UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING
FRIDAY 4th SEPTEMBER 2015

Title:	**QUALITY ACCOUNT UPDATE REPORT FOR Q1 2015/16 INCLUDING DELOITTE EXTERNAL AUDIT UPDATE FOR 2014/15**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 13687

Purpose:	To present the following to the Council of Governors: • Quality Account Update Report for Quarter 1 2015/16 • Progress update on the implementation of recommendations following the external audit of the 2014/15 Quality Account carried out by Deloitte.	
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 2015/16 Quality Account Update is shown in Appendix A. Performance for the five Quality Improvement Priorities is included. MRSA bacteraemias were higher than expected during Q1 2015/16. • The Deloitte report on the external assurance of the 2014/15 Quality Account is provided to the Council of Governors for review (Appendix C). • The Trust has been issued with a clean limited assurance opinion on the content of the Quality Report and 28 day readmissions. Deloitte issued the Trust with a qualified opinion on the 18 week indicator. • Deloitte made eight recommendations for improvement relating to the 18 week indicator and the local pain indicators. The recommended actions are either already completed or on track for completion by the end of 2015/16.	
Recommendations:	The Council of Governors is asked to: **Note** the content of this report and all appendices.	
Approved by:	Dr David Rosser	Date: 26/08/2015

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS
FRIDAY 4 SEPTEMBER 2015

QUALITY ACCOUNT UPDATE REPORT FOR Q1 2015/16 INCLUDING DELOITTE EXTERNAL AUDIT UPDATE FOR 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 2015/16 and the findings from Deloitte's external assurance review of the 2014/15 Quality Account. The Council of Governors is asked to note the contents of this report and all appendices.

2. Quarter 1 2015/16 Quality Account Update

2.1 The Quality Account Update report for April-June 2015 is shown in Appendix A and will be presented at the Board of Directors' Seminar in early September 2015. The latest available data is included in the report.

2.2 Performance

Performance for the majority of the Quality Improvement Priorities is in line to meet the targets set for the end of 2015/16. Performance for the medication side effect patient survey question has not however improved but there are plans in place to try to improve this over the next three quarters. Performance for timely analgesia remains the same as for 2014/15 but the Trust is expecting to see an improvement from quarter 3 onwards. The Trust has had a higher than expected number of MRSA bacteraemias. All cases have been reviewed at Executive Root Cause Analysis (RCA) meetings led by the Chief Executive and a Trust-wide action plan is being implemented.

3. External Assurance on 2014/15 Quality Account

3.1 Monitor published its *Detailed guidance for external assurance on quality reports 2014/15* in February 2015. The guidance requires Foundation Trusts' external auditors to provide a published limited assurance report on the content of the Quality Report and two mandated performance indicators:

- **18 weeks referral to treatment (mandatory)**
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers or
- **28 day readmissions (selected).**

External auditors were also required to provide a private report to the Board of Directors and Council of Governors (CoG) on one local indicator: pain assessment and timely administration of analgesia indicators were chosen by the Council of Governors (see Appendix C).

3.2 External Assurance Findings and Recommendations

Deloitte issued the Trust with a clean limited assurance opinion on the content of the Quality Report and 28 day readmissions and a qualified opinion on the 18 week referral to treatment (unfinished pathways) indicator. Deloitte's full audit report is provided separately for information (Appendix C) and contains six recommendations for improvement relating to the 18 week indicator. The two local pain indicators were not subject to a limited assurance opinion but Deloitte made two recommendations for improvement.

3.3 Trust Response to the Recommendations

The latest progress made towards implementing Deloitte's external assurance recommendations is shown in Appendix B. The Trust has implemented five of the eight recommendations with the rest on track for completion by the end of 2015/16. Progress will continue to be monitored and reported to the Audit Committee during the year.

4. Recommendations

The Council of Governors is asked to:

Note the content of this report and all appendices.

Appendix A: Quality Account Update for Quarter 1 (April – June 2015)

Contents

Quality Account Update for Quarter 1 (April – June 2015)

Introduction

The Trust published its seventh Quality Account Report in June 2015 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2014/15, performance data for selected metrics and set out five priorities for improvement during 2015/16:

Priority 1: Reducing grade 2 hospital-acquired pressure ulcers
Priority 2: Improve patient experience and satisfaction
Priority 3: Timely and complete observations including pain assessment
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 2015 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 2014/15.

Quality Improvement Priorities

Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

This quality improvement priority is new for 2015/16. It was proposed by the Council of Governors and approved by the Board of Directors.

Background

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

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

Grade	Description
1	Skin is intact but appears discoloured. The area may be painful, firm, soft, warmer or cooler than adjacent tissue.
2	Partial loss of the dermis (deeper skin layer) resulting in a shallow ulcer with a pink wound bed, though it may also resemble a blister.
3	Skin loss occurs throughout the entire thickness of the skin, although the underlying muscle and bone are not exposed or damaged. The ulcer appears as a cavity-like wound; the depth can vary depending on where it is located on the body.
4	The skin is severely damaged, and the underlying muscles, tendon or bone may also be visible and damaged. People with grade 4 pressure ulcers have a high risk of developing a life-threatening infection.

(*National Pressure Ulcer Advisory Panel, 2014*)

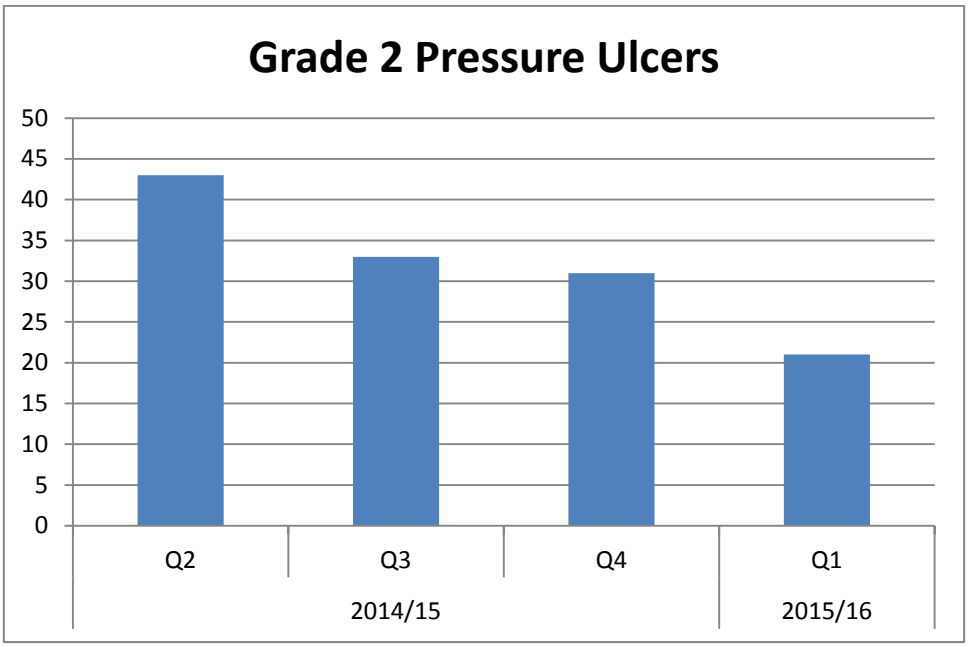
UHB has seen a significant decrease in the number of hospital-acquired pressure ulcers during 2014/15, especially grade 3 and grade 4 ulcers. As a result, the Trust has chosen to focus on reducing grade 2 ulcers. This in turn should reduce the number of grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

Performance

The 2015/16 reduction target agreed with Birmingham Cross City Clinical Commissioning Group (CCG) is 132 non device-related grade 2 pressure ulcers.

