UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
THURSDAY 29 NOVEMBER 2018

Title:	**Quality Account - Half Year Update Report 2018/19**
Responsible Director:	Mark Garrick, Director of Quality Development
Contact:	Imogen Acton, Head of Quality Development Samantha Baker, Quality Support Manager

Purpose:	To present the Quality Account - Half Year Update Report for 2018/19 to the Council of Governors	
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:	The Quality Account - Half Year Update Report for 2018/19 is shown in Appendix A. Performance for the six Quality Improvement Priorities is included along with selected patient safety and clinical effectiveness metrics.	
Recommendations:	The Council of Governors is asked to: • **Note** the content of the Quality Report - Half Year Update Report for 2018/19.	
Approved by:	Mark Garrick	Date: 21st November 2018

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QUALITY ACCOUNT - HALF YEAR UPDATE REPORT 2018/19

PRESENTED BY DIRECTOR OF QUALITY DEVELOPMENT

1. **Introduction**

The aim of this paper is to present the Trust's Quality Account Half Year Update for 2018/19.

The Report is shown in Appendix A and was presented to the Clinical Quality Monitoring Group in January 2018.

2. **Quality Account - Half Year Update Report 2018/19**

2.1 The Quality Account Half Year Update Report for 2018/19 is shown in Appendix A. The latest available data is included in the report.

2.2 Performance for Quality Improvement Priorities:

- The number of grade 2, hospital-acquired avoidable pressure ulcers remains below the trajectory targets for both HGS and QEHB.
- At QEHB, one of the selected Patient Experience questions is meeting the end of year target. Three will have targets set soon now that baseline data has been collected. Seven are not yet meeting their end of year target although many are close.
- At QEHB, performance for the indicator '*observations and pain assessment within 6 hours*' has improved slightly and is now 94.7% against the end of year target of 95%, while performance for the indicator '*timely analgesia*' remains steady compared to the previous Quarters (around 75%).
- At HGS, performance for the observations indicator is meeting the target for all three hospital sites.
- At QEHB, the percentage of missed doses of antibiotics is meeting the target of 4% or below. Non-antibiotics is not yet meeting the target but has improved compared to previous quarters. Cases continue to be presented at the Executive Care Omissions RCA group.
- At HGS, the percentage of missed doses of regular antibiotics remains steady.
- At QEHB, the percentage of falls resulting in harm is meeting the end of year trajectory, as is the percentage of injurious falls at HGS.
- For timely treatment of sepsis at HGS and QEHB, working groups have been set up to align the CQUIN audit definitions and methodology.

3. **Recommendations**

The Council of Governors is asked to:

- **Note** the content of the Quality Account Half Year Update Report 2018/19 (Appendix A).

Appendix A

Half-Year Quality Account Update 2018/19 (April – September 2018)

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Half-Year Quality Account Update 2018/19 (April – September 2018)

Introduction

The Trust published its ninth Quality Account Report in June 2018 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2017/18, performance data for selected metrics and set out six priorities for improvement during 2018/19:

Priority 1: Reducing grade 2 hospital-acquired avoidable pressure ulcers
Priority 2: Improve patient experience and satisfaction
Priority 3: Timely and complete observations including pain assessment
Priority 4: Reducing missed doses
Priority 5: Reducing harm from falls
Priority 6: Timely treatment for sepsis

This report provides an update on the progress made for the period April to September 2018 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 2017/18.

Note regarding merger by acquisition of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust

On 1st April 2018, the merger by acquisition of Heart of England NHS Foundation Trust (HEFT) by University Hospitals Birmingham NHS Foundation Trust (UHB) was formally agreed. The decision was made the Trusts' respective Boards of Directors, with the decision cleared by both Councils of Governors.

The enlarged Trust uses the University Hospitals Birmingham NHS Foundation Trust name (UHB). All individual hospital and clinic names remain the same.

Although the Trust is working to align its systems, some data is being reported by 'block' while this work is underway. The former UHB is now known as Queen Elizabeth Hospital Birmingham site (QEHB), and the former HEFT as the HGS sites (Heartlands, Good Hope, Solihull).

Indicators are being reviewed across the sites, with plans to align where possible, or to develop new indicators.

Quality Improvement Priorities

Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

Background

This quality improvement priority was first proposed by the Council of Governors and approved by the Board of Directors for QEHB in 2015/16, and for HGS in 2017/18. It was chosen because pressure ulcers can affect patients from many different clinical specialties, and can have a significant impact on patients.

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply (NICE, 2014). They are also known as "bedsores" or "pressure sores" and they tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. Some pressure ulcers also develop due to pressure from a device, such as tubing required for oxygen delivery.

Pressure ulcers are painful, may lead to chronic wound development and can have a significant impact on a patient's recovery from ill health and their quality of life. They are graded from 1 to 4 depending on their severity, with grade 4 being the most severe.

Grade	Description
1	Skin is intact but appears discoloured. The area may be painful, firm, soft, warmer or cooler than adjacent tissue.
2	Partial loss of the dermis (deeper skin layer) resulting in a shallow ulcer with a pink wound bed, though it may also resemble a blister.
3	Skin loss occurs throughout the entire thickness of the skin, although the underlying muscle and bone are not exposed or damaged. The ulcer appears as a cavity-like wound; the depth can vary depending on where it is located on the body.
4	The skin is severely damaged, and the underlying muscles, tendon or bone may also be visible and damaged. People with grade 4 pressure ulcers have a high risk of developing a life-threatening infection.
Ungradable (Depth unknown)	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
Suspected Deep Tissue Injury (SDTI) (depth unknown)	Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

National Pressure Ulcer Advisory Panel / European Pressure Ulcer Advisory Panel / Pan Pacific Pressure Injury Alliance (2014)

As well as the categories above, it the Trust also records whether the pressure ulcer was caused by medical device (e.g., nasogastric tubes, urinary catheters), or not.

Due to very low numbers of hospital-acquired grade 3 and grade 4 ulcers at UHB, the Trust focus is on further reducing grade 2 ulcers. This in turn should help towards aiming for zero avoidable hospital-acquired grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

It should also be noted that changes to some definitions are expected during 2018/19, which will affect reporting of pressure ulcers.

Performance

Targets for HGS and QEHB are different, as they are based on the targets set with the CCG (Clinical Commissioning Group) prior to the merger. These have carried over into 2018/19.

QEHB

During 2017/18, QEHB reported 62 patients with non-device related, hospital-acquired avoidable grade 2 pressure ulcers, and 14 patients with device-related, hospital-acquired avoidable grade 2 pressure ulcers.

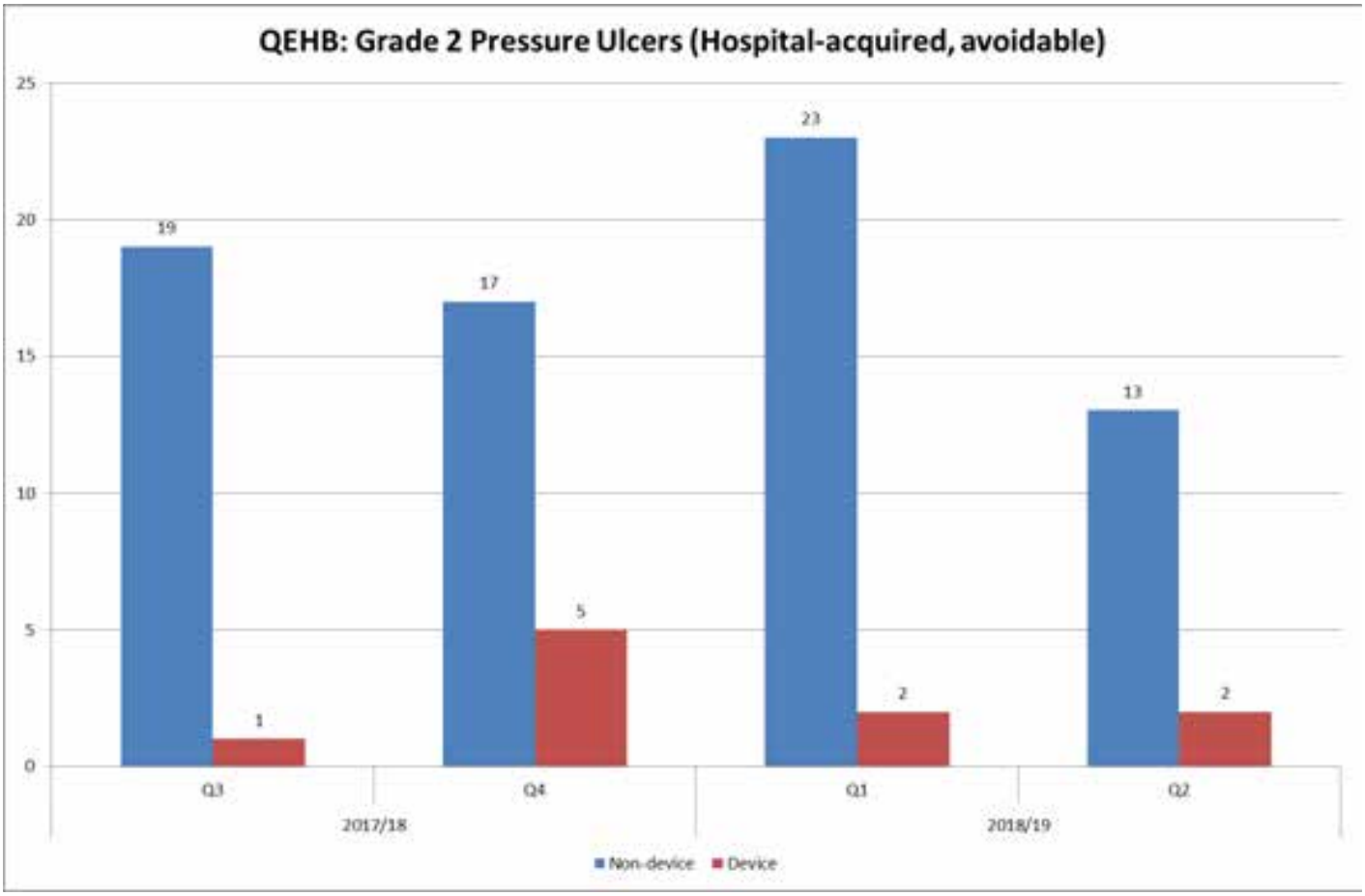
The 2018/19 targets agreed with Birmingham CrossCity Clinical Commissioning Group (CCG) for grade 2, avoidable, hospital-acquired pressure ulcers are:

- Device related – no more than 75 patients with such ulcers
- Non-device related – no more than 42 patients with such ulcers

These are the same as the targets set for 2017/18.

