AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 26 APRIL 2012

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

Purpose:	To present the Trust's draft Quality Report for 2011/12 for review.
Confidentiality Level & Reason:	
Medium Term Plan Ref:	1.1 To improve clinical quality outcomes for patients 1.2 To deliver the milestones and targets contained with the Commissioning for Quality and Innovation (CQUIN) indicators and the Quality Report.
Key Issues Summary:	• The Trust's draft Quality Report for 2011/12 is attached in Appendix A for review. • The Board of Directors may wish to supplement the mandatory statements with explanatory wording and/or make changes to the draft content. • The Trust must provide its draft report to NHS South Birmingham and Birmingham LINk by 30 April 2012 for official comment.
Recommendations:	The Board of Directors is asked to: 1. Discuss the proposed content of the Trust's 2011/12 Quality Report 2. Recommend supplementary wording and/or changes to the content 3. Approve the content of the Trust's 2011/12 Quality Report for review by NHS South Birmingham and Birmingham LINk.

Signed:	**Date:** 19 April 2012

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 26 APRIL 2012

DRAFT QUALITY REPORT FOR 2011/12

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. **Introduction**

The aim of this paper is to present the Trust's draft Quality Report for 2011/12 to the Board of Directors for review. The draft report has been produced in line with the guidance from Monitor and the Department of Health (DH) and is presented in Appendix A for review. The draft report will then be provided to NHS South Birmingham and the Birmingham Local Involvement Network (LINk) for review and comments by 30 April 2012.

2. **Mandatory Content**

2.1 The Trust's Quality Report must contain the following information (in order):

Part 1:	Statement on quality from the Chief Executive
Part 2:	Priorities for improvement and statements of assurance from the Board of Directors
Part 3:	Other information on quality
Annex:	Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees.
Annex:	Statement of directors' responsibilities

2.2 As for last year, the Trust has to include a number of mandatory statements in Part 2 of the report, some of which are at odds with the Trust's focused approach to the management of quality. For ease of reference, the content of the draft 2011/12 Quality Report in Appendix A is colour coded as follows:

Black text:	Content decided by the Trust
Blue text:	Mandatory content which requires no further explanation
Red text:	Mandatory statement which the Board of Directors may wish to qualify

2.3 The Trust is required to include detailed information on participation in both national and local clinical audits in Part 2 (section 2.2.2) which has been provided by the Governance Team. As for last year, brief summaries of the actions following **local** and **national** clinical audits are included with a link to the more detailed actions which will be published on the Quality web pages.

2.4 The Board of Directors is requested to consider the mandatory statements in Part 2 of the report and suggest changes to the supplementary wording as necessary.

2.5 The final version of the Trust's 2011/12 Quality Report will be formatted by Medical Illustration before publication in June 2012.

3. The Audience

3.1 In line with the report published by the Audit Commission in January 2012 and advice from audit firms, the format and content of the Trust's 2011/12 Quality Report is consistent with the slightly revised format used last year. This is to try to make the report more accessible to patients and the public. This year's report includes:

- 3.1.1 Expanded section on learning from complaints
- 3.1.2 Examples of compliments received in addition to numbers
- 3.1.3 Some Staff Survey data
- 3.1.4 Summary of Outpatient Survey results
- 3.1.5 Expanded section on Research and Development (R&D) including patient benefits of research
- 3.1.6 Shorter section on national clinical audit actions
- 3.1.7 Shorter section on the specialty quality indicators
- 3.1.8 Percentage of patient safety incidents resulting in severe harm or death
- 3.1.9 Anonymised summary of Never Event

4. 2011/12 Data

The most recent data and information for 2011/12 is included within the draft report. Some of the data will need to be updated and additional information added into the final report which will be presented to the Board of Directors in May 2012 as follows:

Section 2.2.4:	Finalised CQUIN payment information will be available in May/June 2012
Section 3.2:	MRSA, *C.difficile* and readmissions data
Section 3.3:	Performance against the National Priorities for the full 2011/12 year will be available in May 2012
Section 3.12:	An updated Glossary of Terms will be added at the end of the report
Annex 1:	Statements from NHS South Birmingham and the Birmingham LINk will be received in May 2012
Annex 2:	Statement of directors' responsibilities will be completed during the KPMG audit of the Quality Report in May 2012.

5. Specialty Quality Indicators

5.1 As for 2010/11, the draft 2011/12 Quality Report contains a summary of performance for the specialty indicators in Part 3 of the report. Validated data for the full 2011/12 year is expected to ready in time to be tabled at the April 2012 Board of Directors meeting and is therefore not included in the draft report shown in Appendix A.

5.2 The 2011/12 contains a link to the detailed performance data for all indicators which will be made available on the website. A table listing any changes made to indicator methodologies during 2011/12 will also be available on the Quality web pages for completeness.

6. Performance

6.1 The Trust's draft Quality Report for 2011/12 provides performance information for a broad range of quality indicators across the organisation and is not just limited to good performance. The Trust has made improvements in relation to all six quality priorities and a range of other measures. Areas of potential reputational risk in the draft Quality Report for 2011/12 are detailed below:

6.1.1 Mortality

The draft report contains an expanded section on mortality which details the Trust's approach to monitoring mortality (including the Care Quality Commission's methodology for monitoring mortality) and performance for the Summary Hospital Mortality Indicator (SHMI). The Hospital Standardised Mortality Ratio (HSMR) is also included for completeness. Emergency mortality and crude overall mortality have however increased during quarters 3 and 4 2011/12. This is mainly due to the introduction of the Ambulatory Care Clinics during 2012/13 which has reduced the number of emergency admissions and means that the Trust has treated a higher proportion of sicker patients who were more likely to die. The Trust will continue to monitor mortality in a number of ways through the CQMG.

6.1.2 National Audits

The Governance Team has provided the data on the National and Clinical Audits detailed in section 2.2.2 of the draft report. The Trust has not participated in all of the National Audits as agreed at the Clinical Quality Monitoring Group and the Chief Executive's Advisory Group during the year. Participation rates in some of the National Audits are rather low; the Governance Team have plans in place to improve these during 2012/13. Participation rates for the Patient Reported Outcome Measures relating to Groin Hernias and Varicose Rates are particularly poor which means there is no published outcome data available for UHB for 2011/12. The Associate Director of Patient Affairs

will be providing a detailed report to the CQMG in May 2012 where improvement actions will be decided.

6.2 Specialty Quality Indicators

The Trust has improved performance for over 45% of the specialty quality indicators included in the Quality Report during 2011/12, based on performance for the period April 2011-February 2012. Performance has stayed about the same for 37% and deteriorated for 17%. Although this is good news overall and some significant improvements have been delivered, the Trust will need to focus on improving performance for those where performance has not improved or deteriorated. The Informatics and Quality teams are developing a Performance Indicator Framework which will enable potential exceptions to be more robustly identified and reviewed. Indicators where performance is proving particularly challenging to improve will be brought to the Executive Root Cause Analysis (RCA) meetings later in 2012/13 to drive improvements.

7. National Core Set of Quality Indicators

7.1 The Department of Health and Monitor have jointly proposed a national core set of quality indicators for inclusion in trusts' Quality Reports from 2012/13. The Trust had originally intended to include performance for the majority of these indicators in the 2011/12 Quality Report following initial discussion at the Clinical Quality Monitoring Group in March 2012. It is now clear however that the required methodologies conflict with other DH guidance such as for readmissions and published data for the majority of indicators relates to previous years.

7.2 The Trust has therefore included performance in relation to some of these areas – readmissions, mortality and patient safety incidents resulting in severe harm or death – calculated using the Trust's own data and external data where it is available. UHB will take part in the consultation over inclusion of these indicators from 2012/13 to ensure that the methodologies are consistent with other national requirements where possible. The Trust plans to start monitoring performance during 2012/13 and to include a detailed section on these in next year's Quality Report.

8. Next Steps

The content of the Trust's draft Quality Report for 2011/12 will be finalised following the Board of Directors meeting and provided to NHS South Birmingham and Birmingham LINk for review and comment by 30 April 2012. Birmingham City Council Overview and Scrutiny Committee (OSC) has again opted not to provide a comment but will be provided with the Trust's draft report anyway. The Trust's final Quality Report for 2011/12 will be provided to the Board of Directors' meeting in May 2012.

9. Recommendations

The Board of Directors is asked to:

1. Discuss the proposed content of the Trust's 2011/12 Quality Report
2. Approve the supplementary wording and/or changes to the content
3. Approve the content of the Trust's 2011/12 Quality Report for review by NHS South Birmingham and Birmingham LINk.

University Hospitals Birmingham NHS
NHS Foundation Trust

2011/12
Quality Report

This report covers the period 1 April 2011 to 31 March 2012

Contents

Part 1: Chief Executive's Statement

2011/12 has been an exciting year for University Hospitals Birmingham NHS Foundation Trust as the remaining services and departments moved into the new Queen Elizabeth Hospital Birmingham (QEHB). The Trust also took over the provision of Reproductive Sexual Health (RSH) and Genito-Urinary Medicine (GUM) from Heart of Birmingham Teaching Primary Care Trust from 1 April 2011.

The past year has also been a challenging one as the Trust has focused on continuously improving the quality of care it delivers in the new QEHB whilst delivering efficiency savings. This is against the backdrop of the wider economic situation and the Quality, Innovation, Productivity and Prevention (QIPP) programme which aims to improve the quality of care across the NHS whilst making £20billion of efficiency savings by 2014-15. The Trust's Vision is "to deliver the best in care" to our patients. Quality in everything we do supports this Vision in the overall Trust Strategy and the Corporate, Divisional and Specialty Strategies which underpin it. Clinical Quality and Patient Experience are two of the Trust's Core Purposes and provide the framework for the Trust's robust approach to managing quality.

UHB has made very good progress in relation to all six quality improvement priorities for 2011/12 identified in last year's Quality Report: reducing delays in antibiotic delivery; completion of venous thromboembolism (VTE) risk assessments; improving patient experience and satisfaction; completeness of observation sets; reducing medication errors and reducing infection. The Trust has chosen to continue with five of these priorities in 2012/13 to deliver further improvements for our patients.

The Trust's focused approach to quality, based on driving out errors and making small but significant improvements, is driven by innovative and bespoke information systems which allow us to capture and use real-time data in ways which few other UK trusts are able to do. We have expanded our programme of Executive Root Cause Analysis (RCA) meetings over the past year to include a wider range of care omissions which cover all four clinical divisions as well as support services and other areas. Cases are selected for review from a range of sources and include: wards selected for review, missed or delayed drugs, Serious Incidents Requiring Investigation (SIRIs), serious complaints and infection incidents. The Trust will also be including some hospital-acquired grade 3 or 4 pressure ulcers from 2012/13.

A key part of UHB's commitment to quality is being open and honest with our staff, patients and the public, with published information not simply limited to good performance. The Quality web pages provide up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm. A wide range of information was published during 2011/12 including quarterly Quality Report updates, Trust-level patient experience data, performance for specialty level indicators and the A&E Clinical Quality Indicators. The Trust will be using the feedback provided by Members in response to the patient information survey carried out in 2011/12 to drive quality communication strategies over the coming year.

An essential part of driving up quality at UHB continues to be the scrutiny and challenge provided through proper engagement with staff and other stakeholders such as the Trust Council of Governors, the Birmingham Local Involvement Network and Birmingham and Solihull NHS Cluster. Clinical staff have continued to develop and use a wide range of specialty level quality indicators through the Trust's Quality and Outcomes Research Unit (QuORU), some of which are shown in Part 3 of this report. The Trust will continue to work with local Clinical

Commissioning Groups (CCGs) and Birmingham and Solihull NHS Cluster to improve quality and prepare for the new NHS structure led by General Practitioners (GPs) which will come into force in April 2013.

Data quality and the timeliness of data are fundamental aspects of UHB's management of quality. Data is provided to clinical and managerial teams as close to real-time as possible through various means such as the Trust's digital Clinical Dashboard. Information is subject to regular review and challenge at specialty, divisional and Trust levels, by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors for example.

