AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 23 FEBRUARY 2012

Title:	**QUALITY ACCOUNT UPDATE FOR Q3 2011/12**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 13687

Purpose:	To present the Trust's Quality Account Update for Quarter 3 2011/12.
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 Q3 Quality Account Update is shown in Appendix A. • The Mortality section has been expanded to include the Summary Hospital-level Mortality Indicator (SHMI). • Performance for the Quality Improvement Priorities and selected is generally strong. • Performance for the specialty indicators will be included as an appendix to the update report before publication; performance issues are being followed up with clinicians and Divisional Management Teams as required.
Recommendations:	The Board of Directors is asked to: **Approve** the content of the Quality Account Update for Quarter 3 2011/12 for external publication.

Signed:	**Date:** 15 February 2012

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 23 FEBRUARY 2012

QUALITY ACCOUNT UPDATE FOR QUARTER 3 2011/12

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. **Introduction**

The aim of this paper is to present the Trust's Quality Account Update for Q3 2011/12 prior to external publication at the end of February 2012.

2. **Performance**

2.1 The Trust's Quality Account Update report for April-December 2011 is shown in Appendix A following discussion at the Clinical Quality Monitoring Group (CQMG) in February 2012. The section on mortality was expanded in the quarter 2 report and includes the latest performance for the Summary Hospital-level Mortality Indicator (SHMI). The Trust is within the expected range.

2.2 Performance for the six Quality Improvement Priorities and selected metrics is strong overall. Performance for the 'Time from prescription to administration of first antibiotic dose' indicator remains variable; the Emergency Department does not yet have PICS so the denominator is very small. The general trend is around the 60 minute target time.

2.3 Patient feedback has shown a slight dip in quarter 3 2011/12, particularly around the discharge questions, which is being followed up by the Associate Director for Patient Affairs and the Care Quality Group.

3. **Specialty Quality Indicators**

3.1 Performance for the specialty indicators will be added at the end of the update report before publication but is not included here for brevity. There are no particular concerns over publication of this information; performance issues are being followed up with clinicians and Divisional Management Teams as required. Actions are being focused on those indicators where performance has not improved or has got worse during 2011/12: Heart Failure, Pharmacy and Imaging indicators.

3.2 In order to make the process for identifying potential specialty indicator performance exceptions more robust, a framework is being developed with Health Informatics. The framework will take into account performance over time, natural variation and denominator changes.

This is expected to take around three months to develop and will be implemented during 2012/13. The Head of Quality Development will develop the process to accompany the framework which will set out the reporting arrangements between the Quality and Outcomes Research Unit (QuORU), the CQMG and the Board of Directors.

4. 2011/12 Quality Account/Report

The Trust is awaiting guidance from the Department of Health and Monitor on the requirements for the 2011/12 Quality Accounts/Reports. As for previous years, the requirements will be discussed at the CQMG and Care Quality Group in March and reported to the Board of Directors in due course.

5. External Assurance

5.1 The draft guidance on the external assurance arrangements for the 2011/12 Quality Accounts has been published by Monitor. The Trust has arranged for KPMG to undertake the required indicator testing during early March 2012 for the two mandatory indicators plus the local one selected in principle by the Council of Governors (CoG) in January 2012:

5.1.1 *C. difficile* infection
5.1.2 Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers and;
5.1.3 Patient experience data (due to be finally approved by the CoG in February 2012)

5.2 The audit of the content of the Trust's 2011/12 Quality Account/Report will be carried out by KPMG during April/May 2012.

6. Recommendations

The Board of Directors is asked to:

Approve the content of the Quality Account Update for Quarter 3 2011/12 for external publication.

Quality Account Update for April-December 2011

Contents

Quality Account Update for April-December 2011

1. Introduction

The Trust published its third Quality Account Report in June 2011 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2010-11, performance data for selected metrics and set out six priorities for improvement during 2011-12:

Key Priorities:

Priority 1: Time from prescription to administration of first antibiotic dose
Priority 2: Completion of VTE (venous thromboembolism) risk assessments on admission
Priority 3: Improve patient experience and satisfaction
Priority 4: Electronic observation chart – completeness of observation sets (to produce an early warning score)

Ongoing Priorities:

Priority 5: Reducing medication errors (missed doses)
Priority 6: Infection prevention and control

