NHS

University Hospitals Birmingham

NHS Foundation Trust

Quality Report 2019/20

This annual report covers the period 1 April 2019 to 31 March 2020

2019/20 Quality Report

Contents

1 Chief Executive's Statement

Maintaining high quality patient care through effective day-to-day operational and financial performance across our hospitals and services remained a key strategic priority during 2019/20. The Trust has focused on standardising high quality patient care across the four main hospital sites alongside digital and technological transformation. Planning for the implementation of common electronic systems across the sites began in earnest in 2019/20. Key systems are due to be implemented across Heartlands, Good Hope and Solihull hospitals in 2020/21 including the Oceano Patient Administration System (PAS) and the Prescribing Information and Communication System (PICS). These systems will enable the quality of care to be measured in the same way, compared, monitored and improved across the hospital sites.

Performance for the six quality improvement priorities set out for 2019/20 in the 2018/19 Quality Report has been mixed across the Trust:

Priority 1: Reducing grade 2 pressure ulcers
Priority 2: Improve patient experience and satisfaction
Priority 3: Timely and complete observations including pain assessment
Priority 4: Reducing missed doses
Priority 5: Reducing harm from falls
Priority 6: Timely treatment for sepsis

The Board of Directors has therefore chosen to continue with five of these overall priorities with an updated focus for each and associated targets to drive improvement. The Board of Directors has also selected two new priorities for improvement in 2020/21:

- Freedom to Speak Up
- Timely medical review

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. The Clinical Dashboard Review Group was set up in August 2019 which meets monthly and is chaired by the Deputy Chief Nurse and Director of Strategy and Quality Development. The purpose of the group is to review performance at ward level in a supportive, learning environment with the clinical staff involved to drive continuous improvement.

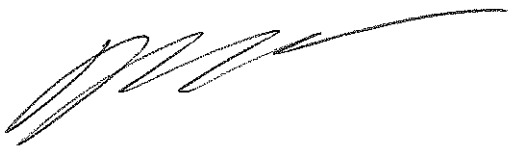
A wide range of omissions in care were reviewed in detail during 2019/20 at the Executive Care Omissions Root Cause Analysis (RCA) meetings chaired by the Chief Executive. Cases are selected for review from a range of sources including missed or delayed medication, serious incidents, serious complaints, IT incidents, infection incidents 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).

The Trust's external auditor Deloitte usually provides an additional level of scrutiny over key parts of the Quality Report. Due to the nationwide Covid-19 pandemic response, NHS England and NHS Improvement issued guidance to trusts in March 2020 advising that they would not be required to seek external assurance on the 2019/20 Quality Reports.

2020/21 will be a particularly challenging year for UHB as we work towards achieving the ambitious priorities set out above in the context of the continuing Covid-19 pandemic. The Trust will continue working with health and social care providers, commissioners, regulators and other organisations to implement improved models of care delivery and further improvements to quality during 2020/21.

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
22 October 2020

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

2.1 Priorities for Improvement

The Trust's 2018/19 Quality Report set out six priorities for improvement during 2019/20:

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

Performance has been mixed for the priorities and across the different Trust sites during 2019/20. Further details for each priority are provided in the following pages. The Board of Directors has chosen to continue with five of these overall priorities for improvement in 2019/20 and two new priorities:

1	Reducing pressure ulcers	To focus on reducing device-related pressure ulcers.
2	Improving patient experience and satisfaction	Not continuing for 2020/21
3	Timely and complete observations including pain assessment	One indicator to be replaced
4	Reducing missed doses	Indicators will be combined to enable performance across all sites to be compared
5	Reducing harm from falls	To focus on reducing the falls rate (number of patient falls per 1000 occupied bed days)
6	Timely treatment for sepsis	To continue for 2020/21
NEW	Freedom to Speak Up	New for 2020/21
NEW	Timely Medical Review	New for 2020/21

The improvement priorities for 2019/20 were discussed and confirmed by the Trust's Clinical Quality Monitoring Group chaired by the Executive Chief Medical Officer, following consideration of performance in relation to patient safety, patient experience and effectiveness of care.