The Trust Board of Directors and Council of Governors have selected patient experience data as the local indicator for review by our external auditors as part of the external assurance of the 2011/12 Quality Report. This indicator has been selected to ensure that UHB provides the same level of rigour to reporting of patient feedback as with other types of information. The Trust's internal auditors will review the performance indicator framework, currently in development, in 2012/13 to ensure that it will enable us to identify and investigate potential performance exceptions for the specialty quality indicators.

On the basis of the processes the Trust has in place for the production of the Quality Report, I can confirm that to the best of my knowledge the information contained within this report is accurate.

Finally, 2012/13 will be another challenging year as the Trust aims to deliver further improvements to quality whilst working with local Clinical Commissioning Groups and Birmingham and Solihull NHS Cluster to deliver efficiency savings and prepare for the new NHS structure which will come into force in April 2013.

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Julie Moore, Chief Executive May 31, 2012

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality Improvement Priorities

2011/12

The Trust's 2010/11 Quality Report 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

The Trust has made good progress in relation to all six quality improvement priorities during 2011/12 with further improvements identified for 2012/13 as described below.

2012/13

The Board of Directors has chosen to continue with five of these improvement priorities for 2012/13 as follows:

Priority 2: Improving VTE prevention
Priority 3: Improve patient experience and satisfaction
Priority 4: Electronic observation chart – completeness of observation sets (to produce an early warning score)
Priority 5: Reducing medication errors (missed doses)
Priority 6: Infection prevention and control

The improvement priorities for 2012/13 were initially selected by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then shared with the Trust's Governors and the Birmingham Local Involvement Network (LINk). The focus of the patient experience priority was decided by the Care Quality Group which is chaired by the Executive Chief Nurse and also has Governor representation. The priorities for 2012/13 were then finally approved by the Board of Directors.

The performance for 2011/12 and the rationale for the changes to the priorities are provided in detail below. This report should be read alongside the Trust's Quality Report for 2010/11.

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

Background

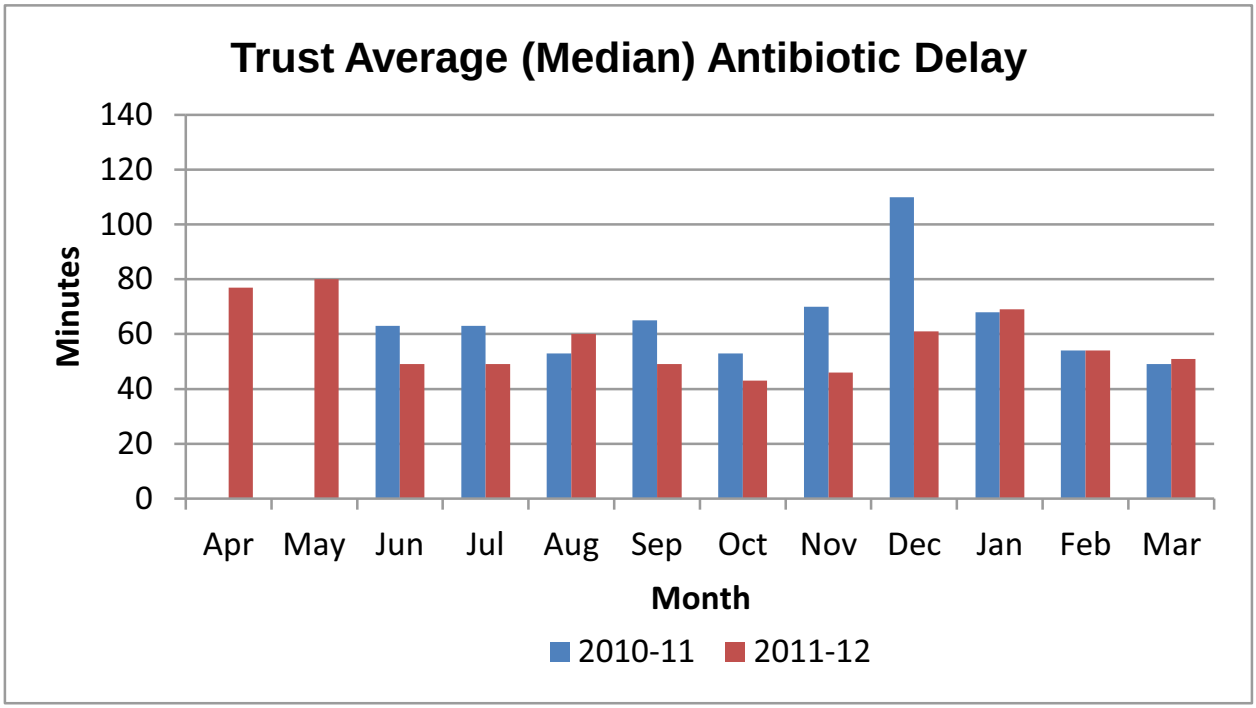
There is evidence within the clinical literature that rapid antibiotic delivery can reduce patient harm and improve outcomes. The recommended time from prescription to administration of first antibiotic dose for certain conditions should ideally be 60 minutes or less.

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 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.

Performance

The graph below shows performance by month for 2010/11 and 2011/12. The Trust has generally performed well against the target time of 60 minutes since June 2011.



Initiatives implemented in 2011/12:

- An antimicrobial stewardship programme has been developed with local commissions and is led by the trust's Antimicrobial Steering Group. The group has a clear work plan to improve

the prescription of antibiotics more generally and includes education for doctors, nurses and pharmacists about the timely provision of antibiotics.

- An electronic ward round tool has been developed to monitor prescribing practice and dosing of antibiotics. This tool extracts data on a daily basis from the Prescribing Information and Communication System on all patients treated with antibiotics so they can be reviewed by Microbiology staff to ensure that appropriate and timely treatment is being provided.
- The time difference between prescribed antibiotics and administration of first doses forms part of the Medicines Management Clinical Dashboard and is routinely reviewed by clinical teams. In addition, outliers are identified for review at the Executive Care Omissions Root Cause Analysis meetings.

Changes to Improvement Priority for 2012/13:

The time from prescription to administration of first antibiotic dose for patients identified as having likely infections remains important but its scope is rather narrow. This is important for all medicines, but a number of new measures are being regularly monitored for particular groups of medicines such as antibiotics, insulin and anti-thrombotic drugs (used to prevent blood clots).

The Trust therefore intends to continue monitoring performance for this indicator but will not be making it an improvement priority for 2012/13. The indicator will be reviewed as soon as the Prescribing and Communication System has been implemented within the Emergency Department and more data becomes available.

Initiatives to be implemented in 2012/13:

- The Antimicrobial Steering Group is going to develop more in-depth reporting from PICS in order to monitor compliance with the antibiotic policy and general usage of antibiotics. This will help prescribers and pharmacy staff to ensure that the right antibiotics are being given to the right patients in the right manner. This will reduce delays due to inappropriate prescribing of non-routine antibiotics which are not widely available in the clinical areas.
- Work will continue regarding the implementation of the Prescribing and Communication System into the Emergency Department.
- A new Patient Information Leaflet has been developed and standards for providing information to patients regarding antibiotics have been set. The plan is to give this to patients in 2012/13 to encourage them to query any delays or other problems with the administration of their medicines.

How progress will be monitored, measured and reported:

- Performance will continue to be measured and monitored at specialty and ward levels using PICS data and the Trust's usual reporting tools.
- Progress will be reported in the quarterly Quality Report updates and monitored by the Clinical Quality Monitoring Group following the implementation of PICS in the Emergency Department.

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

Background

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

preventative measures are taken.

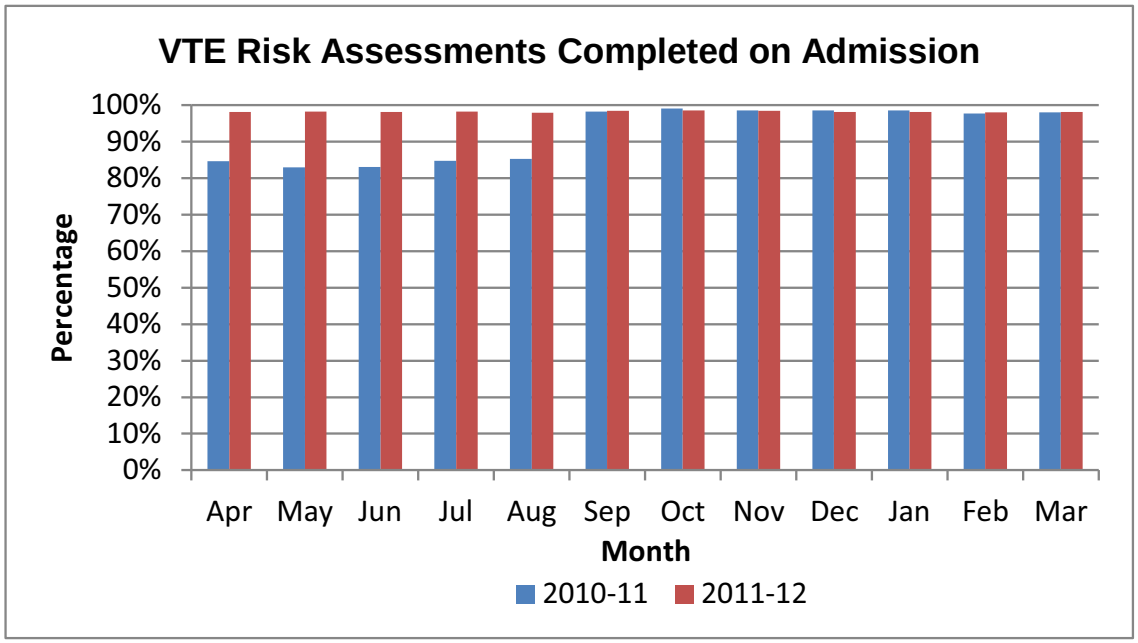
Whilst many other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored 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 CG92). Ambulatory care (day case) admissions have been included in the electronic risk assessment tool since February 2011 as well as all inpatients.

Performance

The graph shows performance by month for 2010/11 and 2011/12. 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 91%*.

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

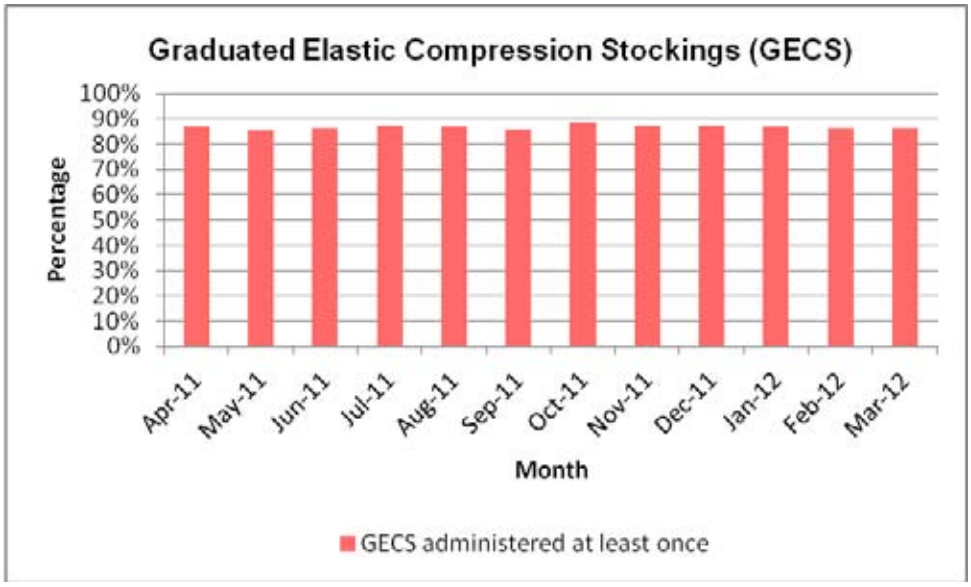


Changes to Improvement Priority for 2012/13:

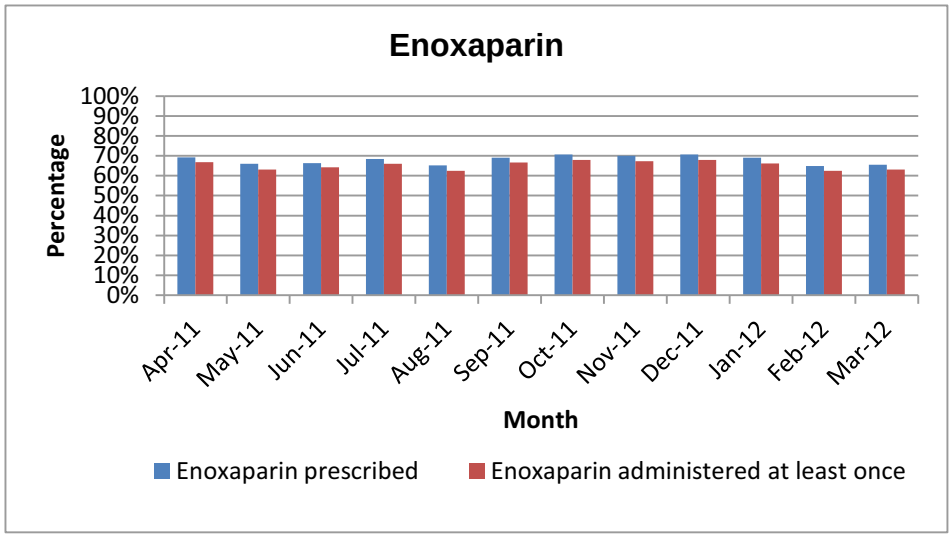
As the Trust has performed consistently highly for completion of VTE risk assessments in 2011/12, the focus of this priority will change to VTE prevention through appropriate administration of preventative (prophylactic) treatment during 2012/13. This includes graduated elastic compression stockings (GECS) and enoxaparin (medication used to reduce the risk of blood clots forming). The Trust will be focusing on improving compliance with the outcomes of completed VTE risk assessments so that a higher percentage of patients receive the preventative treatment they require, particularly pharmacological treatment (Enoxaparin medication).

During 2011/12, the Trust started to regularly monitor whether patients are given VTE prevention treatment, if required, following risk assessment. 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 graduated elastic compression 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. If the outcome of a VTE risk assessment shows that a patient requires GECS, they are automatically prescribed by PICS. It is not always appropriate to administer compression 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.



The table below shows the percentage of patients who required enoxaparin medication following VTE risk assessment and were prescribed it and the percentage who were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Initiatives implemented during 2011/12:

- The Trust's electronic VTE risk assessment tool was revised to take into account the latest NICE guidance.
- Electronic VTE risk assessment was implemented within Ambulatory Care during 2011/12.
- Review of and modifications made to Ambulatory Care risk assessment tool to enhance clinical utility.
- Nurse training on use of compression stockings has been established at induction and through the use of an e-learning package for all nurses to complete to a satisfactory standard.

Initiatives to be implemented in 2012/13:

- Modification of PICS tool to remind clinicians to follow the recommendations of VTE risk assessments.
- Ongoing programme of education for junior doctors through induction, compulsory teaching sessions and the SCRIPT project.
- Revise e-learning tool for nursing staff to coincide with the introduction of a new type of graduated elastic compression stocking.

How progress will be monitored, measured and reported:

- Performance will continue to be measured using PICS VTE risk assessment data.
- The Trust's Thrombosis Group, working closely with the PICS team, will be responsible for providing education and feedback about performance throughout the Trust.
- Performance will be monitored by the Trust's Clinical Quality Monitoring Group and the Board of Directors.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

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.

Performance

Patient Experience Data

Over 23,044 patients responded to the electronic inpatient survey and 618 responded to the discharge survey during 2011/12 providing a wealth of information about their experience. The table below shows the patient experience data collected by UHB during 2010/11 and 2011/12. The survey results show that the Trust has made improvements across a number of areas of patient experience and will continue to focus on delivering improvements, particularly around communication about medication side effects, during the coming year. The Trust's latest National Adult Inpatient Survey and Outpatient Department Survey results are shown in Part 3 of this report.

		Performance					
Question	**Answer**	**2010/11**	**2011/12**	**Q1 2011/12**	**Q2 2011/12**	**Q3 2011/12**	**Q4 2011/12**
1. Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	73.4%	77.3%	76.6%	77.9%	76.3%	77.8%
	Yes, to some extent	20.9%	17.8%	18.8%	16.5%	18.1%	17.9%
	No	5.8%	4.8%	4.5%	5.5%	5.6%	4.3%
2. Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely	60.8%	67.2%	64.0%	66.4%	67.3%	69.6%
	Yes, to some extent	27.5%	22.5%	25.2%	22.1%	22.9%	21.1%
	No	11.8%	10.3%	10.8%	11.5%	9.8%	9.3%
3. Were you given enough privacy when discussing your care and treatment?	Yes, always	87.4%	89.6%	90.0%	89.8%	88.6%	89.7%
	Yes, sometimes	10.6%	8.4%	8.4%	8.1%	9.1%	8.3%
	No	2.0%	2.0%	1.6%	2.1%	2.3%	2.0%
4. Do you think that hospital staff do all they can to help control your pain?	Yes, definitely	80.8%	83.3%	83.9%	83.1%	82.9%	83.2%
	Yes, to some extent	16.0%	14.3%	14.2%	14.1%	14.1%	14.4%
	No	3.1%	2.4%	1.9%	2.8%	2.9%	2.4%
5. Did a member of staff tell you about medication side effects to watch for when you went home?	Yes, completely	60.3%	46.2%	*Not enough data**	48.4%	41.0%	46.3%
	Yes, to some extent	12.2%	8.5%		8.3%	12.0%	7.3%
	No	27.5%	45.3%		43.3%	47.0%	46.3%
6. Did hospital staff tell you who to contact if you were worried about your	Yes	88.9%	72.8%	*Not enough data**	70.8%	73.5%	76.1%
	No	11.1%	27.2%		29.2%	26.5%	23.9%

condition or treatment after you left hospital?							
7. Overall how would rate the hospital food you have received?	Excellent	Data collection for these questions began in April 2011	20.5%	17.7%	20.9%	21.4%	21.3%
	Very good		27.8%	27.9%	29.0%	27.0%	27.6%
	Good		26.9%	29.3%	26.2%	27.3%	25.9%
	Fair		16.7%	16.6%	16.1%	16.8%	16.6%
	Poor		8.1%	8.5%	7.8%	7.5%	8.6%
8. Have you been bothered by noise at night from hospital staff?	No, never		66.2%	65.2%	67.2%	66.1%	66.1%
	Yes, occasionally		28.0%	28.6%	27.2%	28.2%	27.8%
	Yes, often		5.8%	6.2%	5.5%	5.7%	6.0%
9. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never		70.1%	69.0%	70.4%	68.1%	71.9%
	Yes, sometimes		24.3%	25.7%	23.7%	26.2%	22.1%
	Yes, often		5.6%	5.2%	5.9%	5.8%	6.0%

Note on Patient Experience Data

Data for questions 2-4 was collected from June 2010, data for questions 5-6 was collected from August 2010 and data for questions 7-9 was collected from April 2011.

Initiatives implemented in 2011/12:

- Following an audit of noise at night, involving all inpatient areas of the Trust, a set of good practice guidelines for staff and for patients were introduced. These were developed in collaboration with members of the Trust Patient and Carer Councils.

- Satisfaction with food has been monitored by use of a survey on the back of the patient menu card. These results have been benchmarked against the results of the last National Patient Survey and put the Trust in the top 20% of NHS Trusts. Information from the survey system has been used to highlight improvements at individual ward level.

- The Patient Experience Champion Programme was launched and currently has 219 champions registered which include Patient and Carer Council representatives. An education programme for champions commenced in the Autumn and has evaluated well. The programme will continue to recruit new champions and is supported by future planned education days.

- On-line patient experience surveys were developed and tested by members of the Patient & Carer Councils. They went live on our website in March 2012, giving patients another method to provide feedback on the care and services provided.

- A Patient and Carer Council for Mystery Shoppers was established in June 2011, and a programme of Mystery Shopper visits commenced in July 2011, which have evaluated well. Members have worked with the Customer Care Facilitator to develop standards for Receptionists. The shoppers have undertaken benchmarking visits to Reception areas, and will repeat the visits following implementation of the standards.

- Following feedback from carers, a set of Principles to Support Carers were developed by the Carers Advisory Group which included Patient and Carer Council members, a Governor and representatives of Birmingham Carers Association. The principles were launched in February 2012 and will form the basis of an educational programme for staff to improve the experience of carers. This Trust won an award for this work at the 2011 National Patient Experience Network Awards.

- A patient experience questionnaire has been introduced in the Emergency Department to gain feedback from patients. The responses are fed into the Trust electronic system, which will allow performance to be viewed by staff on the Clinical Dashboard.

Changing to Improvement Priority for 2012/13:

The Trust has chosen to continue with the same questions in 2012/13 to deliver further improvements plus one new local question:

- Do you think that the ward staff do all they can to help you rest and sleep at night?

As in previous years, the questions were selected by the Trust's Care Quality Group which has Governor representation and then approved by the Board of Directors. These questions will also form part of the national Commissioning for Quality and Innovation (CQUIN) patient experience indicator for 2012/13.

Initiatives to be implemented in 2012/13:

- The Patient Experience Champion Programme will be expanded to include outpatient areas, imaging and non-clinical support services.
- The Mystery Shopping programme will be extended to include monitoring of the Trust switchboard and restaurant services.
- The Friends and Family question (net promoter) will be included in all patient surveys.
- A method of gaining feedback from outpatients prior to leaving the department will be developed.
- The Complaints Department and Patient Advice and Liaison Service (PALS) will be integrated to improve efficiency in dealing with concerns from patients and relatives.
- In response to feedback from patients, an electric golf buggy will be implemented to transport patients and visitors with mobility difficulties from the car park to the hospital entrance.

How progress will be monitored, measured and reported:

- Feedback rates and responses will continue to be measured and communicated via the Clinical Dashboard.
- Performance will continue to be monitored as part of the Back to the Floor visits by 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 and via the Mystery Shopper visits
- Regular patient experience reports will be provided to the Care Quality Group and to the Board of Directors.
- Progress will also be reported via a quarterly Quality report update published on the Trust quality web pages.

Complaints

The number of complaints received in 2011/12 was 797, which represents a reduction of more than 5% compared to the previous year.

	2008/09	2009/10	2010/11	2011/12
Total number of complaints	609	643	840	797

Top 3 main subjects of complaints	2008/09	2009/10	2010/11	2011/12
Clinical treatment	254	272	390	373
Outpatient appointment delay/cancellation	97	109	116	100
Attitude of staff			88	
Inpatient appointment delay/cancellation				81
Communication and information	69	76		

Ratio of complaints to activity	2008/09	2009/10	2010/11	2011/12

Inpatients	FCEs*	121653	124589	123139	118504
	Complaints	294	277	444	434
	Rate per 100 FCEs	**0.24**	**0.22**	**0.36**	**0.37**
Outpatients	Appointments**	466798	499981	517516	544876
	Complaints	263	309	312	289
	Rate per 100 appointments	**0.06**	**0.06**	**0.06**	**0.05**
A&E	Attendances	83051	82632	82925	87744
	Complaints	52	57	84	72
	Rate per 100 attendances	**0.06**	**0.07**	**0.10**	**0.08**

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant.
** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech and Language Therapy and Occupational Therapy). Outpatient activity data increased during 2011/12 as UHB took over the provision of the

Learning from complaints

The table below provides examples of how the Trust has responded to complaints where, serious issues have been raised or where we have received a number of complaints about the same or similar issues or same location.

