UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING
MONDAY 23 FEBRUARY 2015

Title:	**QUALITY ACCOUNT UPDATE FOR QUARTER 3 2014/15**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 13687

Purpose:	To present the Quality Account Update Report for Quarter 3 2014/15 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 draft Q3 2014/15 Quality Account Update is shown in Appendix A. • The latest SHMI and HSMR values are within tolerance. • Performance for the five Quality Improvement Priorities is included. • Performance for the specialty indicators will be included as an appendix to the update report before publication.	
Recommendations:	The Council of Governors is asked to: **Note** the content of the report.	
Approved by:	Dr David Rosser	Date: 12/02/2015

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS
MONDAY 23 FEBRUARY 2015

QUALITY ACCOUNT UPDATE FOR QUARTER 3 2014/15

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. **Introduction**

The aim of this paper is to present the Trust's Quality Account Update for Quarter 3 2014/15 which will be published in March 2015. The Trust's Quality Account Update report for April-December 2014 is shown in Appendix A and will be presented to the Clinical Quality Committee (CCQ) on 5 March 2015.

2. **Data Completeness**

The latest available data is included for all parts of the report. Data for the full period April-December 2014 is not yet available for all indicators and will be added in later, where available, prior to publication.

3. **Performance**

3.1 Mortality: SHMI and HSMR

The report contains the Trust's Summary Hospital-level Mortality Indicator (SHMI) figure for the period October 2013 - September 2014 which has been calculated by Health Informatics. The SHMI is 100.80 and is within tolerance. The Trust's latest Hospital Standardised Mortality Ratio (HSMR) value for the period December 2013 - November 2014 is 93.39 as calculated by Health Informatics which is also within tolerance. The HSMR has been included in the Quality Account Update for Q3 2014/15 simply for completeness with a statement explaining that the underlying methodology is largely discredited.

3.2 Quality Improvement Priorities

3.2.1 Improving venous thromboembolism (VTE) Prevention

The Trust is aiming to maintain enoxaparin prescription performance at 90% or higher for patients where it is recommended following risk assessment and administration of anti-embolism stockings at 83% or higher during 2014/15. The Trust has maintained performance at 93.5% for enoxaparin prescription within 12 hours during the period April-December

2014, and performance for administration of stockings stands at 88.4%

3.2.2 Improve patient experience and satisfaction

The Trust received a similar number of complaints in Quarter 3 2014/15 (197) compared to Quarter 2 2014/15 (193). Performance for the majority of the patient survey questions is slightly lower again in Quarter 3 2014/15 compared to 2013/14. Performance has been discussed with the Head of Patient Experience and improvement plans will be developed with the Divisions.

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

The Trust has achieved over 98% for completeness of observation sets within 12 hours for the period April-December 2014 overall.

Individual wards which are performing below the 98% target continue to be reviewed at the Executive Root Cause Analysis (RCA) meetings. The Head of Quality Development presented to Senior Sisters and Matrons during October and November 2014 to ensure all senior nursing staff understand the end of year target, performance and future Clinical Dashboard changes.

3.2.4 Reducing Medication Errors (Missed Doses)

The Trust has maintained performance for antibiotic missed doses at 4.0% during the period April-December 2014.

The Trust was aiming to reduce non-antibiotic missed doses to 8.4% by the end of 2014/15, however this rate has been over 10.0% for the period April-December 2014 so there is further work to be done to reduce avoidable missed doses. Poorly performing wards are being called to attend Executive RCA meetings to review their performance for missed doses and identify where improvements need to be made. Performance will also be discussed at the Clinical Quality Monitoring Group (CQMG) at the end of February 2015.

3.2.5 Infection Prevention and Control

The Trust has had two MRSA bacteraemia during Quarter 3 2014/15, one of which was subject to further review at the Executive RCA meeting in January 2015. The Trust's performance for *C. difficile* infection during the period April-December 2014 remains in line with the 2014/15 trajectory.

3.3 Selected Metrics

The incident and other indicators have performed as expected during Quarter 3 2014/15. The incident reporting rate has increased due to automated incident reporting from the Trust's Prescribing Information and Communication System (PICS). Reports for incomplete sets of observations within 12 hours were automated from 8 September 2014. Emergency readmissions have been slightly higher during 2014/15 and continue to be monitored via the Clinical Quality Monitoring Group.

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 Quality and Outcomes Research Unit (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.

Quality Account Update for April-December 2014

Contents

Quality Account Update for April-December 2014

1. Introduction

The Trust published its sixth Quality Account Report in June 2014 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2013/14, performance data for selected metrics and set out five priorities for improvement during 2014/15:

Priority 1: Improving VTE prevention
Priority 2: Improve patient experience and satisfaction
Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)
Priority 4: Reducing medication errors (missed doses)
Priority 5: Infection prevention and control

This report provides an update on the progress made for the period April-December 2014 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 2013/14.

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.

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

This 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

[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.

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 Health and Social Care Information Centre publishes 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 SHMI is 100.80 for the period October 2013-September 2014 which is slightly higher than expected but within tolerance as calculated by the Trust's Health Informatics team. The latest SHMI value for the Trust which is available on the Health and Social Care Information Centre website is 102.86 for the period July-2013 to June 2014, which 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 93.39 for the period December 2013 - November 2014 as calculated by the Trust's Health Informatics team. 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[2,3]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

