SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST

Quarterly Patient Experience Report

Report to:	Trust Board 28th September 2010
Report from:	Julia Barton Associate Director of Nursing & Patient Experience
Sponsoring Executive:	Judy Gillow, Director of Nursing
Aim of Report/ Principle Topic:	Second quarterly report for 2010/11, detailing trust level performance against patient experience KPIs. The report has been further developed this quarter and includes a summary patient experience dashboard incorporating all patient experience metrics on one sheet. Covers reporting period **May**, **June, July 2010**, however some data is presented in traditional quarter format.
Review History to date:	This is the 4th Trust Board detailed patient experience report. The report has been received at the following groups: • Trust Executive Committee (8th September 2010); • Quality Governance Steering Group; • Patient Experience Steering Group; • Nursing & Midwifery Group. **Outcome of the review by Trust Executive Committee (TEC):** a) **Confirmed** the divisional and corporate actions to address the hotspot areas identified in the report. b) **Agreed** the proposed target for number of complaints dissatisfied at 132 (average 11 per month) for 2010/11 (section 2.2.5 of the report refers), to significantly improve the quality of the first response to complainants. c) **Supported** the stretch target of 85% to ensure continuous improvement in managing patient's property and pain (section 2.2.7 of the report refers). d) **Agreed** that Divisions would review the top 3 themes relating to patient feedback from complaints and PALs issues, and focus on setting local improvement targets for improvement.
Strategic Objective Ref:	SO1: Trusted on Quality SO2: Excellence in Healthcare
Recommendation(s):	Trust Board is asked to: 1. Note the actions agreed by TEC on 8th Sept 2010 as noted above. 2. Agree the new format of the report. 3. Advise any areas requiring further assurance and/or action.

1. Strategic context

1.1 Introduction

This report is the 5th trust wide patient experience report to TEC. It provides details of progress against key performance indicators for patient experience which are detailed in the patient experience strategy, 2010/11 Patient Improvement Framework and in the PCT quality schedule 3(4a) 2010/11. The format of the report has been adapted to reduce streamline content and focus on actions being taken or planned to address hotspot areas.

2. Specific Detail

2.1 Patient Experience Dashboard - A revised patient experience dashboard is presented. This reflects the following 2010 key performance indicators:

Patient Improvement Framework Targets

- Nutrition and Hospital Food
- Communication and Customer Care
- End of Life Care
- Discharge - Targets for patient involvement in Discharge decisions have been collected via the monthly patient survey and will be presented in the next Q report.
- Safeguarding Adults and Children – targets are under review.
- Same Sex Accommodation (National Performance Target)

CQUINS - Patient Experience Amalgamated Patient Survey Score

Patient Experience Strategy KPIs

- Privacy & Dignity
- Patient Information
- Complaints and PALS
- Overall Satisfaction with care

Key Areas for Improvement from 2009 National Inpatient Survey and Monthly Patient Survey

