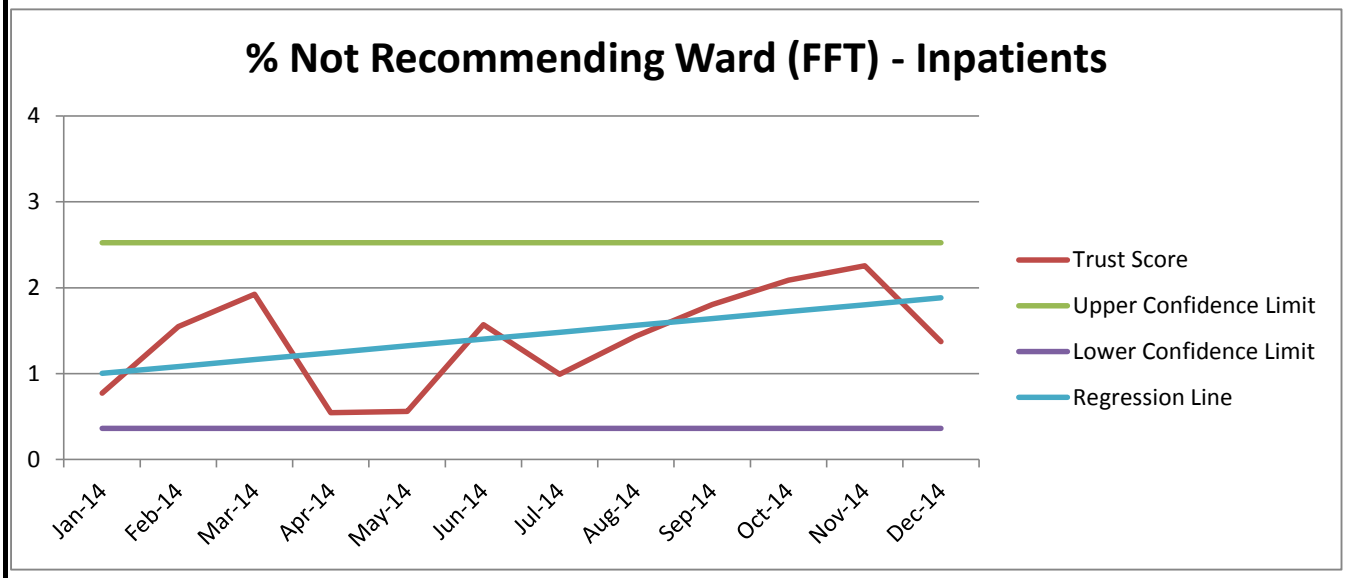
Brighton and Sussex University Hospitals NHS Trust

Safety and Quality Scorecard - How Can I Be Sure….

Month: January
Year: 2015

Metric description	Apr 13 - Mar 14	Apr 14 - Mar 15
I will be treated with kindness and compassion		
% Not Recommending Ward (FFT) - Inpatients	**1.8**	**1.6**
% Not Recommending - A&E	**15.0**	**11.6**



Following consultation the methodology for calculating the Friends and Family Score has moved from using the "Net Promoter Score" to a simpler calculation based on the percentage of patients who would and the percentage of patients who would not recommend their care provider.
The above graph plots the percentage of patients who would not recommend the ward they were discharged from. Overall the percentage of patients who would not recommend their ward is lower this financial year (1.6%), however, because of October's and November's higher rates of dissatisfaction (2.1% and 2.3%) the regression line is indicating an upward trend. Nationally, 1.7% of inpatients would not recommend their ward. Nationally 6.4% of patients would not recommend the A&E department they attended, this compares to 11.6% in BSUH. Response rates in A&E remain low, although have shown some improvement in RSCH A&E, with a dedicated member of staff now supporting data collection.

