ENCLOSURE 6

Birmingham Women's NHS
NHS Foundation Trust

SUBJECT :	Quality Report March 2013
REPORT BY :	Peter Thompson, Medical Director and Helen Young, Director of Nursing and Midwifery
AUTHOR :	Peter Thompson, Medical Director, Helen Young, Director of Nursing and Midwifery and Michelle Walsh, Quality and Compliance Manager

RECOMMENDATIONS

The Board are invited to review both this report and the quality dashboard, and note the issues highlighted in the executive summary.

Links to Strategic objectives	To deliver an excellent experience that exceeds our patients' expectations (Patients) Patient Experience: • To create a culture of two way communication involving all patients in their care – 'no decision without me' • To focus on areas that show least patient satisfaction to improve patient care year on year • To continue to examine different methods to capture patient experience and feedback • To maintain a culture in which customer care is seen as a critical part of achieving an excellent outcome for patients • To actively embrace the 'patient revolution' • To ensure that patients always have information to make choices and are treated with dignity, honest and respect
	To consistently deliver clinical and laboratory outcomes that place us amongst the top hospitals (Excellence) Trust-wide: • To ensure the Trust continues at the leading edge of quality, demonstrating this openly and publicly to our stakeholders.
Links to BAF risks	Commissioners adjust their choices to reflect new player/perception of Trust services
	Quality of care needs to meet Trust and patient expectations
Links to compliance requirements	Care Quality Commission: Essential Standards of Quality and Safety CQUINS

EXECUTIVE SUMMARY

This monthly report presents the data from the month of February 2013 and is to be presented at Management Board in March 2013.

Together with the Quality dashboard, it details the progress against the quality metrics for the Trust. It summarises the learning and recommendations from the root cause analyses completed, as well as outlining feedback from users of our services.

The report is divided into three sections following the three domains of quality: safety, experience and effectiveness (Darzi, 2008).

The key messages from the report are:

Safety:

- 7 SIs reported

Experience:

- Friends and Family Test down to 75, but still above target

Effectiveness:

- CQC unannounced visit - compliant with the 2 standards inspected
- Breast feeding initiation and WHO checklist improving
- Unexpected admissions to NNU will need re baselining in new year

1. PATIENT SAFETY

1.1 Weekly Patient Safety Indicator results

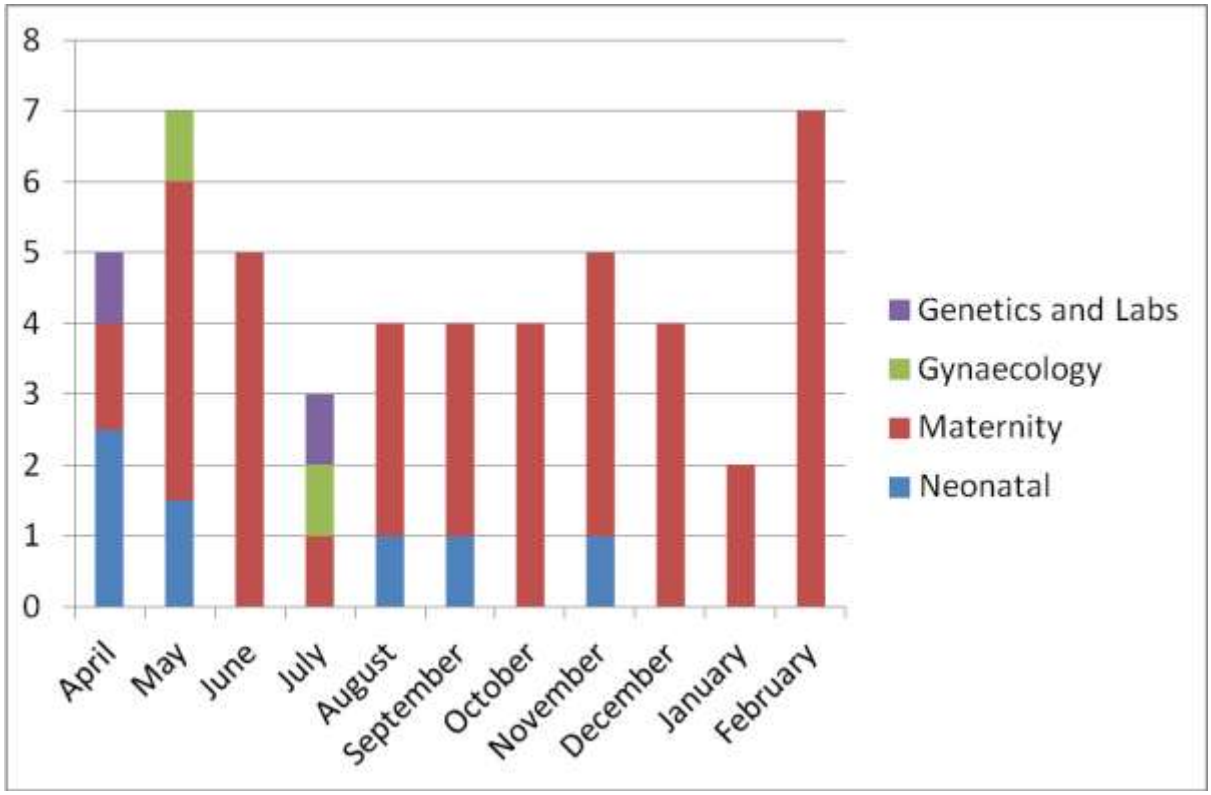
Table 1 – Patient Safety Indicator Results as at 15/03/2013

Indicator	Number of weeks since last occurrence (start date 7/1/2010)	Number of occurrences year to date, commencing from 6th April 2012 (figs in brackets refer to comparable numbers this time last year)
MRSA bacteraemia	1 year 45 weeks	0 (1)
Clostridium Difficile	2 years 30 weeks	0 (0)
Inadvertent bowel or bladder damage during gynaecological surgery	21	4 (10)
Unexpected returns to gynaecology theatre	6	6 (14)
Caesarean sections for placenta praevia where the consultant anaesthetist and obstetrician were not present	32	1 (2)
Inborn babies that require therapeutic hypothermia for presumed peripartum hypoxia	5	9 (15)
Ventilated inborn babies below 28 weeks gestation where administration of surfactant within 1 hour of birth was not achieved	17	1 (2)
Inborn births before 25 weeks where the neonatal consultant was not present at the resuscitation when required to be present by the Trust's early care guideline	15	6 (3)
Incorrect laboratory report released by genetics laboratories	21	2 (3)

1.2 Serious Incidents (SIs)

Seven SIs were reported during February 2013, which is one above the estimated occurrence of six per month. This threshold target is calculated on the monthly average of reported SIs during 2011-12.

Table 2 – SIs occurring during 2012-13 by Directorate



1.3 Feedback from root cause analysis (RCA) reports

Four RCAs reports were reported to the Patient Outcome Committee on 1st March 2013 relating to a possible delayed diagnosis, 2 unexpected admissions to the Neonatal Intensive Care Unit (NICU) and a term IUD. All SIs were graded as Grade 1: Some suboptimal care, but different management would have made no difference to the outcome.

W12334 - Possible delayed diagnosis

An investigation was undertaken following an incident regarding the diagnosis of a woman with cervical cancer postnatally. The case was reported to the Trust by a consultant from the Oncology Centre as concerns were raised that there were missed opportunities to diagnose the woman's condition.

The case looked in detail at the antenatal care that the woman received, particularly at her admissions with repeated post coital bleeding (PCB) and also at her referral postnatally for continued vaginal bleeding.

A multi-directorate meeting was held to discuss the care provided and the root cause was agreed at the meeting that there was no delay in diagnosing her condition.

The woman was seen during her pregnancy by an experienced gynaecologist and colposcopist who was on duty as the Obstetric 'Senior Registrar', she saw no features at that time suggestive of cervical cancer, nor did the consultant who saw her postnatally, and the team agreed at the meeting that this was an unusual presentation of an uncommon malignancy.