During Quarters 1-2 2018/19, QEHB reported 36 patients with non-device related, hospital-acquired avoidable grade 2 pressure ulcers, and 4 patients with device-related, hospital-acquired avoidable grade 2 pressure ulcers.

Number of patients with grade 2 hospital-acquired, avoidable pressure ulcers, by Quarter



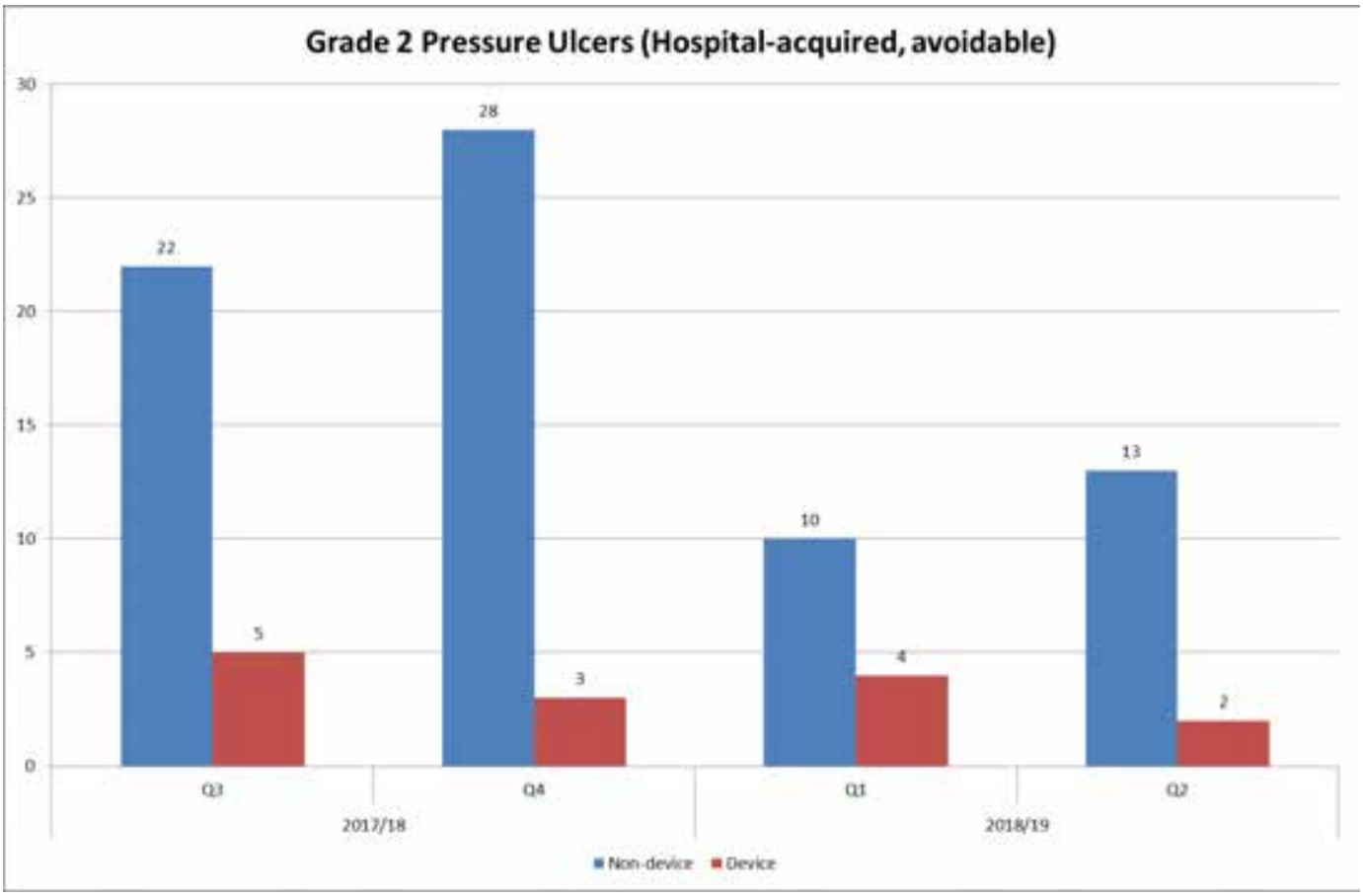
HGS

The target agreed with the CCG was a two year reduction plan of 20% by the end of March 2019.

During 2017/18, HGS reported 108 hospital-acquired avoidable grade 2 pressure ulcers. This equated to a 14.3% reduction at the end of year one. (Note – this data has undergone final validation and may have changed slightly compared to the 2017/18 report). This compares to 128 avoidable grade 2 pressure ulcers reported in 2016/17, and 196 reported in 2015/16.

During Quarters 1-2 2018/19*, HGS reported 29 hospital-acquired avoidable grade 2 pressure ulcers (6 device related, and 23 non-device related).
**September data included but subject to change following validation*

Number of patients with grade 2 hospital-acquired, avoidable pressure ulcers, by Quarter*
**September data included but subject to change following validation*



Initiatives to be implemented during 2018/19

To continue to build on the improvements seen in 2017/18, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly. Initiatives to aid improvements include:

- Develop and launch seating leaflet and detailed seating guidelines in conjunction with Therapies.
- Set up a task and finish group to determine the changes required to refocus on repositioning.
- Ensure all wards have React to RED discs, key rings and grading cards.
- Continue to promote the prevention of heel drag through educational activities and clinical practice.

- To trial new and innovative pressure relieving equipment including mattresses, trolley mattresses and cushions through the Equipment Standardisation group.
- To re-devise and re-launch the Equipment Selection Flowchart to promote effective utilisation of equipment.
- Work in conjunction with other disciplines to link in with national campaigns e.g. “get up, get dressed, get moving”.

How progress will be monitored, measured and reported

- All grade 2, 3 and 4 pressure ulcers are reported via the Trust’s incident reporting system Datix, and then reviewed by a Tissue Viability Specialist Nurse.
- Monthly reports are submitted to the Trust’s Preventing Harms meeting, which reports to the Chief Nurse’s Care Quality Group.
- Data on pressure ulcers also forms part of the Clinical Risk report to the Clinical Quality Monitoring Group.
- Staff can monitor the number and severity of pressure ulcers on their ward via the Clinical Dashboard.

Priority 2: Improve patient experience and satisfaction

The Trust measures patient experience via feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test, complaints and compliments and online sources (e.g., NHS Choices). This vital feedback is used to make improvements to our services. This quality priority focuses on improving scores in our local surveys, and also takes into account national survey results and correlations with what ranks as most important to patients in giving a high rating of care.

HGS

This priority is new for HGS. Work will take place to develop and select questions to be included.

QEHB

Patient experience data from local surveys

Survey	No. responses 2018/19	Data up to
Inpatient	4687	Q1 & Q2 2018/19
Emergency Department	278	Q1 & Q2 2018/19
Outpatient	956	Q1 & Q2 2018/19
Discharge	833	Q1 & Q2 2018/19

Methodology

Until Quarter 3 2017/18, the local inpatient survey was undertaken predominantly utilising the bedside TV system, allowing patients to participate in surveys at their leisure. Areas that did not have the bedside TVs used either paper or computer tablets for local surveys. During Quarter 3 the Trust decided not to renew the bedside TV survey contract with its external provider. Whilst exploring other electronic methods of feedback the Trust has implemented an interim solution using paper based surveys to replace those done on the bedside TV system. The Emergency Department survey is a paper-based survey, and the outpatient and discharge surveys are postal; both sent to a sample of 750 patients per month.

Improvement targets

For 2018/19, 2017/18 performance was reviewed for the questions set for this priority. Some of the questions that achieved or maintained their target during the previous year were replaced as part of the questions included within the Quality Account priority. The questions that were replaced as part of the priority will continue to be monitored as part of local surveys.

This improvement priority was agreed at the Trust's Care Quality Group meeting in February 2018, which is a Chief Nurse-led sub-committee of the Board, attended by clinical staff and also patient Governors who provide the patients' perspective. Rationale for keeping, removing or adding questions was included in the report to this committee. This was based on data available at that time (Quarter 3, 2017/18 data).

- **Questions carried forward** – targets reviewed based on Q3 2017/18 performance
- **New questions with a 2017/18 Q3 baseline score from local surveys** – targets were set by the Care Quality Group.
- **New questions without a 2017/18 baseline** – target to be set at Care Quality Group following collection of baseline data.

Results from local patient surveys

This table shows results for 2017/18 and 2018/19 along with the status for each question.