- Noise at Night
- Care of Patient Property
- Control of Pain

Patient Experience Dashboard 2010/11

	Monthly Trend								Year to Date (Average)	Forecast Year End
	Target	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10		
Overall Satisfaction with Care	90%	94%	89%	96%	97%	95%	95%	97%	96%	G
Recommend Hospital to Family and Friends	85%	94%	92%	94%	97%	93%	96%	97%	96%	G
Same Sex Accommodation Breaches clincially justified	TBC							n=44 (0.4% of total activity)	n=44	TBC
Same Sex Accommodation Breaches NON clincially Justified	0%							0.0%	0.0%	A
Same Sex Accommodation (Estates Compliance)	99%	90%	90%	99%	99%	99%	99%	99%	99.0%	G
Same Sex Accommodation (% of patients sharing sleeping accommodation after first	5%	25.3%	16.3%	12.0%	9.9%	9.2%	6.0%	2.0%	6.7%	G
Patient Experience National Survey Score (baseline 65.5%	73.50%								TBC	TBC
Overall Privacy and Dignity (yes always)	95%	84%	83%	90%	93%	94%	92%	95%	93.50%	A
Privacy & Dignity When Discussing Condition or treatment	90%	75%	74%	80%	82%	88%	90%	91%	88%	A
Custmer Care Trainng	100%	Q4			Q1 46%				46%	R
Staff talking in Front of Patients	90%	80%	76%	88%	89%	80%	86%	90%	86%	G
Printed Information about Hospital Received	80%	37%	54%	50%	68%	68%	66%	78%	70%	G
Printed Information about Condition Received	80%	52%	54%	60%	71%	77%	70%	73%	73%	G
% of patients given right information on wards	80%	79%	71%	76%	81%	86%	81%	84%	83%	G
Quality of Hospital Food (good & Very Good)	90%	43%	41%	46%	51%	53%	60%	66%	58%	R
Must Score within 24 hours	100%					71%			71%	R
Mealtimes Assistance	80%	50%	29%	49%	62%	64%	67%	79%	68%	A
Total No. Complaints	60	49	80	82	64	53	48	56	221	A
Complaints Response Times	75%	88.3%	96.0%	98.5%	97.6%	86.0%	94.0%	96.0%	93.4%	G
Ombudsman Referrals	max 4 per Q	**2009/10** - 18 referred, 15 stood down and 3 investigated			**Q1** - 3 referred, 2 stood down and 1 taken up				3	G
Number of Dissatisfied Complaints	TBC	9	8	10	12	10	9	13	TBC	TBC
PALS	TBC	267	986	454	296	379	234	267	TBC	TBC
End of Life Care % of relevant staff trained	40%	TNA in progress to baseline								A
End of Life Care LCP Compliance	25%				31.95	36.72	40.49	43.14		G
Noise at Night From Staff and patients not experienced (note change in question July 2010)	80%	74%	69%	73%	77%	75%	80%	67%	75%	A
Property - somewhere to keep belongings on ward	80%	79%	79%	79%	82%	82%	79%	88%	83%	G
PAIN - staff definitely did everything they could to control	80%	69%	63%	76%	81%	77%	76%	80%	79%	A

2.2 Areas of improving or sustained performance

2.2.1 **Overall satisfaction with care** – Over 95% of patients continue to report high levels of satisfaction with care. In July this rose to 97%. Similar percentages of patients also consistently report that they would recommend the hospital to family and friends.

2.2.2 **Same Sex Accommodation** – There have been zero non-clinically justified breaches in July since individual breach monitoring commenced. There were 44 clinically justified breaches reported which represents 0.4% of the total activity for the period. Estates compliance remains at over 99%. The numbers of patients reporting mixed sex accommodation experiences after their first move has continued to decrease month on month and stands at 2% in July 2010. A detailed same sex accommodation report is also being presented to this committee.

2.2.3 **Privacy and Dignity** – performance in the Q has improved and may be attributable to the easing of bed pressures over the summer period.

2.2.4 **Patient Information** – Whilst there is still some way to go to sustain achievement in the target, there has been improvement in the Q. The numbers of patients receiving pre admission printed information rose to the highest level ever in July at 78%. Over 80% of patients say they receive the right amount of information on the ward. The % of patients receiving printed information about their condition has improved in comparison to the previous Q but is still off target.

2.2.5 **Complaints** – The number of complaints received fell to below 60 per month for each of the 3 months in the reporting period. Complaints response times are being achieved at an average of 93% each month. This is the first Q that the report has presented the number of complainants who return dissatisfied with their response, which represents the quality as well as timeliness of individual responses. It is proposed that a baseline target of no more than 11 per month is agreed for the remainder of 2010 (total 132 for the year) and that an improvement target of 10% is applied in 2011/12.

2.2.6 **End of Life Care LCP Compliance** – The CQUIN target requires 25% of patients who died to have been on the LCP. Performance has improved month on month and now stands at over 43%.

2.2.7 **Property and Pain** – patient feedback on both elements is normally just reaching the 80% satisfaction target. It is proposed that this target creates a low threshold of acceptance. For improved performance to be achieved this target should be raised to 85% in Q3.

