

**UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST  
COUNCIL OF GOVERNORS MEETING  
TUESDAY 18 FEBRUARY 2014**

<b>Title:</b>	<b>QUALITY ACCOUNT UPDATE FOR QUARTER 3 2013/14</b>	
<b>Responsible Director:</b>	David Rosser, Executive Medical Director	
<b>Contact:</b>	Imogen Gray, Head of Quality Development, 13687 Mark Garrick, Head of Medical Director's Services, 13699	
<b>Purpose:</b>	To present the Quality Account Update Report for Quarter 3 2013/14 to the Council of Governors.	
<b>Confidentiality Level &amp; Reason:</b>	N/a	
<b>Annual Plan Ref:</b>	Strategic Aim: To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking	
<b>Key Issues Summary:</b>	<ul style="list-style-type: none"> <li>• The Q3 2013/14 Quality Account Update is shown in Appendix A.</li> <li>• The latest mortality data is within tolerance (green).</li> <li>• Performance for the six Quality Improvement Priorities is included.</li> <li>• Performance for Selected Metrics is included with exceptions highlighted.</li> <li>• Performance for the specialty indicators will be included as an appendix to the update report before publication.</li> </ul>	
<b>Recommendations:</b>	The Council of Governors is asked to: <b>Note</b> the content of the report.	
<b>Approved by:</b>	Dr David Rosser	Date: 04/02/2014

# UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

## COUNCIL OF GOVERNORS TUESDAY 18 FEBRUARY 2014

### QUALITY ACCOUNT UPDATE FOR QUARTER 3 2013/14

#### PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

#### 1. Introduction

The aim of this paper is to present the Trust's Quality Account Update for Quarter 3 2013/14 to the Council of Governors. The Trust's Quality Account Update report for April-December 2013 is shown in Appendix A following approval by the Clinical Quality Monitoring Group in January 2014. The Council of Governors is asked to note the contents of the report.

#### 2. Background

The Trust's official Quality Account Report for 2012/13 was approved by the Board of Directors in May 2013 and published in June 2013. The Quarter 3 2013/14 update report is due to be presented to the Board of Directors' meeting on 6 February 2014 and is attached in Appendix A. The report shows performance for the period April-December 2013 and includes the latest data available. Data for the full period April-December 2013 is not yet available for all indicators and will be added in later, where available, prior to publication at the end of February 2014.

#### 3. Performance

##### 3.1 Mortality

The report contains the latest values for the Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) which are both within tolerance (green).

##### 3.2 Quality Improvement Priorities

##### 3.2.1 Improving venous thromboembolism (VTE) Prevention

The Trust is aiming for preventative enoxaparin medication to be prescribed for at least 80% of all patients where it is recommended following risk assessment by the end of 2013/14. Performance has remained stable during 2013/14 to date. The Trust implemented automatic prescription proposals for enoxaparin in PICS where it is recommended following risk assessment at the end of January 2014. This should deliver a step change in performance for enoxaparin prescription rates

after VTE risk assessment. In addition, Junior Doctor Monitoring Clinics specifically for VTE will be implemented shortly to help drive improvements in prescribing practice.

### 3.2.2 Improve patient experience and satisfaction

Responses to the patient survey are generally very positive and show a continued improvement. Performance remains low for the discharge survey medication question which is being addressed by the Discharge Quality Group. The number of complaints and compliments received in quarter 3 2013/14 remains stable.

### 3.2.3 Electronic observation chart – completeness of observation sets (to produce an early warning score)

The Trust continues to achieve over 99% for completeness of observation sets within 24 hours. The vast majority of wards are performing at over 98% for completeness of observation sets within 24 hours. An update on performance for observations was communicated via Team Brief at the end of January 2014; the expectation is that all wards should achieve the target by the end of the year.

### 3.2.4 Reducing Medication Errors (Missed Doses)

The Trust has managed to maintain performance for antibiotic missed doses during 2013/14: 3.9% for April-December 2013. The Trust is aiming to reduce non-antibiotic missed doses by 20% compared to last year (10.25% for March 2013). Performance is 9.35% for April-December 2013 so the Trust therefore has a way to go to reduce non-antibiotic missed doses by another percentage point by the end of March 2014.

### 3.2.5 Infection Prevention and Control

MRSA bacteraemias are above trajectory and *C.difficile* infection is above the Monitor trajectory for April-December 2013. Further information is provided in the Executive Chief Nurse's Infection Prevention and Control Report to the Council of Governors.

### 3.2.6 Improving patient safety through barcoded patient wristbands

The Trust is due to start the full roll-out of active patient identification through barcoded wristbands during quarter 4 2013/14. Implementation is dependent upon delivery of hardware from an external supplier and due to be complete by mid April 2014. The project sponsor is the Executive Medical Director; progress will be reported to the Clinical Quality Monitoring Group.

### 3.3 Selected Metrics

#### 3.3.1 Readmissions (Indicators 5a and 5b)

Performance is included in Section 4 for the readmissions indicators using the new national methodology approved by the Board of Directors in September 2013. The Trust's readmission rate is therefore much higher than it was previously but slightly lower than for the whole of England.

#### 3.3.2 Betablockers given on the morning for first-time coronary artery bypass surgery (Indicator 8)

Performance has dropped for this indicator during the period April-December 2013: 86.0% compared to 96.4% in 2012/13. This indicator has flagged as an exception in the Quality and Outcomes Research Unit (QuORU) Indicator Framework. Performance has been investigated with the Cardiac Surgery team and improvement actions put in place. Performance has significantly improved: 100% for November-December 2013.

## 4. **Specialty Quality Indicators**

4.1 Performance for the specialty indicators will be added at the end of the update report before publication but is not included here for brevity. The Trust's official Quality Account Reports, quarterly updates and appendices are routinely made available on the Trust's website: <http://www.uhb.nhs.uk/quality-reports.htm>

4.2 Performance Exceptions continue to be identified through the QuORU Indicator Framework and reported through the Clinical Quality Monitoring Group (CQMG) as per the agreed process.

