NHS

University Hospitals Birmingham

NHS Foundation Trust

Quality Account 2018/19

This annual report covers the period 1 April 2018 to 31 March 2019

2018/19 Quality Account

Contents

1 Chief Executive's Statement

The work to bring together Birmingham's two largest NHS trusts finally came to fruition on 1 April 2018 when the merger by acquisition of Heart of England NHS Foundation Trust (HEFT) by University Hospitals Birmingham NHS Foundation Trust (UHB) was formally agreed. The decision was approved by the trusts' respective Boards of Directors, with the decision cleared by both Councils of Governors. "Building healthier lives" is the vision of the enlarged organisation and demonstrates our commitment to the health of our population, before, during and after patients need hospital care - from maternity to the end of our lives.

The Trust has set out three key priorities:

- **To maintain high quality patient care** and NHS operational standards in each hospital and service, even in the face of rising demand
- **To integrate services across our hospitals and sites**, so that patients can expect the same high standards and joined up care wherever they enter our system, and so we use our new scale to operate as efficiently as possible
- **To transform the model of healthcare**, particularly using technology, so patients are cared for in the most appropriate place, with many more being seen in the community or virtually and hospitals concentrating on the most acute and specialised care

Maintaining high quality patient care is a key priority for the years ahead. During 2018/19, the Trust began reviewing and harmonising the systems and processes in place across the different hospital sites and community services. The Trust is aiming to have Trust-wide quality indicators agreed and in place across the main hospital sites by the end of 2019/20. This work will be dependent on the implementation of common electronic systems across the sites to enable the quality of care to be measured, monitored and improved.

Performance for the six quality improvement priorities set out for 2018/19 in the 2017/18 Quality Reports has been mixed:

Priority 1: Reducing grade 2 Trust-acquired avoidable pressure ulcers
Priority 2: Improving patient experience and satisfaction
Priority 3: Timely and complete observations and pain assessment
Priority 4: Reducing missed doses
Priority 5: Reducing harm from falls
Priority 6: Timely treatment for sepsis.

The Board of Directors has chosen to continue with these six overall priorities for improvement in 2019/20 with a different focus for each and associated targets to drive improvement.

UHB's focused approach to quality, based on driving out errors and making incremental 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. A wide range of omissions in care were reviewed in detail during 2018/19 at the regular Executive Care Omissions Root Cause Analysis (RCA) meetings chaired by the Chief Executive. Cases are selected for review from a range of sources including those put forward by senior medical and nursing staff, e.g., individual wards selected for review, missed or delayed medication, serious incidents, serious complaints, infection incidents, incomplete observations and cross-divisional issues.

Data quality and 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. An essential part of improving quality at the Trust continues to be the scrutiny and challenge provided through proper engagement with staff and other stakeholders. These include the Trust's Council of Governors and Birmingham and Solihull Clinical Commissioning Group (CCG).

A key part of the Trust's commitment to quality is being open and honest with our staff, patients and the public, with published information not limited to good performance. The Quality web pages provide up-to-date information on UHB's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm.

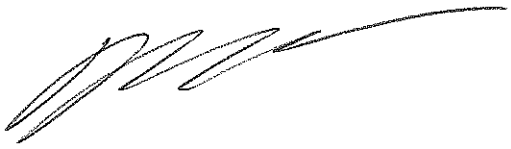
The Trust's external auditors provide an additional level of scrutiny over key parts of the Quality Report. The Trust's external auditor Deloitte has reviewed the content of the 2018/19 Quality Report and undertaken testing for three indicators in line with the NHS Improvement guidance on external assurance:

1. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.
2. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.
3. Summary Hospital-level Mortality Indicator (SHMI).

The findings from this year's external audits were reported to the Audit Committee and Board of Directors in May 2019. No significant issues were identified with the content review or the testing for the indicators. Deloitte made three recommendations for improvement; the implementation of recommendations will be monitored via the Trust's Audit Committee. The report provided by our external auditor is included in Annex 3 of this report.

2019/20 will be a very challenging year for UHB as we work towards achieving the ambitious priorities set out above. The Trust will continue working with regulators, commissioners, healthcare providers and other organisations as part of the Sustainability and Transformation Partnership (STP) to influence future models of care delivery and deliver further improvements to quality during 2019/20.

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.



Dr David Rosser, Chief Executive
24 May 2019

Note regarding the merger by acquisition of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust

On 1st April 2018, the merger by acquisition of Heart of England NHS Foundation Trust (HEFT) by University Hospitals Birmingham NHS Foundation Trust (UHB) was formally agreed. The decision was made the Trusts' respective Boards of Directors, with the decision cleared by both Councils of Governors.

For 2017/18, a Quality Report was written for each Trust. For 2018/19 there is now one Quality Report. UHB is working to align its systems and reporting, this is an ongoing process due to differing IT systems and priorities across the sites.

The former UHB is now known as Queen Elizabeth Hospital Birmingham site (QEHB), and the former HEFT sites are Heartlands Hospital (BHH), Good Hope Hospital (GHH) and Solihull Hospital (SH) – these acronyms are used throughout this Quality Report.

The enlarged Trust uses the University Hospitals Birmingham NHS Foundation Trust name (UHB).

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

2.1 Priorities for Improvement

The Trust's 2017/18 Quality Report set out six priorities for improvement during 2018/19:

- **Priority 1**: Reducing grade 2 Trust-acquired avoidable pressure ulcers
- **Priority 2**: Improving patient experience and satisfaction
- **Priority 3**: Timely and complete observations and pain assessment
- **Priority 4**: Reducing missed doses
- **Priority 5**: Reducing harm from falls
- **Priority 6**: Timely treatment for sepsis.

Progress has been mixed across the priorities and across the different Trust sites. Further details for each priority are provided in the following pages. The Board of Directors has therefore chosen to continue with these six overall priorities for improvement in 2019/20 with a different focus for each and associated targets to drive improvement.

1	Reducing pressure ulcers	New national guidance on the categorisation of pressure ulcers was released at the start of 2019/20, so baseline data will be collected and targets agreed
2	Improving patient experience and satisfaction	To focus on areas highlighted via patient surveys and complaints – nutrition and hydration, and pain control in the emergency departments
3	Timely and complete observations including pain assessment	Targets to remain the same and a new indicator to be developed
4	Reducing missed doses	Certain indicators will remain as targets were not met during 2018/19. Others will be replaced by new indicators
5	Reducing harm from falls	To focus on reducing the overall number of falls and associated harm
6	Timely treatment for sepsis	This is no longer a CQUIN but remains a KPI

The improvement priorities for 2019/20 were confirmed 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.

The focus of the patient experience priority was decided by the Patient Experience Group and the priorities for improvement in 2019/20 were then approved by the Board of Directors in March 2019. The priorities for 2019/20 will be presented to the Joint Consultative Committee (JCC) and cascaded to all staff via Team Brief in 2019.

They have also been discussed with, or there are plans to present at, various Trust groups including staff, patient and public representatives as shown in the table below.

Group	Key members
Care Quality Group	Executive Chief Nurse, Associate Directors of Nursing, Matrons, Senior Managers with responsibility for Patient Experience, and Patient Governors
Chief Operating Officer's Group	Executive Chief Operating Officer, Deputy Chief Operating Officer, Directors of Operations, Divisional Directors, Director of Operational Finance, Deputy Chief Nurse, Director of Patient Services, Director of Estates and Facilities, Director of IT Services plus other Managers
Joint Consultative Committee	Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives
Chief Executive's Team Brief (cascaded to all Trust staff)	Chief Executive, Executive Directors, Directors, Clinical Service Leads, Heads of Department, Associate Directors of Nursing, Matrons, Managers

Although some of the 2019/20 priorities have been in place for a number of years, the specific focus and targets within each priority are regularly reviewed and updated in line with changes in performance and in response to priorities within the Trust.

The performance for 2018/19 and the rationale for any changes to the priorities are provided in detail below. It might be useful to read this report alongside the Trust's two Quality Reports for 2017/18.

Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

Background

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

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

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

(Please note that as of 2019/20, the categories will be replaced by a new system).

Grade	Description
1	Skin is intact but appears discoloured. The area may be painful, firm, soft, warmer or cooler than adjacent tissue.
2	Partial loss of the dermis (deeper skin layer) resulting in a shallow ulcer with a pink wound bed, though it may also resemble a blister.
3	Skin loss occurs throughout the entire thickness of the skin, although the underlying muscle and bone are not exposed or damaged. The ulcer appears as a cavity-like wound; the depth can vary depending on where it is located on the body.
4	The skin is severely damaged, and the underlying muscles, tendon or bone may also be visible and damaged. People with grade 4 pressure ulcers have a high risk of developing a life-threatening infection.
Ungradable (Depth un-known)	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed.
Suspected Deep Tissue Injury (SDTI) (depth un-known)	Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

National Pressure Ulcer Advisory Panel / European Pressure Ulcer Advisory Panel / Pan Pacific Pressure Injury Alliance (2014)

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

Due to very low numbers of hospital-acquired grade 3 and grade 4 ulcers at UHB, the Trust's focus is on further reducing grade 2 ulcers. This in turn should help towards aiming for zero avoidable hospital-acquired grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

The target for QEHB and the target for Heartlands, Good Hope and Solihull Hospitals are different, as they are based on the targets set with the CCG (Clinical Commissioning Group) prior to the merger and these carried over into 2018/19.

QEHB had separate targets for device-related and non-device-related, Heartlands, Good Hope and Solihull Hospitals had one overall target.

Performance - QEHB

Non-device related

The target agreed with the CCG for 2018/19 was no more than 75 patients with non-device related hospital-acquired avoidable grade 2 pressure ulcers.

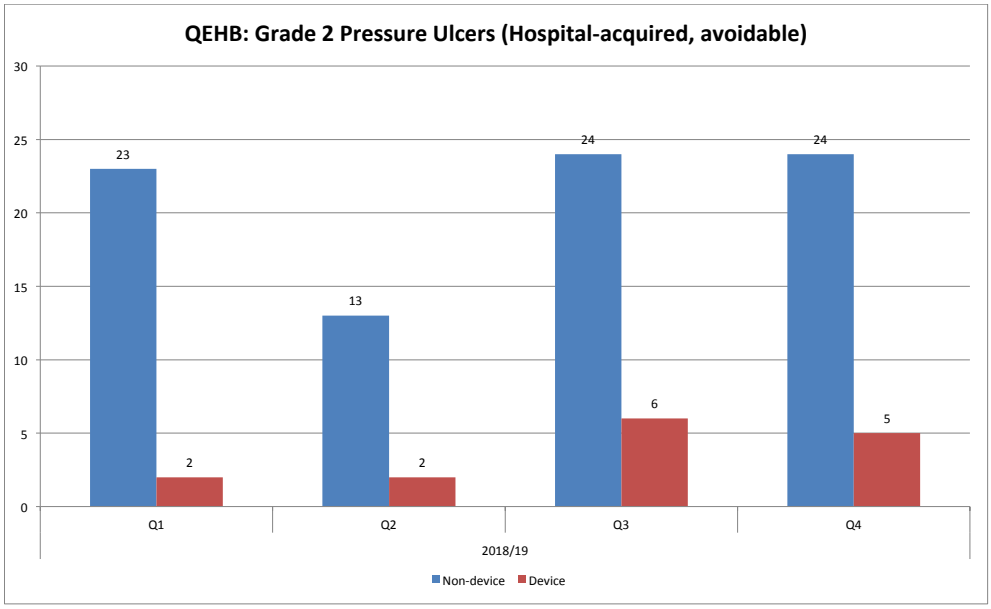
During 2018/19 QEHB reported 84 patients with such pressure ulcers. This compares to a total of 62 during 2017/18 and 71 during 2016/17. An exception report was provided to the CCG. For more information on actions taken, further detail is provided below.

Device related

The target agreed with the CCG for 2018/19 was no more than 42 patients with device-related hospital-acquired avoidable grade 2 pressure ulcers.

During 2018/19 QEHB reported 15 patients with such pressure ulcers. This compares to a total of 14 during 2017/18 and 28 during 2016/17.

Number of patients with grade 2 hospital-acquired, avoidable pressure ulcers, by Quarter



Performance - Heartlands, Good Hope and Solihull Hospitals

The target agreed with the CCG was a reduction of 20% on the number of hospital-acquired avoidable grade 2 pressure ulcers, over two years ending March 2019.

During 2018/19* Heartlands, Good Hope and Solihull Hospitals reported 72 such pressure ulcers (14 device related, and 58 non-device related).

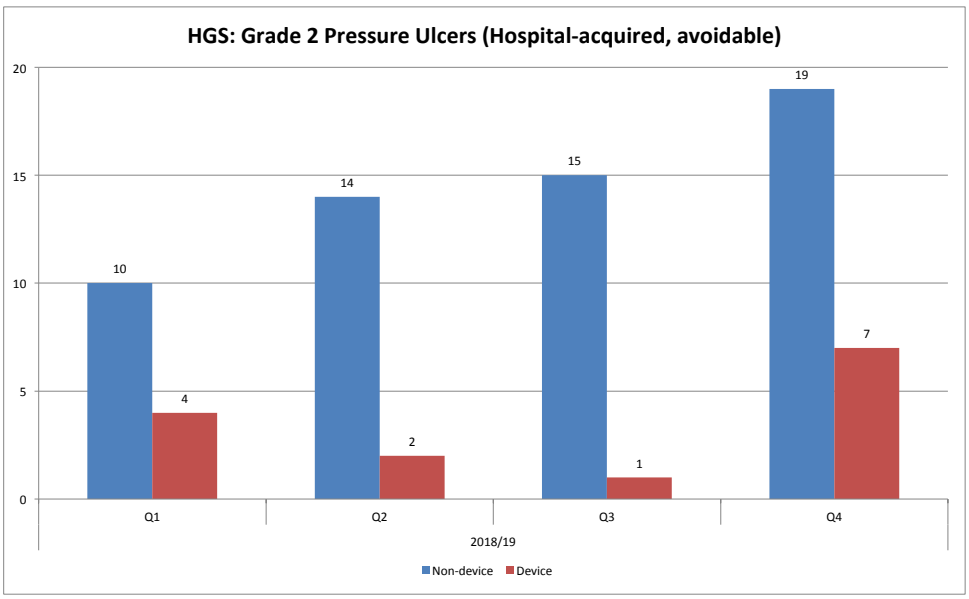
This is a reduction of 43.8% compared to 2016/17 (128), meeting the two year reduction target of 20%.

**March 2019 data included but subject to change following validation*

This compares to a total of 108 during 2017/18. (Please note that this data has undergone final validation since the 2017/18 Quality Report and may have changed slightly).

Number of patients with grade 2 hospital-acquired, avoidable pressure ulcers, by Quarter*

**March 2019 data included but subject to change following validation*



Changes to improvement priority for 2019/20
The 2019/20 targets for pressure ulcers are currently being agreed with Birmingham & Solihull Clinical Commissioning Group (CCG).

It should be noted that to reflect the NHS Improvement recommendations, changes to definitions and terminology will be implemented during 2019/20. This will affect reporting of pressure ulcers and moisture lesions, and there will be a potential increase in figures.

It should also be noted that in line with the recent acquisition by merger of Heartlands, Good Hope and Solihull hospitals by UHB, all processes, policies and documentation relating to pressure ulcers are in the process of being aligned.

Initiatives implemented during 2018/19
- A leaflet promoting safe patient movement for seated patients was developed and launched in conjunction with Therapies.
- A Task and Finish group set up to determine the changes required to refocus on repositioning. These have included the development of a story board to show what good repositioning looks like, and the development of a MOVED campaign and poster that were launched Trust-wide as part of the International Stop the Pressure day in November 2018.
- The Tissue Viability team have been part of the collaborative initiative led by NHSI. This has involved Ward 411, Queen Elizabeth Hospital and Ward 12, Good Hope Hospital. Members of ward staff, therapies and the Tissue Viability Team attended events to share ideas and present changes in practice to colleagues.
- Tissue Viability quality audits and Back to the Floor visits have taken place to ensure all wards have React to RED discs and grading cards.
- A video and poster was devised and launched to promote the prevention of heel drag and this has been incorporated into educational activities and clinical practice. These were presented at divisional forums, Matron and Band 7 meetings, Link Nurse, Skin Champions and Patient Handling Champions days. The training is included in the pressure ulcer study days and on mandatory manual handling training. The campaign was shortlisted for a British Journal of Nursing award.
- New pressure relieving mattresses were successfully trialled and purchased.
- A pressure relieving mattress audit was carried out monthly by the mattress company. Offering bedside training to troubleshoot provision of equipment and any equipment problems. Equipment training is available via the intranet with self-verification forms as assurance. Re-training is expected every three years as part of the update of pressure ulcer competencies.
- The Tissue Viability team has worked in conjunction with other disciplines to link in with national campaigns e.g. "get up, get dressed, get moving".
- Multidisciplinary approach employed with tissue viability, physiotherapy and manual handling working together to educate, demonstrate and promote safe side lying and documentation of repositioning.
- A poster regarding safe side lying was produced to inform on appropriate technique and optimal side lying position. This practice was promoted by link nurses, skin champions and patient handling champions days. The training is included in the pressure ulcer study days and on mandatory manual handling training.

Initiatives planned for 2019/20
The Trust plans to continue to build on the improvements seen in 2018/19, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly. Initiatives to aid improvements include:
- Planning the Tissue Viability service provision for the whole of UHB
- Aligning Tissue Viability policies, processes and documentation across UHB
- Aligning Tissue Viability related patient information leaflets across UHB
- Standardising equipment and wound dressing formularies across UHB
- Agreeing and standardising the education provision, including competency based practice across UHB
- Continue to roll out the MOVED, heel drag, safe side lying and other campaigns throughout the Trust.
- Develop closer working relationships with other specialist teams, e.g. Infection Prevention and Control, Moving and Handling, and Therapies.
- Review of the PICS repositioning tool. Tissue Viability have met with PICS developer to implement changes discussed following the repositioning questionnaire and focus groups. First re-draft is in progress.