	2017/18 Score	2018/19					
		Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target	YTD number of responses
Inpatient survey							
1. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.6	8.4	8.4			**9.0**	4356
2. If you needed attention, were you able to get a member of staff to help you within a reasonable time?	NA	8.8	8.9			**9.3****	3832
3. Do you think the hospital staff did everything they could to help control your pain?	9.3	9.2	9.2			**9.6**	3868
4. Did you have confidence and trust in the nurses treating you?	NA	9.5	9.6			**9.6****	2993
Outpatient survey*							
5. How long after the stated appointment time did the appointment start?	7.0	6.6	6.8			**7.0**	945
6. If you had an intimate examination/procedure performed during your outpatient appointment, were you offered a chaperone?	NA	5.5	5.7			**5.9****	176
Emergency Department survey							
7. During your time in the Emergency Department did you feel well looked after by hospital staff?	8.8	8.8	8.5			**9.0**	165
8. How would you rate the courtesy of the Emergency Department reception staff?	8.7	8.6	8.3			**9.0**	224
9. Were you kept informed of what was happening at all stages during your visit?	8.1	8.0	7.4			**8.5**	271
10. Do you think the hospital staff did everything they could to help control your pain?	8.2	8.3	7.9			**9.0**	224
Discharge survey*							
11. Did you feel you were involved in decisions about going home from hospital?	7.1	7.4	7.6			**7.4**	766

**postal surveys - data is not complete due to time lag*

***TBC targets to be proposed to Care Quality Group in the Quarter 2 report now that baseline data has been collected.*

How progress will be monitored, measured and reported

- This priority is measured using the local survey results as detailed in the methodology.
- The new questions 'confidence and trust in nurses' and 'offering a chaperone' will be added to the relevant local surveys and targets set once sufficient baseline data has been collected.
- The call bell question will be reworded to match the new wording in the national inpatient survey for improved benchmarking. A target will be set once sufficient baseline data has been collected.
- The operational Patient Experience Group (reporting to the Care Quality Group) monitors this priority.
- Monthly exception reports to Divisional Heads of Nursing (HONs) highlight individual wards not meeting the quality priority so that action can be taken. This report is presented to the Care Quality Group and includes a section from each HON with actions for their division.
- This patient experience quality priority is also reported on the Clinical Dashboard so is always available for staff to view; updated monthly.
- Quarterly patient experience reports, including progress on the patient experience quality priorities, are provided to the Care Quality Group (summarised to the Board of Directors) and the local Clinical Commissioning Group.
- Feedback on patient experience is also provided by members of the Patient and Carer Councils as part of the Adopt a Ward / Department visits and via Governor drop-in sessions.

Initiatives to be implemented in 2018/19

- Increased identification and support of carers driven by the recently introduced Carer Coordinator role.
- Further development of feedback methods to ensure 'hard to reach' groups have a voice and their views are listened to and acted on.
- Develop work started around the use of chaperones, ensuring patients are informed and staff are educated to ensure chaperones are proactively offered and used appropriately in relevant situations (the patient experience team input into this will focus on monitoring the patient experience).
- Continued staff engagement in relation to patient experience, empowering multi-disciplinary team members to understand their role in influencing the overall patient experience, including production of a video highlighting the patient experience quality priorities.
- Introduction of android tablets to all wards and some departments to make it easier for patients to feed back electronically.
- Development of the information screen in the Emergency Department to include different pathways to help patients understand why they may wait different times, and the use of paracetamol as first line pain relief.

Priority 3: Timely and complete observations including pain assessment

Background

All inpatient wards have been recording patient observations (temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness) electronically since 2011. The observations are recorded within the Prescribing Information and Communication System (PICS).

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool automatically triggers an early warning score called the SEWS (Standardised Early Warning System) score if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible.

In 2015/16, the Board of Directors chose to tighten the timeframe for completeness of observation sets to within 6 hours of admission or transfer to a ward and to include a pain assessment.

In addition, the Trust monitors the timeliness of analgesia (pain relief medication) following a high pain score. The pain scale used at UHB runs from 0 (no pain at rest or movement) to 10 (worst pain possible). Whenever a patient scores 7 or above, they should be given analgesia within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work.

The Trust is working on the implementation of NEWS2 – a new early warning system that is to be used nation-wide. Once in place, the indicators will be updated to reflect use of this new system.

Performance (QEHB)

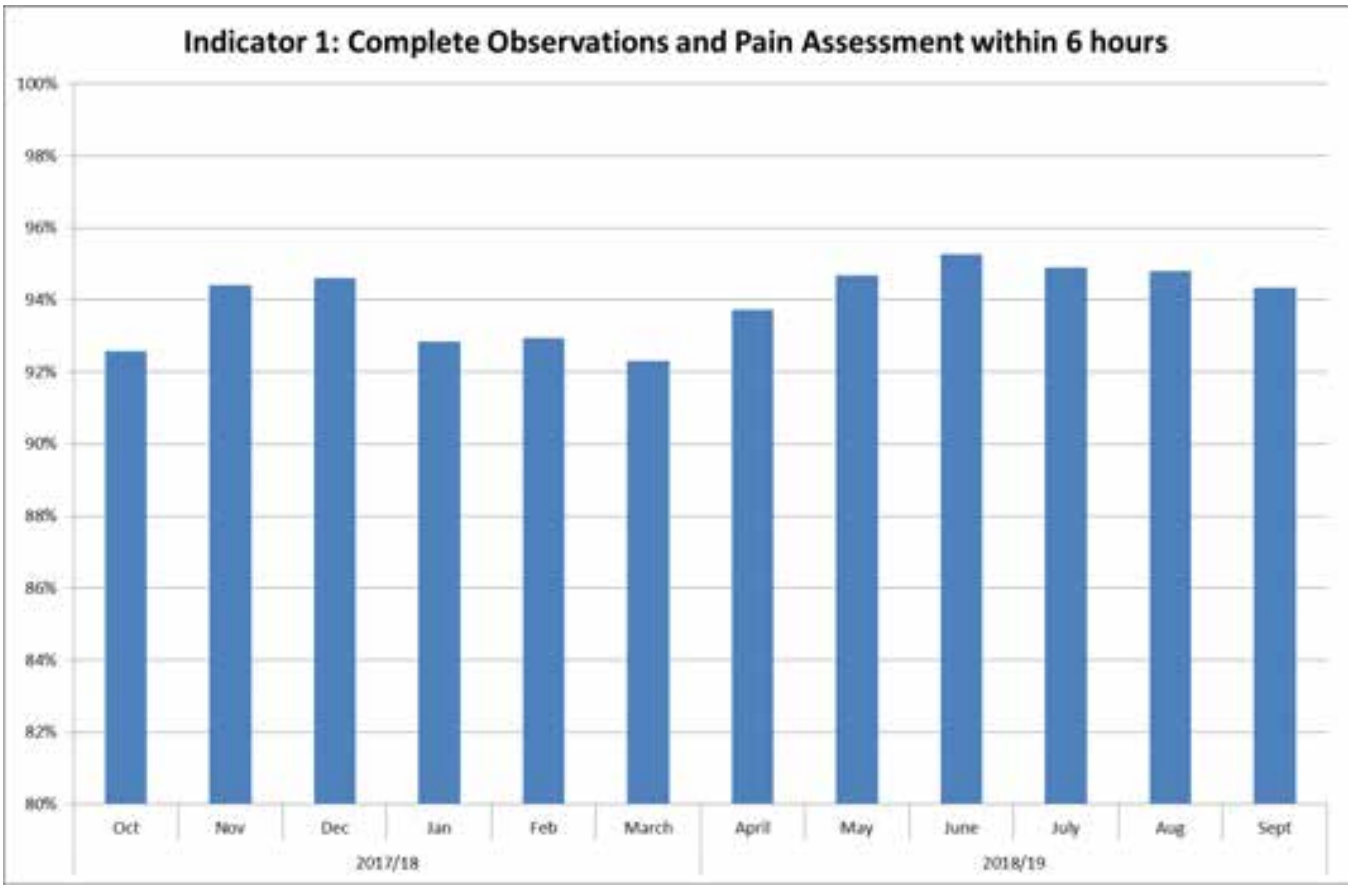
Indicator 1 had achieved the target during 2016/17, so the target was raised to 95% for 2017/18. Performance improved again during 2017/18 (reaching 93.8% during Quarter 3) but did not meet the final target. Therefore the target of 95% has been kept for 2018/19. QEHB is very close to meeting this target for Quarters 1 and 2.

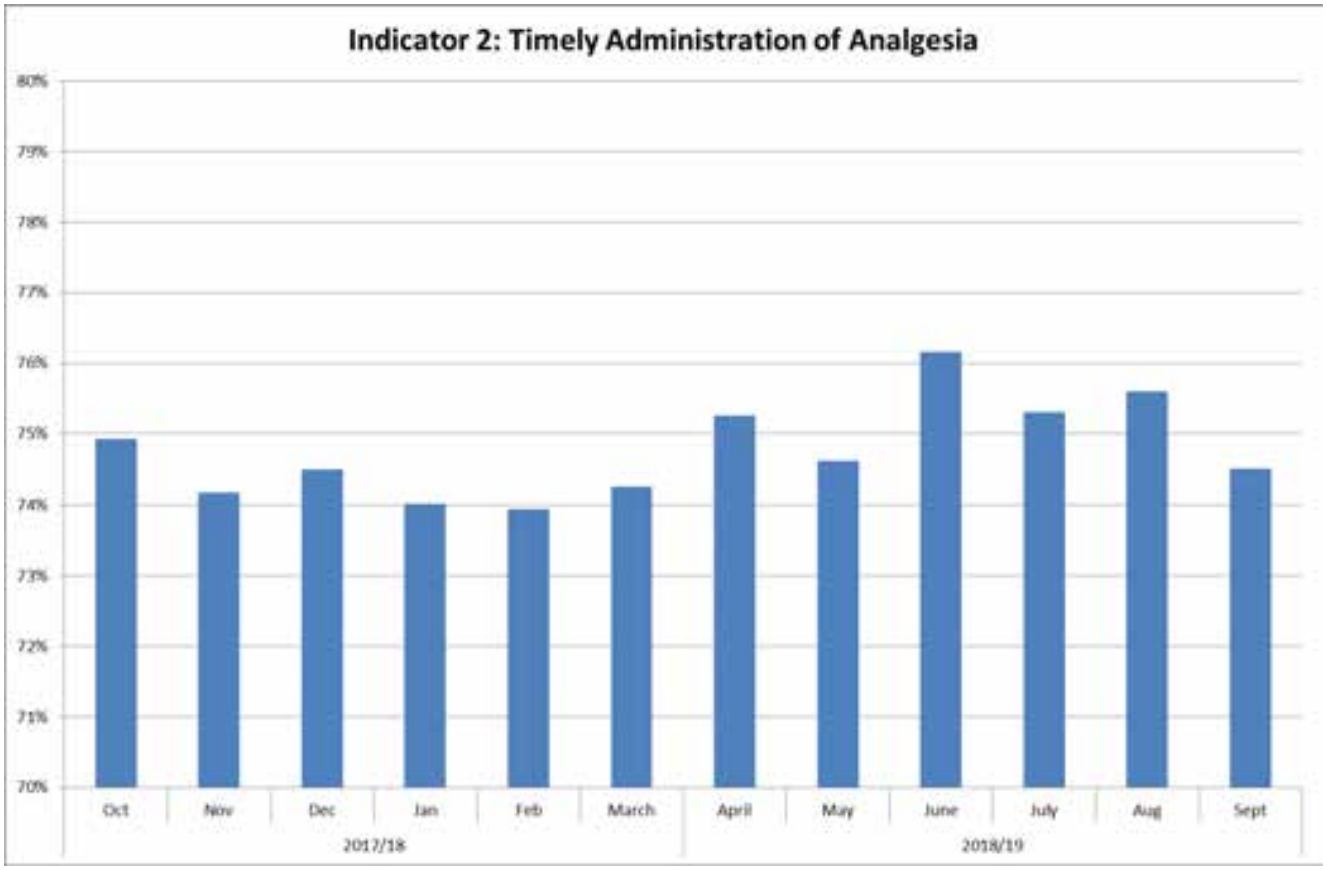
Indicator 2 had not achieved the target during 2016/17, so the same target was kept for 2017/18. Performance was again steady throughout the year, around 74% to 76% each month, however the target of 85% was not achieved, so it has again been kept for 2018/19. Performance for Quarters 1 and 2 is in line with previous quarters of around 75%.

