UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING
FRIDAY 5 SEPTEMBER 2014

Title:	**QUALITY ACCOUNT UPDATE FOR QUARTER 1 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 1 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 Q1 2014/15 Quality Account Update is shown in Appendix A. • The latest SHMI and HSMR values are within tolerance (green). • 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: 27/08/2014

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS
FRIDAY 5 SEPTEMBER 2014

QUALITY ACCOUNT UPDATE FOR QUARTER 1 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 1 2014/15 which will be published by the end of August 2014. The Trust's Quality Account Update report for April-June 2014 is shown in Appendix A following presentation to the Board of Directors in July 2014.

2. **Data Completeness**

The latest available data is included for all parts of the report. Data for the full period April-June 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 April 2013-January 2014 which has been calculated by Health Informatics. The SHMI is 100.16 and is within tolerance (green). The Trust's latest Hospital Standardised Mortality Ratio (HSMR) value for April 2013-February 2014 is 96.63 as calculated by Health Informatics which is also within tolerance (green). The HSMR has been included in the Quality Account Update for Q1 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 93.7% for enoxaparin prescription within 12 hours during quarter 1 2014/15. The methodology for administration of anti-embolism stockings is currently being refined to match the latest enoxaparin prescription methodology. Performance for quarter 1 2014/15 will therefore be added as soon as it becomes available.

3.2.2 Improve patient experience and satisfaction

The Trust received a slightly higher number of complaints in quarter 1 2014/15 (185) compared to quarter 4 2013/14 (166). The percentage of positive responses to the new selection of patient survey questions covering inpatients, outpatients, the Emergency Department and discharge has been included for quarter 1 2014/15. Performance for the majority of questions is slightly lower for quarter 1 2014/15 which will be followed up through the Care Quality Group.

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

The Trust achieved over 98% for completeness of observation sets within 12 hours for the first time in May and June 2014. Individual wards which are performing below the 98% target are being selected for review at the Executive Root Cause Analysis (RCA) meetings.

3.2.4 Reducing Medication Errors (Missed Doses)

The Trust has managed to maintain performance for antibiotic missed doses at 3.9% or below during quarter 1 2014/15. The Trust is aiming to reduce non-antibiotic missed doses to 8.4% by the end of 2014/15. The percentage of missed non-antibiotics was over 10% for quarter 1 2014/15 so there is further work to be done to reduce avoidable missed doses. The Trust is focusing on reducing missed doses due to drugs being out of stock and a number of cases were reviewed at the Executive RCA meeting on 24th July 2014 with the wards involved, Pharmacy and Stores.

3.2.5 Infection Prevention and Control

The Trust has met the required 2014/15 trajectories for both MRSA and *C. difficile* infection cases during quarter 1 2014/15.

3.3 Selected Metrics

The incident and other indicators have performed as expected during quarter 1 2014/15. There was however one never event which occurred during the quarter due to a biopsy being taken of the wrong skin lesion with no significant harm to the patient. The incident has been reported and investigated to ensure preventative actions are put into place.

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.

Appendix A: Quality Account Update for April-June 2014

Contents

Quality Account Update for April-June 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-June 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.

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[1]. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control

[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.

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 100.16 for the period April 2013-January 2014 which is within tolerance. The latest SHMI value for the Trust which is available on the Health and Social Care Information Centre website is 103 for the period April-June 2013. This is 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 96.63 for the period April 2013-February 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[23]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

