University Hospitals
Birmingham

NHS

NHS Foundation Trust

Quality Account Update
for October – December 2015

Contents

1. 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 avoidable 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-December 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.

2. Quality Improvement Priorities

Priority 1: Reducing grade 2 hospital-acquired avoidable 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*)

At UHB, pressure ulcers are split into two groups: those caused by medical devices and those that are not.

UHB saw 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 chose 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 patients with non device-related, hospital-acquired avoidable grade 2 pressure ulcers.

In Quarter 3 2015/16, UHB reported 21 patients with non device-related, hospital-acquired avoidable grade 2 pressure ulcers, meaning a total of 58 to date in 2015/16. In the same period last year (April to December 2014), there were 113 patients with such pressure ulcers.

Number of patients with grade 2 hospital-acquired, non device-related avoidable pressure ulcers, by Quarter
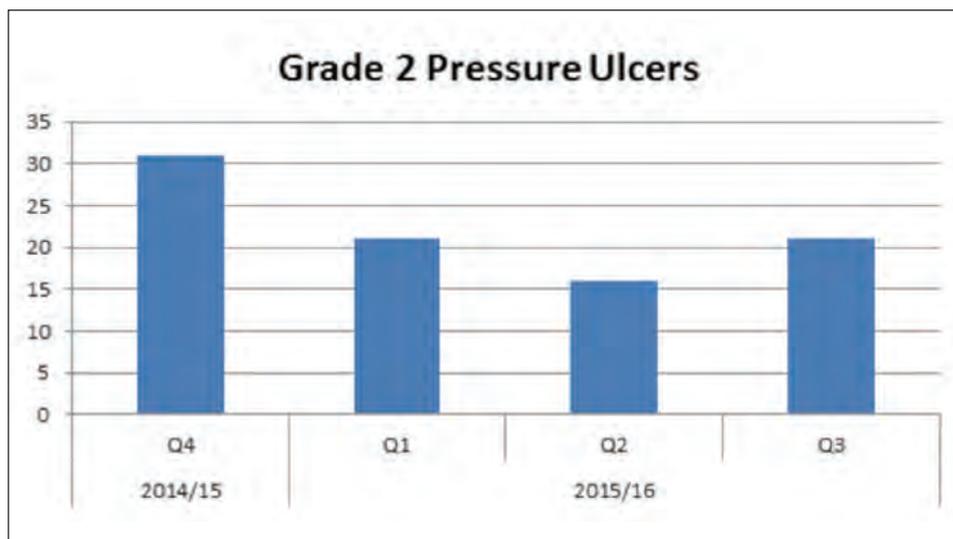
Initiatives to be implemented during 2015/16
To continue to build on the improvements seen in 2014/15, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly. The team also plan to relaunch the "React to RED campaign" which is a visual awareness campaign: when a staff member identifies a potential pressure ulcer, they think "RED" which prompts them to consider Repositioning, Equipment and Documentation.

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 website. This vital feedback is used to make improvements to our services.

Patient experience data from surveys

Performance

During Quarter 3 2015/16, 4539 patient responses were received to our local inpatient survey (1st October to 9th December), 202 responses to our discharge survey (October only), 203 responses to the Emergency Department Survey (October to November) and a further 205 responses to our Outpatient postal survey (October only).

The table below shows results to key questions for Quarters 1, 2 and 3* plus the last two financial years. The results show that in this partial reporting period the Trust has maintained performance, there are no significant (+/- 5% or more) changes in score: where there are slight changes, the majority show movement in a positive direction.

* Please note this report contains partial data only for Quarter 3 2015/16 as the full dataset was not available at the time of reporting.