Table: Performance by quarter

Performance		Indicator 1	Indicator 2
		Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward	Analgesia administered within 30 minutes of a high pain score
Performance 2014/15		71%	64%
Performance 2015/16		79%	76%
Performance 2016/17		90%	75%
Performance 2017/18		93%	75%
2018/19	**Target**	**95%**	**85%**
	Q1	94.6%	75.3%
	Q2	94.7%	75.2%
	Q3		
	Q4		
	Year to date	**94.6%**	**75.3%**

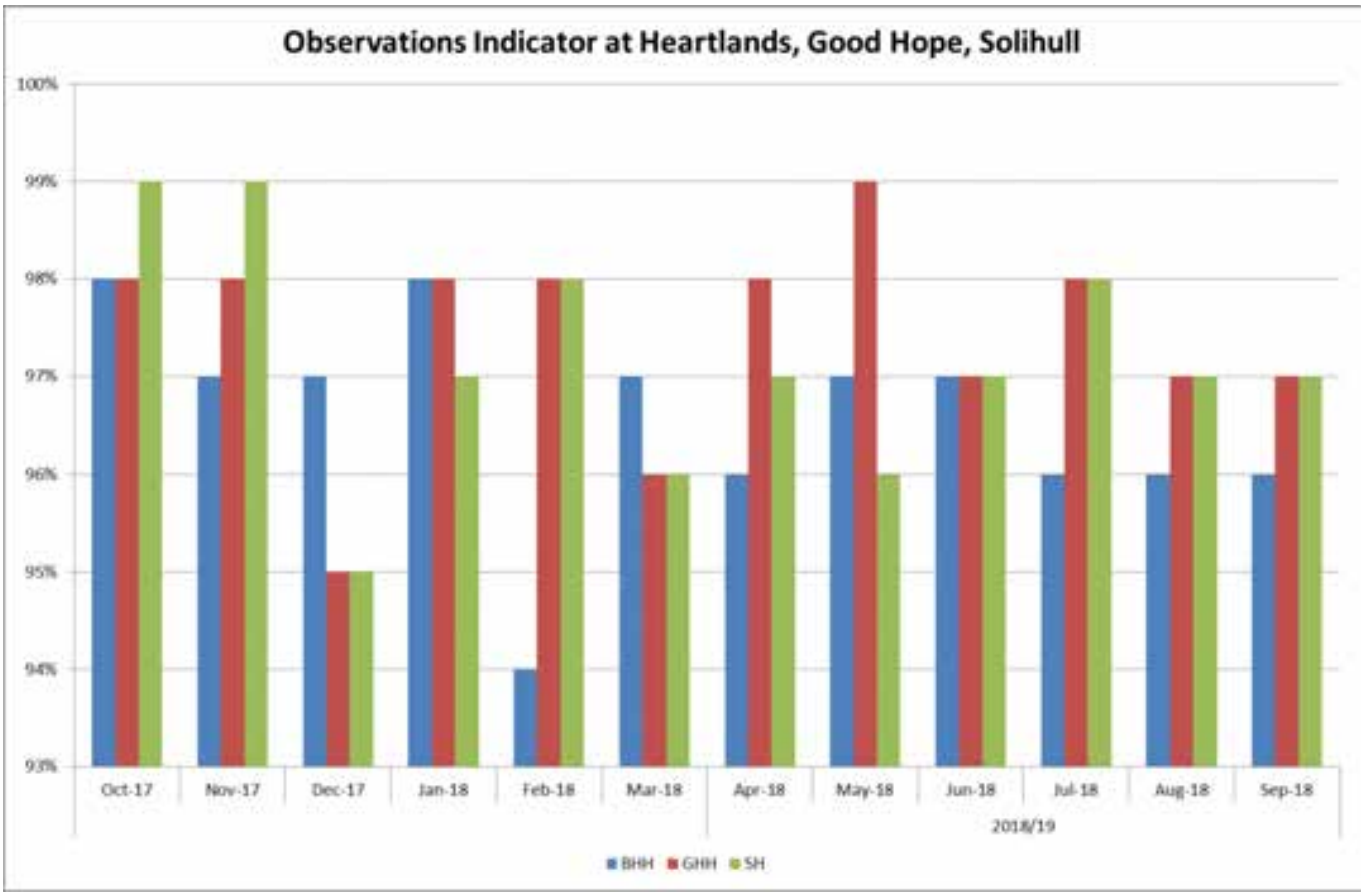
Graphs: Performance by month





Performance (HGS)

Data at HGS is drawn from the monthly notes audit which takes place on the wards. One of the standards is adherence to observations, performance is displayed below.



Initiatives to be implemented in 2018/19

- Wards performing below target will continue to be reviewed at the Executive Care Omissions Root Cause Analysis (RCA) meetings to identify where improvements can be made. Observations and pain assessment compliance will be monitored as part of the unannounced monthly Board of Directors' Governance Visits to wards.

How progress will be monitored, measured and reported

- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and other reporting tools. The Clinical Dashboard allows staff to compare their ward performance to the Trust as a whole, as well as seeing detailed data about which of the six observations or pain assessment were missed.
- Performance will continue to be measured using PICS data from the electronic observation charts.
- Progress will be reported monthly to the Clinical Quality Monitoring Group and the Board of Directors in the performance report. Performance will continue to be publicly reported through the quarterly Quality Report updates on the Trust's website.

Priority 4: Reducing missed doses

Background

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

The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and when the Executive Care Omissions Root Cause Analysis (RCA) meetings started at the end of March 2010.

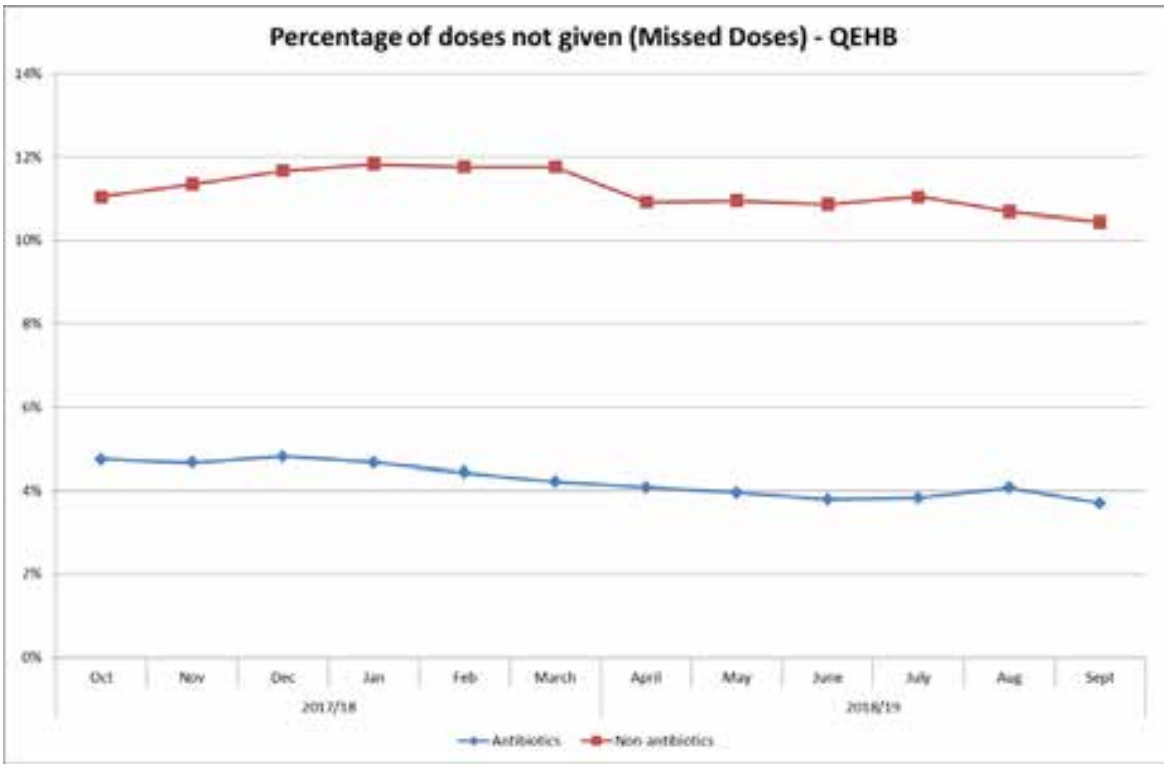
In the absence of a national consensus on what constitutes an expected level of drug omissions, the Trust has set targets based on previous performance.

It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time, and when a patient refuses a drug this is also recorded as a missed dose. The Trust has decided to record patient refusals as missed doses, as it is important for the staff looking after the patient to encourage them to take the medication, and to consider the reasons for refusal and whether a different medication would be more appropriate.

Performance

Performance at the end of 2016/17 for missed doses of antibiotics was 4.1%, so in the 2016/17 Quality Report the Trust committed to reducing this to 4.0% by the end of 2017/18. The end of year performance for 2017/18 was 4.4%, so the target of 4.0% has been kept for 2018/19. In Quarters 1 and 2, QEHB achieved 3.9%, the best quarterly performance for over two years.