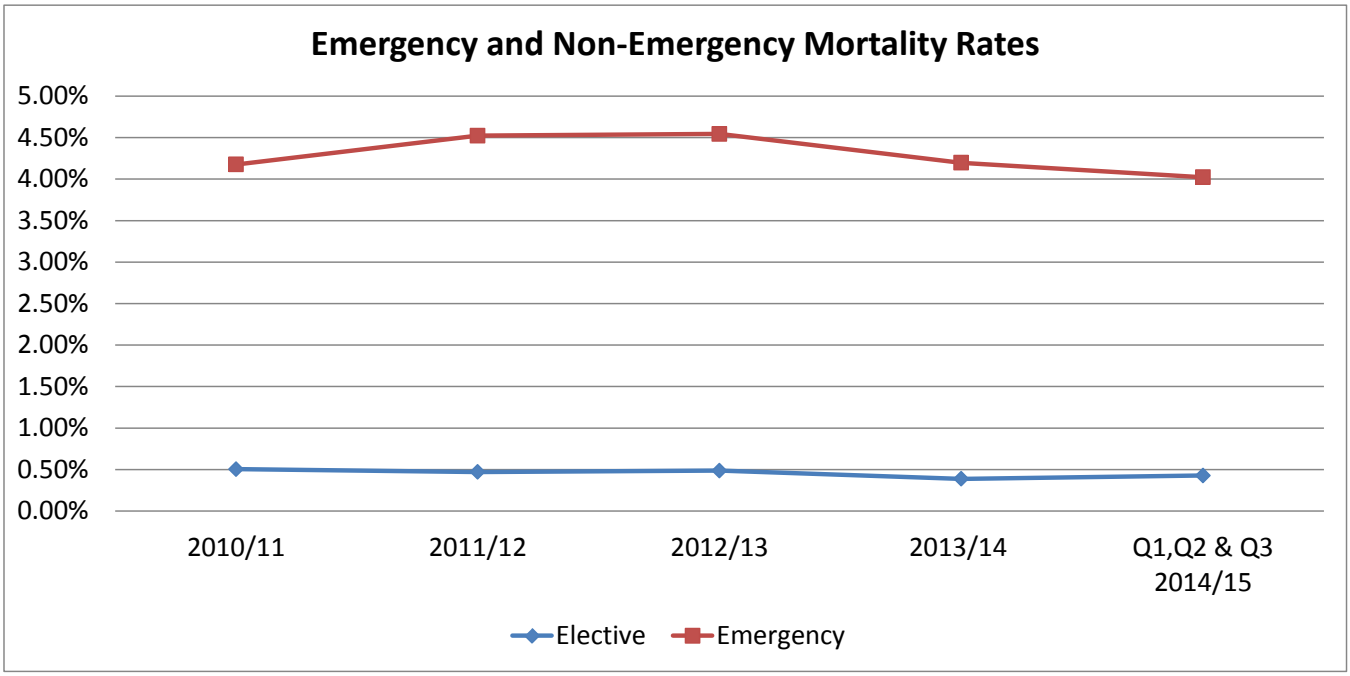
Crude Mortality

The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past four 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.

[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.

Emergency and Non-Emergency Mortality Graph



Overall Crude Mortality Graph

The Trust's overall crude mortality rate had decreased in Q1 & Q2 2014/15 (2.77%) compared to 2013/14 (3.10%) and 2012/13 (3.14%). This was due to an increase in the number of patient admissions and a reduction in the number of deaths in Q1 & Q2 2014/15.

Mortality rate has increased in Q3 2014/15 (3.34%) when compared to Q3 2013/14 (2.93%) but has reduced when compared to Q3 2012/13 (3.35%), however all these changes are small (less than half of one percentage point).

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. 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.

During 2014/15, the Trust is focusing on maintaining performance for administration of anti-embolism stockings at 83% or above and enoxaparin prescription at 90% or above. The Trust will continue to monitor administration of enoxaparin medication to ensure it remains high.

Performance

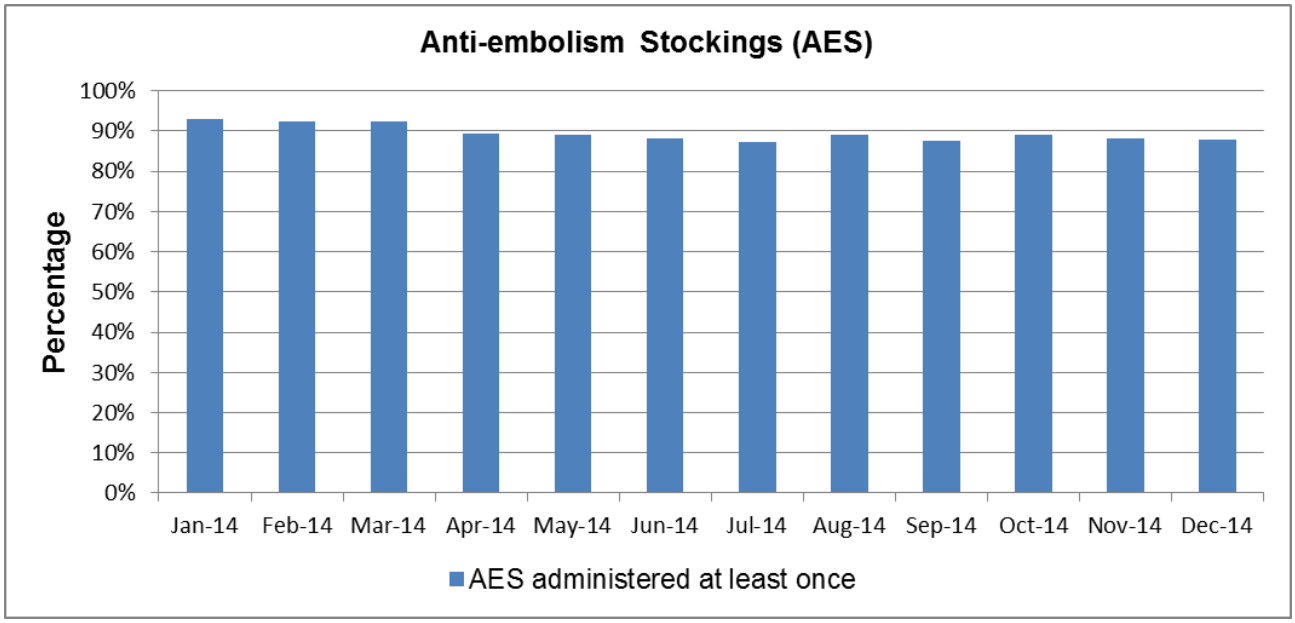
VTE Risk Assessment Completion

The Trust continues to achieve a VTE risk assessment completion rate of above 99%, and has done since June 2012. This is above the national average of 96% for NHS acute providers published on the NHS England website (July – September 2014).

