

AGENDA ITEM NO:

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 FEBRUARY 2013**

Title:	QUALITY ACCOUNT UPDATE FOR Q3 2012/13
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 13687

Purpose:	To present the Trust's Quality Account Update for Quarter 3 2012/13.
Confidentiality Level & Reason:	N/A
Annual Plan Ref:	Strategic Aim: To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking
Key Issues Summary:	<ul style="list-style-type: none"> • The Q3 2012/13 Quality Account Update is shown in Appendix A. • The latest SHMI is below expected. The latest HSMR for April-November 2012 is above expected (110.71) and included for completeness. • Performance for two of the Quality Improvement Priorities is strong: patient experience and observations. • Performance for VTE prevention and missed doses has plateaued. CDI and MRSA are slightly above trajectory. • Performance for the specialty indicators will be included as an appendix to the update report before publication.
Recommendations:	<p>The Board of Directors is asked to:</p> <p>Approve the content of the Quality Account Update for Quarter 3 2012/13 for external publication.</p>

Signed:	Date: 19 February 2013
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UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS THURSDAY 28 FEBRUARY 2013

QUALITY ACCOUNT UPDATE FOR QUARTER 3 2012/13

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. Introduction

The aim of this paper is to present the Trust's Quality Account Update for Q3 2012/13 prior to external publication in March 2013. The Trust's Quality Account Update report for April-December 2012 is shown in Appendix A following discussion at the Clinical Quality Monitoring Group (CQMG) in February 2013.

2. Performance

2.1 Mortality: SHMI and HSMR

The report contains the Trust's Summary Hospital-level Mortality Indicator (SHMI) figure for April-September 2012 which has been calculated by Health Informatics. The SHMI is below expected. The Trust's latest Hospital Standardised Mortality Ratio (HSMR) value for April-November 2012 is 110.71 as calculated by Health Informatics. This value is higher than expected but below the upper control limit. The HSMR has been included in the Quality Account Update for Q3 2012/13 simply for completeness with a statement explaining that the underlying methodology is largely discredited.

2.2 Quality Improvement Priorities

Performance for two of the five 2012/13 Quality Improvement Priorities remains strong: Improving Patient Experience and Satisfaction and Electronic Observation Chart – Completeness of Observation Sets. Performance for observations finally hit over 98% in January 2013. Performance for the remaining three Quality Improvement Priorities remains challenging as detailed below and continues to be monitored by the Clinical Quality Monitoring Group.

2.2.1 Improving VTE Prevention

Performance for VTE prevention has plateaued for April-December 2012. As reported previously, the Trust is now focusing on improving rates of enoxaparin prescription through the Junior Doctors' monitoring programme work. The first weekly Junior Doctor monitoring clinics started in January 2013 with

VTE performance issues being reviewed in the clinics from February 2013. There is unlikely to be a step change in performance before the end of March 2013 so VTE prevention will continue as an improvement priority in 2013/14.

2.2.2 Reducing Medication Errors (Missed Doses)

Performance for missed antibiotic and non-antibiotic doses has also plateaued in 2012-13 following significant reductions in previous financial years. Although it is expected that reductions would not continue at the same rate, the Trust will need to focus on reducing non-antibiotics going forwards. There are plans in place for the automatic reporting of two consecutive antibiotic doses and four consecutive non-antibiotic doses from PICS into the Datix incident reporting database in the future. This will help to identify specific areas where improvement actions need to be directed.

2.2.3 Infection Prevention and Control

C.difficile infection and MRSA are both slightly above trajectory for April-December 2012; actions are detailed in the Executive Chief Nurse's Infection Prevention and Control Report to the Board of Directors.

2.3 Selected Metrics

The Trust is continuing to see a higher proportion of harm incidents due to increased reporting of pressure ulcers. As a result, there is a reduction in the percentage of patient safety incidents which are no harm (indicator 4a) for April-December 2012 compared to 2011-12. There has however been a reduction in the percentage of incidents categorised as severe harm in October-December 2012 (indicator 4b).

3. **Specialty Quality Indicators**

Performance for the specialty indicators will be added at the end of the update report before publication but is not included here for brevity. There are no particular concerns over publication of this information. Exceptions continue to be identified through the QuORU Indicator Framework and reported through the Clinical Quality Monitoring Group as per the process. The first quarterly progress paper was reported to the Chief Executive's Advisory Group in December 2012.

4. **Recommendations**

The Board of Directors is asked to:

Approve the content of the Quality Account Update for Quarter 3 2012/13 for external publication.