The main issue highlighted at the meeting was that there was no information sent to the GP regarding PCB following discharge from the ward. Whilst adding more information to the summary would not have changed the outcome, it was felt that it maybe a valuable way of informing GPs of pregnancy related issues now that formal discharge letters are no longer sent.

The incident was therefore graded as Grade 1: Some suboptimal care, but different management would have made no difference to the outcome.

W12418 - Unexpected admission to NICU for intensive care

An investigation was undertaken into the patient journey and care received by a woman and her baby who was unexpectedly admitted to NICU for intensive care following birth.

She was initially booked under consultant led care due to hypothyroidism which was being treated with Thyroxine, and later referred back to midwifery led care. She was admitted for induction of labour at 41+5 weeks and progressed to a forceps delivery the following day. The CTG had been interpreted as pathological and there was thick particulate meconium noted. The baby was transferred to NICU following birth due to a failure to maintain regular respirations.

The root cause of the outcome for the baby is meconium aspiration.

The following issues were highlighted as giving cause for concern but did not impact on the outcome - sequential use of instruments for delivery not reported on Datix, incomplete operation notes, awareness of birth centre suitability criteria and the CTG on admission in early labour was incorrectly categorised. An action plan has been developed to address these issues. The incident was therefore graded as Grade 1: Some suboptimal care, but different management would have made no difference to the outcome.

The review of the case highlighted an example of good practice - Continuous Positive Airway Pressure (CPAP) was available on delivery suite for resuscitation purposes.

W12435 - Term Intrauterine Death

An investigation was undertaken into the patient journey and actual care received by a patient who suffered an intrauterine death at term. The woman was a 22 year old woman with a normal BMI. She had no medical or social problems. This was her first pregnancy. The woman was booked under midwifery led care and received the appropriate level of antenatal surveillance. Her baby was born with no apparent abnormalities apart from a birth weight below the 1st centile on the mother's customised GROW chart. The provisional post-mortem report showed the baby had a small thymus which is reflective of chronic intrauterine stress. The placenta was normal in size, and did not show any obvious cause to explain the very low birth weight, therefore samples have been sent for genetics.

The investigation undertaken concluded that the root cause of the antenatal intrauterine death is IUGR despite appropriate screening.

The following issue was highlighted as giving cause for concern, although this did not impact on the outcome - the woman waited over 90 minutes before being attended to in triage. The incident was therefore graded as Grade 1: Some suboptimal care, but different management would have made no difference to the outcome.

Actions have been identified to improve the pathway of patients treated in triage, including the development of the Triage Integrated Care Pathway, and a plan for interim procedures to be developed until the launch of the new pathway. The review of the case highlighted an example of good practice - quick referral from the community midwife when the fundal height measurement had crossed centiles.

W12493 - Unexpected admission to NICU

An investigation was undertaken following an unexpected admission to the Neonatal Intensive Care Unit (NICU).

This baby did not require intensive care / ventilatory support and therefore it did not appear to meet the criteria for SIRI reporting, however, when a request was received from the mother to view her case notes and have some feedback from an investigations (which was she was told by an unidentified member of staff would occur) it came to light that this infant had significant Hypoxic Ischemic Encephalopathy (HIE). This was discussed with the Medical Director and it was agreed that due to the significant injury to baby that this would be reported and investigated as an SI

The woman laboured spontaneously, but because of a delay in first stage and suspicious fetal monitoring an emergency caesarean section was performed. The baby was born in poor condition, but with normal cord gases and was admitted to NICU requiring high dependency care for respiratory distress. The baby subsequently began to have apnoeic episodes at 2 hours of age associated with seizures. Subsequent MRI showed widespread changes consistent with HIE. The root cause was agreed as a probable hypoxic ischaemic event at some time (unknown) prior to delivery.

There were several care delivery issues highlighted during the investigation of this case which have resulted in learning points but did not adversely affect the outcome for this mother and baby, including delays in the timing for FBS, equipment was not prepared prior to delivery, although all equipment was available and the baby should have been transferred to NICU with oxygen support. The incident was therefore graded as Grade 1: Some suboptimal care, but different management would have made no difference to the outcome.

The review of the case highlighted an example of good practice - there was evidence of clear documentation and good communication by all staff involved to the family.

2. PATIENT EXPERIENCE

2.1 Complaints

7 complaints were received in February 2013, which is 6 less than the monthly estimation of 13.