In Quarter 1 2015/16, UHB reported 21 non device-related grade 2 pressure ulcers. This is a decrease compared to the previous Quarter. There were also no grade 3 or grade 4 ulcers reported.

For comparison, during the period April 2014 to March 2015, there were 144 non device-related grade 2 pressure ulcers reported at UHB.



Initiatives to be implemented during 2015/16
To continue to build on the improvements seen in 2014/15, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly.

How progress will be monitored, measured and reported:

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

Priority 2: Improve patient experience and satisfaction

The Trust measures patient experience via feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test, complaints and compliments and online sources (e.g. NHS Choices). This vital feedback is used to make improvements to our services.

Patient experience data from surveys

Performance

During Quarter 1 2015-16, 8421 patient responses were received to our local inpatient survey, 203 responses to our discharge survey and a further 205 responses to our Outpatient postal survey.

The table below shows results to key questions for Quarter 1 and the last two financial years. The results show that in this reporting period the Trust has made improvements or maintained performance in all but one area of patient experience. However, a slight decline was seen in positive responses relating to information about medication side effects.

Methodology

From the start of 2015/16 we changed the way we report our patient experience results to match the national survey scoring method, which takes account of all responses received. This will allow transparency and comparison as well as simpler interpretation. In previous years we have reported the percentage of most positive responses received out of all applicable responses received. The data in the table below shows the new scoring system.

Improvement target for 2015/16

The questions chosen for our improvement priority for 2014/15 included our lowest performing questions from our regular inpatient, outpatient, Emergency Department and discharge surveys. As we have not managed to show improvement in these areas during the year (see below table) we have decided to maintain this important improvement priority for 2015/16.

- Questions scoring 9 or above in 2014/15 are to maintain a score of 9 or above.
- Questions scoring below 9 in 2014/15 are to increase performance by at least 5%, and/or achieve a score of 9.

Results from local patient surveys

	Score			Target	No. responses (local survey)
	2013/14	2014/15	2015/16	2015/16	2015/16
Inpatient survey			**Q1**		**Q1**
1. Did you find someone on the hospital staff to talk about your worries or fears?	8.7	8.4	**8.5**	8.8	2709
2. Do you think that the ward staff do all they can to help you rest and sleep at night?	9.1	8.8	**8.8**	9	3577
3. Have you been bothered by noise at night from hospital staff?	8.4	8.1	**8.2**	8.5	3598
4. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.6	8.6	**8.7**	9	6290
5. Did the staff treating and examining you introduce themselves?	New for 2014/15	8.9	**9.7**	9	5540
Outpatient survey*					
6. Was your appointment changed to a later date by the hospital?	9.2	9	**9***	9	199*
7. Did the staff treating and examining you introduce themselves?	8.6	8.5	**8.8***	8.9	200*
8. Did a member of staff tell you about medication side effects to watch out for?	6.6	6.7	**6.6***	7	71*
Emergency Department survey					
9. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.1	7.9	**9.0**	8.3	703
10. Do you think the hospital staff did everything they could to help control your pain?	8	7.8	**9.1**	8.2	649
Discharge survey*					
11. Did a member of staff tell you about medication side effects to watch for when you went home?	5.9	5.8	**6.4***	6.1	166*
12. Did you feel you were involved in decisions about going home from hospital?	7.2	7.0	**7.5***	7.4	203*

**At time of reporting, 2015/16 data for outpatient and discharge survey questions is available for April 2015 only*

Friends and Family Question

The Trust has continued to monitor performance for the Friends and Family Test (FFT) question during Quarter 1 2015/16:

- How likely are you to recommend our (ward / emergency department / service) to friends and family if they needed similar care or treatment?

Patients asked the question could choose from six different responses as follows:

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

Patients attending as a day case or staying overnight on an inpatient ward were asked on discharge from hospital. Those attending the emergency department were asked either on leaving, or afterwards via an SMS text message. Outpatients have the opportunity to answer the question via the self-check in kiosk, a feedback card or a web based survey on the trust web page. Most outpatients choose the feedback card to answer the question.

From April 2015 there is no longer a CQUIN attached to response rates, however the expectation is that the current rates are maintained or improved. The trust has set internal targets to ensure we achieve this.

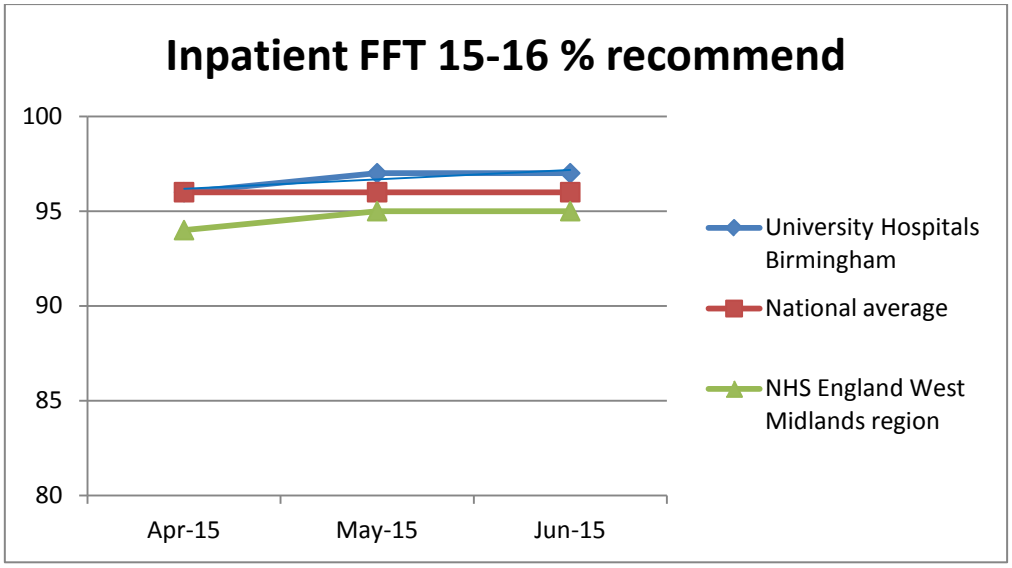
Methodology

In 2014/15 there was a national change to the methodology for reporting results. Results are now shown as a percentage of those who 'would recommend' (those who answered 'extremely likely' or 'likely') and those who 'would not recommend' (those who answered 'unlikely' or extremely unlikely').