How progress will be monitored, measured and reported
- All hospital acquired category 2, 3 and 4, ungradable and DTI pressure ulcers are reported via the Trust's incident reporting system Datix, and then reviewed by a Tissue Viability Specialist Nurse.
- All category 1 pressure ulcers and moisture lesions are reported via Datix.
- Monthly reports are submitted to the Trust's Preventing Harms meeting, which reports to the Executive Chief Nurse's Care Quality Group.
- Data on pressure ulcers also forms part of

the Clinical Risk report to the Clinical Quality Monitoring Group.
- Staff at QEHB can monitor the number and severity of pressure ulcers on their ward via the Clinical Dashboard.
- Introduction of a new standard operating procedure outlining the process for serious incident reporting. This includes a new reducing harm group chaired by the Deputy Chief Nurse.

Priority 2: Improving patient experience and satisfaction

The Trust measures patient experience via feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test, complaints and compliments and online sources (e.g., the NHS website). This vital feedback is used to make improvements to our services. This quality priority focuses on improving scores in our local surveys, and also takes into account national survey results and correlations with insight gained from other sources.

Patient experience data from local surveys

Survey	No. responses 2018/19	Data Period: April 2018 to
Inpatient	25,371	March 2019
Emergency Department	836	March 2019
Outpatient	3,644	Mar 2019
Discharge	2,029	March 2019
Maternity	1,005	March 2019
Community	1,017	March 2019

In addition, UHB publishes findings from the National Inpatient Survey, run by the Picker Institute on behalf of the Care Quality Commission (CQC) – please see Part 3 of this Quality Report.

Methodology
The majority of local survey data collection is via paper surveys; in some instances these are postal surveys, but the majority are at the point of care.

Improvement targets
In setting the patient experience quality priorities for 2019/20, the first quality priorities to be set as a merged Trust, a different approach has been taken to previous years.

Historically UHB has set quality priorities based on a number of questions from local patient surveys where patients scored the Trust lower than the internal targets that had been set. However, Heartlands, Good Hope and Solihull hospital sites do not have such priorities in place, nor do they ask all of the same questions on their surveys. With that in mind, and to ensure that significant focus can be given to key priorities across all sites of the enlarged Trust, the Trust's Patient Experience Group (which includes Trust Governors) has decided to focus its patient experience improvement for 2019/20 on two key aspects that patients have told us are important to them:
- Nutrition and hydration
- Pain control in our Emergency Departments

Update on the 2018/19 Patient Experience Priorities for QEHB
It is acknowledged that the majority of 2018/19 priorities were not met, and these will continue to be measured and improved via the ongoing patient surveys. Some questions, such as whether patients were offered a chaperone, are part of a specific project group which will also report to the Patient Experience Group so that progress can be tracked (see more information below under 2018/19 initiatives).

It is pleasing to see that patients told us that they had confidence and trust in nursing staff and this target was met.

Results from local patient surveys for 2018/19 patient experience priorities
This table shows results for 2017/18 and 2018/19.

	2017/18 Score	2018/19 Target	2018/19 Score	2018/19 no. of responses
Inpatient survey				
Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.6	**9.0**	8.3	7,972
If you needed attention, were you able to get a member of staff to help you within a reasonable time?	NA	**9.3**	8.8	6,979
Do you think the hospital staff did everything they could to help control your pain?	9.3	**9.6**	9.2	7,101
Did you have confidence and trust in the nurses treating you?	NA	**9.6**	9.6	6,359
Outpatient survey*				
How long after the stated appointment time did the appointment start?*	7.0	**7.0**	6.6*	1,820*
If you had an intimate examination/procedure performed during your outpatient appointment, were you offered a chaperone?*	NA	**7.5**	5.9*	380*
Emergency Department survey				
During your time in the Emergency Department did you feel well looked after by hospital staff?	8.8	**9.0**	8.4	437
How would you rate the courtesy of the Emergency Department reception staff?	8.7	**9.0**	8.2	399
Were you kept informed of what was happening at all stages during your visit?	8.1	**8.5**	7.4	440
Do you think the hospital staff did everything they could to help control your pain?	8.2	**9.0**	7.7	371
Discharge survey*				
Did you feel you were involved in decisions about going home from hospital?*	7.1	**7.4**	7.3*	1,394*

Patient Experience initiatives in 2018/19

Initiative	Update
Increased identification and support of carers driven by the recently introduced Carer Coordinator role.	Since the appointment of two Carer Coordinators in February 2018 a range of resources and training has been developed and implemented across all four hospital sites. This has resulted in increased staff awareness of carer needs, signposting for further support and an additional route for further referral on for a Carers Assessment via third sector partners. Please see the annual report for more information.
Further development of feedback methods to ensure 'hard to reach' groups have a voice and their views are listened to and acted on.	Demographic information collected alongside patient experience feedback has been expanded to ensure compliance with the Stonewall LGBT guidance. Whilst further work is required to ensure this information is collected across all four sites this is a step forward and will assist in identifying groups of patients who are not feeding back or are having a different experience. Feedback has also been obtained from patients with a learning disability via a pilot of an easy read version of the friends and family test. The bespoke version will be rolled out across the Trust and can also be used by other patient groups requiring easy read where appropriate.
Develop work started around the use of chaperones, ensuring patients are informed and staff are educated to ensure chaperones are proactively offered and used appropriately in relevant situations	A survey was completed through which patients were asked whether they understood what a chaperone was, whether they were offered one for their appointment and if so what their experience was of having a chaperone. Results showed a lack of patient understanding in relation to what a chaperone was and why they might need one for certain intimate examinations or procedures. A task and finish group has been established to look at raising awareness and understanding for patients; and ensuring that access to a chaperone is provided in accordance with patient choice. The group is also reviewing staff training to support this.
Continued staff engagement in relation to patient experience, empowering multi-disciplinary team members to understand their role in influencing the overall patient experience, including production of a video highlighting the patient experience quality priorities.	An overview is given to all staff during the main Trust Induction session and other patient experience related training of multi-disciplinary staff has continued throughout 2018/19. An exciting development has been the opportunity to teach on the Trainee Nursing Associate (TNA) curriculum with sessions provided relating to Patient Experience, Carers and Compassionate Care. Student Nurses are also being targeted whilst on placement with Compassionate Care workshops well attended; there are plans in place to extend this training as part of the University based curriculum similar to the TNA training mentioned above. A training video highlighting aspects of care relating to some of the 2018/19 patient experience priorities was made and successfully shared in a variety of forums, including the Trust's annual nursing conference.
Introduction of tablet computers to all wards and some departments to make it easier for patients to provide feedback electronically.	This piece of work has suffered significant delays due to technical issues. In the interim a paper-based alternative is working well and enabling patients to be able to feed back on the services they have received.
Development of the information screen in the Emergency Department to include different pathways to help patients understand why they may wait different times, and the use of paracetamol as first line pain relief.	Updated information is now showing on the Emergency Department television screen. This includes: › Current longest waiting time to be assessed or treated › Information regarding the ED journey/pathway › Other treatment centre options e.g. Pharmacy or NHS Walk in Centres › Emergency dental care information › Self-help advice › Important public health messages e.g. increased measles prevalence › How to provide feedback about your experience

New Patient Experience Priorities for 2019/20
As indicated above, the two patient experience priorities for 2019/20 are ensuring good nutrition and hydration, particularly for those patients who need additional help, and pain control in emergency departments.

Nutrition and Hydration	
Survey questions	1a) If you needed help to eat your meals, who helped you? 1b) Did you get enough help? (filtered for those who needed help only) 2) During your time in hospital, did you get enough to drink?
Local target for 2019/20	Baseline data to be gathered in Quarter 1 2019/20 across all sites to enable a target to be set.
Initiatives for 2019/20	› Ensure consistent surveys across all sites to gain site and ward specific patient insight › New charts and guidance under development › Refresh of the Nutrition and Hydration Steering Group › Review mealtime leadership and support and develop consistent approach. › Review criteria for referral to dietetics › Roll out dedicated beverage trolleys across all sites › Roll out snack boxes across all sites › Increase the number of ward volunteers who provide the beverage trolley service › Develop urine colour charts for staff and patients › Nutrition and Hydration Steering Group 'rounds' (bi-monthly ward visits) › Pilot dining companions scheme and roll out if suitable › *Eat, drink, dress, move* programme to be rolled out across all sites

Pain control in Emergency Departments	
Survey question	1) Do you think the hospital staff did everything they could to control your pain?
Local target for 2019/20	9.0
Initiatives for 2019/20	› Undertake an in depth data analysis to further understand this issue and produce an action plan. › Increase volunteers in Emergency Department to improve collection of patient experience feedback › Quarterly audit of pain scores and time from assessment to analgesia given › Development of a dashboard to show Emergency Department assessment performance

How progress will be monitored, measured and reported

- This priority will be measured using results from the local surveys. Complaints and feedback from other sources will also be included.
- Pain control in the Emergency Departments will also be assessed via quarterly records audit.
- Patient feedback will be analysed alongside clinical data.
- Aspects of nutrition and hydration will be assessed during patient-led visits to clinical areas (PLACE-Lite visits)
- All sites already ask the question relating to pain control in the emergency department, therefore a target has already been set for this.
- Not all sites collect local patient experience data relating to nutrition and hydration. This will be added to all local inpatient surveys and baseline data collected in quarter one in order for targets to be set.
- Results will be published on the Trust's Patient Experience dashboard available to all staff.
- The Patient Experience Group monitors this priority via a bi-monthly report. The Patient Experience Group is led by the Executive Chief Nurse and attended by Governors from each hospital site. This Group reports to the Care Quality Group and onwards to Board and Council of Governors meetings.
- Reports will also be received by the Nutrition and Hydration Steering Group and the Emergency Department's management team.

The Friends and Family Test (FFT)
The Friends and Family Test (FFT) asks patients the following question to help us to listen to feedback from our patients:

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

Patients can choose from six different responses as follows:

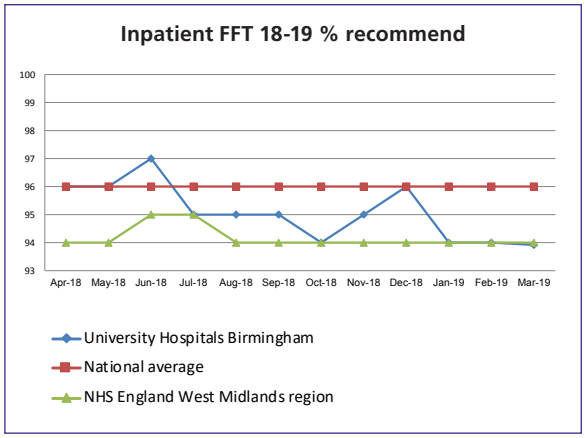
- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely Unlikely
- Don't know

This is asked via a number of methods, primarily via paper, tablet or SMS text messaging. The Trust follows the national guidance for undertaking and scoring of the FFT.

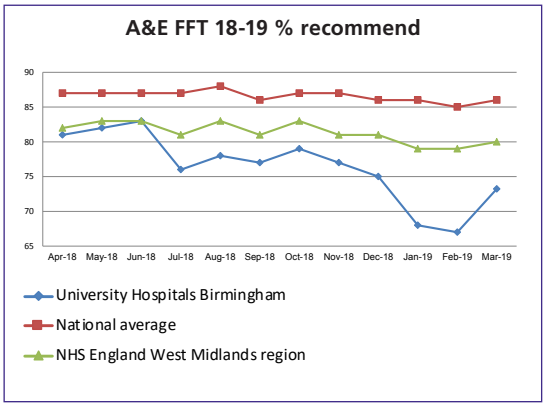
Response rates and positive recommendation percentages were closely monitored throughout 2018/19 against internal targets set and tracked against national and regional averages to benchmark against peers. The charts below show benchmark comparisons for the positive recommendation percentages for the Friends and Family Test for Inpatients, A&E, Outpatients, Maternity and Community Services.

Performance

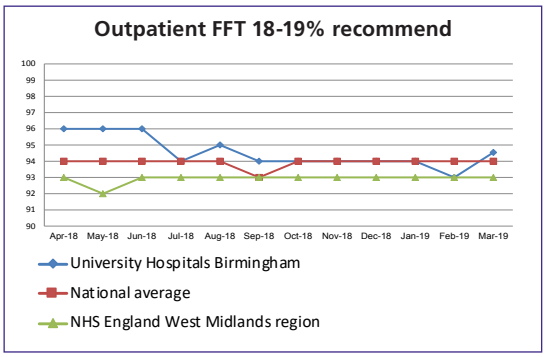
Inpatients: During 2018/19 the Trust maintained a positive recommendation rate that was above or equal to the West Midlands regional average. The Trust scored below or equal to the national average with the exception of June 2018.



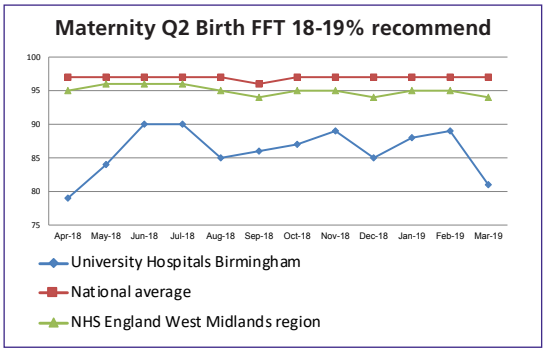
A&E: During 2018/19 the Trust's positive recommendation rate reduced over the year tracking the four-hour wait target. It remained below or equal to the West Midlands regional average and below the national average reflecting the challenges that the Trust has seen in this area.

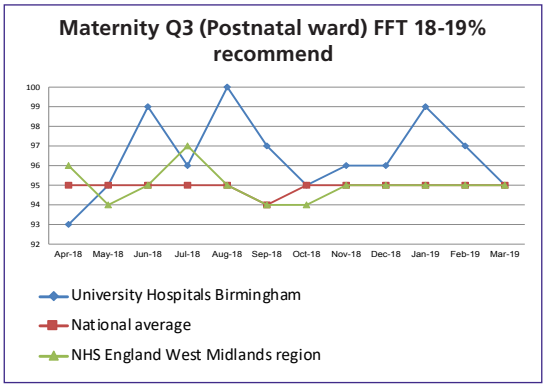


Outpatients: During 2018/19 the Trust maintained a positive recommendation rate, which for most months is significantly higher than the West Midlands regional average, and higher or equal to the national average. February 2019 saw a transient dip slightly below the national average but remaining equal to the regional average.

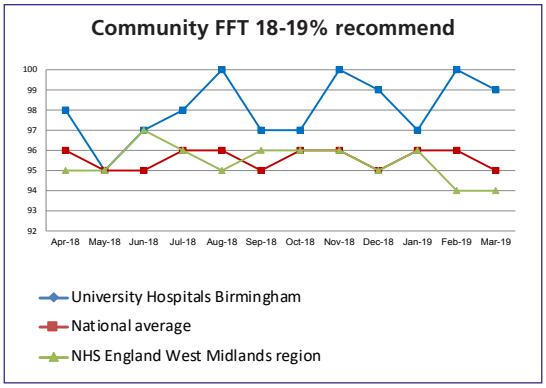


Maternity: During 2018/19 the Trust remained below the national and regional average for birth, but above the national and regional averages for postnatal care on the ward. Some additional focused work is being undertaken to understand these figures and actions will be implemented to improve the birth experience.





Community: During 2018/19 the Trust achieved a high positive recommendation rate for community services in Solihull, which is significantly higher or equal to both the West Midlands regional average, and the national average.



Complaints

The total number of complaints received in 2018/19 was 1950, an increase of 8.6% on the 1796 complaints received in 2017/18. The main subjects related to clinical treatment communication and patient care.

	2016/17	2017/18	2018/19
Total number of complaints	1,902	1,796	1,950

The table below compares complaints received against activity data. The number of inpatient, outpatient and emergency department complaints received in 2018/19 increased compared to the previous year, whilst activity also increased in all those areas. Whilst the complaints to activity ratios for inpatients and the emergency department were stable, there was an increase in the ratio of complaints to activity ratio for outpatients.

Rate of all complaints to activity		2016/17	2017/18	2018/19
Inpatients	FCEs*	494,152	503,631	539,603
	Complaints	902	879	900
	Rate per 1000 FCEs	**1.8**	**1.7**	**1.7**
Outpatients	Appointments	1,812,279	1,809,916	1,901,636
	Complaints	606	631	691
	Rate per 1000 appointments	**0.3**	**0.3**	**0.4**
Emergency Department	Attendances	382,247	389,726	408,310
	Complaints	341	272	304
	Rate per 1000 attendances	**0.9**	**0.7**	**0.7**

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant

Learning from complaints

The table below provides some examples of how the Trust responded to complaints where serious issues were raised; a number of complaints were received about the same or similar issues or for the same location, or where an individual complaint resulted in specific learning and/or actions. The actions may have taken place in one department/ site, but learning is shared across all sites to see if further improvements can made Trust-wide.

Issue	Action taken
Hot stuffy waiting room conditions.	Dyson cooling fans ordered and installed in some of the outpatient departments.
Patient with ICD (implantable cardiac defibrillator) attended for colonoscopy but the procedure could not go ahead because appropriate staff to disable device not there on Sunday	Reminder to referring clinician of importance of highlighting such issues. Patient leaflet updated to highlight ICDs. Issue highlighted to other specialties to check whether changes need to be made to their processes and/or leaflets to take account of such situations.
Discharge and transfer arrangements from ward to hospice without advising patient's family.	Whiteboard in the discharge lounge to track patients' journeys through the lounge. Designated member of staff to be allocated areas in the lounge to ensure patients in that area have everything they need.