Table 3 – Complaints received by Directorate

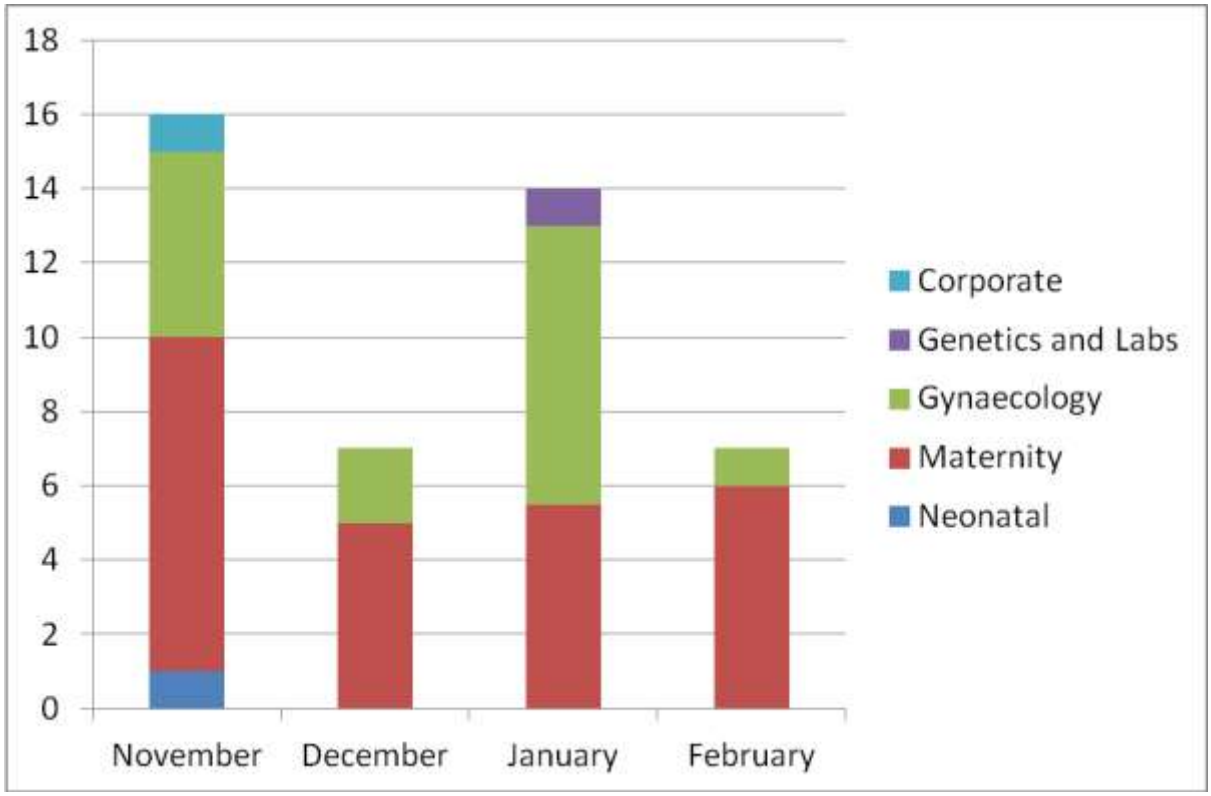
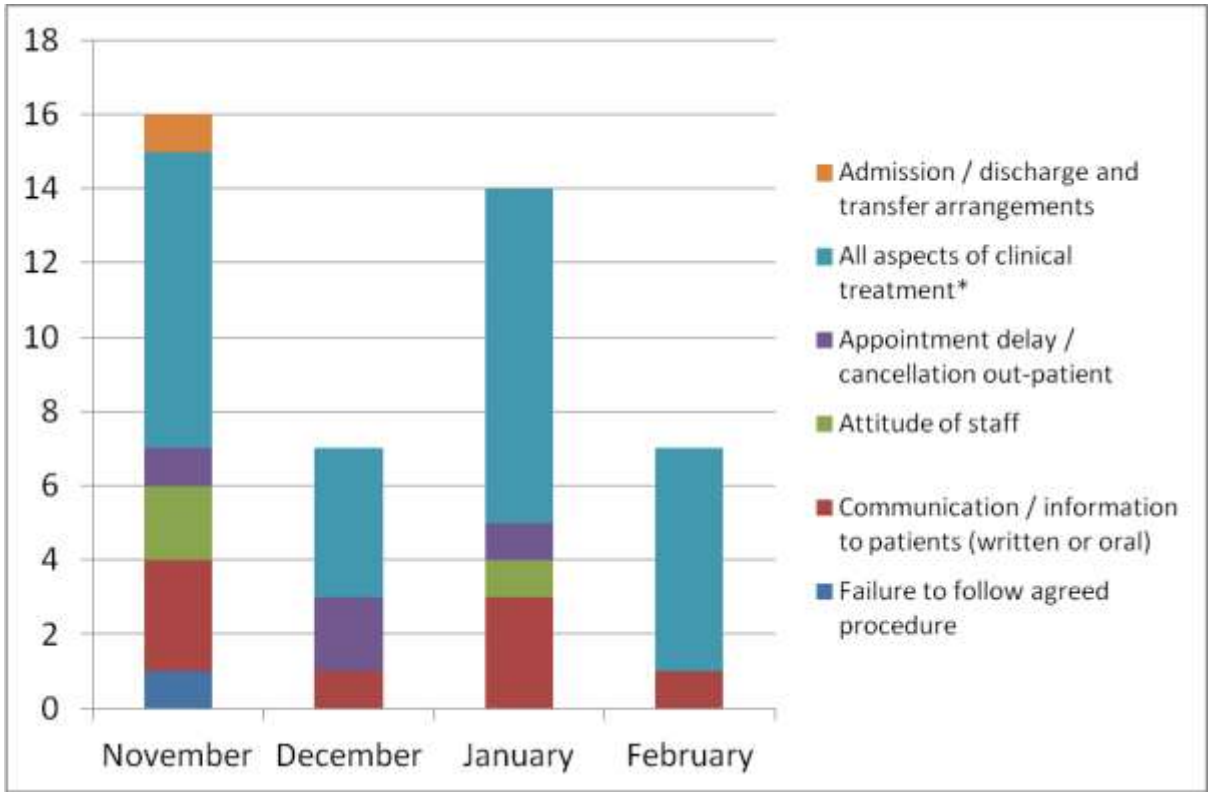
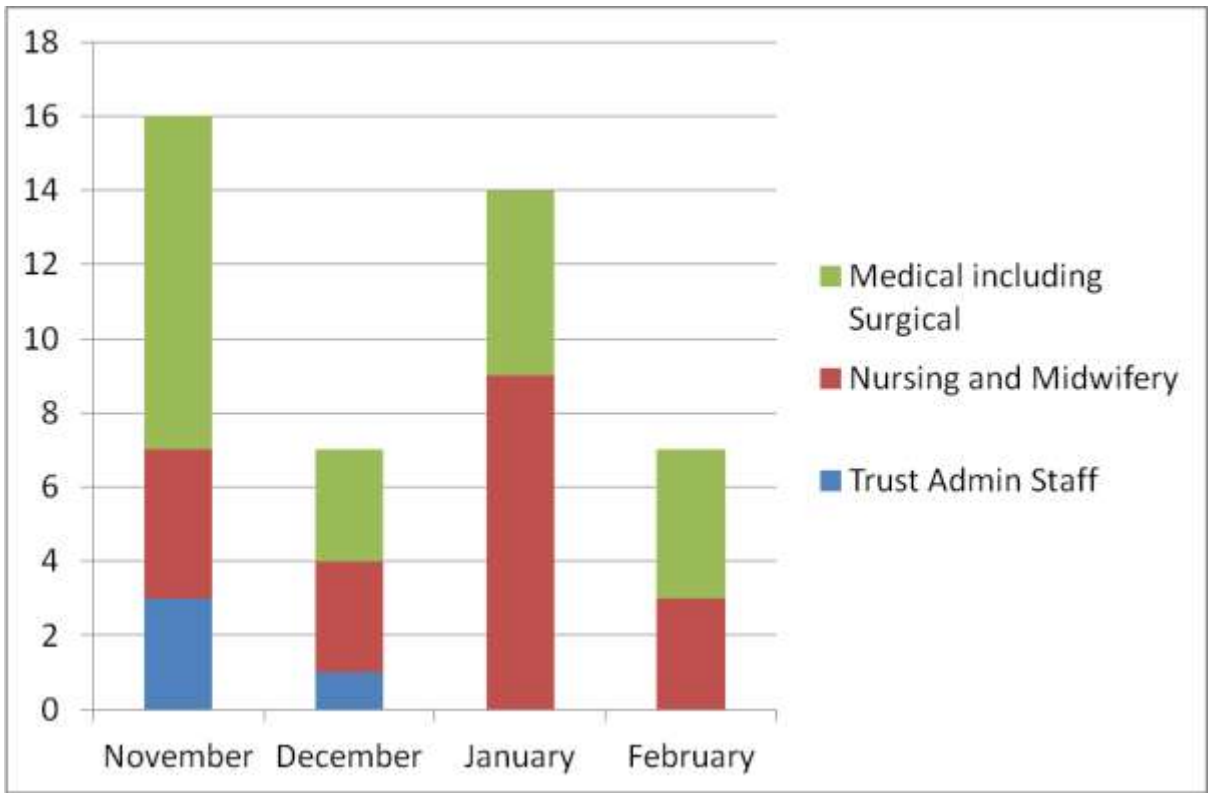


Table 4 – Themes from complaints



*On investigation it is sometimes found that the clinical treatment they are complaining about is not at fault, but that the communication was not adequate and therefore their understanding of what was taking place was causing them to think the clinical care was not good.

Table 5 – Complaints by Profession



13 responses were due out in February, of which 100% were issued on time.