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 for 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	Q2	Q3		Q3
1. Did you find someone on the hospital staff to talk about your worries or fears?	8.7	8.4	8.5	8.5	**8.4***	8.8	1583*
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	8.9	**8.8***	9	2015*
3. Have you been bothered by noise at night from hospital staff?	8.4	8.1	8.2	8.2	**8.3***	8.5	2031*
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	8.7	**8.7***	9	4526*
5. Did the staff treating and examining you introduce themselves?	New for 2014/15	8.9	9.7	9.1	**9.1***	9	4508*
Outpatient survey*							
6. Was your appointment changed to a later date by the hospital?	9.2	9	**9.1**	**9.1**	**9.3****	9	202**
7. Did the staff treating and examining you introduce themselves?	8.6	8.5	**8.7**	**8.8**	**8.6****	8.9	199**
8. Did a member of staff tell you about medication side effects to watch out for?	6.6	6.7	**6.8**	**7.3**	**7.5****	7	64**
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**	**8.9**	8.8*	8.3	377*

	Score					Target	No. responses (local survey)
	2013/14	2014/15	2015/16			2015/16	2015/16
Inpatient survey			Q1	Q2	Q3		Q3
10. Do you think the hospital staff did everything they could to help control your pain?	8	7.8	9.1	8.9	**9.0***	8.2	346*
11. Did the staff treating and examining you introduce themselves?	New for 2014/15	8.1	9.0	8.8	**8.9***	8.5	354*
Discharge survey*							
12. Did a member of staff tell you about medication side effects to watch for when you went home?	5.9	5.8	6.1	5.6	**5.7****	6.1	141**
13. Did you feel you were involved in decisions about going home from hospital?	7.2	7.0	7.4	7.2	**7.1****	7.4	188**

*At time of reporting, 2015/16 data for Q3 Inpatient and Emergency Department survey data are partial up to December 2015 and
** Outpatient and discharge postal survey data are available for October 2015 only.

Friends and Family Question

The Trust has continued to monitor performance for the Friends and Family Test (FFT) question during Quarter 3 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. National data has now also been published for the Outpatient Friends and Family Test, so this data is now shown here.

Friends and Family Test: "Would recommend" percentages

Inpatients: Published data for Quarter 3 2015/16* shows the Trust has increased 1% on the inpatient positive recommendation rate and is above the national average and NHS England West Midlands region.