The improvement priorities have also been discussed at, or will be communicated to, the following Trust groups.

Group	Key members
Care Quality Group	Executive Chief Nurse, Divisional Directors of Nursing, Matrons, Senior Managers with responsibility for Patient Experience, and Patient Governors
Council of Governors	Chair, Non-Executive Directors, Governors, Chief Executive, Directors and Senior Managers
Chief Executive's Team Brief (cascaded to all Trust staff)	Chief Executive, Executive Directors, Directors, Clinical Service Leads, Heads of Department, Divisional Directors of Nursing, Matrons, Managers

Although some of the 2020/21 priorities have been in place for a number of years, the specific focus and targets within each priority are regularly reviewed and updated.

The performance for 2019/20 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 Quality Report for 2018/19.

Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

Background

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply (NICE, 2014). They are also known as "bedsores" or "pressure sores" and they tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. Some pressure ulcers also develop due to pressure from a device, such as 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 categorised from 1 to 4 depending on their severity, 4 being the most severe. A new categorisation tool came into use from 2019:

Category	Description
1	Intact skin with non-blanching erythema (redness) of a localised area, usually over a bony prominence. Change Intact skin with non-blanching erythema (redness) of a localised area, usually over a bony prominence. Changes in sensation, temperature, or firmness may precede visual changes. Darker skin may not have visible blanching.
2	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, without non-removable slough and may also present as an intact or ruptured serum-filled blister.
3	Full thickness loss of skin. Subcutaneous layer may be visible but bone, tendon or muscles are not exposed. Some slough or necrosis may be present. May include undermining and tunnelling. The depth of a Category 3 varies by anatomical location e.g. bridge of the nose, ear, back of the head and malleolus do not have subcutaneous tissue and these ulcers can be shallow.
4	Full thickness tissue loss with exposed tendon, muscle, bone or palpable bone. Slough or necrosis may be present. Often include undermining/ tunnelling. The depth of a Category 4 varies by anatomical location e.g. bridge of the nose, ear, back of the head and malleolus do not have subcutaneous tissue and these ulcers can be shallow.
Ungradable (Depth unknown)	Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough or necrosis. Until enough slough and/or necrosis are removed to expose the base of the wound, true depth cannot be determined, but it will be Category 3 or 4. Stable (dry, adherent, intact without erythema) eschar/necrosis on the heels serves as 'the body's natural (biological) cover' and should not be removed.
Suspected Deep Tissue Injury (SDTI) (depth unknown)	Purple or maroon area of localised discoloured intact skin or blood-filled blister. Pain and temperature change often precede skin colour changes. Discolouration may appear differently in darker pigmented skin. Evolution may be rapid exposing additional layers of tissue even with optimal treatment or may resolve without tissue loss.

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

NHS Improvement (NHSi) Consensus
The consensus document from NHSi recommended that all NHS organisations use the same definitions and measurements for pressure ulcers.

The Tissue Viability (TV) team worked closely with Risk Management to redesign incident report forms and processes to ensure these meet the recommendations. A new concise RCA document was devised to replace the mini RCA document at QEHB and the pressure ulcer checklist at the BHH / GHH / SH sites. Where lapses in care have been identified an action plan is required and is attached to the patient's Datix record. This is an aligned process for the organisation as a whole.

Key changes include the terms as to where and when pressure damage has occurred, time frames, and what tissue damage is reported. The avoidability status was replaced by lapses in care (see table below).

Workshops were delivered on each of the hospital sites for key staff to educate on accurate pressure ulcer categorisation, pressure ulcer reporting and completion of the concise RCA document.

New pressure ulcer categorisation posters and cards were distributed to staff across the organisation.