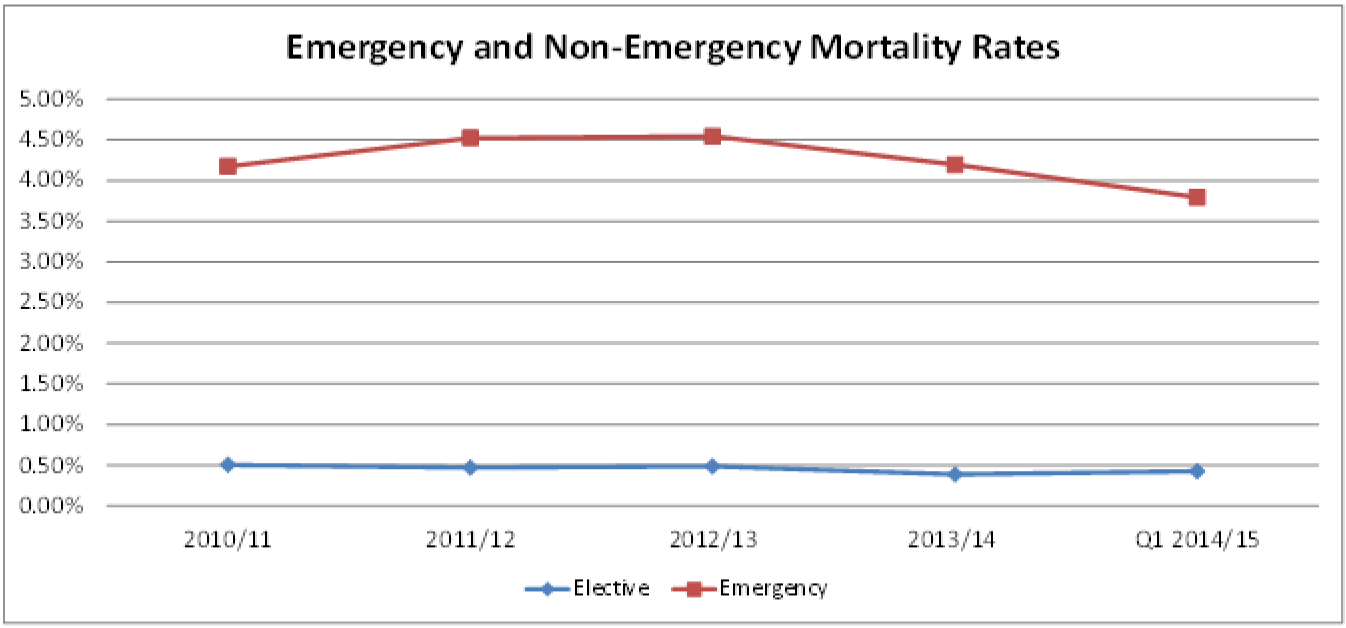
Crude Mortality

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 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.

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

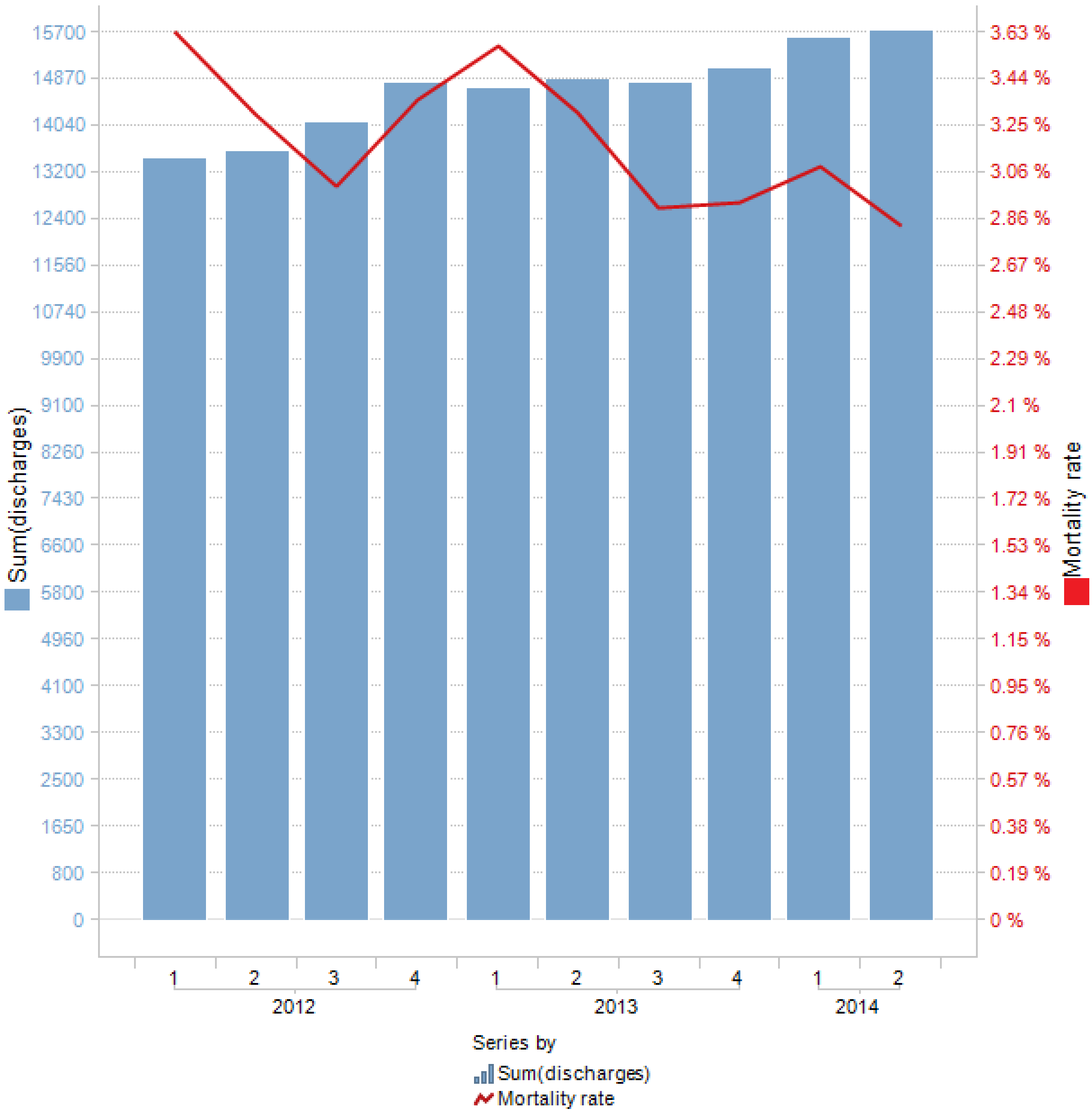
[2] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Emergency and Non-Emergency Mortality Graph