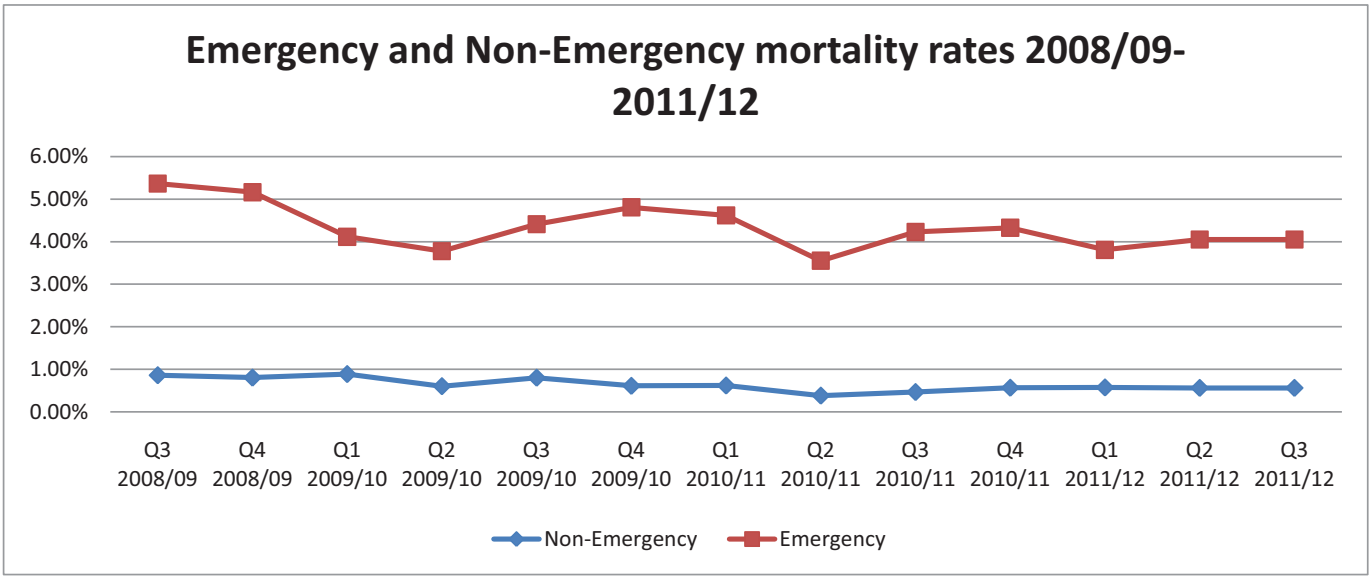
This report provides an update on the progress made for the period April-December 2011 towards meeting these priorities and updated performance data for the selected metrics. This update report should be read alongside the Trust's Quality Account Report for 2010-11.

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.

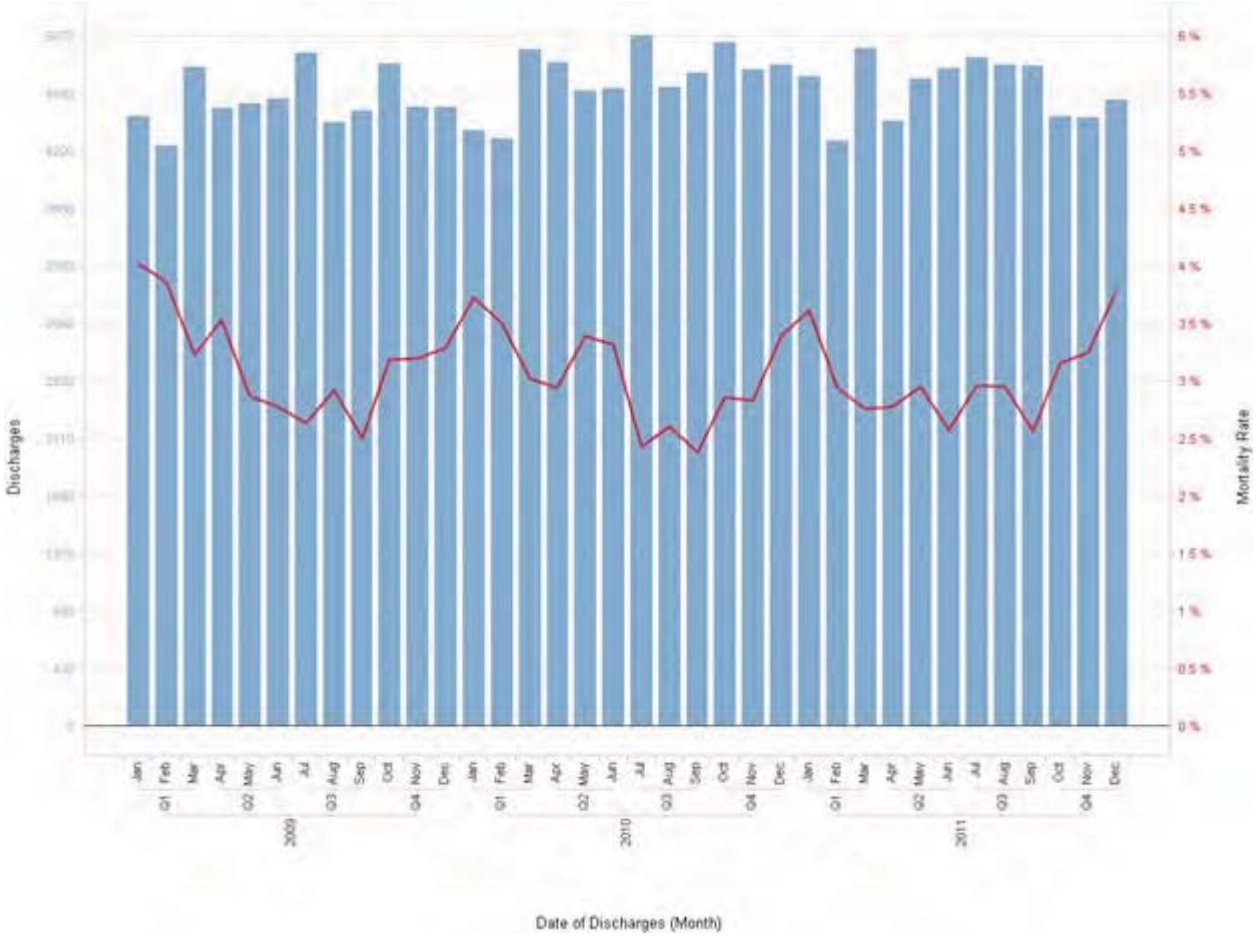
Emergency and Non-Emergency Mortality

The graph below shows the non-emergency and emergency mortality rates by quarter for the last three financial years. Although the Trust is generally treating more elderly patients and patients with complex conditions, mortality continues to remain stable. The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.