I was *"Treated with kindness and compassion"*	**4.76**	**4.76**

Source - Patient Voice Inpatient 1=Disagree Strongly, 5=Agree Strongly

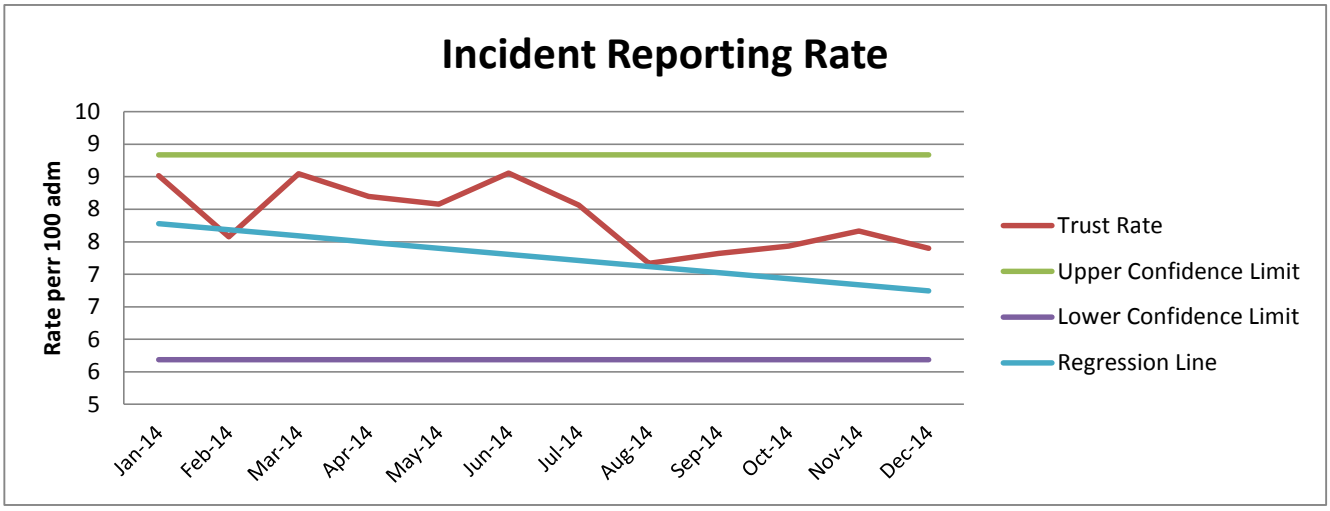
Source - Patient Voice Inpatients: ***Something that was good***

I have been treated with the utmost care and consideration since arriving on the ward. The standard of nursing is of the highest with nothing too much trouble and the kindness and approachability of all staff has been much appreciated. A very hard working team which gives 100% all the time - thank you all. (Albion and Lewes ward)

Source - Patient Voice Inpatients: ***Something that could be improved***

When using the shower there is no sign pointing to the hot and cold water. It would be nice for a hook to hang up clean clothes in the shower room.

Metric description	Apr 13 - Mar 14	Apr 14 - Mar 15
The care I receive will not harm me		
Incident Reporting Rate - per 100 admissions	7.7	7.8
Total Incidents Reported	8449	6399
Reported Externally as an SI	36	44
Never Events	1	5
Severe / Catastrophic	13	12
Moderates	148	159



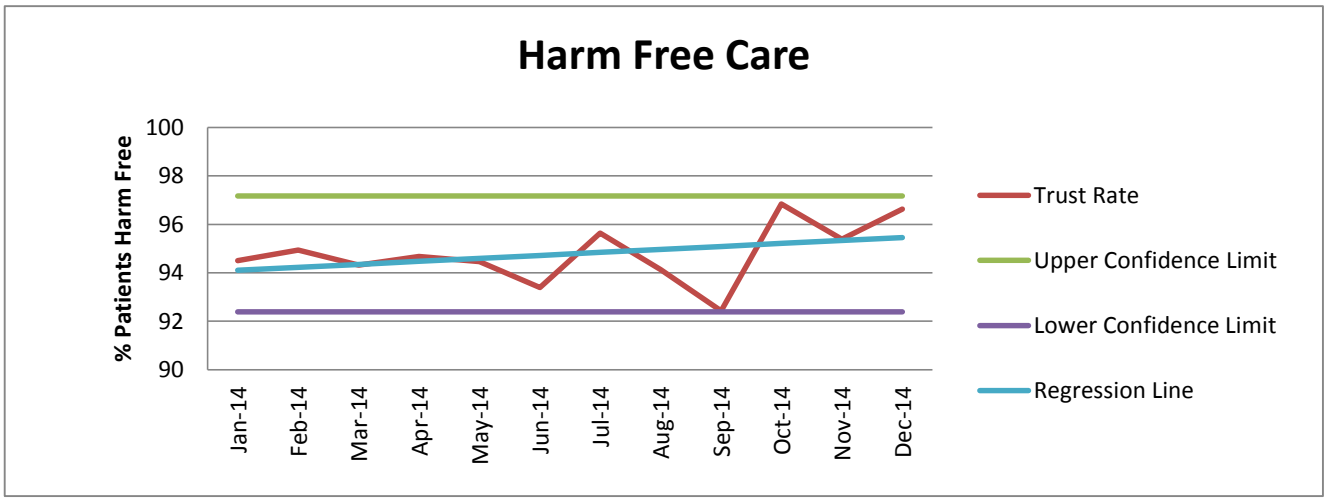
At month 9 the overall rate of incident reports for this financial year is higher than last year. However, the number of incidents reported monthly in the past five months is on average 100 fewer each month compared to the previous five months when an average of 768 reports per month were submitted.
Although the number of severe and moderate harm incidents appears to be much greater pro rata than last year, it should be noted that incidents being reviewed retain their original severity coding until the investigation is completed. Consequently a large proportion of the 2014-15 incidents are likely to be downgraded. The number of SI's reported this year is higher because the definition of an SI has been expanded to include all patient falls with a fracture.