Overall Crude Mortality Graph

The Trust's overall crude mortality rate is slightly lower for Q1 2014/15 (2.84%) compared to 2013/14 (3.15%) and 2012/13 (3.42%). This is due to an increase in the number of patient admissions and a reduction in the number of deaths.



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 will focus 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.

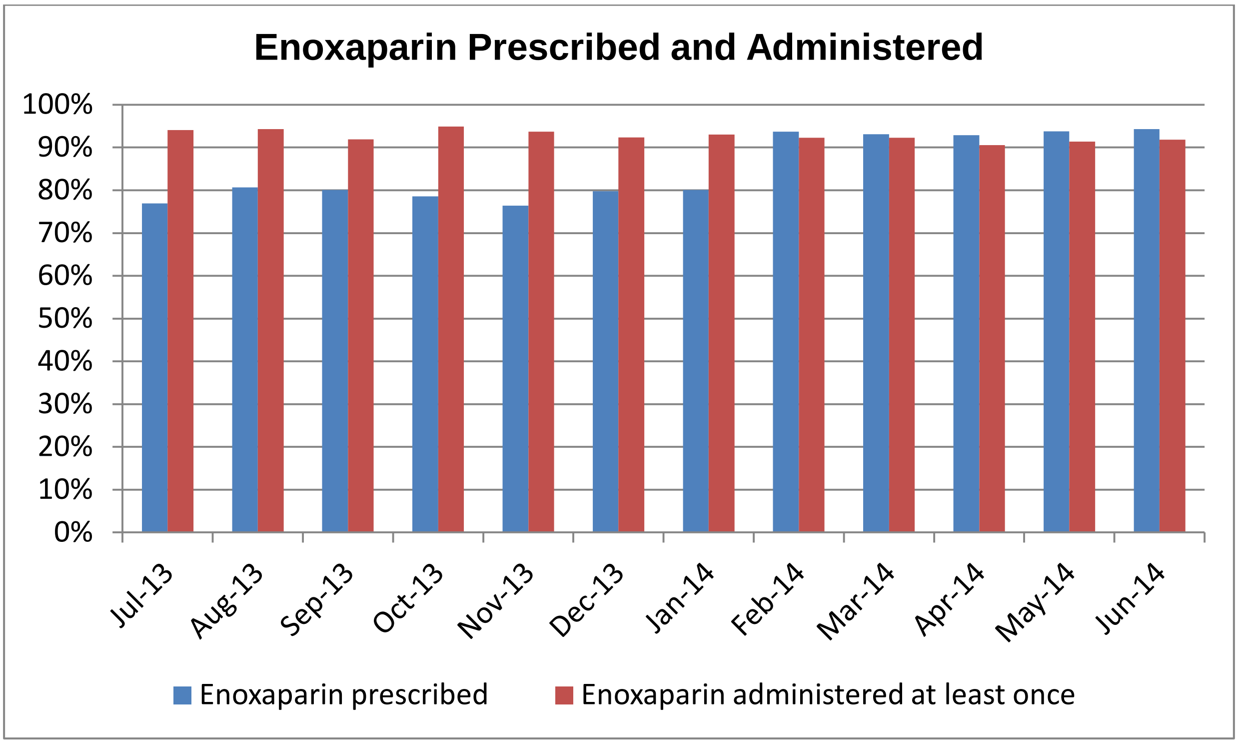
Performance

VTE Risk Assessment Completion

The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 and 99% or over since June 2012. This is above the national average of 96% for NHS acute providers as published on the NHS England website (April 2014).

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. 93.7% of patients who required enoxaparin following VTE risk assessment were prescribed it in quarter 1 2014/15. Of the patients who were prescribed enoxaparin, 91.3% 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

The questions below have been selected from four different surveys undertaken at UHB.

The percentage of positive responses for each question is calculated by dividing the number of the most positive responses e.g., 'Yes, definitely' by the total number of responses. 'Yes, sometimes' is not classed as a positive response as the Trust is aiming for all patients to receive the best experience all of the time. 'Not applicable' or 'Don't know' responses are excluded. Please note that for questions 3, 4 and 6 below the most positive answer is 'No'.

Patient survey questions for 2014/15:

Type of Survey	Survey Question	% positive responses 2013/14	% positive responses Q1 2014/15
Inpatient	1. Did you find someone on the hospital staff to talk about your worries or fears?	79.7%	75.0%
	2. Do you think that the ward staff do all they can to help you rest and sleep at night?	83.5%	78.8%
	3. Have you been bothered by noise at night from hospital staff?	73.5%	69.6%
	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%
	5. Did the staff treating and examining you introduce themselves?	New question from April 2014	78.8%
Outpatient	6. Was your appointment changed to a later date by the hospital?	80.6%	78.9% *
	7. Did the staff treating and examining you introduce themselves?	78.0%	68.9% *
	8. Did a member of staff tell you about medication side effects to watch out for?	54.9%	45.5% *