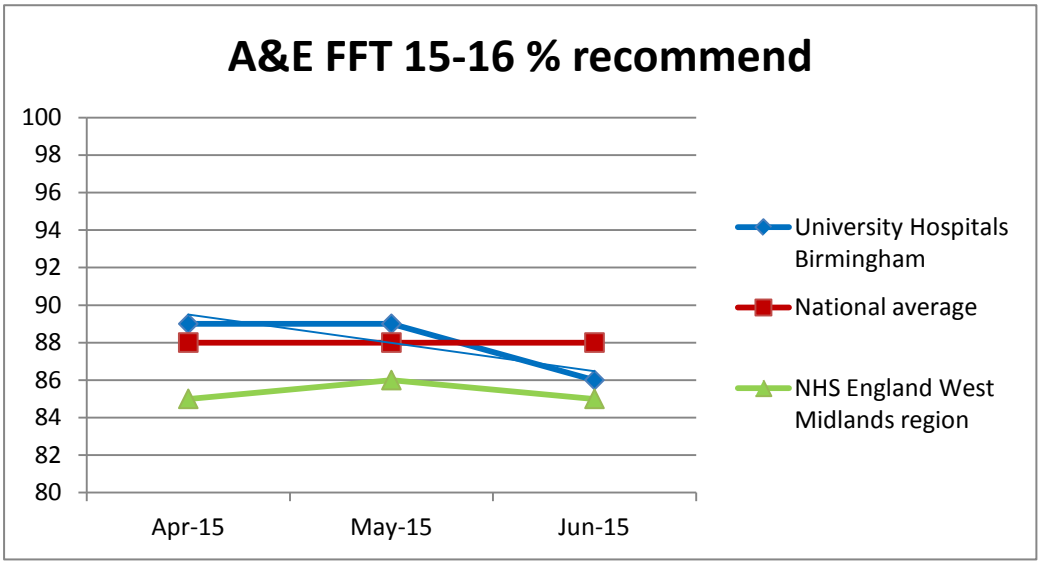
Performance and Response Rates

The charts below show the 'would recommend' percentages for the Friends and Family Test (FFT) for Inpatients, and for Accident & Emergency (A&E). Figures are also shown to illustrate where the Trust sits in relation to the national average and the NHS England West Midlands region. Outpatient data is not shown here as national data has not yet been published.

Inpatients: During Quarter 1 2015/16 the Trust has maintained a positive recommendation rate that is equal to or above the national average, and above the NHS England West Midlands region positive recommendation rate.



A&E: During Quarter 1 2015/16 the Trust initially maintained its positive recommendation rate to sit just above the national average. This has dipped slightly during the last month of the quarter. However the Trust has remained above the NHS England West Midlands region rate.



Complaints

The number of formal complaints received in Quarter 1 2015/16 was 136. A further 21 complaints were dealt with informally, such as via a telephone call to resolve an appointment issue, without the need for formal investigation.

The main subjects of complaints received in Quarter 1 2015/16 were clinical treatment (78), communication and information (24), attitude of staff (14) and inpatient appointments delays and cancellations (13), largely reflecting the main subjects identified in 2014/15 complaints.

The rate of formal complaints received against activity across Inpatients, Outpatients and the Emergency Department has declined, against reduced activity in Outpatients, stable activity in Inpatients and increased activity in the Emergency Department, compared to Quarter 4 2014/15.

	2014/15	**2015/16 Q1**
Total number of formal complaints	654	136

Rate of formal complaints to activity		**2014/15**	**2015/16 Q1**
Inpatients	FCEs*	127,204	31,314
	Complaints	371	77
	Rate per 1000 FCEs	**2.9**	**2.5**
Outpatients	Appointments**	752,965	186,799
	Complaints	201	45
	Rate per 1000 appointments	**0.3**	**0.2**
Emergency Department	Attendances	102,054	26,119
	Complaints	82	14
	Rate per 1000 attendances	**0.8**	**0.5**

* 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)

Serious Complaints

The Trust uses a risk matrix to assess the seriousness of every complaint on receipt. Those deemed most serious, scoring four or five for consequence on a five-point scale, are highlighted separately across the Trust at the Chief Executive's Advisory Group, with detailed analysis of the cases, subsequent investigation and related actions presented to the Divisional Management Teams at their Divisional Clinical Quality Group meetings. A recent revision of the Terms of Reference for the Trust's Patient Safety Group allows for serious complaints, where there is potential for Trustwide learning, to be presented to the Group for consideration of how best to share that learning across the organisation.

Learning from complaints

The table below provides an example 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
Level of complaints around cancelled/ delayed surgery	Twelve complaints principally about this during the quarter.	Details of trend highlighted in the Patient Relations reports to the Chief Executive's Advisory Group and the relevant Divisional Clinical Quality Groups. Separate report for particular specialties sent to relevant senior divisional staff for review and action.	Action plan under development. Action plan will be monitored by the Operational Delivery Group, chaired by the Chief Operating Officer. Improve the current escalation process to ensure, where possible, that all relevant patients are rescheduled within 48 hours of their procedure being cancelled and that the date of the rescheduled procedure is within 28 days. Working with Informatics and operational teams to develop dashboard reports that indicate where we may have data quality issues to investigate.

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. All actions from individual complaints are captured on the Complaints database. A regular report is sent to each clinical division's senior management team with details of every complaint for their division with actions attached; highlighting any of those cases where any of the agreed actions remain outstanding. Reports are shared at several Trust meetings including Divisional Clinical Quality Groups, Clinical Quality Committee, Care Quality Group and Chief Executive's Advisory Group meeting.

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

PHSO Involvement	2014/15	2015/16 Q1
Cases referred to PHSO by complainant for investigation	23	8
Cases which then required no further investigation	2	0
Cases which were then referred back to the Trust for further local resolution	1	0
Cases which were not upheld following review by the PHSO	5	2
Cases which were partially upheld following review by the PHSO	9	7
Cases which were fully upheld following review by the PHSO	0	2

The total number of cases referred to the Ombudsman for assessment, agreed for investigation and ultimately upheld or partially upheld remain relatively low, in proportion to the overall level of complaints received by the Trust.

Nine cases were upheld or partially upheld by the Ombudsman in Quarter 1 2015/16, the same as for all of 2014/15. Discussion with complaints leads elsewhere suggests that this trend is mirrored at many Trusts across the country, including the larger acute Trusts which form the Shelford Group. In every case, appropriate apologies were provided, action plans were developed where requested and the learning from the cases was shared with relevant staff. Among the learning identified and shared was a case related to a liver cancer patient and confusion around their referral to a Macmillan nurse. Since the time of the complaint another member of staff has been added to the team who has specific responsibility for completing the referrals to Macmillan in a timely manner.

