case Reviews during the period. Three common assessment framework (part1) referrals were made to the Integrated Access teams both within the City and outside the City boundary.

6. Same Sex Accomodation

6.1 The revised Operating Framework for 2010/2011 made it clear that NHS Organisations are expected to eliminate mixed-sex accommodation except where it is in the overall best interest of the patient or reflects their personal choice.

6.2 Progress

On 14 January 2011 the Trust declared compliance having eliminated mixed sex accommodation within the hospital. The declaration is published on our external web site and we are required to make an annual declaration in relation to compliance.

6.3 Breach Declaration

Since December 2010 we have been submitted breach data in relation to incidents of mixed sex accommodation.

To date the following data has been submitted:

Year	Month	No of incidents	Number of patients affected	Internal RCA Outcome	Contract Review outcome
2010	Dec	0	0		
2011	Jan	0	0		
	Feb	0	0		
	Mar	1	4	Clinically Justified	Agree
	Apr	0	0		
	May	1	4	Clinically Justified	Agree
	Jun	2	5	Clinically Justified	Not yet reviewed
	July	0	0		
	Aug	0	0		
	Sep	0	0		
	Oct	0	0		
	Nov	0	0		
	Dec	0	0		
Total		**4**	**13**		

7. End of Life/Bereavement

7.1 One day Advanced Communication Skills workshop

Traditionally advanced communication skills training programmes have been delivered over a three day period. However, recognising that it is difficult for staff to be released from their clinical commitments, a one day advanced communication skills workshop is to be piloted. The course will focus on how participants have difficult conversations and break bad news to patients, their families and other health professionals. There are 2 workshops in May/June aimed at both medical and surgical consultants. As a part of the evaluation process of the pilot, patients and their families will be asked to complete pre and post workshop questionnaires on the communication skills of the candidates.

7.2 Bereavement

Improving Death Certification Process

The Trust will to be an ‘early adopter’ for the new Medical Certification process. This is planned to commence in March 2012. Medical Examiners will:

- Improve the quality and accuracy of medical certificates of cause of death
- Introduce a single system of effective medical scrutiny for all deaths that do not require a Coroner’s Post Mortem or Inquest and introduce a unified approach for burials and cremations
- Provide education, support and guidance in the completion of MCCD’s for junior doctors

- Facilitate a close working relationship with the medical examiner(s) and HM Coroner
- Provide improved information on causes of death to strengthen local clinical governance and public health surveillance
- Provide information, support, and assistance to bereaved relatives

7.3 Last offices Audit

The mortuary audit assesses the clinical practice of last offices against the standards as stated in the Bereavement Care Policy. Each Division has received their report and the lead nurse for bereavement will meet each ward within the divisions to ensure appropriate action plans are devised

8. Nursing Quality Indicators

The Nursing Quality Indicator group continues to progress implementation of a number of National and Regional Quality Indicators which are nurse specific and relate to care delivery. The care quality measures outlined in national strategies have been brought together within the existing quality frameworks outlined in the 2010/2011 Operating Framework, Quality Accounts and CQUINs. The measurement of these quality measures is now in place, they continue to be reported at the Care Quality Group, with each indicator lead presenting progress on a quarterly basis.

9. Complaints Report

9.1 Number of Formal Complaints by Month: November and December 2011

A total of 63 complaints were received in November 2011 and 45 in December 2011. This maintains the downward trend in complaints, a consequence in part, of pro-active triaging of complaints to more appropriate avenues of resolution (eg PALS, direct Divisional staff contact). This not only reduces the overall burden on the Patient Services team but also enables the Trust to provide a more responsive service to the complainant.

9.2 Patient Services Department actions

The Department continues to work hard to deliver a service that will meet the expectations of patients, their representatives and the Trust. Every effort is made to provide a personal service whilst observing “best practice” guidelines and meeting legislation. Wherever possible, complainants are contacted to discuss their concerns and to elicit their preferred method of resolution. This provides the opportunity to offer a fast-track complaints service, where arrangements are made for the complainant to receive a telephone call from senior medical or nursing staff. There are benefits to the Trust in providing a service in this way but, most importantly; it allows patients and the public to be reassured

that their complaints receive speedy and personal attention. The intention is that, rather than complainants being driven through a process, we deal very directly with their specific concerns and their desired outcomes.

9.3 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. A monthly complaints report is also presented at the Chief Executive's Advisory Group. Each quarter, a detailed analysis of complaints is presented to the Audit Committee and data are also included in quarterly updates to the Quality Account. Selected complaints form part of the Executive root cause analysis sessions into omissions in care and, where trends are identified; trust-wide actions can be implemented to prevent recurrence.

The Customer Care Facilitator has been meeting Divisional Associate Directors of Nursing to discuss issues around complaints, as well as any associated training needs, eg customer care training for staff where high levels of attitude or communication complaints are being received.

10. Discharge Quality

The Trust Policy stipulates that or 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.

10.1 Audit of practice

As part of the Quality Improvement Cycle during October 2011 the Trust undertook a large scale audit of current practice across all clinical divisions by reviewing over 1000 discharges. The aims were to identify areas of good practice and to explore where further action was required to improve the consistency and quality of discharge practices.

Key points arising from the audit

- The Admission Discharge Screening Tool was rarely used. Staff use the Nursing Assessment Document to identify discharge planning needs and where internal referrals to other health care professional are required.
- Expected date of discharge is not always recorded and varies between divisions .There is a function within PICS to record this but use is patchy and mainly medically led.
- Most patients are not informed of their planned date of discharge prior to the day they are discharged.

- OLOS (Outstanding Length of Stay) is not often checked or updated on PICS, this is driven by entering the estimated discharge date into PICS.
- Completion of the Nursing Discharge Letter varied across Divisions .The Nursing Discharge Letter was signed in 67% of cases; again this varies between Divisions
- The post discharge PALS survey suggests that patients are fairly happy with the discharge process

Actions Agreed

- 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 Discharge and Transfer of Care Policy and Procedure were amended following the audit and approved in January 2012. The ongoing audit of the revised procedural documents lies within Divisions and is included in the new policy.

- The audit outcomes have been developed into Divisional reports and Divisions are developing action plans specific to their services which are to be tabled at the Discharge Quality Group.

- Some amendments to PICS have enabled Nurses and Medical staff to enter estimated discharge dates into PICS. The PICS nursing discharge letter has been updated and includes a space for designation and for the registered nurse to print their name.

11. Recommendations

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

Kay Fawcett
Executive Chief Nurse
February 2012