Emergency Department	9. Were you involved as much as you wanted to be in decisions about your care and treatment?	68.8%	64.7%
	10. Do you think the hospital staff did everything they could to help control your pain?	70.3%	65.1%
Discharge	11. Did a member of staff tell you about medication side effects to watch for when you went home?	47.3%	46.3% *
	12. Did you feel you were involved in decisions about going home from hospital?	54.7%	54.2% *

**Data covers April-May 2014 only*

Performance

During Quarter 1 2014/15, 6,931 patient responses were received for the electronic inpatient survey and 356* patients responded to the discharge survey following inpatient stays in April and May.

**Discharge data for Quarter 1 is incomplete as patients are given a window of time in which to respond; full data for May and June 2014 will be available in August 2014.*

Friends and Family Question

Background

The Trust has monitored performance for the Friends and Family Test question during Quarter 1 2014/15:

- 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 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 Quarter 1 with the exception of May 2014 where technical difficulties resulted in some data being unavailable for reporting. The Trust's overall response rate has increased significantly, assisted by the increase in responses from ED patients.

Methodology

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, 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 is 100; the lowest possible score is -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 Q1 2014/15.

Inpatients	**Jul 13**	**Aug 13**	**Sept 13**	**Oct 13**	**Nov 13**	**Dec 13**	**Jan 14**	**Feb 14**	**Mar 14**	**Apr 14**	**May 14**	**Jun 14**
Extremely Likely	1150	884	651	956	894	840	1039	919	1250	1277	1187	1404
Likely	203	172	120	207	223	192	164	199	295	279	299	299
Neither Likely or Unlikely	18	28	12	16	24	21	16	14	31	21	21	34
Unlikely	15	8	9	12	9	10	2	8	17	8	8	13
Extremely Unlikely	15	19	8	18	15	11	8	9	21	13	10	13
Don't Know	10	10	4	11	13	8	9	2	11	13	13	10
Total Responses	1411	1121	804	1220	1178	1082	1238	1151	1625	1611	1538	1773
Total Discharges	3106	2911	2773	3042	2887	2885	3104	2901	3153	2957	3249	3111
Score	**79**	**75**	**78**	**75**	**73**	**74**	**82**	**77**	**73**	**77**	**75**	**76**
Monthly Response Rate	45.43%	38.51%	28.99%	40.11%	40.80%	37.50%	39.88%	39.68%	51.54%	54.48%	47.34%	56.99%
Quarterly Response Rate	Not monitored									52.8% (Target: 25%)		