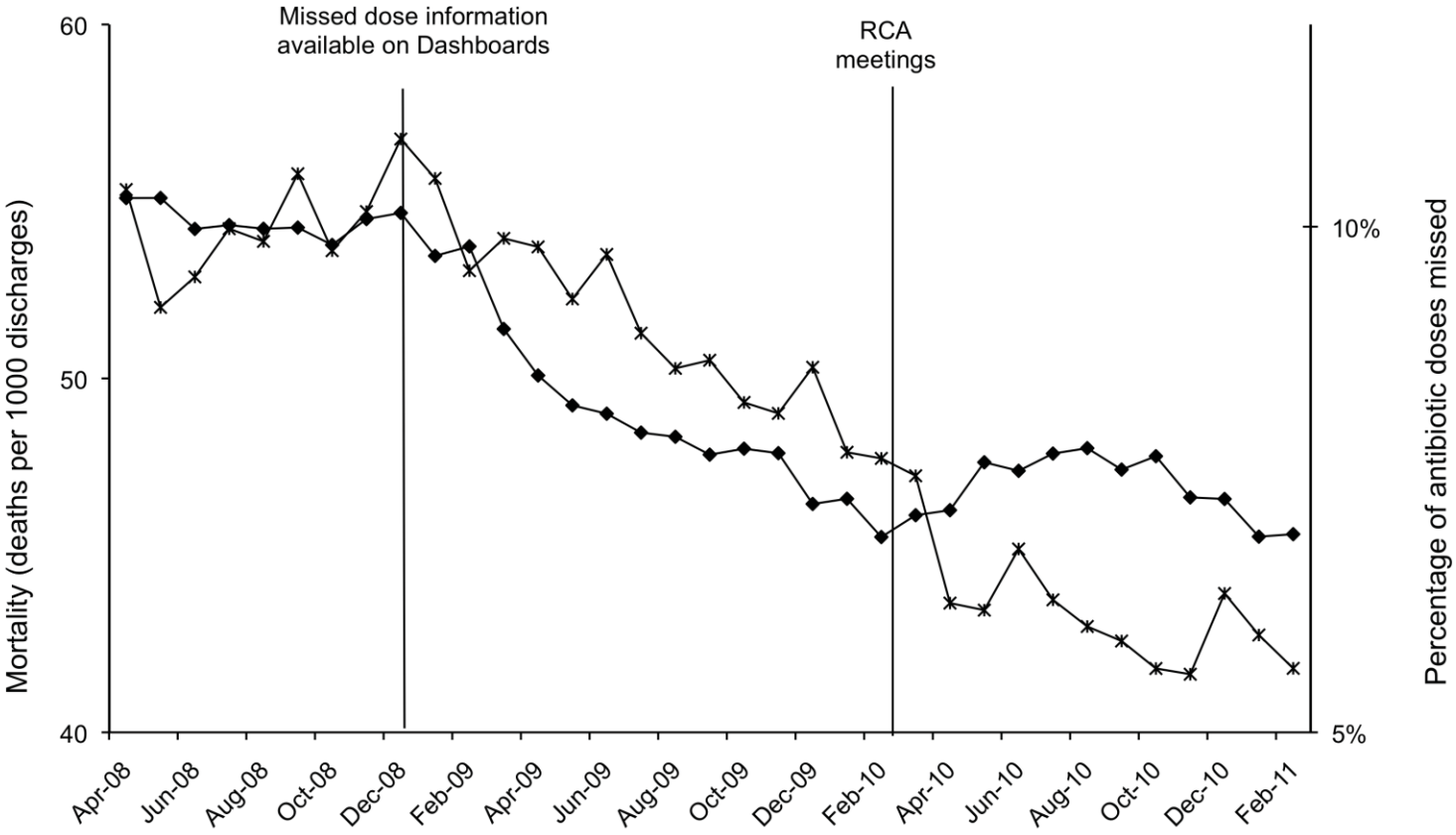
Crude Mortality

The graph below shows the Trust's crude mortality rate against activity (patient discharges) by quarter for the past three calendar years:



Deaths in Hospital within 30 days of Interventional Procedures for Emergency Admissions

The Trust has seen a significant reduction in deaths in hospital within 30 days of non-diagnostic interventional procedures for emergency admissions over the past four years. The Trust has also seen a marked decline in the percentage of missed doses of antibiotics over this same time period as shown in the graph below. This reduction correlates with the publication of missed doses information on the Clinical Dashboard and introduction of the monthly Executive Root Cause Analysis (RCA) meetings.



Time series plot of 12-month moving average UHB mortality rates (diamonds) and missed antibiotic doses (crosses) by month.