NHSi Consensus changes for pressure ulcers

What's in ?	What's out?	What does this mean for me?
Categories	Grades	Use new term
Unstageable	Ungradable	Use new term
Pressure ulcer on admission (POA)	Community acquired pressure ulcers (CAPU) /Non hospital acquired (NHA)	Skin inspect within 8 hrs of admission (2 at HGS) and report any damage on Pressure Ulcer and MASD Datix form
Trust acquired pressure ulcer (TAPU)	Hospital acquired pressure ulcer (HAPU)	Skin inspect within 8 hrs of admission (2 at HGS) and report any damage on Pressure Ulcer and MASD Datix form
Report all moisture associated skin damage (MASD)	Not previously mandatory to report	Report all MASD from incontinence/wound exudate/perspiration/stoma output on Pressure Ulcer and MASD Datix form
Accurately documented skin inspection	72 hour rule	Will affect number of Trust acquired pressure ulcers if existing damage not documented correctly

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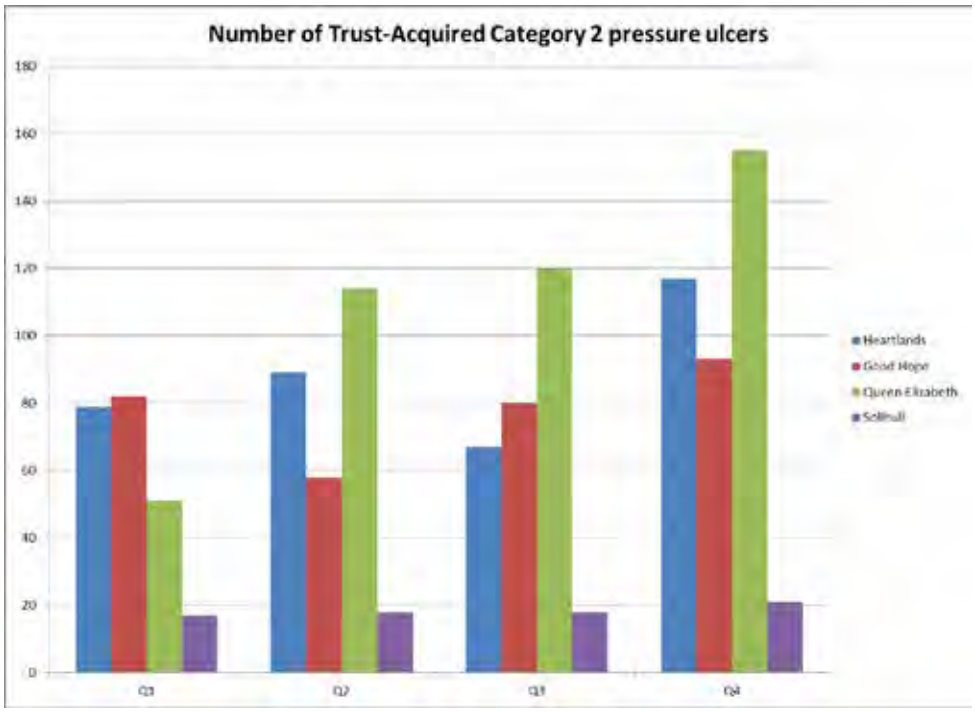
Performance

To reflect the NHS Improvement recommendations, changes to definitions and terminology were implemented during 2019/20. Data was collected during the year and is presented below and will be used as baseline data to set targets for 2020/21, however no target was set for 2019/20.

The figures for 2019/20 were not subject to a KPI. This was in part to allow for alignment of reporting and processes, and in part to allow for the national recommendations around consensus from NHSi (2018) to be embedded.

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



Changes to improvement priority for 2020/21
At UHB, pressure ulcers are split into two groups: those caused by pressure as a direct result of a medical device being in use and those that are not. For 2020/21, the Quality Account will focus on device-related pressure ulcers.

These are then further categorised as mucosal or non-mucosal. The layers in the mucosa are different to that of normal skin meaning that the normal categorisation of pressure damage cannot be applied. Wound healing is the same in mucosa as it is in the skin, except for the formation of scar. Scar tissue of the mucosa is remodelled and most injuries heal without scar formation.