VTE Prevention – Anti-embolism Stockings

The graph below shows the percentage of anti-embolism stockings administered at least once for those patients who were prescribed them as recorded in the electronic Prescribing Information and Communication System (PICS). Overall, 88.4% of prescribed anti-embolism stockings were administered at least once per episode during the period April-December 2014.

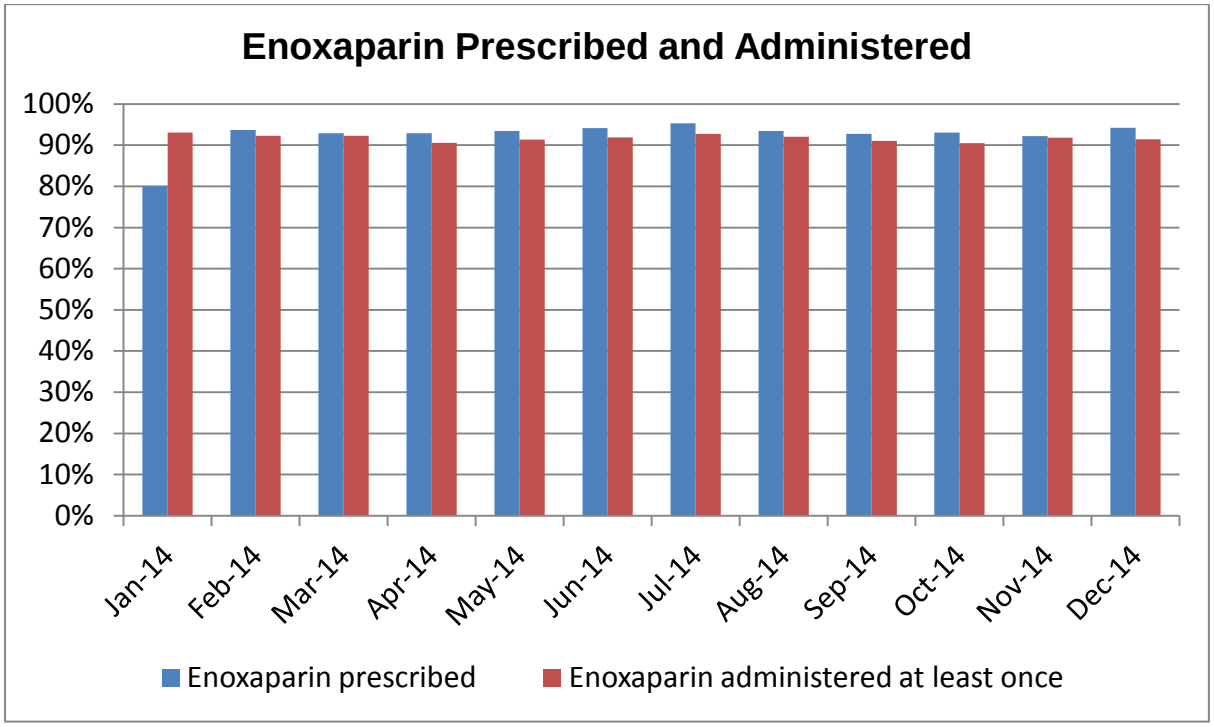
If the outcome of a VTE risk assessment shows that a patient requires anti-embolism stockings, they are automatically prescribed by PICS except in Critical Care where doctors make the decision to prescribe them or not. It is not always appropriate to administer anti-embolism stockings every day for a variety of reasons including patient choice and clinical contraindications such as sore or swollen skin for example. These two categories account for around two-thirds of the stockings not administered.



***** *The Trust has changed the methodology for measuring administration of anti-embolism stockings from April 2014 so that each VTE risk assessment is counted. Some patients will have a number of VTE risk assessments completed during their stay, particularly if they change from Medicine to Surgery.*

VTE Prevention – Enoxaparin Medication

The graph below shows the percentage of patients who required enoxaparin medication following VTE risk assessment and were prescribed it within 12 hours. 93.5% of patients who required enoxaparin following VTE risk assessment were prescribed it in the period April - December 2014. Of the patients who were prescribed enoxaparin, 91.5% were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Priority 2: Improve patient experience and satisfaction

Background

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

Changes to improvement priority for 2014/15

A new set of local survey questions for 2014/15 was chosen by the Care Quality Group which has Governor representation and then approved by the Board of Directors. The new set of questions includes the lowest performing ones from the Trust's regular inpatient, outpatient, Emergency Department and discharge surveys.

Improvement target for 2014/15

In line with the Trust's Annual Plan for 2014/15, the improvement targets for the proportion of positive responses are as follows:

- Questions scoring 87% or more in 2013/14 are to maintain or improve this performance.
- Questions scoring less than 87% in 2013/14 are to increase performance by at least 5%, and/or achieve 87%.

How progress will be monitored, measured and reported:

- Feedback rates and responses will continue to be measured and reported via the Clinical Dashboard.
- Regular patient experience reports will be provided to the Care Quality Group and to the Board of Directors
- Performance will continue to be monitored as part of the Back to the Floor visits by Governors and the senior nursing team with action plans developed as required
- Feedback will be provided by members of the Patient and Carer Councils as part of the Adopt a Ward / Department visits.
- Progress will also be reported via the quarterly Quality Report update published on the Trust Quality web pages.

Patient Experience Data

Performance

During Quarter 3 2014/15, 6,201 patient responses were received for the electronic inpatient survey and 391* patients responded to the discharge survey following inpatient stays in October and November. For the year to date, the quality priority questions are, in the main, not showing improvements. A gap analysis has been provided to priority leads to indicate the requirements for Quarter 4.

**December 2014 data is not yet available for these questions as patients are given around 6 weeks to respond.*

Methodology

The questions below have been selected from four different surveys undertaken at UHB. The proportion of positive responses is calculated by dividing the number of the most positive responses e.g., 'Yes, definitely' by the total number of applicable responses.