Table 6 – Complaints responses issued on time

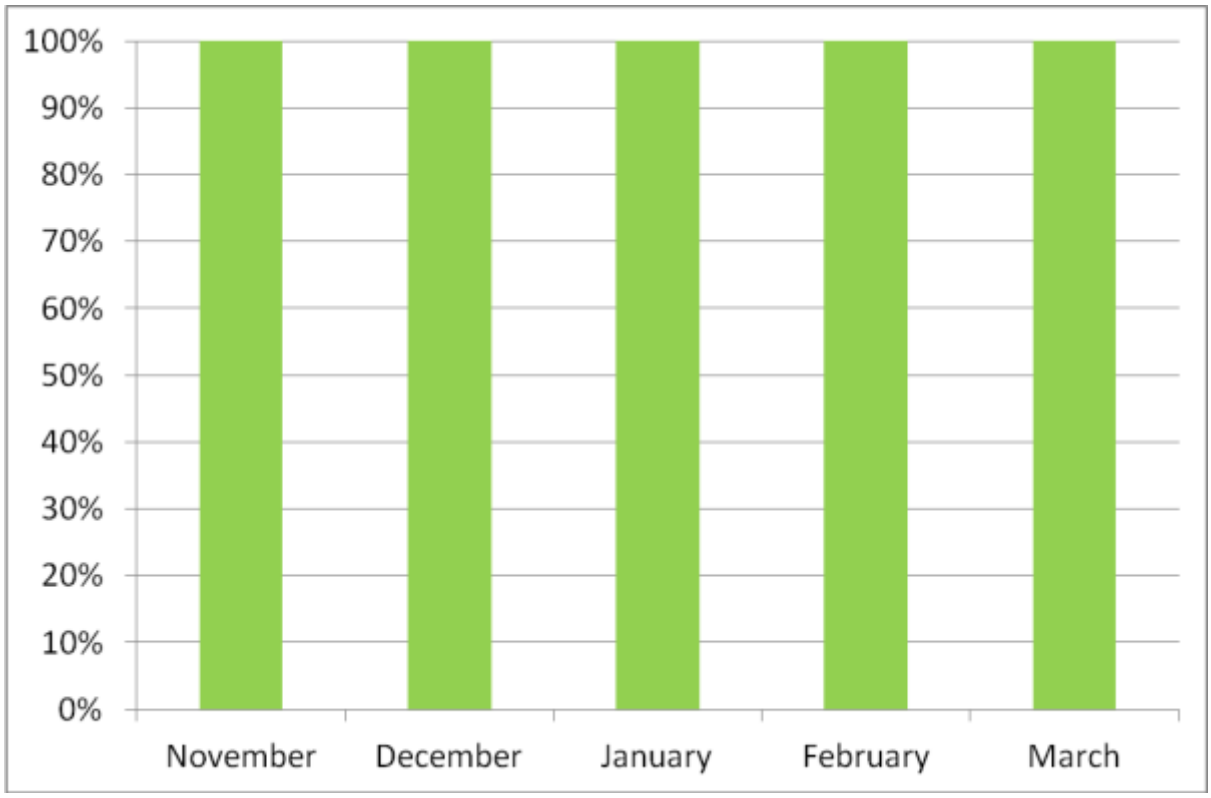


Table 7 – Complaints responses issued on time by Directorate

	November	December	January	February
Corporate	0	1	0	0
Genetics and Labs	2	0	0	0
Gynaecology	5	6	2.5	6
Maternity	11.5	6	4.5	6
Neonatal	0.5	0	0	1

2.2 Patient Feedback

In February 2013 we received 330 items of patient feedback:

- 0 paper comment/suggestion leaflets
- 125 real-time surveys
- 8 completed online surveys
- 197 Net Promoter Score paper surveys
- 0 Patient Opinion / NHS Choices posting

The following charts illustrate the responses to the trust-wide patient experience measures, based on 125 surveys.

Chart 1 – Were you involved as much as you wanted to be in decisions about your care and treatment?

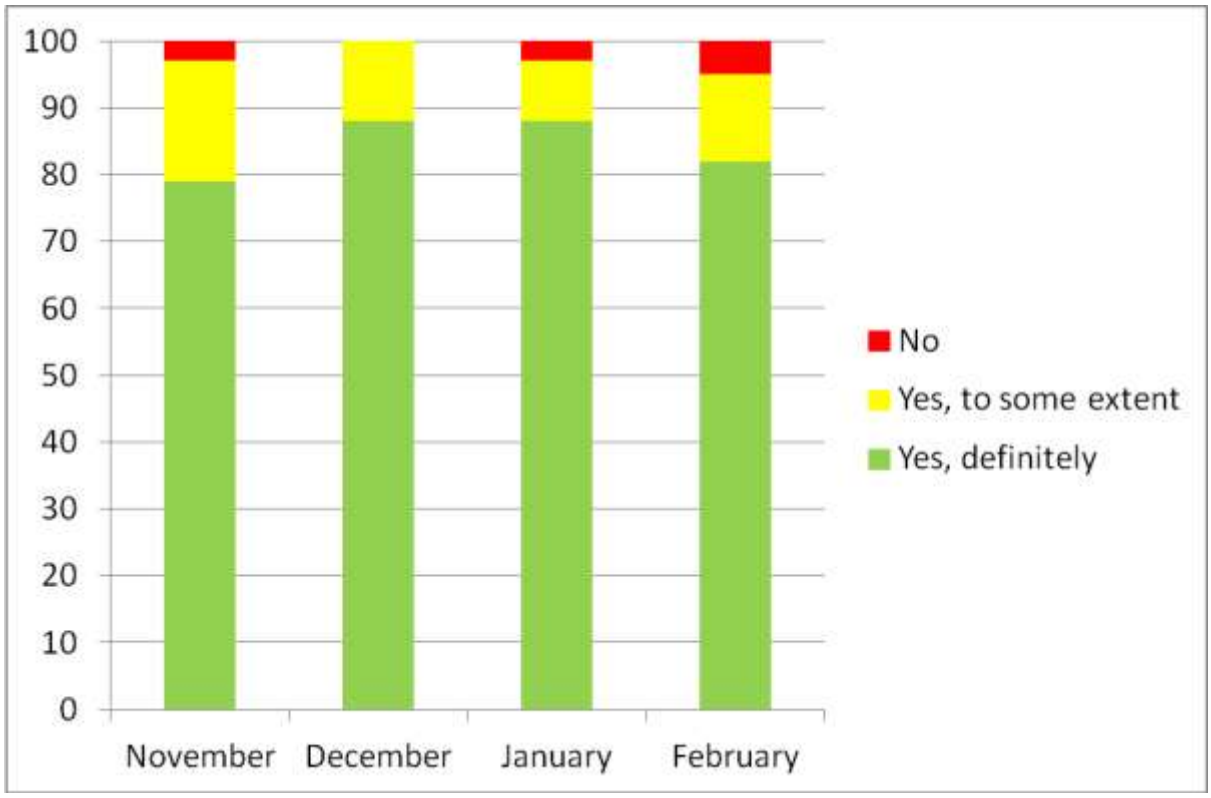


Chart 2 – Were you able to speak to someone on the hospital staff about your worries and fears?

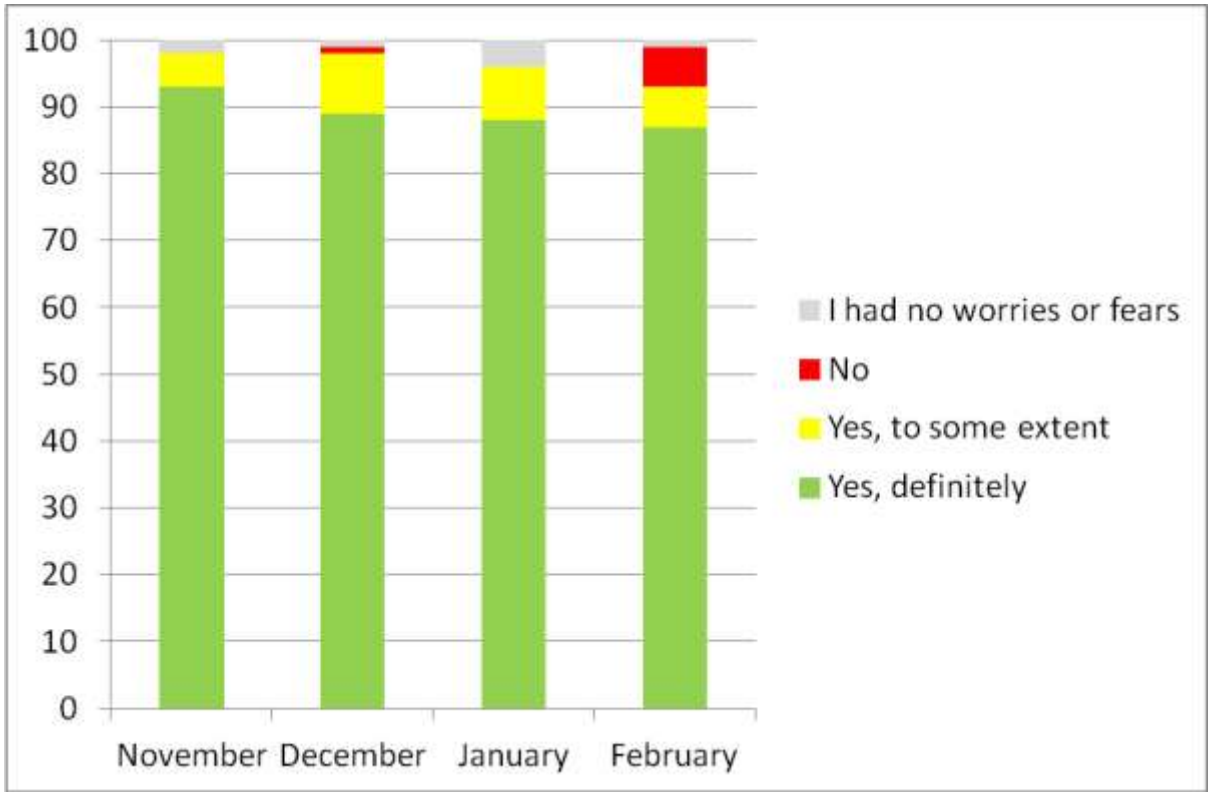


Chart 3 – When you had an important question to ask, did you get the answers that you could understand?