2.2.8 The improved performance in the majority of patient experience metrics over the last Q is highly likely to be correlated with reduced pressures on bed capacity over the summer period. The hospital alert status has been predominantly green over this period. Further correlational analysis will be of value and will be undertaken in Q3.

2.3 Areas of concern or deteriorating performance and actions

2.3.1 Customer Care and Communication

The percentage of staff accessing customer care training has increased over the Q but remains off target at **46%.** Customer care training is currently provided on rolling half days and is well evaluated. Local customer care training is also being provided in care groups and it is possible that some of this is not being captured in the statistic. The number of formal complaints and written and oral communication appear to have decreased month on month in the Q. The number of PALS concerns about lack of information increased in July.

ACTIONS
Divisional/care Group:
1. Clinical teams to work with their education leads and IDEAL to ensure all forms of customer care and attitudinal training are captured in the trust's training database.
2. Divisions and care groups to actively follow up attitudinal complaints with staff concerned and offer challenge, support and training/retraining

Strategic
3. The organisational development work with the Brand Inside company refining organisational values has completed and is due to be rolled out in Q3.
4. The Brand Inside have developed the "Values Game" – 50 managers will be trained to deliver this with their teams.
5. IDEAL are developing a new E-learning programme and are reviewing customer care training at induction
6. A complaints and communication board game (AKD) is going to be piloted in Q3.
7. A formal launch of the new Trust values and their associated behaviours is being planned.

2.3.2 **End of Life Care Training** – The 2010/11 CQUIN required 40% of relevant staff to be trained in End of Life Care. At present the actual % is unknown. Achievement of the target represents a significant challenge and creative utilisation of available resources.

ACTIONS
Strategic
1. A detailed training needs analysis has been completed in Q2 and a revised training strategy is being developed by the Trust's End of Life Care group.
2. A solution has yet to be found to meet the ICT requirements necessary to implement the SHA developed End of Life Care e-learning programme.

2.3.3 **Hospital Food and Nutrition** – Patient experience of hospital food via the monthly survey has improved month on month in the Q but the target remains red at 66% (against 90%) for July 2010. The COO continues to monitor the KPIs of the Catering contract closely via bi-monthly meetings.

The number of patients receiving mealtime assistance has also improved in the Q and now stands at amber (79% in July). A trust wide MUST audit in May 2010 demonstrated improved compliance at **71%** of patients who had MUST scores completed within 24 hours of admission.

ACTIONS
Divisional/Care Group
1. Deliver 100% compliance with MUST by end of Q3
2. Deliver 100% patients who need mealtimes assistance to receive this by end of Q4
3. Support the implementation of a new red tray in Q3.
4. Guidelines for protected mealtimes have been updated. Divisions and care groups to fully implement in all appropriate areas.
5. The BRU are working alongside the Trust and will be commencing a detailed research study into ward based nutritional care and MUST compliance. Support and involvement from clinical teams will be requested.

Strategic
1. A ward based approach to MUST audits is being developed using the SNAP audit tool and ward based monthly audits will be implemented in Q3, thus providing data for local performance and improvement monitoring.
2. A Trust wide Nutrition Strategy is under development.
3. A self-assessment against recently released nutrition standards (BAPEN) is underway.

2.3.4 **Noise at Night** – the target for patients not being disturbed by excessive noise at night has only been reached once in the Q.