## 5. **Recommendations**

The Council of Governors is asked to:

**Note** the content of the report.

## **Appendix A: Quality Report Update for Q3 2013/14**

### **Quality Account Update for April-December 2013**

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Priority 5: Infection prevention and control

Priority 6: Improving patient safety through barcoded wristbands

4. Selected Metrics

## Quality Account Update for April-December 2013

### 1. Introduction

The Trust published its fifth Quality Account Report in June 2013 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2012/13, performance data for selected metrics and set out six priorities for improvement during 2013/14.

**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

**Priority 6:** Improving patient safety through barcoded wristbands

This report provides an update on the progress made for the period April-December 2013 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 2012/13.

### 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.

#### Summary Hospital-level Mortality Indicator (SHMI)

In October 2011, the Health and Social Care Information Centre (HSCIC) 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 of 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 the 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 care<sup>[1]</sup>. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies

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<sup>[1]</sup> 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.

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 Health and Social Care 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 99.66 for the period April-September 2013 which is within tolerance (green). The latest SHMI value for the Trust which is available on the Health and Social Care Information Centre website is 105.60 for the period April-March 2013. This is also within tolerance.

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 102 for the period April-October 2013 as calculated by the Trust's Health Informatics team which is within tolerance (green). 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 discredited<sup>[2][3]</sup>. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

#### Crude Mortality

The first graph below shows the Trust's overall crude mortality rate against 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.

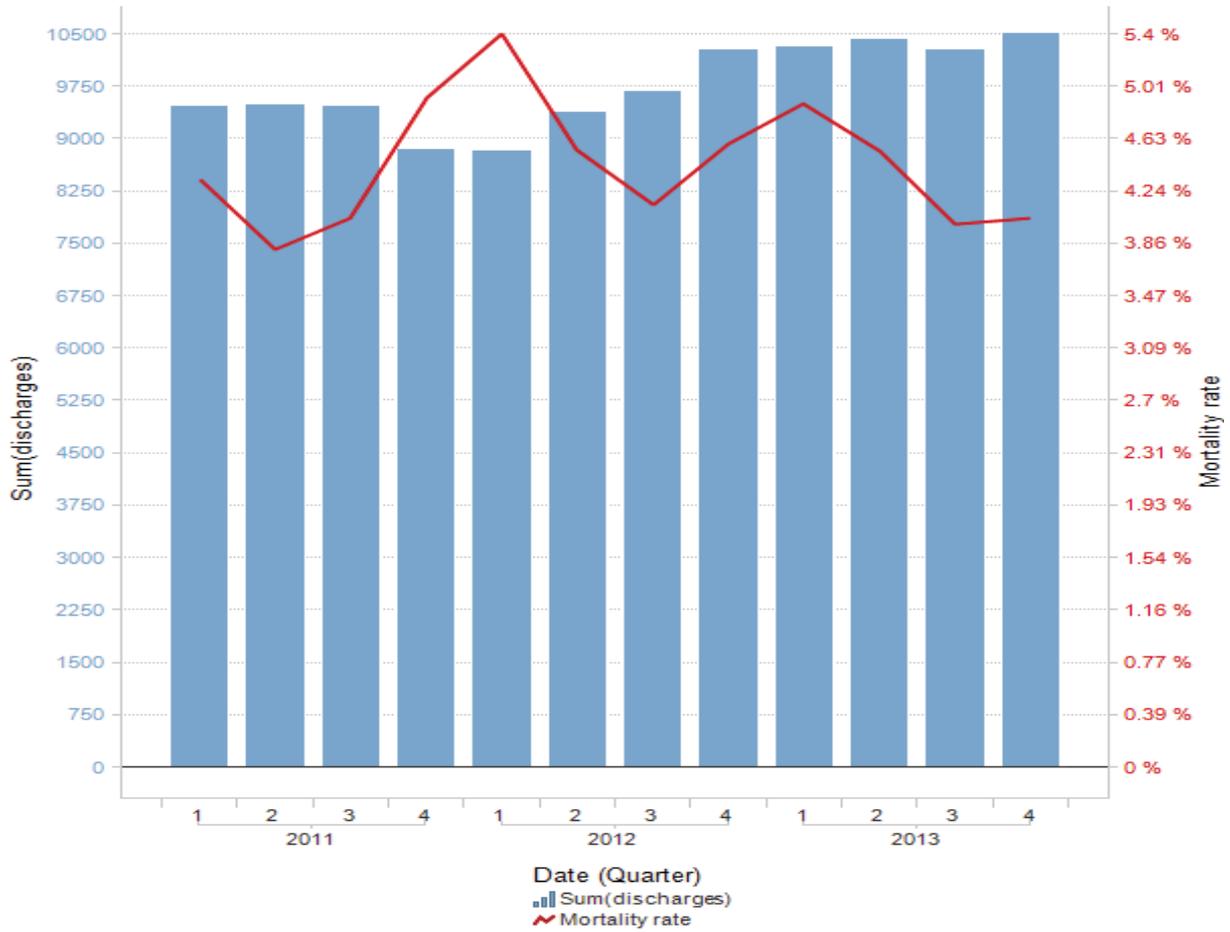
The second graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients.

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<sup>[2]</sup> 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.