Theme	Area of Concern	Action taken	Outcome
Attitude of staff	Attitude of some members of Trust staff on occasion.	Appointed Customer Care Facilitator in January 2011. Customer Care training sessions delivered to over 2000 staff in 2011/12.	Number and ratio of complaints received highlighting staff attitude reduced in 2011/12 compared to 2010/11.
Outpatient appointment delay/ cancellation	Delays in Cardiology Outpatient clinic.	Review identified underlying issues causing the delays. Changes made to clinic booking process.	Clinic delays reduced and no further complaints received about these issues after changes made.
Clinical Treatment/ Communication	Care, treatment and attitude on a surgical ward	Following an Executive Governance Visit carried out by the Trust and complaints received, the following actions were implemented: Complainant invited to talk directly with ward staff about their experience. Team-based care introduced. Communication sheet at the end of every patient's bed prompting patient/relatives to talk to staff about concerns	Complaints about this ward have reduced and the ward's performance in key areas has improved, evidenced by data on the Trust's Clinical Dashboard.

Inpatient appointment delay/ cancellation	Cancellation of operations at weekends at short notice due to theatre staff not being available.	A positive check was introduced to confirm that all necessary staff were available prior to theatre slots being released.	No further complaints were received about this specific issue since the change was implemented.

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.

Serious Complaints

The Trust uses a risk matrix to assess the seriousness of every complaint on receipt. Those deemed most serious, which score either 4 or 5 for consequence on a 5 point scale, are highlighted separately across the Trust. Serious complaints are reported to the Board via the Audit Committee, to the PCT, to the Chief Executive's Advisory Group and to the Divisional Management Teams at their Divisional Clinical Quality Group meetings. It is the Divisional Management Team's responsibility to ensure that following investigation of the complaint, appropriate actions are put in place to ensure learning takes place and every effort is made to prevent a recurrence of the situation or issue which triggered the complaint being considered 'serious'.

Independent reviews

In 2011/12, a total of 16 cases were referred to the Parliamentary and Health Service Ombudsman for independent investigation at the request of the complainant, the same number that was referred in 2010/11.

During 2011/12, the Ombudsman determined that no further investigation was required by them in 8 cases, whilst the outcome of their investigation is still awaited in 6 cases. In another case the Ombudsman has suspended the investigation, pending the outcome of an associated Inquest by HM Coroner. A final case was referred back to the Trust for further investigation and local resolution, the outcome of which, the Ombudsman was satisfied with.

During the full year, the Ombudsman partially upheld one complaint, which had originally been received by the Trust in January 2009 and was subsequently received by the Ombudsman for investigation in September 2010. Their final report upholding the complaint was received in July 2011, which partially upheld the complaint due to maladministration, partly relating to aspects of the Trust's complaints handling procedures. Since the time of receipt of the original complaint, the Trust had revised aspects of its complaints handling procedures, which had addressed issues highlighted in the Ombudsman's report. Significant action had also been taken in response to the other issues highlighted in the original complaint, which were around the Trust's provision of spinal services.

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	**2008/09**	**2009/2010**	**2010/11**	**2011/12**
Nursing care	11	92	310	**603**
Friendliness of staff	26	76	306	**492**
Treatment received	142	130	251	**300**
Medical care	9	21	122	**389**
Other	3	4	54	**20**
Efficiency of service	8	37	47	**123**
Information provided	1	3	17	**16**
Facilities	11	4	9	**17**
Totals:	**211**	**367**	**1116**	**1960**

Examples of Compliments received during 2011-12

Date received	**Compliment (Anonymised)**
April 2011	I will remember the great gift I have been given now my life has endless possibilities. Thank you for your care, compassion & profession conduct. Its appreciated.
May 2011	The treatment and service received was outstanding. From the receptionist, to the nurse in charge…to the final surgeon and theatre staff they were all very attentive efficient and caring. He received first class treatment from start to finish, many thanks to all concerned.
July 11	Thanking staff for amazing standard of care, support, understanding, dedication and professionalism.
Aug 2011	The care he received was excellent, he felt all his needs were met and staff treated him with respect and dignity.
Oct 2011	Thank you for all the wonderful care and attention given to me on Ward X when I was treated with breathing problems. Everyone I came in contact with gave me 100% when it came to care and nursing skills; everyone was so friendly and made me feel welcome.
Nov 11	To all the doctors & nurses, thanks for all the dedicated services that you've shown to my son may your hard work be rewarded as you carry on, kindness is a gift that people are always grateful to receive thank you so much.
Nov 2011	From the moment I stepped into the hospital, to moment I left I could not have received better care anywhere and would like to thank all the staff from the doctors, nurses. I compare the QE to a 5 star hotel.
Dec 2011	We would like to express our heartfelt thank and appreciation for all the help and support that you all provided for our mother. We know that she felt very safe and happy in your care and this made her last weeks in your care and this made her last weeks easier for all of us to bear. She told us how much she liked you all and that you made her laugh. Thank you from all of us for

	treating our mother with such kindness and dignity
Jan 2012	Thanking all staff and those behind the scenes who helped deliver my…..treatment over the past years. The QEHB is clearly the place to be! Much impressed and appreciate the highly professional, calm and sensitive approach of all staff.
March 2012	First class treatment, our heartfelt gratitude for the wonderful way you cared for me.

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 forwarded to the relevant service/department manager for information and action. A response is posted to each comment received acknowledging the comment and providing generic 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. The number of comments posted on each of these two websites continues to be extremely low in comparison to other methods of feedback received.

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

Background

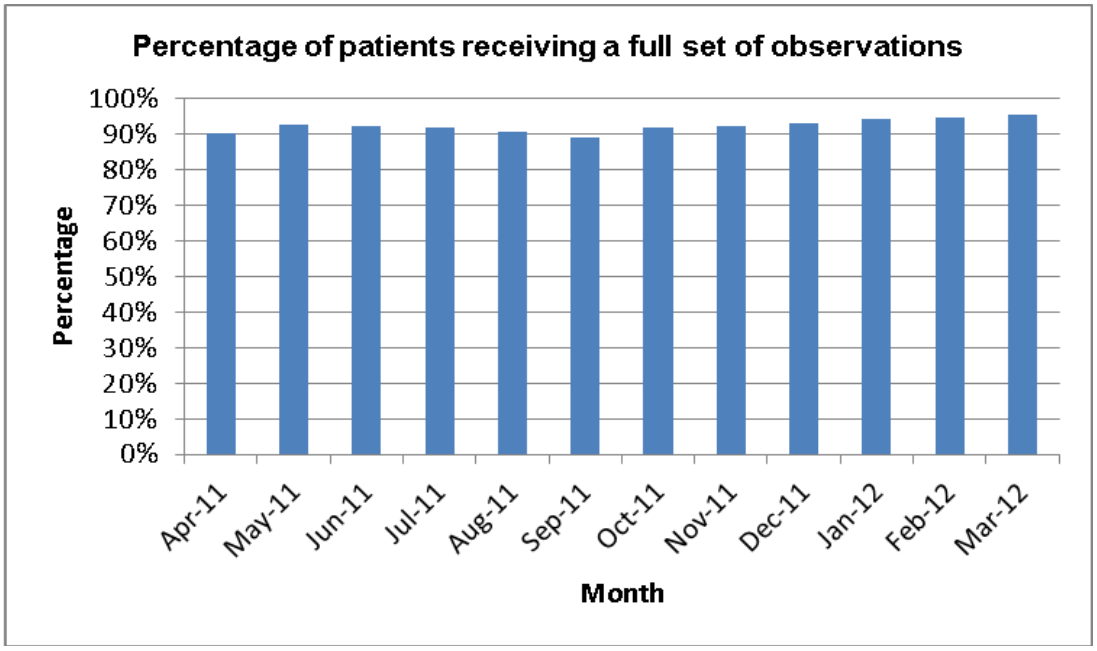
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool enables an early warning score called the SEWS (Standardised Early Warning System) score to be triggered automatically if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible. This indicator measures the percentage of patients who receive at least one full set of observations in a 24-hour period.

The Trust completed the roll out of the electronic observation chart to the remaining wards during 2011/12 so all inpatient wards are now recording patient observations electronically. The four Critical Care areas have very different requirements for recording observations compared to the inpatient wards so do not currently record these on the standard electronic observation chart in PICS. There is a plan to develop a specific and detailed electronic observation chart for Critical Care in the future.

Performance in 2011/12

The Trust's baseline performance was 79% for 2010/11 for the wards which were using the electronic observation chart in PICS. The Trust was 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. The Trust has improved performance significantly during 2011/12 with 95.4% of all inpatients receiving at least one full set of observations in March 2012:



Initiatives implemented in 2011/12:

- The roll out of the electronic observation chart to all remaining inpatient general acute beds was completed.
- This indicator was added to the Clinical Dashboard to enable clinical staff to monitor and benchmark performance against other similar wards.
- A dedicated Task and Finish Group was set up to monitor and resolves issues around non-completion of observations.

Changes to Improvement Priority for 2012/13:

The Trust is now aiming for at least 98% of all observation sets to be complete for all inpatient wards by the end of 2012/13.

Initiatives to be implemented in 2012/13:

- Next phase roll-out plan being developed to include other areas such as Dialysis Unit, Coronary Care and Endoscopy.
- Analysis of data to find out where missing or incomplete observations are occurring to identify reasons for this and implement mitigating actions.
- Identification of areas that have high levels of agency/bank staff to understand whether this may impact on performance for this indicator.
- Identify and address any training requirements.
- Development of central training record for all types of Prescribing and Information Communication System (PICS) training.

How progress will be monitored, measured and reported:

- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and other reporting tools.
- Performance will continue to be measured using PICS data from the electronic observation charts.
- Progress will be reported monthly to the Clinical Quality Monitoring Group and the Board of Directors in the performance report. In addition, performance will be publicly reported publicly through the quarterly Quality Report updates on the Trust's website.

Ongoing Priorities

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

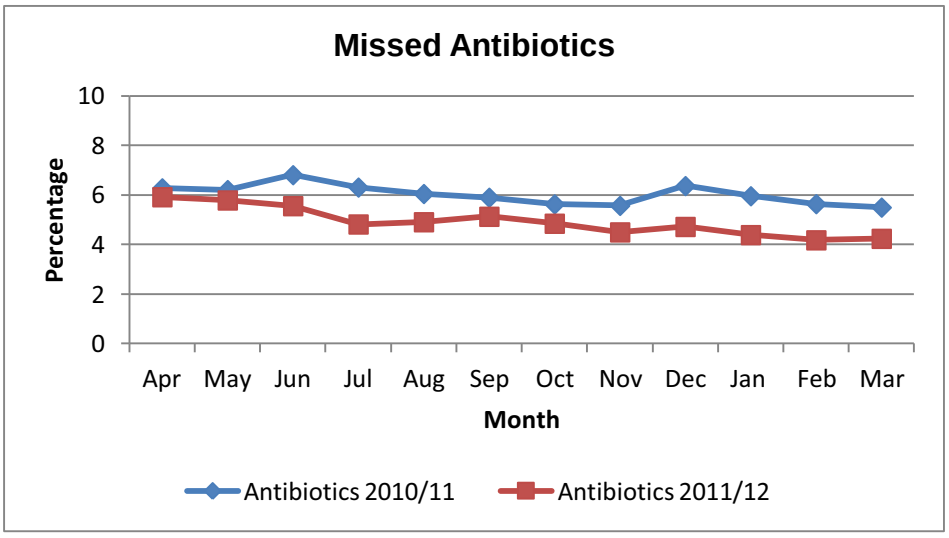
Background

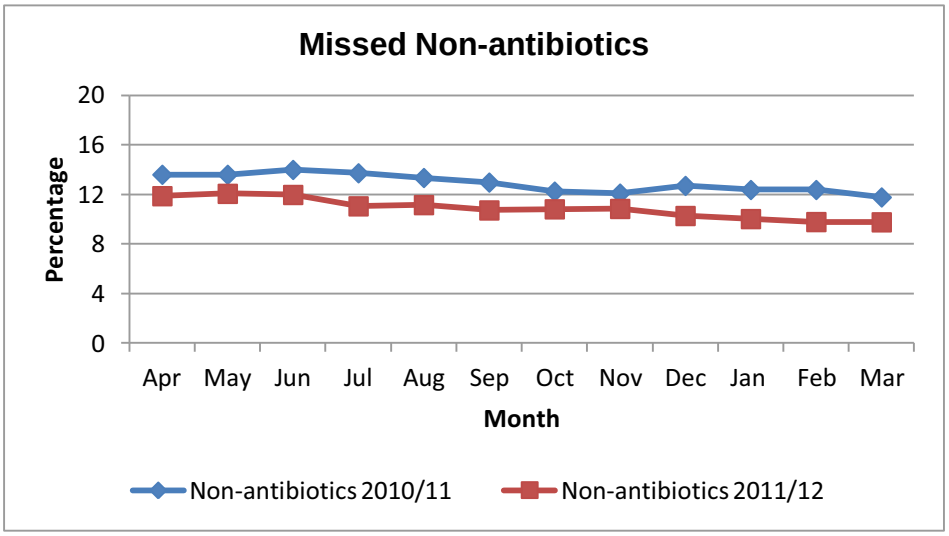
Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System.