ACTIONS
Divisional/Care Group

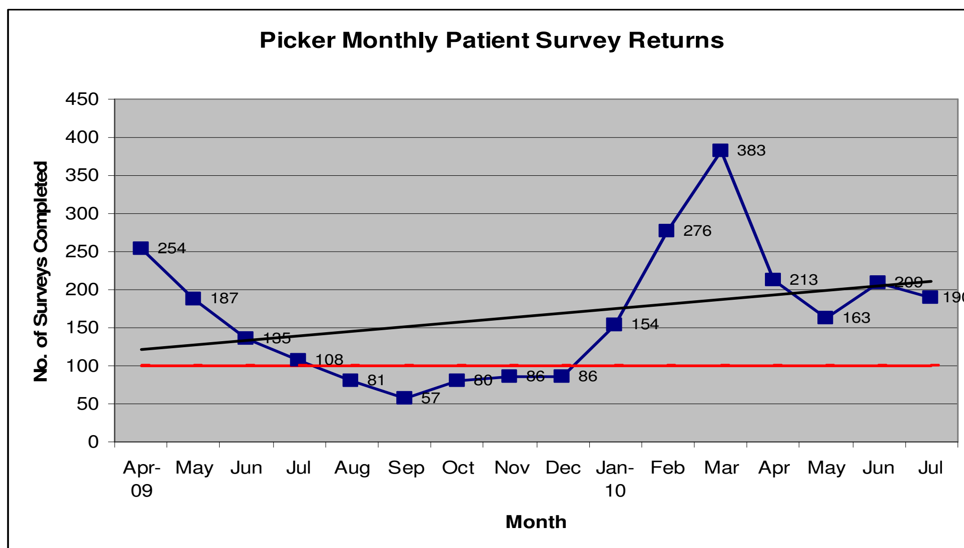
1. Involvement in late evening and night Matron and Senior Nurse walkabouts are planned in Q3 to discuss with night staff some of the challenges they may be facing in this area.
2. Implement care group specific actions for this following feedback from the 2009 inpatient survey findings.
3. Disseminated findings, develop and implement actions in response to the recent essence of care privacy and dignity audit results.

3 Staff, Patient and Public Involvement

3.1 Summary of Patient Feedback Themes

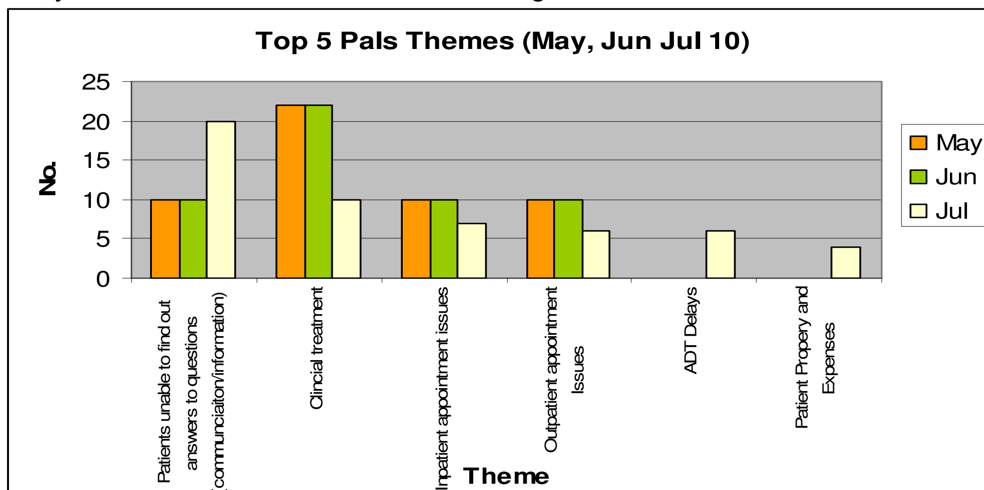
3.1.1 Picker Monthly Frequent Feedback Survey

Volunteers have surveyed over 150 patients each month in the reporting period. The survey has been amended from July 2010 to include questions relating to the CQUIN indicators for patient experience. The survey reveals generally positive and improving trends over the reporting quarter.