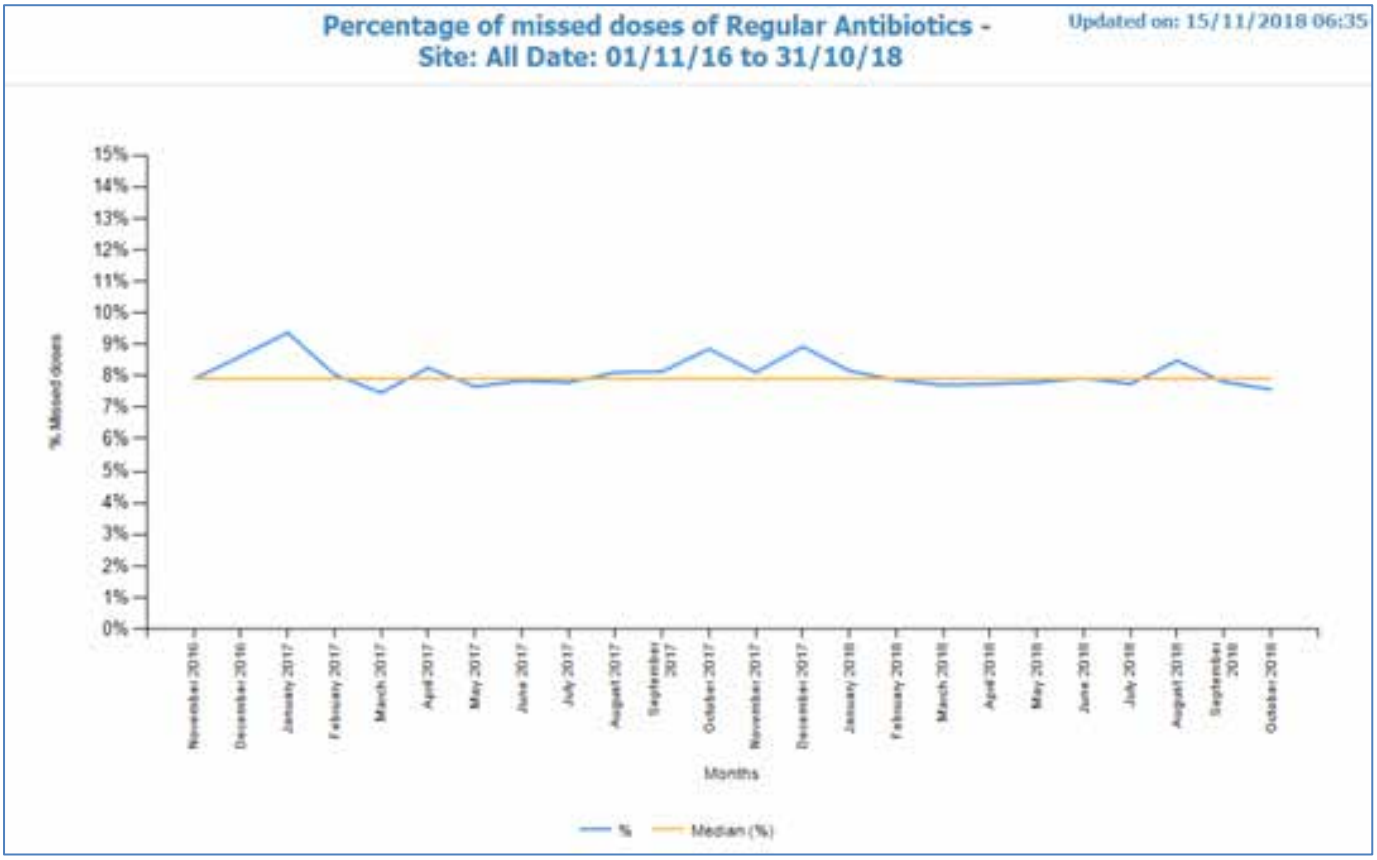
Performance at the end of 2016/17 for missed doses of non-antibiotics was 10.8%, so in the 2016/17 Quality Report the Trust committed to reducing this to 10.0% by the end of 2017/18. The end of year performance for 2017/18 was 11.8%, so the target of 10.0% has been kept for 2018/19. In Quarters 1 and 2, QEHB achieved 10.9% and 10.7%; an improvement on recent quarters.



		Antibiotics	Non-antibiotics
Performance 2014/15		4.0%	10.5%
Performance 2015/16		3.9%	10.5%
Performance 2016/17		4.1%	10.6%
Performance 2017/18		4.5%	11.3%
2018/19	**Target**	**4% or lower**	**10% or lower**
	Q1	3.9%	10.9%
	Q2	3.9%	10.7%
	Q3		
	Q4		
	Year	**3.9%**	**10.8%**

Performance (HGS)

HGS measure the percentage of missed doses of regular antibiotics. Performance has been steady for around the last two years:



Initiatives to be implemented in 2018/19

- Individual cases will continue to be selected for further review at the Executive Care Omissions RCA meetings.
- To consider new reports to identify types and patterns of missed doses across the Trust.
- The Corporate Nursing team and Pharmacy will continue work together to identify where improvement actions should be directed to try to reduce missed doses.

How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System (PICS).
- Data on missed drug doses is available to clinical staff via the Clinical Dashboard and includes a breakdown of the most commonly missed drugs and the most common reasons recorded for doses being missed. This is also monitored at divisional, specialty and ward levels.
- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken.
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages. Performance for missed doses by specialty will continue to be provided to patients and the public on the mystay@QEHB website.

Priority 5 – Reducing harm from falls

This quality improvement priority was proposed by the Council of Governors and approved by the Board of Directors. It was first included in the 2016/17 Quality Report.

Background

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital are the most common reported patient safety Incident, with more than 240,000 reported in acute hospitals and Mental Health trusts in England and Wales every year (*Royal College of Physicians, National Audit of Inpatient Falls, 2015*). About 30% of people 65 years of age or older have a fall each year, increasing to 50% in people 80 years of age or older (*National Institute of Health and Clinical Excellence - NICE*).

All falls can impact on quality of life; they can cause patients distress, pain, injury, prolonged hospitalisation and a greater risk of death due to underlying ill health. Falls can result in loss of confidence and Independence which can result in patients going into long term care. Falling also affects the family members and carers of people who fall.

When a fall occurs at UHB, the staff looking after the patient submit an incident form via Datix, the Trust's incident reporting system. All falls incidents at QEHB are reviewed by the Falls Team, a team of clinical nurse specialists. The lead for the area where the fall happened, usually the Senior Sister / Charge Nurse, investigates the fall and reports on the outcome of the fall, and whether there is any learning or if any changes in practice / policy need to be made.

Most falls do not result in any harm to the patient. Any falls resulting in severe harm undergo an RCA (root cause analysis) process to identify any issues or contributory factors. Falls resulting in specific harm, e.g., a fractured neck of femur (broken hip), are also reported to the local Clinical Commissioning Group and externally reported via STEIS.

For all severe falls at HGS a round table clinical review is held within 48-72 hours of the fall occurring, the review includes the senior nurse for the clinical area, the Matron and the falls coordinator, details from this review are then incorporated into the detailed RCA that is signed off at the relevant Divisional harm free care forum where the senior nurse is challenged by the Head Nurse to ensure that all learning from the incident has been incorporated into the RCA and implemented across the clinical team.

At QEHB, a mini RCA is carried out by the falls team within 72 hours for all falls resulting in moderate or severe harm. Then at 25 days post-fall an RCA round table is held for falls resulting in severe harm; these are attended by a senior nurse from the Division, the ward sister/charge nurse and staff from the falls team and risk management. Other staff pertinent to the incident may also attend, e.g. physiotherapist.

Falls prevention

All inpatients should undergo a Falls Assessment on admission/transfer to a ward or if their clinical condition changes. If a patient is found to be at an increased risk at of falls, staff will identify the risk factors and the precautions that can be taken to reduce these risks. These may include a medication review by pharmacy staff, provision of good-fitting footwear, ensuring chairs are the correct height and width for the patient, or moving the patient to a height-adjustable bed.

The Falls Team (QEHB) / Falls Coordinator (HGS) also receive information on patients who have fallen more than once during their hospital stay. These patients are reviewed, taking account of

mobility, medication, continence and altered cognition. The Falls Team will make suitable recommendations to the ward staff around intervention and prevention of further falls.

The Falls Team / Coordinator provide training on falls assessment, prevention and management to ward staff, junior doctors and students.