Appendix A

Quality Account Update for April-December 2012

Contents

Introduction

Mortality

Quality Improvement Priorities

Priority 1: Improving VTE Prevention

Priority 2: Improve patient experience and satisfaction

Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Priority 4: Reducing medication errors (missed doses)

Priority 5: Infection prevention and control

Selected Metrics

Quality Account Update for April-December 2012

1. Introduction

The Trust published its fourth Quality Account Report in June 2012 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2011/12, performance data for selected metrics and set out five priorities for improvement during 2012/13:

Priority 1: Improving VTE Prevention

Priority 2: Improve patient experience and satisfaction

Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Priority 4: Reducing medication errors (missed doses)

Priority 5: Infection prevention and control

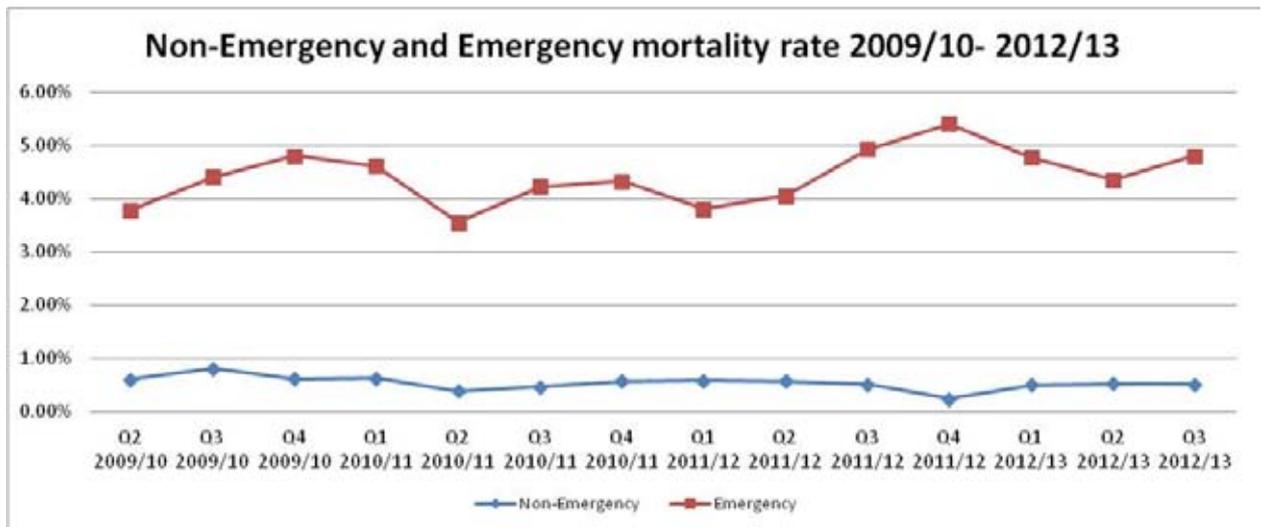
This report provides an update on the progress made for the period April-December 2012 towards meeting these priorities and updated performance data for the selected metrics. This update report should be read alongside the Trust's Quality Account Report for 2011/12.

2. Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

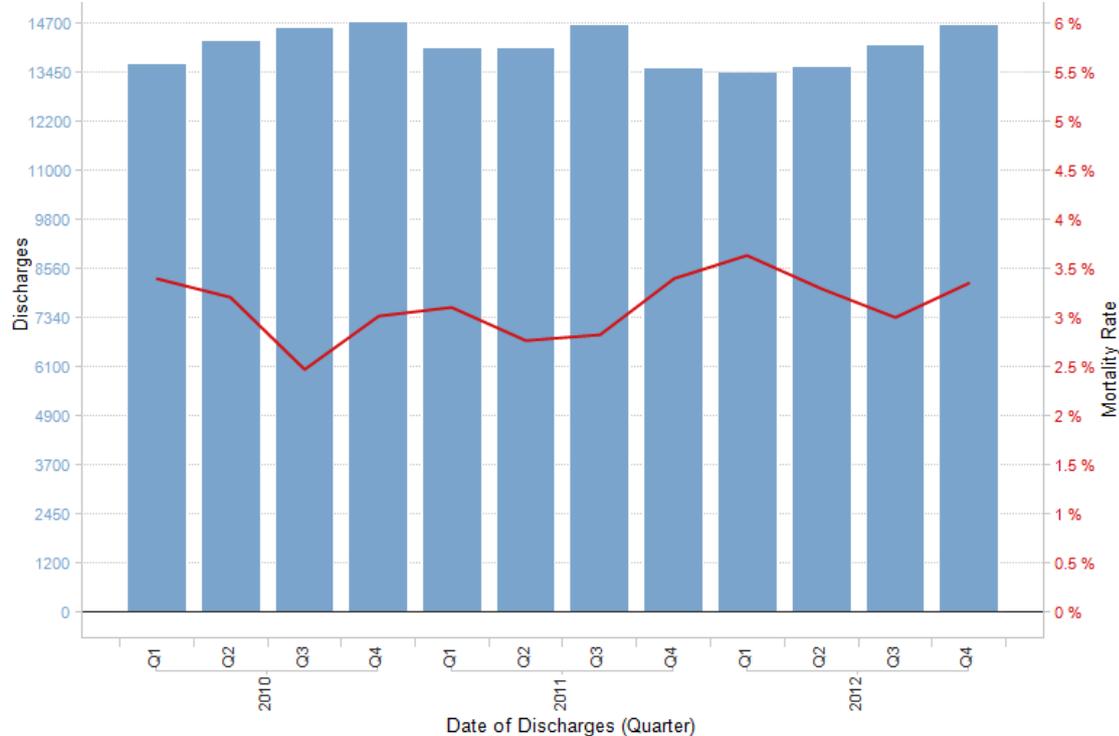
Emergency and Non-Emergency Mortality

The graph below shows the non-emergency and emergency mortality rates by quarter for the last three financial years. Although the Trust is treating more elderly patients and patients with complex conditions, mortality continues to remain generally stable. The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.