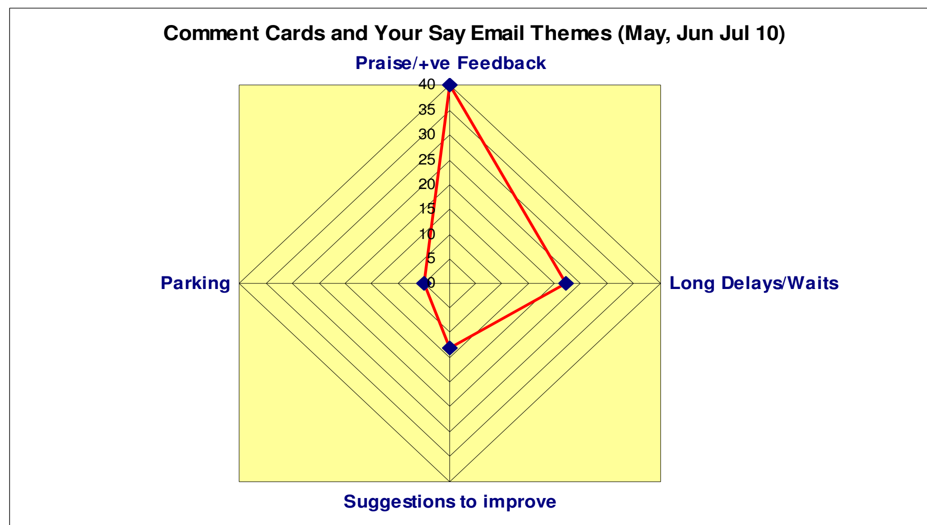
3.1.2 PALS

The top 5 PALS themes for the relevant months are represented in the following chart. July saw an increase in PALS enquiries from patients/significant others who were unable to find out the information they needed, and some enquiries about property and delays in admission, transfer and discharge. There was a decrease in all other themes.



3.1.3 Comment Cards and Your Say Email

A total of **125** patients or their significant others provided feedback via comment cards or the "your say" email facility. Of the 5 consistent themes, 50% constituted positive praise and feedback and 28% related to long delays and waiting times.



3.1.4 Online Feedback Facility

A new online patient feedback facility was established in May 2010, available via the public web site. From May to July 2010, a total of 27 pieces of feedback were provided via this route. 10 of these were to express positive praise and 17 were to provide negative feedback or raise concerns.

Positive Feedback	PICU; G4; Learning Disabilities patient in OPD; Neonatal unit; ED X 3; Cardiac MRI x 2; Eye clinic; E7	
Negative Feedback	Neuro	Cancellations
	Main Hospital	Availability of wheelchairs and help for elderly
	Audiology	Hearing Aids (not a SUHT service)
	Hepatology clinic	Unable to contact
	E5 ward	Operation delay and lack of meals
	E5 Ward	Wait for X rays and lack of communication
	Eaterie	Quality of Food
	E4 Ward	CHDU lack of communication about move to E4
	HAS	Unsafe ambulance transfer at home (not SUHT service)
	Orthopaedics	Length of OP waiting time
	ED	Poor staff attitudes
	ED	Clinical treatment – staff did not listen
	Rheumatology	Confusion about recording contact details
	Matty Scanning	Poor staff attitudes
	Matty Scanning	Poor staff attitudes and lack of info
	Disabled parking	Size of bays insufficient
	Stone Clinic	Clinical treatment confusion

The facility will be further developed to direct PALS enquiries and elicit feedback in Q3. All feedback has been passed on to the relevant care groups/teams. Actions already taken in response to this feedback include a planned team based customer care training session for maternity scanning.

3.1.5 CQUIN for Patient Experience

The national CQUIN patient experience indicator is derived from an amalgamation of 5 questions in the national inpatient survey, carried out on patients who have had experiences in SUHT in August 2010. The trust has been in contract negotiations with SHIP, proposing that the incentive payment should be considered at year-end rather than from August data. SHIP and other trusts agree but this change would require derogation from the DoH. Further consideration by both parties is now complete. The overall indicator

will remain unchanged. There will however be local negotiations if the trust is able to demonstrate improvement on the score via its real time data by year end.

The 5 questions from the national CQUIN score have been added to the Picker real time patient survey form July 2010.