Inpatient FFT 15-16 % recommend
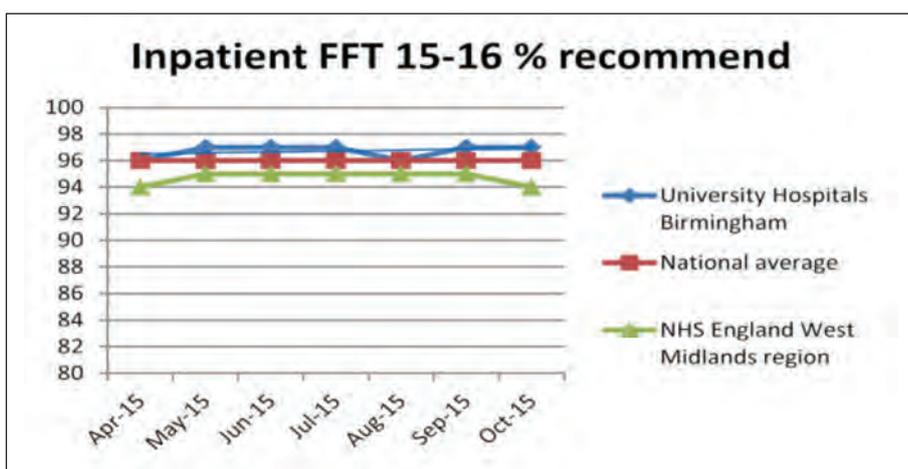
A&E: During Quarter 3 2015/16* the Trust has stayed at just below the national average positive recommendation rate, but above the NHS England West Midlands region rate.
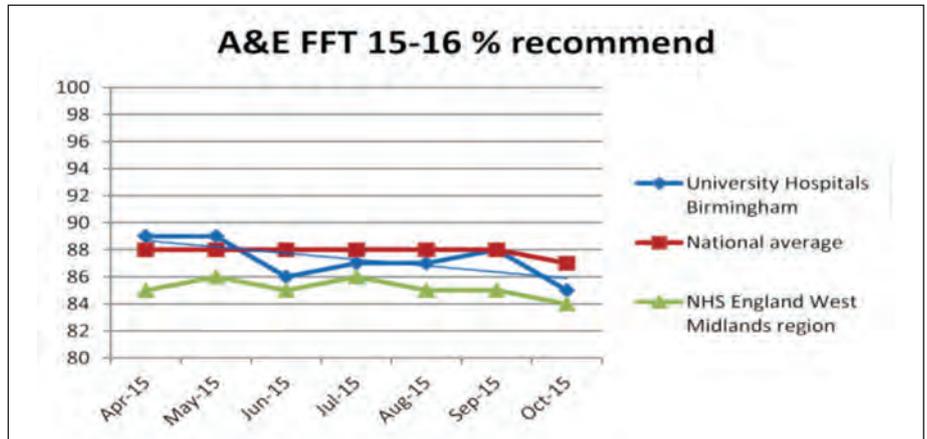
Outpatients: During Quarter 3 2015/16* the Trust positive recommendation rate remains above both national and NHS England West Midlands region recommendation rate.
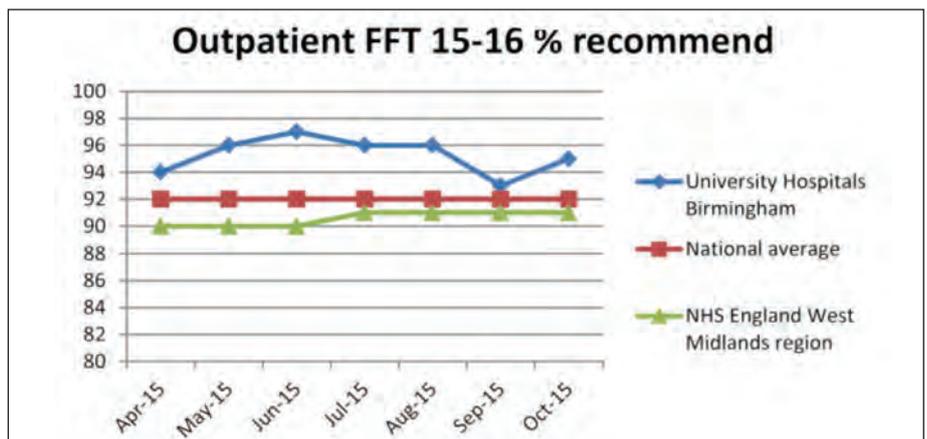
* Please note the data for Quarter 3 2015/16 only includes October 2015 as the full dataset was not available at the time of reporting.

Complaints

The number of formal complaints received in Quarter 3 2015/16 was 175, which was a slight increase on the 169 formal complaints received in Quarter 2. A further 7 complaints were dealt with informally, such as via a telephone call to resolve an appointment issue, without the need for formal investigation.

The top three main subjects of complaints received in Quarter 3 2015/16 were clinical treatment (58), communication and information (17) and attitude of staff (16); largely reflecting the main subjects identified in Quarter 2 2015/16 complaints.

The rate of formal complaints received in Quarter 3 against activity in Inpatients has increased, whilst the rate of formal complaints received against activity in Outpatients and the Emergency Department has decreased, compared to Quarter 2 2015/16.

	2014/15	2015/16 Q1	2015/16 Q2	2015/16 Q3
Total number of formal complaints	**654**	136	169	175

Ratio of formal complaints to activity		2014/15	2015/16 Q1	2015/16 Q2	2015/16 Q3
Inpatients	FCEs*	127,204	31,314	32,730	32,522
	Complaints	371	77	85	94
	Rate per 1000 FCEs	**2.9**	**2.5**	**2.6**	**2.9**
Outpatients	Appointments**	752,965	186,799	194,267	193,693
	Complaints	201	45	59	62
	Rate per 1000 appointments	**0.3**	**0.2**	**0.3**	**0.3**
Emergency Department	Attendances	102,054	26,119	26,604	27,135
	Complaints	82	14	25	18
	Rate per 1000 attendances	**0.8**	**0.5**	**0.94**	**0.66**

* FCE: Finished Consultant Episode. This 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.