Crude Mortality

The graph below shows the Trust’s crude mortality rate against emergency and non-emergency activity (patient discharges) by quarter for the past three calendar years. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.



The Trust's crude mortality rate has slightly increased in 2012-13. UHB became a Level 1 Major Trauma Centre from April 2013 and is therefore treating more complex and seriously ill patients compared to previous years. The Trust is also doing more procedures as day cases so that patients do not need to stay overnight in hospital. This means that the patients who are now being admitted tend to be sicker and require more complex treatment.

Summary Hospital-level Mortality Indicator (SHMI)

In October 2011, the NHS Information Centre published data for the Summary Hospital-level Mortality Indicator. This is the new national hospital mortality indicator which replaces previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The new indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care¹. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model. A higher than expected SHMI should be used as a trigger for further investigation. The NHS Information Centre will publish updated SHMI data on a quarterly basis and is expected to make refinements to the way the indicator is calculated over time. The Trust's latest SHMI is 99.30 for the period April-September 2012 which is below expected. The latest SHMI value for the Trust which is available on the Health and Social Care Information Centre website is 106 for the period July 2011-June 2012 which is within the expected range.

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio which has been superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 110.71 for April-November 2012, as calculated by the Trust's Health Informatics team. This is above expected but below the upper control limit. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited²³. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

¹ Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. *BMJ Open*. 31 January 2013.

² Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. *BMJ Quality & Safety*. Online First. 7 July 2012.

² Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. *The Lancet*. 3 April 2004.

3. Quality Improvement Priorities

Priority 1: Improving VTE Prevention

Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods of immobility and can largely be prevented if appropriate preventative measures are taken.

Whilst many other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

During 2011/12, the Trust started to regularly monitor whether patients are given VTE prevention treatment, if required, following risk assessment. Performance for individual wards and the Trust overall is now available on the electronic Clinical Dashboard to allow real-time audit of performance by nursing and medical staff.

As the Trust has performed consistently highly for completion of VTE risk assessments in 2011/12, the Trust is focusing on trying to improve VTE prevention through appropriate administration of preventative (prophylactic) treatment during 2012/13. This includes graduated elastic compression stockings (GECS) and enoxaparin (medication used to reduce the risk of blood clots forming). The Trust will be focusing on improving compliance with the outcomes of completed VTE risk assessments so that a higher percentage of patients receive the preventative treatment they require, particularly pharmacological treatment (Enoxaparin medication).

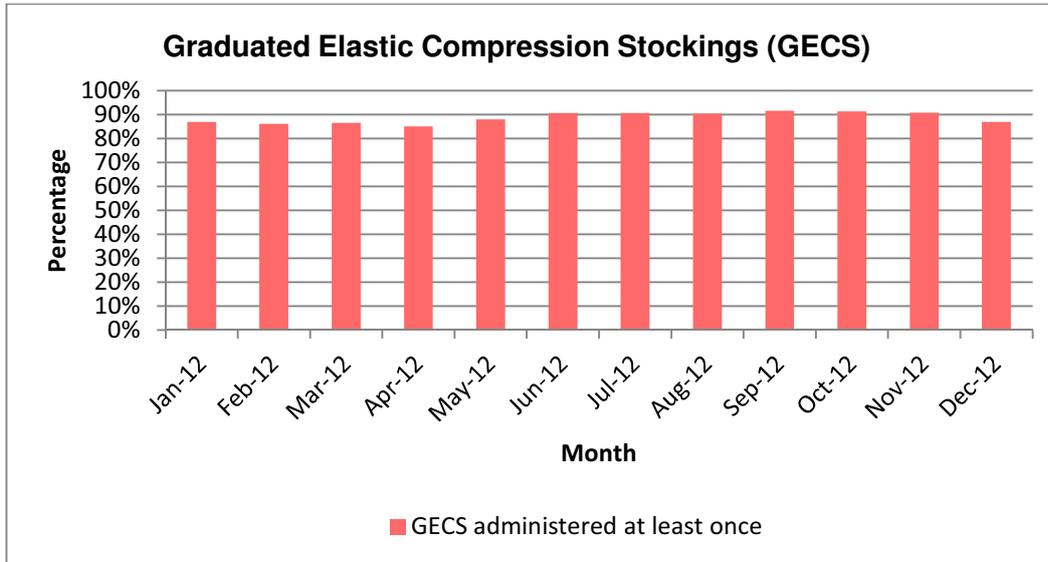
Performance

VTE Risk Assessment Completion

The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 and over 99% since June 2012. This is well above the national average of 93.9% for NHS acute providers as published on the Department of Health website (April-September 2012).