Performance – QEHB

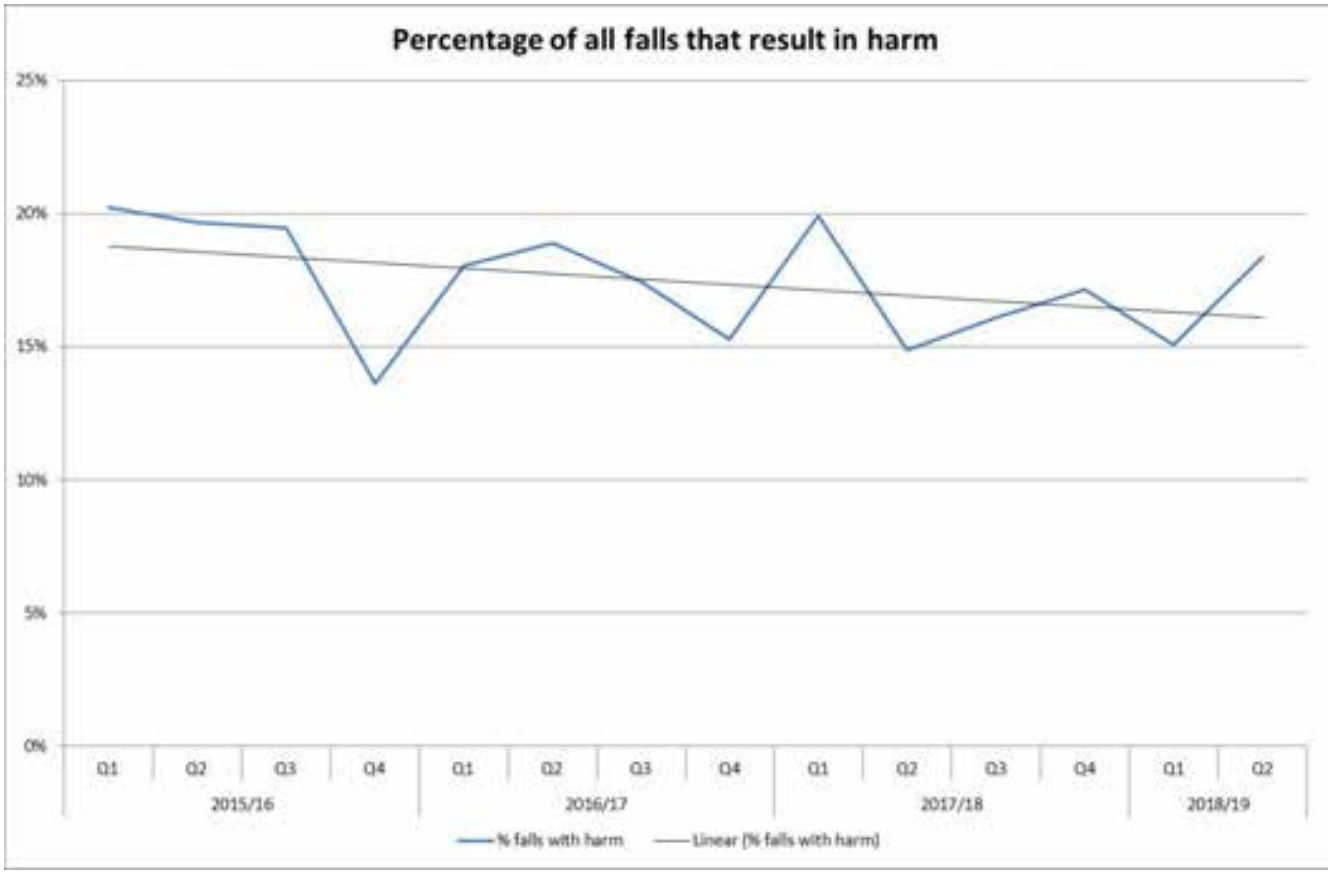
For QEHB, the Trust has chosen to measure 'percentage of falls resulting in harm'.
While staff take precautions to prevent falls from occurring, it is not possible to prevent all falls, therefore it is also important to attempt to minimise the harm that occurs due to falls.

Data for 2018/19 plus the last three years is presented below:

Year	Quarter	Percentage (%) of falls with harm
2015/16	Q1	20.2%
	Q2	19.6%
	Q3	19.5%
	Q4	13.6%
	Year	**18.1%**
2016/17	Q1	18.1%
	Q2	18.9%
	Q3	17.4%
	Q4	15.3%
	Year	**17.4%**
2017/18	Q1	19.9%
	Q2	14.9%
	Q3	16.1%
	Q4	17.1%
	Year	**17.0%**
2018/19	Q1	15.1%
	Q2	18.4%
	Q3	-
	Q4	-
	Year	**16.7%**

For 2018/19, the Trust has decided to set a target of 16.9% by the end of 2018/19 – this is a 1.5% reduction on the Quarter 4 2017/18 data.

During Quarter 1 2018/19, QEHB recorded 15.4% of all falls resulting in harm, which was a reduction compared to recent quarters. In Quarter 2 the rate was 18.4%, which was higher, but the overall performance for the year to date is 16.7%, which is within the target.



Performance – HGS

For HGS, the Trust has chosen to measure 'percentage of all falls that are injurious', i.e., the number of falls that result in harm that must be reported nationally; these include falls that result in a fractured neck of femur (broken hip), and certain head injuries.

While staff take precautions to prevent falls from occurring, it is not possible to prevent all falls. Therefore it is also important in minimise the harm that occurs due to falls.

As the injurious harm rate at HGS is already low, the Trust has chosen to set a maintenance target for 2018/19, i.e., to stay at or below the performance reported for 2017/18 (1.7%).

During Quarter 1 2018/19, HGS recorded 1.9% of all falls being injurious, which was an increase compared to the previous quarter. In Quarter 2 the rate was 1.0%, which was lower, and the overall rate for the year to date is 1.4%, which is within the target.

Data for this year, and the last two years is presented below:

Year	Quarter	Percentage (%) of all falls that are injurious
2016/17	Q1	1.3%
	Q2	1.1%
	Q3	1.5%
	Q4	2.0%
	Year	**1.5%**
2017/18	Q1	1.4%
	Q2	2.5%
	Q3	1.9%
	Q4	1.1%
	Year	**1.7%**
2018/19	Q1	1.9%
	Q2	1.0%
	Q3	-
	Q4	-
	Year	**1.4%**

It should also be noted that there has been an increase in activity across the Trust, so when other measures are used (for example, number of falls as a rate against 1000 bed days), performance has improved, i.e., the rate has dropped.

Initiatives to be implemented during 2018/19

- HGS and QEHB colleagues to work collaboratively to develop a UHB strategy for achieving further reductions in falls with harm during 2018/19.
- Continue to work with Divisions on their plans for 2018/19. Key focus will be on falls prevention, post fall care and management, and driving compliance in the completion of lying and standing blood pressure (BP) measurement. A programme of training and education has been completed across all QEHB Divisions to further improve compliance with lying and standing BP completion where over 900 nursing staff have received training since May 2018. This includes; training key staff to support cascade training within their own clinical areas, delivery of face to face ad-hoc training sessions, inclusion on the existing falls mandatory training sessions, and provision of written guidance on how/when to complete a lying and standing BP measurement.
- Developing Moodle Module to teach staff how to/and the importance of recording postural blood pressures
- Continue to raise the profile of the Trust Falls Prevention Team, for example by ensuring active engagement in Back to the Floor (BTTF) visits, attendance at Divisional Preventing Harm meetings, supporting clinical staff in implementing falls prevention strategies, audit of falls assessment compliance and interventions, problem solving, and RCA completion and action planning.
- Continue providing Falls training to all Divisions on their mandatory training days, FY1 (junior doctor) training induction days, new starters on the HPIP course and bespoke training in clinical areas.
- HGS and QEHB colleagues to explore further opportunities for joint working.
- Work with a nominated Consultant in Geriatric Medicine and HGS colleagues to develop a strategy for inclusion in the Royal College of Physicians' National Audit of Inpatient Falls in 2019.

- Continue to monitor and re-evaluate the Trust compliance with NICE guidelines CG161 and Falls Quality Standards 2017, and implement any actions identified.
- Assist with the development and implementation of a combined Trust-wide falls Datix (incident reporting) form and RCA tool, and explore how to further improve SI learning and sharing across teams.
- To work with commissioners on improving the patient pathway on discharge from hospital, including discharge information and appropriate referral processes.

How progress will be monitored, measured and reported

- Data on falls is presented to the monthly Trust Preventing Harm group, which reports to the Chief Nurse's Care Quality Group. Data on falls is also provided to the Medical Director's monthly Clinical Quality Monitoring Group.
- Ward-level and trust-level data on falls is available to clinical staff via the Clinical Dashboard.
- Falls with specific outcomes, e.g., a fractured neck of femur (broken hip), are reported to the local Clinical Commissioning Group.
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 6 – Timely treatment for sepsis

This quality improvement priority was proposed by the Clinical Quality Monitoring Group, agreed by the Council of Governors and approved by the Board of Directors.

Background

Sepsis is a potentially life-threatening condition which is the result of a bacterial infection in the blood. It affects an estimated 260,000 people per year in the UK and is a significant cause of preventable mortality. Approximately 44,000 people die each year as a result of sepsis; a quarter of which are avoidable.

Although there are certain groups in whom sepsis is more common, the very young and very old, people with multiple co-morbidities, people with impaired immunity and pregnant women, it can occur in anybody, regardless of their age or health status.

Though sepsis is common, it is poorly addressed. It is important to understand that if sepsis is recognised early and appropriately managed it is treatable. However, if recognition is delayed and appropriate treatment not instituted (usually oxygen, intravenous fluids and antibiotics), significant harm or even death can occur.

Sepsis has been on the national agenda as a high priority area for the Commissioning for Quality and Innovation (CQUIN) system. In 2016/17 certain trusts had a key target to implement systematic screening for sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. This CQUIN has been extended in the 2017–19 plan, which UHB is participating in.

The Trust intranet pages have a library of information on recognising the symptoms of sepsis, screening patients and treating sepsis. These pages are available for all staff to view and have been promoted by the Trust's Communications team.

The Trust's aim is to improve the early recognition and management of patients with sepsis.

Performance

For 2018/19, the Trust will continue to aim to meet the targets set out in the serious infection CQUIN, which have been agreed with the CCG.

Indicator 2a: Quarterly audit of 300 patients (150 emergency admissions and 150 inpatients) that meet the criteria for screening for sepsis (e.g., for inpatients this is a SEWS trigger of 4 and above). Target: over 90% of patients to have evidence of screening for sepsis using the Trust screening tool.

Indicator 2b: Quarterly audit of patients identified as having sepsis from part 2a above. Time between diagnosis of sepsis and antibiotics administered is then assessed. Target: over 90% to be given within 60mins.

A new monthly Trust cross site strategic group has been convened and has been working to align the CQUIN audit definitions and methodology across HGS and QEHB. This group will work with the local sepsis groups to monitor and improve the overall sepsis recognition and treatment performance for the CQUIN and also longer term the quality of the whole of the septic patient's pathway, developing indicators for a sepsis dashboard.

At QEHB the Antibiotic Stewardship and Sepsis Group (ASSG), formed at the end of September 2017, meets monthly to review and take action, where required, to address performance .
HGS have now convened a monthly sepsis group meeting to look at the quality of the whole of the sepsis pathway along with a fortnightly sepsis task and finish group to focus on the CQUIN where there is underperformance.

A sepsis nurse started at HGS in September and is initially undertaking the inpatient audits and providing feedback and education in real time.

A Trust wide educational package is being reviewed and training on sepsis recognition and management will be included in the launch of NEWS 2 at HGS.

Initiatives to be implemented during 2018/19

- Roll out of updated Sepsis training (Tier 2) to nursing staff and doctors.
- 10 day rolling audit in Emergency department (ED) by consultant to identify and feedback to staff patients that did not receive antibiotics within 60 minutes.
- PICS implementation of Sepsis screening question in June 2018. This will allow staff to record patients with Sepsis to help prioritise treatment promptly.