Emergency Department	**Jul 13**	**Aug 13**	**Sept 13**	**Oct 13**	**Nov 13**	**Dec 13**	**Jan 14**	**Feb 14**	**Mar 14**	**Apr 14**	**May 14**	**Jun 14**
Extremely Likely	68	91	142	415	370	421	494	655	1129	1293	617	932
Likely	27	43	59	112	86	105	119	165	253	322	190	254
Neither Likely or Unlikely	8	10	15	24	28	23	19	41	72	67	47	55
Unlikely	2	7	13	12	22	15	20	31	50	49	33	45
Extremely Unlikely	5	14	22	29	19	19	31	38	76	115	71	71
Don't Know	1	4	5	3	4	4	3	15	14	19	11	11
Total Responses	111	169	256	595	529	587	686	945	1594	1865	969	1618
Total Discharges	6667	6392	6113	6617	6065	5904	6122	5742	6820	6314	6567	6712
Score	**48**	**36**	**37**	**59**	**57**	**62**	**62**	**59**	**59**	**58**	**49**	**54**
Response Rate	1.7%	2.6%	4.2%	9.0%	8.7%	9.9%	11.2%	16.5%	23.4%	29.5%	14.8%	24.11%
Quarterly Response Rate	Not monitored									22.7% (Target: 15%)		

Patient Experience initiatives to be implemented in 2014/15:

- Family and Friends Test to be implemented in Outpatients and day-case settings from October 2014. A project group set up to implement this has outlined the preferred methodology and is developing additional technology required to support this process. This has proved challenging due to the delay in publication of the national guidance which is now expected mid-July.
- A publicity campaign to ensure that staff always introduce themselves to patients and carers; an additional question was added to the patient surveys in Quarter 1 enabling us to monitor the effectiveness of the campaign.
- Launch of a dedicated Carers page on the Trust website. This is nearing completion with patient and carer representatives involved throughout the process. This is expected to be launched in Quarter 2.
- Buddy Scheme for 16-25 year olds to be implemented in key wards 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.

Complaints

	Q4 2013/14	Q1 2014/15
Total number of complaints	166	185

Ratio of complaints to activity		Q4 2013/14	Q1 2014/15
Inpatients	FCEs*	33,540	**33,732**
	Complaints	100	**94**
	Rate per 100 FCEs	0.30	**0.28**
Outpatients	Appointments**	186,556	**181,679**
	Complaints	39	**70**
	Rate per 100 appointments	0.02	**0.04**
Emergency Department	Attendances	24,461	**25,853**
	Complaints	27	**21**
	Rate per 100 attendances	0.11	**0.08**

* 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)

Top 6 Main subjects of complaints	Q4 2013/14	Q1 2014/15
Clinical treatment	71	**87**
Inpatient appointment cancelled, delayed	23	**21**
Communication & information	18	**17**
Outpatient appointment cancelled, delayed	11	**16**
Staff Attitude	8	**14**
Admission, Discharge, Transfer	19	**13**

Learning from complaints

The table below gives examples of how we are responding to complaints where a trend has been identified, or where serious issues have been raised, or where we have received a number of complaints 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
Aspects of discharge arrangements	Concerns around appropriateness of discharge, accuracy of discharge information, arrangements for discharge and keeping family members informed.	A report has been sent to the senior divisional management teams, highlighting the cases concerned and the overall trend. Specific instances are addressed as part of complaints investigations. Existing groups around discharge have been reconfigured into a single Discharge Quality Group, led by the Executive Chief Nurse. Complaints relating to discharge are now reviewed by this group to enable Trust-wide actions and learning to take place.
Delays with tertiary referrals to Neurosurgery progressing to an appointment/ admission.	Long waiting times for an initial appointment and subsequent admission for surgery.	Specific instances are addressed as part of complaints investigations. Trend highlighted to the Group Manager for Neurosciences. Additional outpatient clinics have been provided. The service improvement team are carrying out a demand versus capacity analysis of neurosurgical clinics. The Spinal Consultant Lead is carrying out an audit of referrals and determining if other patient pathways would be better. Discussions with the Commissioners have taken place to reinforce agreed referral pathways as some referrals should be directed to other service providers.