Patient survey questions for 2014/15:

		% positive responses			
Type of Survey	**Survey Question**	**2013/14**	**Q1 2014/15**	**Q2 2014/15**	**Q3 2014/15**
Inpatient	1. Did you find someone on the hospital staff to talk about your worries or fears?	79.7%	75.0%	74.5%	73.3%
	2. Do you think that the ward staff do all they can to help you rest and sleep at night?	83.5%	78.8%	78.5%	77.7%
	3. Have you been bothered by noise at night from hospital staff?	73.5%	69.6%	67.7%	66.0%
	4. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	77.3%	76.4%	76.3%	75.6%
	5. Did the staff treating and examining you introduce themselves?	New question from Q1 2014/15	78.8%	80.6%	80.3%
Outpatient	6. Was your appointment changed to a later date by the hospital?	80.6%	80.0%	79.5%	84.3%*
	7. Did the staff treating and examining you introduce themselves?	78.0%	69.3%	73.6%	74.2%*
	8. Did a member of staff tell you about medication side effects to watch out for?	54.9%	47.1%	52.4%	42.6%*

		% positive responses			
Type of Survey	**Survey Question**	**2013/14**	**Q1 2014/15**	**Q2 2014/15**	**Q3 2014/15**
Emergency Department	9. Were you involved as much as you wanted to be in decisions about your care and treatment?	68.8%	64.7%	67.1%	65.7%
	10. Do you think the hospital staff did everything they could to help control your pain?	70.3%	65.1%	70.3%	68.3%
	11. Did the staff treating and examining you introduce themselves?	New question from Q2 2014/15		71.3%	65.7%
Discharge	12. Did a member of staff tell you about medication side effects to watch for when you went home?	47.3%	47.0%	51.2%	46.5%*
	13. Did you feel you were involved in decisions about going home from hospital?	54.7%	54.3%	51.4%	50.1%*

**October-November 2014 data only. December 2014 data is not yet available for these questions as patients are given around 6 weeks to respond.*

Friends and Family Question

Background

The Trust has monitored performance for the Friends and Family Test question during Quarter 3 2014/15:

- "How likely are you to recommend our [ward/A&E department/service] to friends and family if they needed similar care or treatment?"

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 1 April 2013, the Trust transferred to the new Department of Health guidance for the Friends and Family Test requirements. This involved the expansion of the survey to the Emergency Department. Response rates are reported together with the

scores for each ward and the Emergency Department (ED) on the Trust website. Response rates from ED were poor during the first half of 2013/14 despite promotion and publicity. As a result a three-month pilot, survey via text messaging was implemented at the end of September 2013 for Emergency Department patients. Initial response rates were encouraging and so the pilot was extended until the end of March 2014. Response rates significantly improved in the final three months of the year. Text messaging has continued and has shown sustained performance during (with the exception of May 2014 where technical difficulties resulted in some data being unavailable for reporting). Quarter 2 has seen a further increase in the responses coming through from ED, the overall figure for this period is a response rate of 22.7% against a target of 15%. Quarter 3 achieved 20.2% response rate.

There has also been consistency in the responses from inpatients in Quarter 3, the overall response rate is 48.4% against a target of 25%.

Methodology

A new scoring mechanism was introduced during Quarter 3 in line with national guidance. Results are now reported as the percentage of patients who would recommend (extremely likely and likely), and the percentage of patients who would not recommend (unlikely and extremely unlikely).

The net promoter score is no longer used, but both ways of scoring are displayed in this report for completeness.

For the previous scoring method (net promoter), only those patients who picked ‘extremely likely’ were classed as promoters, ‘likely’ responses were classed as passive and all the rest were classed as detractors. The score was calculated by subtracting the detractors from the promoters, dividing the result by the number of responses (excluding the ‘don’t know’ responses), then multiplying by 100 to give the final score. The highest possible score was 100; the lowest possible score was -100.

Performance and Response Rates

The tables below show the Trust’s response rates and scores for the past twelve months.

The quarterly response rate is monitored via a CQUIN in 2014/15. Both Inpatients and Emergency Department met their CQUIN targets in Q3 2014/15.

Friends and Family Question – results, scores and response rates

Inpatients	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Extremely Likely	1039	919	1250	1277	1187	1404	1490	1092	925	1348	1067	1166
Likely	164	199	295	279	299	299	309	238	227	316	324	311
Neither Likely or Unlikely	16	14	31	21	21	34	26	16	20	38	47	34
Unlikely	2	8	17	8	8	13	11	12	8	11	15	18
Extremely Unlikely	8	9	21	13	10	13	13	14	12	20	26	13
Don't Know	9	2	11	13	13	10	17	13	6	20	11	7
'Net Promoter' Score	**82**	**77**	**73**	**77**	**75**	**76**	**78**	**77**	**74**	**74**	**66**	**71**
Would Recommend	**97.2%**	**97.1%**	**95.1%**	**96.6%**	**96.6%**	**96.1%**	**96.4%**	**96.0%**	**96.2%**	**94.9%**	**93.4%**	**95.4%**
Would Not Recommend	**0.8%**	**1.5%**	**2.3%**	**1.3%**	**1.2%**	**1.5%**	**1.3%**	**1.9%**	**1.7%**	**1.8%**	**2.8%**	**2.0%**
Total Responses	1238	1151	1625	1611	1538	1773	1866	1385	1198	1753	1490	1549
Total Discharges	3104	2901	3153	2957	3249	3111	3328	2896	2998	3234	3242	3426
Monthly Response Rate	39.9%	39.7%	51.5%	54.5%	47.3%	57.0%	56.1%	47.8%	40.0%	54.2%	46.0%	45.2%
Quarterly Response Rate	Not monitored			52.8% (Target: 25%)			48.2% (Target: 25%)			48.4% (Target: 25%)		