How progress will be monitored, measured and reported

- Performance against the CQUINs is reported to the Antimicrobial stewardship and sepsis group (ASSG), Chief Operating Officer Group, CQUIN tracker meeting and the Clinical Commissioning Group.
- Progress will be publicly reported in the quarterly Quality Account updates published on the Trust's quality web pages.
- Performance will be reported to the Clinical Quality Monitoring Group as part of the quarterly Quality Account update reports.

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 Groups. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Summary Hospital-level Mortality Indicator (SHMI)

The Health and Social Care Information Centre (HSCIC, now NHS Digital) first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced 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 Summary Hospital-level Mortality Indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care[1]. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

The latest SHMI value for the QEHB site is 102.99 for the period April 2017 – March 2018, this is within tolerance control limits. The latest SHMI value for the QEHB site available on the NHS Digital (formerly HSCIC) website is 102 for the period April 2017 – March 2018. This is within tolerance.

The latest SHMI value for the HGS sites is 97 for the period April 2017 – March 2018 which is within tolerance. The latest SHMI value for the HGS sites available on the NHS Digital website is 96 for the period April 2017 – March 2018. This is within tolerance.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR values for the period April – August 2018 are 104 for the QEHB site and 106 for the HGS sites, as calculated by the Trust's Health Informatics team.

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. The validity and appropriateness of the HSMR methodology used to calculate the expected range has been the subject of much national debate and is largely discredited[2][3]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

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[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.

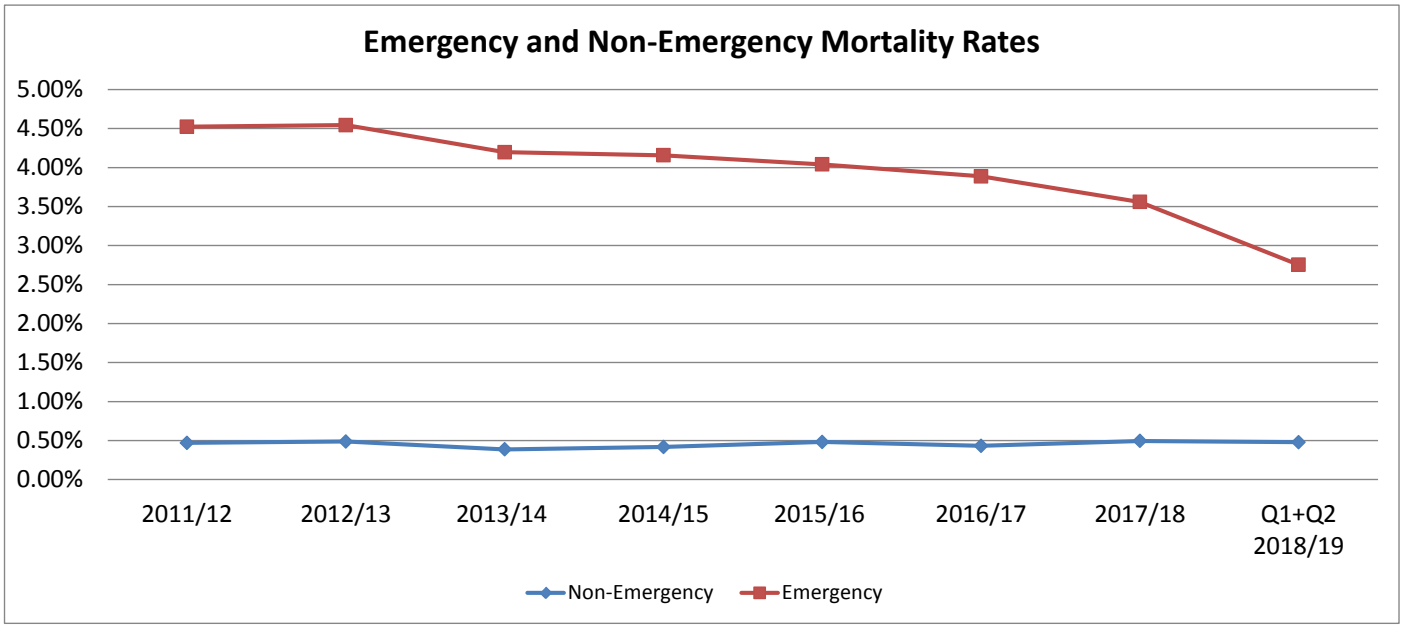
[3] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Crude Mortality – QEHB

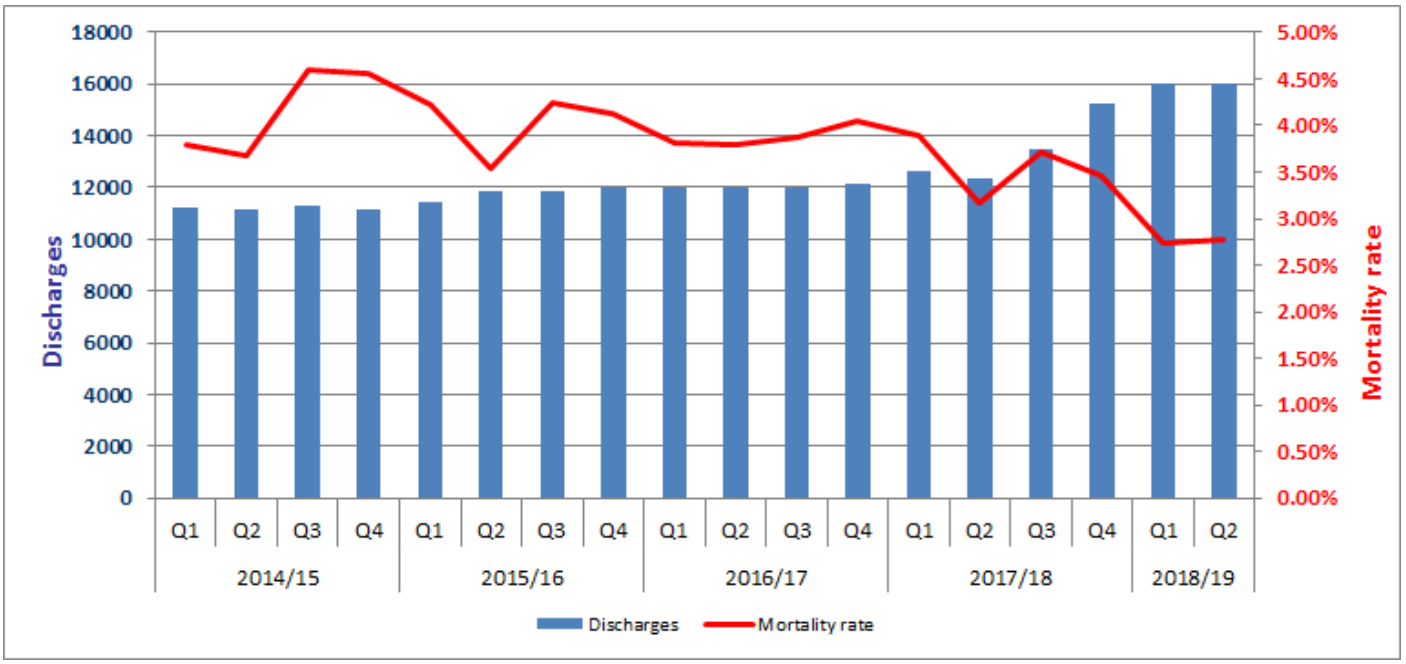
The first graph shows the QEHB site's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the QEHB site's overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number 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.

QEHB's overall crude mortality rate for 2018/19 Quarter 1 & 2 is 2.35%, which is a decrease compared to 2017/18 (2.85%) and 2016/17 (2.96%).

Emergency and Non-emergency Mortality Graph (QEHB)



Overall Crude Mortality Graph (QEHB)



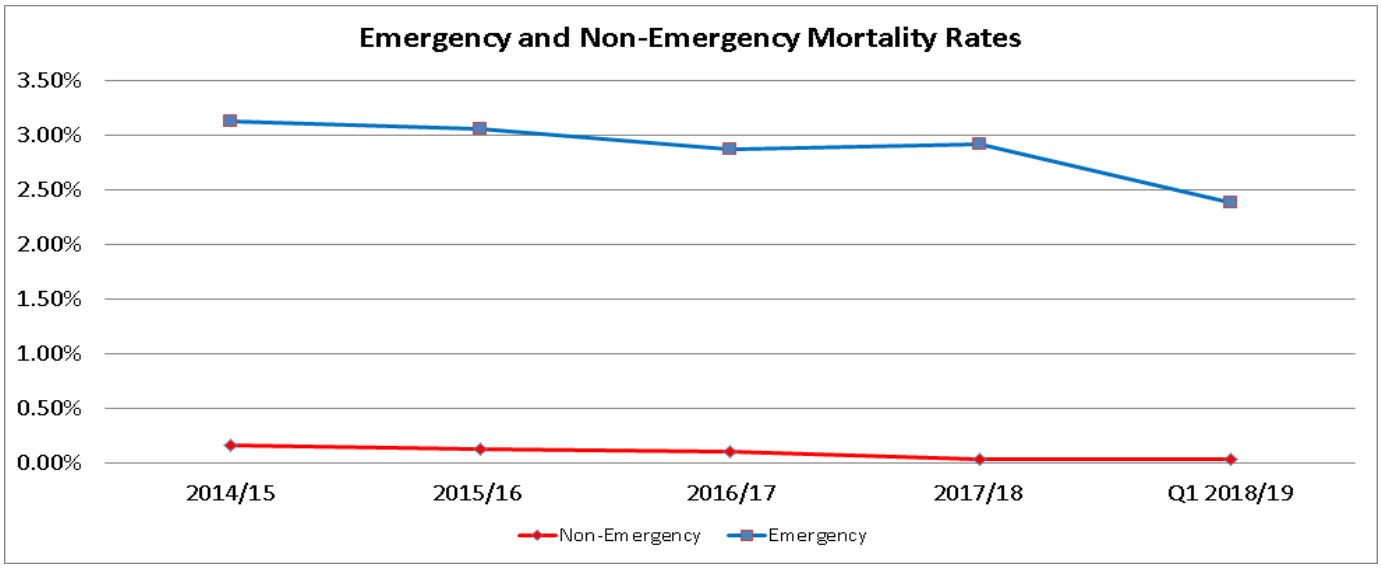
Note – increase in discharges is largely due to Emergency Observation Unit (EOU) being recorded as inpatient admission from November-2017