Non-mucosal
For 2020/21 the chosen measure for the Quality Account will be the number of patients with category 2, device-related, non-mucosal pressure ulcers. In 2019/20 there were 202 patients with this type of ulcer; therefore a 5% reduction target has been set for 2020/21, which equates to no more than 192 patients with this type of ulcer.

Examples of devices that can cause these ulcers are POP (plaster of Paris, i.e. plaster casts), nasal specs, oxygen tubing and anti-embolism stockings.

Mucosal
UHB will also report the number of patients with category 2, device-related, mucosal pressure ulcers, however a reduction target for these will not be set.

In 2020/21 so far, the majority of this type of ulcer have been facial ulcers that have occurred in Covid-positive patients in ITU; this is because these patients have to spend prolonged hours lying on their front (known as "proning") which causes pressure to be exerted on areas of the body that are not usually subject to this. There are further complications in these patients in that this positioning can result in a lot of facial oedema and maintaining the patient's airway is the priority. Therefore whilst staff have received education and updated guidelines around pressure ulcer prevention in proned patients and different devices are being explored, it is often difficult to prevent some damage from occurring.

Initiatives implemented during 2019/20
- The Tissue Viability Nurses (TVNs) from Queen Elizabeth, Heartlands, Good Hope and Solihull hospital sites became one team and underwent a change in management structure. TVNs were allocated to Divisions rather than being site based to provide support.
- Tissue Viability (TV) service provision for the whole of UHB was reviewed to ensure it was equitable and met the needs of the organisation.
- Differences in TV related practices were identified and plans developed for the alignment. The team previously based at QEHB adopted the practice of no longer reviewing all patients with a category 2 hospital acquired pressure ulcer to align with practice on the other sites.
- All TV related policies, guidelines and patient information are in the process of being reviewed and aligned.
- The TVNs are working in conjunction with Facilities, Procurement and senior staff to standardise pressure reducing/relieving equipment and wound dressing formularies across UHB to ensure unnecessary expenditure is reduced without compromising on quality.
- The TV team has agreed a format to standardise the education provision, including competency based practice across UHB.
- The team continued to roll out the MOVED, heel drag, safe side lying and other campaigns throughout the Trust.
- The team continued to work closely with other specialist teams e.g. Infection Prevention, Moving and Handling and Therapies.
- The repositioning record on PICS was amended to make it more accurate and user friendly.
- A trust wide pressure ulcer steering group has been set up. Good practice, themes and strategies for improvement will be discussed and monitored via this group.
- Regular themed reviews have taken place to identify common areas where lapses in care have taken place to allow targeted actions for improvement.

Initiatives planned for 2020/21
To continue to build on the initiatives seen in 2019/20, to further identify common themes behind hospital-acquired pressure ulcers and to target training and resources accordingly. Initiatives to aid improvements include:
- Alignment of tissue viability practices and services across all hospital sites.
- A QI project to refocus on the MOVED campaign with an emphasis on repositioning.
- A joint initiative to improve communication regarding the discharge of patients with a wound to external care providers.
- Establishing and embedding TV related divisional support and guidance.
- Improving wound assessment and diagnosis for three priority wound groups: pressure ulcers, leg ulcers and surgical wounds.
- Focus on device related pressure damage.

How progress will be monitored, measured and reported

- All hospital acquired category 2, 3 and 4, unstageable and DTI pressure ulcers are reported via the Trust's incident reporting system Datix, and reviewed by a Tissue Viability Specialist Nurse.
- All unstageable and DTI hospital acquired pressure ulcers are monitored for the duration of the inpatient stay or until resolved, whichever is sooner, by a Tissue Viability Specialist Nurse.
- All category 1 pressure ulcers and moisture lesions are reported via Datix.
- Category 3 and 4 hospital acquired pressure ulcers are subject to a full RCA.
- A concise RCA must be completed for all category 2, DTI and unstageable pressure ulcers to identify any lapses in care. If these are significant they trigger the completion of a full RCA.
- Monthly reports are submitted to the Trust's Pressure Ulcer Steering Group, 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.
- All staff can access their pressure ulcer scorecard to monitor the number and severity of pressure ulcers on their ward.
- Staff at QEHB can monitor the number and severity of pressure ulcers on their ward via the Clinical Dashboard.
- All serious incidents are reviewed at the Nursing Incidence Quality Assurance Meeting chaired by the Divisional Deputy Directors of Nursing.
- The Safety Thermometer is completed monthly as per NHS England requirement.