More information around how learning is shared across the Trust can be found in our annual report.

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

PHSO Involvement	2016/17	2017/18	2018/19
Cases which were not upheld following review by the PHSO	22	13	15
Cases which were partially upheld following review by the PHSO	22	13	5
Cases which were fully upheld following review by the PHSO	2	0	0
Total cases reported on following investigation by the PHSO	**46**	**26**	**20**

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

There was a significant reduction in the number of cases reported on by the Ombudsman in 2018/19.

Only five cases were upheld or partially upheld by the Ombudsman in 2018/19, a reduction on the 13 cases in the previous year. A further 15 cases were not upheld by the Ombudsman, compared to 13 last year. In every case, appropriate apologies were provided, action plans were developed where requested and learning from the cases shared with relevant staff.

Compliments

The majority of compliments are received in writing – by letter, card, email, website contact or via the Trust Patient Experience feedback leaflet, the rest are received verbally via telephone or face to face. Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale.

UHB consistently receives considerably more compliments than it does complaints. Overall however the Trust recorded fewer formal compliments in 2018/19 (1,970) than in 2017/18 (2,136)

The Patient Experience team provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments.

Compliment Categories	2016/17	2017/18	2018/19
Nursing care	306	468	531
Friendliness of staff	97	141	121
Treatment received	1,582	1,210	941
Medical care	88	101	174
Other	19	22	24
Efficiency of service	287	167	138
Information provided	28	25	39
Facilities	2	2	2
Total	**2,409**	**2,136**	**1,970**

Examples of compliments received during 2018/19:

"We wish to express our appreciation and gratitude to the ward staff at **Good Hope Hospital**, who provided exemplary care over the last 8 days of our mother's life. The team were able to answer our questions and make the necessary arrangements for the administration of the antibiotics and eventual analgesics and anti-anxiety drug. Special thanks to staff who demonstrated exemplary compassion and care and made sure our mother was comfortable throughout her stay."

"The **Heartlands Hospital** staff were wonderful. Some staff in particular were incredibly efficient, put me on medication straight away, kept me informed, and were compassionate and thoughtful."

"It was a comfort to all of us to know that he had been receiving the best possible care when he was being looked after on your ward at **QEHB**. I would particularly like to thank the nurses who looked after him – you were so kind to him and to our family whenever we visited. What you do is so important and you do it with a huge amount of patience and generosity. Thank you. I would also like to thank the doctor who sat down with me a few weeks ago and talked me through the whole situation. I arrived at the hospital that day feeling extremely anxious about Dad and I left so much more assured that he had the best possible team looking out for him and that he was safe in your care."

"The food at **Solihull Hospital** was of outstanding quality – it helped me to recover following surgery."

Feedback received through The NHS Website, Care Opinion and Healthwatch websites

The Trust has a system in place to monitor feedback posted on three external websites; The NHS Website (previously NHS Choices), Care Opinion and Healthwatch. Feedback is sent to the relevant service / department manager for information and action. A response is posted to each comment received which acknowledges the comment and provides general information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response, or to ensure a thorough investigation into any concerns raised.

Feedback received by this method has shown a significant increase of 212 per cent during the year (from 183 in 2017/18 to 571 in 2018/19). These figures include feedback received via this method relating to all four hospital sites. Numbers remain low compared to other methods of feedback used by patients and carers although are increasing year on year. Most feedback posted on these external websites is positive; concerns raised via this method reflect themes raised via more direct methods, for example via PALS, complaints or locally received verbal feedback.

Priority 3: Timely and complete observations including pain assessment

Background – QEHB

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

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool automatically triggers an early warning score called the SEWS (Standardised Early Warning System) score if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible.

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

In addition, the timeliness of analgesia (pain relief medication) following a high pain score is monitored. The pain scale used at QEHB runs from 0 (no pain at rest or movement) to 10 (worst pain possible). Whenever a patient scores 7 or above, they should be given analgesia within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work.

Performance – QEHB

Indicator 1 (Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward)

As performance had improved during 2017/18 but did not quite met the 95% target, this target was kept for 2018/19.

2018/19 improved compared to 2017/18 but did not quite meet the 95% target for the year, although there were individual months where this was achieved.

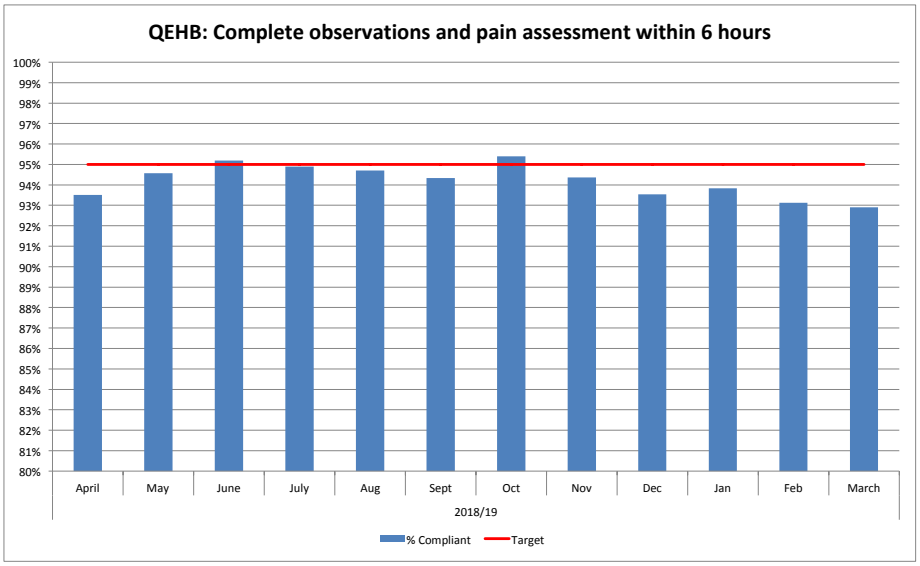
Indicator 2 (Analgesia administered within 30 minutes of a high pain score)

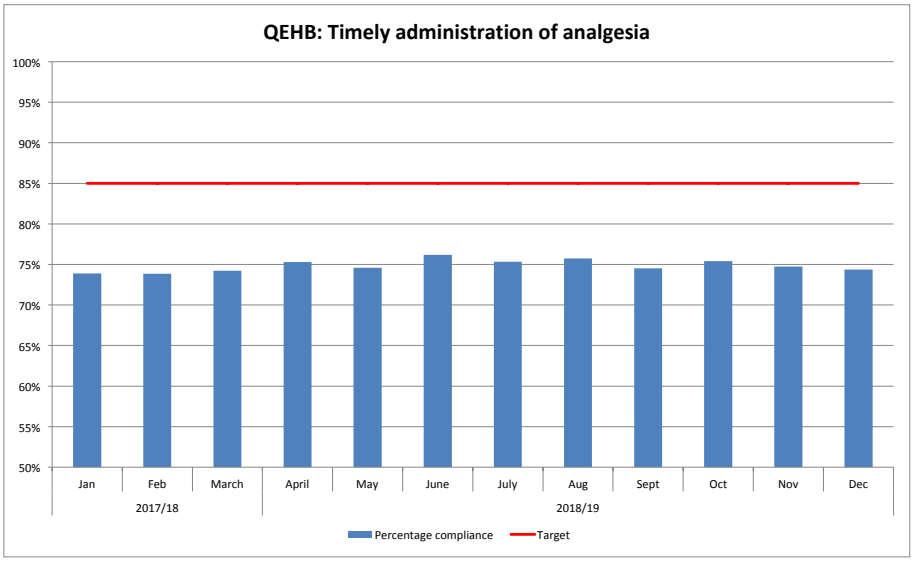
The target had not been achieved during 2017/18, so the same target of 85% was kept for 2018/19. Performance was again steady throughout the year, around 74% to 76% each month, however the target of 85% was not achieved – overall performance was 75%.

Table: Performance by quarter

		Indicator 1	Indicator 2
		Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward	Analgesia administered within 30 minutes of a high pain score
Performance 2014/15		71%	64%
Performance 2015/16		79%	76%
Performance 2016/17		90%	75%
Performance 2017/18		93%	75%
2018/19	**Target**	**95%**	**85%**
	Q1	94.6%	75.3%
	Q2	94.7%	75.2%
	Q3	94.5%	74.8%
	Q4	93.3%	74.7%
	Year	**94.3%**	**75.0%**

Graphs: Performance by month





Background – Heartlands, Good Hope and Solihull Hospitals
The Board of Directors agreed to introduce this Priority in the 2017/18 Quality Report.

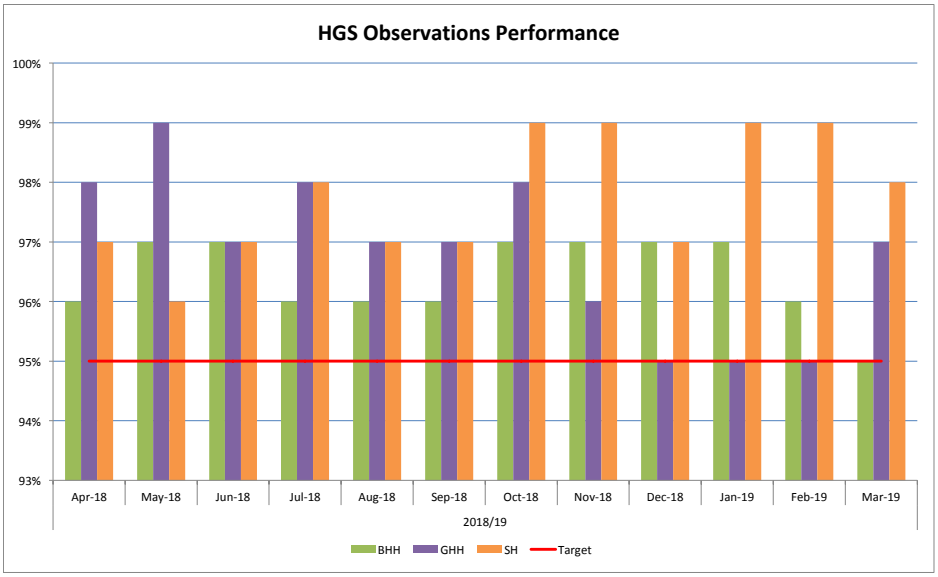
When nursing staff carry out patient observations, it is important that they complete the full set of observations, as this allows them to calculate an early warning score which highlights if a patient's condition is starting to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible.

Currently at Heartlands, Good Hope and Solihull Hospitals, observations are recorded on paper charts, but there are plans to roll out PICS across the Heartlands, Good Hope and Solihull Hospitals sites and this will allow electronic recording of observations.

The data gathered for the Heartlands, Good Hope and Solihull Hospitals sites is drawn from a monthly audit of nursing notes across the wards, known as the Nursing Metrics. The score is based on an aggregate of various standards relating to observations.

Performance – Heartlands, Good Hope and Solihull Hospitals
The target is 95%, which has been met by each site and for Heartlands, Good Hope and Solihull Hospitals overall every month during 2018/19.

Performance is displayed in the graph below.



Initiatives implemented in 2018/19
- Wards' performance is monitored at a divisional and Trust level. Lower performing wards developed action plans to make improvements, and have been called to Executive Care Omissions Root Cause Analysis (RCA) meetings.
- Wards and Divisions have taken actions at their local level; these include:
  - Use of computers in handover to immediately identify any outstanding observations which have occurred
  - Ensuring PICS tablets are calibrated to the correct ward to avoid data errors
  - Training for HCAs to assist qualified nurses with observations
  - Spot-checks by Matrons
  - PICS team invited to give refresher training to ward staff

Changes to Improvement Priority for 2019/20
UHB is working on the implementation of NEWS2 (National Early Warning Score) – a new system that is to be used nationally. Once in place, the indicators will be checked, and if necessary updated, to reflect use of this new system.

QEHB
Indicator 1 - as the performance improved but did not achieve the target at the end of 2017/18, the Trust has chosen to keep the target for 2018/19:
1. Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward: 95% by the end of the year.

QEHB Indicator 2 - as performance was steady throughout the year, meaning the target was not achieved, the Trust has chosen to keep the same

target for 2018/19:

2. Analgesia administered within 30 minutes of a high pain score: 85% by the end of the year.

UHB also plans to review the underlying data in more detail, to break the time down into prescription time and administration time to better identify the reasons that this indicator is not being achieved. Depending on the findings from this, the indicator may change to be more targeted.

Heartlands, Good Hope and Solihull Hospitals
The observations indicator will stay the same, pending introduction of PICS.

UHB will review the Nursing Metrics data to scope the development of an indicator relating to pain assessment for Heartlands, Good Hope and Solihull Hospitals pending introduction of PICS. Baseline data will be reviewed and targets set accordingly.

Initiatives to be implemented in 2019/20

- Wards performing below target will continue to be reviewed at the Executive Care Omissions Root Cause Analysis (RCA) meetings to identify where improvements can be made. Observations and pain assessment compliance will be monitored as part of the unannounced monthly Board of Directors' Governance Visits to wards.
- To include pain assessment for Heartlands, Good Hope and Solihull Hospitals sites.
- To review the data behind the timely analgesia indicator, to identify the time taken to prescribe and the time taken to administer the medication.

How progress will be monitored, measured and reported

- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard (QEHB) and Nursing Metrics (Heartlands, Good Hope and Solihull Hospitals). The Clinical Dashboard allows staff to compare their ward performance to the Trust as a whole, as well as seeing detailed data about which of the six observations or pain assessment were missed.
- Performance will continue to be measured using PICS data from the electronic observation charts, and data from the Nursing Metrics.
- Progress and exceptions will be reported to the Clinical Quality Monitoring Group and the Board of Directors in the Quality Performance report.
- Progress will be publicly reported in the mid-year Quality Report update published on the Trust's quality web pages.

Priority 4: Reducing missed doses

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

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

In the absence of a national consensus on what constitutes an expected level of drug omissions, the Trust has set targets based on previous performance.

It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time, and when a patient refuses a drug this is also recorded as a missed dose. The Trust has decided to record patient refusals as missed doses, as it is important for the staff looking after the patient to encourage them to take the medication, and to consider the reasons for refusal and whether a different medication would be more appropriate.

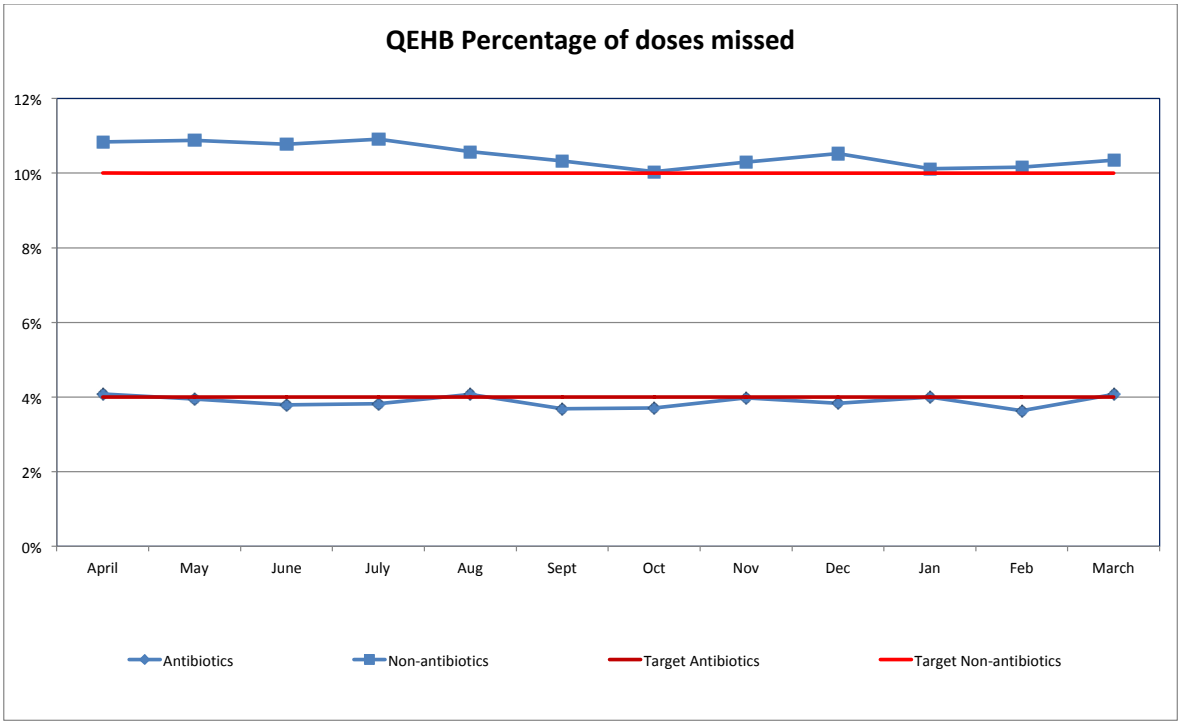
At Heartlands, Good Hope and Solihull Hospitals, drug prescriptions and administrations are recorded on a different electronic system, and the chosen indicator is the rate of missed doses of regular antibiotics.

Performance - QEHB
Antibiotics: performance in the last quarter of 2017/18 was 4.4%, so in the 2017/18 Quality Report the Trust committed to reducing this to 4.0% by the end of 2018/19.

In 2018/19 QEHB achieved 3.9%, and also met the target every quarter.

Non-antibiotics: performance in the last quarter of 2017/18 was 11.8%, so in the 2017/18 Quality Report the Trust committed to reducing this to 10.0% by the end of 2018/19.