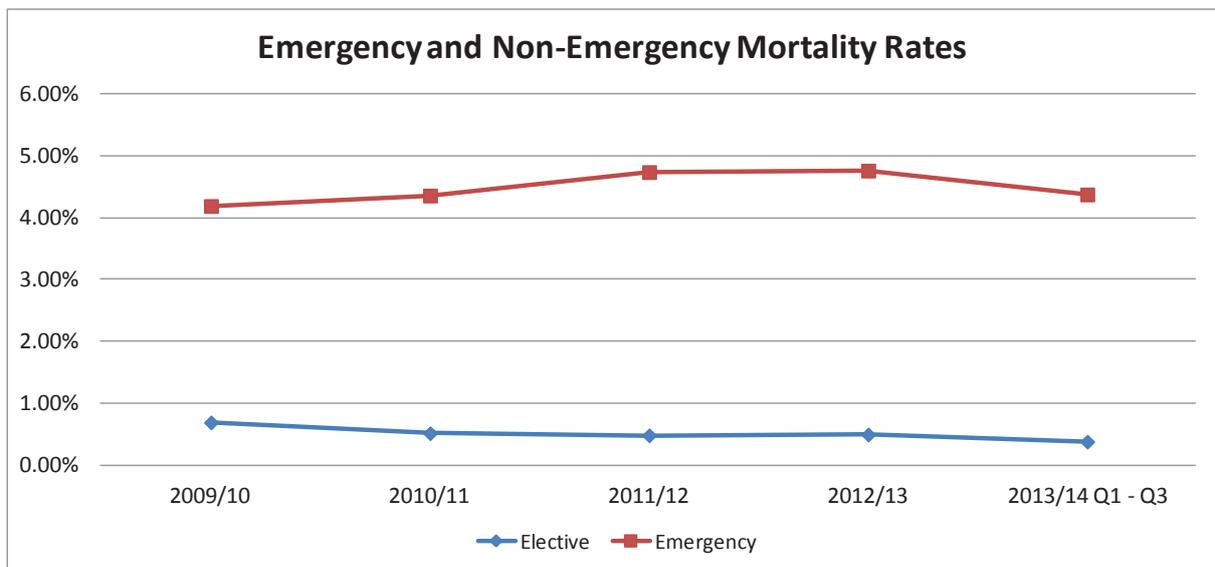
<sup>2</sup> Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. *The Lancet*. 3 April 2004.

### Overall Crude Mortality Graph



**Note:** Quarters are based on the calendar year so quarter 4 is October-December.

### Crude Emergency and Non-emergency Mortality Graph



### **3. Quality Improvement Priorities**

#### **Priority 1: Improving VTE Prevention**

##### **Background**

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 (PICS) 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.

The Trust has performed consistently highly for completion of VTE risk assessments and therefore chose to focus on improving compliance with the outcomes of completed VTE risk assessments from 2012/13. This means improving VTE prevention through appropriate administration of preventative (prophylactic) treatment. Preventative treatments include anti-embolism stockings (AES) and/or enoxaparin (medication used to reduce the risk of blood clots forming).

##### **Performance**

###### **VTE Risk Assessment Completion**

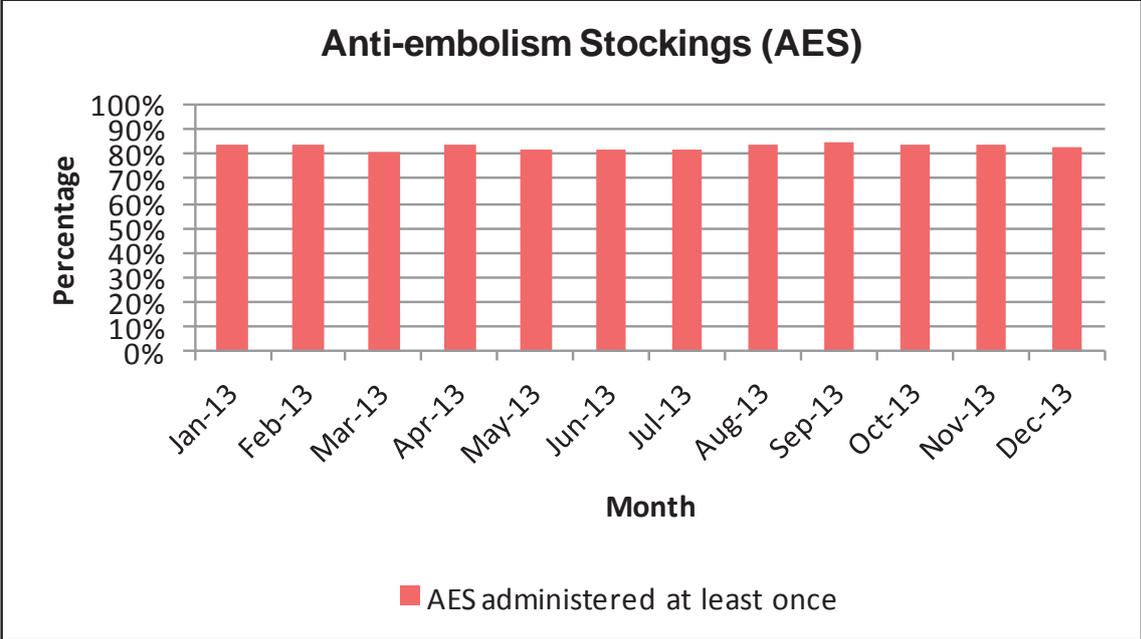
The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 and over 99% since June 2012. This is above the national average of 96% for NHS acute providers in England published on the NHS England website (July-September 2013).

###### **VTE Prevention – Anti-embolism Stockings (AES)**

The graph below shows the percentage of anti-embolism stockings administered at least once by episode as recorded on the electronic Prescribing and Information Communication System. Overall, 83% of anti-embolism stockings were administered at least once per episode during the period April-December 2013.