Compliments

Compliments are recorded by the Patient Experience Team. Compliments recorded include those sent to the Chief Executive's office, the patient experience email address, PALS, via the Trust website and those sent directly to wards and departments. Where compliments are included in complaints, concerns or customer care award nominations 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 recorded fewer compliments in Quarter 1 2015/16 compared to the same period in 2014/15. Some of this is due to a delay in data entry which has been rectified from Quarter 2. The Patient Experience team have continued to provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments.

The table below shows the number of compliments broken down by the aspect of patient experience they relate to.

Compliment Subcategories	2014/15	2015/16 Q1
Nursing care	242	42
Friendliness of staff	142	13
Treatment received	1,743	317
Medical care	56	15
Other	17	3
Efficiency of service	104	35
Information provided	12	2
Facilities	12	0
Totals:	**2,328**	**427**

Examples of compliments received during Quarter 1 2015/16:

"…I feel my husband is in very safe hands. The hospital is clean and tidy, volunteers on hand when needed. Birmingham should be very proud of this wonderful hospital." (April 2015)

" …Obviously it has been a very difficult and stressful time for all the family, however I just wanted to say a big "Thankyou" to all those people that looked after my dad and treated him with such dignity and respect." (May 2015)

"Absolutely delighted! Nurses and Doctor very caring and compassionate, very good at their job." (June 2015)

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 a further 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. The majority of feedback received via this method is extremely positive.

Initiatives to be implemented in 2015/16

- A review of our patient experience dashboard and reporting processes.
- Launch of a dedicated Carers page on the Trust website.
- Further work to reduce noise at night to be undertaken following a second trust wide audit.
- Use of shadowing and patient stories as feedback mechanisms.
- Development on an internal buggy system to complement the external buggy.

How progress will be monitored, measured and reported

- Feedback rates and responses will continue to be 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 be monitored as part of drop-in patient experience 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.

Priority 3: Timely and complete observations including pain assessment

Background

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

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool 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.

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 piloted during 2015/16.

Changes to Improvement Priority for 2015/16

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

In addition, the Trust is monitoring the timeliness of analgesic (pain relief) medication following a high pain score. The pain score used at UHB runs from 0 (no pain) to 3 (severe pain at rest). Whenever a patient scores 3, they should be given analgesic medication within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work.

These two measures have replaced the previous quality improvement priority of patients having at least one full set of observations every 12 hours, as the Trust performed consistently well. UHB continues to monitor this indicator internally to ensure performance remains high.