Duty of Candour

The national start date for Trusts to implement the statutory Duty of Candour was moved from October to the end of November. As part of the Trust's commitment to learning, the Safety and Quality Team are now producing podcasts at the end of every Serious Incident investigation. Although all Serious Incident reports are available in the SI directory on the Trust's Intranet, the podcasts are designed to be an easier way of sharing the key findings and promote discussion. The audio file contains a brief summary of the incident, the key lessons learnt, and actions taken. The audio file will be created at the end of every Serious Incident investigation by the investigator.

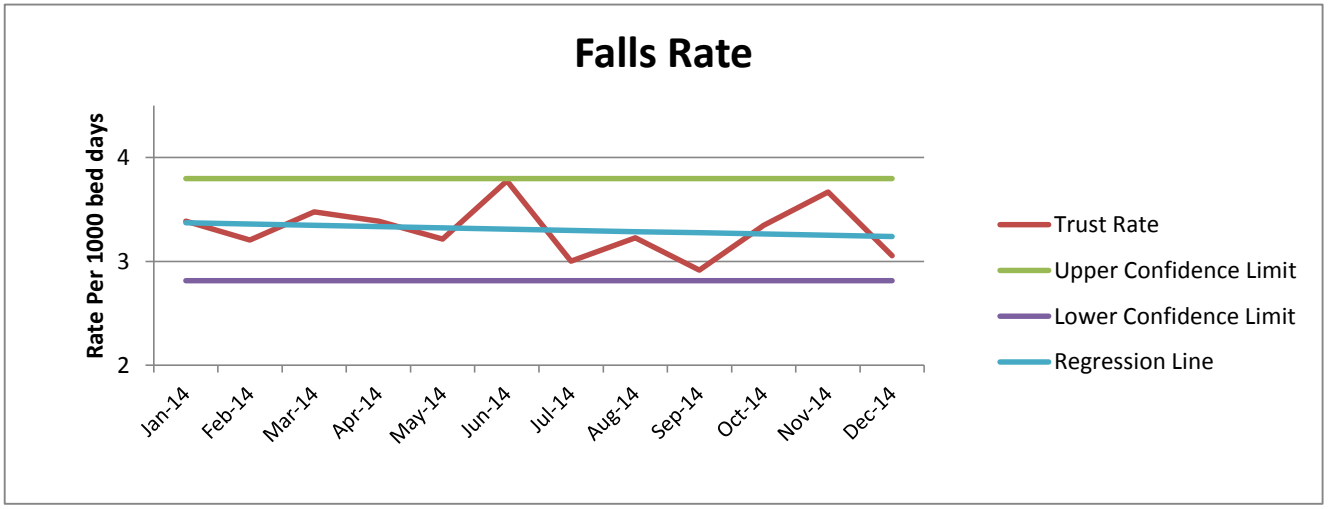
Harm Free Care