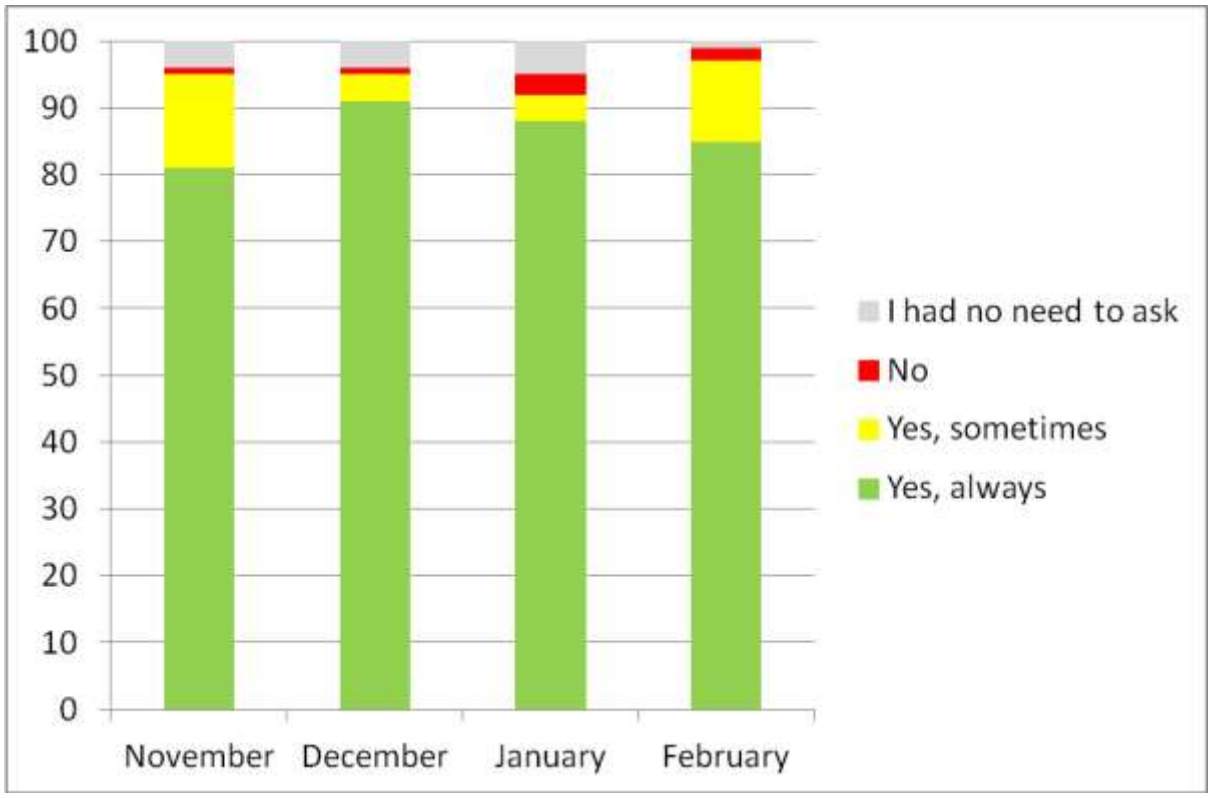


Chart 4 – Were you given enough privacy when discussing your condition or treatment?

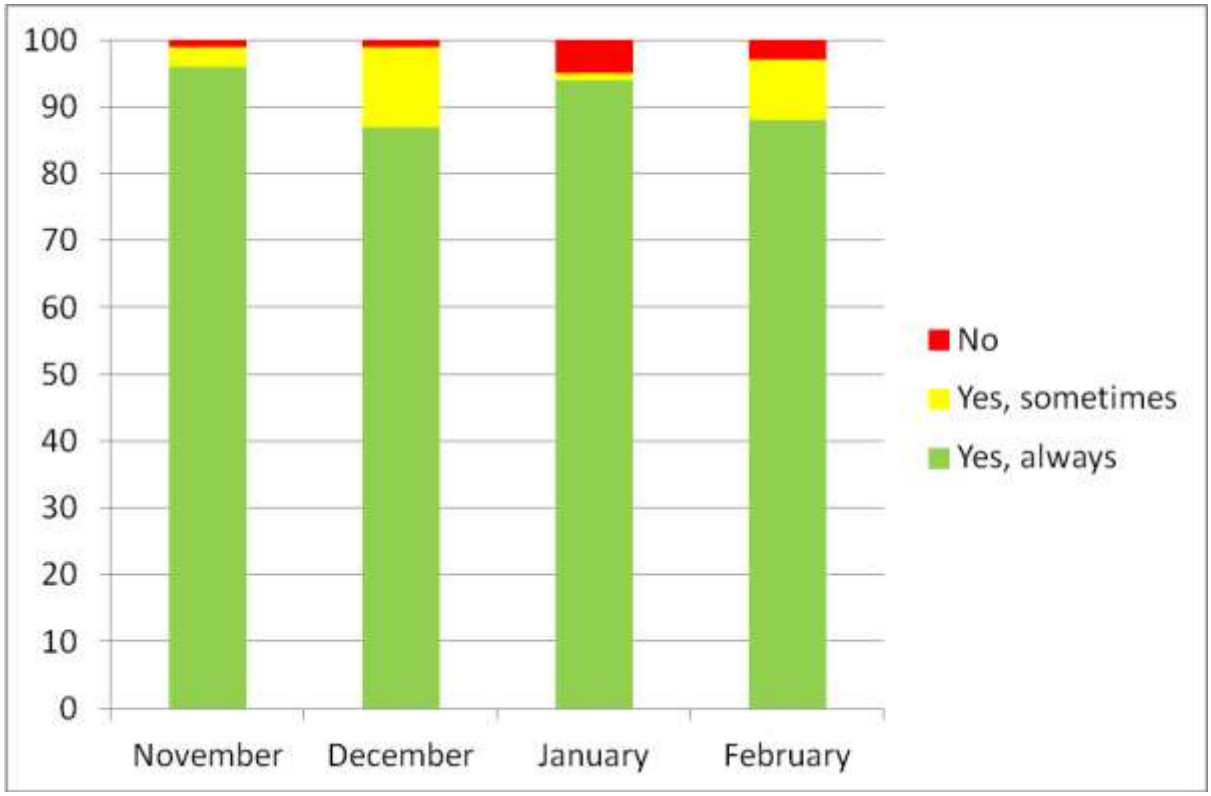


Chart 5 – In your opinion, how clean was the hospital room or ward that you were in?