Learning from complaints

The table on p13 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
Communication by medical staff with patients and their families	Level of complaints and PALS concerns	Details of trend and specific cases highlighted as part of reports provided to relevant senior Trust groups.	• Issue reviewed in detail at the Trust's multi-disciplinary Communication Skills Group, where the Trust's approach to supporting staff around communication is reviewed and developed. • The Group has a management representative from Medical Education and a Consultant representative. • Case studies from complaints have been discussed in detail at this group. One of the complaints was also discussed at an Executive Root Cause Analysis (RCA) meeting, where issues are critically reviewed by Board members and relevant senior staff. • The RCA outcome was that a senior Consultant who attended the meeting, who also met with the complainant and is a member of the Communication Skills Group, would take the issue of medical staff communication forward in conjunction with the Head of Patient Relations

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	2015/16 Q2	2015/16 Q3
Cases referred to PHSO by complainant for investigation	23	8	1	4
Cases which then required no further investigation	2	0	0	0
Cases which were then referred back to the Trust for further local resolution	1	0	0	0
Cases which were not upheld following review by the PHSO	5	2	1	0
Cases which were partially upheld following review by the PHSO	9	7	2	1
Cases which were fully upheld following review by the PHSO	0	2	0	0

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.

Just one case was partially upheld by the Ombudsman in Quarter 3 2015/16, compared with two in Quarter 2. In this case, the Ombudsman found that the medical team had not given the family a realistic picture of their relative's condition. Consequently, an apology letter was provided to the complainant as requested, informing them that the case had been reviewed at the Trust's Communication Skills Group and at the Patient Safety Group to ensure learning was shared.

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 more compliments in Quarter 3 2015/16 compared to previous quarters. 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	2015/16 Q2	2015/16 Q3
Nursing care	242	42	381	165
Friendliness of staff	142	13	36	22
Treatment received	1,743	317	148	489
Medical care	56	15	24	26
Other	17	3	5	7
Efficiency of service	104	35	91	75
Information provided	12	2	3	7
Facilities	12	0	2	2
Totals:	**2,328**	**427**	**690**	**793**

Examples of compliments received during Quarter 3 2015/16:

"I wish to express my thanks for the care you gave me... In addition to a high level of professionalism, every member of staff showed me great kindness and concern for my comfort" (November 15)

"We wish to express our sincere thanks for the way we have both been treated for our respective illnesses. Professionalism of all staff has been outstanding" (November 15)

"Your staff were very competent but more than that they showed great humanity and compassion... I greatly appreciate the care your staff took of me" (December 15)

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 automatically triggers an early warning score called the SEWS (Standardised Early Warning System) score 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 use 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 analgesia (pain relief medication) following a high pain score. Until December 2015, the pain scale used at UHB went from 0 (no pain) to 3 (severe pain at rest). Whenever a patient scores 3, they should be given analgesia 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.

The new pain scale was introduced in December 2015 which runs from 0 to 10, instead of 0 to 3. A score of 7 or more is now classed as a high pain score.

These two indicators 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 highly for this indicator. 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

	2014/15	Target	2015/16		
			Q1	Q2	Q3
1. Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward	71%	**85%**	75%	81%	81%
2. Analgesia administered within 30 minutes of a high pain score	64%	**80%**	78%	77%	76%

During Quarter 3 2015/16 the first indicator remained at 81%. Performance for the second indicator decreased very slightly during Quarter 3 2015/16 compared to Quarter 2 2015/16, but performance has been steady for the past twelve months.