VTE Prevention – Graduated Elastic Compression Stockings

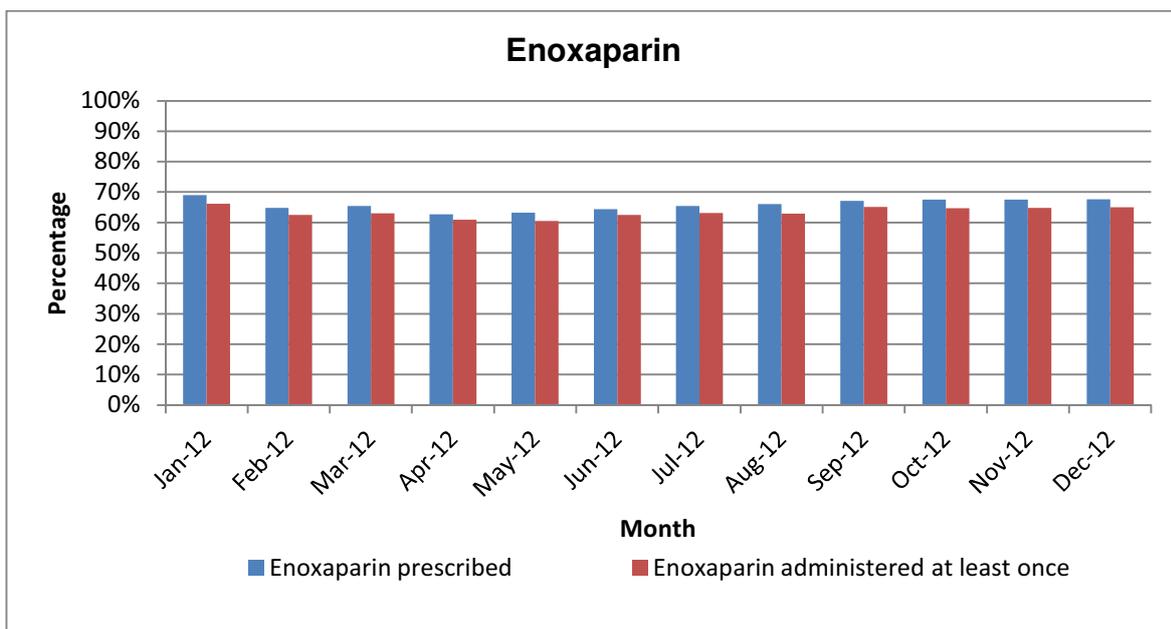
The graph below shows the percentage of graduated elastic compression stockings administered at least once by episode as recorded on the electronic Prescribing and Information Communication System.



One patient admission or spell in hospital can comprise a number of different episodes of care. If the outcome of a VTE risk assessment shows that a patient requires GECS, they are automatically prescribed by PICS. It is not always appropriate to administer compression stockings every day for a variety of reasons including patient choice and clinical contraindications such as sore or swollen skin for example. These two categories account for over two-thirds of the stockings not administered.

VTE Prevention – Enoxaparin Medication

The graph below shows the percentage of patients who required enoxaparin medication following VTE risk assessment and were prescribed it and the percentage who were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Priority 2: Improve patient experience and satisfaction

The Trust measures patient experience and satisfaction in a variety of ways, including local and national patient surveys, complaints and compliments.

Patient Experience Data

Responses to the patient survey remain high with just under 6,000 responses in quarter 3 2012/13. Responses remain generally very positive and some improvements have been made during quarter 3 2012/13.

Question	Answer	2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13
1. Were you involved as much as you wanted to be in decisions about your care and treatment?	Yes	77.20%	79.33%	80.95%	81.88%
	Yes to some extent	17.90%	16.61%	14.99%	14.57%
	No	5.00%	4.05%	4.06%	3.55%
2. Did you find someone on the hospital staff to talk to about your worries and fears?	Yes, definitely	66.90%	68.14%	73.91%	76.92%
	Yes, to some extent	22.70%	22.00%	18.33%	15.94%
	No	10.30%	9.86%	7.76%	7.13%
3. Were you given enough privacy when discussing your condition or treatment?	Yes, always	89.50%	89.60%	91.25%	91.73%
	Yes, sometimes	8.50%	8.24%	6.91%	6.66%
	No	2.00%	2.16%	1.85%	1.62%
4. Do you think that the ward staff do all they can to help you rest and sleep at night?	Yes, definitely	Data collection started from April 2012	77.96%	79.23%	80.72%
	Yes, to some extent		19.59%	17.89%	16.44%
	No		2.45%	2.89%	2.84%
5. Do you think the hospital staff do all they can to help control your pain?	Yes, definitely	83.30%	83.38%	84.89%	86.08%
	Yes, to some extent	14.20%	14.26%	12.99%	11.71%
	No	2.50%	2.36%	2.11%	2.21%
6. Have you been bothered by noise at night from hospital staff?	No, never	66.20%	67.93%	72.38%	72.46%
	Yes, occasionally	28.00%	27.02%	23.05%	22.81%
	Yes, often	5.90%	5.06%	4.57%	4.73%