Actions already taken include:

- The development of patient pocket cards including vital discharge prompts
- The development of weekly discharge listening clinics
- Review of the discharge policy nearing completion
- Discharge and transfer checklist being updated.
-

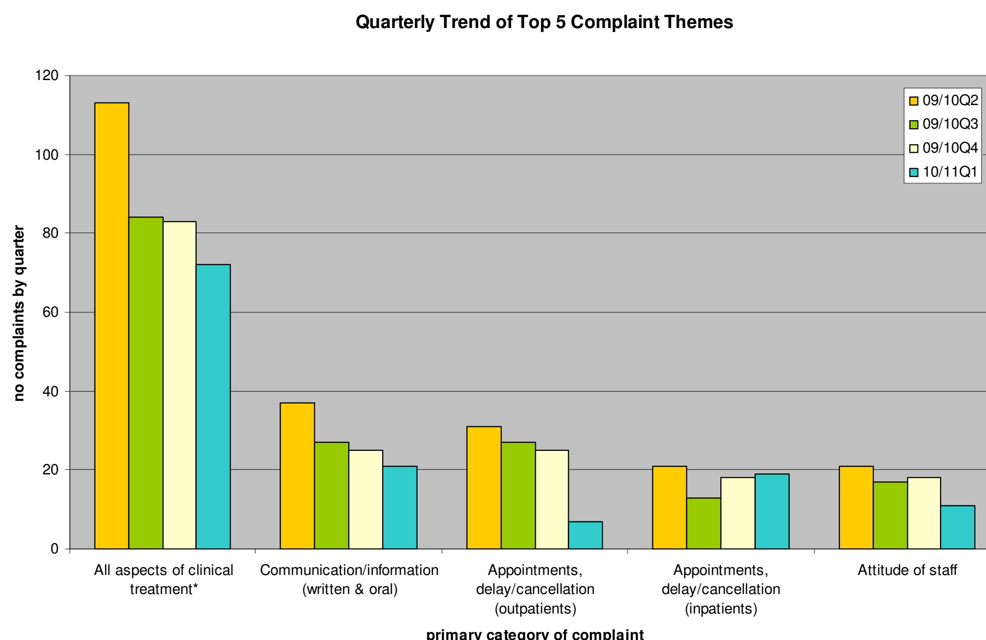
Feedback will be provided to individual areas from the August survey.