In 2018/19 QEHB achieved 10.5% for the year, and Quarter 4 was 10.2%. While this did not meet the target, performance improved compared to the previous year.



	Antibiotics	Non-antibiotics
Performance 2014/15	4.0%	10.5%
Performance 2015/16	3.9%	10.5%
Performance 2016/17	4.1%	10.6%
Performance 2017/18	4.5%	11.3%

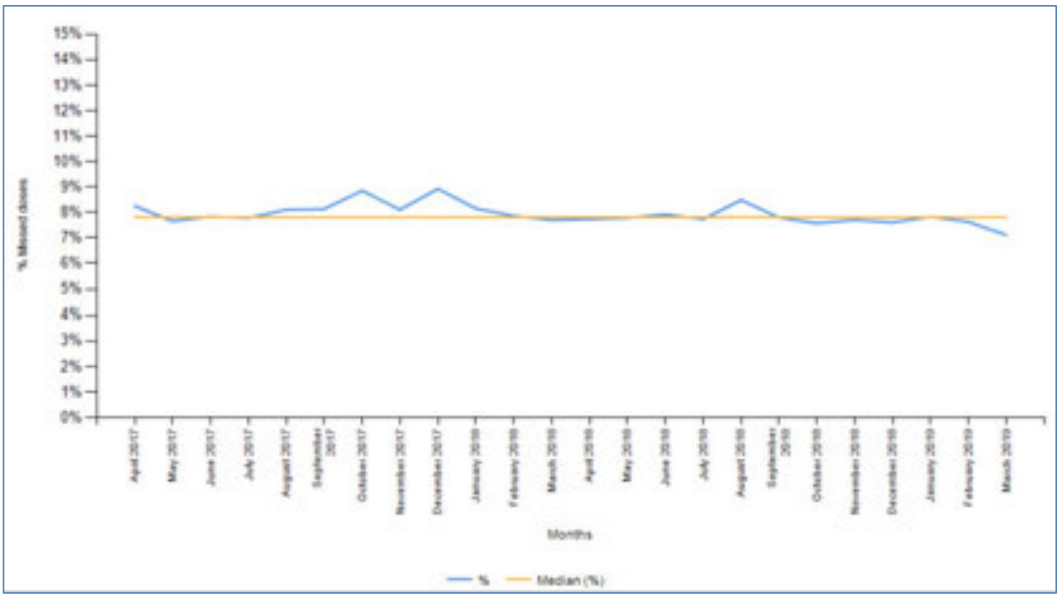
2018/19	**Target**	**4% or lower**	**10% or lower**
	Q1	3.9%	10.8%
	Q2	3.9%	10.6%
	Q3	3.8%	10.3%
	Q4	3.9%	10.2%
	Year	**3.9%**	**10.5%**

Performance (Heartlands, Good Hope and Solihull Hospitals)

For Heartlands, Good Hope and Solihull Hospitals, the Trust chose to measure the percentage of missed doses of regular antibiotics.

Performance has been steady at around 8-9% for the last two years.

Graph: percentage of missed doses of regular antibiotics (Heartlands, Good Hope and Solihull Hospitals)



Initiatives implemented during 2018/19

- Reports which display rates of missed doses, and missed doses due to medication being intermittently out of stock, continued to be used to identify cases for review at the Executive Care Omissions RCA meetings (Executive RCAs).
- Wards that are identified as exceptions for missed doses have been called to the Executive RCAs, where they talk through their data, any problems identified and actions taken.
- Development of a 'missed doses training pack' to ensure information on missed doses is fully recorded on PICS, to allow for analysis and identification of trends.
- Development of indicators that monitor timely administration of Parkinson's medications, and ensuring these are aligned across the hospital sites.
- Wards and Divisions have taken actions at their local level, these include:
  - Establishing regular in-depth reviews of their data to identify trends.
  - Ensuring that missed doses form part of the handover between staff.
  - Continuing to roll out PGD training (Patient Group Directions) which allow nurses with the relevant competencies to give certain painkillers without the need for a prescription from a doctor.
  - Reminding staff to use the dropdown box on the electronic drugs chart to accurately record the reason for a drug being recorded as missed. This will help identify common problems.
  - Continuation of monthly assurance meetings where a ward presents their performance against a number of indicators, and discusses actions taken to make improvements. Attendees include senior nurses for the area, and lead nurses for Pharmacy and Standards.

Changes to Improvement Priority for 2019/20

- The focus will change from missed doses of antibiotics to reducing consecutive missed doses, and missed doses of selected high risk medicines (to be agreed).
- Missed doses of antibiotics will continue to be monitored internally.
- The indicator on missed non-antibiotics will be retained along with the 10% target. Work will be undertaken to measure this on all four hospital sites.

Initiatives to be implemented in 2019/20

- UHB will scope the development of new indicators that measure omissions of selected high risk medications, and consecutive missed doses.
- Individual cases will continue to be selected for further review at the Executive Care Omissions RCA meetings.
- Multi-disciplinary work will continue to identify further opportunities to reduce missed doses.

How progress will be monitored, measured and reported

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded electronically.
- Data on missed drug doses will continue to be made available to clinical staff. This will also be monitored at divisional, specialty and ward levels.
- Progress and exceptions will be reported to the Clinical Quality Monitoring Group and the Board of Directors in the Quality Performance report.
- Progress will be publicly reported in the mid-year Quality Report update published on the Trust's quality web pages.

Priority 5 – Reducing harm from falls

This quality improvement priority was originally proposed by the Council of Governors and approved by the Board of Directors. It was first included in the 2016/17 Quality Report.

Background

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital are the most common reported patient safety incident, with more than 240,000 reported in acute hospitals and Mental Health trusts in England and Wales every year (Royal College of Physicians, National Audit of Inpatient Falls, 2015). About 30% of people 65 years of age or older have a fall each year, increasing to 50% in people 80 years of age or older (NICE).

All falls can impact on quality of life; they can cause patients distress, pain, injury, prolonged hospitalisation and a greater risk of death due to underlying ill health. Falls can result in loss of confidence and independence which can result in patients going into long term care. Falling also affects the family members and carers of people who fall.

When a fall occurs at UHB, the staff looking after the patient submit an incident form via Datix, the Trust's incident reporting system. All falls incidents are reviewed by the Trust's Falls Team, a team of clinical nurse specialists. The lead for the area where the fall happened, usually the Senior Sister / Charge Nurse, investigates the fall and reports on the outcome of the fall, and whether there is any learning or if any changes in practice / policy need to be made.

Most falls do not result in any harm to the patient. Any falls resulting in severe harm undergo an RCA (root cause analysis) process to identify any issues or contributory factors. Falls resulting in specific harm, e.g., a fractured neck of femur (broken hip), are also reported to the local Clinical Commissioning Group and externally reported via STEIS (the system used to report and monitor the progress of Serious Incident investigations across the NHS).

For all severe falls an initial investigation is undertaken within three days of the fall in order to highlight any immediate actions required, a round table clinical review is then held within thirty days following a more in-depth investigation. The review is multidisciplinary and includes the senior nurse for the clinical area, the matron and the falls coordinator, therapy staff and medical staff where appropriate. Details from this review are then incorporated into the detailed RCA (root cause analysis) that is signed off at the relevant Nursing Incident Quality Assurance meeting where the senior nurse is challenged by the Head Nurse to ensure that all learning from the incident has been incorporated into the RCA, and implemented across the clinical team.

Falls prevention

All inpatients should undergo a Falls Assessment on admission/transfer to a ward or if their clinical condition changes. If a patient is found to be at an increased risk at of falls, staff will identify the risk factors and the precautions that can be taken to reduce these risks. These may include a medication review by pharmacy staff, provision of good-fitting footwear, ensuring chairs are the correct height and width for the patient, or moving the patient to a height-adjustable bed.

The Falls Team also receives information on patients who have fallen more than once during their hospital stay. These patients are reviewed, taking account of mobility, medication, continence and altered cognition. The Falls Team then make suitable recommendations to the ward staff around intervention and prevention of further falls.

The Falls Team provides training on falls assessment, prevention and management to ward staff, junior doctors and students.

Performance – QEHB
For QEHB, the Trust has chosen to measure 'percentage of falls resulting in harm'.

(This refers to all levels of harm, from minor to catastrophic/death).

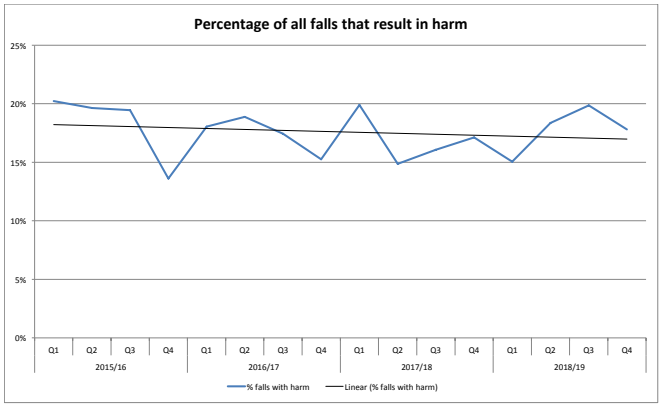
While staff take precautions to prevent falls from occurring, it is not possible to prevent all falls, therefore it is also important to attempt to minimise the harm that occurs due to falls.

Data for the last three years is presented below:

Year	Quarter	Percentage of falls with harm
2016/17	Q1	18.1%
	Q2	18.9%
	Q3	17.4%
	Q4	15.3%
	Year	**17.4%**
2017/18	Q1	19.9%
	Q2	14.9%
	Q3	16.1%
	Q4	17.1%
	Year	**17.0%**
2018/19	Q1	15.1%
	Q2	18.4%
	Q3	19.9%
	Q4	17.8%
	Year	**17.8%**

The Trust decided to set a target of 16.9% by the end of 2018/19 – this was a 1.5% reduction on the Quarter 4 2017/18 data.

At the end of Quarter 4 2018/19, the target was not met.



Performance – Heartlands, Good Hope and Solihull Hospitals
For Heartlands, Good Hope and Solihull Hospitals, the Trust chose to measure 'percentage of all falls that are injurious', i.e., the number of falls that result in harm that must be reported nationally; these include falls that result in a fractured neck of femur (broken hip), and certain head injuries (i.e. those deemed to be severe harm).

While staff take precautions to prevent falls from occurring, it is not possible to prevent all falls. Therefore it is also important to minimise the harm that occurs due to falls.

As the injurious harm rate at Heartlands, Good Hope and Solihull Hospitals is already low, the Trust chose to set a maintenance target for 2018/19, i.e., to stay at or below the performance reported for the previous year (1.7%).

For 2018/19, the rate of injurious falls was 1.4%, meeting the target of 1.7% or lower.

Data for the last three years is presented below:

Year	Quarter	Percentage (%) of all falls that are injurious
2016/17	Q1	1.3%
	Q2	1.1%
	Q3	1.5%
	Q4	2.0%
	Year	**1.5%**
2017/18	Q1	1.4%
	Q2	2.5%
	Q3	1.9%
	Q4	1.0%
	Year	**1.7%**
2018/19	Q1	1.9%
	Q2	1.0%
	Q3	1.4%
	Q4	1.2%
	Year	**1.4%**

(Please note that this data has undergone final validation since the 2017/18 Quality Report and may have changed slightly).

It should also be noted that there has been an increase in activity across the Trust, so when other measures are used (for example, number of falls as a rate against 1000 bed days), performance has improved, i.e., the rate has dropped.

Initiatives implemented during 2018/19

- QEHB and Heartlands, Good Hope and Solihull Hospitals are now using a merged RCA tool and are following the same standardised RCA investigation process
- The falls team held a falls summit in March 2019 where key stakeholders from across the Trust have identified and agreed on several work streams that will inform and assist with a falls strategy for 2019/20
- In January 2019 the Royal College of Physicians National Inpatient Falls Audit commenced which the Trust is participating in

Initiatives to be implemented during 2019/20

- The falls team are working collaboratively with key stakeholders across the Trust in the development of a UHB strategy for achieving further reductions in falls and falls with harm during 2019/20
- The falls team continue to raise the profile of the Trust Falls Prevention Team, for example by ensuring active engagement in Back to the Floor visits, attendance at Divisional Preventing Harm meetings, supporting clinical staff in implementing falls prevention strategies, audit of falls assessment compliance and interventions, problem solving, and RCA completion and action planning
- The falls team are working collaboratively with the Trust clinical education team to review and plan falls training so that it remains targeted and appropriate, whilst aligning with the wider educational strategy
- Continue to monitor and re-evaluate the Trust compliance with NICE guidelines CG161 and Falls Quality Standards 2017, and implement any actions identified
- Assist with the development and implementation of a combined Trust-wide falls Datix (incident reporting) form and explore how this can be incorporated into existing IT systems to ensure a more efficient and effective method of capturing incident information and investigation
- To work with commissioners on improving the patient pathway on discharge from hospital, including discharge information and appropriate referral processes

Changes to Improvement Priority for 2019/20

The Trust has chosen to focus on reducing the overall number of falls that occur and associated harm.

In 2018/19, 6123 inpatient falls occurred at UHB. Therefore the Trust has chosen to set a target of no more than 5817 falls during 2019/20, which is equivalent to a 5% reduction.

How progress will be monitored, measured and reported

- Data on falls will continue to be presented to the monthly Trust Preventing Harm group, which reports to the Chief Nurse's Care Quality Group.
- Data on falls will also provided to the Medical Director's monthly Clinical Quality Monitoring Group
- Ward-level and trust-level data on falls is available to clinical staff via electronic dashboards and reports
- Falls with specific outcomes, e.g., a fractured neck of femur (broken hip), will continue to be reported to the local Clinical Commissioning Group
- Progress and exceptions will be reported to the Clinical Quality Monitoring Group and the Board of Directors in the Quality Performance report.
- Progress will be publicly reported in the mid-year Quality Report update published on the Trust's quality web pages

Priority 6 – Timely treatment for sepsis

This important quality improvement priority remained in place during 2018/19.

Background

Sepsis is a potentially life-threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to sepsis annually. Of these it is estimated that 11,000 could have been prevented.

Sepsis has been on the national agenda as a high priority area for the Commissioning for Quality and Innovation (CQUIN) system and in 2016/17 certain trusts had a key target to implement systematic screening for sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. This CQUIN was extended into the 2017–19 plan, and UHB sites participated in this by submitting separate data to the CCG (NHS England 2015).

The purpose of the CQUIN was to embed a systematic approach towards the prompt identification and appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics.

Although there are certain groups in whom sepsis is more common, the very young and very old, people with multiple co-morbidities, people with impaired immunity and pregnant women, it can occur in anybody, regardless of their age or health status.

Sepsis is common and can be treatable if it is recognised early and appropriately managed. It can be difficult to diagnose sepsis early and if recognition is delayed and appropriate treatment not instituted (usually oxygen, intravenous fluids and antibiotics), significant harm or even death can occur.

The Trust's intranet pages have a library of information on recognising the symptoms of sepsis, screening patients and treating sepsis. These pages are available for all staff to view and have been promoted by the Trust's Communications team.

The Trust's aim for 2018/19 was to improve the early recognition and management of patients with sepsis.

Performance

Indicator 2a: Timely identification of sepsis in emergency departments and acute inpatient settings.

Quarterly audit of 150 emergency admissions and 150 inpatients that met the criteria for screening for sepsis as per local protocol.

Target: over 90% of patients to have evidence of screening for sepsis using the Trust screening tool.

Indicator 2b: Timely treatment of sepsis in emergency departments and acute inpatient settings.

Quarterly audit of patients identified as having sepsis from part 2a above. Time between diagnosis of sepsis and antibiotics administered is then assessed.

Target: over 90% to be given with 60mins.

		Indicator 2a: Timely identification of sepsis			Indicator 2b: Timely treatment of sepsis		
		Emergency Departments	Acute Inpatient	Overall	Emergency Departments	Acute Inpatient	Overall
Q1	BHH/ GHH/SH	57.1%	63.2%	59.7%	53.8%	68.6%	60.8%
	QEHB	95.2%	99%	97%	88.7%	89.1%	88.8%
Q2	BHH/ GHH/SH	62.5%	83.7%	70.5%	46.7%	69.2%	57.1%
	QEHB	85.7%	98%	91%	93.4%	92.5%	93%
Q3	BHH/ GHH/SH	65%	82.7%	74.3%	56.6%	73%	66.1%
	QEHB	82.6%	96%	88.9%	86.9%	86.7%	86.9%
Q4	BHH/ GHH/SH						
	QEHB						

At time of writing, Quarter 4 is not yet available.

It should be noted that at the start of 2018/19, different audit methodologies and screening criteria were in place at the QEHB site and the Heartlands, Good Hope and Solihull sites. This has since been addressed but means that performance should not be compared for this time period.

For 2019/20, the CQUIN is not in place but the Trust will continue to aim to meet the Key Performance Indicator targets set out above and will report these quarterly to the CCG in line with national 2019/20 contract.

Initiatives implemented during 2018/19

- A Trust Sepsis Group was created in August 2018 and now meets monthly with the two "local" sepsis teams from across the merged UHB sites. Work has been undertaken to align audit methodologies, standards and education.
- A sepsis learning module for MOODLE has been developed and will form part of mandatory training plus optional modules for those looking for a more in-depth knowledge
- At QEHB a screening question was implemented in PICS at the beginning of July 2018. This tool was updated on 31st January 2019 with the introduction of the NEWS2 score, which replaced the SEWS score.
- The QEHB Sepsis guidelines were reviewed and updated in line with new NEWS2 score.
- The QEHB antimicrobial guideline underwent a major review in key sections such as sepsis of unknown origin, community and hospital acquired pneumonia, pyelonephritis and complicated UTI, promoting the use of narrower spectrum antibiotics.