Crude Mortality – HGS

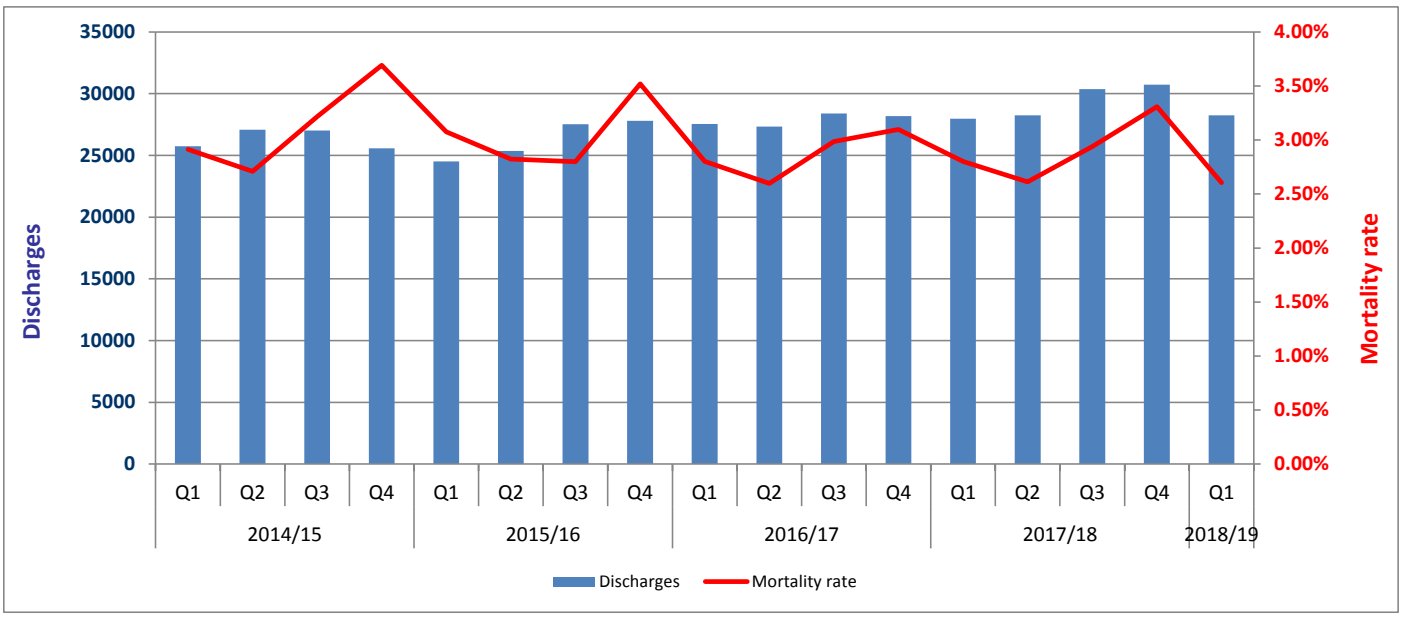
The first graph shows the HGS sites' crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the HGS sites' overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated 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 for emergency admitted patients in April – June 2018 is 2.39%, this has decreased compared to 2017/18 (2.92%), 2016/17 (2.87%) and 2015/16 (3.06%).

Emergency and Non-emergency Mortality Graph (HGS)



Emergency Crude Mortality Graph (HGS)



Selected Metrics - Patient safety indicators

Indicator	Site/s	Data source	2016/17	2017/18	2018/19 Q1-2	Peer Group Average (where available)
1a. Patients with MRSA infection / 100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	QE	Trust MRSA data reported to PHE, HES data (bed days)	**1.01**	**0.00**	**0.0**	**0.00 (TBC)** April 2018 – August 2018 Acute trusts in West Midlands
	HGS		**1.9**	**0.4**	**0.7**	
1b. Patients with MRSA infection / 100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	QE	Trust MRSA data reported to PHE, HES data (bed days)	**1.01**	**0.00**	**0.0**	**0.00 (TBC)** April 2018 – August 2018 Acute trusts in West Midlands
	HGS		**0.4**	**0.4**	**0.8**	
2a. Patients with *C. difficile* infection / 100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	QE	Trust CDI data reported to PHE, HES data (bed days)	**21.73**	**19.05**	**27.32**	**15.64** April 2018 – August 2018 Acute trusts in West Midlands
	HGS		**16.0**	**12.4**	**13.4**	
2b. Patients with *C. difficile* infection / 100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	QE	Trust CDI data reported to PHE, HES data (bed days)	**21.85**	**18.94**	**27.16**	**14.16** April 2018 – August 2018 Acute trusts in West Midlands
	HGS		**6.8**	**13.8**	**15.1**	

Indicator	Site/s	Data source	2016/17	2017/18	2018/19 Q1-2	Peer Group Average (where available)
3a. Patient safety incidents (reporting rate per 1000 bed days) *Higher rate indicates better reporting*	QE	Datix (incident data), Trust admissions data	**63.6**	**65.4**	**67.5**	**70.0** October 2017 – March 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	HGS		**34** (NRLS data April – September 2016)	**49.3**	**49.5**	
3b. Never Events The number of Never Events that occurred during the time period *Lower number indicates better performance*	QE	Datix (incident data)	**1**	**6**	**3**	*Not available*
	HGS		**2**	**8**	**2**	
4a. Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	QE	Datix (incident data)	**83.1%**	**85.1%**	**86.3%**	**89.2%** October 2017 – March 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	HGS		**75%** (NRLS data April – September 2016)	**97.6%**	**97.5%**	

Indicator	Site/s	Data source	2016/17	2017/18	2018/19 Q1-2	Peer Group Average (where available)
4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death *Lower % indicates better performance*	QE	Datix (patient safety incidents reported to the NRLS)	**0.12%**	**0.22%**	**0.22%**	**0.14%** October 2017 – March 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	HGS		**0.6%** (NRLS data April – September 2016)	**0.84%**	**0.61%**	
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	QE	Datix (patient safety incidents reported to the NRLS)	**22,532**	**24,568**	**12,838**	**13,470** (6 months) October 2017 – March 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	HGS		**7,899** (NRLS data April – September 2016)	**19,664**	**12,053**	

Selected Metrics - Clinical effectiveness indicators

Indicator		Data source	2016/17	2017/18	2018/19 Q1-2	Peer Group Average (where available)
5a. Emergency readmissions within 28 days (%) (Medical and surgical specialties - elective and emergency admissions aged >17) % *Lower % indicates better performance*	QE	HED data	**14.14%**	**13.87%**	**16.07%** April – August 2018	**14.27%** April – August 2018 University hospitals
	HGS		**7.90%**	**8.22%**	**8.77%** April – July 2018	
5b. Emergency readmissions within 28 days (%) (all specialties) *Lower % indicates better performance*	QE	HED data	**14.10%**	**13.84%**	**16.07%** April – August 2018	**12.61%** April – August 2018 University hospitals
	HGS		**8.23%**	**8.54%**	**9.10%** April – July 2018	
5c. Emergency readmissions within 28 days of discharge (%) *Lower % indicates better performance*	QE	Internal SUS data	**10.80%**	**11.35%**	**12.38%**	*Not available*
	HGS	PMS 2	**15.09%**	**15.22%**	**15.84%**	
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	QE	Datix (incident data), Trust admissions data	**2.2%**	**2.2%**	**1.9%** April – August 2018	*Not available*
	HGS		**0.98%**	**1.00%**	*Not yet available*	

Indicator		Data source	2016/17	2017/18	2018/19 Q1-2	Peer Group Average (where available)
7. Stroke in-hospital mortality *Lower % indicates better performance*	QE	SSNAP data	**1.8%**	**5.8%**	**11.6%**	*Not available*
	HGS		**11.0%**	**12.2%**	**13.2%** April – May 2018	
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	QE	Trust PICS data	**97.4%**	**94.8%**	**87.8%**	*Not available*

Notes on patient safety & 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 specialty activity, taking into account that the Trust does not undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties 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.

1a, 1b: Peer group figures are not final.

1a, 1b, 2a, 2b: These indicators uses HES data for the bed days, as this allows trusts to benchmark against each other. UHB also has an internal measure of bed days which uses a different methodology, and this number may be used in other, similar, indicators in other reports.
Receipt of HES data from the national team always happens two to three months later, these indicators will be updated in the next quarterly report.

3a: The NHS England definition of a bed day ("KH03") differs from UHB's usual definition. For further information, please see this link:
http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/.
NHS England have also reduced the number of peer group clusters (trust classifications), meaning UHB is now classed as an 'acute (non specialist)' trust and is in a larger group. Prior to this, UHB was classed as an 'acute teaching' trust which was a smaller group.

3b: QEHB had three Never Events during Quarters 1-2 2018/19. One was classified as wrong site surgery, one was a guidewire being left in situ (investigation underway), the other was a patient requiring oxygen being connected to an air port rather than an oxygen port (investigation underway).

HGS had two Never Events during Quarters 1-2 2018/19. One was a retained foreign object (swab) following surgery. The investigation has been completed and actions are being monitored. The other was an overdose of insulin, which is currently under investigation.

4c: The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

5a, 5b: Data for these indicators has been taken from UHB's own data tool (HED), as the HES data has not been made available. Data for previous years has also been updated to allow for comparison in this report, so will not match data in the previous Quality Reports. This change also means that indicator 5a looks at readmissions for patients >17, instead of the previous >15.

5c: This indicator only includes patients readmitted as emergencies to the Trust within 28 days of discharge and excludes UHB cancer patients. The data source is the Trust's patient administration system (Lorenzo, replaced by Oceano during 2017/18). The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology. Any changes in previously reported data are due to long-stay patients being discharged after the previous years' data was analysed.

5a, 5b, 5c: QEHB - The step change in readmissions is due to Emergency Observation Unit (EOU) recorded as inpatient admission from November-2017.

8: QE indicator only. HGS does not carry out cardiac surgery. 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.