% of patients that experience **Harm Free Care**	94.9	94.8



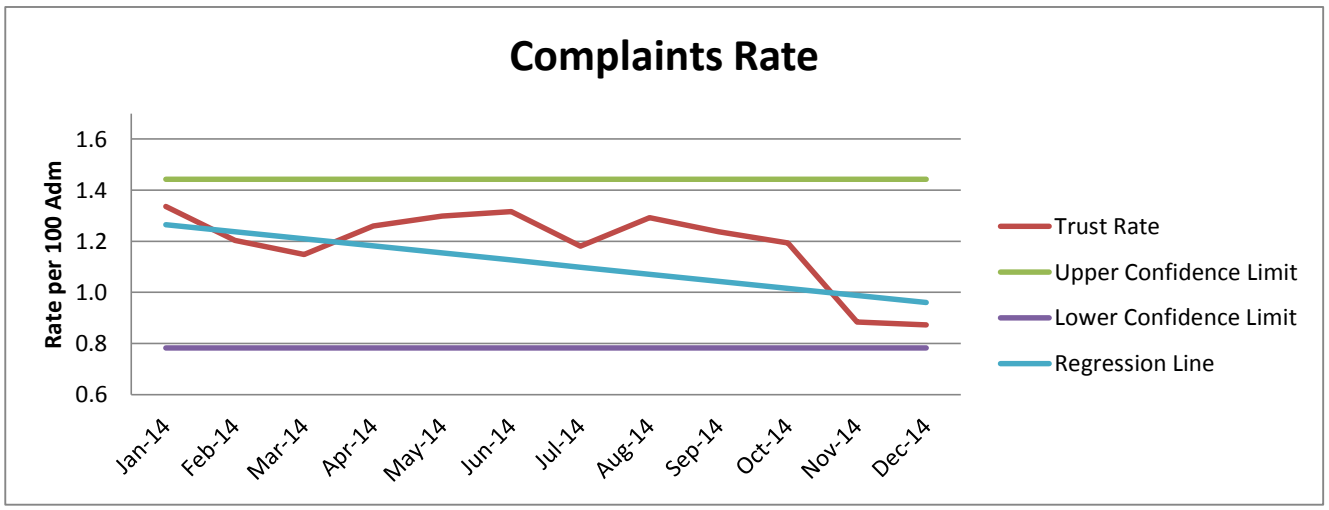
The percentage of patients experiencing harm free care in BSUH (the Safety Thermometer see glossary) is slightly better than the national average of 92.7%.

Falls Rate per 1000 bed stay days	3.48	3.29
Pressure Damage per 1000 bed stay days	0.47	0.46

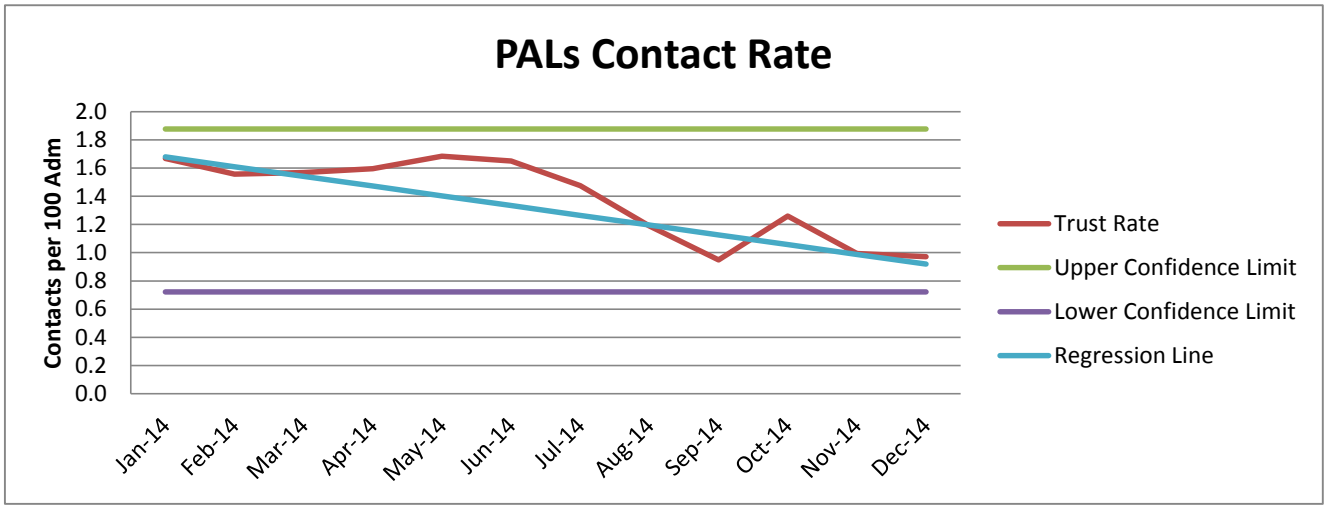


The falls rate is still continuing to fall although not as steeply as in previous years. The rate of reduction this financial year is 5.5%, overall since 2009-10 the rate has come down by 48%.
The pressure damage rate for this financial year is static, although overall the rate is down 70% on 2010-11 when the rate was 1.5 per 1000 bed stay days.