The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive root cause analysis (RCA) meetings were introduced at the end of March 2010.

Performance

The graphs show that the Trust has made further reductions in the percentage of omitted antibiotic and non-antibiotic drug doses during 2011/12, 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.





Initiatives implemented during 2011/12:

- Targets for reducing omitted antibiotics and non-antibiotics were reviewed in 2011/12 to ensure they remained challenging on the Clinical Dashboard, in the absence of any national agreement on an acceptable omitted dose rate.
- Monthly Executive Care Omissions Root Cause Analysis (RCA) meetings were expanded during 2011/12, covering a wide range of omitted/delayed drugs and associated medication issues, with greater input from Pharmacy and other support services.
- The Trust has focused on improving the consistency of prescribing practice, particularly amongst junior doctors, through the Junior Doctor Monitoring Tool and dedicated Consultant support.

Changes to Improvement Priority for 2012/13:

The Trust will again be reviewing the reduction targets for antibiotics and non-antibiotics to drive further improvements in 2011/12, with a greater focus on reducing avoidable non-antibiotic missed doses through appropriate prescribing and administration.

Initiatives to be implemented in 2012/13:

- Themes from the omitted/delayed drug cases which were reviewed at Executive Care Omissions RCA meetings during 2011/12 will be reviewed to ensure that the learning is shared and implemented across the Trust.
- Focused education programmes for specific conditions such as Diabetes will be provided to medical and nursing staff to improve performance in insulin management across the Trust for example.
- Enhanced monitoring of prescribing practice, particularly by new cohorts of junior doctors, will be implemented alongside additional Consultant support to review performance and share learning.

How progress will be monitored, measured and reported:

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System. This includes automatic email alerts to different levels of management staff where specialty performance is outside agreed targets.

- Omitted drug doses will continue to be communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level) and monitored at divisional, specialty and ward levels.
- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken.
- Progress will also be reported in the quarterly Quality Report updates published on the Trust's quality web pages.

Priority 6: Infection prevention and control

Performance in 2011/12

The Trust ended the year under the agreed national trajectories for *C. difficile* infection and MRSA bacteraemia. This has been achieved through a continued focus on improving clinical management of patients with identified or suspected infection. In addition, the Trust commenced mandatory reporting for *Staphylococcus aureus* (MSSA) bacteraemias and *Escherichia coli* (*E. coli*) bacteraemia and introduced an extensive surveillance programme to support ongoing clinical improvement across the organisation.

Time Period/ Infection Type	**2008/09**	**2009/10**	**2010/11**	**2011/12**
***C. difficile* infection (post-48 hour cases)**	357 (526)	178 (348)	145 (164)	85 (114)
MRSA bloodstream infections	35 (48)	13 (30)	11 (11)	4* (7)

* The number shown reflects agreement made following a PCT expert panel review that one case would not be attributed to UHB.

Initiatives implemented in 2011/12:

- The Trust commenced mandatory reporting for meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias and *Escherichia coli* (*E. coli*) bacteraemia in accordance with the Department of Health requirements.

- The Trust has convened a multi-disciplinary Task and Finish Group chaired by the Deputy Medical Director to support a reduction in surgical site infection. The group has focused on reviewing current practices that may influence the development of post-operative surgical site infection.
- The Trust is developing an electronic solution within PICS to enable better data capture and surveillance urinary catheter usage and subsequent urinary tract infections,
- The Trust has implemented a new 'closed system' for blood collection across the organisation which has been shown to reduce the incidence of contamination.
- The Trust places great emphasis on the good management of all invasive devices and is developing an electronic solution to enable surveillance of all vascular invasive devices and any subsequent infections associated with them.
- All infection incidents are subject to investigation using root cause analysis and there is an established programme of Executive review at the Executive RCA meetings.

Changes to Improvement Priority for 2012/13:

While much of this work will continue in the coming year, the agreed trajectories for MRSA and CDI in 2012/13 are very challenging and will require innovative management to maintain the momentum of improvement.

Initiatives to be implemented in 2012/13:

- Implement a two-stage laboratory diagnostic test for the detection of toxigenic *Clostridium difficile* in line with the latest Department of Health guidance on CDI testing.
- Maintain improvements in patient safety through a robust Infection Prevention and Control surveillance programme. This will include all alert organisms, surgical site infection, urinary catheter associated infection, incidence of blood culture contamination and the identification and management of multi-drug resistant microorganisms.
- Undertake monthly prevalence audit of urinary tract infections as part of the nationally agreed CQUIN (Commissioning for Quality and Innovation) indicator.
- Continue to minimise the risk from healthcare associated infections to patients through better management of invasive devices.

How progress will be monitored, measured and reported:

- The number of MRSA bacteraemia and *C. difficile* infection will be submitted monthly to the Health Protection Agency and measured against the 2012/13 trajectories.
- Performance will be monitored daily via the Clinical Dashboard. Performance data will be discussed monthly at the Board of Directors, Chief Executive's Advisory Group and Infection Prevention and Control Committee meetings.
- All MRSA bacteraemias and CDI deaths will be reported as serious incidents requiring investigation (SIRIs) to NHS South Birmingham and Solihull Cluster.
- Root cause analysis will continue to be undertaken for all MRSA bacteraemias and CDI cases.
- Progress against the Trust IP&C delivery plan will be submitted quarterly to the Board of Directors and shared with Commissioners.

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2011/12 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 63 NHS services.

The Trust has reviewed all the data available to them on the quality of care in 63 of these NHS services**.

The income generated by the NHS services reviewed in 2011/12 represents 100% per cent of the total income generated from the provision of NHS services by the Trust for 2011/12.

In line with the Transforming Community Services Programme, the Trust took over responsibility for the provision of Reproductive Sexual Health (RSH) and Genito-Urinary Medicine (GUM) from Heart of Birmingham Teaching Primary Care Trust as of 1 April 2011.

* University Hospitals Birmingham NHS Foundation Trust will be referred to as the Trust/UHB in the rest of the report.

** The Trust has appropriately reviewed the data available on the quality of care for all its services. Due to the sheer volume of electronic data the Trust holds in various information systems, this means that UHB uses automated systems and processes to prioritise which data on the quality of care should be reviewed and reported on. These are described further in Part 3 of this report.

Data is reviewed and acted upon by clinical and managerial staff at specialty, divisional and Trust levels by various groups including the Clinical Quality Monitoring Group chaired by the Executive Medical Director.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2011/12, 47 national clinical audits and 3 national confidential enquiries covered NHS services that UHB provides.

During that period UHB participated in 74% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2011/12 are as follows: (see tables below)

The national clinical audits and national confidential enquiries that UHB participated in during 2011/12 are as follows: (see table below)

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (See tables below).

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme	IBD (Inflammatory Bowel Disease) Audit	Yes	62.5%
	IBD - Biologics Audit	Yes	N/A no required case target
	IBD – inpatient Experience Questionnaire	Yes	N/A no required case target
	Oesophago-gastric (stomach) Cancer	Yes	Data will be submitted by the October 2012 deadline.
	Bowel cancer (NBOCAP)	Yes	100%
	Adult cardiac surgery	Yes	100%
	Heart failure	Yes	126.3% (submitted more than the required number of cases)
	Adult cardiac interventions (e.g., angioplasty)	Yes	100%
	Myocardial Infarction (MINAP)	Yes	N/A no required case target

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
	Cardiac rhythm management (Pacing / Implantable Defibrillators)	Yes	100%
	Congenital heart disease (children and adults) / Paediatric cardiac surgery	Yes	100%
	Carotid Endarterectomy Audit	Yes	42%
	National Lung Cancer Audit	Yes	100%
	National Diabetes Audit	Yes	32%
	National Diabetes Inpatient Audit (NaDIA)	Yes	N/A no required case target
	Pain Database Audit	Yes	N/A organisational questionnaire completed only
	National Audit of Continence Care (pilot)	Yes	0% - Audit form not appropriate for an acute trust
	Head and Neck Cancer (DAHNO)	Yes	100%
	Hip Fracture Database	Yes	100%
	SINAP	No	N/A

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
Not part of the National Clinical Audit and Patient Outcomes Programme	Renal Registry – Renal Replacement Therapy	N/A	N/A. Deadline for 2011/12 data submission not yet known.
	UK Transplant registry: 1. Cardiothoracic	Yes	100%
	UK Transplant registry: 2. Liver	Yes	100%
	UK Transplant registry: 3. Kidney	Yes	100%
	National Vascular Database (NVD) Abdominal Aortic Aneurysm – AAA	Yes	19%
	National Vascular Database (NVD) Amputation	Yes	N/A no required case target
	National Vascular Database (NVD) Infrainguinal Bypass Surgery - IIB	Yes	N/A no required case target
	National Vascular Database (NVD) AAA Turn down audit	No	0%
	National Vascular Database	Yes but not	100%

Audit type	Audit UHB eligible to participate in	UHB participation 2011-12	Percentage of required number of cases submitted
	(NVD) AAA – Mortality	accredited.	
	National Cardiac Arrest Audit	No	N/A
	ICNARC - Adult Critical Care Case Mix Programme	Yes	100%
	National Elective Surgery Patient Reported Outcome Measures (PROMS): Groin hernia	Yes	April-11 to Sept-11 Pre-operative questionnaire participation by patients: 3%* Post-operative questionnaire participation by patients: Not available due to low number of responses*
	National Elective Surgery Patient Reported Outcome Measures (PROMS): Varicose Veins	Yes	April-11 to Sept-11 Pre-operative questionnaire participation by patients: Not available due to low number of responses* Post-operative questionnaire participation by patients: Not available due to low number of responses*
	Potential Donor Audit	Yes	100%
	BTS Adult Asthma	Yes	600% (submitted more than the required number of cases)
	BTS Emergency Oxygen	Yes	N/A - no required case target
	BTS Pleural Procedures	Yes	317% (submitted more than the required number of cases)
	BTS Adult Community Acquired Pneumonia	No	N/A
	BTS Non-Invasive Ventilation	Yes	147% (submitted more than the required number of cases)
	BTS Bronchiectasis	Yes	350% (submitted more than the required number of cases)
	CEM Sepsis	No	N/A
	CEM Pain in Children	No	N/A
	Parkinson's Audit	Yes	100%
	Severe Trauma - TARN (Trauma Audit and Research Network)	Yes	100%
	NASH National Audit of Seizure Management in Hospitals	No	N/A
	National Care of the Dying Audit Hospitals	No	N/A
	National Health Promotion in Hospitals Audit (NHPH)	No	N/A

* Data is only available on the Information Centre website until September 2011. The Trust focused on raising the pre-operative response rate durin1g the second half of 2011/12 so an improvement is expected once the full year data is finally published.

National Confidential Enquiries

National Confidential Enquiries	UHB participation 2011-12	Percentage of required number of cases submitted
Bariatric Surgery	Yes	N/A
Cardiac Arrest Procedures	Yes	100%
Peri-operative Care	Yes	100%

Percentages given are the latest available figures.