Theme/Issue	Area of Concern	Action taken/Outcome
Experience in the Emergency Department and Clinical Decision Unit (CDU)	Level of complaints compared to in-patient areas	Specific instances addressed as part of complaints investigations. Reports provided at monthly meetings involving complaints representative and the Matrons for the A&E department and CDU. Regular complaints reports are provided to the Emergency Medicine Governance Lead for their monthly governance meetings. Complaint levels are relatively low compared to activity.
Delays experienced by patients with various aspects of their care and treatment	Delays experienced with: - receiving appointments - in clinic - obtaining results - treatment	Specific instances addressed as part of complaints investigations. Broader trends to be highlighted in Divisional Clinical Quality Group reports and at meetings with divisional staff. Issues around delays receiving outpatient appointments and delays in clinics explored at monthly Governor drop-in sessions.

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 to the complainant or at the local resolution meeting where appropriate. Staff involved with the complaint can use it as a learning tool for themselves and with colleagues, where there is broader learning.

An innovative way in which the Trust has sought to learn from complaints has been to invite a complainant back to the Trust, following resolution of their complaint, to talk about their experience to staff. This meeting was recorded and the resultant CD has been played at a number of educational sessions to provide real insight into how the experiences of this relative of a patient made her and her loved one feel and to generate discussion around how staff can ensure such experiences are not repeated, wherever possible.

Serious Complaints

The Trust uses a risk matrix to assess the seriousness of every complaint on 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 a detailed analysis of the cases and the subsequent investigation and 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

PHSO involvement	Quarter 4 2013/14	Quarter 1 2014/15
Cases referred to PHSO by complainant for assessment	6	9
Cases which, following the initial review, are being fully investigated – outcome awaited	5	9
Cases which then required no further investigation	1	1
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	3	2
Cases which were fully upheld following review by the PHSO	0	0

The total number of outcomes of cases received and awaited does not match the total referred to the Ombudsman as, in some cases, final outcome reports were received in Q1 2014/15, which related to cases which were originally referred to the Ombudsman in a previous quarter.

Two cases were partially upheld by the Ombudsman in Quarter 1 2014/15. In the first case, issues around discharge, provision of hot meals outside meal times, aspects of nursing care, documentation and communication were highlighted. A comprehensive action plan to address all these issues has been developed in response to the report. The other case related to a delay in informing the family about the death of their loved one. An action plan to address this issue is currently being developed.

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 481 compliments in Quarter 1 2014/15 which is consistent with previous numbers received. The Patient Experience team continue to provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments. Additional methods of capturing positive feedback received are being explored.

Compliment Subcategories	2011/12	2012/13	2013/14	**Q1 2014/15**
Nursing care	605	356	424	**34**
Friendliness of staff	492	207	191	**27**
Treatment received	300	766	1202	**368**
Medical care	391	92	79	**9**
Other	20	38	9	**11**
Efficiency of service	124	151	187	**28**
Information provided	16	10	27	**0**
Facilities	18	24	12	**4**
Totals:	1,966	1,644	2,131	**481**