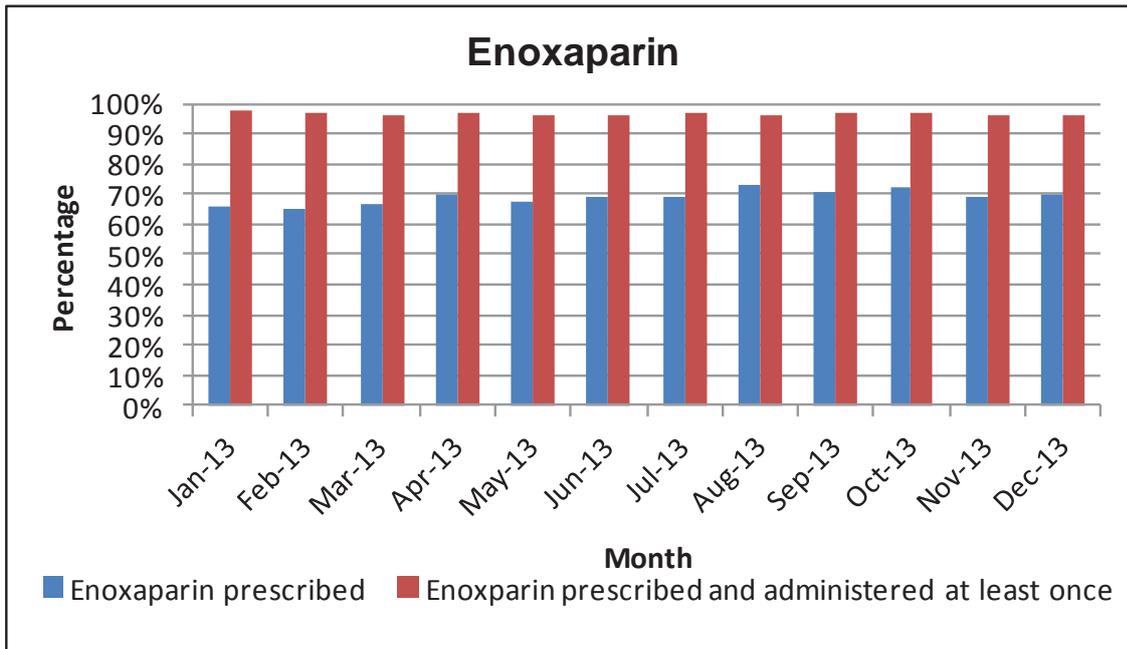
One patient admission or spell in hospital can comprise a number of different episodes of care. If the outcome of a VTE risk assessment shows that a patient

requires anti-embolism stockings, they are automatically prescribed by PICS. It is not always appropriate to administer anti-embolism 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 of those, the percentage who were given it at least once. Overall, 70% of patients who required enoxaparin following VTE risk assessment were prescribed it in the period April-December 2013. Of the patients who were prescribed enoxaparin, 96% 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.



The Trust will focus on maintaining performance for administration of graduated elastic compression stockings and improving performance for enoxaparin prescription. The aim is for 80% of patients who require enoxaparin following VTE risk assessment to have it prescribed by the end of 2013/14. The Trust will continue to monitor administration of enoxaparin medication to ensure it remains high.

**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**

During quarter three, 8,225 patient responses were received for the electronic inpatient survey, a total of 23,937 for the year to date. 431 patients responded to the discharge survey (1,018 year to date) and 692 to the outpatient survey (1,564 year to date) for August-October 2013 attendances. All of these surveys have provided a wealth of information about the experiences of patients. The results show that the Trust has continued to improve overall during the year.

Question	Answer	2012/13	Q1 2013-14	Q2 2013-14	Q3 2013-14
Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	81.30%	85.68%	86.10%	82.80%
	Yes, to some extent	15.18%	11.72%	11.57%	13.96%
	No	3.52%	2.61%	2.32%	3.24
Did you find someone on the hospital staff to talk	Yes, definitely	74.32%	82.56%	80.96%	77.31%
	Yes, to some	18.18%	13.18%	13.56%	16.46%

about your worries and fears?	extent				
	No	7.50%	4.27%	5.48%	6.24%
Have you been given enough privacy when discussing your care and treatment?	Yes, always	91.35%	94.29%	93.01%	93.10%
	Yes, sometimes	6.93%	4.56%	5.43%	5.59%
	No	1.72%	1.15%	1.55%	1.31%
Do you think that the ward staff do all they can to help you rest and sleep at night?	Yes, definitely	80.03%	85.08%	85.56%	82.22%
	Yes, to some extent	17.38%	12.89%	12.18%	15.24%
	No	2.58%	2.03%	2.26%	2.55%
Do you think the hospital staff do all they can to help control your pain?	Yes, definitely	85.37%	88.61%	89.43%	86.98%
	Yes, to some extent	12.61%	9.82%	9.05%	11.14%
	No	2.02%	1.57%	1.52%	1.88%
Have you been bothered by noise at night from hospital staff?	No, never	71.33%	75.41%	76.63%	71.86%
	Yes, occasionally	23.87%	20.11%	19.32%	22.75%
	Yes, often	4.81%	4.48%	4.05%	5.39%
Overall how would you rate the hospital food you have received?	Excellent	21.85%	29.53%	30.59%	27.27%
	Very good	28.51%	24.95%	26.48%	28.45%
	Good	26.11%	26.06%	25.08%	23.92%
	Fair	15.91%	14.03%	12.36%	14.24%
	Poor	7.62%	5.44%	5.49%	6.12%
Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never	74.30%	77.39%	77.98%	76.45%
	Yes, sometimes	20.77%	17.55%	17.16%	19.32%
	Yes, often	4.93%	5.05%	4.86%	4.24%
Did a member of staff tell you about medication side effects to watch for when you went home? (From Discharge survey)	Yes, completely	41.26%	43.21%	49.20%	45.70%*
	Yes, to some extent	22.39%	23.59%	19.81%	19.20%*
	No	36.35%	33.20%	30.99%	35.10%*
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?(From Discharge Survey)	Yes	78.95%	80.22%	81.98%	81.82%*
	No	21.05%	19.78%	18.02%	18.18%*

\*Oct-13 and Nov-13 data only.