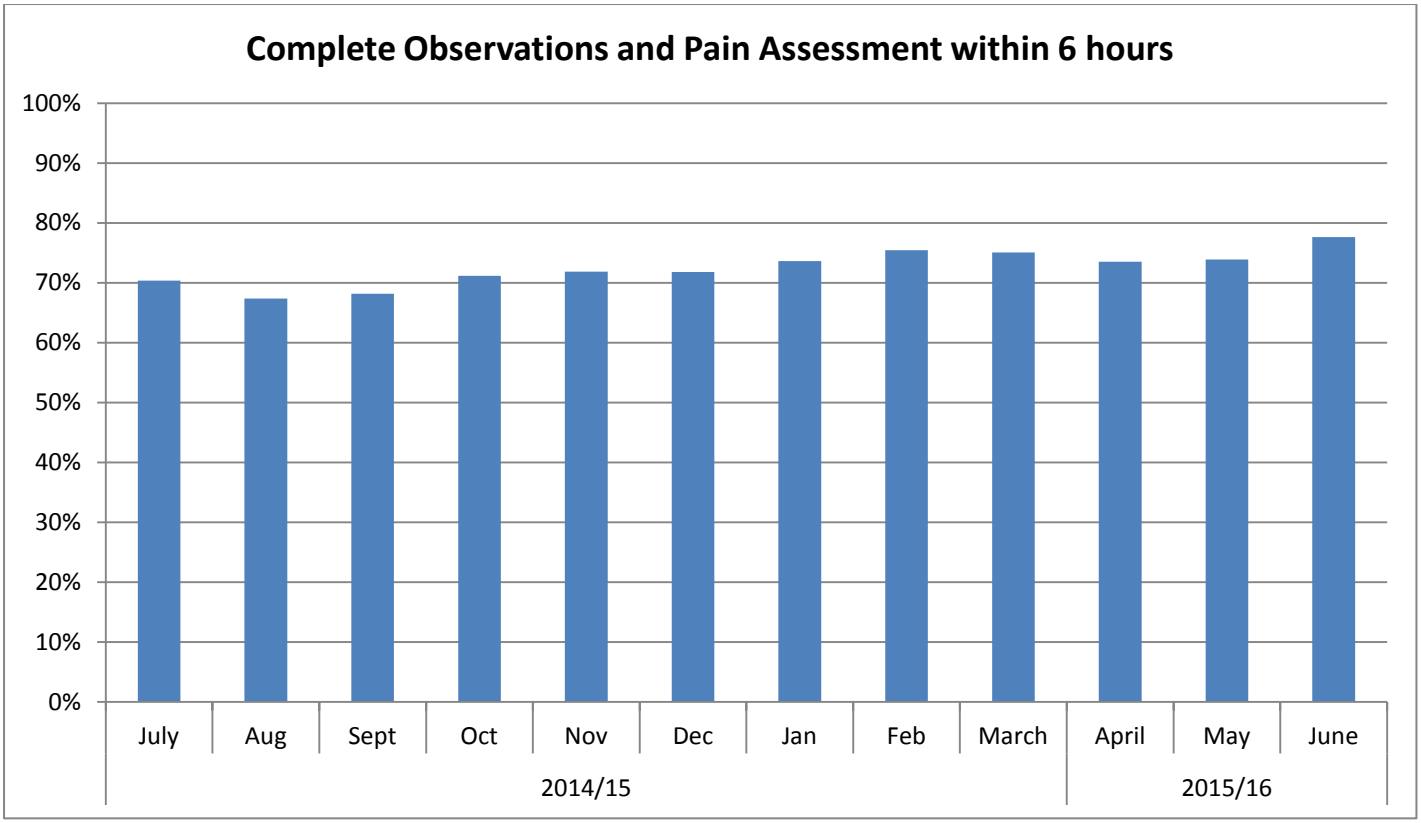
Performance

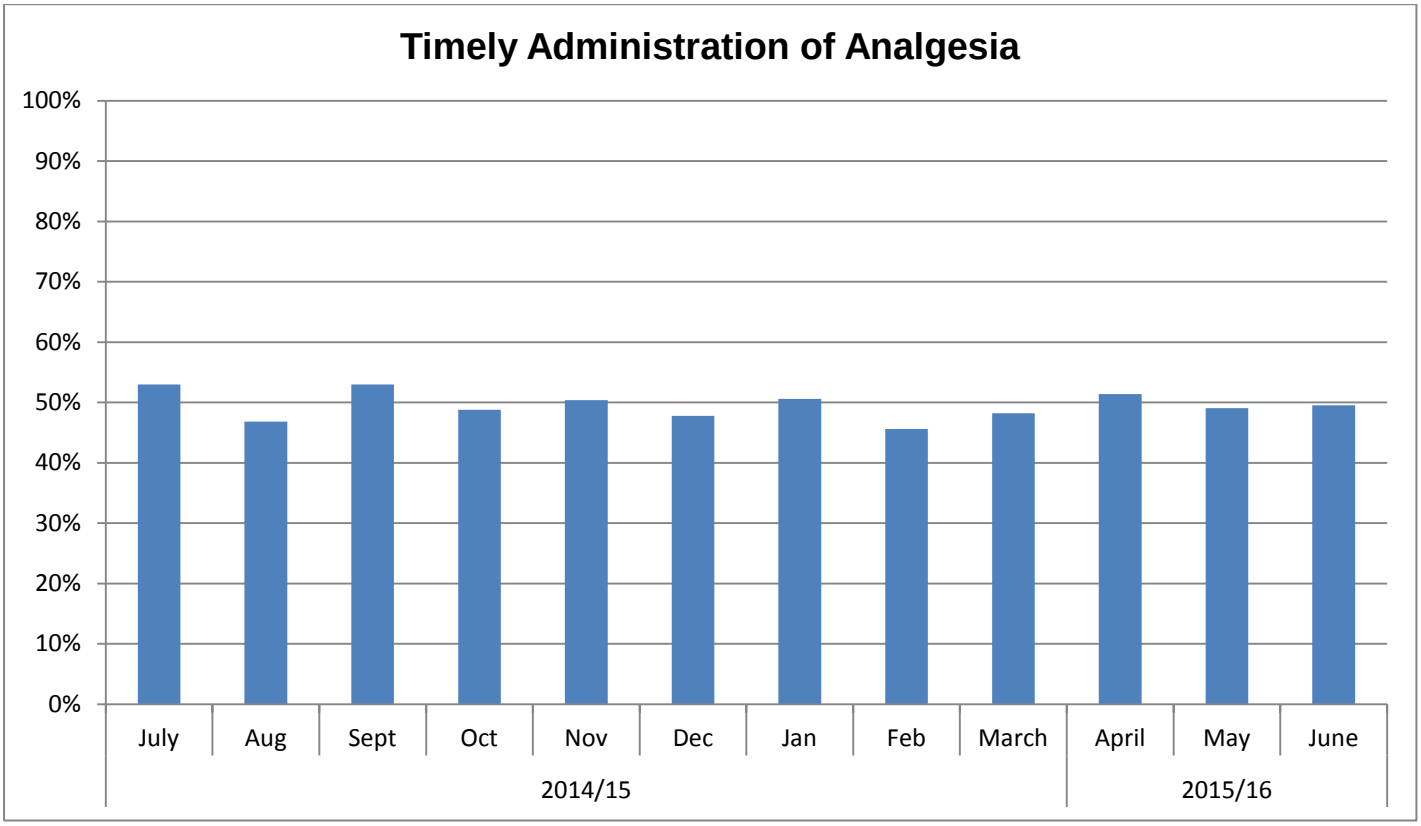
These are new indicators so challenging and ambitious improvement targets have been set for the Trust to achieve by the end of 2015/16.

During Quarter 1 the first indicator improved and is now at 75%. However performance for the second indicator remained steady at 50%.

		2015/16	
	2014/15	Target	Q1
Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward	71%	**85%**	75%
Analgesia administered within 30 minutes of a high pain score	50%	**75%**	50%

Performance by month is displayed in the graphs below.





Initiatives to be implemented in 2015/16

Wards' performance is being monitored, and lower performing wards will be called to Executive Root Cause Analysis meetings for review in the last six months of the year.

These two indicators have been included in the revised Clinical Dashboard, so wards can see their performance and compare it to the hospital as a whole.

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, or missed) to patients on the Prescribing Information and Communication System (PICS).

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

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.

It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time, and when a patient refuses a drug this is also recorded as a missed dose.

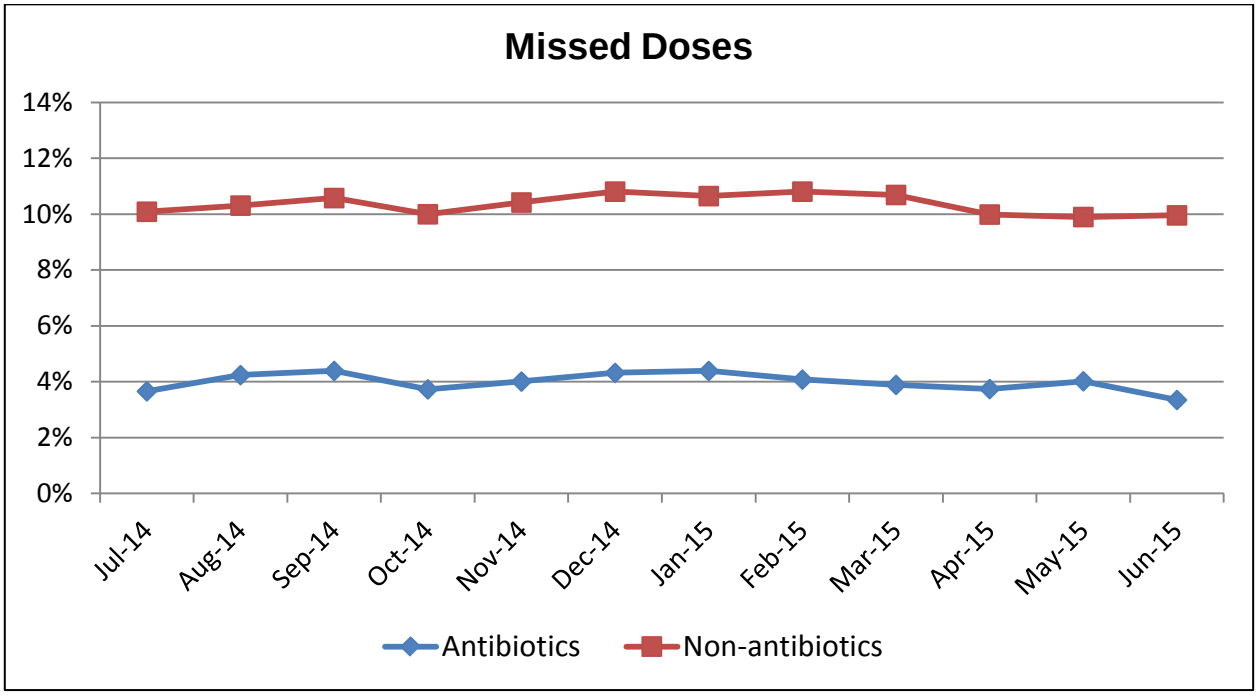
Performance

The Trust is aiming to maintain performance for antibiotics and to reduce the number of missed non-antibiotics compared to the 2014/15 performance – see table for details.