Summary Hospital-level Mortality Indicator (SHMI)

In October 2011, the NHS Information Centre published data for the Summary Hospital-level Mortality Indicator. This is the new national hospital mortality indicator which replaces previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period 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. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model. A higher than expected SHMI should be used as a trigger for further investigation. The NHS 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 98.2 for quarter 1 2011/12 which is within the expected range and below the national mortality rate for hospital-related deaths, including those which occurred outside hospital.

3. Quality Improvement Priorities

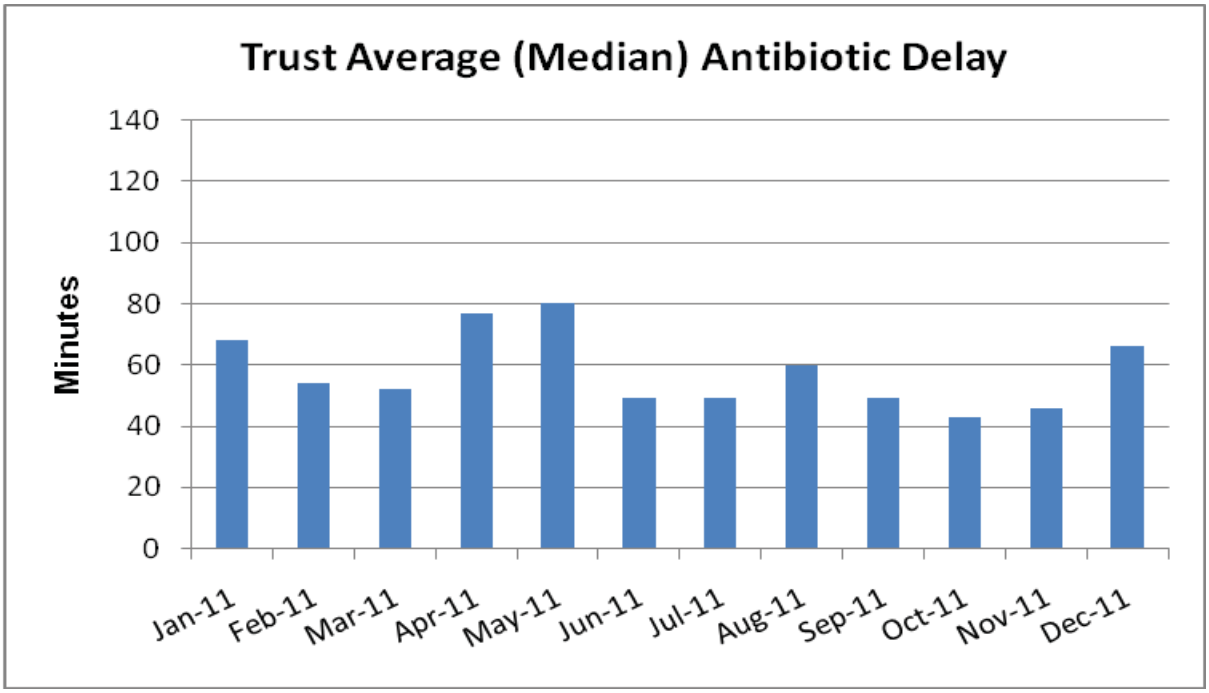
Priority 1: Time from prescription to administration of first antibiotic dose Performance

There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes. The recommended time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

This indicator focuses on the first prescription of antibiotics for patients identified as having likely infections (based on white blood cell counts) and measures the time delay between the antibiotic prescription being made and the first dose of this drug being given. All courses of antibiotics lasting for three days are included even where they include a discharge prescription.

The Trust has now identified clinical exception rules with clinicians and refined the methodology for measuring performance against this indicator. Data has been collected from the Trust's electronic Prescribing Information and Communication System (PICS) for patients admitted with acute illnesses. This does not however include Emergency Department (ED) referrals where prescribing data is not yet captured electronically. The Trust implemented a new electronic information system called Oceano in the Emergency Department in October 2011 to enable better data capture. This is the first step towards implementing the Prescribing and Information Communication System within the ED in the future.

The Trust is generally performing well against the target time of 60 minutes.