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.

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) decided to focus on two key aspects that patients have told us are important to them:

- Nutrition and hydration
- Pain control in our Emergency Departments (ED)

Methodology

Nutrition and hydration data is from the inpatient / day case paper surveys carried out at patients' bedsides. The data for the question on pain in ED is from the paper survey done in the Emergency Department upon discharge.

Performance

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.

Baseline data was gathered in Quarter 1 2019/20 across all sites to enable targets to be set

Nutrition and Hydration	2019/20					
	Target	Q1*	wQ2	Q3	Q4	YTD
Did you get enough help to eat? (where help was required)	**9.3**	9.1*	9.0	8.7	8.6	8.9
Number of responses	-	236*	266	286	210	998
During your time in hospital, did you get enough to drink?	**9.8**	Not asked	9.7	9.7	9.7	9.7
Number of responses	-		1607	2065	1396	5068

*QEHB only.

Pain in Emergency Departments	2019/20					
	Target	Q1*	wQ2	Q3	Q4	YTD
Do you think the hospital staff did everything they could to control your pain?	**9.0**	**6.7***	**6.6**	**7.7**	**8.6**	**7.6**
Number of responses	-	90*	189	200	239	718

*QEHB only.

Calculation of scores
The most positive response is given a 10, the least positive response is given a 0 and any 'middle' responses receive a value between those. Responses such as "don't know" or "not applicable" are excluded from the calculations. The total score is then divided by the number of responses (i.e. the mean average is calculated), giving a score between 0 (lowest) and 10 (highest).

For example, the possible responses and scores for a question could be:
- Yes, completely = 10
- Yes, to some extent = 5
- No = 0

Initiatives implemented during 2019/20
Nutrition and Hydration:
- Routine monitoring of nutrition and hydration experience is in place for inpatients, outpatients and ED attendees.
- Additional volunteers recruited to ED to support access to adequate nutrition and hydration for patients (where clinically appropriate) and carers.
- Implementation of Mealtime Council to improve operational processes in relation to nutrition and hydration practice.
- Nutrition Strategy under development.
- Through Eat, Drink, Dress, Move, Therapy Support Workers promote nutrition, hydration and mobility.
- Hydration assessment and new charts to monitor food and fluid intake and to accurately record fluid balance, now launched across all sites with 140 wards visited as part of the staff education and engagement.
- Provision of detailed allergen information to ensure patient safety.

Pain in ED:
- Updated patient experience survey rolled out across all sites; including a further pain related question in order to elicit further insight "Did someone explain to you about pain relief'?"
- Patients (or carers where relevant) given information regarding their pain relief and signposted to leaflets supplied with dispensed medication.
- A tracker tool introduced to monitor how actions implemented impact on both Friend and Family (FFT) Survey responses and recommender scores
- Information screens updated in all Emergency Departments, with a variety on information focussing on waiting times, the ED journey/ pathway, other treatment centre options e.g. Pharmacy or NHS Walk-in Centres, self-help advice and use of non-medicinal pain relief strategies.
- Comprehensive pain audit being undertaken (this piece of work has been delayed due to COVID-19)
- Additional volunteers recruited specifically for ED to support the patient experience; as part of their role they will inform nursing staff if patients report pain/poor pain control.

Other wider patient experience activity is detailed in the Trust's 2019/20 Annual Report.