Emergency Department	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Extremely Likely	494	655	1129	1293	617	932	1166	972	990	942	857	790
Likely	119	165	253	322	190	254	320	281	272	274	226	176
Neither Likely or Unlikely	19	41	72	67	47	55	72	67	91	67	53	33
Unlikely	20	31	50	49	33	45	60	51	53	53	58	27
Extremely Unlikely	31	38	76	115	71	71	98	70	94	72	86	67
Don't Know	3	15	14	19	11	11	26	27	30	15	15	10
'Net Promoter' Score	**62**	**59**	**59**	**58**	**49**	**54**	**55**	**54**	**50**	**53**	**52**	**61**
Would Recommend	**89.4%**	**86.8%**	**86.7%**	**86.6%**	**83.3%**	**73.3%**	**85.3%**	**85.4%**	**82.5%**	**85.5%**	**83.6%**	**87.6%**
Would Not Recommend	**7.4%**	**7.3%**	**7.9%**	**8.8%**	**10.7%**	**7.2%**	**9.1%**	**8.2%**	**9.6%**	**8.8%**	**11.1%**	**8.5%**
Total Responses	686	945	1594	1865	969	1618	1742	1468	1530	1423	1295	1103
Total Discharges	6122	5742	6820	6314	6567	6712	6996	6394	6718	6708	6334	5910
Response Rate	11.2%	16.5%	23.4%	29.5%	14.8%	24.1%	24.9%	23.0%	22.8%	21.2%	20.5%	18.7%
Quarterly Response Rate	Not monitored			22.7% (Target: 15%)			23.6% (Target: 15%)			20.2% (Target: 15%)		

Patient Experience initiatives to be implemented in 2014/15:

- The Family and Friends Test has been implemented in Outpatients and day-case settings from October 2014. Outpatients can now choose to feed back via the Self Check-in kiosks (where available), postcards or a web-based survey accessed via the Trust website. Day case patients will continue to feed back via paper based surveys.
- A publicity campaign is underway to ensure that staff always introduce themselves to patients and carers. An additional question was added to the patient surveys in Quarter 1 2014/15 enabling us to monitor the effectiveness of the campaign. Data for Quarter 2 2014/15 shows some initial improvement for inpatients but results are variable for Outpatients. This will continue to be monitored alongside the implementation of the Communication Skills Portal which was launched in Quarter 3.
- Launch of a dedicated Carers page on the Trust website. This is nearing completion with patient and carer representatives involved throughout the process. The content is currently being finalised ready for publication.
- Buddy Scheme for 16-25 year olds to be implemented in key wards across the Trust. A pilot carried out by the Young Person's Council was successful and discussions are underway regarding recruitment of buddy volunteers, procedural documents and training required prior to being rolled out across the trust.
- Review and revision of patient menus to reflect patient choice and ethnicity. The patient survey questions have been amended slightly to enhance monitoring of changes made.
- A new Task and Finish group has been set up to help patients rest and sleep better. The first meeting took place in September 2014. A further Trust-wide patient audit of rest and sleep took place in Quarter 3 2014/15 with results expected in Quarter 4 2014/15.

Complaints

The number of complaints received in Quarter 3 2014/15 was 197, which is an increase of 4 cases compared to Quarter 2.

	Q2 2014/15	Q3 2014/15
Total number of complaints	193	**197**

Top 6 Main subjects of complaints	Q2 2014/15	Q3 2014/15
Clinical treatment	95	**85**
Communication & information	10	**31**
Staff Attitude	17	**22**
Inpatient appointment cancelled, delayed	21	**18**
Admission, Discharge, Transfer	18	**15**
Outpatient appointment cancelled, delayed	15	**14**

Ratio of complaints to activity		Q2 2014/15	Q3 2014/15
Inpatients	FCEs*	31,203	**30,964**
	Complaints	102	**105**
	Rate per 100 FCEs	0.33	**0.34**
Outpatients	Appointments**	176,152	**189,271**
	Complaints	68	**69**
	Rate per 100 appointments	0.04	**0.04**
Emergency Department	Attendances	26,284	**25,317**
	Complaints	23	**23**
	Rate per 100 attendances	0.09	**0.09**

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

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

Learning from complaints

The table below provides some examples of how the Trust has responded to complaints where serious issues have been raised, a number of complaints have been received about the same or similar issues or for the same location, or where an individual complaint has resulted in specific learning and/or actions.

Theme/Issue	Area of Concern	Action taken/Outcome
Attitude of staff in Imaging department	Relatively low but persistent level of complaints and PALS concerns highlighting specific examples of poor attitude being shown by staff toward patients and /or their families	• Highlighted in a report and email to the Group Manager for Imaging, who advised that he had also noted the trend and had recently discussed it in a meeting with department heads. • Agreed for Head of Patient Relations to arrange a programme for the delivery of customer care training to Imaging staff - the training will incorporate anonymised examples of the feedback received.
Neurosurgery complaints	High levels of complaints and PALS concerns about Neurosurgery. Principally about the cancellation of surgery but also around aspects of nursing care and aspects of medical care and treatment.	• Highlighted in a report and email to the Associate Director of Nursing • Head of Patient Relations met with Associate Director of Nursing and Matron to discuss nursing aspects of complaints. • Head of Patient Relations took a report to the monthly Neurosurgery Morbidity and Mortality meeting, which highlighted themes/trends and specific issues. • Head of Patient Relations to attend future meetings to discuss complaints received and any learning/actions from closed complaints. • Legal Services representative to report on claims at future meetings.

Theme/Issue	Area of Concern	Action taken/Outcome
Outpatient appointments delayed/ cancelled	Level of complaints and PALS concerns around delays receiving appointments, including follow up appointments and delays in clinic.	• Governor drop-in visits to Outpatient areas provide an opportunity to talk with patients and their carers about their experience. A briefing paper is provided to the Governors prior to the visit, highlighting the key issues for that specific outpatient area, which is drawn from complaints, PALS contacts, incidents and other feedback. Discussions encompass how long they had to wait before receiving their appointment, how long they have been waiting in clinic and what they felt about their overall experience. An action plan is developed from the issues raised, which is sent to relevant managers for updating and the completed action plan is subsequently shared at the Executive Chief Nurse's Care Quality Group. The vast majority of the feedback received is overwhelmingly positive and this is shared with the staff concerned.
Communication with patients and their families	Increase in level of complaints received around this subject in Quarter 3	• All complaints about communication are investigated in detail and the findings reviewed by a member of the senior Divisional Management Team. • The Head of Patient Relations discusses individual cases and any associated trends with the relevant Matrons and/or Associate Directors of Nursing and highlights them in reports to Divisional Clinical Quality Group meetings. • Communication behaviours for all staff ("Communicating well") launched at Trust Team Brief on 28 November 2014 and via leaflet with payslips. • "One-stop shop" on Trust intranet – featuring information, resources and links to related training session for various aspects of communication.