	2013/14	2014/15	2015/16 Target	2015/16 Q1
Antibiotics	3.9%	4.0%	4.0% or below	**3.7%**
Non-antibiotics	9.3%	10.5%	9.5% or below	**10.0%**

Both indicators have shown an improvement in Quarter 1 compared to 2014/15.

Data by month is displayed in the graph below.



In 2015/16, the Trust is focusing on trying to reduce missed non-antibiotics across the Trust particularly those due to patient refusals, medication being out of stock on the ward and nil by mouth. Wards which perform better than average will be asked to share best practice with others to ensure learning is widely known and acted upon.

Initiatives implemented during Quarter 1:

- The Clinical Dashboard has been revised; the updated Missed Doses indicators allow ward staff to see their most frequently missed drugs, the most common reasons provided for the missed doses and the patients with the most missed doses.
- A new report has been developed on intermittently out of stock medication.
- Cases identified on this report will be selected for review at the Executive Care Omissions Root Cause Analysis meetings to identify where changes need to be made.

Initiatives to be implemented during 2015/16:

- New reports will be developed to monitor consecutive missed doses of non-antibiotics and repeated patient refusals.
- Automated incident reporting from PICS to Pharmacy will be implemented for drugs which are recorded as out of stock.

Priority 5: Infection prevention and control

MRSA Bacteraemia

The national objective for all Trusts in England in 2015/16 is to have zero avoidable MRSA bacteraemia. During Quarter 1 2015/16, there were four MRSA bacteraemias apportioned to UHB. This compares to six for 2014/15.

All MRSA bacteraemias are subject to a post infection review by the Trust in conjunction with the Clinical Commissioning Group. MRSA bacteraemias are then apportioned to UHB, the Clinical Commissioning Group or a third party organisation, based on where the main lapses in care occurred. Trust-apportioned MRSA bacteraemias are also subject to additional review at the Trust's Executive Care Omissions Root Cause Analysis meetings chaired by the Chief Executive.

Due to the increase in number of bacteraemias, UHB has implemented a number of key actions to minimise risk of infection:

- Improved screening and decolonisation processes
- Monitoring and review of patients who have acquired MRSA while in the hospital (e.g. on their skin, or in their nose)
- Promotion of hand hygiene and the correct use of protective equipment, such as gloves and aprons.
- Regular review of the care and use of devices in order to minimise risk of patient developing an infection such as MRSA
- Implemented an enhanced rolling programme of deep cleans for the wards, where wards move out to allow a full deep clean and general maintenance to be carried out

The table below shows the number of Trust-apportioned cases reported to Public Health England since 2012/13:

Time Period	2012/13	2013/14	2014/15	2015/16 Q1
Actual performance	5	5	6	4
Agreed annual trajectory	5	0	0	0

***Clostridium difficile* Infection (CDI)**

The Trust's annual agreed trajectory is a total of 63 cases for 2015/16. During Quarter 1, there were 13 CDI cases apportioned to UHB. This is slightly below the trajectory and UHB continues to work to reduce the number of cases.

The Trust uses a review tool with the local Clinical Commissioning Group to establish whether cases were avoidable or unavoidable, so that the Trust could focus on reducing avoidable (preventable) cases. The majority of the Trust's CDI cases were deemed to be unavoidable following this joint review.

The table below shows the number of Trust-apportioned cases reported to Public Health England since 2012/13:

Time Period	2012/13	2013/14	2014/15	2015/16 Q1
Actual performance	73	80	66	13
Agreed annual trajectory	76	56	67	63

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)

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

The Summary Hospital-level Mortality Indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care[1]. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

The Trust's latest SHMI is 103.68 for the period April 2014 to March 2015 which is within tolerance. The latest SHMI value for the Trust, which is available on the HSCIC website, is 98.37 for the period April to September 2014. This is within tolerance.

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 101.29 for the period April 2015 to May 2015 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.

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

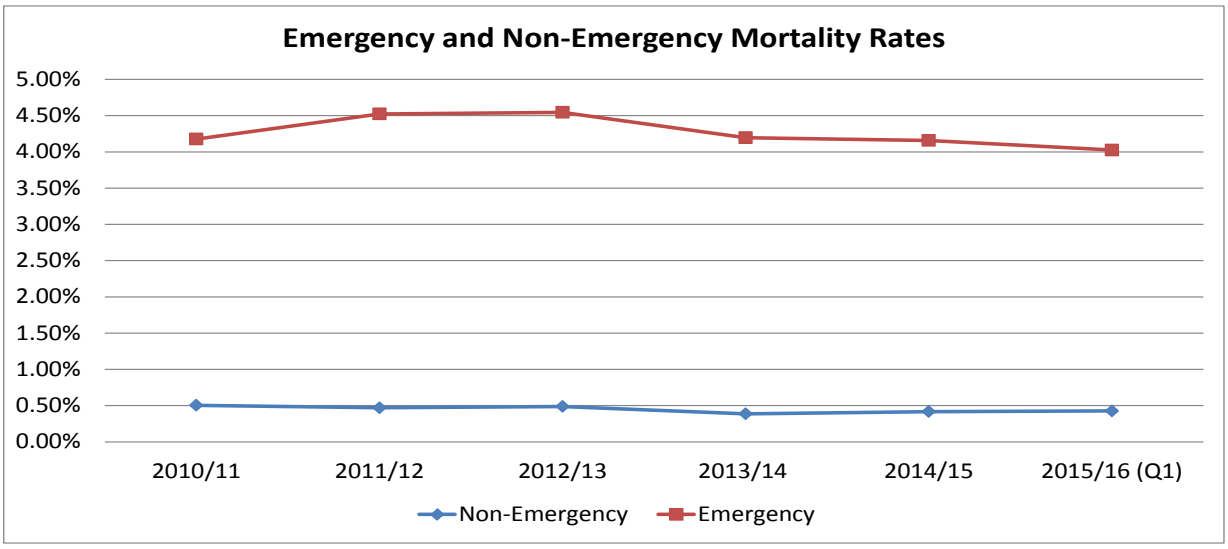
[2] Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. BMJ Quality & Safety. Online First. 7 July 2012.