7. Overall how would you rate the hospital food you have received?	Excellent	20.30%	20.88%	20.68%	20.24%
	Very Good	27.90%	27.63%	29.61%	28.93%
	Good	27.20%	26.23%	26.03%	26.92%
	Fair	16.50%	17.08%	16.46%	15.88%
	Poor	8.10%	8.18%	7.21%	8.04%
8. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never	70.00%	71.88%	74.09%	75.42%
	Yes, sometimes	24.30%	22.47%	20.98%	19.89%
	Yes, often	5.70%	5.65%	4.92%	4.69%
9. Did a member of staff tell you about medication side effects to watch for when you went home? (<i>From Discharge survey</i>)	Yes, completely	46.30%	41.38%	36.00%	36.08%
	Yes, to some extent	9.30%	13.79%	22.86%	22.68%
	No	44.40%	44.83%	41.14%	41.24%
10. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (<i>From Discharge Survey</i>)	Yes	72.40%	78.46%	80.95%	75.57%
	No	27.60%	21.54%	19.05%	24.43%

Notes on Patient Experience Data

Performance for quarters 1 and 2 has been restated in the table above to include all discharge survey responses which may be received after the end of the quarter.

The Trust has continued to raise awareness of the need to provide a conducive environment for rest and sleep for inpatients. As a result there has been a further improvement in the percentage of patients who answered positively to the question 'Do you think that the ward staff do all they can to help you rest and sleep at night?' Responses to rating of hospital food have also improved this quarter.

Friends and Family Question

The Trust started monitoring performance for the new friends and family question during quarter 1 2012/13:

- How likely is that you would recommend this service to your friends and family?

This question has been introduced in all acute trusts covered by the Midlands and East Strategic Health Authority (SHA) area. Patients are asked this question from 24 hours before and up to 48 hours after discharge from hospital and can choose from six different responses as follows:

- Extremely likely?
- Likely?
- Neither likely or unlikely?
- Unlikely?
- Not at all?
- Don't know?

Only those patients who pick 'extremely likely' are classed as promoters, 'likely' responses are classed as passive and all the rest are classed as detractors. The Net Promoter Score is calculated by subtracting the detractors from the promoters and then dividing by the number of responses. The passive responses are excluded from the calculation.

The table below shows the Trust's responses and scores for the period April-December 2012. The scores have improved during quarter 3 (October - December 2012).

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Patient Discharges	3876	3945	6168	5121	5172	6341	5391	5278	5869
Number of Responses	533	437	1144	959	1148	1100	1129	1090	1128
Response Percentage	13.75%	11.08%	18.55%	18.73%	22.20%	17.35%	20.94%	20.65%	19.22%
Promoter	361	282	801	667	835	774	852	786	850
Passive	129	106	255	228	243	248	186	220	215
Detractor	43	49	88	64	70	78	91	84	63
Score	59.66	53.32	62.33	62.88	66.64	63.27	67.40	64.40	69.77

Key actions being taken to improve patient experience include:

- There are Lead Patient Experience Champions in each ward to inform and educate staff on the collection and use of patient feedback.
- A prompt has been included in the electronic discharge checklist to remind staff to encourage patients to complete the survey on their bedside TV.
- Following the successful implementation of the postal Discharge Survey, the Trust has now introduced a postal survey for Outpatients.
- Following feedback from patients and visitors with sight impairment, all of our front of house volunteers have been trained in sighted guiding.

Complaints

The Trust received slightly fewer complaints in quarter 3 2012-13 compared to the previous quarter:

	Q2 2012/13	Q3 2012/13
Total number of complaints	179	168

Top 5 Main subjects of complaints	Q2 2012/13	Q3 2012/13
Clinical treatment	86	91
Admission, discharge & transfer arrangements	11	18
Outpatient appointment delays/cancellations	14	14
Staff Attitude	13	14
Communication & information	17	11

Ratio of complaints to activity		Q2 2012/13	Q3 2012/13
Inpatients	FCEs*	29,990	32,810
	Complaints	104	87
	Rate per 100 FCEs	0.35	0.27
Outpatients	Appointments**	146,513	149,599
	Complaints	53	59
	Rate per 100 appointments	0.04	0.04
A&E	Attendances	24,038	23,957
	Complaints	22	22
	Rate per 100 attendances	0.09	0.09

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant.

** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech and Language Therapy and Occupational Therapy)

Learning from complaints

The Trust takes a number of steps to review learning from complaints and to take action as necessary. Complaints are reported monthly to the Care Quality Group, as part of a wider Patient Experience report. A monthly complaints report is also presented at the Chief Executive's Advisory Group. Each quarter, an aggregated report detailing information relating not only to Complaints, but also PALS concerns, incidents and claims is provided to the Trust's Audit Committee. This report uses those services shared database to identify common themes and

trends. A report on complaints is also provided to the Board of Directors every two months.

A more detailed analysis of complaints trends, themes and associated learning by clinical Division is reported at Divisional Clinical Quality Group meetings. This is the forum where learning/actions identified following a complaint investigation are reported and any such learning/actions which have not been completed are highlighted and followed up until the Division confirm that the specific learning/action has been completed.

The Head of Patient Relations also uses complaints data to identify opportunities for delivering Customer Care training to wards or departments where themes around staff attitude or communication have been identified. Anonymised complaints for the specific area are used as part of the training.