The reports of 32 national clinical audits were reviewed by the provider in 2011/12 and UHB intends to take the following actions to improve the quality of healthcare provided:

Actions reported from national clinical audits include measures such as:

- Education and knowledge;
- Undertaking additional local clinical audit
- Review or development of care plans, guidance and procedures
- Continued review of data quality and use of data for benchmarking purposes
- Review or development of patient information leaflets.

The Trust will also be focusing on improving the pre-operative questionnaire response rate for the National Patient Reported Outcome Measures for groin hernia and varicose vein procedures during 2012/13. This should in turn help to improve the post-operative questionnaire response rate.

A list of examples of specific actions for individual national clinical audits can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm.

At UHB a wide range of local clinical audit is undertaken in clinical specialties and across the Trust. These may be highly specialised audits examining whether treatments or services for specific medical conditions, such as diabetes, are meeting standards of best practice; or they may be broader audits of particular aspects of services, such as monitoring staff hand hygiene. A total of 712 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2011-12.

The reports of 231 local clinical audits were reviewed by the provider in 2011/12 and UHB intends to take the following actions to improve the quality of healthcare provided:

This figure indicates that the results of 231clinical audits were reported within clinical areas and those reports were submitted to UHB's clinical audit team. At UHB, staff undertaking clinical audit are required to report any actions that should be implemented to improve service delivery and clinical quality. A list of examples of specific actions reported can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm These include measures such as:

- reviewing or developing new protocols or guidelines for staff
- arranging training or education sessions in order to increase staff awareness of required standards
- employing new staff
- drafting research and development proposals
- multidisciplinary collaborative working
- developing new data capture tools.

Each clinical specialty at UHB is required to plan a programme of audit for the year ahead, based on national audit priorities, areas of risk and locally determined priorities.

2.2.3 Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by UHB that were recruited during that period to participate in research approved by a research ethics committee was 6158.

The table below shows the number of clinical research projects registered with the Trust's Research and Development (R&D) Team during 2010/11 and 2011/12. The number of studies which were abandoned is also shown for completeness. The main reason for studies being abandoned is that not enough patients were recruited due to the study criteria or patients choosing not to get involved.

Reporting Period	**2010/11**	**2011/12**
Total number of projects registered with R&D	181	164
Out of the total number of projects registered, the number of studies which were abandoned	13	15 + 1 declined by UHB
Trust total patient recruitment	**7300**	**6158**

The provisional number of studies registered with Research & Development and Trust total patient recruitment for 2011/12 show reductions compared to 2010/11. The reductions are due to:

- national difficulties in recording studies and patient recruitment in the new National Institute for Health Research (NIHR) IT system; and
- and the closure of certain high recruiting studies – low intensity Band 2 observational studies – at the end of 2010/11.

Total patient recruitment is however likely to increase once the final number for 2011/12 is known. The R&D team continues to regularly monitor the number of new R&D studies registered and patient recruitment to ensure that the Trust makes the most of all research opportunities available in 2012/13.

The table below shows the number of projects registered in 2011/12 split by discipline:

Projects registered during this period by discipline	**Registered**	**Abandoned**
Cancer Oncology:24; Haematology:11; Imaging:1; Neurosurgery:1; Respiratory Medicine:1; Radiotherapy: 1; Dermatology:1; Histopathology: 2; Liver Medicine:1; Neuropsychology:1; GI Surgery:2; GI Medicine:1; No Objection Studies: 3	**50**	**5 + 1 declined**
Heart and Vascular Disease Cardiology:12; Cardiac Surgery:1; Endocrinology:2; Renal Medicine:2; Anaesthetics:1; Rheumatology:1; Imaging:2; GI Surgery:1; Diabetes:1; Respiratory Medicine:2; No Objection Studies:2	**27**	**2**

Inflammation and Infection Critical Care:1; Nursing:1; ENT:1; Burns & Plastics: 4; Anaesthetics:1; Rheumatology:5; Microbiology:2; Respiratory Medicine:1; Liver Medicine:10; Neurology:2; Dermatology:1; Renal Medicine:2; Urinary Medicine:1; Imaging:1; GI Surgery:1; Haematology:1; GI Medicine:3; Ophthalmology:2; No Objection Studies:2	**42**	**4**
Molecular & Genetic Basis for Disease Nursing:1; Endocrinology:4; Renal:1; Diabetes:4; ENT:1; Oncology:1; Haematology:2; GI Medicine:1; Respiratory Medicine:1; Genito-Urinary Medicine:1; Liver Medicine:1; Anaesthetics:1; Ophthalmology:1; No Objection Studies 3	**23**	**2**
Neurosciences and Aging Neurology:6; Endocrinology:2; Therapy Services:1; ENT:2; GI Medicine:1; Stroke Services:1; Neurosurgery:1; Geriatric Medicine:1	**15**	**2**
Transplantation Renal Medicine:3; Haematology:1; Liver Medicine:2; No Objection Studies:1	**7**	**0**
Total	**164**	**15 + 1 declined**

Patient Benefits of Research

The Trust's extensive and innovative Research & Development portfolio enables us to have access to new medicines earlier as part of clinical trials which can provide hope for patients for whom conventional treatments might have failed. During 2011/12, UHB has been able to deliver benefits to patients on clinical trials including reduced symptoms, improved survival times and improved quality of life for example. These include patients with prostate cancer, cancers of the blood, relapsing remitting multiple sclerosis (RRMS) and Hepatitis C Virus (HCV) infection.

2.2.4 Information on the use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of UHB income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between UHB and NHS South Birmingham, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2011/12 which was conditional upon achieving quality improvement and innovation goals was £6.76m* and the Trust received £XXm** in payment.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2011/12 accounts and does not represent actual outturn (as an estimate has to be included for Month 12 income). The actual figure will not be known until June 2012 when we will have a final position as reconciled with the HCS (Healthcare Commissioning Services). Also whilst we have received payment throughout the year as each month has been agreed with HCS, final payment of CQUIN monies will not take place until the June 2012 reconciliation point.

** Final payment is however subject to verification with NHS South Birmingham for 2011/12.

2.2.5 Information relating to registration with the Care Quality Commission (CQC) and periodic/special reviews

UHB is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions. UHB has the following conditions on registration: the provider conditions that the regulated activities UHB has registered for may only be undertaken at Queen Elizabeth Medical Centre and Selly Oak Hospital.

Following the final moves into the new Queen Elizabeth Hospital Birmingham, the Trust has applied to remove the Selly Oak Hospital location from its CQC registration. Only one outpatient service remains at Selly Oak Hospital and so the site no longer meets the CQC's definition of a 'location'.

The Care Quality Commission has not taken enforcement action against UHB during 2011/12.

UHB has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12: Dignity and Nutrition Inspection (6 April 2011) and Emergency Department Inspection (30 December 2011).

UHB intends to take the following actions to address the conclusions or requirements reported by the CQC:

The random Dignity and Nutrition Inspection undertaken by the CQC found that the Queen Elizabeth Hospital Birmingham (QEHB) was meeting both of the essential standards of quality and safety that were reviewed: Outcome 1 – respecting and involving people who use services and Outcome 5 – meeting nutritional needs. In order to maintain compliance the CQC proposed some improvements in relation to Outcome 5. UHB submitted an action plan to the CQC setting out a number of actions: changing menu options; undertaking ongoing patient meal surveys; procurement of adapted cutlery, plate guards and non slip mats for patient use; liaising with the supplier to make changes to food offered; making changes to the way food is served; and auditing and taking action to improve documentation.

The Emergency Department Inspection at QEHB was undertaken in response to concerns relating to two outcomes: Outcome 04 - Care and welfare of people who use services and Outcome 13 – Staffing. The CQC found that overall the essential standards were being met and therefore no actions were required by UHB.

UHB has made the following progress by 31 March 2012 in taking such action: all actions are now complete.

2.2.6 Information on the quality of data

UHB submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was: 97.5% for admitted patient care; 98.2% for outpatient care; and 94.1% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was: 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care.

UHB Information Governance Assessment Report overall score for 2011/12 was 77% and was graded green (satisfactory).

UHB was subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect [8.0%]
- Secondary Diagnoses Incorrect [15.5%]
- Primary Procedures Incorrect [16.1%]
- Secondary Procedures Incorrect [9.0%].

The results should not be extrapolated further than the actual sample audited. The following services were reviewed within the sample: Cardiology and a random sample covering all specialties.

The reduction in performance compared to the last audit which was carried out in 2009/10 is mainly due to:

- the appropriateness of national guidelines on the coding of ablation procedures which is being followed up with the Information Centre.
- some but not all comorbidities being coded.

UHB will be taking the following actions to improve data quality:

- Accreditation of the collaborative West Midlands Clinical Coding Academy by the National Classifications Service to help develop appropriate national standards for clinical coding.
- Increasing clinician engagement by piloting the electronic use of clinical terminology (Snomed) by clinicians to automatically generate accurate clinical coding for Payment by Results.
- Review of the Data Quality Policy to incorporate learning from 2011/12 initiatives and development of the Data Quality Specialist Role to support its implementation.
- Maintaining Level 2 compliance with the Information Governance Toolkit Data Quality Initiatives and working towards Level 3 compliance.

Part 3: Other information

3.1 Overview of quality of care provided during 2011/12

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.

3.2 Performance of Trust against selected indicators

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*	**0.16**	**0.08**	**0.33**	**0.42**
Time period	April-Dec 2011	April-Dec 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		
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.16**	**0.10**	**0.33**	**0.43**
Time period	April-Dec 2011	April-Dec 2011	2010/11	2009/10
Data source	Trust MRSA data reported to HPA, HES data (bed	Trust MRSA data reported to HPA, HES data (bed	Trust MRSA data reported to HPA, HES	Trust MRSA 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(a). *C. difficile:* Patients with *C. difficile* infection/100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**27.08**	**29.49**	**43.33**	**53.43**
Time period	April-Dec 2011	April-Dec 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		
2(b). *C. difficile:* Patients with *C. difficile* infection/100,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**27.08**	**34.76**	**43.34**	**55.09**
Time period	April-Dec 2011	April-Dec 2011	2010/11	2009/10
Data source	Trust C.diff data reported	Trust C.diff data reported	Trust C.diff data	Trust C.diff data

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
	to HPA, HES data (bed days)	to HPA, HES data (bed days)	reported to HPA, HES data (bed days)	reported to HPA, HES data (bed days)
Peer group		Acute trusts in West Midlands SHA		
3(a) Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**11.3**	**6.6**	**11.3**	**9.7**
Time period	2011/12	April-Sept 2011	2010/11	2009/10
Data source	Datix (incident data), Trust admissions data	Based on data from NPSA NRLS report	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data
Peer group		Acute teaching organisations		
3(b) Never Events *Lower number indicates better performance*	**1** (see explanatory note below table)	*To be confirmed*	*To be confirmed*	*To be confirmed*
Time period	2011/12	2011/12	2010/11	2009/10
Data source	Datix (incident data)	NPSA	Datix (incident data)	
Peer Group		Acute teaching organisations		

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
4(a) Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**70.4%**	**70.8%**	**81.3%**	**89.9%**
Time period	2011/12	April-Sept 2011	2010/11	2009/10
Data source	Datix (incident data)	Based on data from NPSA NRLS report	Datix (incident data)	Datix (incident data)
Peer group		Acute teaching organisations		
4(b) Percentage of patient safety incidents resulting in severe harm or death *Lower % indicates better performance*	**0.98%**	**0.68%**	*Not available*	*Not available*
Time period	April-Sept 2011	April-Sept 2011		
Data source	Based on data from NPSA NRLS report	Based on data from NPSA NRLS report		
Peer group		Acute teaching organisations		

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): The data shown for 2009/10 differs to that shown in previous Quality Reports. This is due to a change in the method and data source used to calculate bed days. The data for *c.difficile* infection has been calculated using 100,000 bed days rather than 1,000 used previously, in line with DH guidance.