- At QEHB audits on the management of sepsis and implementation of the elements of sepsis bundle were undertaken in a few specialist areas.
- At Heartlands, Solihull and Good Hope Hospitals a sepsis nurse was appointed in the autumn which has led to better quality audits, with sufficient numbers reviewed and an increasing role in education on the wards. A new audit tool was developed to capture timings and increased collaboration with Critical Care Outreach Team who are now recording audit data in real time.
- At Heartlands, Solihull and Good Hope Hospitals there was the successful roll-out of NEWS2 with new paper observation charts and education required.

Initiatives to be implemented during 2019/20

- Datix incidents will be completed for all identified instances of non-compliance with sepsis screening and delay in administration of antibiotics over 60 minutes.
- The education tools will be completed with annual refreshes and updates on cases.
- A sepsis dashboard will be created, where performance can be monitored in real time at ward level, initially at QEHB.
- The role of the sepsis nurse will be reviewed and defined with probable four site working.
- Further work will be undertaken to align tools and processes across the four sites.
- Moving to the requirements of the KPI whilst developing a quality surveillance and education framework for the care of the deteriorating patient (Heartlands, Good Hope and Solihull Hospitals)
- Improving online resources to allow wards to undertake their own Quality Improvement Priorities (QIPs) for sepsis.

How progress will be monitored, measured and reported

- Performance against the KPIs will be reported to the Trust's Sepsis Group and local sepsis groups, in addition to the Clinical Commissioning Group (CCG).
- Progress and exceptions will also be reported to the Clinical Quality Monitoring Group and the Board of Directors in the Quality Performance report.
- Progress will be publicly reported in the mid-year Quality Report update published on the Trust's quality web pages.

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2018/19 the University Hospitals Birmingham NHS Foundation Trust provided and/or sub-contracted 74 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in 74 of these relevant health services*.

The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2018/19.

*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.

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 2018/19, 47 national clinical audits and 4 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 96% (45 of 47) national clinical audits and 100% (4 of 4) 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 2018/19 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in during 2018/19 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2018/19, 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.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2018/2019	Percentage of required number of cases submitted
Adult Cardiac Surgery	Yes	100%
Adult Community Acquired Pneumonia	Yes	Data collection ongoing.
BAUS Urology Audit- Cystectomy	Yes	99%
BAUS Urology Audit- Female Stress Urinary Incontinence (SUI)	Yes	100%*
BAUS Urology Audit- Nephrectomy	Yes	100%*
BAUS Urology Audit- Percutaneous Nephrolithotomy	Yes	100%
BAUS Urology Audit- Radical Prostatectomy	Yes	82%
Cardiac Rhythm Management (CRM)	Yes	>80%
Case Mix Programme	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	80%
Feverish Children (care in emergency departments)	Yes	Report not yet published.
Inflammatory Bowel Disease programme/ IBD Registry	Yes	Data collection ongoing.
Major Trauma Unit (TARN)	Yes	91%
Maternal, Newborn and Infant Clinical trauma Review Programme	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	95%
National Asthma and COPD Audit Programme	Yes	Still in pilot stage.
National Audit of Breast Cancer in Older People	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	Data collection not yet started.
National Audit of Dementia	Yes	N/A
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Data collection ongoing.
National Bariatric Surgery Registry (NBSR)	Yes	100%
National Bowel Cancer Audit (NBOCA)	Yes	83%
National Cardiac Arrest Audit (NCAA)	No	UHB did not participate.
National Clinic Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	100%
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	100%
National Comparative Audit of Blood Transfusion programme	Yes	100%
National Congenital Heart Disease (CHD)	Yes	92.5%
National Diabetes Audit	No	100% (Note: UHB only participated in certain aspects of the Diabetes Audit Programme.)
National Emergency Laparotomy Audit (NELA)	Yes	98%
National Heart Failure Audit	Yes	89.5%
National Joint Registry (NJR)	Yes	83.23% (1461 cases)
National Lung Cancer Audit (NLCA)	Yes	68%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	91%
National Oesophago-gastric Cancer (NAOGC)	Yes	85.7%

National Audit UHB eligible to participate in	UHB participation 2018/2019	Percentage of required number of cases submitted
National Ophthalmology Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	87.25%
National Prostate Cancer Audit	Yes	98%
National Vascular Registry	Yes	88.4%
Neurosurgical National Audit Programme	Yes	100.0%
Non-Invasive Ventilation- Adults	Yes	Data collection ongoing.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	100%
Seven Day Hospital Services	Yes	100%
UK Cystic Fibrosis Registry	Yes	63.5%
Vital Signs in Adults (care in emergency departments)	Yes	Reports not yet published.
VTE Risk in lower limb immobilisation (care in emergency department)	Yes	Reports not yet published.

* these audits have submitted a higher number of cases than the minimum required.

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2018/19	Percentage of required number of cases submitted
Perioperative Diabetes	Yes	100%
Pulmonary Embolism	Yes	100%
Bowel Obstruction	Yes	100%
Long Term Ventilation	Yes	On-going Study: 23% completed

Percentages given are the latest available figures.

The reports of 16 national clinical audits were reviewed by the provider in 2018/19 and UHB intends to take the following actions to improve the quality of healthcare provided: (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

The reports of 353 local clinical audits were reviewed by the provider in 2018/19 and UHB intends to take the following actions to improve the quality of healthcare provided (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

At UHB a wide range of local clinical audits are undertaken. This includes Trust-wide audits and specialty-specific audits which reflect local interests and priorities. A total of 1301 clinical audits were registered with UHB's clinical audit team during 2018/19. Of these audits, 457 were completed during the financial year (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

2.2.3 Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was:

NIHR portfolio studies	15,068
Non-NIHR portfolio studies	972
Total	**16,040**

For more information on research carried out at UHB and other highlights, please see the relevant section of the Annual Report.

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

A proportion of UHB income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between UHB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at http://www.uhb.nhs.uk/quality-reports.htm

The amount of UHB income in 2018/19 which was conditional upon achieving quality improvement and innovation goals was £13.6m* (QEHB) and £12.7m* (BHH/GHH/SH). Final payment for 2018/19 will not be known until June 2019.

* These figures represent the amount of income achievable based on the contract plans for NHS England and West Midlands CCGs. They are not precise figures for the following reasons;

- CQUIN would also be payable on any over-performance against these contracts
- CQUIN is also payable on out of area contracts
- A provision has been made in the accounts for non-delivery of some CQUINS
- CQUIN adjustments will also be applied for any adjustments made to the final outturn positions agreed with commissioners for 2018/19.

A proportion of UHB income in 2017/18 was conditional on achieving quality improvement and innovation goals. The Trust received £11.7m (QEHB) and £11.8m (BHH/GHH/SH) in payment for 2017/18.

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

UHB is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions.

The Care Quality Commission has not taken enforcement action against UHB during 2018/19.

UHB has not participated in any special reviews or investigations by the CQC during 2018/19.

Inspection Ratings Grids

The CQC carried out a regular yearly inspection of some of the Trust's Core Services during October 2018. As a result of the inspection the Trust was rated as 'good' overall and full details of the Trust's ratings are below.

As the CQC have not yet inspected every area of Birmingham Heartlands Hospital, Good Hope Hospital or Solihull Hospital, there is not a rating for all services or an overall site rating for these three hospitals.

Queen Elizabeth Hospital Birmingham (QEHB)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Good	Good	Good	Requires Improvement	Good	Good
Medical Care	Requires Improvement	Good	Good	Outstanding	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical Care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of Life Care	Good	Good	Good	Outstanding	Good	Good
Outpatient and diagnostic imaging	Good	N/A	Good	Requires Improvement	Good	Good
Sexual Health Services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Birmingham Heartlands Hospital (BHH)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Maternity	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Good Hope Hospital (GHH)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Maternity	Requires Improvement	Good	Good	Good	Good	Good

Solihull Hospital (SH)						
Domain:	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Maternity	Good	Good	Good	Good	Requires Improvement	Good

2.2.6 Information on the quality of data

Secondary Uses Service data
UHB submitted records during 2018/19 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:

QEHB
- which included the patient's valid NHS Number was*:
  - 99.33% for admitted patient care
  - 99.76% for outpatient care
  - 97.84% for accident and emergency care
- which included the patient's valid General Medical Practice Code was*:
  - 99.98% for admitted patient care
  - 99.64% for outpatient care
  - 99.63% for accident and emergency care

Heartlands, Good Hope and Solihull Hospitals
- which included the patient's valid NHS Number was*:
  - 99.70% for admitted patient care
  - 99.91% for outpatient care
  - 98.83% for accident and emergency care
- which included the patient's valid General Medical Practice Code was*:
  - 99.99% for admitted patient care
  - 100% for outpatient care
  - 99.93% for accident and emergency care

*Figures cover the latest available period: 1st April 2018 to 31st January 2019.

Information Governance Assessment Report / Data Security & Protection (DSP) Toolkit
As of 1st April 2018 the Information Governance Toolkit Assessment has been replaced by the Data Security & Protection (DSP) toolkit. Under this new framework, the overall outcome for UHB for 2018/19 is "due to the exceptional circumstances of the Trust (notably the merger of UHB and HEFT) not all standards have been fully met, however an improvement plan with scheduled updates was agreed upon and has been accepted by NHS Digital."

Payment by Results clinical coding audit
UHB was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

(Note: the Audit Commission has now closed and responsibility now lies with NHS Improvement).

Actions to improve data quality
UHB will be taking the following actions to improve data quality:
- Continue to drive forward the UHB Coding Training programme to further improve training
- Continue to monitor data quality through the Ward Clerk quality monitoring and management programme.
- Ensure continued compliance with the Data Protection & Security Toolkit minimum Level 2 for data quality standards and accuracy checks.
- Review the Data Quality Policy and develop associated procedures.
- Continue to support improvement of the data quality programme for the operational teams by providing data in relation to 18 week referral to treatment time (RTT).
- Continue to report timeliness against the target of within two hours for Admissions, Discharges and Transfers (ADT) via the links on the Data Quality (DQ) SharePoint site for use by Heartlands, Good Hope and Solihull Hospitals operational inpatient areas.
- Continue to provide a monthly Data Quality ADT matrix report detailing the top three areas of concern across Heartlands, Good Hope and Solihull Hospitals monthly to Matrons and Lead Nurses.
- The Data Quality team will continue to focus on any areas of concern that require improvement and ensure actions are put in place to enable the

accurate reporting of data in a timely fashion using the six dimensions of the data quality model.
- A suite of Data Quality indicators form part of monthly Directorate reports with action plans being put in place to improve on performance where areas of concern are identified. Sections of which are reported on a quarterly basis to the Information Governance Group.

2.2.7 Learning from deaths

Since January 2014, UHB has taken part in an 'early adopter' project involving the introduction of the Medical Examiner role at the Trust. UHB currently has a team of Medical Examiners who are Consultant-level staff and are required to review the vast majority of inpatient deaths. The role includes reviewing medical records and liaising with bereaved relatives to assess whether the care provided was appropriate and whether the death was potentially avoidable.

The Trust implemented the Reviewing Inpatient Deaths Policy and associated procedure in October 2017. All deaths must be given a stage one review by a Medical Examiner, except for those meeting defined exception criteria such as forensic deaths where the medical records will not be available to Trust staff.

Any death where a concern has been raised by the Medical Examiner will be escalated for further review, either to a specialty mortality & morbidity meeting, or directly to the Trust's Clinical and Professional Review of Incidents Group (CaPRI). The outcomes of stage two reviews are reported to the Trust's Clinical Quality Monitoring Group where a decision will be made on whether further review or investigation is required.

1.	During 2018/19 5345 of UHB patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: › 1270 in the first quarter › 1229 in the second quarter › 1358 in the third quarter › 1488 in the fourth quarter
2.	By 1st April 2019, 4226 case record reviews and 60 investigations have been carried out in relation to 4252 of the deaths included in item 1. In 34 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: › 984 in the first quarter › 972 in the second quarter › 1092 in the third quarter › 1204 in the fourth quarter
3.	19, representing 0.36% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: › 8 representing 0.63% for the first quarter › 6 representing 0.49% for the second quarter › 5 representing 0.37% for the third quarter › 0 representing 0% for the fourth quarter These numbers have been obtained based on the findings of thorough, independent investigations of all deaths considered potentially avoidable after case record review, using recognised root cause analysis tools and a human factors perspective.
4.	As part of every investigation a detailed report that includes all learning points and an in-depth action plan is produced. Each investigation can produce a number of recommendations and changes, and each individual action is specifically designed on a case by case basis to ensure that the required changes occur. The implementation of these actions and recommendations is robustly monitored to ensure ongoing compliance. Actions are varied and may include changes to, or introductions of, policies and guidelines, changing systems or changing patient pathways. Similarly, the outcomes of every case record review are monitored and ongoing themes and trends are reported and escalated as required to ensure any and all required changes are made.

5.	As described in item 4, each investigation involves the creation of a detailed, thorough action plan which will involve numerous actions per investigation. These actions are specifically tailored to individual cases and monitored on an ongoing basis to ensure the required changes have been made. Examples of actions include: › Ensure learning from the incident is communicated to all relevant staff › To provide feedback to the patient's family on the outcome of the investigation › To provide feedback to staff involved in the incident › The colorectal multi-disciplinary team should consider preoperative CT angiography to clarify the anatomical position of the colonic vessels in complex cases › All patients for elective percutaneous coronary intervention on the Ambulatory Care Unit must be prescribed a loading dose of blood thinning medication so that it can be given before the procedure › There must be a review of the expected timeframes for CT scans that are marked as urgent. This must include consideration of whether the timeframe and process changes according to the day of the week. A clear standard of terminology (e.g. emergency, urgent, routine) and associated timeframes must be established › There must be a process to ensure that there is monitoring and tracking in place for all patients entered on the Somerset Cancer Register irrespective of their diagnosis
6.	All actions are monitored to ensure they have had the desired impact. If this has not happened, actions will be reviewed and altered as necessary to ensure that sustainable and appropriate change has been implemented.
7.	41 case record reviews and 17 investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period.
8.	3 representing 0.19% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been obtained based on the findings of thorough, independent investigations of all deaths considered potentially avoidable after case record review, using recognised root cause analysis tools and a human factors perspective.
9.	5 representing 0.17% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Performance against national core set of quality indicators

A national core set of quality indicators was jointly proposed by the Department of Health and Monitor (now NHS Improvement) for inclusion in trusts' Quality Reports from 2012/13. The data source for all the indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC). The Trust's performance for the applicable quality indicators is shown in Appendix A for the latest time periods available. Further information about these indicators can be found on the NHS Digital website: http://content.digital.nhs.uk/

3 Other information

3.1 Overview of quality of care provided during 2018/19

The tables below show the Trust's latest performance for 2018/19 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 2017/18 Quality Report 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 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.

The Trust is working towards aligning data and indicators, currently some are available at Trust level ("UHB"), and others by site or group of sites.

Patient safety indicators

(March data not yet validated – figures may change before final Quality Report is published.)

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
1a. Patients with MRSA infection / 100,000 bed days › (includes all bed days from all specialties) › Lower rate indicates better performance	QEHB	› Trust MRSA data reported to PHE, › HES data (bed days)	**1.01**	**0.00**	**1.47** (UHB) April – December 2018	**2.31** April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		**1.9**	**0.4**		
1b. Patients with MRSA infection / 100,000 bed days › (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) › Lower rate indicates better performance	QEHB	› Trust MRSA data reported to PHE, › HES data (bed days)	**1.01**	**0.00**	**1.39** (UHB) April – December 2018	**2.17** April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		**0.4**	**0.4**		
2a. Patients with C. difficile infection / 100,000 bed days › (includes all bed days from all specialties) › Lower rate indicates better performance	QEHB	› Trust CDI data reported to PHE, › HES data (bed days)	**21.73**	**19.05**	**10.79** (UHB)	**8.08** April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		**16.0**	**12.4**		
2b. Patients with *C. difficile* infection / 100,000 bed days › (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) › Lower rate indicates better performance	QEHB	› Trust CDI data reported to PHE, › HES data (bed days)	**21.85**	**18.94**	**10.17** (UHB)	**7.65** April – December 2018 Acute trusts in West Midlands
	BHH / GHH / SH		**6.8**	**13.8**		
3a. Patient safety incidents › (reporting rate per 1000 bed days) › Higher rate indicates better reporting	QEHB	› Datix › (incident data), › Bed days data	**63.6**	**65.4**	**68.3**	**44.5** April – December 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	BHH / GHH / SH		**34** (NRLS data April – Sept 2016)	**49.3**	**46.7**	
3b. Never Events › The number of Never Events that occurred during the time period › Lower number indicates better performance	QEHB	› Datix › (incident data)	**1**	**6**	**9** (UHB)	Not available
	BHH / GHH / SH		**2**	**8**		
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	QEHB	› Datix › (incident data)	**83.1%**	**85.1%**	**88.9%**	**78.5%** April – September 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	BHH / GHH / SH		**75%** (NRLS data April – Sept 2016)	**97.6%**	**97.7%**	

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death › Lower % indicates better performance	QEHB	› Datix › (patient safety incidents reported to the NRLS)	**0.12%**	**0.22%**	**0.26%**	**0.34%** April – September 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	BHH / GHH / SH		**0.6%** (NRLS data April – Sept 2016)	**0.84%**	**0.64%**	
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	QEHB	› Datix › (patient safety incidents reported to the NRLS)	**22,532**	**24,568**	**26,342**	**5,583** (6 months) April – September 2018 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
	BHH / GHH / SH		**7,899** (NRLS data April – Sept 2016)	**19,664**	**21,811**	

Clinical effectiveness indicators

(March data not yet validated – figures may change before final Quality Report is published.)