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

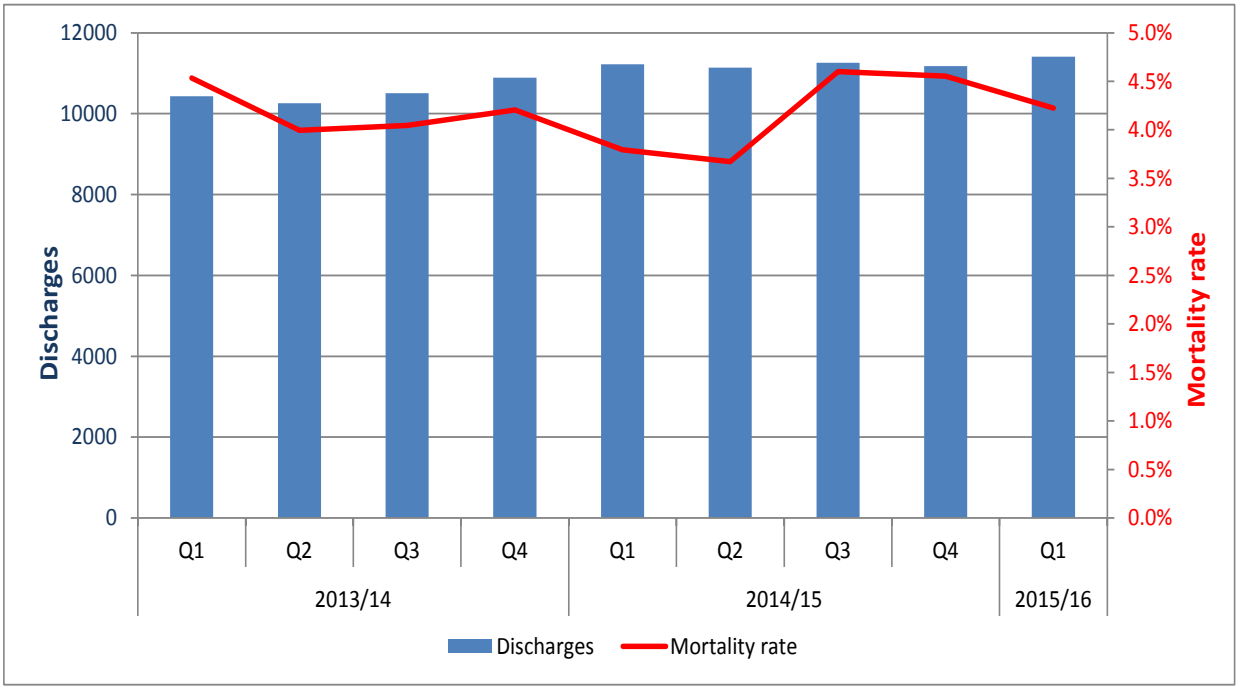
Crude Mortality

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 two calendar years. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

Emergency and Non-emergency Mortality Graph



Overall Crude Mortality Graph



Selected Metrics

Patient safety indicators

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
1(a). Patients with MRSA infection/ 100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**1.04**	**1.52**	**6.13**	**1.40**
Time period	2013/14	2014/15	2015/16 (April-May)	2015/16 (April-May)
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)
Peer group				Acute trusts in West Midlands
1(b). Patients with MRSA infection/ 100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**1.04**	**1.52**	**6.16**	**1.63**
Time period	2013/14	2014/15	2015/16 (April-May)	2015/16 (April-May)
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)
Peer group				Acute trusts in West Midlands

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
2(a). Patients with *C. difficile* infection /100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**20.76**	**16.73**	**16.87**	**15.39**
Time period	2013/14	2014/15	2015/16 (April-May)	2015/16 (April-May)
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)
Peer group				Acute trusts in West Midlands SHA
2(b). Patients with *C. difficile* infection /100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**20.89**	**16.82**	**16.95**	**18.72**
Time period	2013/14	2014/15	2015/16 (April-May)	2015/16 (April-May)
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)
Peer group				Acute trusts in West Midlands

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
3(a) Patient safety incidents (reporting rate per 1000 bed days) *Higher rate indicates better reporting*	Not available (new measure)	**47.2**	**56.6**	**35.9**
Time period		2014/15	April – June 2015	April - September 2014
Data source(s)		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 (non specialist) hospitals
3(b) Never Events *Lower number indicates better performance*	**2**	**3**	**1**	*Not available*
Time period	2013/14	2014/15	April – June 2015	
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
4(a) Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**71.1%**	**81.0%**	**78.3%**	**73.7%**
Time period	2013/14	2014/15	April – June 2015	April - September 2014
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute (non specialist) 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*	**0.24%**	**0.12%**	**0.20%**	**0.50%**
Time period	2013/14	2014/15	April – June 2015	April - September 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 (non specialist) hospitals

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	**9,828**	**16,222**	**4,495**	**4,196**
Time period	2013/14	2014/15	April – June 2015	April - September 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 (non specialist) hospitals

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): there has been a delay in receiving the HES data from the national team, these indicators will be updated in the next quarterly report.

3(a): NHS England recently changed the methodology for calculating incident reporting rates from 'per 100 admissions' to 'per 1000 bed days'. Both measures were presented in the 2014/15 Quality Account for completeness, however for 2015/16 only the new measure of 'per 1000 bed days' is displayed. NHS England have also reduced the number of peer group clusters (trust classifications), meaning UHB is now classed as an 'acute (non specialist)' trust and is in a larger group. Prior to this, UHB was classed as an 'acute teaching' trust which was a smaller group.

The NHS England definition of a bed day ("KH03") differs from UHB's usual definition. For further information, please see this link:
http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

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 2015/16. The Trust's incident reporting rate has therefore 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): UHB has reported one Never Event for Q1 – a guide wire was left in situ following insertion of a central venous catheter. A scan the next day found the guide wire and it was removed. No harm was caused to the patient as a result of this incident, a full investigation has been carried out and actions will be put in place.

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	2013/14	2014/15	2015/16	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*	**12.86%** **England: 13.50%**	**13.52%** **England: 13.82**	**13.19%**	**12.72 %** **England: 13.39%**
Time period	2013/14	2014/15	April-15	April-15
Data source(s)	HES data	HES data		HES data
Peer group				University hospitals
5(b). Emergency readmissions within 28 days (%) (all specialties) *Lower % indicates better performance*	**12.85%** **England: 12.89%**	**13.52%** **13.21%**	**13.19%**	**12.62%** **England: 12.89%**
Time period	2013/14	2014/15	April-15	April-15
Data source(s)	HES data	HES data		HES data
Peer group				University hospitals
5(c). Emergency readmissions within 28 days of discharge (%) *Lower % indicates better performance*	**10.25%**	**10.75%**	**10.84%**	*Not available*
Time period	2013/14	2014/15	April – June 2015	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	**2.1%**	**2.2%**	**2.0%**	*Not available*
Time period	2013/14	2014/15	April – June 2015	
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*	**8.7%**	**8.5%**	**6.7%**	*Not available*
Time period	2013/14	April 2014 - February 2015	April 2015 – May 2015	
Data source(s)	SSNAP data	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*	**89.0%**	**94.7%**	**96.4%**	*Not available*
Time period	2013/14	2014/15	April 2015 – June 2015	
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, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection for example and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

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.

There has been a delay in receiving the HES data from the national team, these indicators will be updated in the next quarterly report.