Priority 2: Venous thromboembolism (VTE) risk assessment on admission

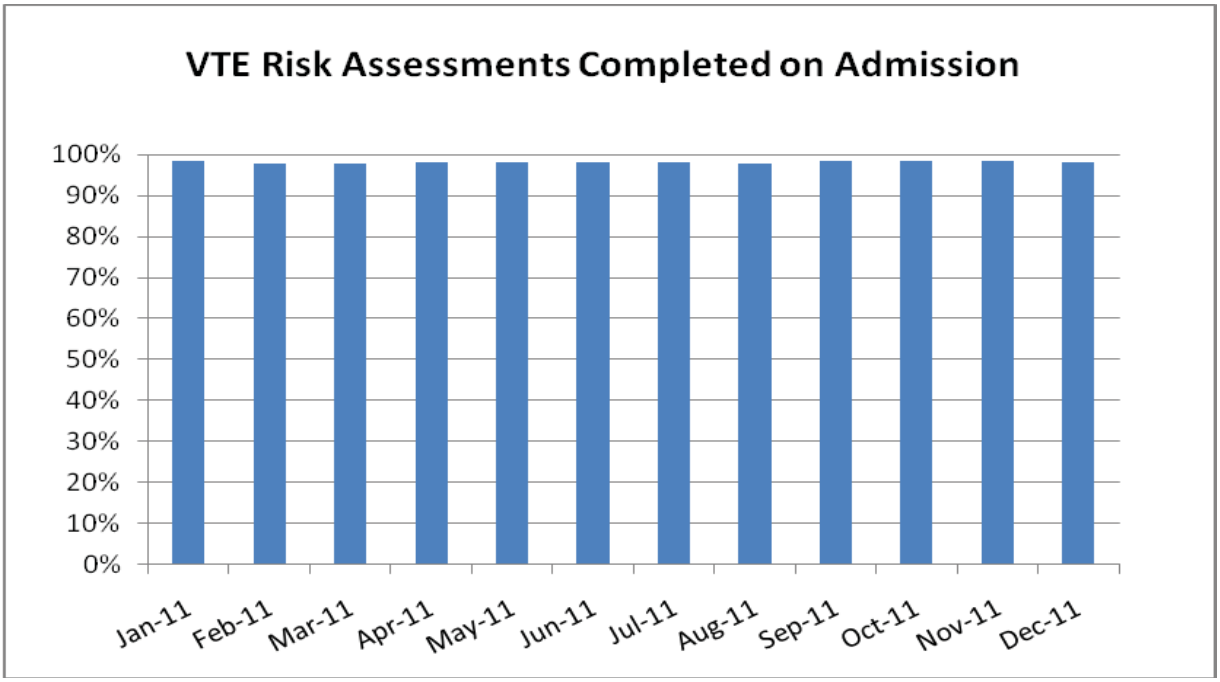
Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods of immobility and can largely be prevented if appropriate preventative measures are taken.

Whilst most 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 since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

The Trust's electronic VTE risk assessment tool has been revised to reflect the latest guidance from the National Institute for Health and Clinical Excellence (NICE). In order to comply with this guidance, new mandatory questions for all inpatients admitted acutely or electively have been included as part of the risk assessment tool. In addition, ambulatory care (day case) admissions have been examined to determine which patients also require a full risk assessment within our systems. Both of these changes have produced a big improvement in VTE risk assessment completion on admission.

The graph shows performance for the past 12 months. The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 which is well above the national average of 88%*. As the VTE risk assessment tool was revised in line with national guidance during 2010/11, data for previous years is not shown.

* This is the latest available national average for NHS acute providers published on the Department of Health website (July to September 2011).



The Trust is now monitoring whether patients are given VTE prevention treatment, if required, following risk assessment. This includes elastic compression stockings (TED stockings) and enoxaparin (medication used to reduce the risk of blood clots forming). Performance for individual wards and the Trust overall is now available on the electronic Clinical Dashboard to allow real-time audit of performance by nursing and medical staff.

The table below shows the percentage of TED stockings administered at least once by episode as recorded on the electronic Prescribing and Information Communication System. One patient admission or spell in hospital can comprise a number of different episodes of care. It is not always appropriate to administer TED stockings every day for a variety of reasons including patient choice and clinical contraindications such as sore or swollen skin for example. These two categories account for over two-thirds of the stockings not administered.

Month	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sept-11	Oct-11	Nov-11	Dec-11
Percentage	83.1%	83.1%	83.3%	84.6%	83.8%	83.8%	88.4%	84.3%	85.1%

The table below shows the percentage of patients who require enoxaparin medication following VTE risk assessment and are prescribed it. Of the patients who required enoxaparin following VTE risk assessment, 67.9% were given it at least once in December 2011. 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.

Month	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sept-11	Oct-11	Nov-11	Dec-11
Percentage	69.2%	65.9%	66.3%	68.4%	65.2%	69.0%	70.5%	69.5%	70.7%

Priority 3: Improve patient experience and satisfaction

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

Patient Experience Data

		Performance			
Question	**Answer**	**2010/11**	**Q1 2011/12**	**Q2 2011/12**	**Q3 2011/12**
1. Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	73.4%	76.6%	77.9%	76.3%
	Yes, to some extent	20.9%	18.9%	16.5%	18.1%
	No	5.8%	4.5%	5.5%	5.6%
2. Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely	60.8%	64.1%	66.4%	67.3%
	Yes, to some extent	27.5%	25.2%	22.1%	22.9%
	No	11.8%	10.7%	11.5%	9.8%
3. Were you given enough privacy when discussing your care and treatment?	Yes, always	87.4%	90.0%	89.8%	88.6%
	Yes, sometimes	10.6%	8.4%	8.1%	9.1%
	No	2.0%	1.6%	2.1%	2.3%
4. Do you think that hospital staff do all they can to help control your pain?	Yes, definitely	80.8%	84.0%	83.1%	82.9%
	Yes, to some extent	16.0%	14.1%	14.1%	14.1%
	No	3.1%	1.9%	2.8%	2.9%
5. Did a member of staff tell you about medication side effects to watch for when you went home?	Yes, completely	*Not enough data**		48.4%	41.0%
	Yes, to some extent			8.3%	12.0%
	No			43.3%	47.0%
6. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Yes	88.9%	*Not enough data**	70.8%	73.5%
	No	11.1%		29.2%	26.5%
7. Overall how would rate the hospital food you have received?	Excellent		17.7%	20.9%	21.4%
	Very good		27.9%	29.0%	27.0%
	Good		29.3%	26.2%	27.3%
	Fair		16.6%	16.1%	16.8%
	Poor		8.5%	7.8%	7.5%
8. Have you been bothered by noise at night from hospital staff?	No, never		65.2%	67.2%	66.1%
	Yes, occasionally		28.6%	27.2%	28.2%
	Yes, often		6.2%	5.5%	5.7%

9. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never		69.1%	70.4%	68.1%
	Yes, sometimes		25.7%	23.7%	5.8%
	Yes, often		5.2%	5.9%	26.2%

* The Trust has set a minimum threshold of 30 responses to each question to ensure the data is representative.