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

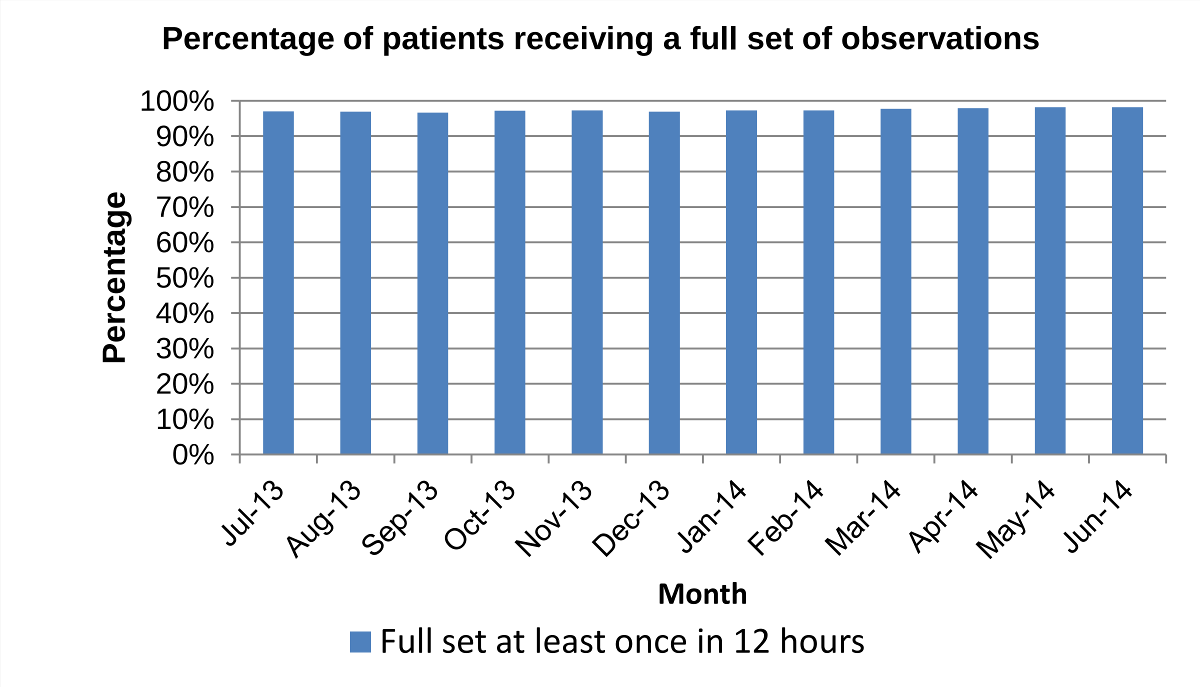
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

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. A specific and detailed electronic observation chart has now been developed for Critical Care and is due to be implemented during 2014/15.

Performance

The Trust overall has now achieved over 98.0% for completeness of observation sets at least once in 12 hours during May and June 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.

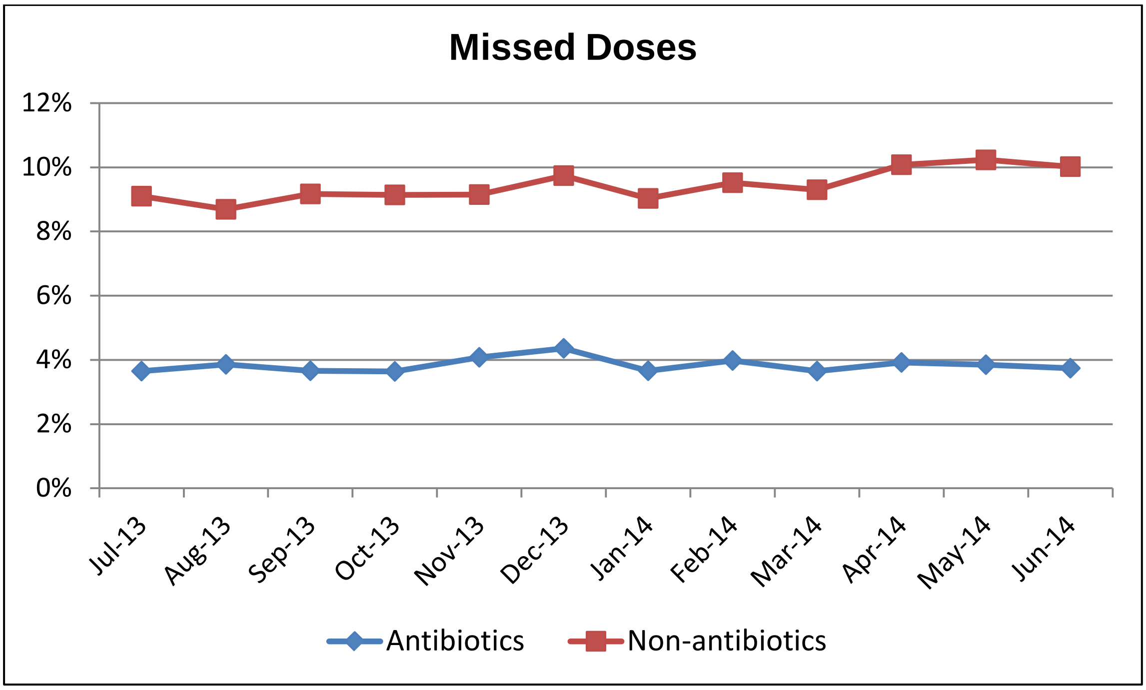
The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive Care Omissions Root Cause Analysis (RCA) meetings started at the end of March 2010.