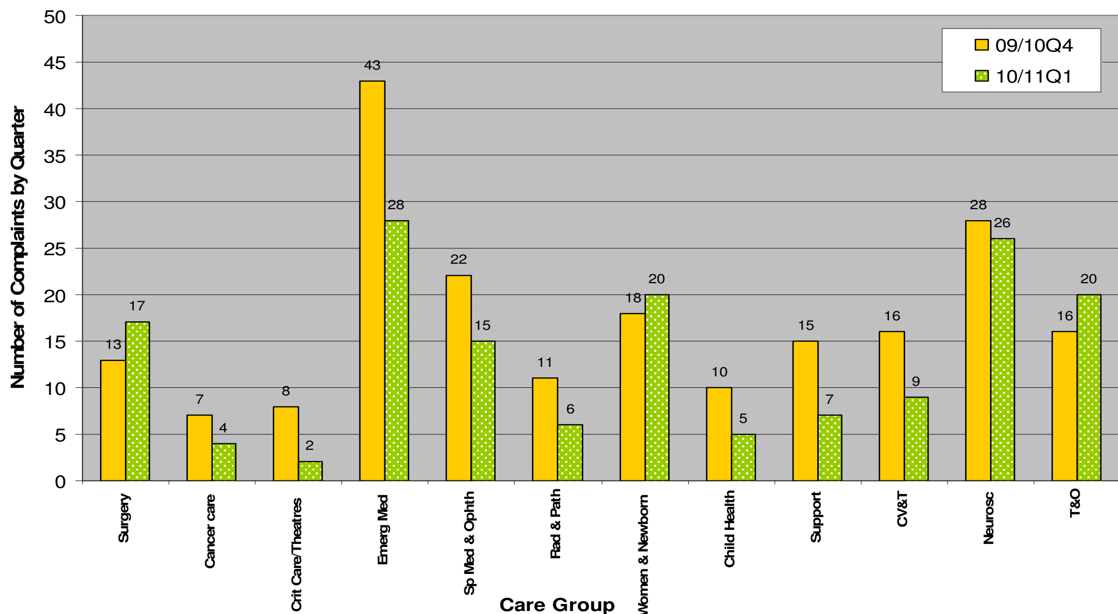
3.1.6 NHS Choices

A total of 5 pieces of patient feedback were left by NHS choices in the reporting period. 1 left positive comments, 2 left negative comments and 2 left both positive and negative comments. There were no emerging themes from this source of feedback. The trust always responds to the feedback and requests patients contact the PALS department in every case. Feedback is forwarded on to the department concerned where named.

No.	Month	Comments	Ward/Dept
1	**May**	**Positive -** Patient felt safe and well cared for. Suggested follow up visit post MI at home.	ED Cardiac
2	**May (experience in April 10)**	**Negative –** lack of cleanliness, insufficient washing of patients, poor diabetes care and lack of staff to patient numbers	No known
3	**May**	**Positive –** ED second to none Treated promptly and with respect at all times. Good communication. **Negative** – Lack of contact from nurses, left waiting for pain relief, nurses lazy with poor bedside manner, elderly patients needs ignored, poor cleanliness, lack of attention to patients from staff, lack of not drinks, poor documentation of medications and notes lost, use of a “condemned” mattress.	ED Surgical Admissions Unit
4	**June**	**Positive –** OPD consultant and staff approach **Negative –** clinical delays and organisation	Not known
5	**Jul (re: an April 10 visit)**	**Negative –** Why do we always ask people to contact PALS on NHS choices (full response and explanation given re: constraints of the site).	

3.1.7 Complaints Top Themes Quarterly Comparison





3.1.8 Additional Patient Surveys Undertaken in the Reporting Period

- **Diabetes National Inpatient Survey (09/09 but recently reported)**
  Patients were asked to identify a word that described how they felt about their diabetes care during their inpatient stay. In Southampton General Hospital, 72% identified a positive word such as 'excellent', 'happy' or 'safe'. This compares to 73% of all questionnaire respondents. Patients were also asked to rate their satisfaction with their diabetes care during their inpatient stay on a scale of 0 (not satisfied) to 6 (very satisfied). The average (mean) score for patients in Southampton General Hospital was 5.1 compared to 5 for all patients responding to the questionnaire.

- **Happy Patient Discharge Lounge Audit** – findings generally represented an improvement on the last audit. Actions are in place.

3.1.9 Patient and Public Engagement Activity

3.1.9.1 SLINKS – SLINK members have been involved in a variety of patient groups. Trust staff have also attended SLINKs committee meetings and public consultation events. In the recent NHS health white paper, it is proposed that in 2011, SLINKs are re-badged as “HealthWatch” groups and these will have stronger links to OSCs and the CQC.

3.1.9.2 Healthy Cities Overview and Scrutiny Committee – The Health Cities Committee (previously OSC) has commissioned an in depth review of patient safety across the Trust. This is currently in progress.

3.1.9.3 The Member’s Council sub group for patient experience has met and is requesting briefings on a number of elements relating to patient experience.

3.1.9.4 A trust wide Patient & Public Engagement strategy is under development.

4. Summary and Recommendations

- It is hoped this more streamlined report enables TEC and the Board to focus more easily on the hot spot areas as well as improving performance.
- Overall the trust can demonstrate am improved or sustained position for the majority of patient experience metrics.
- It would appear from the new dashboard that bed capacity pressures directly influence the quality of patient experiences and this matter will be subject to further review in the next quarter.

5. Financial Information

None to note

6. Risk Register Ref: Same Sex Accommodation

7. Legal Implications:

None to note

8. Trust Wide Impact & Assessments:
This matter has been assessed for potential impact on personal data and privacy: **Yes**
This matter has been assessed in relation to Equality & Diversity: **Yes**

10. Carbon Management: Not Assessed