Communication continues to be an area that the Trust is working on by increasing awareness amongst staff. Whilst overall improvements have been achieved, there was a slight dip in Q3 for the following related areas including:

- Reduction of conflicting information
- Involvement in decisions about care and treatment, and

- Information on discharge medication.

The Trust has continued to focus on providing a conducive environment for rest and sleep for inpatients. Although, in Q3 there has been a shift in responses from patients who answered positively to the questions 'Do you think that the ward staff do all they can to help you rest and sleep at night?' and 'Have you been bothered by noise at night from staff?', overall the Trust has seen an improvement on last year. The Trust has received another national recognition for the good practice developed as part of this work, and has been shortlisted for a National Patient Experience Network Award, the winner of which will be announced at the beginning of February 2014.

### **Friends and Family Question**

The Trust has continued to monitor performance for the Friends and Family Test question during Q3 2013/14:

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

Patients staying overnight on an inpatient ward were asked this question from 24 hours before and up to 48 hours after discharge from hospital and could choose from six different responses as follows:

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

From the 1 April 2013, the Trust transferred to the new Department of Health Guidance for the Family and Friends Test requirements. This involved the expansion of the survey to Accident and Emergency Departments. Response rates are reported together with the scores for each ward and A&E on the Trust website. Response rates from A&E have been very poor despite promotion and publicity of the request to complete the survey before leaving the department. A three-month pilot survey via text messaging was introduced at the end of September 2013 for A&E patients. Initial response rates are encouraging and will be reported in quarter 3.

In line with the national methodology, 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 Friends and Family 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 2013:

Friends and Family Questionnaire Results 2013/14									
	Apr	May	June	July	August	Sept	Oct	Nov	Dec
Extremely Likely?	679	1016	1066	1224	950	804	1390	1247	1261
Likely?	139	254	223	228	212	182	318	303	297
Neither Likely or Unlikely?	19	20	13	24	38	31	41	52	44
Unlikely?	6	13	12	17	14	25	28	31	25
Extremely Unlikely?	11	13	19	19	34	28	49	35	30
Don't Know?	8	13	12	11	13	9	14	17	12
Discharges	8477	9332	8862	9677	8951	8686	9556	8895	8789
Total Responses	862	1329	1345	1523	1261	1079	1840	1685	1669
Response Rate	10.17%	14.24%	15.18%	15.74%	14.09%	12.42%	19.25%	18.94%	18.99%
<b>Score</b>	<b>75</b>	<b>74</b>	<b>77</b>	<b>77</b>	<b>69</b>	<b>67</b>	<b>70</b>	<b>68</b>	<b>70</b>

#### Initiatives implemented in Q3 2013/14:

- Following the audit of patients around involvement in decisions about their care and being given conflicting information the Patient Experience Group, which includes patient representatives, produced a set of recommendations which have been used to share best practice and to develop education and training for staff.
- Volunteer Dining Companions to support nutrition and hydration for patients, have been recruited and the first pilot wards went live at the beginning of November. Further training days have been organised for Quarter 4 to engage more volunteers in the role. The role will be evaluated at the end of Quarter 4 with a view to rolling it out to more wards if successful.
- An audit of the experience of carers has continued with carers of dementia patients. In Quarter 3, 22 questionnaires were completed, bringing the total to 63. 61.5% of respondents are female and are 65 years old or over. Overall, 90% of respondents stated that healthcare professionals acknowledged their role as a carer. There were some areas for improvement, including information and signposting to other help and support. The results will inform education and training of staff.
- A method of gaining feedback from patients attending for outpatient chemotherapy has been developed following the appointment of a new manager for the service. It is due to be implemented during Quarter 4.
- Monthly patient experience reports have been provided to the Care Quality Group and to the Board of Directors

## Complaints

The tables below show the number and type of complaints received by the Trust in the past two financial quarters:

	Q2 2013/14	Q3 2013/14
Total number of complaints	172	163

Top 5 Main subjects of complaints	Q2 2013/14	Q3 2013/14
Clinical treatment	85	65
Communication & information	22	27
Staff Attitude	12	18
In-patient appointment cancelled, delayed	13	16
Out-patient appointment cancelled, delayed	17	10

Ratio of complaints to activity		Q2 2013/14	Q3 13/14
Inpatients	FCEs*	32,649	33,187
	Complaints	86	106
	Rate per 100 FCEs	0.26	0.32
Outpatients	Appointments**	177,974	181,143
	Complaints	58	46
	Rate per 100 appointments	0.03	0.02
A&E	Attendances	24,600	24,265
	Complaints	28	11
	Rate per 100 attendances	0.11	0.05

\* 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 the wider Patient Relations report. A monthly complaints report is also presented at the Chief Executive's Advisory Group. A detailed analysis of complaints, PALS (Patient Advice and Liaison Service) contacts, incidents and legal claims is presented to the Trust's Audit Committee quarterly. Some of the more serious complaints as selected for review by the Executive Care Omissions Root Cause Analysis meetings.

## Serious Complaints

The Trust assesses the seriousness of every complaint on receipt. Serious complaints are reported to the Chief Executive's Advisory Group and to the Divisional Management Teams at their Divisional Clinical Quality Group meetings. It is the Divisional Management Team's responsibility to ensure that following investigation of the complaint, appropriate actions are put in place to ensure learning takes place and every effort is made to prevent a recurrence of the situation or issue which triggered the serious complaint.