The Trust takes a number of steps to review learning from complaints and to take action as necessary. Related actions and learning from individual complaints are shared with the complainant in the Trust's written response or at the local resolution meeting where appropriate.

Specific, individual actions are recorded on the complaints database and followed up with divisional staff to ensure they have been completed. Details of all actions/learning from complaints are shared in a wider Patient Relations report, which is presented at the relevant Division's Clinical Quality Group meeting. This report provides detailed data around complaints, PALS concerns and compliments,

as well as highlighting trends around specific issues and/or wards, departments or specialties.

The Head of Patient Relations has regular meetings with Associate Directors of Nursing and Matrons to discuss themes and trends from PALS contacts and complaints for their specific areas and associated actions are explored at these meetings.

Trends around staff attitude and communication for particular locations feed into customer care training sessions, which are delivered by the Head of Patient Relations to ward/department staff and include anonymised quotes from actual complaints about the specific ward/department.

Complaints and PALS data is also shared in a broader Aggregated Report, which is presented to the Commissioners on a quarterly basis and incorporates information on incidents and legal claims. Complaints and PALS data is reported monthly to the Care Quality Group as part of the Patient Experience report. A monthly complaints report is also presented at the Chief Executive's Advisory Group. Selected complaints are reviewed in detail at Executive Root Cause Analysis case meetings.

Complaints and PALS reports are presented regularly to subject-specific Trust groups including the End of Life/Bereavement, DNACPR (Do Not Attempt Cardio-pulmonary Resuscitation) and Pressure Ulcer Action Groups.

Serious Complaints

The Trust uses a risk matrix to assess the seriousness of every complaint upon receipt. Those deemed most serious, which score either 4 or 5 for consequence on a 5 point scale, are highlighted separately across the Trust. The number of serious complaints is reported monthly to the Chief Executive's Advisory Group and detailed analysis of the cases and the subsequent investigation and any related actions are presented 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 complaint being considered 'serious'.

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

The number of Trust complaints referred to the Parliamentary and Health Service Ombudsman decreased in Quarter 3, compared to the previous quarter. The number of complaints partially upheld by the PHSO remains relatively low with none fully upheld. Detailed action plans are provided for all cases which are upheld or partially upheld. A recent report by the Ombudsman summarising the number of cases referred to them for each NHS provider demonstrated that the Trust's record in this respect was in line with peer Trusts.

PHSO Involvement	Q2 2014/15	Q3 2014/15
Cases referred to PHSO by complainant for assessment	7	3
Cases which, following the initial review, are being fully investigated – outcome awaited	3	1
Cases which then required no further investigation	1	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	2	1
Cases which were partially upheld following review by the PHSO	2	3
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. PALS record any compliments they receive directly from patients and carers. 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. Where compliments are included in complaints they are also extracted and logged as such.

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.

The Trust received 753 compliments in Quarter 3 2014/15 which is a sustained significant increase compared to previous quarters. The Patient Experience team continue to provide support and guidance to divisional staff around the collation and recording of compliments received directly via wards and departments. Additional methods of capturing positive feedback received are being explored.

Compliment Subcategories	2013/14	Q1 2014/15	Q2 2014/15	**Q3 2014/15**
Nursing care	424	34	44	**30**
Friendliness of staff	191	27	18	**35**
Treatment received	1202	368	507	**638**
Medical care	79	9	9	**8**
Other	9	11	2	**3**
Efficiency of service	187	28	22	**29**
Information provided	27	0	0	**6**
Facilities	12	4	3	**4**
Totals:	2,131	481	605	**753**

Feedback received through the NHS Choices and Patient Opinion websites

The Trust has a system in place to routinely monitor feedback posted on two external websites; NHS Choices and Patient Opinion. Feedback is sent to the relevant service/department manager for information and action. A response is posted to each comment received which acknowledges the comment and provides general information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response, or to ensure a thorough investigation into any concerns raised. Whilst there has been an increase in the number of comments posted on each of these two websites the numbers continue to be extremely low in comparison to other methods of feedback received.

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

Background

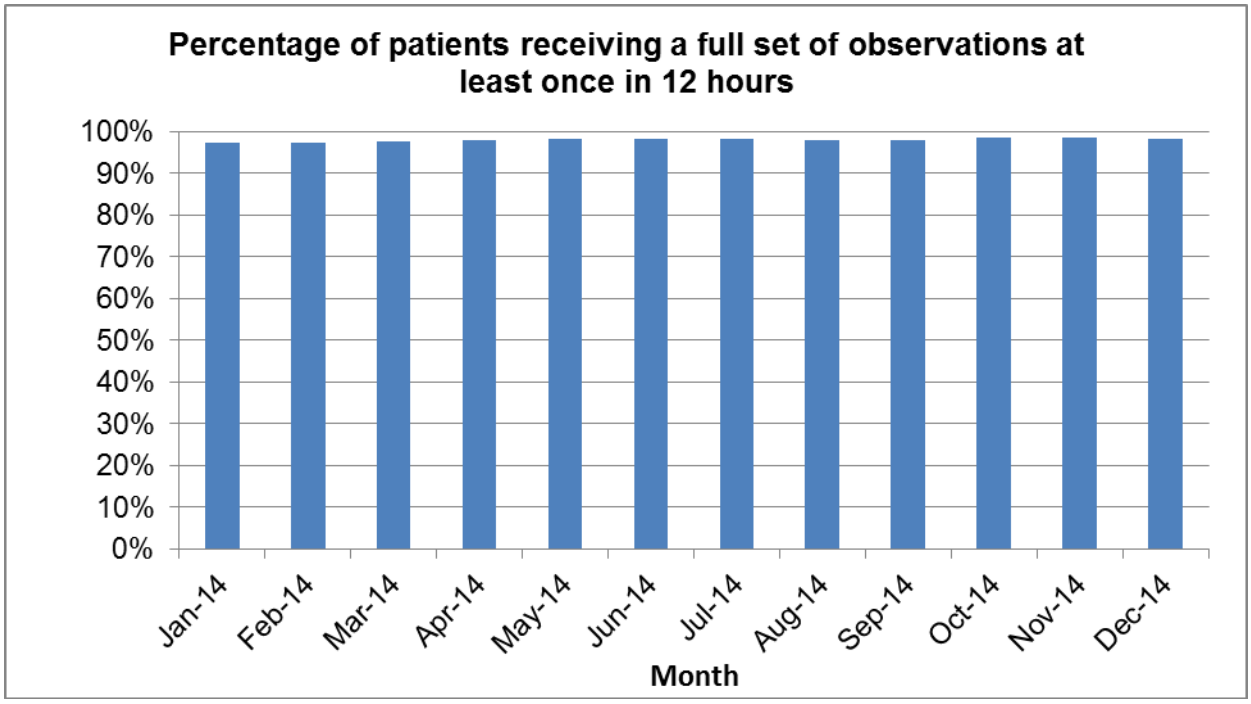
The Trust implemented an electronic observation chart between 2010/11 and 2011/12 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