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
5a. Emergency readmissions within 28 days (%) (Medical and surgical specialties - elective and emergency admissions aged >17) % › Lower % indicates better performance	QEHB	HED data	**14.14%**	**13.87%**	**15.39%** April – December 2018	**15.35%** April – December 2018 University hospitals
	BHH / GHH / SH		**14.09%**	**14.03%**	**14.72%** April – December 2018	
5b. Emergency readmissions within 28 days (%) (all specialties) › Lower % indicates better performance	QEHB	HED data	**14.10%**	**13.84%**	**15.56%** April – December 2018	12.70% April – December 2018 University hospitals
	BHH / GHH / SH		**11.85%**	**12.25%**	**13.06%** April – December 2018	
5c. Emergency readmissions within 28 days of discharge (%) › Lower % indicates better performance	QEHB	Internal SUS data	**10.80%**	**11.35%**	**11.84%** April 2018 – February 2019	Not available
	BHH / GHH / SH	PMS 2	**15.09%**	**15.22%**	**15.60%**	

Indicator	Site/s	Data source	2016/17	2017/18	2018/19	Peer Group Average (where available)
6. Falls (incidents reported as % of patient episodes) › Lower % indicates better performance	QE	Datix (incident data),	**2.2%**	**2.2%**	**2.0%**	Not available
	BHH / GHH / SH	Trust admissions data	**0.98%**	**1.00%**	**0.94%**	
7. Stroke in-hospital mortality › Lower % indicates better performance	QE	SSNAP data	**1.8%**	**5.9%**	**12.6%**	13.7% 2016/17 England & Wales SSNAP crude mortality data
	BHH / GHH / SH		**11.0%**	**12.2%**	**10.8%**	
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	QE	Trust PICS data	**97.4%**	**94.8%**	**92.6%**	Not available

Notes on patient safety & 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 not all hospitals within the Trust 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.

1a, 1b

- Peer group figures are not final.

1a, 1b, 2a, 2b:

- From 2018/19, these figures are now for the whole Trust (UHB) rather than split by site. For MRSA (1a and 1b), the reporting has also changed and includes all cases of MRSA, not just those that are just deemed to be Trust-acquired.
- These indicators use HES data for the bed days, as this allows trusts to benchmark against each other. UHB also has an internal measure of bed days which uses a different methodology, and this number may be used in other, similar, indicators in other reports.
- Receipt of HES data from the national team always happens two to three months later, these indicators will be updated in the next report.

3a

- The NHS England definition of a bed day ("KH03") differs from UHB's usual definition. For further information, please see this link:
  - › http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/.
- NHS England have also reduced the number of peer group clusters (trust classifications), meaning UHB is now classed as an 'acute (non specialist)' trust and is in a larger group. Prior to this, UHB was classed as an 'acute teaching' trust which was a smaller group.

3b

- UHB had nine Never Events during 2018/19 in the following categories: Missed naso-or oro-gastric tube (2), Retained foreign object post procedure (2), Unintentional connection of a patient requiring oxygen to an air flow meter (2), Wrong site surgery (1), Wrong implant/prosthesis (1), Overdose of insulin due to abbreviations or incorrect device (1).
- Immediate corrective actions have been undertaken, and the patients have received the correct procedures where appropriate. An apology has been given to the patients and families. All cases have been investigated and an action plan put in place to reduce the risk of future recurrence.

4c

- The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

5c

- The data source is the Trust's patient administration system. The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology. Any changes in previously reported data are due to long-stay patients being discharged after the previous years' data was analysed.

5a, 5b, 5c

- QEHB - The increase in readmissions is due to patients in the Emergency Observation Unit (EOU) being recorded as inpatients from November 2017.
- BHH/GHH/SH: figures differ from the previous Quality Reports for Heart of England NHS Foundation Trust, as the data in this table has been generated using the same methodology as the QE data.

7

- QEHB – there has been a small change to the 2017/18 data since the 2017/18 Quality Report, as the data source (national SSNAP data) was refreshed after publication.
- It should also be noted that the 2016/17 and 2017/18 figures are not accurate, as some patients who died within 24 hours had not been included in the data collection and submission; this was picked up during 2017/18. In-hospital mortality following stroke is expected to be 10-15%, and the 2018/19 data reflects this.

8

- QEHB indicator only as cardiac surgery is not carried out at the other sites.
- 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.

Patient experience indicators

The National Inpatient Survey is run by the Picker Institute on behalf of the Care Quality Commission (CQC); the QEHB and Heartlands, Good Hope and Solihull Hospitals results for selected questions are shown below. The 2018 survey report has not been published at the time of writing, so the text and table below refer to the latest available results, which are from the 2017 survey. Information on the 2018 results will be added to the published Quality Account once it is available. Alternative patient experience data and indicators are also available in *Priority 2: Improving patient experience* above, these are taken from the Trust's local patient surveys.

Data is presented as a score out of 10; the higher the score for each question, the better the Trust is performing.

Patient survey question	Site/s	2015/16		2016/17		2017/18	
		Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England
Overall were you treated with respect and dignity	QEHB	9.2	About the same	9.2	About the same	9.2	About the same
	BHH/GHH/SH	8.8	About the same	8.9	About the same	8.8	About the same
Involvement in decisions about care and treatment	QEHB	7.5	About the same	7.4	About the same	7.4	About the same
	BHH/GHH/SH	7.1	About the same	7.2	About the same	7.0	About the same
Did staff do all they could to control pain	QEHB	8.2	About the same	8.3	About the same	8.0	About the same
	BHH/GHH/SH	7.9	About the same	7.9	About the same	7.6	Worse
Cleanliness of room or ward	QEHB	9.2	About the same	9.2	About the same	9.1	About the same
	BHH/GHH/SH	8.7	About the same	8.8	About the same	8.6	About the same
Overall rating of care	QEHB	8.4	About the same	8.3	About the same	8.3	About the same
	BHH/GHH/SH	7.9	About the same	8.0	About the same	8.0	About the same
Time period & data source:		2015 Trust's Survey of Adult Inpatients 2015 Report, CQC		2016 Trust's Survey of Adult Inpatients 2016 Report, CQC		2017 Trust's Survey of Adult Inpatients 2017 Report, CQC	

Response rates were 37% for QEHB (441 respondents), 30% for Heartlands, Good Hope and Solihull Hospitals (368 respondents), compared to a national response rate of 41%.

3.2 Performance against indicators included in the NHS Improvement Single Oversight Framework

Indicator	Target	Performance	
		2017/18	2018/19
A&E maximum waiting time of 4 hours from arrival to admission/ transfer/discharge[1]	95%	80.8%	76.7%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway[1,2]	92%	91.6%	88.2%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	80.8%	78.9%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	94.9%	91.2%
C. difficile: variance from plan	≤ 125 cases judged to be lapses in care	18 judged lapses in care (139 total)	30 judged lapses in care (153 total)
Maximum 6-week wait for diagnostic procedures	99%	99.4%	99.5%
Venous thromboembolism (VTE) risk assessment	95%	98.3%	98.3%

The data above is for the whole enlarged Trust, therefore only the current year and one previous year is available. For the SHMI, please refer to the Mortality section of this Quality Report (3.3).
Notes: **1**: Indicators audited by the Trust's external auditor Deloitte as part of the external assurance arrangements for the 2018/19 Quality Report.

3.3 Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.

Summary Hospital-level Mortality Indicator (SHMI)

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

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

Hospital Standardised Mortality Ratio (HSMR)

UHB has concerns about the validity of the HSMR which was superseded by the SHMI but it is included here for completeness. The validity and appropriateness of the HSMR methodology used to calculate the expected range has been the subject of much national debate and is largely discredited[2][3]. UHB continues to robustly monitor mortality in a variety of ways as detailed above.

	QEHB	BHH / GHH / SH	Data period
SHMI, calculated by UHB Informatics	102 - within tolerance	87 - within tolerance	April - December 2018
SHMI, from NHS Digital website	100 - within tolerance	88 - within tolerance	April - September 2018
HSMR, calculated by UHB Informatics	102	102	April - December 2018

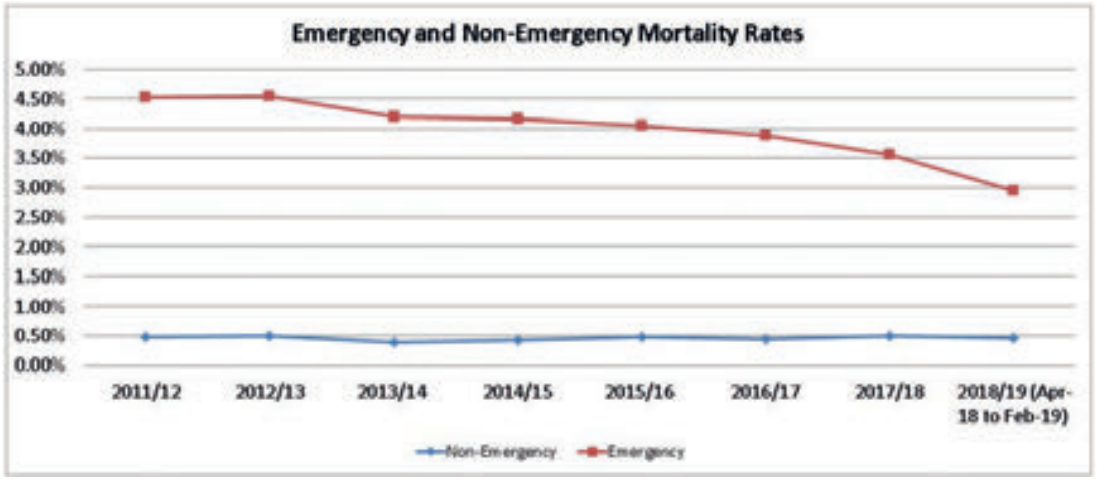
1 Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.
2 Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. BMJ Quality & Safety. Online First. 7 July 2012.
3 Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Crude Mortality – QEHB

The first graph below shows the QEHB site's crude mortality rates for emergency and non-emergency (planned) patients. The second graph shows the QEHB site's overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

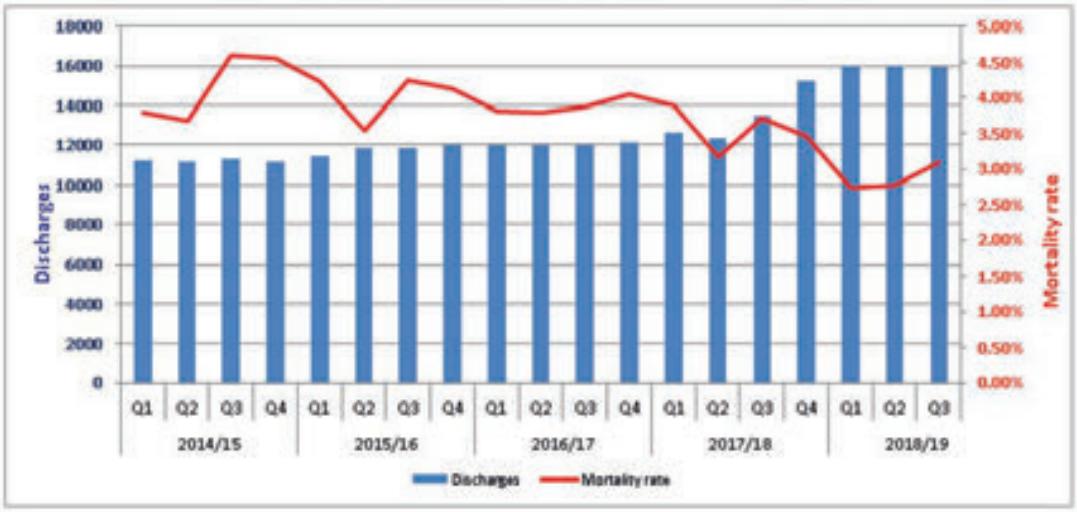
QEHB's overall crude mortality rate for 2018/19 (up to February 2019) is 2.47%, which is a decrease compared to 2017/18 (2.85%) and 2016/17 (2.96%).

Emergency and Non-emergency Mortality Graph (QEHB)



Overall Crude Mortality Graph (QEHB)

(Quarter 4 data not available at time of writing)



Note: the increase in discharges is largely due to patients in the Emergency Observation Unit (EOU) being recorded as inpatients from November 2017.

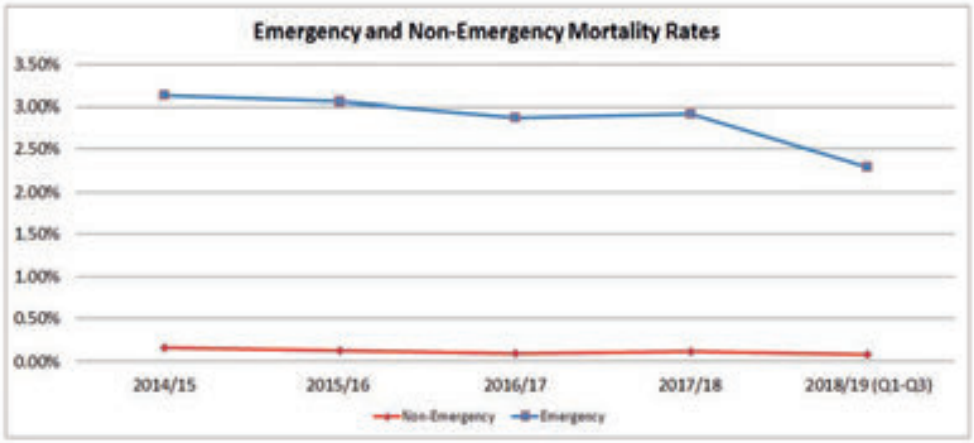
Crude Mortality – Heartlands, Good Hope and Solihull Hospitals

The first graph below shows the combined crude mortality rate for the Heartlands, Good Hope and Solihull Hospitals sites for emergency and non-emergency (planned) patients. The second graph shows the Heartlands, Good Hope and Solihull Hospitals sites' overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period.

The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

Heartlands, Good Hope and Solihull Hospitals' crude mortality rate for emergency admitted patients in 2018/19 (up to February 2019) is 1.77%, this has decreased compared to 2017/18 (2.25%) and 2016/17 (2.19%).

Emergency and Non-emergency Mortality Graph (Heartlands, Good Hope and Solihull Hospitals)



Emergency Crude Mortality Graph (Heartlands, Good Hope and Solihull Hospitals)
(Quarter 4 data not available at time of writing)

3.4 Statement on the implementation of the priority clinical standards for seven day hospital services

The Academy of Medical Royal Colleges have agreed a number of principles which are set out in three patient-centred standards to deliver consistent inpatient care irrespective of the day of the week. NHS England's previous National Medical Director set out a plan to drive seven day services across the NHS, starting with urgent care services and supporting diagnostics.

Ten clinical standards have been identified, of which four are priority standards:
1. Time to consultant review
2. Diagnostics
3. Interventions
4. On-going review

UHB has taken the following actions to implement the above standards:

Provision for consultant review
Consultant job planning in the trust makes provision for a consultant-led ward round on every ward every day through formal provision which includes on-call out-of-hours.

Consultant directed diagnostics
For patients admitted as an emergency with critical care and urgent needs the following diagnostic tests are usually or always available on site: CT, Microbiology, Echocardiograph, Upper GI Endoscopy, MRI and Ultrasound.

Consultant directed interventions
Patients have 24 hr access to consultant directed interventions 7 days a week either on site or via formal network arrangements for the following interventions: Critical Care, Primary Percutaneous Coronary Intervention (PPCI), Cardiac Pacing, Thrombolysis Stroke, Emergency General Surgery, Interventional Endoscopy, Interventional Radiology, Renal Replacement and Urgent Radiotherapy.

On-going review
Daily board reviews (using live interactive boards with details regarding patients on each ward) and daily consultant reviews are in place meaning sick patients are identified and reviewed daily.

3.5 Encouraging staff to Speak Up

The appointment of Freedom to Speak Up Guardians was a recommendation of the Francis Report. UHB's Freedom to Speak Up Guardian is Professor Julian Bion, Honorary Consultant in Critical Care Medicine. Professor Bion is supported by twenty-two Confidential Contacts from across the Trust, who are also a point of contact for raising concerns.

Freedom to Speak Up Guardians have a key role in helping to raise the profile of concerns within the Trust and provide confidential advice and support to staff in relation to concerns they have about, for example, patient safety and/or the way their concern has been handled. Freedom to Speak Up Guardians do not get involved with investigations or complaints, but help to facilitate the process of raising a concern where needed, ensuring policies are followed correctly.

Staff can contact the Freedom to Speak Up Guardian and the Confidential Contacts using a dedicated email address, and there is also an internal webpage with further contact information.

All concerns raised through Confidential Contacts are reviewed by the Freedom to Speak Up Guardian and presented quarterly to the Chief Executive and Trust Board of Directors. The full group discuss patterns, trends and look for solutions and remedies to increase staff support and influence a culture of 'speaking up'.

Raised concerns are also reported quarterly to the CQC (the regulator and monitor of Freedom to Speak Up Guardians nationally), which helps to identify the national picture in terms of the source and types of concerns.

The Freedom to Speak Up Guardian also has regular meetings with Human Resources (HR) and Occupational Health.