Plans for 2020/21
It has been agreed this will no longer be a specific priority for improvement in the Quality Report as patient experience is a routine part of the Trust's work programme which is monitored through the Patient Experience Group.

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)

2019/20 performance was about the same as 2018/19 and was just below the 95% target for the year.

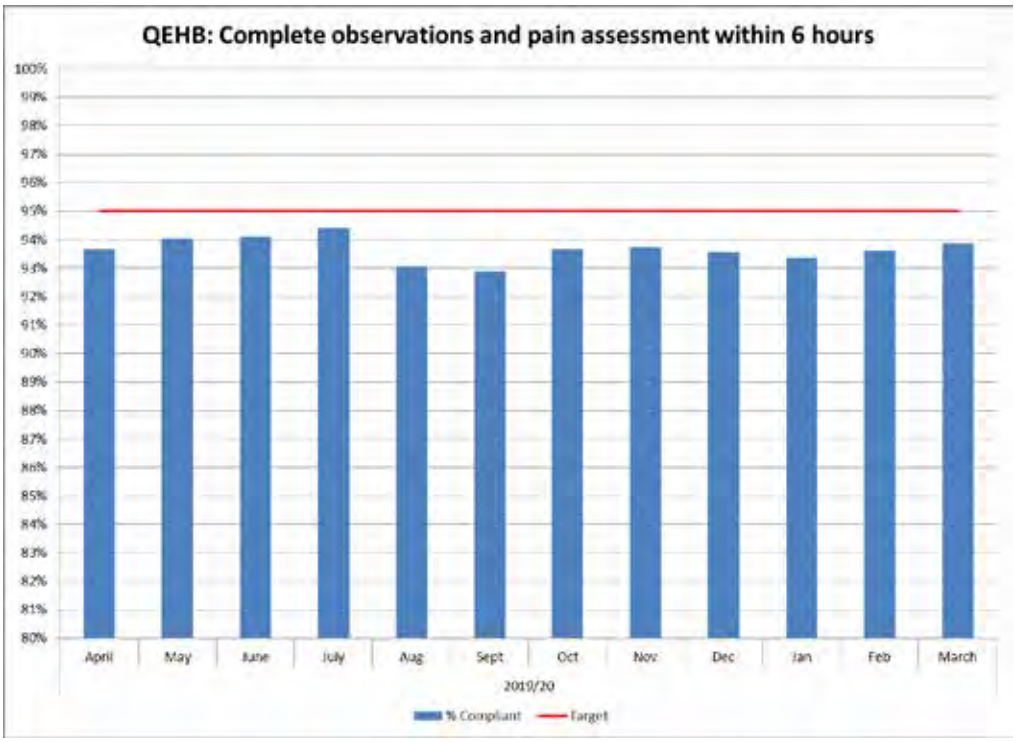
Indicator 2 (Analgesia administered within 30 minutes of a high pain score)

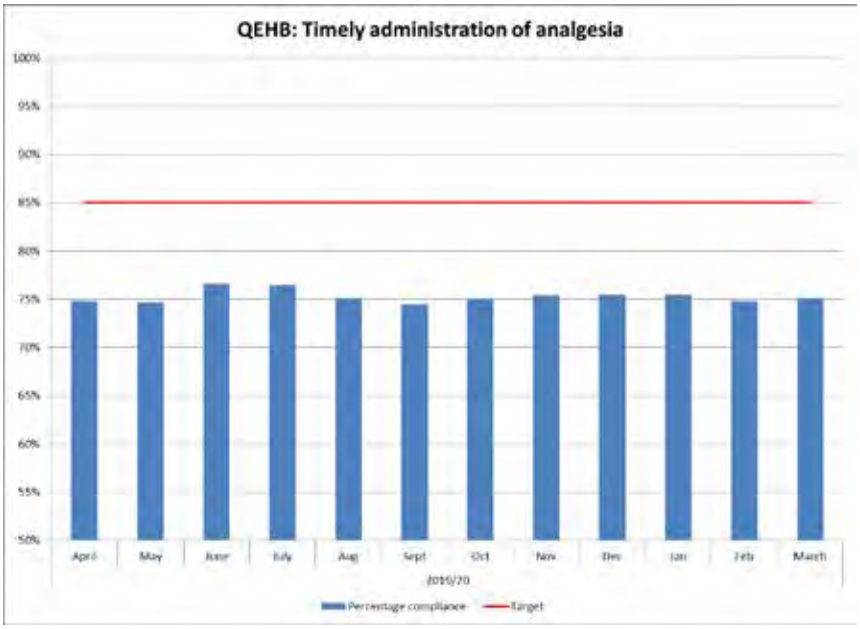
Overall performance was 75.3% for 2019/20 which is significantly below the 85% target. This indicator has been reviewed with the Clinical Service Lead for Pain Medicine. It was agreed that this indicator should be replaced with new ones focusing on regular assessment of pain and reassessment following a high pain score.