3(a): The data shown for 2009/10 differs 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.

3(b): The Trust reported one never event during 2011/12. The incident was recorded as 'retained foreign object post-operation' and related to a swab being left inside a patient during surgery at the Queen Elizabeth Hospital Birmingham. The swab was subsequently removed and the patient suffered no ill-effects as a result.

4(a): The data shown for 2009/10 differs 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 within 30 days: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**4.82%**	**4.92%**	**6.22%**	**5.62%**
Time period	April-Dec 2011	April-Dec 2011	2010/11	2009/10
Data source	HES data	HES data	HES data	HES data
Peer group		University hospitals		

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
5(b). Readmissions within 30 days: Readmission rate (all specialties) % *Lower % indicates better performance*	**4.80%**	**4.02%**	**6.20%**	**5.61%**
Time period	April-Dec 2011	April-Dec 2011	2010/11	2009/10
Data source	HES data		HES data	HES data
Peer group		University hospitals		
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**2.6%**	*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	**100%**	**99.3%**	**100%**	**99.7%**

Indicator	2011/12	Peer Group Average (where available)	2010/11	2009/10
Higher % indicates better performance				
Time period	April 2011-Feb 2012	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.		
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*	**93.1%**	**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 2011-Feb 2012	2010/11	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. The data is now presented for 100,000 bed days rather than 1,000 bed days.

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.

3.2.3 Patient experience indicators

Patient survey question	2011/12	Comparison with other NHS trusts in England (2011/12)	2010/11
9. Overall were you treated with respect and dignity	**9.1**	**About the same**	**8.8**
Time period & data source	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission
10. Involvement in decisions about care and treatment	**7.4**	**About the same**	**6.9**
Time period & data source	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission
11. Did staff do all they could to control pain	**8.0**	**About the same**	**7.9**
Time period & data source	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission
12. Cleanliness of room or ward	**9.2**	**About the same**	**8.9**
Time period & data source	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission

13. Overall rating of care	**8.1**	**About the same**	**7.8**
Time period & data source	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2011, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission	2010, Trust's Survey of Adult Inpatients 2011 Report, Care Quality Commission

Notes on patient experience measures:
9-13: The style of the survey reports produced by the Care Quality Commission for individual trusts has changed from previous years. The new style benchmark report uses the same scoring system as before but presents the data as a score out of 10; the higher the score for each question, the better the Trust is performing. Performance for 2010 has been recalculated to enable comparison with 2011 but not for previous years which are therefore not included in the table above.

3.3 Performance against key national priorities

National targets and regulatory requirements	Time Period for 2011/12	2011/12 Performance	2011/12 Target	2010/11 Performance	2010/11 Target	2009/10 Performance	2009/10 Target
Clostridium difficile (post-48 hour cases)	Apr 2011 – Mar 2012	85	114	145	164	178	348
MRSA (post-48 hour cases)	Apr 2011 – Mar 2012	4	5	11	11	13	30
62-day wait for first treatment from urgent GP referral: all cancers	Apr 2011 – Feb 2012	85.3%	85%	86.5%	85%	85.4%	85%
62-day wait for first treatment from consultant screening service referral: all cancers	Apr 2011 – Feb 2012	94.7%	90%	93.9%	90%	92.6%	90%
31-day wait from diagnosis to first treatment: all cancers	Apr 2011 – Feb 2012	97.2%	96%	98.6%	96%	97.4%	96%
31-day wait for second or subsequent treatment: surgery	Apr 2011 – Feb 2012	98.1%	94%	97.9%	94%	96.6%	94%
31-day wait for second or subsequent treatment: anti cancer drug treatments	Apr 2011 – Feb 2012	99.7%	98%	99.9%	98%	99.1%	98%
31-day wait for second or subsequent treatment: radiotherapy	Apr 2011 – Feb 2012	99.9%	94%	100% (Jan – Mar 2011)	94%	Target introduced in January 2011	

Two week wait from referral to date first seen: all cancers	Apr 2011 – Feb 2012	98.0%	93%	96.0%	93%	94.6%	93%
Two week wait from referral to date first seen: breast symptoms	Apr 2011 – Feb 2012	98.6%	93%	98.4%	93%	98.6% (Jan – Mar 2010)	93%
18-week maximum wait from point of referral to treatment (admitted patients)	Apr 2011 – Feb 2012	95.6%	Not a target from July 2010	95.6%	Not a target from July 2010	95.4%	90%
Crude average of monthly 95th centile Referral to treatment waiting times (admitted patients)	Apr 2011 – Feb 2012	17.8 weeks	23.0 weeks	17.6 weeks	23.0 weeks	Target introduced in July 2010	
18-week maximum wait from point of referral to treatment (non-admitted patients)	Apr 2011 – Feb 2012	98.3%	Not a target from July 2010	98.7%	Not a target from July 2010	98.5%	95%
Crude average of monthly 95th centile Referral to treatment waiting times (non-admitted patients)	Apr 2011 – Feb 2012	15.0 weeks	18.3 weeks	15.2 weeks	18.3 weeks	Target introduced in July 2010	
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Apr 2011 – Mar 2012	96.1%	95%	97.6%	95% from July 2010	98.5%	98%
A&E: Total time in A&E (95th percentile)	Apr 2011 – Mar 2012	240 mins	240 mins	240 mins	240 mins from July 2010	Target introduced in July 2010	
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Apr 2011 – Mar 2012	Certification made	N/A	Certification made	N/A	Certification made	N/A

3.4 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.

UHB did not receive any formal mortality outlier notifications from the Care Quality Commission during 2011/12. The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Summary Hospital-level Mortality Indicator (SHMI)

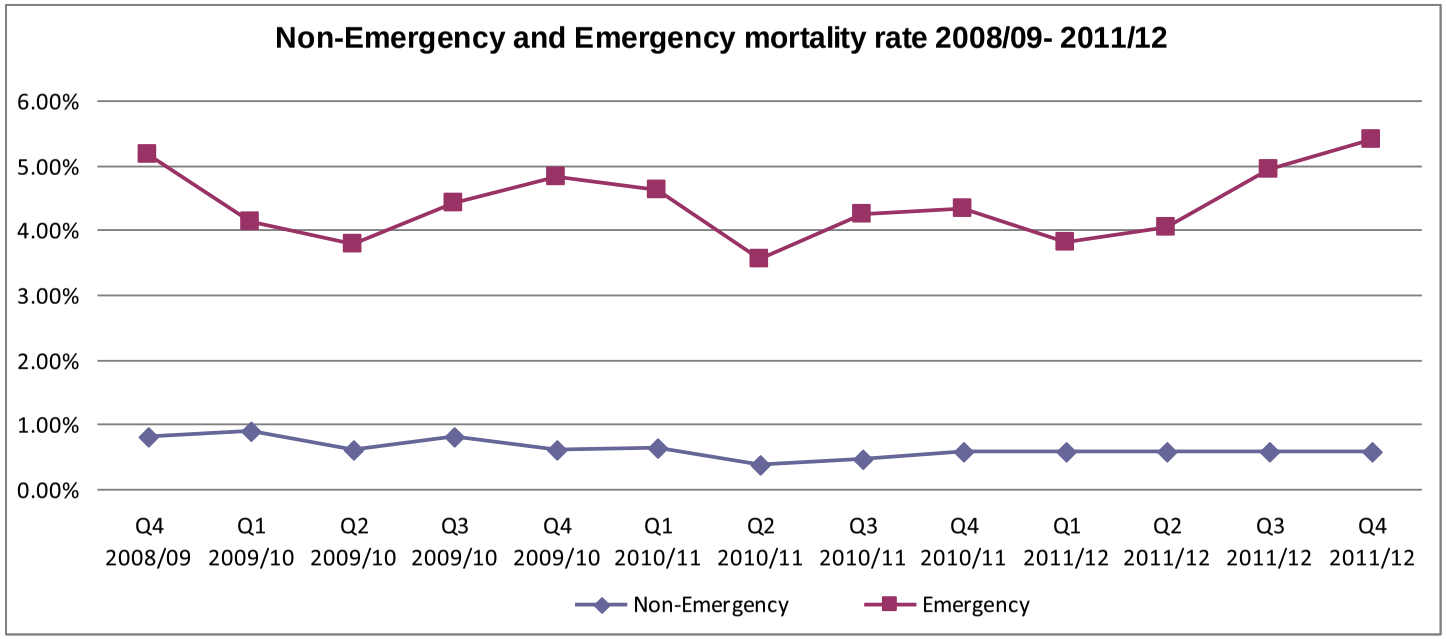
In October 2011, the NHS Information Centre published data for the Summary Hospital-level Mortality Indicator. This is the new national hospital mortality indicator which replaces previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust 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.

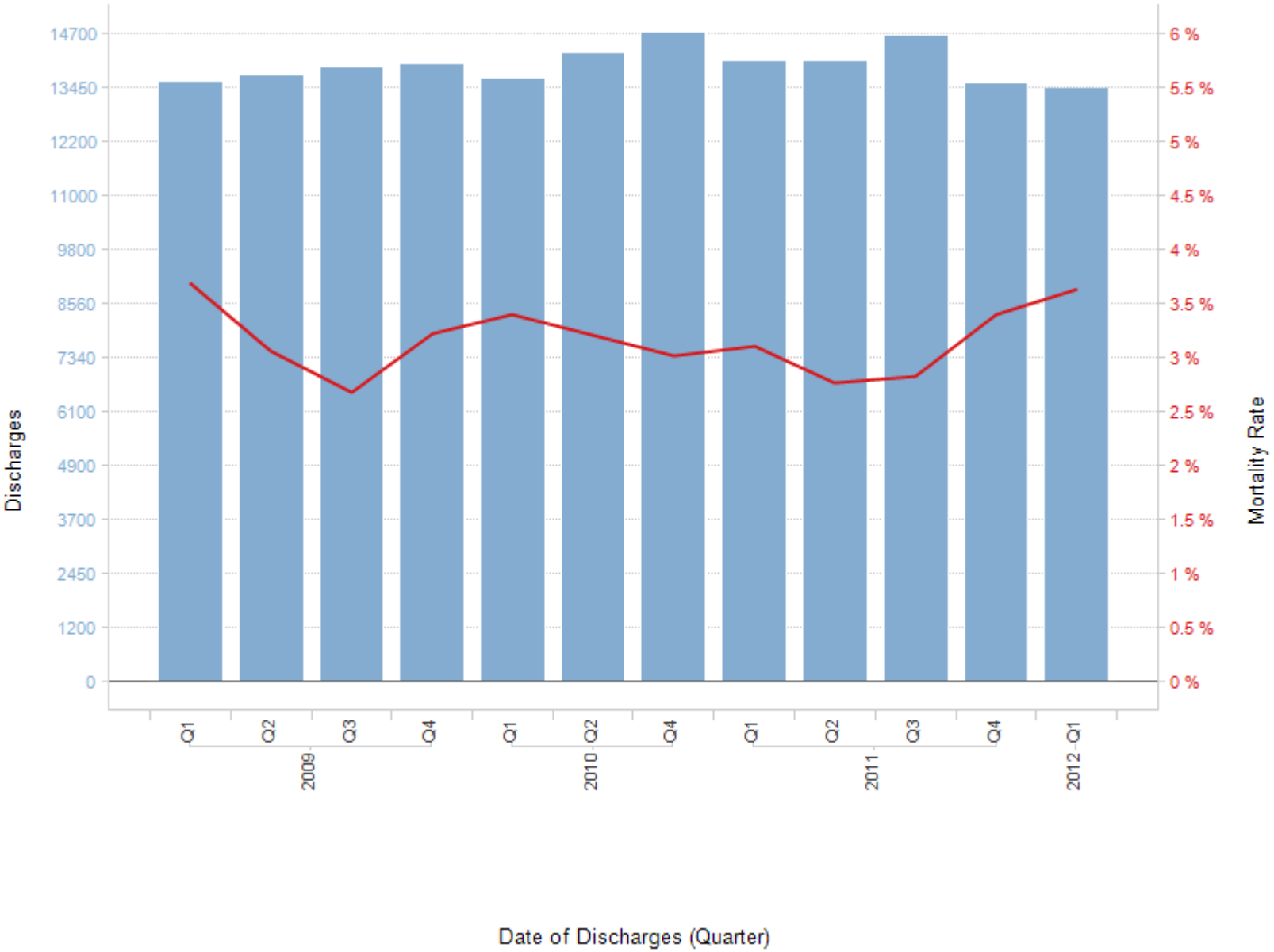
The Trust's latest published SHMI is 98.2 for the period July 2010-June 2011 which is within the expected range (band 2). Although the SHMI has superseded the Hospital Standardised Mortality Ratio and the Trust has concerns about its validity, it is included here for completeness. UHB's overall 1 year HSMR value is 107.2 for 2010-11 which is within the expected range and the latest period available.