Independent reviews

During the third quarter of 2012/13, the Parliamentary and Health Service Ombudsman advised the Trust that seven cases had been accepted for initial assessment. One of these cases has since been closed by the Ombudsman and the Trust is still awaiting the outcome for the rest.

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS) on behalf of the Trust. PALS receive some compliments directly from patients and carers; others are forwarded to PALS by staff after being received in wards and departments throughout the Trust.

The majority of compliments are received in writing – by letter, card, email or feedback leaflet, the rest are received verbally via telephone or face to face.

Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale.

Compliment Subcategories	Q1 2012/13	Q2 2012/13	Q3 2012/13
Nursing care	108	117	53
Friendliness of staff	81	29	53
Treatment received	66	269	214
Medical care	18	10	20
Efficiency of service	35	26	18
Information provided	2	1	2
Facilities	6	15	2
Other	13	6	16
Totals:	329	473	378

Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)

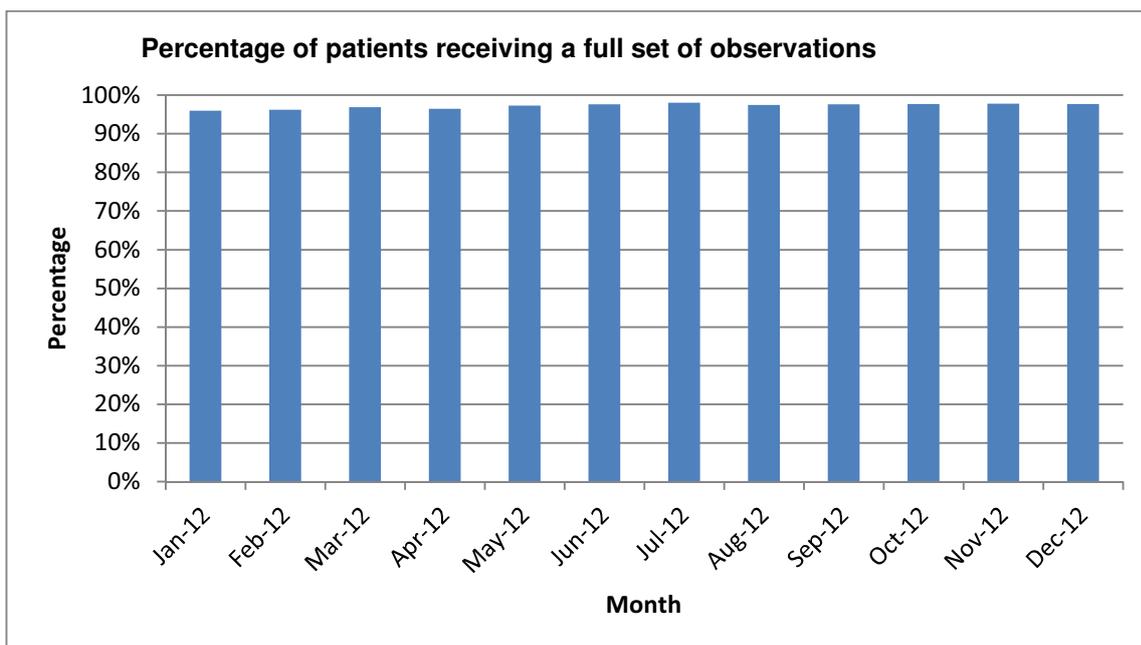
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool enables an early warning score called the SEWS (Standardised Early Warning System) score to be triggered automatically if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible. This indicator measures the percentage of patients who receive at least one full set of observations in a 24-hour period.

The Trust completed the roll out of the electronic observation chart to the remaining wards during 2011/12 so all inpatient wards are now recording patient observations electronically. The four Critical Care areas have very different requirements for recording observations compared to the inpatient wards so do not currently record these on the standard electronic observation chart in PICS. There is a plan to develop a specific and detailed electronic observation chart for Critical Care in the future.

Performance

The figures for Quarter 3 show that the Trust is maintaining a steady rate above 97% with 97.75% of all inpatients receiving at least one full set of observations per day in December 2012. The Trust is aiming for at least 98% of all observation sets to be complete for all inpatient wards by the end of 2012/13.