Table: Performance

	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
Target	**95%**	**85%**
Performance 2017/18	93%	75%
Performance 2018/19	94%	75%
Performance 2019/20	93.7%	75.3%

Graphs: Performance by month





Background – Heartlands, Good Hope and Solihull Hospitals

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.

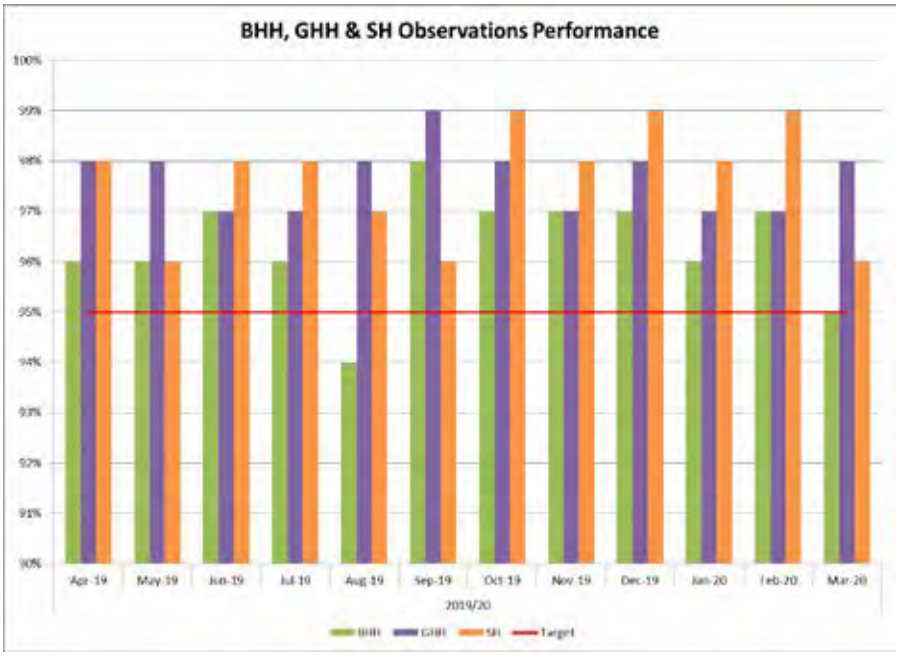
The data gathered for the Heartlands, Good Hope and Solihull Hospitals sites is drawn from a monthly audit of nursing notes across the wards, known as the Nursing Metrics. The score is based on an aggregate of various standards relating to observations.