## Parliamentary and Health Service Ombudsman (PHSO) - Independent review of complaints

The Trust aims to resolve all complaints at a local level. This may involve telephone calls, written responses, meetings or a combination of all of these. All complainants are given information about the Parliamentary and Health Service Ombudsman service when their complaint is first acknowledged and again when a response is sent to them. Complainants can refer their complaint to the Parliamentary and Health Service Ombudsman if they feel it has not been handled or resolved satisfactorily by the Trust. The role of the Parliamentary and Health Service Ombudsman is to assess the original complaint and responses provided by the Trust to determine whether an independent review of the complaint and its handling is required. The number of complaints referred to and upheld by the Parliamentary and Health Service Ombudsman relating to UHB remains low.

<b>PHSO involvement</b>	<b>Quarter 2 2013/14</b>	<b>Quarter 3 2013/14</b>
Cases referred to PHSO by complainant for assessment	1	2
Cases which, following the initial review, are being fully investigated – outcome awaited	0	4
Cases which then required no further investigation	0	0
Cases which were then referred back to the Trust for further local resolution	0	0
Cases which were not upheld following review by the PHSO	1	0
Cases which were partially upheld following review by the PHSO	0	0
Cases which were fully upheld following review by the PHSO	0	0

## Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS), and also by the Patient Experience Team on behalf of the Trust. PALS record any compliments they receive directly from patients and carers while the Patient Experience Team collate and record compliments received via all other sources. This includes those sent to the Chief Executive's office, the patient experience email address, the Trust website and those sent directly to wards and departments.

The majority of compliments are received in writing – by letter, card, email, website contact or trust 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	2012/13	Q1 2013/14	Q2 2013/14	Q3 2013/14
Nursing care	356	109	205	44
Friendliness of staff	207	43	67	31
Treatment received	766	94	278	454
Medical care	92	25	16	11
Efficiency of service	151	60	45	20
Information provided	10	5	9	7
Facilities	24	2	2	4
Other	38	10	5	5
<b>Totals:</b>	<b>1,644</b>	<b>348</b>	<b>627</b>	<b>576</b>

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

#### Background

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.

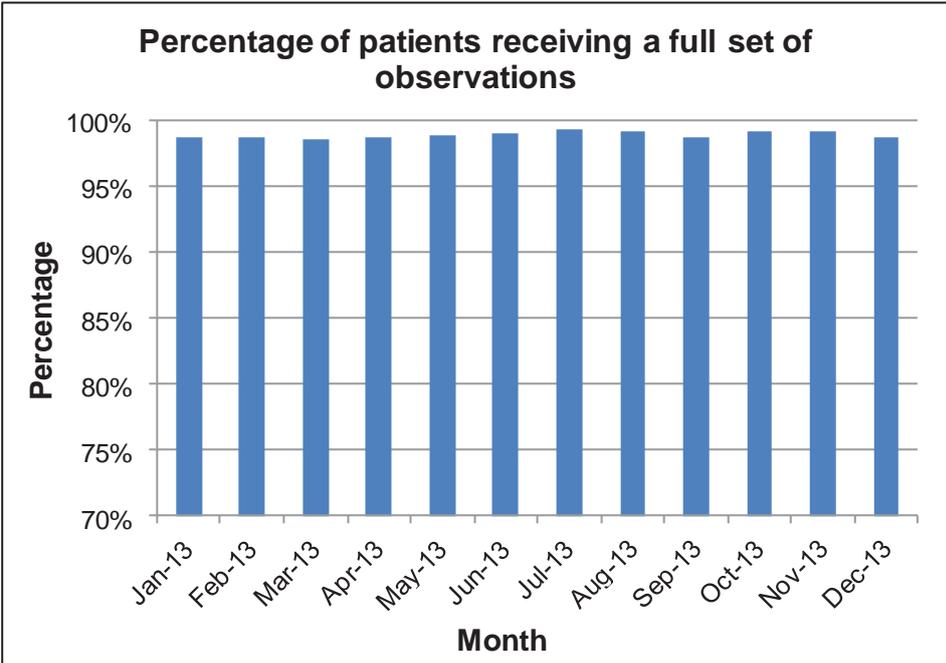
When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool enables an early warning score called the SEWS (Standardised Early Warning System) score to be triggered automatically if a patient's condition starts 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 graph below shows the overall completion rate for observations within 24 hours. The Trust achieved 99% for December 2013. The vast majority of the Trust’s wards now perform at over 98% for completeness of observation sets.



**Priority 4: Reducing medication errors (missed doses)**

**Background**

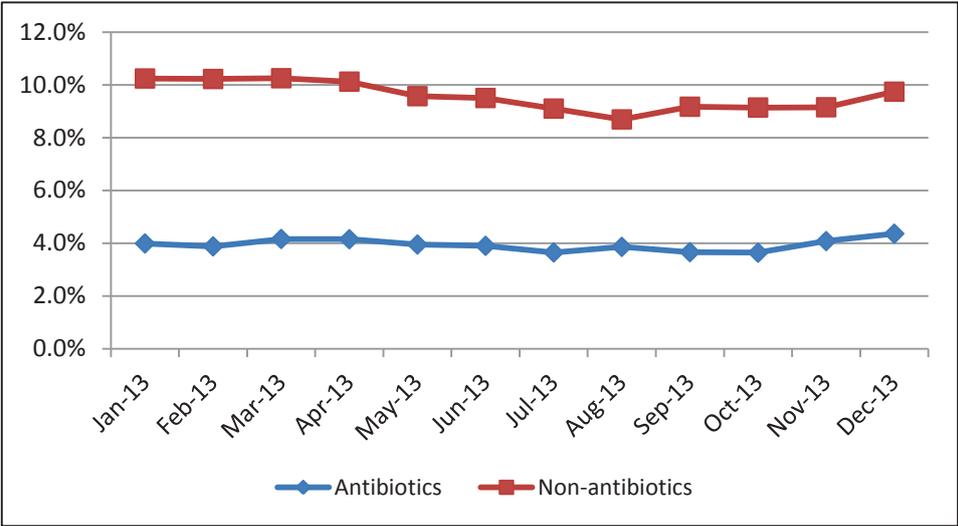
Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System.