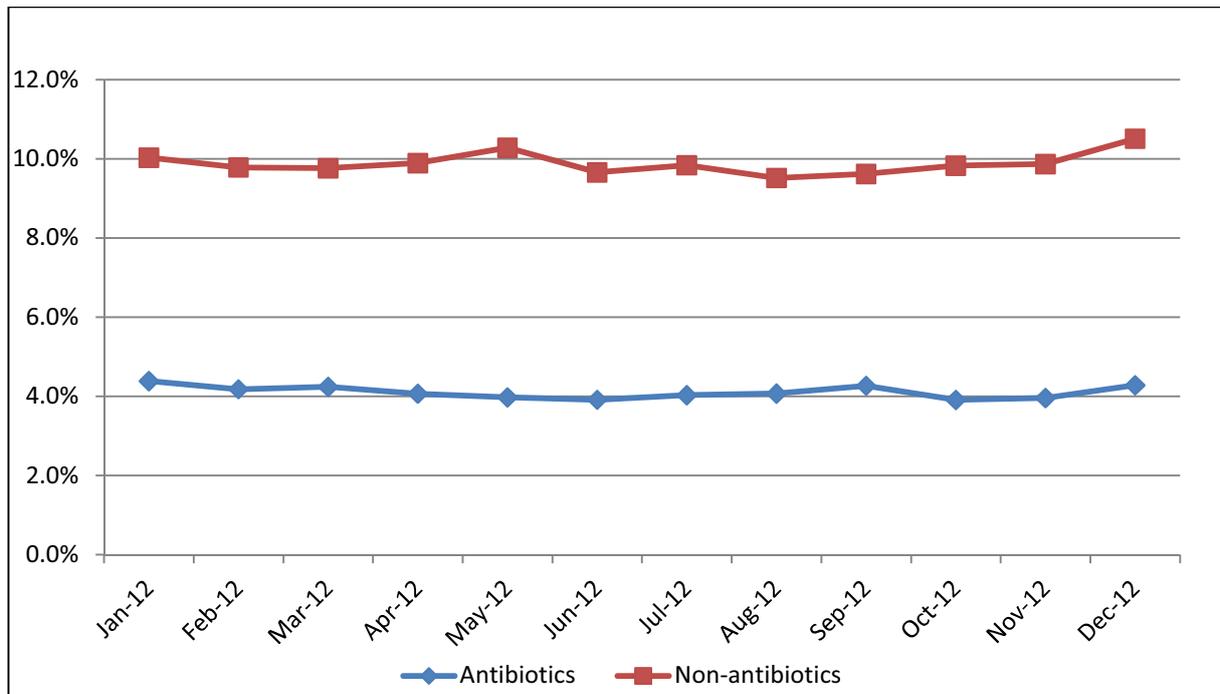
Priority 4: Reducing medication errors (missed doses)

Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System.

The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive root cause analysis (RCA) meetings were introduced at the end of March 2010.

Performance

The graph below shows that missed antibiotic and non-antibiotic doses have stabilised during 2012-13 following big reductions made in previous years. It is however important to remember that some drug doses are appropriately missed due to the patient's condition at the time. The Trust is continuing to try to reduce avoidable missed doses through appropriate prescribing and administration.



Priority 5: Infection prevention and control

The Trust is continuing to reduce the incidence of MRSA bacteraemia and *Clostridium difficile* infection during 2012-13. The Trust needs to be at or below the agreed trajectories for 2012-13. At the end of the quarter 3, the Trust is slightly over trajectory for both MRSA bacteraemia and *C. difficile* infection (CDI) and will focusing on trying to reduce infection rates during quarter 4 2012-13.

MRSA bacteraemia

The Trust is continuing its focus on reducing the incidence of MRSA bacteraemia through improving MRSA screening and decolonisation, the management of invasive devices and compliance with Infection Prevention and Control procedures.

The table below shows the Trust's overall performance against trajectory by quarter and 2012-13 to date:

	Quarter 1 2012-13	Quarter 2 2012-13	Quarter 3 2012-13	Year to date
Actual performance	1	2	2	5
Agreed trajectory	2	1	1	4

***C. difficile* infection**

In April, the Trust implemented a two-stage laboratory test for the detection of toxigenic *C. difficile* in line with Department of Health (DH) guidance. The Department of Health guidance outlines the requirement for mandatory reporting following the implementation of a two-stage test and the Trust apportioned cases are shown in the table below.

The Trust is focusing on reducing the incidence of *Clostridium difficile* infection through multidisciplinary patient assessment, timely isolation of patients, appropriate antimicrobial prescribing, compliance with hand hygiene procedures, environmental cleaning and staff education.

The table below shows the Trust's performance against trajectory by quarter and 2012-13 to date:

	Quarter 1 2012-13	Quarter 2 2012-13	Quarter 3 2012-13	Year to date
Actual performance	19	24	18	61
Agreed trajectory	19	19	19	57

In addition, the Trust continues to report MSSA (Meticillin-sensitive staphylococcus aureus) and *E. coli* bacteraemia during Quarter 3 2012-13 to the Health Protection Agency as part of the mandatory surveillance requirements.

4. Performance of the Trust against selected metrics

The tables below show the Trust's latest performance for 2012/13 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data for 2012/13 is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance is monitored and challenged during the year by the Clinical Quality Monitoring Group and the Board of Directors.

