AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 5 JULY 2012

Title:	**PATIENT CARE QUALITY REPORT**
Responsible Director:	Kay Fawcett, Executive Chief Nurse
Contact:	Michele Owen Deputy Chief Nurse; Extension 14719

Purpose:	To provide an update on the progress with care quality 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:** 25 June 2012

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 5 JULY 2012

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, completion of the "safety thermometer", discharge, pressure ulcer prevention 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 Inpatient Survey, as required by the Care Quality Commission (CQC). The postal survey was sent to 850 patients who were inpatients for one night or more in June 2011 and the response rate was 50%. The National Benchmark results were published by the Care Quality Commission in May.

Results were improved overall compared to last year. We remain broadly consistent with other Acute Trusts.

Specific areas in which the Trust has demonstrated improvement were:

- help with meals
- single sex accommodation
- noise at night

Key areas for further improvement:

- conflicting information
- discharge delays

2.2 Enhanced Patient Feedback

For 2011 - 2012, 33,701 items of feedback from patients, carers and the public have been received. This figure includes all the different methods of feedback including patient surveys, compliments, PALS contacts, complaints, and feedback from 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 May there were 1,337 responses to the electronic bedside survey bringing the total so far this year to end of May to 2,703. 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. These all achieved a score of over 95%. The least positive responses were for someone to talk about worries, noise at night, and conflicting information which achieved scores below 75%

The on line Patient Experience surveys went live on 1 March 2012. Work is ongoing with the Communications Team to promote the surveys to patients and the public. In particular it is anticipated that this will support an increase in feedback received relating to discharge from hospital.

The Patient Experience Team are currently exploring additional methods of obtaining feedback from patients about their discharge and their experience of attending the Outpatient's department. This is due to low response rates to the telephone surveys that focus on these aspects of care,

As part of the Regional Commissioning Framework 2012/13 from the Strategic Health Authority (SHA) there is now a requirement to include the friends and family "net promoter question" for inpatients from 1 April 2012. The net promoter score is identified by subtracting the percentage of detractors from the percentage of promoters. The results for May are detailed below:

	Week 1	Week 2	Week 3	Week 4	Week 5
START DATE	29/04/2012	06/05/2012	13/05/2012	20/05/2012	N/A
END DATE	05/05/2012	12/05/2012	19/05/2012	26/05/2012	N/A
3.1 Total number of inpatients in period (number of defined DISCHARGES within the period)	1032	894	1037	982	
3.2 Total number of responses in period (number of NPS responses from cohort in 3.1)	134	82	92	129	
3.3 Number of promoters	84	57	53	88	
3.4 Number of passives	37	15	25	29	
3.5 Number of detractors	13	10	14	12	

4.0 Net Promoter Score

	Week 1	Week 2	Week 3	Week 4	Week 5
4.1 Organisation NPS - weekly (automatically populates from data entered above)	52.98507463	57.31707317	42.39130435	58.91472868	#DIV/0!
4.2 Organisation Monthly (automatically populates from data entered above)	53.3180778				

3. Falls

3.1 Harm from inpatient falls

This update provides an overview of patient fall incidents which have been reported across the Trust in the financial year 2011-12 (April 2011 to March 2012).

There were a total of 2570 patient falls incidents reported Trust wide during 2011 -12 which showed a 2% decrease (42) compared to 2010 - 11, of the total reported incidents falls accounted for 2570 (20%) this is an average of 214 per month.

3.2 Subcategory of falls

Subcategory of falls	2011 year	2010 Year	2009 Year
Mobilising	769	729	629
Unknown cause	592	560	302
From bed	391	504	401
Toilet/Bathroom	351	327	148
From chair	205	181	143
Managed	109	80	55
Due to fit/faint	80	106	102
From commode	12	42	60
Transferring	61	83	60
Grand Total	2570	2612	1899

The most common type of fall reported was upon mobilising (30% - 769). In 2010-11 these accounted for 28% (729) of falls reported. The second most common type of fall reported was that of unwitnessed falls which increased by 6% (32) compared with 2010-11.

There has been a decrease in falls from the bed as compared with 2010. During 2011-12 the falls team have been working with the ward teams to ensure that patients at risk of falling from bed are placed on a hi/lo bed at the appropriate time.

Patient falls from the bed accounted for 15% of total falls reported (2011-12) compared to 26% (504) of all falls in 2010-11. Falls from a commode decreased by 29% (30) during 2011-12. Managed falls increased by 36% (29) from 80 (in 2010-11) to 109 in 2011-12

3.3 Severity of harm

27 falls resulted in moderate or major harm to a patient (10-11; 46) and included:

15 fracture neck of femurs

5 haematomas to the head (3 Sub/extra-dural haematoma & 2 Subarachnoid haematomas)

2 Fractured hips
2 Fractured arms
2 Fractured wrists
1 Fractured Shoulder

The number of fractures sustained during a fall has decreased (38%) from 34 in 2010-11 to 21 in 2011-12. There has been a reduction in major harm by 34% in 2011-12 compared to 2010-11.

3.4 Serious Incidents Requiring Investigations (SIRIs)

Key themes learnt from the SIRI investigations throughout 2011-12 are as follows:

- The need for timely assessment of patients' risk of falls in ED/CDU and on transfer
- Communications on transfer need to include any history or risk of falls
- Utilisation of Communication transfer sheet.
- Reassessment needed after a fall has occurred
- Timely interventions with regards to Radiology (X-Rays & scans) to meet NPSA requirements
- Identification of fractures and timely management plan.
- The need to follow protocol of Neurological observations if the patient has hit their head or there is suspicion that they may have hit their head during a fall.