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: Stroke in-hospital mortality – data is one month in arrears due to the nature of the indicator methodology.

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. During 2014/15 there was a small adjustment to the methodology of this indicator, resulting in a very small change to the indicator results.

Appendix B: Trust Response to Deloitte Recommendations

Indicator	Deloitte Recommendation	Priority	Management Response
18 week referral-to-treatment	**1) Unknown clock start dates** In absence of clear national guidance, the Trust has taken a reasonable approach to recording clock starts when receiving referrals with unknown start dates. The Trust should ensure that this approach is documented in the patient access policy and is communicated to commissioners.	**Medium**	**Initial response:** The refreshed Trust Access Policy includes clear guidance on unknown clock starts. The Policy will be shared with commissioners by the Executive Director of Partnerships. **Progress update:** The Trust's 18 Week Access Policy has been reviewed and will now be shared with commissioners by the Executive Director of Partnerships. **Responsible Officer:** Head of Operational Performance, Executive Director of Partnerships **Timeline:** 30 September 2015
18 week referral-to-treatment	**2) Formalise local agreements** We acknowledge there are instances where the Trust has agreed exceptions from national guidance in the interest of patient safety and experience. Such exceptions should be documented appropriately, approved by commissioners, and communicated to all staff responsible for data entry and validation.	**Medium**	**Initial response:** The Executive Director of Partnerships has established a process with the host Clinical Commissioning Group (CCG) for discussing and approving local arrangements that, in the interests of patient safety and experience, provide detail over and above that in national guidance. The example given within the audit regarding MRI referrals to neurosurgery will be formally agreed. **Progress update:** The Executive Director of Partnerships wrote to the Director of Performance at Birmingham Cross-City CCG at the end of June 2015 about the draft Deloitte 18 week audit findings. The final report is due to be discussed at a meeting in September 2015 where a joint approach will be agreed around local 18 week agreements. **Responsible Officer:** Executive Director of Partnerships **Timeline:** 30 September 2015

Indicator	Deloitte Recommendation	Priority	Management Response
18 week referral-to-treatment	**3) Staff training – Data entry** The Trust should remind staff of the rules and requirements of national RTT guidance. As part of this, there should be a focus on ensuring accurate data entry and recording of outcomes which subsequently inform the identification of key steps of the RTT pathway.	**High**	**Initial response:** 18 week RTT refresher training was commissioned in response to the audit carried out by the Trust in December 2014. Training for all staff involved in RTT pathways commenced 1st May and comprises a half-day taught session with an assessment of competence at the end. In addition the new Patient Administration System, scheduled for implementation at the end of 2015, will recognise the patient's current pathway and only display relevant status options linked to the current status. This is expected to reduce validation burden. **Progress update:** A three hour training course was offered to Medical Secretaries, Booking Centre staff and Booking Co-ordinators from mid- May to mid-July 2015 with a competency test at the end of the session. 271 core staff were identified as requiring training. All identified staff have attended the courses offered during May to July 2015 and passed the competency test. The training course will now form part of the programmes continually offered by the Training Department for new staff and for refresher training. **Responsible Officer:** Director of Patient Services **Timeline:** Completed 15 July 2015; Implementation of PAS currently expected to take place from December 2015.

Indicator	Deloitte Recommendation	Priority	Management Response
18 week referral-to-treatment	**4) Investigate automated clock starts and stops** The Trust should generate a monthly report detailing automated clock starts and clock stops recorded. These should then be investigated as part of the Trust's ongoing validation arrangements.	**High**	**Initial response:** A weekly report will be available within the RTT dashboard which will allow analysis of automated clock starts and stops in each specialty down to patient level. The validation team will sample audit automated clock starts and stops, reporting to the Director of Performance. Oversight will be provided via the existing weekly RTT Assurance Meeting. **Progress update:** Informatics have finalised a report to allow weekly sample audits to be undertaken by the validation team. The results will be analysed and shared at the RTT weekly meeting. **Responsible Officer:** Director of Patient Services, Head of Service Improvement **Timeline:** Completed 31 July 2015
18 week referral-to-treatment	**5) Staff training – validation** The validation team should be reminded of the rules and requirements of national RTT guidance. As part of this, there should be a focus on identifying appropriate clock starts and clock stops, and how to correctly nullify RTT pathways.	**High**	**Initial response:** Specific, tailored training will be provided to the validation team in addition to the 18 week RTT refresher training that has already commenced. The scheduled RTT audits will indicate any ongoing training needs for this group of staff. **Progress update:** As per action number 3 above, the validation team staff have all attended the RTT refresher training course. **Responsible Officer:** Director of Patient Services, Head of Service Improvement **Timeline:** Completed 15 July 2015

Indicator	Deloitte Recommendation	Priority	Management Response
18 week referral-to-treatment	**6) Sample audit** In line with best practice, the Trust should consider undertaking sample audits across RTT lists. Audits should focus on data quality across the RTT pathways, as well as data completeness to monitor whether patients are being transferred between RTT lists appropriately.	**Medium**	**Initial response:** The Trust commenced a programme of scheduled RTT audits in December 2014. A detailed audit of approximately 800 pathways will be carried out annually by the Service Improvement Team. A smaller sample audit will be undertaken mid-way through each year to provide assurance that recommendations have been addressed. **Progress update:** The Service Improvement team are planning the next mid-year sample audit which will commence in August 2015. **Responsible Officer:** Head of Service Improvement **Timeline:** Audit of 800 pathways in December each year; smaller sample audits to be undertaken mid-year.
Pain and observations	**7) Update the analgesia drugs list** The Trust should update the analgesia drug list to include all pain relief.	**Medium**	The Trust has already acted upon this recommendation. The analgesics drug class in the Prescribing Information and Communication System (PICS) has been revised by the Lead Pharmacist for Electronic Prescribing. The methodology for this indicator has been revised to ensure it always refers to the analgesics drug class in PICS so that the list of analgesic drugs remains up to date. **Responsible Officer:** Head of Quality Development **Timeline:** Completed 30 April 2015

Indicator	Deloitte Recommendation	Priority	Management Response
Pain and observations	**8) Consider processes to pick up checks before admission** The Trust may wish to consider amending the methodology so that all observations completed as part of the same set are counted even where one observation was done just before the due time.	**Medium**	**Initial response:** The Trust will review the methodology with the Informatics team, the Executive Medical Director and Executive Chief Nurse to decide if it can and should be changed. **Progress update:** The Trust has decided to keep the observation part of the indicator methodology consistent during 2015/16 to enable performance to be monitored. The Trust is currently reviewing how pain is assessed and recorded with the key Consultants representing chronic pain, acute pain and palliative care. This may result in a change being made to pain assessment in the Trust's Prescribing Information and Communication System (PICS) and the indicator may then need to be revised. **Responsible Officer:** Head of Quality Development **Timeline:** Completed 31 July 2015