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 the percentage of missed antibiotic and non-antibiotic doses for the past 12 months. Antibiotic missed doses performance remains strong at 3.9%. Missed non-antibiotics are at 9.4% for the period April-December 2013; there is still work to do to reduce these by the end of the year. It is however important to remember that some drug doses are appropriately missed due to the patient’s

condition at the time. There is further work to be done to reduce non-antibiotic missed doses. The Trust is focusing on reducing patient refusals, improving stock availability and ensuring all doses are appropriately recorded as given or not.



**Priority 5: Infection prevention and control**

**MRSA Bacteraemia**

The national objective for all Trusts in England in 2013/14 is to have zero MRSA bacteraemia. To date in 2013/14, there have been three Trust apportioned cases (cases linked to UHB) of MRSA bacteraemia. These will be subject to additional review at the Trust’s Executive Root Cause Analysis meeting chaired by the Chief Executive.

The table below shows the Trust apportioned cases reported to Public Health England (PHE):

	Q1 2013/14	Q2 2013/14	Q3 2013/14	Year to Date
<b>Actual performance</b>	0	0	3	<b>3</b>
<b>Agreed trajectory</b>	0	0	0	<b>0</b>

The Trust is continuing to focus on clinical practice to try to prevent further MRSA bacteraemia:

- Improving the clinical management of invasive devices including peripheral and central venous cannulae and urinary catheters in accordance with the Trust standard. This includes ensuring the availability of long-term access for patients who are likely to encounter difficulties with peripheral venous cannulae. A Multidisciplinary Group has been tasked to look at use and care of urinary catheters using the Safety Thermometer data.
- Ensuring awareness of MRSA status and the optimal management of all patients with MRSA colonisation and infection.
- Reviewing all aspects of the Trust’s MRSA screening programme in line with national recommendations to ensure it remains fit for purpose.

### **C.difficile infection (CDI)**

The Trust's annual agreed trajectory is a total of 56 cases for 2013/14. The Trust is using a new review tool with the local Clinical Commissioning Group to establish whether cases are avoidable or not so that the Trust can focus on reducing avoidable (preventable) cases. The majority of the Trust's CDI cases to date have been unavoidable; there have been 13 CDI cases which were deemed to be avoidable.

	<b>Q1 2013/14</b>	<b>Q2 2013/14</b>	<b>Q3 2013/14</b>	<b>Year to Date</b>
<b>Actual performance</b>	24	21	20	<b>65</b>
<b>Agreed trajectory</b>	14	14	14	<b>42</b>

The Trust is continuing to focus on clinical practice to maintain current performance and meet this objective by:

- Maintaining an antimicrobial stewardship programme. This includes ensuring that antibiotic prescribing is in line with Trust guidelines, documenting the reason for every antibiotic prescription and early review of whether prescribed antibiotics are still appropriate.
- Ensuring clear and accurate documentation of all aspects of the pathway for cases of *C.difficile* infection.
- Ensuring multi-disciplinary review of patient bowel management procedures and the appropriateness of stool sampling with clear documentation of the decision-making process.

### **Priority 6: Improving patient safety through barcoded wristbands**

#### **Background**

The Trust takes correct patient identification very seriously as patients with similar names and/or dates of birth can often be on the same ward at the same time. The main risks associated with patient identification include identifying the wrong patient and/or the wrong patient record which the introduction of barcoded wristbands will help to reduce.

Patients currently have their identity confirmed on admission and are then given a printed wristband. The printed wristband includes a patient's first and last names, date of birth, hospital number and NHS number. Patients are asked to verbally confirm their name and other details are correct before medication is given or they go for a procedure to ensure that the correct patient is identified.

The Trust plans to improve patient safety by implementing barcoded patient wristbands in addition to the processes currently used to check patient identity for medication administration. This will mean that patients will be asked to verbally confirm their details and their wristband will be scanned before they are given their medication during a drug round. Scanning a barcoded patient wristband will automatically open the correct patient's drug chart in the Trust's Prescribing Information and Communication System (PICS).

The Trust is aiming to implement barcoded wristbands for all inpatients for medication administration by the end of 2013/14. The plan is to use barcoded wristbands to improve patient safety in other areas in the future such as when ordering scans or blood tests for patients.

**Update on initiatives to be implemented in 2013/14:**

- An implementation sub-group has been established to oversee the implementation of barcoded wristbands. The sub-group reports to the Trust's Electronic Patient Record (EPR) Executive Group and to the Clinical Quality Monitoring Group chaired by the Executive Medical Director.
- A two week trial of barcoded wristbands was completed on a 36-bed ward in September 2013. The aim of the trial was to identify any potential issues and provide information to guide the Trust-wide implementation of barcoded wristbands. The trial was a success and a meeting has been planned to agree the Trust-wide roll out plan for barcoded wristbands.
- An implementation plan will be developed which will clarify the staff training requirements and staff roles.
- The IT hardware requirements will be reviewed at ward level to ensure that enough barcode scanning equipment is ordered for staff to use.
- A mechanism to monitor ward compliance with the use of barcoded wristbands to improve patient safety will be developed.

**How progress will be monitored, measured and reported:**

- Progress will be monitored and measured through the implementation sub-group and reported to the Electronic Patient Record (EPR) Executive Group.
- Ward compliance with the use of bar-coded wristbands will be monitored following implementation. A clinical dashboard indicator will be developed to monitor compliance.
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages.