Metric description	Apr 13 - Mar 14	Apr 14 - Mar 15
Feedback on my experiences will be acted upon		
Complaints - Rate per 100 Admissions	1.17	1.17
PALs Contacts - Rate per 100 Admissions	1.46	1.31



As a consequence of the lower number of complaints received in November and December, the complaints rate for this financial year is identical to last years at 1.17 per 100 admissions. For the past two years the complaints team has on average received 107 complaints per month, however, as with the previous year, in November and December this number dropped to 79 and 80 respectively. Elective Orthopaedics (n=40) and Digestive Diseases (n=34) received the most complaints during this quarter. Communication (n=112) and clinical care (N=84) were the most frequenly raised issue in the complaints made.
As previously discussed we are, wherever possible, managing complaints quickly and without recourse to a formal written response from the Chief Executive. Greater emphasis continues to be given to the role of PALS and a pilot project, increasing the PALS team by one WTE has paid significant dividends with 42% of complaints received April – October now having been resolved by Early Resolution.



Like complaints, the number of PALs contact was lower in November and December with 90 and 88 contacts compared to an average of 131 over the past two financial years. The overall contact rate for PALs is lower this year at 1.31 per 1000 bed stay days.

December's - Patients 1st focuses on:

Pressure damage can cause significant pain and grade 3 or 4 damage puts patients at risk of severe infection and increased mortality. The estimated annual cost to the UK of treating pressure damage is 2 billion pounds. 97% of that cost is nurses' time; the remaining 3% is spent on pressure relieving equipment. The cost of treating an incidence of grade 3 or 4 pressure damage is about £14,500

Regular changing of position is the most effective way to prevent and relieve pressure damage. No matter what pressure relieving aids are being used, it's vital to ensure a patient's position is changed every 2 hours. Research has shown that even a 30° tilt is sufficient to relieve pressure.