After the Quarter 1 2015/16 report, the methodology for the second indicator was reviewed in advance of the pain scale change. Baseline 2014/15 performance was higher than previously reported and the target was reviewed accordingly – the target is to achieve 80% by the end of Quarter 4. This was signed off by the Executive Chief Nurse in January 2016.

Performance by month is displayed in the graphs on the right.

Complete Observations and Pain Assessment within 6 hours

Timely Administration of Analgesia

Initiatives to be implemented in 2015/16

Performance is being monitored at ward level, and lower performing wards will be called to Executive Care Omissions Root Cause Analysis meetings for review.

These two indicators will be published in the revised Clinical Dashboard, so wards can see their performance and compare themselves 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	Q1	Q2	Q3
Antibiotics	3.9%	4.0%	4.0% or below	**3.7%**	**3.9%**	**4.1%**
Non-antibiotics	9.3%	10.5%	9.5% or below	**10.0%**	**10.5%**	**10.6%**

Both indicators continue to show a slight decrease in performance compared to Quarter 2 2015/16, and are at a similar level to 2014/15 performance. The graph below shows performance by month for missed antibiotics and non-antibiotics.

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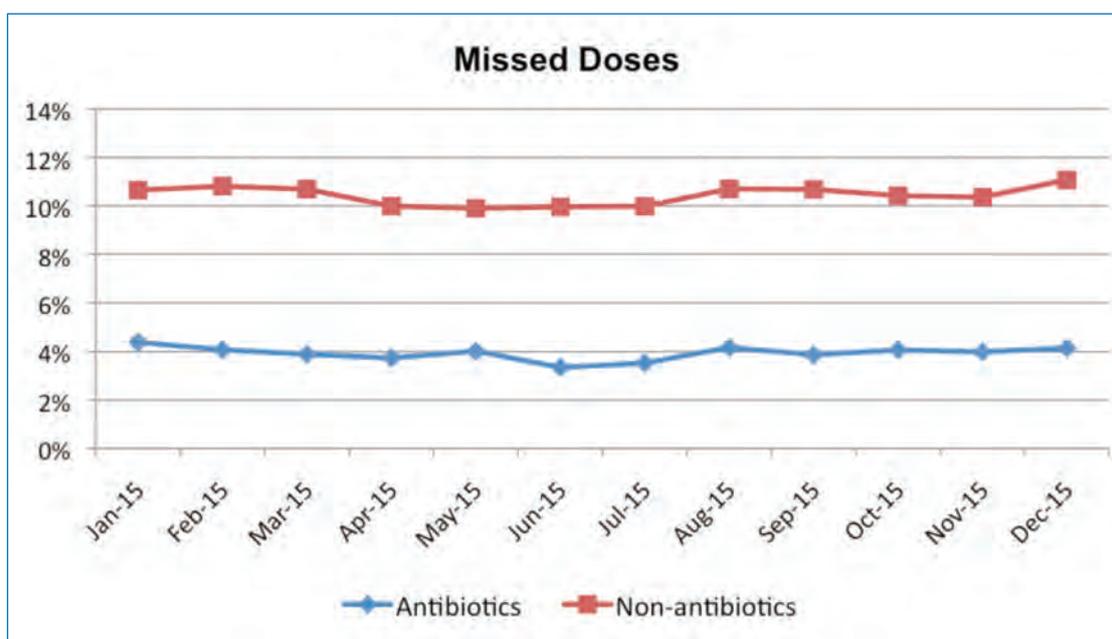
In 2015/16, the Trust is focusing on trying to reduce missed non-antibiotics across the Trust particularly those due to patient refusals, medication being out of stock on the ward and nil by mouth. Wards which perform better than average will be asked to share best practice with others to ensure learning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

Initiatives implemented during 2015/16:

- The Clinical Dashboard has been revised; the updated Missed Doses indicators allow ward staff to view 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 which displays missed doses due to medication being intermittently out of stock.
- Cases identified on this report are 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 3 2015/16, there was one MRSA bacteraemia apportioned to UHB, meaning a total of seven for 2015/16 to date. This compares to six during 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	Q2	Q3	Total
Actual performance	5	5	6	4	2	1	**7**
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 3, there were 21 CDI cases apportioned to UHB. This means there have been 51 CDI cases to date during 2015/16; 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			Total
				Q1	Q2	Q3	
Actual performance	73	80	66	13	17	21	**51**
Agreed annual trajectory	76	56	67	-	-	-	**63**

3. 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 95.24 for the period April to August 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 98.39 for the period April to September 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.