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 12-hour period.

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. A specific and detailed electronic observation chart has now been developed for Critical Care and is due to be implemented from June 2015.

Performance

The Trust has achieved 98.2% overall for completeness of observation sets at least once in 12 hours during the period April-December 2014. The Trust is aiming for all wards to achieve 98.0% or above by the end of 2014/15. Wards which are not yet achieving 98.0% or higher will be called to Executive Root Cause Analysis meetings for review.



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 Care Omissions Root Cause Analysis (RCA) meetings started at the end of March 2010.

The Trust has chosen to focus on maintaining performance for missed antibiotics and reducing non-antibiotic missed doses in the absence of a national consensus on what constitutes an expected level of drug omissions. The Trust is aiming for a 10% reduction in missed non-antibiotic doses by the end of 2014/15.

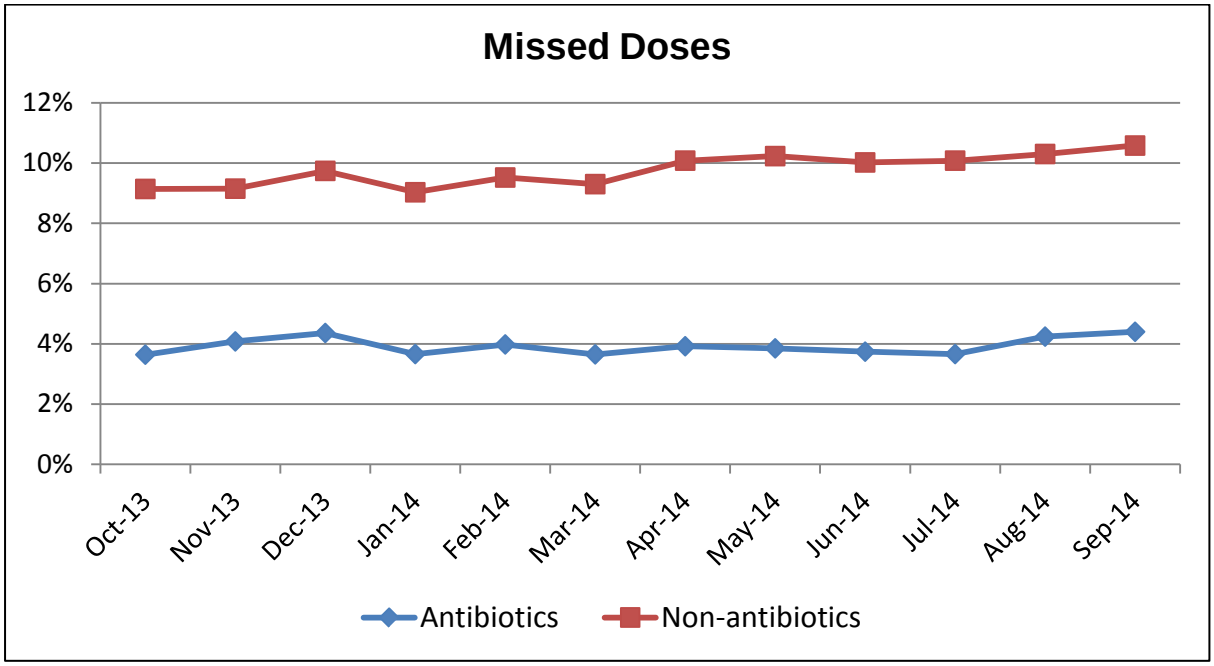
In 2014/15, the Trust is focusing on trying to reduce patient refusals, reducing missed doses due to medication being out of stock and ensuring all doses are appropriately recorded as given or not.

Performance

The graph below shows performance for missed antibiotics and non-antibiotics for the past twelve months. UHB has maintained performance for antibiotics at 4.0% during the period April - December 2014.

The rate of missed non-antibiotics was 10.3% for the period April - December 2014. The Trust was aiming to reduce this rate to around 8.4% by the end of the year (from 9.3% in 2013/14), however this has not been achieved.

The Trust continues to focus on reducing missed doses due to medication being out of stock. It is also important to remember that some drug doses are appropriately missed due to the patient's condition at the time.



Priority 5: Infection prevention and control

Performance

For 2014/15, the zero tolerance approach to avoidable MRSA bloodstream infections with timely post infection reviews will continue as previously. For *C. difficile* infections, the national approach will closely mirror what was done at UHB during 2013/14 with a system of joint reviews with commissioners to assess avoidable (preventable) factors and those cases will count towards penalties based on breaching trajectory. For 2014/15 the UHB trajectory will be 67, based on a reduction from actual performance in 2013/14.

MRSA Bacteraemia

All MRSA bacteraemias are subject to a post infection review by the Trust in conjunction with the Clinical Commissioning Group. MRSA bacteraemias are then

assigned to UHB, the Clinical Commissioning Group or a third party organisation, based on where the main lapses in care occurred.