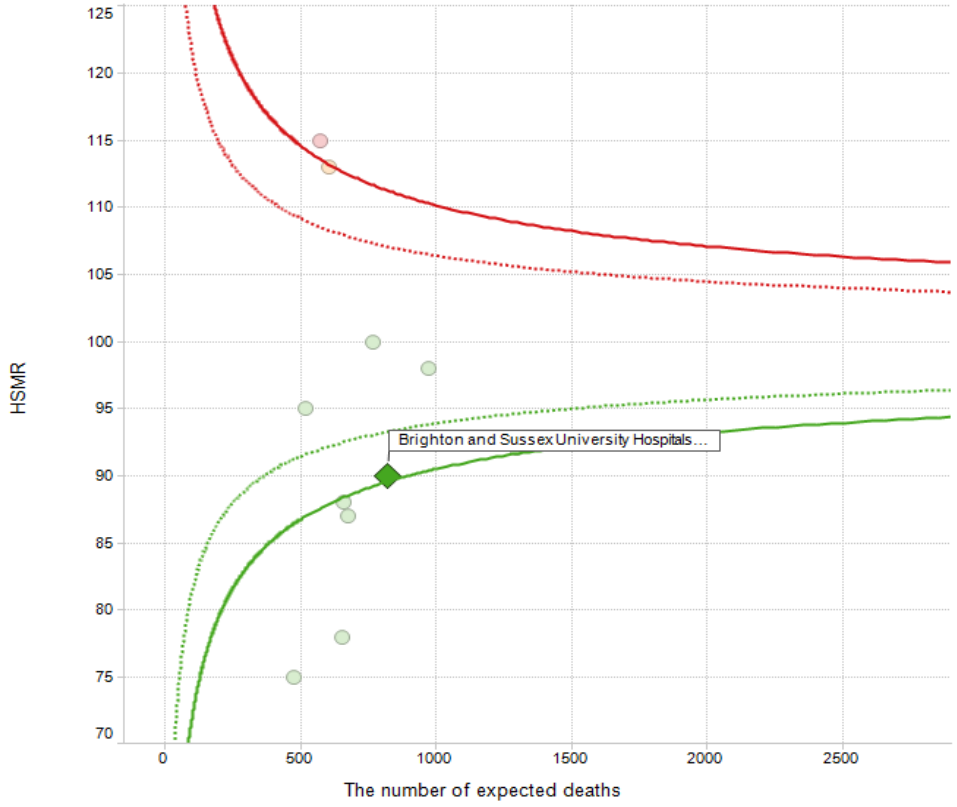
Hyperlink to Patients 1st

Metric description	Apr 14 - Mar 15	Apr 13 - Mar 14
I will be involved in decisions that effect me		
I was Involved in decisions about my treatment and care	4.41	4.45
Source - Patient Voice Inpatients: ***Something that was good***		
I was so impressed by the nursing team who have given me so much. Also the doctors who always try to explain their decision. (Baily)		
Source - Patient Voice Inpatients: ***Something that could be improved***		
Where possible when a decision is made to be discharged to be kept on a ward related to your condition. I had a back injury/operation, the last 2 or 3 days were spent in the eye hospital		
I am treated fairly as an individual		
I am treated as an individual and my needs are recognised	4.61	4.62
Source - Patient Voice Inpatients: ***Something that was good***		
All the nursing staff… seem to know what is needed by patients before they do (Howard 1)		
Source - Patient Voice Inpatients: ***Something that could be improved***		
Occasionally nurses get distracted when on their way to get something and go off to do another job. Don't always ask if patients are deaf or need glasses. (Catherine James & Egremont)		

Metric description	Apr 13 - Mar 14	Apr 14 - Mar 15	Overall
I will receive the best possible care			
Hospital standardised mortality ratio HSMR			
Expected number of deaths	1395.9	817.8	2213.7
Actual Number of Deaths	1357	735	2092
HSMR	**97.21**	**89.97**	**94.5**
HSMR 95% Lower CI	92.1	83.5	90.5
HSMR 95% Upper CI	102.5	96.6	98.6

The funnel plot below illustrates the position of BSUH in relation to its current HSMR compared to other Trusts in the South East.
The plot illustrates that mortality in BSUH is lower than expected. For the period April 2013 to date the overall HSMR is 94.5%. This equates to 122 fewer deaths than expected.