3.5 The Falls Team.

The appointment of a Falls Clinical Educator in March 2011 has enabled there to be a review of every patient reported to have fallen within 48 hours of the incident to ensure the staff have completed the correct assessments and implemented the actions to ensure patient safety. Additionally the Falls Educator has met with individual staff highlighted in the SIRI process or incident reports for the purpose of training and reinforcing good practice.

This post will enable the falls team to meet the mandatory training required by NHSLA Standard 4.

4. Safety Thermometer

This year there are 4 National CQUIN's, one of these uses the NHS Safety Thermometer which is a standardised data collection / improvement tool that allows NHS organisations to measure patient outcomes in four key areas:-

- Pressure Ulcers
- Falls
- Urine infections and urinary catheter use
- VTE (Venous Thromboembolisim)

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.

Methodology

- The data is collected monthly as point prevalence outcome data against a pre set criteria by nursing staff.
- The data is collected on the same date throughout NHS organizations
- Data is collected on all inpatients at the time of the survey; there are nationally agreed exclusion criteria, which ensure consistency of measurement.
- At UHB a local data collection tool has been developed to capture patient outcome measures , the data is then subject to further review and validation prior to submission

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

The first 2 months audits have been completed and the outcome data will be reported each quarter with Q1 data being shared following the June 2012 audit.

5. Work on Safeguarding Adults and Children

5.1 Adult Safeguarding

During the period there have been forty new safeguarding adult investigations. Of these, twenty five were formal multi-agency alerts. The remainder comprised enquiries related to complex care arrangements. Four patients without family or close friends required independent mental capacity advocates to be appointed for serious medical treatment and changes to accommodation after discharge for patients lacking mental capacity to make such decisions. Two DoLS assessments were made but did not proceed to the need for authorisation of deprivation of liberty. There were three requests for domestic homicide reviews and in one case both adults identified had attended the Trust.

5.2 Safeguarding Children

There were no requests from Birmingham Safeguarding Children Board for individual management reviews for Serious Case Reviews during the period. Two referrals were made to the integrated access teams where adults presented to ED and had the responsibility for the care of children and one call for advice was received from sexual health

services. One level 3 MAPPA case is ongoing where an adult patient poses a significant risk to those less than 18 years of age.

6. End of Life/Bereavement

6.1 Rapid discharge Pathway

A rapid discharge pathway for patients who wish to die at home is currently under development. Internal processes such as the identification of patients and prompt access to discharge medications are under review. There is already an agreement with West Midlands Ambulance Service to transfer dying patients within one hour and we have recently agreed an escalation process with community services, to ensure that appropriate support services are in place.

6.2 Bereavement Conference

The Third National Bereavement conference Small Actions Big Difference was held at UHB on 15th May 2012. Over 200 delegates attended from across the country. The conference highlighted the work of the Birmingham Bereavement Project and the development of a seamless model for bereavement across traditional boundaries.

6.3 Follow up care and compassion telephone calls

The bereavement care office carried out Care and Compassion telephone calls from April 2011 –March 2012. The service has been very well received by relatives and provides a Conclusion to care and a bridge between the hospital and 'home' for the relatives. The service was made available to 1130 relatives during the pilot of whom 725 requested a call.

7. Pressure Ulcer Prevention / Management

Background

All patients are assessed using a Waterlow risk assessment tool on admission and where their condition changes or at least weekly. Within UHB this assessment is recorded on PICS and performance is monitored through a variety of measures including the clinical dashboard.

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 determines if the pressure ulcer was avoidable or unavoidable.

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	9	5	8	3	25
Q4	15	1	11	5	32
Total	34	14	37	16	100

2012/2013	Division A	Division B	Division C	Division D	Total
Q1	8	6	13	2	29
Q2					
Q3					
Q4					
Total					

There is a monthly pressure ulcer action group (PUAG) which supports and monitors the Trust action plan to reduce avoidable hospital acquired pressure ulcers. Divisions have developed sub groups which cascade the information and actions agreed at PUAG.

A local CQUIN has been agreed with commissioners which will be agreed following the end of Q1 and validation of all Grade 3 &4 RCA's, a target for improvement will be agreed which will be monitored monthly .

8. Complaints Report

8.1 Number of Formal Complaints by Month: March and April 2012

A total of 74 complaints were received in March 2012 and 59 in April 2012. Complaints numbers continue to vary monthly; although the sustained, pro-active triaging of complaints to more appropriate avenues of resolution (e.g. PALS, direct Divisional staff contact) has ensured that the overall trend is downwards. This process has enabled the Trust to provide a more responsive service to the complainant.

8.2 Complaints actions

In order to provide an improved service to patients and relatives who have concerns about their experience at the Trust, a new department is being created in July 2012 which will encompass Complaints (Patient Services), PALS and Customer Care. The Head of Patient Relations will have overarching responsibility for these services, whilst a Patient Relations Manager will be responsible for the day to day management of these functions, as well as the Patient Experience team. The aim is to deliver a seamless service, where there is a single point of contact for concerns, which will then be directed to the most appropriate route, having been triaged by the Chief Nurse as currently.

8.3 Trust actions in response to complaints

A revised version of the Complaints and PALS elements of the Datix database system, where Incidents and Legal Claims are also recorded, is nearing completion which will enable Divisional staff to have direct access to the complaints for their areas. This will also provide a means of highlighting and capturing the learning from individual complaints.

Customer care training sessions will continue to be delivered to areas where negative feedback has been received about staff attitude or communication.

9. Discharge Quality

A Trust wide Discharge Quality group has been developed to improve the discharge experience and ensure adherence with the discharge policy. Actions taken in the last quarter include:

- Development of a trust wide action plan for improvement.
- The 2012 Discharge and Transfer of Care Policy and Procedure were approved in January 2012.
- 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.

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.

10. Recommendations

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

Kay Fawcett
Executive Chief Nurse
25 June 2012