All Trust-assigned MRSA bacteraemia are subject to additional review at the Trust's Executive Care Omissions Root Cause Analysis meetings chaired by the Chief Executive.

The table below shows the MRSA bacteraemia reported to Public Health England (Health Protection Agency prior to April 2013) for the past three financial years and the first three quarters of 2014/15:

				2014/15		
Time Period	**2011/12**	**2012/13**	**2013/14**	**Q1**	**Q2**	**Q3**
Actual performance	4	5	5	0	1	2
Agreed annual trajectory	7	5	0	0	0	0

C. difficile infection (CDI)

In Quarter 1 2014/15, the Trust had 16 CDI cases, of which 3 were deemed to be avoidable. In Quarter 2 2014/15 the Trust had 20 CDI cases of which 5 were deemed avoidable. In Quarter 3 2014/15, the Trust had 16 CDI cases, of which 4 were deemed to be avoidable. The Trust uses a review tool with the local Clinical Commissioning Group to establish whether cases are avoidable so that the Trust can focus on reducing avoidable (potentially preventable) cases.

The table below shows the total Trust assigned cases reported to Public Health England for the past three financial years and the first three quarters of 2014/15:

				2014/15		
Time Period	**2011/12**	**2012/13**	**2013/14**	**Q1**	**Q2**	**Q3**
Actual performance	85	73	80	16	20	16
Agreed annual trajectory	114	76	56	67	67	67

4. Performance of the Trust against selected metrics

The tables below show the Trust's latest performance for 2014/15 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 2014/15 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	**2012/13**	**2013/14**	**2014/15**	**Peer Group Average (where available)**
1(a). MRSA: **Patients with MRSA infection/100,000 bed days (includes all bed days from all specialties)** *Lower rate indicates better performance*	**1.41**	**1.04**	**0.86**	**0.70**
Time period	2012/13	2013/14	April-October 2014	April-October 2014
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
1(b). MRSA: **Patients with MRSA infection/100,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics)** *Lower rate indicates better performance*	**1.42**	**1.04**	**0.86**	**0.83**
Time period	2012/13	2013/14	April-October 2014	April-October 2014
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands
2(a). *C. difficile:* **Patients with *C. difficile* infection/100,000 bed days (includes all bed days from all specialties)** *Lower rate indicates better performance*	**20.31**	**20.76**	**17.66**	**12.96**
Time period	2012/13	2013/14	April-October 2014	April-October 2014
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
2(b). *C. difficile:* Patients with *C. difficile* infection/100,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**20.44**	**20.89**	**17.75**	**15.86**
Time period	2012/13	2013/14	April-October 2014	April-October 2014
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands
3(a) Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**10.4**	**10.7**	**15.9**	**8.7**
Time period	2012/13	2013/14	April-December 2014	October 2013 - March 2014
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
3(b) Never Events *Lower number indicates better performance*	**0**	**2**	**2** (see explanatory note below table)	*Not available*
Time period	2012/13	2013/14	April-December 2014	
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				
4(a) Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**64.4%**	**71.1%**	**80.4%**	**76.6%**
Time period	2012/13	2013/14	April-December 2014	October 2013 – March 2014
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death *Lower % indicates better performance*	**0.27%**	**0.24%**	**0.10%**	**0.4%**
Time period	2012/13	2013/14	April-December 2014	October 2013 – March 2014
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)	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	**9,536**	**9,828**	**11,589**	**6,184**
Time period	2012/13	2013/14	April-December 2014	October 2013 – March 2014
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)	Average number of patient safety incidents reported calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals

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 increase in reported incidents is due to the implementation of automatic reporting in January 2014, whereby incidents are directly reported from the Trust's Prescribing Information and Communication System (PICS). These include missed observations and patients who need to be discharged off PICS. The plan is to include other automated incidents such as consecutive missed drug doses during 2014/15. The Trust's incident reporting rate has therefore slightly increased and this trend is likely to continue. The purpose of automated incident reporting is to ensure even small errors or omissions are identified and addressed as soon as possible.

3(b): The Trust reported two never events in 2013/14 relating to wrong site surgery. The Trust reported two never events in the period April-September 2014 due to a biopsy being taken of the wrong skin lesion and a guidewire being left in a patient post procedure. There was no significant harm caused to the patients involved.

4(c): The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System. See also comment for 3(a) above.

Clinical effectiveness indicators

Indicator	**2012/13**	**2013/14**	**2014/15**	**Peer Group Average (where available)**
5(a). Emergency readmissions within 28 days (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**12.65%**	**12.86%**	**13.85%**	**13.69%** **England: 13.77%**
Time period	2012/13	2013/14	April-September 2014	April-September 2014
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
5(b). Emergency readmissions within 28 days (all specialties) % *Lower % indicates better performance*	**12.62%**	**12.85%**	**13.82%**	**13.23%** **England: 13.10%**
Time period	2012/13	2013/14	April-September 2014	April-September 2014
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(c). Emergency readmissions within 28 days of discharge % *Lower % indicates better performance*	**9.87%**	**10.25%**	**10.96%**	*Not available*
Time period	2012/13	2013/14	April-October 2014	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	**2.2%**	**2.1%**	**2.3%**	*Not available*
Time period	2012/13	2013/14	April-December 2014	
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
7. Stroke in-hospital mortality *Lower % indicates better performance*	*Data collected as part of national audit from April 2013*	**8.7%**	**10.6%**	*Not available*
Time period		2013/14	April-November 2014	
Data source(s)		SSNAP data	SSNAP data	
Peer group				
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**96.4%**	**88.2%**	**94.7%**	*Not available*
Time period	2012/13	2013/14	April-November 2014	
Data source(s)	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 specialty activity, taking into account that the Trust does not undertake paediatric, obstetrics, 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.

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 day cases and regular day case 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://mqi.ic.nhs.uk/IndicatorDefaultView.aspx?ref=1.01.17

5(c): 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). 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.

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 in-hospital mortality* – measures the percentage of patients who die in hospital following admission 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 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.