Key actions being taken to improve patient experience include:

- Following an audit of noise at night involving all inpatient areas of the Trust, the results have been used by each clinical Division to inform their action plans for improvement. As part of the Trustwide actions, a task and finish group has developed a set of good practice guidelines for staff and for patients. These will be introduced in Q4.

- Satisfaction with food has been benchmarked against the results of the last National Patient Survey and would put the Trust in the top 20% of NHS Trusts. A survey on the back of the patient menu card continues to be used to get feedback at the time of food delivery. This information is inputted into the electronic survey system and is used to highlight improvements at individual ward level.

- The Patient Experience Champion Programme launched in Q2 currently has 219 champions registered which include Patient and Carer Council representatives. An education programme for champions commenced in Q3 and evaluated well. Further education days are planned for Q4 and are already subscribed to.

- The on-line patient experience surveys are currently being tested by members of the Patient & Carer Councils, following which they will go live, giving patients another method to provide their feedback on the care and services provided.

- The programme of Mystery Shopper visits have evaluated well. The Mystery Shopper Council members have been working with the Customer Care Facilitator to help develop standards for receptionists. The shoppers will be visiting reception areas in Q4 to provide a benchmark observation prior to the standards being introduced. Once the standards are implemented a repeat visit will be conducted to test the standards.

- Responses to questions 5 and 6 continue to provide statistically viable data. The patient experience team will be working to increase the numbers of patients surveyed in Q4.

Complaints

The number of complaints received in the third quarter of 2011/12 was 175, which represents a reduction of 28% against the preceding quarter.

	Q2 2011/12	Q3 2011/12
Total number of complaints	244	175

Top 3 main subjects of complaints	Q2 2011/12	Q3 2011/12
Clinical treatment	112	80
Outpatient appointment delay/cancellation		19
Attitude of staff		
Inpatient appointment delay/cancellation	28	21
Communication and information	27	

Ratio of complaints to activity		Q2 2011/12	Q3 2011/12
Inpatients	FCEs*	30853	28782
	Complaints	139	99
	Rate per 100 FCEs	0.45	0.34
Outpatients	Appointments**	133095	135606
	Complaints	83	62
	Rate per 100 appointments	0.06	0.04
A&E	Attendances	21822	21760
	Complaints	13	14
	Rate per 100 attendances	0.06	0.06

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant.
** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech and Language Therapy and Occupational Therapy)

Learning from complaints

The Trust takes a number of steps to review learning from complaints and to take action as necessary. Complaints are reported monthly to the Care Quality Group as part of the wider Patient Experience report. A monthly complaints report is also presented at the Chief Executive's Advisory Group. Each quarter, a detailed analysis of complaints is presented to the Trust's Audit Committee. Selected complaints form part of the Executive root cause analysis sessions into omissions in care and, where trends are identified, trust-wide actions are implemented to prevent recurrence.

Independent reviews

During the third quarter of 2011/12, the Parliamentary and Health Service Ombudsman advised the Trust that four cases had been accepted for initial assessment. One of those new cases was closed during the Quarter, pending the outcome of the HM Coroner's Inquest. A further case originally referred earlier in the year has now been accepted by the Ombudsman for investigation. The Ombudsman has closed another case following the Trust's further response to the complainant.

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS) on behalf of the Trust. PALS receive some compliments directly from patients and carers; others are forwarded to PALS by staff after being received in wards and departments throughout the Trust.

The majority of compliments are received in writing – by letter, card, email or feedback leaflet, the rest are received verbally via telephone or face to face.

With robust systems now in place for capturing positive feedback the number of recorded compliments continues to increase. Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale.

Compliment Subcategories	**2010/11**	**Q1 2011/12**	**Q2 2011/12**	**Q3 2011/12**
Nursing care	309	109	117	140
Friendliness of staff	306	116	165	50
Treatment received	251	80	64	67
Medical care	122	25	55	180
Other	54	7	3	0
Efficiency of service	47	14	7	21
Information provided	17	3	6	4
Facilities	9	4	0	9
Totals:	**1115**	**361**	**417**	**471**

Priority 4: Electronic observation chart – completeness of observation sets (to produce an early warning score)

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. At the end of December 2011, 98% of inpatient wards were using the electronic chart with the remainder continuing to use the existing paper charts to record patient observations. The Trust is rolling out the electronic observation chart to the remaining wards during the final quarter of 2011-12.