3.6 Statement regarding junior doctor rota

The Trust has appointed a Guardian of Safe Working (GSW), an experienced consultant who is supported by the Junior Doctors Monitoring Office (JDMO). The JDMO administers the following functions, amongst others:
- Junior doctor rota templates (as issued with work schedules)
- Hours of work/working patterns
- Exception reporting (e.g. if doctors experience differences in hours of work / rest breaks / the work pattern itself)

It is a requirement of the 2016 Junior Doctor contract that the GSW holds responsibility for ensuring that issues of compliance with safe working hours are addressed in accordance with the terms and conditions of the new Junior Doctor contract - this includes the overall responsibility for overseeing the Junior Doctors' Exception Reporting (ER) process. The GSW is required to submit a report at least quarterly, on the analysis of the

exception reports submitted by junior doctors. A final extended Annual Report is presented at the end of each academic year to the Trust's Board of Directors.

Information is available to staff on the Trust Intranet, this includes guidance, contacts and a link for junior doctors to report exceptions.

Template rotas are set at the minimum levels to reflect expected numbers of junior doctors, however with rotas in excess of 150 across the Trust, gaps are inevitable. Reasons include:

- Posts not filled by HEE (Health Education England), or variation in specialty numbers
- Failure to recruit to Junior Specialist Doctor/other doctor posts
- Less than full time trainees occupying full time rota slots
- Unplanned leave, e.g. sickness, maternity, paternity, special leave
- Special occupational health reasons where some doctors are unable to undertake certain duties, e.g. on-call, night working

Rota gaps are highlighted in quarterly Guardian of Safe Working Reports. When gaps do arise, out of hours duties are filled using locum staff to ensure that junior doctors are not mandated to work in excess of their contracted hours.

Recent actions taken to address rota gaps include:

- Recruitment of locum staff and junior specialist doctors
- Review of rotas by deputy GSWs with the Clinical Services Leads, to ensure that work patterns match clinical need
- Consideration of appointment of Advanced Clinical Practitioners (ACPs) and Physicians Associates to take on some of the junior doctors' work
- Coaching on 'handover' techniques to reduce the amount of time staff need to work over at the end of a shift
- Consideration of funding for administrative support for rota management and exception reporting

3.7 Glossary of Terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
ADT	Admissions, discharges and transfers
Analgesia	A medication for pain relief
BAUS	British Association of Urological Surgeons
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark	A method for comparing (e.g.) different hospitals
Beta blockers	A class of drug used to treat patients who have had a heart attack, also used to reduce the chance of heart attack during a cardiac procedure
BHH	Birmingham Heartlands Hospital
Back to the Floor	Senior members of staff taking on junior, patient facing roles for a shift or period of time
CABG	Coronary Artery Bypass Graft
CaPRI	Trust's Clinical and Professional Review of Incidents Group
CCG	Clinical Commissioning Group
CDI	*Clostridium difficile* infection
Chief Executive's Advisory Group	An internal group, chaired by the Chief Executive
Chief Operating Officer's Group	An internal group for senior management staff
Clinical Audit	A process for assessing the quality of care against agreed standards
Clinical Coding	A system for collecting information on patients' diagnoses and procedures
Clinical Dashboard	An internal website used by staff to measure various aspects of clinical quality
Commissioners	See CCG
Congenital	Condition present at birth
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQG	Care Quality Group; a group chaired by the Executive Chief Nurse, which assesses the quality of care, mainly nursing
CQMG	Clinical Quality Monitoring Group; a group chaired by the Executive Medical Director, which reviews the quality of care, mainly medical
CQUIN	Commissioning for Quality and Innovation payment framework
CRM	Cardiac Rhythm Management
Datix	Database used to record incident reporting data
Deloitte	The Trust's external auditor
Division	Specialties are grouped into Divisions
DQ	Data Quality
DTI	Deep tissue injury
Duty of Candour	Requirement for trusts to be open and transparent with services users about care and treatment, including failures
Echo / echocardiogram	Ultrasound imaging of the heart
ED	Emergency Department (also known as A&E)
Elective	A planned admission, usually for a procedure or drug treatment
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
FFFAP	Falls and Fragility Fractures Audit Programme

Term	Definition
FFT	The Friends and Family Test; a questionnaire to determine how likely a patient is to recommend the services used
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities.
GHH	Good Hope Hospital
GI	Gastro-intestinal
GP	General Practitioner
HCA	Healthcare Assistant
Healthwatch	An independent group who represent the interests of patients
HEFT	Heart of England NHS Foundation Trust
HES	Hospital Episode Statistics
HSCIC	Health and Social Care Information Centre – now known as NHS Digital
HSMR	National Hospital Mortality Indicator
Informatics	Team of information analysts
IT	Information Technology
JCC	Joint Consultative Committee
KPI	Key performance indicator: a measurable value demonstrating how effectively targets are being met
MINAP	Myocardial Ischaemia National Audit Project
Missed Dose	A dose of prescribed medication not given to the patient
Monitor	Independent regulator of NHS Foundation Trusts – now replaced by NHS Improvement
MOODLE	A digital learning platform used for obtaining training courses and information
Mortality	A measure of the number of deaths compared to the number of admissions
MOVED	A campaign to increase movement and repositioning of patients to reduce pressure ulcers
MRI	Magnetic Resonance Imaging – a type of diagnostic scan
MRSA	Meticillin-resistant Staphylococcus aureus
Myocardial Infarction	Heart attack
NBSR	National Bariatric Surgery Registry
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure
NELA	National Emergency Laparotomy Audit
Never Events	An incident that has the potential to cause serious harm/death
NEWS2	National Early Warning Score a new national system for identifying patients at risk of deterioration.
NHS	National Health Service
NHS Digital	Formerly HSCIC - Health and Social Care Information Centre. A library of NHS data and reports
NHS Improvement	The national body that provides the reporting requirements and guidance for the Quality Report
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme

Term	Definition
NPDA	National Paediatric Diabetes Audit
NRLS	National Reporting and Learning System
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
Ombudsman	Public independent advocate charged with presenting the interests of the public by addressing complaints or violations of rights
OOH	Out Of Hours
PALS	Patient Advice and Liaison Service
PCCC	Primary Care Commissioning Committee
PCI	Percutaneous Coronary Interventions
Peri-operative	Period of time prior to, during, and immediately after surgery
PGD	Patient Group Direction
PHE	Public Health England
PHSO	Parliamentary and Health Service Ombudsman
PICS	Prescribing Information and Communication System
PLACE-Lite	Patient-led assessments of the care environment (i.e. wards and clinics)
PPCI	Primary Percutaneous Coronary Intervention; a surgical treatment for myocardial Infarction (heart attack)
Pressure Ulcers	Area of damaged skin also known as pressure sores or bedsores
Preventing Harm Meeting	Internal group to review incidents reported through Datix
QEHB	Queen Elizabeth Hospital Birmingham
QIPs	Quality Improvement Priorities
QuORU	Quality and Outcomes Research Unit
RCA	Root Cause Analysis
Readmissions	Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days
RTT	Referral to Treatment
SDTI	Suspected Deep Tissue Injury. A pressure ulcer of unknown depth
Sepsis	A potentially life-threatening condition resulting from a bacterial infection of the blood
SEWS	Standardised Early Warning System – being replaced by NEWS 2
SH	Solihull Hospital
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SSNAP	The Sentinel Stroke National Audit Programme
STEIS	System used to report and monitor the progress of Serious Incident investigations across the NHS
STP	Sustainability and Transformation Partnership
TARN	Trauma Audit and Research Network
Team Brief	Meeting open to all staff, where directors present information to staff, and information is then cascaded to colleagues
TNA	Trainee Nursing Associate
TV / TVT	Tissue viability / Tissue Viability Team
UHB	University Hospitals Birmingham NHS Foundation Trust
UTI	Urinary tract infection
VTE	Venous thromboembolism, also known as a blood clot

Appendix A: Performance against core indicators

The Trust's performance against the national set of quality indicators jointly proposed by the Department of Health and Monitor (now NHS Improvement) is shown in the tables below. There are eight indicators which are applicable to acute trusts. The data source for all the indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC) and performance is shown for the most recent periods available. Data for the latest two time periods is included for each indicator and is displayed in the same format as NHS Digital. National comparative data is included where available.

Where available, data for the whole Trust (UHB) has been provided, otherwise QEHB and Heartlands, Good Hope and Solihull Hospitals are provided separately.

Further information about these indicators can be found on the NHS Digital website: http://content.digital.nhs.uk/qualityaccounts

1. **Mortality**

	Previous Period (Oct 2016 - Sept 2017)	Current period (Oct 2017 - Sept 2018)			
	UHB	UHB	National Performance		
			Overall	Lowest	Highest
(a) Summary Hospital-level Mortality Indicator (SHMI) value	0.99	**0.97**	1.00	0.69	1.27
(a) SHMI banding	2	**2**	-	3	1
(b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level	28.42	**26.30**	33.36	14.18	59.47

The Trust considers that this data is as described for the following reasons as this is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the technical approach UHB takes to improving quality detailed in this report. The Trust does not specifically try to reduce mortality as such but has robust processes in place, using more recent data, for monitoring mortality as detailed in Part 3 of this report. It is important to note that palliative care coding has no effect on the SHMI.

2. **Patient Reported Outcomes Measures (PROMs) – Average Health Gain**

	Previous Period (April 2016 - March 2017)		Current period (April 2017 - Sept 2017 (i/ii)) (April 2017 - March 2018 (iii/iv))				
	QEHB	BHH/ GHH/SH	QEHB	BHH/ GHH/SH	National Performance		
					Overall	Best	Worst
(i) Groin hernia surgery	0.098	0.092	**0.065**	**0.096**	0.089	0.136	0.029
(ii) Varicose vein surgery	N/A	0.116	N/A	**0.124**	0.096	0.134	0.035
(iii) Hip replacement surgery	N/A	0.393	N/A	**0.426**	0.458	0.549	0.357
(iv) Knee replacement surgery	N/A	0.309	N/A	**0.328**	0.337	0.406	0.254

The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to focus on improving participation rates for the pre-operative questionnaires which we have control over.

3. **Readmissions to hospital within 28 days**

	Previous Period* (April 2010 - March 2011)		Current period (April 2011 – March 2012)*				
	QEHB	BHH/ GHH/ SH	QEHB	BHH/ GHH/ SH	National Performance		
					Overall (England)	Best (Acute Teaching Providers)	Worst (Acute Teaching Providers)
(i) Patients aged 0-15 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	-	11.39	**-**	**10.85**	10.01	5.86	12.50
(ii) Patients aged 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	11.60	14.06	**11.54**	**12.81**	11.45	10.64	13.55

The Trust considers that this data (standardised percentages) is as described for the following reasons as this is the latest available on the NHS Digital (HSCIC) website. UHB is however unable to comment on whether it is correct as it is not clear how the data has been calculated.

The Trust intends to take the following actions to improve this data (standardised percentages), and so the quality of its services, by continuing to review readmissions which are similar to the original admission on a quarterly basis. UHB monitors performance for readmissions using more recent Hospital Episode Statistics (HES) data as shown in Part 3 of this report.

3(i) is not applicable to QEHB as the Trust does not provide a Paediatrics service

*The Trust has included the latest data available on the NHS Digital/HSCIC website – this has not been updated since the previous Quality Report.

4. **Responsiveness to the personal needs of patients**

	Previous Period (2016/17)		Current period (2017/18)				
	QEHB	BHH/ GHH/SH	QEHB	BHH/ GHH/SH	National Performance		
					Overall	Best	Worst
Trust's responsiveness to the personal needs of its patients – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	72.5	65.1	**70.1**	**63.4**	68.6	85.0	60.5

The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to collect real-time feedback from our patients as part of our local patient survey. The Board of Directors has again selected improving patient experience and satisfaction as a Trust-wide priority for improvement in 2019/20 (see Part 2 of this report for further details).

5. **Staff who would recommend the trust as a provider of care to their family and friends**

	Previous Period (2017)		Current period (2018)			
	QEHB	BHH/ GHH/SH	UHB	National Performance		
				Average	Best	Worst
Staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends. Performance shown is based on staff who agreed or strongly agreed.	81%	60%	**72%**	71%	87%	40%

The Trust considers that this data (scores) is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by trying to maintain performance for this survey question.

6. **Venous thromboembolism (VTE) risk assessment**

	Previous Period (Q2 2018/19)	Current period (Q3 2018/19)			
	UHB	UHB	National Performance		
			Overall	Best	Worst
Percentage of admitted patients risk-assessed for VTE	98.22%	**98.28%**	95.65%	100%	54.86%

The Trust considers that this data (percentages) is as described for the following reasons as UHB has consistently performed above the national average for the past few years.

The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to ensure our patients are risk assessed for venous thromboembolism (VTE) on admission using electronic systems in place at its hospitals.

7. ***C. difficile*** **infection**

	Previous Period (2016/17)		Current period (2017/18)				
	QEHB	BHH/ GHH/SH	QEHB	BHH/ GHH/SH	National Performance		
					Overall (England)	Best	Worst
C. difficile infection rate per 100,000 bed-days (patients aged 2 or over)	24.5	15.2	**20.4**	**12.7**	13.7	0	91.0

The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this rate, and so the quality of its services, by continuing to reduce *C. difficile* infection through the measures outlined in Priority 5: Infection prevention and control in its earlier Quality Reports.

8. **Patient Safety Incidents**

	Previous Period (Oct 2016 - March 2017)		Current period (October 2017 – March 2018)				
	QEHB	BHH/ GHH/SH	QEHB	BHH/ GHH/SH	National Performance (Acute Non-Specialist Trusts)		
					Overall	Best	Worst
Incident reporting rate per 1,000 bed days	59.1	33.8	**70.0**	**35.0**	-	24.2	124
Number of patient safety incidents that resulted in severe harm or death	15	60	**19**	**48**	-	0	99
Rate of patient safety incidents that resulted in severe harm or death rate per 1,000 bed days	0.08	0.23	**0.10**	**0.17**	-	0	0.55

The Trust considers that this data is as described for the following reasons as the data is the latest available on the NHS Digital (HSCIC) website.

The Trust intends to take the following actions to improve this data and so the quality of its services, by continuing to have a high incident reporting rate by actively encouraging staff to report both clinical and non-clinical incidents. Although this table refers to 'best' and 'worst', a high incident reporting rate can be reflective of a good, open reporting culture. The Trust routinely monitors incident reporting rates and the percentage of incidents which result in severe harm or death as shown in Part 3 of this report.

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

The Trust has shared its 2018/19 Quality Report with

- Birmingham and Solihull Clinical Commissioning Group,
- Healthwatch Birmingham,
- Healthwatch Solihull,
- Birmingham Health & Social Care Overview and Scrutiny Committee, and
- Solihull Health & Social Care Overview and Scrutiny Committee.

These organisations have provided the statements below.

Statement provided by Birmingham and Solihull Clinical Commissioning Group

1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as coordinating commissioner for University Hospitals Birmingham NHS Foundation Trust (UHB), welcomes the opportunity to provide this statement for inclusion in the Trust's 2018/19 quality account.

1.2 A draft copy of the quality account was received by the CCG on the 26th April 2019 and this statement has been developed from the information presented to date.

1.3 This is the first quality account for the merged Trust, the merger by acquisition was in place from 1st April, 2018, however it is to be noted that the Trust is continuing to review and harmonise its systems and processes across the four hospital sites. The current reporting arrangements may differ by site but work is in place for there to be Trust wide quality indicators by the end of 2019/20.

1.4 In the version of the quality account we viewed, some full year data was not yet available, and so we have not been able to validate those areas; we assume, however, that the Trust will be populating these gaps in the final published edition of this document.

1.5 In compiling the quality account, the Trust has presented the reader with a well-balanced and clear picture regarding performance against the 2018/19 priorities. The report describes the six quality priorities, the initiatives which have been implemented, and has identified areas where the Trust requires further improvement and how the Trust aims to achieve the priorities for 2019/20.

1.6 The Trust has made a decision to continue with the six priorities for improvement previously identified in 2018/19. All targets for these priorities have been reviewed and the CCG supports the Trust's review of progress and setting of either revised or continuation of targets.

1.7 It is disappointing that the Trust did not meet its target for reducing grade 2 hospital-acquired pressure ulcers, but the commissioners are pleased to see that this remains high on the Trust's quality agenda. A significant amount of work has been undertaken across all hospital sites to reduce the numbers of grade 2 pressure ulcers, these initiatives include the setting up of a task and finish group to determine the changes required to practice, development of the MOVED campaign and the involvement of the tissue viability team in the collaborative initiative lead by NHSI. The CCG carried out an assurance visit in April 2019 and were able to see first-hand the initiatives introduced to help reduce the numbers of grade 2 pressure ulcers.

1.8 The Trust did not meet the majority of the patient experience priorities set for 2018/19, and these will continue to be monitored for 2019/20. However, it is good to note that overall patients feel that they had confidence and trust in the nursing staff and this target was met. It is pleasing to note that the Trust is working to ensure that it receives feedback from all groups of patients and has expanded the demographic information collected alongside patient experience to ensure compliance with Stonewall LGBT guidance. Additionally, an easy read version of the FFT has been developed to make it easier to obtain feedback from patients with a learning disability. The Trust has identified two new patient experience priorities for 2019/20, they are: ensuring good nutrition and hydration, particularly for those patients who need additional help, and pain control in emergency departments. The CCG are pleased that the Trust has developed these based on previous feedback from patients.

1.9 It is encouraging that the Trust has improved its position for recording of a full set of patient observations, reaching 94.3% against a target of 95%, this was an improvement from 93% the previous year. This will remain as a quality priority. Currently 75% of patients with a high pain score have analgesia administered within 30 minutes. The Trust has acknowledged there is more work needed to improve this area of care and has

developed a series of actions to improve this over the next twelve months.

1.10 It was noted in section 2.2.5 that the Care Quality Commission undertook a core services visit during October 2018 and as a result of this inspection the Trust was overall rated good.

1.11 Learning from deaths section 2.2.7 outlines the systems and processes that the Trust has in place, this includes being an 'early adopter' of the Medical Examiner in Trust.