HSMR Funnel Plot

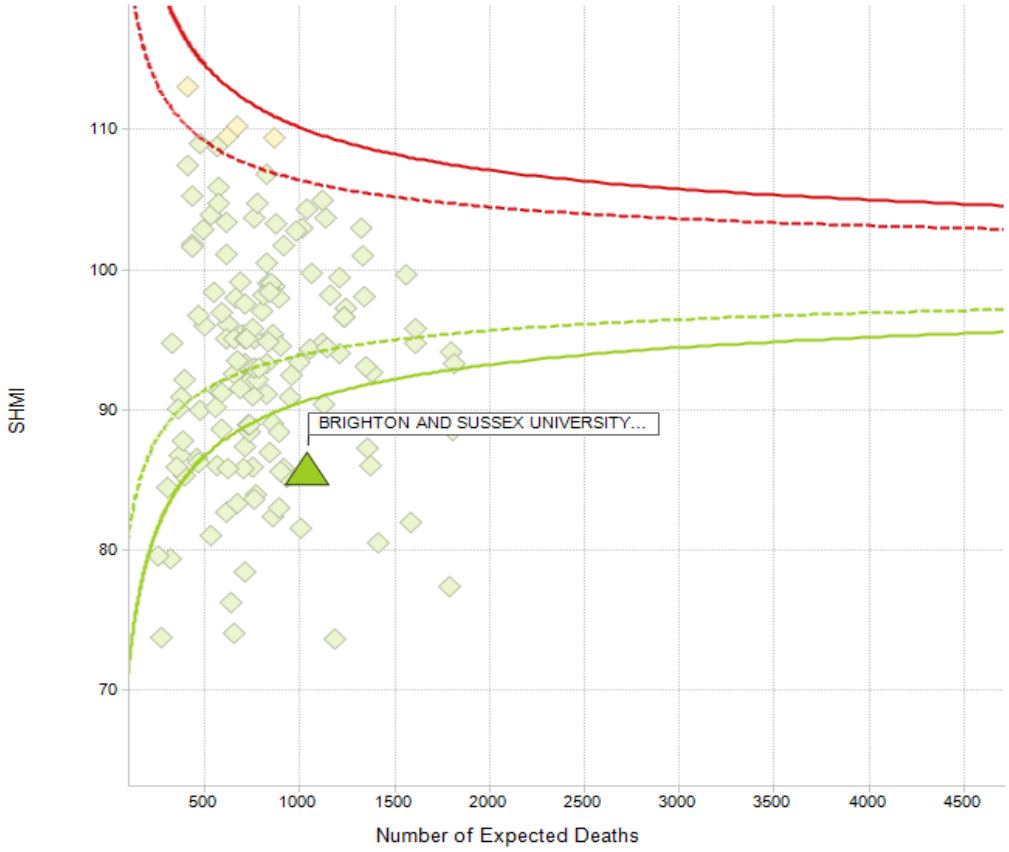


I will receive the best possible care

Metric description	Apr 13 - Mar 14	Apr 14 - Mar 15	Overall
Summary Hospital-level Mortality Indicator	96.50	85.81	93.22
SHMI 95% CI Lower	92.60	80.30	90.0
SHMI 95% CI Upper	100.60	91.60	96.5
Expected number of deaths	2354.4	1040.7	3395.1
Number of patients discharged who died in hospital or within 30 days	2272	893	3165

The funnel plot below illustrates the position of BSUH in relation to its current SHMI compared to other Trusts nationally.
The plot illustrates that mortality in BSUH is lower than expected. For the period April 2013 to date the overall SHMI is 93.22. This equates to 230 fewer deaths than expected.

SHMI Funnel Plot



Brighton and Sussex University Hospitals NHS Trust

Safety and Quality Scorecard - How Can I Be Sure….

Glossary

Friends and Family Test

Since April 2013, patients have been asked whether they would recommend hospital wards, maternity and A&E departments to their friends and family if they needed similar care or treatment.
Friends and Family Test results were originally calculated using “Net Promoter Score” methodology. The score being calculated using ‘proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent’.
Following consultation the score is now calculated on those who would and those who would not recommend their hospital ward.

Patient Voice

Patient Voice is the Trusts questionnaire that is handed out to patients upon discharge. The questionnaire includes the Friends and Family question and 16 other questions that are based on frequent patient complaints, concerns or incidents. Approximately 700 questionnaires are completed each month; the results are delivered to individuals wards as part of the monthly metric reports.
The narrative feedback from Patient Voice is used to generate the You said - We did actions which are displayed on the ward posters.

Serious Incident (SI)

Serious incidents requiring investigation were defined by the NPSA’s 2010 National Framework for Reporting and Learning from Serious Incidents Requiring Investigation. In summary, this definition describes a serious incident as an incident that occurred during NHS funded healthcare which resulted in one or more of the following;
• unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
• a never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death.
• a scenario that prevents, or threatens to prevent, an organisation’s ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
• allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
• loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.
The types of incidents that we are required to report has expanded over the past 12 months and now includes all falls with a fracture and any patient that develops a grade 3 or grade 4 pressure damage as an inpatient.

Safety Thermometer

Harm free care' is described as a new mindset in patient safety improvement. The aim is to deliver harm free care as defined by the absence of pressure ulcers, falls, CA-UTI and VTE

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during a 3 day period each month. All inpatient areas with the exception of paediatrics take part in the survey. The % of Harm free delivered by individual wards is reported each month via the wards metric reports.

Never Events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They include incidents such as:

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy

Duty of Candour

Candour is defined in the Robert Francis report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

Hospital Standardised Mortality Ratio - HSMR

The hospital standardised mortality ratio (HSMR) compares a hospital's mortality (death) rate with the overall average rate. The calculation is based on 56 diagnosis which account for 80% of inpatient deaths.
HSMR is calculated as a ratio of the actual number of deaths to the expected number of deaths among patients in acute care hospitals. An HSMR of 100 indicates there is no difference between the hospital's mortality rate and the overall average rate. Therefore a rate greater than 100 means the hospital's mortality rate is higher than the overall average and a rate lower than 100 means the hospital's mortality rate is lower than the overall average.
When evaluating the HSMR it's important to also look at the upper and lower confidence limits as these will give an indication of the significance of the HSMR.

Summary Hospital-level Mortality Indicator - SHMI

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England. Like HSMR the SHMI is calculated on the ratio between the actual number of patients who die against the number that would be expected to die. SHMI calculations are also risk adjusted to take account of the variations in patients presenting.
Unlike HSMR the SHMI includes all hospital deaths and those who die within 30 days of a hospital admission regardless of their diagnosis.