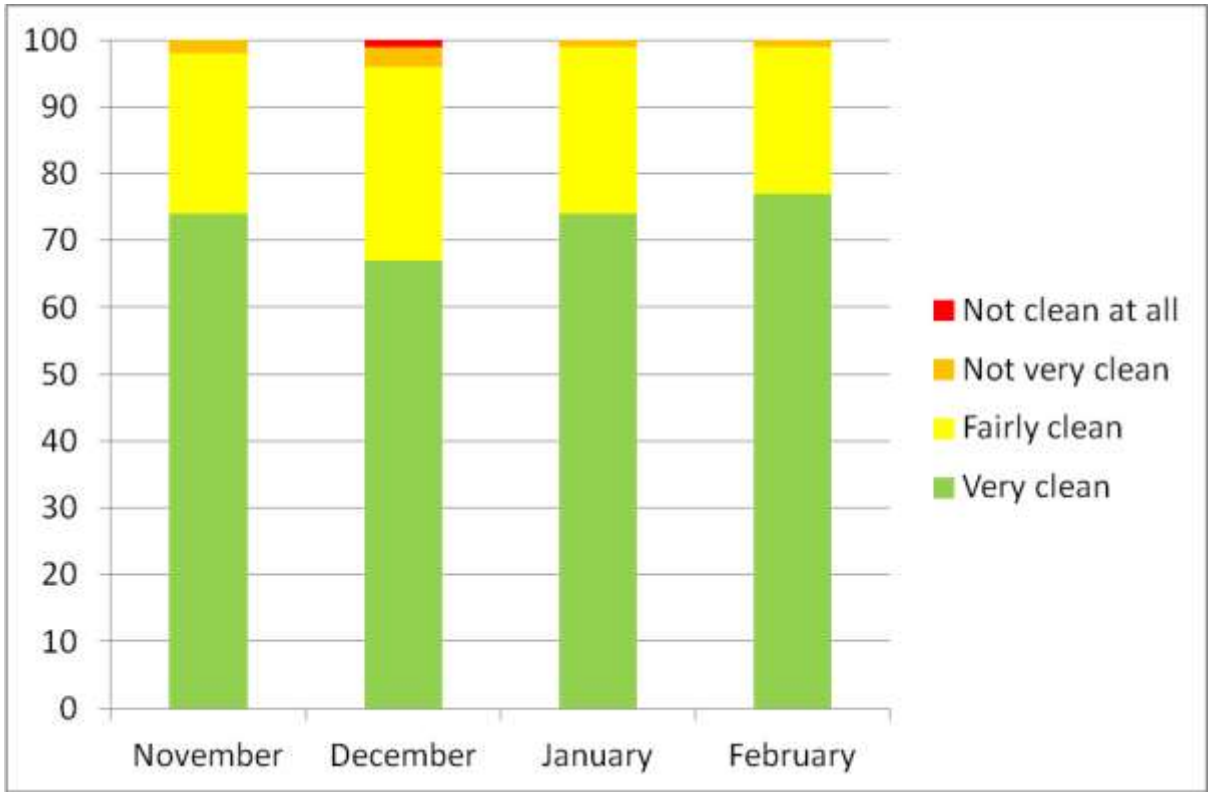


Chart 6 – Overall, did you feel you were treated with respect and dignity?

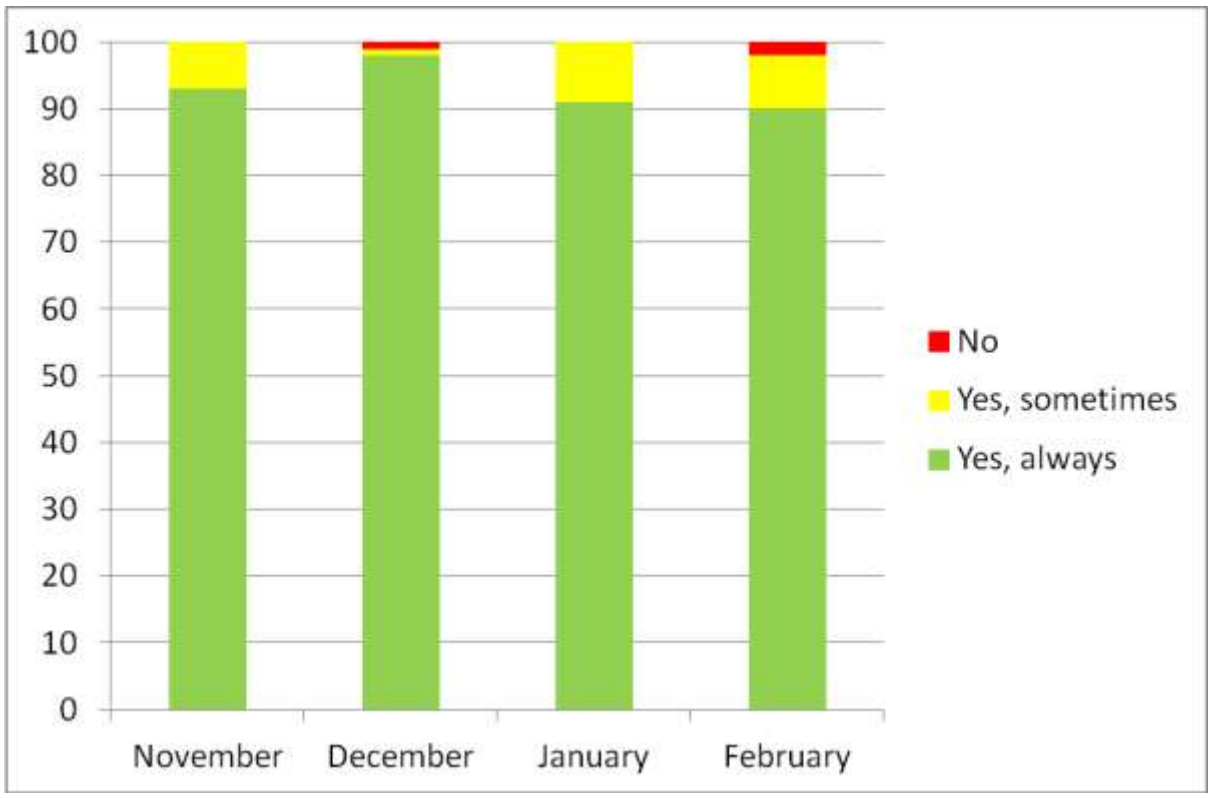


Chart 7 – Overall, how would you rate the care you received?