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[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.

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

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
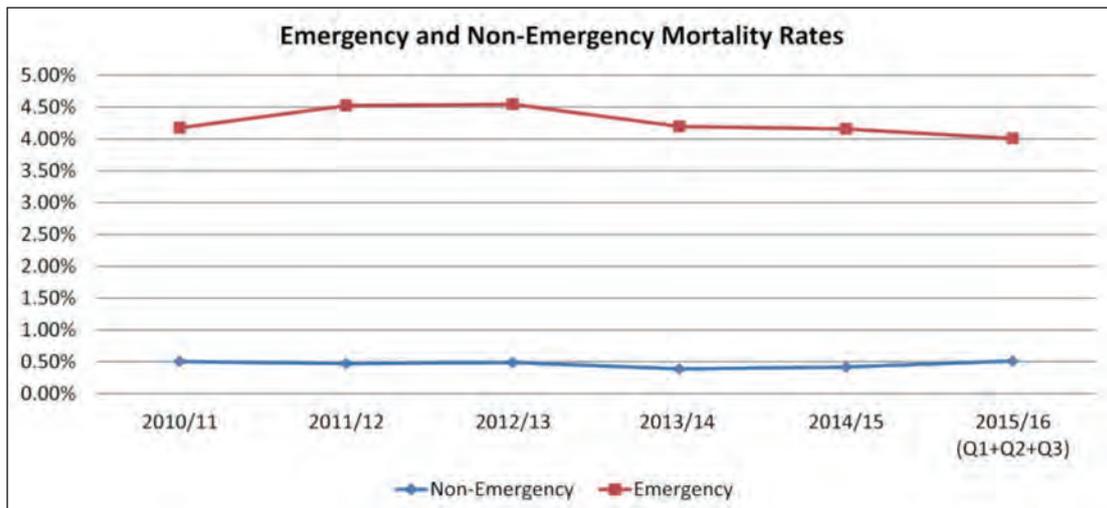
Overall Crude Mortality Graph
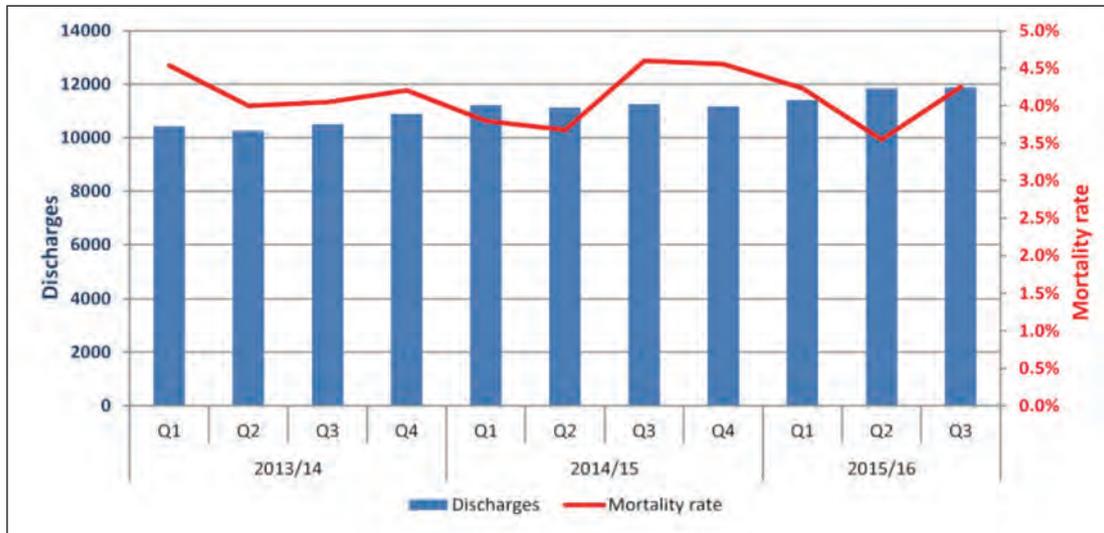
4. Selected Metrics