Patient safety indicators

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialities)	0.33	0.15	0.20	0.07
<i>Lower rate indicates better performance</i>				
Time period	2010/11	2011/12	April-Oct 2012	April-Oct 2012
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA

Indicator	2010/11	2011/12	2012/13	Peer Group (where available)	Average
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics)	0.33	0.15	0.20	0.09	
<i>Lower rate indicates better performance</i>					
Time period	2010/11	2011/12	April-Oct 2012	April-Oct 2012	
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	
Peer group				Acute trusts in West Midlands SHA	
2(a). C. difficile: Patients with C. difficile infection/1,000 bed days (includes all bed days from all specialties)	43.33	25.43	25.21	18.02	
<i>Lower rate indicates better performance</i>					
Time period	2010/11	2011/12	April-Oct 2012	April-Oct 2012	
Data source	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	
Peer group				Acute trusts in West Midlands SHA	

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
2(b). C. difficile: Patients with <i>C. difficile</i> infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics)	43.34	25.43	25.21	21.22
<i>Lower rate indicates better performance</i>				
Time period	2010/11	2011/12	April-Oct 2012	April-Oct 2012
Data source	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA
3(a) Patient safety incidents (reporting rate per 100 admissions)	9.1	9.3	10.5	Not yet available
<i>Higher rate indicates better reporting</i>				
Time period	2010/11	2011/12	April-Dec 2012	
Data source	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
3(b) Never Events	2	1 (see explanatory note below table)	0	<i>Not available</i>
<i>Lower number indicates better performance</i>				
Time period	2010/11	2011/12	April-Dec 2012	
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer Group				
4(a) Percentage of patient safety incidents which are no harm incidents	81.3%	70.4%	64.24%	<i>Not yet published</i>
<i>Higher % indicates better performance</i>				
Time period	2010/11	2011/12	April-Dec 2012	
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				
4(b) Percentage of patient safety incidents resulting in severe harm or death	<i>Not available</i>	1.4%	1.47%	<i>Not yet available</i>
<i>Lower % indicates better performance</i>				
Time period		2011/12	April-Dec 2012	
Data source		Datix (incident data)	Datix (incident data)	
Peer group				

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): The data for *C.difficile* infection has been calculated using 100,000 bed days rather than 1,000 used previously, in line with DH guidance.

3(a): The admissions data has been changed to include dialysis patients from Q1 2012/13 as these are also classed as admissions. The data for 2010/11 and 2011/12 has been recalculated to aid comparison and therefore differs from that shown in the Trust's 2011/12 Quality Account.

3(b): The Trust reported one never event during 2011/12. The incident was recorded as 'retained foreign object post-operation' and related to a swab being left inside a patient during surgery at the Queen Elizabeth Hospital Birmingham. The swab was subsequently removed and the patient suffered no ill-effects as a result.

4(a): The reduction in the percentage of no harm incidents in 2010/11, 2011/12 and April-December 2012 is largely due to the reporting of all grades of pressure ulcer as harm incidents from April 2010 and a reduction in the number of (no harm) incidents relating to missing medical records following the introduction of the electronic Clinical Portal in Outpatients.

4(b): There was 1 patient safety incident (fall) reported during 2011/12 which resulted in death. There were 3 deaths following falls reported in the period April-September 2012 which have been fully investigated in line with the Trust's procedure for Serious Incidents Requiring Investigation (SIRIs).

Clinical effectiveness indicators

Indicator	2010/11	2011/12	2012/13	Peer Group (where available)	Average
5(a). Readmissions: rate (Medical and surgical specialties - elective and emergency admissions aged >15) %	6.22%	5.18%	4.45%	5.26%	
<i>Lower % indicates better performance</i>					
Time period	2010/11	2011/12	April-September 2012	April-September 2012	April-September 2012
Data source	HES data	HES data	HES data	HES data	HES data
Peer group					University hospitals

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
5(b). Readmissions: Readmission rate (all specialities) %	6.20%	5.16%	4.43%	4.19%
<i>Lower % indicates better performance</i>				
Time period	2010/11	2011/12	April-Sept 2012	April-Sept 2012
Data source	HES data	HES data	HES data	HES data
Peer group				University hospitals
6. Falls (incidents reported as % of elective and emergency admissions)	2.1%	2.2%	2.10%	<i>Not available</i>
<i>Lower % indicates better performance</i>				
Time period	2010/11	2011/12	April-December 2012	
Data source	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	

Indicator	2010/11	2011/12	2012/13	Peer Group (where available)	Average
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin	100%	100%	100%		
<i>Higher % indicates better performance</i>					
Time period	2010/11	2011/12	April-Dec 2012		
Data source	Trust PICS data	Trust PICS data	Trust PICS data		
Peer group					
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG)	92.6%	93.6%	96.8%		
<i>Higher % indicates better performance</i>					
Time period	2010/11	2011/12	April-Dec 2012		
Data source	Trust PICS data	Trust PICS data	Trust PICS data		
Peer group					

Notes on clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect speciality activity, taking into account that the Trust does not undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialities are known to be very low risk in terms of hospital acquired infection for example and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

5(a), 5(b): The data shown relates to patients who are readmitted within 30 days of being discharged from UHB to any provider in England, including private sector providers. In line with guidance from the Department of Health, the new methodology also includes patients who were originally admitted as daycases (for a planned procedure) and regular daycases (e.g., patients attending dialysis): http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125490.pdf. The data is now presented for 100,000 bed days rather than 1,000 bed days.

6: The admissions data includes daycase patients as well as all elective and emergency admissions. The admissions data now also includes dialysis patients from Q1 2012/13 as these are also classed as admissions. The data for 2010/11 and 2011/12 has been recalculated to aid comparison and therefore differs from that shown in the Trust's 2011/12 Quality Account.

7: Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke. Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate.

8: Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.