The graph below shows the Trust's non-emergency and emergency mortality rates by quarter for the last three financial years. The Trust is generally treating more elderly patients and patients with complex conditions. Emergency mortality has increased slightly during quarters 3 and 4 2011/12 which is mainly due to the introduction of the Ambulatory Care Clinics in the second half of 2011/12.

The Trust has been working with NHS South Birmingham to reduce unnecessary medical admissions and these clinics were introduced for General Practitioners (GPs) to directly refer general medical patients for review by UHB's clinicians in an outpatient setting rather than sending them to the Emergency Department and the Clinical Decisions Unit (CDU). This has reduced the number of emergency admissions and means that the Trust has treated a higher proportion of sicker patients which have both impacted upon the emergency mortality rate.



The graph below shows the Trust's crude mortality rate against activity (patient discharges) by quarter for the past three calendar years. The graph again shows the slight increase during the final two quarters of 2011/12 (quarter 4 2011 and quarter 1 2012 on the graph) as explained above.


Discharges
14700
13450
12200
11000
9800
8560
7340
6100
4900
3700
2450
1200
0
Mortality Rate
6 %
5.5 %
5 %
4.5 %
4 %
3.5 %
3 %
2.5 %
2 %
1.5 %
1 %
0.5 %
0 %
Q1
Q2
Q3
Q4
Q1
Q2
Q4
Q1
Q2
Q3
Q4
Q1
2009
2010
2011
2012
Date of Discharges (Quarter)

3.5 Performance against national core set of quality indicators

A national core set of quality indicators has been jointly proposed by the Department of Health and Monitor for inclusion in trusts' Quality Reports from 2012/13. The Trust has included performance in relation to some of these in this year's report, where the data is available for 2011/12, including readmissions, patient safety incidents and mortality. UHB will take part in the consultation over inclusion of these indicators from 2012/13 to ensure that the methodologies are consistent with other national requirements where possible. The Trust plans to include a detailed section on these in next year's Quality Report.

Further details of the proposed set of quality indicators can be found on the Department of Health website:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132727.pdf

3.6 Outpatient Department Survey

The Trust performed very well in the 2011 Outpatient Department Survey. The results are based on responses from 423 patients which represents a response rate of 50% compared to 53% for all trusts. The table provides a summary of the survey results grouped into categories:

Performance	Number of Questions	Percentage of Questions
Best performing 20% of trusts	13	33.3%
Intermediate 60% of trusts	22	56.4%
Worst performing 20% of trusts	4	10.2%

The Trust's Outpatient Department Survey 2011 detailed benchmark report can be accessed from the Care Quality Commission website:
http://www.nhssurveys.org/Filestore/documents/OP11_RRK.pdf

3.7 Staff Survey

The Trust's Staff Survey results for 2011 show that performance was average or better for 31 (82%) of the 38 survey questions and below average for 7 (18%) questions. The results are based on responses from 449 staff which represents an improved response rate of 55% compared to 45% last year. The results for the Staff Survey questions which most closely relate to quality of care are shown in the table below. The Trust will be aiming to improve performance for those questions which were below average, including staff reporting of errors, near misses or incidents and the availability of hand washing materials across the Trust.

Staff survey question	2011/12	Comparison with other NHS trusts 2011/12	2010/11	2009/10
1. Percentage feeling satisfied with the quality of work and patient care they are able to deliver	**76%**	**Above (better than) average**	**79%**	**83%**
Time period & data source	Trust's 2011 Staff Survey Report, Care Quality Commission		Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2009 Staff Survey Report, Care Quality Commission
2. Percentage agreeing their role makes a difference to patients	**91%**	**Above (better than) average**	**93%**	**93%**
Time period & data source	Trust's 2011 Staff Survey Report, Care Quality Commission		Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2009 Staff Survey Report, Care Quality Commission
3. Staff recommendation of the trust as a place to work or receive treatment	**3.78**	**Highest (best) 20%**	**3.81**	**3.79**
Time period & data source	Trust's 2011 Staff Survey Report, Care Quality Commission		Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2009 Staff Survey Report, Care Quality Commission

4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	**95%**	**Below (worse than) average**	**96%**	**95%**
Time period & data source	Trust's 2011 Staff Survey Report, Care Quality Commission		Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2009 Staff Survey Report, Care Quality Commission
5. Percentage of staff saying hand washing materials are always available	**60%**	**Below (worse than) average**	**63%**	**71%**
Time period & data source	Trust's 2011 Staff Survey Report, Care Quality Commission		Trust's 2010 Staff Survey Report, Care Quality Commission	Trust's 2009 Staff Survey Report, Care Quality Commission

Notes on staff survey
3. Possible scores range from 1 to 5, with a higher score indicating better performance.

3.8 Specialty Quality Indicators

The Trust's Quality and Outcomes Research Unit (QuORU) was set up in September 2009. The unit has linked a wide range of information systems together to enable different aspects of patient care, experience and outcomes to be measured and monitored. Performance for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Quality and Outcomes Research Unit was included in the Trust's 2009/10 and 2010/11 Quality Reports.

During 2011/12, the unit has continued to provide support to clinical staff in the development of innovative quality indicators with a greater focus on research. The Trust has expanded the web-based tool which enables clinical staff to track performance on a monthly basis and emails are now automatically sent out to clinical and managerial teams if performance deteriorates. The tool allows clinical staff to drill down to patient level data to facilitate validation, audit and research activity. In addition, the Trust has further expanded the number of specialty quality indicator web pages during

2011/12 to enable patients and the public to track performance. These pages include graphs showing performance and explanatory text which are updated regularly.

The Trust's clinical and management teams have improved performance for over 40% of the indicators during 2011/2 with support from the Quality and Informatics teams. Performance for 40% has stayed about the same and performance for 21% has deteriorated during 2011/12. Table 1 shows the performance for those specialty quality indicators where the most notable improvements have been made during 2011/12. The data has been checked by the appropriate clinical staff to ensure it accurately reflects the quality of care provided. Benchmarking data has been included where possible.

Table 2 shows performance for some of the indicators where performance has deteriorated during 2011/12. Performance for the remaining indicators can be viewed on the Quality web pages: http://www.uhb.nhs.uk/quality.htm. The goals for all indicators are being reviewed by the clinicians involved to ensure they are both challenging and realistic for 2012/13. The Trust's Informatics and Quality teams are currently developing a performance indicator framework based on a statistical model which will highlight potentially significant changes in performance and any unusual patterns in the data. The framework will be used from quarter 2 2012/13 to provide a more rigorous approach to quality improvement and to direct attention to those indicators where performance is proving most challenging to improve.

Table 1

Specialty	Indicator	Goal	Numerator Apr 11-Mar 12	Denominator Apr 11-Mar 12	Percentage Apr 11-Mar 12	Percentage Apr 10-Mar 11	Percentage Apr 09-Mar 10	Data Sources	Benchmarking (where available)

Table 2

Specialty	Indicator	Goal	Numerator Apr 11-Mar 12	Denominator Apr 11-Mar 12	Percentage Apr 11-Mar 12	Percentage Apr 10-Mar 11	Percentage Apr 09-Mar 10	Data Sources	Benchmarking

Notes on data sources:

BMT = Bone Marrow Transplant
Cleveland Clinic and US data = published on Cleveland Clinic website
CRIS = Radiology database
Galaxy = Theatres database
Lorenzo = Patient administration system
MARS = Renal database
PATS = Cardiac database
PICS = Prescribing Information and Communication System

3.9 Quality Web Pages

The Trust first launched the Quality web pages on its website in November 2009 to provide patients and the public with up to date information on quality of care: http://www.uhb.nhs.uk/quality.htm

The information was expanded during 2011/12 and now includes:

- Quality Reports: this includes the Trust's annual Quality Reports plus quarterly progress reports
- A&E Clinical Quality Indicators: graphs showing performance and explanatory text which are updated at the end of each month
- Patient Experience Data: graphs showing Trust-level, electronic patient experience data collected locally through bedside televisions and telephone surveys.
- Specialty Quality Indicators: graphs showing performance and explanatory text for specialty quality indicators which are updated monthly

A patient information survey went out to Trust members in the Autumn edition of 'Trust in the Future' to find out what types and formats of information patients want before they come into hospital. The results from over 700 responses received have been analysed and will be used by the Communications, Informatics and Quality teams to drive website developments and quality communication strategies in 2012-13. Further information and specialty quality indicator pages are likely to be added during 2012/13.

3.10 Healthcare Evaluation Data (HED) Tool

The Trust developed the interactive healthcare evaluation data (HED) tool during 2009/10 which enables clinical and managerial staff to evaluate the quality of healthcare delivery and operational efficiency in comparison to acute and mental health trusts in England. The tool uses national Hospital Episode Statistics (HES) data and incorporates advanced methodologies which account for casemix and other variables, incorporate all care delivered and include anonymised patient level data.

Over the past year, new methodologies and datasets have been included including the Summary Level Hospital Mortality Indicator (SHMI) and Death Certificate data from the Office of National Statistics (ONS). The HED tool now enables both comparison of care in distinct areas as well as more innovative overviews of performance for a range of acute care indicators monitored across the NHS as a whole.

3.11 MyHealth@QEHB

MyHealth@QEHB is a web-based system that provides patients with chronic health conditions with high-quality information and support to allow informed choice and shared decision-making. A secure, prototype version of the system has been successfully piloted by Liver Medicine patients since 2010, under the supervision of a Consultant. MyHealth@QEHB provides patients with access to key parts of their clinical information held by the Trust including clinical letters, medications and laboratory results. Patients can also update the system with their own healthcare information such as results/readings taken at their local hospital, GP surgery or via home monitoring equipment, and they will soon have the option to share and incorporate this into their QEHB health record.

The system enables patients to create their own support networks of patients with similar chronic conditions and to access reliable information on their condition. Early feedback suggests the innovative system gives patients more control over their care and improves their experience, particularly those

who have complex conditions and undergo regular tests. Further development of the system is currently underway in preparation for its implementation in a number of other clinical specialties during 2012/12.

3.12 Glossary of Terms

To be confirmed

Annex 1: Statements from stakeholders

The Trust has shared its 2011/12 Quality Report with the commissioning Primary Care Trust, NHS South Birmingham, the Birmingham Local Involvement Network (LINk) UHB Action Group and Birmingham City Council Overview and Scrutiny Committee.

NHS South Birmingham and the Birmingham LINk UHB Action Group have reviewed the Trust's Quality Report for 2011/12 and provided the statements below. Birmingham City Council Overview and Scrutiny Committee has chosen not to provide a statement.

Statement provided by NHS South Birmingham:

To be confirmed

Statement provided by Birmingham LINk:

To be confirmed

Annex 2: Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2011 to June 2012
    - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
    - Feedback from the commissioners dated XX/XX/20XX
    - Feedback from governors dated XX/XX/20XX
    - Feedback from LINks dated XX/XX/20XX
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
    - The [latest] national patient survey XX/XX/20XX
    - The [latest] national staff survey XX/XX/20XX
    - The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
    - CQC quality and risk profiles dated XX/XX/20XX
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

.....Date.....Chairman
.....Date.....Chief Executive