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 (Scottish 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 electronic observation sets which are complete. The Trust's baseline performance was 79% for 2010/11 for the wards which were using the electronic observation chart in PICS. The Trust is aiming for at least 91% of all observation sets to be complete for those wards already live and at least 75% to be complete for the remaining wards by the end of quarter 4 2011/12.

Percentage of patients receiving full set of observations to generate a SEWS score

	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sept-11	Oct-11	Nov-11	Dec-11
Percentage	90.4%	92.9%	92.8%	92.0%	90.7%	88.9%	91.5%	91.3%	93.5%

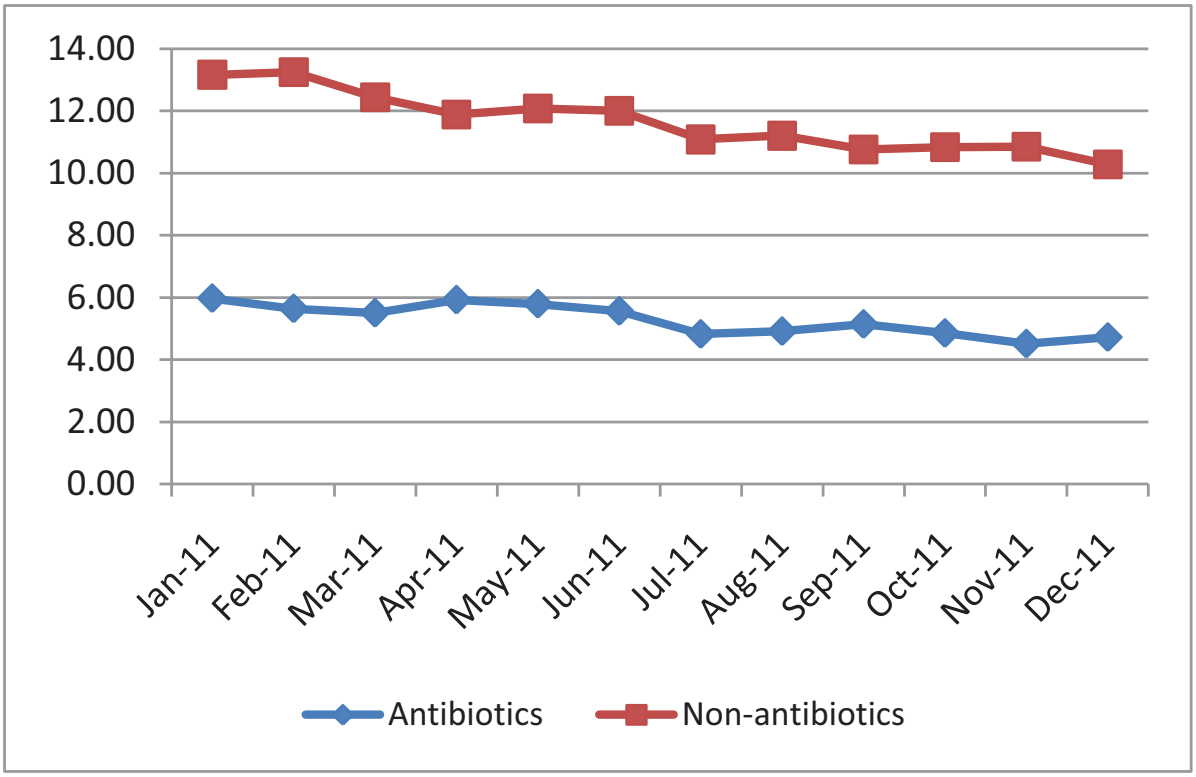
Priority 5: Reducing errors (with a particular focus on medication errors)

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 graph shows that the Trust has delivered significant and sustained reductions in the percentage of omitted antibiotics and non-antibiotics. The biggest step change improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive root cause analysis (RCA) meetings were introduced at the end of March 2010.

The Trust made further significant reductions in the percentage of omitted antibiotic and non-antibiotic drug doses during 2010/11, although the rate of decline has now slowed as expected. UHB is aiming to make further reductions during 2011/12, particularly for non-antibiotics. It is however important to remember that some drug doses are appropriately missed due to the patient's condition at the time. The Trust is therefore evaluating the target reductions in 2011/12 to ensure they are appropriate in the absence of any national agreement on what constitutes an expected level of drug omissions. The percentage of missed antibiotics and non-antibiotics continued to reduce during quarter 3 2011-12.

Missed Doses Performance by Month



Priority 6: Infection prevention and control

The Trust is continuing to reduce MRSA bacteraemia and *C. difficile* infection. At the end of quarter 3, the Trust is 1.5 cases below the year to date trajectory for MRSA bacteraemia and 18.5 cases under year to date trajectory for *C. difficile* infection (CDI).

MRSA bacteraemia

In line with the annual Infection Prevention and Control delivery plan, the Trust is continuing its focus on reducing the incidence of MRSA bacteraemia though improving MRSA screening and decolonisation, the management of invasive devices and compliance with Infection Prevention & Control procedures.

The table below shows the Trust's overall performance against trajectory for quarter 3 2011-12 and the year to date:

	Q1 2011-12	**Q2 2011-12**	**Q3 2011-12**	**2011-12**
Actual performance	2	1	0	3 (to date)
Agreed trajectory	1.5	1.5	1.5	7

C. difficile infection

The Trust is continuing to reduce the incidence of *C. difficile* infection through timely isolation of patients, appropriate antimicrobial prescribing, hand hygiene, environmental cleanliness and staff and patient education.