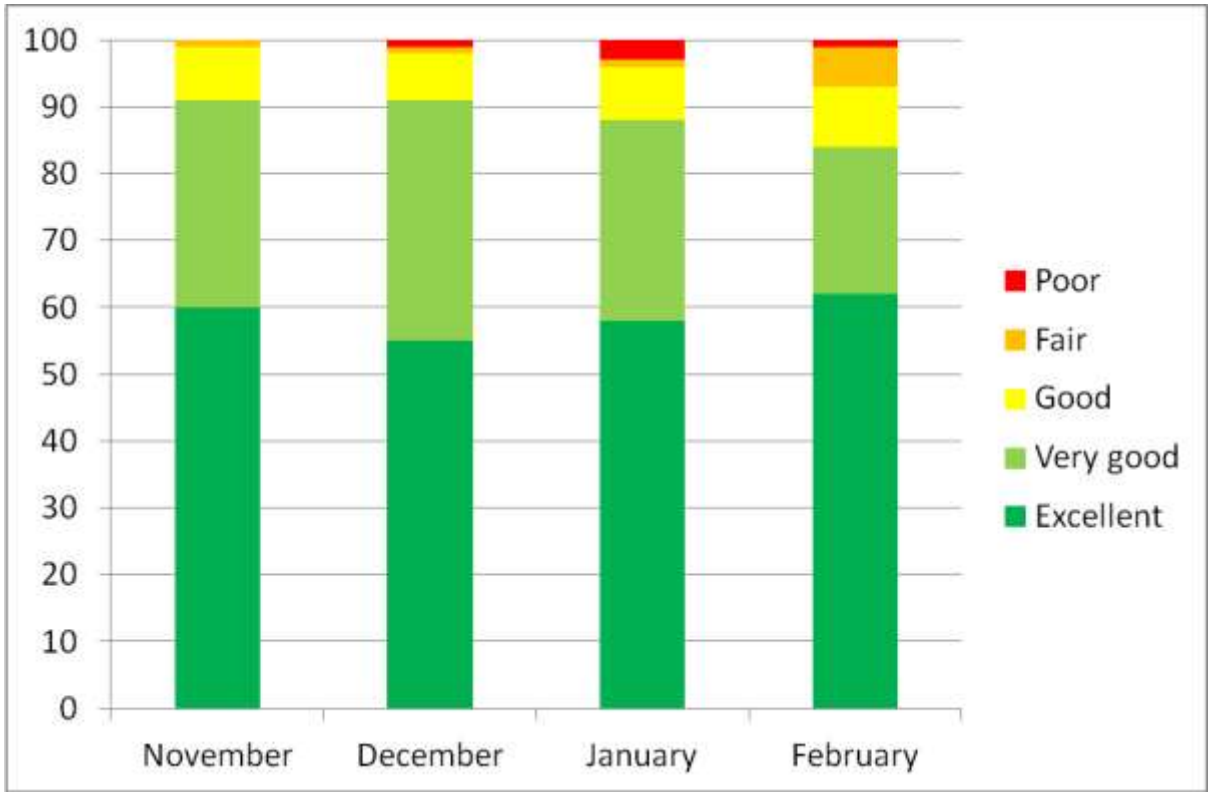


Table 8 – Positive themes

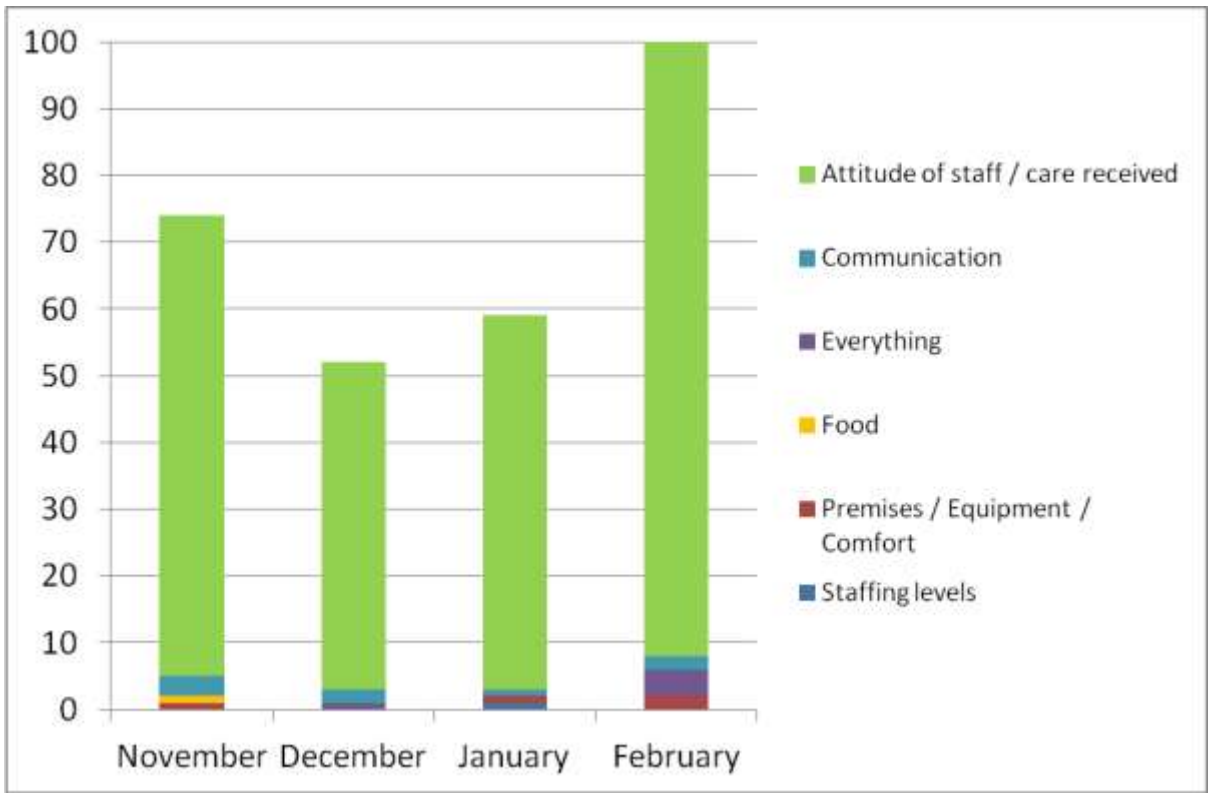
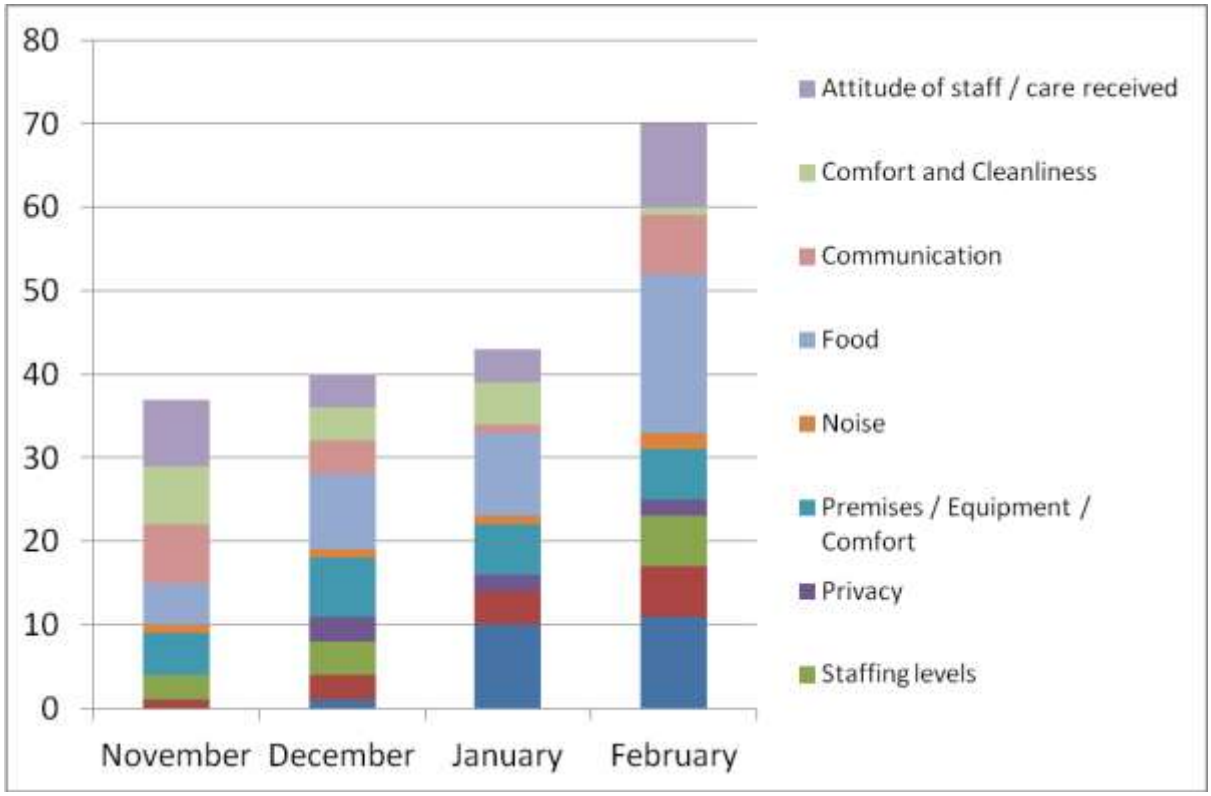


Table 9 – Themes for improvement



2.3 Friends and Family Test (Net Promoter Score)

The Net Promoter Score (NPS) for February 2013 is 75, which is above our end of year target of 71:

Table 10 – NPS

Month	Score
April	64
May	65
June	52
July	64
August	80
September	76
October	75
November	80
December	78
January	84
February	75

2.4 "Colleague of the Month" Recognition Awards

Our "Colleague of the Month" award (staff nominations) for February 2013 goes to Jo Smith, ODP in Theatres.