#### 4. Performance of the Trust against selected metrics

The tables below show the Trust's latest performance for 2013/14 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 2013/14 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	2011/12	2012/13	2013/14	Peer Group Average (where available)
1(a). MRSA: Patients with MRSA infection/100,000 bed days (includes all bed days from all specialties)	1.50	1.41	0.00	0.89
<i>Lower rate indicates better performance</i>				
Time period	2011/12	2012/13	April-Oct 2013	April-Oct 2013
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	2011/12	2012/13	2013/14	Peer Group Average (where available)
<b>1(b). MRSA: Patients with MRSA infection/100,000 bed days (aged &gt;15, excluding Obstetrics and Gynaecology and elective Orthopaedics)</b> <i>Lower rate indicates better performance</i>	1.51	1.42	0.00	1.04
Time period	2011/12	2012/13	April-Oct 2013	April-Oct 2013
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
<b>2(a). C. difficile: Patients with C. difficile infection/100,000 bed days (includes all bed days from all specialties)</b> <i>Lower rate indicates better performance</i>	25.44	20.31	24.91	14.45
Time period	2011/12	2012/13	April-Oct 2013	April-Oct 2013
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)	Acute trusts in West Midlands SHA
Peer group				Acute trusts in West Midlands SHA

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
<b>2(b). C. difficile: Patients with C. difficile infection/100,000 bed days (aged &gt;15, excluding Obstetrics Gynaecology and elective Orthopaedics)</b>	25.60	20.44	25.06	17.58
<i>Lower rate indicates better performance</i>				
Time period	2011/12	2012/13	April-Oct 2013	April-Oct 2013
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
<b>3(a) Patient safety incidents (reporting rate per 100 admissions)</b>	9.3	10.4	10.4	Not available
<i>Higher rate indicates better reporting</i>				
Time period	2011/12	2012/13	April-Dec 2013	
Data source	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
<b>3(b) Never Events</b>	<b>1</b>	<b>0</b>	<b>2</b> (see explanatory note below)	<i>Not available</i>
<i>Lower number indicates better performance</i>				
Time period	2011/12	2012/13	April-Dec 2013	
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer Group				
<b>4(a) Percentage of patient safety incidents which are no harm incidents</b>	<b>70.4%</b>	<b>64.4%</b>	<b>68.6%</b>	<i>Not yet published</i>
<i>Higher % indicates better performance</i>				
Time period	2011/12	2012/13	April-Dec 2013	
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				
<b>4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death</b>	<b>1.06%</b>	<b>0.27%</b>	<b>0.25%</b>	<i>Not yet available</i>
<i>Lower % indicates better performance</i>				
Time period	2011/12	2012/13	April-Dec 2013	
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
<b>4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)</b>	<b>9,295</b>	<b>8,514</b>	<b>6,907</b>	<i>Not yet published</i>
Time period	2010/11	2011/12	April-Dec 2013	
Data source(s)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	
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 2012/13 as these are also classed as admissions. The data for 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 two never events in quarter 1 2013/14 relating to wrong site surgery. There was no significant harm caused to either patient.

**4(a):** The reduction in the percentage of no harm incidents 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(c):** The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

### Clinical effectiveness indicators

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
<b>5(a). Emergency readmissions within 28 days (Medical and surgical specialties - elective and emergency admissions aged &gt;15) %</b>	<b>12.56%</b> <b>England:13.18%</b>	<b>12.66%</b> <b>England:13.39%</b>	<b>11.73%</b>	<b>12.23%</b> <b>England: 13.33%</b>
<i>Lower % indicates better performance</i>				
Time period	2011/12	2012/13	April-Sept 2013	April-Sept 2013
Data source	HES data	HES data	HES data	HES data
Peer group				University hospitals
<b>5(b). Emergency readmissions within 28 days (all specialties) %</b>	<b>12.54%</b> <b>England:12.40%</b>	<b>12.63%</b> <b>England:12.52%</b>	<b>11.71%</b>	<b>11.75%</b> <b>England: 12.94%</b>
<i>Lower % indicates better performance</i>				
Time period	2011/12	2012/13	April-Sept 2013	April-Sept 2013
Data source	HES data	HES data	HES data	HES data
Peer group				University hospitals

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
<p><b>6. Falls (incidents reported as % of elective emergency admissions)</b></p> <p><i>Lower % indicates better performance</i></p> <p>Time period</p>	<p>2.2%</p> <p>2011/12</p> <p>Datix (incident data), Trust admissions data</p>	<p>2.2%</p> <p>2012/13</p> <p>Datix (incident data), Trust admissions data</p>	<p>2.1%</p> <p>April-Dec 2013</p> <p>Datix (incident data), Trust admissions data</p>	<p><i>Not available</i></p>
<p><b>7. Stroke 30-day mortality</b></p> <p><i>Lower % indicates better performance</i></p> <p>Time period</p> <p>Data source</p>	<p>N/a</p>	<p>N/a</p>	<p>8.4%</p> <p>April-Dec 2013</p> <p>Trust SSNAP (Sentinel Stroke National Audit Programme) data</p>	
<p>Peer group</p>				

Indicator	2011/12	2012/13	2013/14	Peer Group Average (where available)
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG)	93.6%	96.4%	86.0%	
<i>Higher % indicates better performance</i>				
Time period	2011/12	2012/13	April–Dec 2013	
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 methodology has been updated to reflect the latest guidance from the Health and Social Care Information Centre. The key change is that daycases and regular daycase patients, all cancer patients or patients coded with cancer in the previous 365 days are now excluded from the denominator. This indicator includes patients readmitted as emergencies to the Trust or any other provider within 28 days of discharge. Further details can be found on the Health and Social Care Information Centre website: <https://mql.ic.nhs.uk/IndicatorDefaultView.aspx?ref=1.01.17>

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

**7:** The previous stroke indicator - Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin – has been replaced as the Trust consistently performs at over 99% for this indicator. The new indicator – Stroke 30-day mortality – measures the percentage of patients who die following admission to

hospital with a stroke. The goal is for stroke mortality to be less than 20%. Data collection for the SSNAP audit started from April 2013 so no data is shown for 2011/12 or 2012/13.

**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.