The table below shows the Trust's performance against trajectory for quarter 3 2011-12 and the year to date:

	Q1 2011-12	**Q2 2011-12**	**Q3 2011-12**	**2011-12**
Actual performance	28	17	22	67 (to date)
Agreed trajectory	28.5	28.5	28.5	114

In addition, the Trust continued to report MSSA (Meticillin-sensitive staphylococcus aureus) and *E. coli* bacteraemia during quarter 3 2011-12 to the Health Protection Agency as part of the mandatory surveillance requirements.

4. Performance of the Trust against selected metrics

The tables below show the Trust's latest performance for 2011/12 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The Board of Directors has chosen to include the same selection of indicators as reported in the Trust's previous Quality Reports to enable patients and the public to understand performance over time.

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 2011/12 is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance is monitored and challenged during the year by the Clinical Quality Monitoring Group and the Board of Directors.

Patient safety indicators

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**0.24***	**0.10**	**0.33**	**0.42**
Time period	April-Sept 2011	April-Sept 2011	2010/11	2009/10
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
Peer group		Acute trusts in West Midlands SHA		
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.24**	**0.11**	**0.33**	**0.43**
Time period	April-Sept 2011	April-Sept 2011	2010/11	2009/10
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA		
2(a). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**0.28**	**0.30**	**0.43**	**0.53**
Time period	April-Sept 2011	April-Sept 2011	2010/11	2009/10
Data source	Trust C.diff data reported to HPA, HES data (bed	Trust C.diff data reported to HPA, HES data (bed	Trust C.diff data reported to HPA, HES	Trust C.diff data reported to HPA, HES

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
	days)	days)	data (bed days)	data (bed days)
Peer group		Acute trusts in West Midlands SHA		
2(b). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.28**	**0.35**	**0.43**	**0.59**
Time period	April-Sept 2011	April-Sept 2011	2010/11	2009/10
Data source	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)	Trust C.diff data reported to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA		
3. Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**10.8**	*Not yet published*	**11.3**	**9.7**
Time period	April-Dec 2011		2010/11	2009/10
Data source	Datix (incident data), Trust admissions data		Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
Peer group				
4. Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**72.4%**	*Not yet published*	**81.3%**	**89.9%**
Time period	April-Sept 2011		2010/11	2009/10
Data source	Datix (incident data)		Datix (incident data)	Datix (incident data)
Peer group				

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): The data shown for 2009/10 and 2008/09 differ to that shown in previous Quality Reports. This is due to a change in the method and data source used to calculate bed days.

3: The data shown for 2009/10 and 2008/09 differ to that shown in previous Quality Reports. This is due to a change in the method of calculation which uses admissions data rather than episodes; an admission is classed as the first episode of care.

4: The data shown for 2009/10 and 2008/09 differ to that shown in previous Quality Reports. This is due to a change in the method of calculation which now includes near miss as well as no harm incidents. The reduction in the percentage of no harm incidents in 2010/11 and 2011/12 is largely due to the reporting of all grades of pressure ulcer as harm incidents from April 2010 and a reduction in the number of (no harm) incidents relating to missing medical records following the introduction of the electronic Clinical Portal in Outpatients.

Clinical effectiveness indicators

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**5.09%**	**5.10%**	**5.35%**	**5.63% (5.62%)**
Time period	April-Sept 2011	April-Sept 2011	2010/11	2009/10
Data source	HES data	HES data	HES data	HES data
Peer group		University hospitals		
5(b). Readmissions: Readmission rate (all specialties) % *Lower % indicates better performance*	**5.08%**	**4.18%**	**5.84%**	**5.62%**
Time period	April-Sept 2011	April-Sept 2011	2010/11	2009/10
Data source	HES data		HES data	HES data
Peer group		University hospitals		

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**2.56%**	*Not available*	**2.5%**	**2.0%**
Time period	April-Dec 2011		2010/11	2009/10
Data source	Datix (incident data), Trust admissions data		Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**100%**	**99.3%**	**100%**	**99.7%**
Time period	April-Dec 2011	2009	2010/11	2009/10
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.		

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
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*	**92.2%**	**98.0%** NB This data is for all surgery patients with heart conditions who were on betablockers and is based on a sample of cases.	**92.6%**	**93.3%**
Time period	April-Sept 2011	July 2009-June 2010	2010/11	2009/10
Data source	Trust PICS data	Cleveland Clinic website	Trust PICS data	Trust PICS data
Peer group		Cleveland Clinic, Ohio, U.S.A.		

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 for emergency readmissions has been revised. The data shown relates to patients who are readmitted within 30 days of being discharged from UHB to any provider in England, including private sector providers. In line with guidance from the Department of Health, the new methodology also includes patients who were originally admitted as daycases (for a planned procedure) and regular daycases (e.g., patients attending dialysis):
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125490.pdf The new methodology cannot be applied to 2008/09 data due to a change in the national grouping of diagnosis codes.

6: The admissions data includes daycase patients as well as all elective and emergency admissions. The increase in 2010/11 is due to a higher number of falls being reported as a result of increased awareness.

7: Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke. Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate.

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.