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 will focus 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 successfully maintained performance for antibiotics at 3.9% or below during quarter 1 2014/15. Missed non antibiotics have been over 10.0% during quarter 1 2014/15; the Trust is aiming to reduce these to around 8.4% by the end of the year which represents a 10% reduction on 2013/14 performance. The Trust is focusing 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 bacteraemia are subject to a post infection review by the Trust in conjunction with the Clinical Commissioning Group. MRSA bacteraemia are then assigned to UHB, the Clinical Commissioning Group or elsewhere based on where the main lapses in care occurred.

All Trust-assigned MRSA bacteraemia will be 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 quarter of 2014/15. It should be noted that avoidable cases are included for 2013/14.

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

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

In quarter 1 2014/15, the Trust had 16 CDI cases, 3 of which were deemed to be avoidable. The Trust now 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 (preventable) cases.

The Trust's annual agreed trajectory was 56 cases for 2013/14. The majority of the Trust's CDI cases were unavoidable; there were 16 CDI cases which were deemed to be avoidable out of a total of 80 reportable cases (64 unavoidable).

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

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

4. Performance of the Trust against selected metrics

The tables below show the Trust's latest performance for Quarter 1 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 Quarter 1 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	Q1 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**	*Not available yet*	**0.88**
Time period	2012/13	2013/14		2013/14
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	Q1 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**	*Not available yet*	**1.03**
Time period	2012/13	2013/14		2013/14
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**	*Not available yet*	**14.51**
Time period	2012/13	2013/14		2013/14
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	Q1 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**	*Not available yet*	**17.69**
Time period	2012/13	2013/14		2013/14
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**	**12.5**	**7.9**
Time period	2012/13	2013/14	April-June 2014	April-Sept 2013
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	Q1 2014/15	Peer Group Average (where available)
3(b) Never Events *Lower number indicates better performance*	**0**	**2** (see explanatory note below table)	**1**	*Not available*
Time period	2012/13	2013/14	April-June 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%**	**75.7%**	**75.7%**
Time period	2012/13	2013/14	April-June 2014	April-Sept 2013
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
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%**	**0.08%**	**0.3%**
Time period	2012/13	2013/14	April-June 2014	April-Sept 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)	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals

Indicator	2012/13	2013/14	Q1 2014/15	Peer Group Average (where available)
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	**9,536**	**9,828**	**3,045**	**5,664**
Time period	2012/13	2013/14	April-June 2014	April-Sept 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)	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 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. In January 2014 the Trust implemented an automatic incident reporting process 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 and one never event in quarter 1 2014/15 due to a biopsy being taken of the wrong skin lesion. 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.

Clinical effectiveness indicators

Indicator	2012/13	2013/14	Q1 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*	**12.66%** **England: 13.39%**	**12.86%**	*Not available yet*	**13.15%** **England: 13.40%**
Time period	2012/13	April 2013-February 2014		April 2013-February 2014
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(b). Emergency readmissions within 28 days (all specialties) % *Lower % indicates better performance*	**12.63%** **England: 12.52%**	**12.79%**	*Not available yet*	**12.68%** **England: 12.81%**
Time period	2012/13	April 2013-February 2014		April 2013-February 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%**	**10.18%**	**10.51%**	*Not available*
Time period	2012/13	2013/14	April-June 2014	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				

Indicator	2012/13	2013/14	Q1 2014/15	Peer Group Average (where available)
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	Apr-June 2014	
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				
7. Stroke in-hospital mortality *Lower % indicates better performance*	*Data collected as part of national audit from April 2013*	**8.7%**	**10.8%**	*Not available*
Time period		2013/14	Apr-June 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%**	**93.8%**	*Not available*
Time period	2012/13	2013/14	Apr-June 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 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.