Our "Colleague of the Month" award (patient nominations) for February 2013 goes jointly to Jenny Henry, Head of Midwifery, Rosie Hemming, Midwife Manager and Carrie-Anne Stanley, Assistant Complaints Manager.

3. EFFECTIVENESS

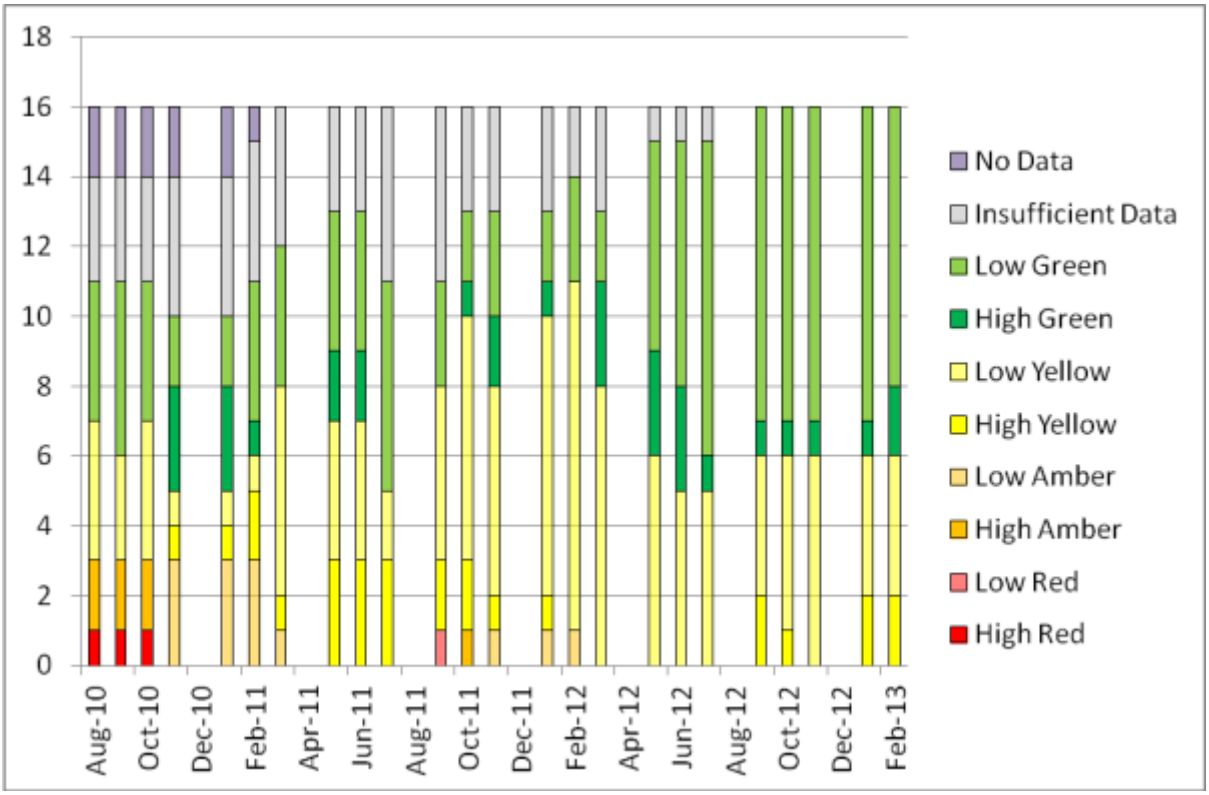
3.1 Care Quality Commission (CQC) Quality Risk Profile (QRP)

There has been one change in the QRP this month. Outcome 13 (staffing) has increased from low green to high green. One piece of data has been amended: 2010/11 cancer peer review staffing data has been updated with 2011/12 data. Though staffing levels have not changed, the data is slightly more recent and therefore the item has a higher weighting, which has caused the calculation to increase from low green to high green.

Table 11 – CQC QRP Risk Status in February 2013

Risk Status	Outcomes
Insufficient Data	0
High Red	0
Low Red	0
High Amber	0
Low Amber	0
High Yellow	2
Low Yellow	4
High Green	2
Low Green	8

Table 12 – CQC QRP Risk Status over time



3.2 Quality Dashboard

Indicators of Quality Feb-13 Month 11

Exception Report:
CQC unannounced visit - compliant with the 2 standards inspected
Breast feeding initiation and WHO checklist improving
Unexpected admissions to NNU will need re baselining in new year

Safety		Target Month	Actual Month	Monthly RAG	Yr to Date RAG	Trend	Target Red Measure blue
	Infections						
	Hand Hygiene	95%	98%				
	Mandatory Reportable Infections	0	0			1 0	
	Other Reportable Infections	1	1				
	Delivering Safe care						
	Serious Incidents	6	7				
	Patient Safety Incidents	120	82				

	New Pressure Ulcers	0	0			1 0
	WHO Surgical Checklist - Compliance (1month delay in reporting audit results)	100%	98.9%			100 85 70
	WHO Surgical Checklist - Completion (1month delay in reporting audit results)	95%	91.1%			100 85 70
	A Safe Workforce					
	Sickness Absence Rate %	3.39%	4.56%			
	Staff Turnover Rate %	14.10%	11.67%			
	Staff Appraisal%	85.00%	87.12%			
	Safety Indictors					
	VTE Risk Assessment	90%	91.0%			
	IUGR detection - Quarterly	35%	21%			
Effectiveness						
	Direct Nursing Care - Quarterly	55%				50.00% 45.00% 40.00%
	Caesarean Section rate	27%	28.1%			30.00% 20.00%
	Unexpected admission of term babies to NICU	20	46			0.3 0.2
	Corrected NNMR/1000	0	0			
	Crude NNMR/1000	1	1.4			
	Stillbirth Rate - Corrected	3	4.40			
	Crude Stillbirth Rate/1000	5	7.4			

	Breast Feeding initiated	69.3%	68.19%			
	Smoking during pregnancy	11%	5.6%			
Experience	**Complaints**					
	Written Complaints	13	7			
	Responded to within agreed timescale	85%	100%			
	Timely Care					
	% of Women seen by 12 weeks	90%	91.6%			
	Admitted within 18 weeks	90%	95.7%			
	Non-admitted within 18 weeks	95%	96.6%			
	95th Percentile Admitted (weeks)	23.0	18.0		N/A	
	95th Percentile Non Admitted (weeks)	18.3	16.0		N/A	
	Cancer 2 week wait	93%	97.3%		95.8%	
	Cancer 1 month to treatment standard	96%	100.0%		94.4%	
	Cancer 1 month subsequent treatment standard	94%	100.0%		100.0%	
	Cancer 2 month GP urgent referral to treatment	85%	66.7%		94.1%	
	Cancer 2 month Cervical Screening Report RTT	90%	100.0%		100.0%	
	Cancer 2 month from upgrade to treatment	90%	100.0%		92.3%	
	Cancellations					

Cancelled Operations on day of surgery	1	1			
Outpatient DNA Rate - Gynaecology	9.0%	8.6%			
Outpatient DNA Rate - Maternity	6.0%	10.1%			
Outpatient DNA Rate - Neonatology	8.9%	11.0%			
Outpatient DNA Rate - Genetics	10%	9.5%			
Environment and satisfaction					
Net Promoter Score	71.0%	75.1%			