1.12 The CCG felt the quality account gave little information about the challenges regarding managing patients with cancer. Given the Trust's ongoing capacity challenges, it would be helpful to add in the robust and regular oversight by clinical leads to ensure that patients are managed in the best way possible.

1.13 The quality account contained limited information regarding the serious incidents and never events at the Trust. It is acknowledged that the never event position had improved from 14 for 2017/18 across the two previous organisations to 9 during 2018/19 at the merged Trust, however it would have been appropriate to include some more narrative to explain what learning was gained from reviewing the events and how this has been embedded across the Trust.

1.14 As Commissioners we have worked closely with UHB over the course of 2018/19, meeting with the Trust regularly to review the organisations' progress in implementing its quality improvement initiatives. We are committed to engaging with the Trust in an inclusive and innovative manner and are pleased with the level of engagement from the Trust. We hope to continue to build on these relationships as we move forward into 2019/20.

Phil Johns
Deputy CEO
Birmingham and Solihull CCG

Statement provided by Healthwatch Birmingham

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for University Hospital Birmingham (UHB) NHS Foundation Trust. We recognise the work the Trust has focused on over the year in order to integrate services across the Queen Elizabeth Hospital Birmingham (QEHB), Good Hope Hospital (GHH), Birmingham Heartlands Hospital (BHH) and Solihull Hospital (SH). We welcome plans to ensure that there is a Trust-wide agreement on quality indicators and to align systems and reporting. We hope to see the impact of this on the standards of care across the Trust.

We note that the Trust does not yet have an overall CQC rating, although from previous inspections QEHB has a rating of 'good'. However, its rating is requires improvement in the safe (medical care) and responsive (urgent and emergency services, and outpatient and diagnostic imaging). We also note that CQC yearly inspection of core services has rated:

- BHH as requires improvement in urgent and emergency services, medical care, surgery and maternity;
- GHH requires improvement in urgent and emergency services, medical care, surgery and good in maternity; and
- SH requires improvement in urgent and emergency services and was rated as good in medical care, surgery and maternity.

We would have liked to see outlined in the draft Quality Account specific actions to specific issues raised by the CQC. We hope to see these included in the published Quality Account. In addition, that the work outlined in the Quality Account will lead to an improved in future CQC inspections.

We appreciate our continued close working relationship with the Trust. For example, through our online feedback centre 'right to respond' function, our patient and public involvement (PPI) quality standard and our recent waiting room study. We are pleased with the Trust's response to our recommendations in that report. We hope to continue to work with the Trust to improve the experiences of patients and carers as they access the Trusts services.

Patient and Public Involvement

We welcome the various initiatives that were implemented during 2018/19 under the patient experience priority. These include the introduction of a Carer Coordinator role, which led to the development of training for staff. We are pleased that this has increased staff awareness of carer's needs, and the ability to signpost for further support (e.g. carer's assessment). It is positive to see that the Trust is developing feedback methods to ensure that it is listening to 'hard to reach' groups by making the necessary changes so that the views of these groups are reflected in changes and improvements. For instance, changes made to ensure that demographic information collected by the Trust is compliant with the Stonewall LGBT Guidance and the planned pilot of an easy read Friends and Family Test (FFT) survey to collect experience from patients with a learning disability. We look forward to reading about the impact of these initiatives in the 2019/20 Quality Account. We would also like to read the impact on numbers of patients leaving feedback following the introduction of tablet devices to all wards to enable patients to feedback electronically.

At Healthwatch Birmingham, we believe that having a staff team that understands the Trust's strategic approach for patient experience is important for developing a shared vision around the use of patient experience and feedback. We, therefore, welcome continued staff engagement in relation to patient experience. In particular, the inclusion of sessions on patient experience, carer support and compassionate care during Trust staff induction and Trainee Nursing Associate training sessions.

Regarding the Friends and Family Test (FFT) scores, we note that the Trust continues to face challenges in meeting the target for A & E positive recommender score. Since 2016/17, the positive recommender score for A & E has decreased year on year and over the past year has been mostly below or equal to the West Midland average of about 80%. Equally, the positive recommender for maternity (birth) has remained below the national and West Midlands average throughout the past year. The positive recommender scores for inpatients, outpatients, and especially community tend to perform better than A & E. This reflects the experiences people have told Healthwatch Birmingham over the past year. We note that the Trust is planning to review scores for maternity. We would like to read about the themes that have been identified from the review of these scores and the impact of the actions taken. We encourage the Trust to extend this review to A & E scores to understand better the challenges being faced, and why the introduction of an information screen in A & E has not had the desired impact on the score.

We are unable to comment on the patient experience indicators, as the National Inpatient Survey results for 2018 are not yet published. However, we note that the scores across the different questions asked have remained the

same from 2015/16 to 2017/18 and lower in at least three cases. It is disappointing that the score for the '*involvement in decisions about care and treatment'* question has remained on average 7.4 against the score of 10 for the past three years.

Equally, there has been a decrease in the scores for the Trust's responsiveness to the personal needs of patients. According to the National Inpatient Survey, there has been a decrease in the responsiveness to patients for QEHB (from 72.5% in 2016/17 to 70.1% in 2017/18) and for BHH/GHH/SH (from 65.1% in 2016/17 to 63.4% 2017/18). With the different activities around engagement the Trust has outlined in the Quality Account, we would have hoped to see an improvement in this. We would like to read in the 2019/20 Quality Account the actions taken following the collection and evaluation of patient experience the Trust is planning to carry out.

Healthwatch Birmingham believes that the Trust should consider taking a structured approach towards its PPI activities. The best way for the Trust to improve on its scores, such as the patient experience indicators and responsiveness to personal needs, is to understand these needs. This can only be done by listening to what these needs are from patients, service users and carers. We therefore still believe that the Trust would benefit from developing a Patient Public Involvement (PPI) Strategy that would ensure that engagement activities are equitable and representative of the localities the Trust works in. A PPI strategy would outline:

- Why the Trust is listening
- What the Trust is listening for
- How the Trust listens
- Who the Trust wants to hear from (including 'seldom-heard' groups)
- How the Trust will use what it hears
- Clear arrangements for collating feedback and experience.

Over the past year, Healthwatch Birmingham has worked with clinical commissioning groups (CCGs) and trusts to benchmark their patient and public involvement (PPI) processes using Healthwatch Birmingham's Quality Standard. Thus enabling them to identify areas of good PPI practice or areas that need to improve. This has led to the development of actions aimed at embedding systems for delivering consistently high-quality PPI. Healthwatch Birmingham has been in contact with the patient experience staff at UHB on this project and we hope to continue supporting the Trust's PPI activities in 2019/20.

Regarding the NHS Staff Survey, the Trust should provide more information on how many responded to the survey, including BAME Staff. More information could have been given on how staff are engaged apart from through the 'speak up guardian' and how staff view the Trust as a place to work. We note that 72% of the staff would recommend the Trust as a provider of care for their family and friends. This is significantly lower than the FFT positive recommender scores. We ask the Trust to look into the difference between staff and patient views and feed the findings into service improvement.

Trust Performance 2018/2019

Quality Priorities 2018/19

It is disappointing that performance on the 2018/19 priorities has been inconsistent and mixed across priorities and across different sites.

During 2018/19, QEHB has seen an increase in the number of reported incidents of grade 2 pressure ulcers (non-device related) from 62 during 2017/18 to 84 in 2018/19. This is above the agreed target with the CCG of 75. Regarding device related grade 2 pressure ulcers, we note that although there was a slight increase from 14 to 15, this was below the agreed target of 42. We note that in Quarter 2 both non-device and device-related pressure ulcers were lower than the other quarters. The Trust needs to investigate this and see what led to this difference and feed the findings into service improvement.

We note that BHH, GHH and SH have surpassed the target set by the CCG of a reduction of 20% for grade 2 pressure ulcers reducing this by 43.8%. What lessons are being shared across the Trust in terms of practices that led to this reduction? We are, however, still concerned that incrementally the number of grade 2 ulcers increased quarter on quarter within these three hospital sites.

We note the changes in definitions and terminology to be implemented in 2019/20, which could potentially affect numbers. In addition, that the Trust is in the process of aligning policies, documentation and tissue viability processes across the Trust. We still hope that the Trust's actions, as outlined in the Quality Account, have been developed with these changes in mind and are challenging enough to lead to an improvement in this area. We, therefore, hope to read in the 2019/20 Quality Account the impact of the leaflet promoting patient movement, the revised Prescribing Information and Communication System (PICS) repositioning tool, and the various campaigns planned such as the safe side lying or moved, heel drag.

Regarding the timely and complete observation and pain assessment priority, we note that whilst BHH/GHH/SH met the target of 95% (within six hours of admission or transfer) consistently during 2018/19, QEHB did not. We, however, are mindful that this was an improved score (94.3%) on 2017/18 (93%). It is concerning that the indicator for patients (QEHB) receiving pain relief medication following a high pain score has remained between 74% and 75% throughout 2018/19, below the target of 85%. We would like to read in the 2019/20 Quality Account, the actions taken following the review of this data to identify reasons the indicator is not being achieved.

We note the initiatives that the Trust plans to implement in 2019/20 to address the 'timely treatment for sepsis' priority. In particular, we note the introduction of a sepsis dashboard where performance can be monitored in real time at ward level. We would like to read about the impact of these in the 2019/20 Quality Account.

Patient Safety Indicators

We note that there has been some improvement in some indicators such as patients with C.difficile infection /100,000 bed days from 19.05 (QEHB) and 12.4 (BHH/GHH/SH) to 10.79 across the Trust. However, whilst we acknowledge the impact changes in reporting might have had on numbers, we note that there has been an increase in the number of patients with MRSA infection/100,000 bed days from 0.4 (BHH, GHH, SH) and 0 at QEHB in 2017/18 to 1.47 across the Trust in 2018/19 (although still lower than peer group average).

The Trust reports that there have been nine never events across the Trust in 2018/19. There were six (QEHB) and eight (BHH/GHH/ SH) never events in 2017/18. We note the categories of never events the Trust has provided (e.g. retained foreign object post procedure, unintentional connection of a patient requiring oxygen to an air flow meter, wrong site surgery). We welcome that the Trust took immediate corrective actions and the patients have received the correct procedures where appropriate. We would like to read in the 2019/10 Quality Account the impact of the actions implemented on practice and patients safety.

We are concerned that there appears to be an upward trend in the level of safety indicators:

- The number of patient safety incidents reported to the National Reporting and Learning System has increased 24,568 (2017/18) to 26,342 (2018/19) at QEHB and 19,664 (2017/18) to 21,811 (2018/19) at BHH/GHH/SH. We however do recognize that higher levels of reporting represent a good culture of openness and reporting within the Trust but also supports local learning. We would like to read in the 2019/20 Quality Account examples of learning that has taken place following reviews and the impact on practice.
- The percentage of safety incidents leading to severe harm has increased at QEHB from 0.22 to 0.26%.
- Emergency readmissions within 28 days of discharge (medical and surgical specialties) have increased across the Trust, from 13.87% (2017/18) to 15.39 % (2018/19) at QEHB and from 14.03% (2017/18) to 14.72% (2018/19) at GHH/BHH/SH. Similarly, emergency readmissions within 28 days of discharge (all specialties) – 13.84 to 15.56 at QEHB and 12.25 to 13.06% at BHH/GHH/SH.
- Percentage of patients receiving beta-blockers on the morning of the procedure for patients undergoing first-time coronary bypass graft (CABG) has decreased from 94.8% (2017/18) to 91.9% (2018/19).

We ask the Trust to investigate these areas further, to reflect Trust plans to investigate why the number of patients receiving beta-blockers is decreasing. This will help the Trust understand the lack of improvement and use the findings to inform service improvement.

Learning from deaths

During 2018/19, 5345 of the Trust's outpatients died and by April 2019 4226 case record reviews and 60 investigations were carried out. Thirty-four cases were subject to both a case review and an investigation. Nineteen cases (representing 0.36%) of patient deaths were judged by the Trusts review process to have been more likely than not caused by problems in the care provided. We note that various actions have been implemented in response and this has included responses to individual cases, changes or introduction of policies or guidelines, changing systems and patient pathways. We note action to communicate learning to relevant staff, provide feedback to family and staff involved in the incident, review of timeframes for CT scans and ensure that there is monitoring and tracking for patients entered on the Somerset Cancer Register. We hope to read on the impact of these in the 2019/20 Quality Account especially on changes to practice to ensure high-quality care.

Learning from Audits
We note the number of national (47) and local (4) clinical audits in which the Trust has participated in 2018/19. We note that the Trust carried out reviews of these audits and has developed actions to improve the quality of healthcare. It would be helpful to the public if the Trust included some examples of the actions to be taken especially on audit reviews that are relevant to the 2019/20 priorities.

Complaints and Compliments
Patients and carers do tell us positive experiences of care, but they have also told us negative experiences of accessing the Trust's services. The concerns raised by patients and carers to Healthwatch Birmingham are reflected in the complaints reported in the Quality Account. Over the year, we have heard about issues with waiting times, delays in clinics, the waiting room environment, poor A & E treatment, poor follow up checks (e.g. cancer test screening), poor communication with carers, the quality of treatment, poor attitude of staff, poor communication, lack of advice and support. We share real-time patient and carer experiences with the Trust and provide them with the right to respond to feedback left on our online feedback centre. We note the actions that are being taken to address these issues. We would like to see examples and the impact of follow on actions developed in the 2019/20 Quality Accounts.

The Trust's Priorities for 2019/20
Healthwatch Birmingham has taken note of the Trust's priorities for 2019/20. We are pleased that the priorities have been discussed or are to be presented at various Trust groups including to staff, patient and public representatives. We hope this process will help the Trust to develop further the priorities so that they effectively meet the various challenges facing the Trust and reflect the needs of the population. We welcome plans to include experience data relating to nutrition and hydration in all local inpatient surveys to measure success in 'improving patient experience' priority. We look forward to collaborating with the Trust on these priorities over the coming year.

Andy Cave
CEO
Healthwatch Birmingham

Statement provided by Healthwatch Solihull

Healthwatch Solihull welcomes the opportunity to review and comment on University Hospitals Birmingham Quality Accounts 2018/19. We also welcome that patient experience gathering through direct patient engagement is being set as a priority area of focus for Trust and congratulate the Trust on the steps it has taken in relation to this area.

The report format ensures that the priorities for the year ahead are identified as the ongoing programme of work. However, Healthwatch Solihull are unable to validate the priorities as they have not been involved in specific stakeholder consultation around these priorities.

In relation to the Trust patient experience priorities for improvement for 2019/20, service user contributions are key and Healthwatch Solihull would welcome the opportunity to work collaboratively with the trust to focus on improving patient experience and supporting the Trust in the achievement of its aims.

Healthwatch Solihull looks forward to closer dialogue with University Hospitals Birmingham NHS Foundation Trust and to reviewing progress against the forthcoming years priorities and to reviewing outcomes measured in the 2019/20 Quality Report to be able to assess how the quality initiatives have impacted on the residents of Solihull.

Kind Regards

Anthony Martlew
Manager
Healthwatch Solihull

Statement provided by Birmingham Health & Social Care Overview and Scrutiny Committee

The Birmingham Health and Social Care Overview Scrutiny Committee has indicated that it is not in a position to provide a statement on the University Hospitals Birmingham NHS Foundation Trust draft Quality Account 2018/19.

Statement provided by Solihull Health & Social Care Overview and Scrutiny Committee

The Solihull Health & Social Care Overview and Scrutiny Committee has confirmed that it is not in a position to provide a statement on the 2018/19 Quality Report.

Annex 2: Statement of directors' responsibilities for the Quality Report

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

NHS Improvement 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 NHS 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 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- 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 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from the commissioners dated 21/05/2019
  - feedback from governors dated 28/03/2019
  - feedback from local Healthwatch organisations dated 15/05/2019 (Solihull) and 21/05/2019 (Birmingham)
  - feedback from Overview and Scrutiny Committee dated 15/03/2019 (Solihull) and 21/05/2019 (Birmingham)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019
  - the 2017 national patient survey June 2018; this is the latest available survey.
  - the 2018 national staff survey, February 2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated April 2018
  - CQC inspection report dated 15/05/2015 (QEHB) and 23/02/2019 (Heartlands, Good Hope and Solihull Hospitals).
- 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
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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: 24th May 2019 ..... Chair

Date 24th May 2019 .....Chief Executive

Annex 3: Independent Auditor's Report on the Quality Report

Independent auditor's report to the council of governors of University Hospitals Birmingham NHS Foundation Trust on the quality report

We have been engaged by the council of governors of University Hospitals Birmingham NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Birmingham NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of University Hospitals Birmingham NHS Foundation Trust as a body, to assist the council of governors in reporting University Hospitals Birmingham NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and University Hospitals Birmingham NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;

- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with the 2016 National Cancer Breach Allocation Guidance.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation Trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation Trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:
    - board minutes for the period April 2018 to April 2019;
    - papers relating to quality reported to the board over the period March 2018 to April 2019;
    - feedback from governors dated 28th March 2019;
    - feedback from Healthwatch Solihull, dated 15th May 2019;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24th April 2019;
    - the 2017 national patient survey;
    - the 2018 national staff survey;
    - Care Quality Commission inspection report, dated 13th February 2019; and

- the Head of Internal Audit's annual opinion over the Trust's control environment, dated April 2019;

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation Trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the 'documents').

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation Trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these

criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation Trust annual reporting manual'.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University Hospitals Birmingham NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation Trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the 'NHS Improvement Detailed requirements for external assurance for quality reports 2018/19' for foundation Trusts; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual' and supporting guidance.

Deloitte LLP
Birmingham
United Kingdom
24 May 2019