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	3.04	1.04
Time period	2013/14	2014/15	April – September 2015	April – September 2015
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands
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	3.05	1.21
Time period	2013/14	2014/15	April – September 2015	April – September 2015
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands

Indicator	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**	**15.21**	**14.42**
Time period	2013/14	2014/15	April – September 2015	April – September 2015
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands
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**	**15.28**	**17.58**
Time period	2013/14	2014/15	April – September 2015	April – September 2015
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
3(a) Patient safety incidents (reporting rate per 1000 bed days)	Not available (new measure)	47.2	60.6	37.2
Higher rate indicates better reporting				
Time period		2014/15	April – September 2015	October 2014 – March 2015
Data source(s)		Datix (incident data), Trust admissions data	Datix (incident data), HES data (bed days)	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute (non specialist) hospitals
3(b) Never Events	2	3	2	*Not available*
Lower number indicates better performance				
Time period	2013/14	2014/15	April – December 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%	77.8%	74.3%
Time period	2013/14	2014/15	April – November 2015	October 2014 – March 2015
Data source(s)	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%	0.17%	0.50%
Time period	2013/14	2014/15	April – November 2015	October 2014 – March 2015
Data source(s)	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	12,819	9,566
Time period	2013/14	2014/15	April – November 2015	October 2014 – March 2015
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), 3(a): receipt of HES data from the national team always happens two to three months later, 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 two Never Events in 2015/16:
In Q1 2015/16, 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 are being implemented.
In Q2 2015/16, laser Pan-Retinal Photocoagulation (PRP) treatment (an ophthalmology procedure) was carried out on an incorrect patient. After the procedure had commenced the staff realised and the procedure was stopped immediately. The patient was informed of what happened at the time of the incident and an apology was made. The patient has also since been contacted and informed that an investigation is taking place. There was no immediate harm to the patient, who will be closely monitored in clinic. Immediate precautionary measures have been put in place and the pre-operative checklist is to be adapted.
There were no Never Events reported in Q3 2015/16.

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: 13.85%**	**13.93%**	**13.54 %** **England: 14.37%**
Time period	2013/14	2014/15	April - August 2015	April - August 2015
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(b). Emergency readmissions within 28 days (%) (all specialties) *Lower % indicates better performance*	**12.85%** **England: 12.89%**	**13.52%** **England: 13.23%**	**13.93%**	**13.25%** **England: 13.37%**
Time period	2013/14	2014/15	April - August 2015	April - August 2015
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
5(c). Emergency readmissions within 28 days of discharge (%)	**10.25%**	**10.75%**	**10.72%**	*Not available*
Lower % indicates better performance				
Time period	2013/14	2014/15	April – October 2015	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				
6. Falls (incidents reported as % of patient episodes)	**2.1%**	**2.2%**	**2.0%**	*Not available*
Lower % indicates better performance				
Time period	2013/14	2014/15	April – November 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	*Not available*	**8.5%**	**6.0%**	*Not available*
Lower % indicates better performance				
Time period		2014/15	April – November 2015	
Data source(s)		SSNAP data	SSNAP data	
Peer group				

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**89.0%**	**94.7%**	**97.4%**	*Not available*
Time period	2013/14	2014/15	April – November 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.

Receipt of HES data from the national team always happens two to three months later, 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.

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.