Performance – Heartlands, Good Hope and Solihull Hospitals

Observations

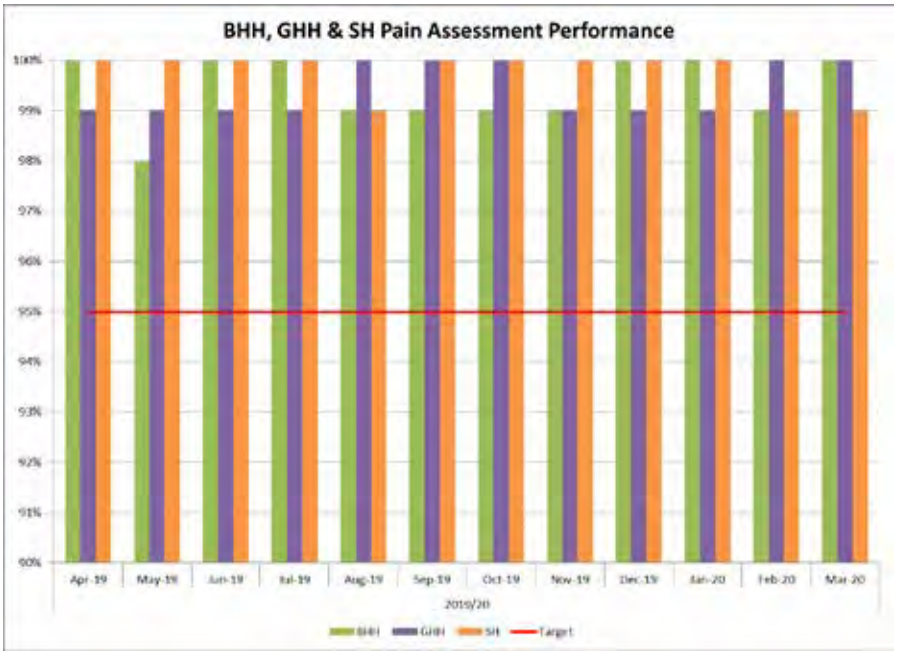
The target is 95%, which has been met by each site and for Heartlands, Good Hope and Solihull Hospitals overall almost every month during 2019/20.

Performance is displayed in the graph below.



Pain assessment
This metric is new to the Quality Report this year pending introduction of PICS. The score is a composite score drawn from a number of questions in the monthly Nursing Metrics. The target is 95%, which has been met by each site and for Heartlands, Good Hope and Solihull Hospitals overall every month during 2019/20.

Performance is displayed in the graph below.



Initiatives implemented in 2019/20

- Wards' performance is monitored at a divisional and Trust level. The Clinical Dashboard Review Group was established during 2019/20 – each month wards are selected based on their performance against certain indicators, including observations indicators.
- Wards complete a document that helps them review the causes of any misses, and break them down into issues they can resolve themselves, and those that are out of their control.
- For the issues they can resolve, they explain what they have already done, and what they plan to do.
- Examples of actions taken by individual wards at local level include:
  - Reminding staff of the correct order of actions on PICS when admitting a patient to their ward.
  - Monitoring missed observations, to see if certain staff were having difficulties – those staff were offered additional training, or if misses were more likely to occur at certain times of day or on certain shifts.
  - Weekly summary of the ward's Clinical Dashboard performance added into the staff "Focus of the Week" team meetings, to highlight issues and good practice to all ward staff.
  - Ward-organised monthly quality audits introduced, so that performance could be monitored closely and presented to staff to increase ownership of performance.

Changes to Improvement Priority for 2020/21

QEHB
Indicator 1 – Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward
As performance was just below the target set for 2019/20, the Trust has chosen to keep the 95% target for 2020/21.

Indicator 2 – Analgesia administered within 30 minutes of a high pain score
This indicator will be replaced following discussion with the Clinical Service Lead for Pain Medicine. The focus needs to be on ensuring all patients have their pain assessed and reassessed regularly. Two replacement indicators will be developed as follows:

- Full set of observations plus pain assessment every 12 hours
- Reassessment of pain following a high pain score (time interval to be agreed)

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

Initiatives to be implemented in 2020/21
- Wards performing below target will continue to be reviewed at the Clinical Dashboard Review Group (CDRG) meetings to identify where improvements can be made.
- The Clinical Dashboard refresh and associated indicators to be reviewed and updated where required
- Continued work to roll out PICS at Heartlands, Good Hope and Solihull; indicators can be then be drawn from the available data.

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.

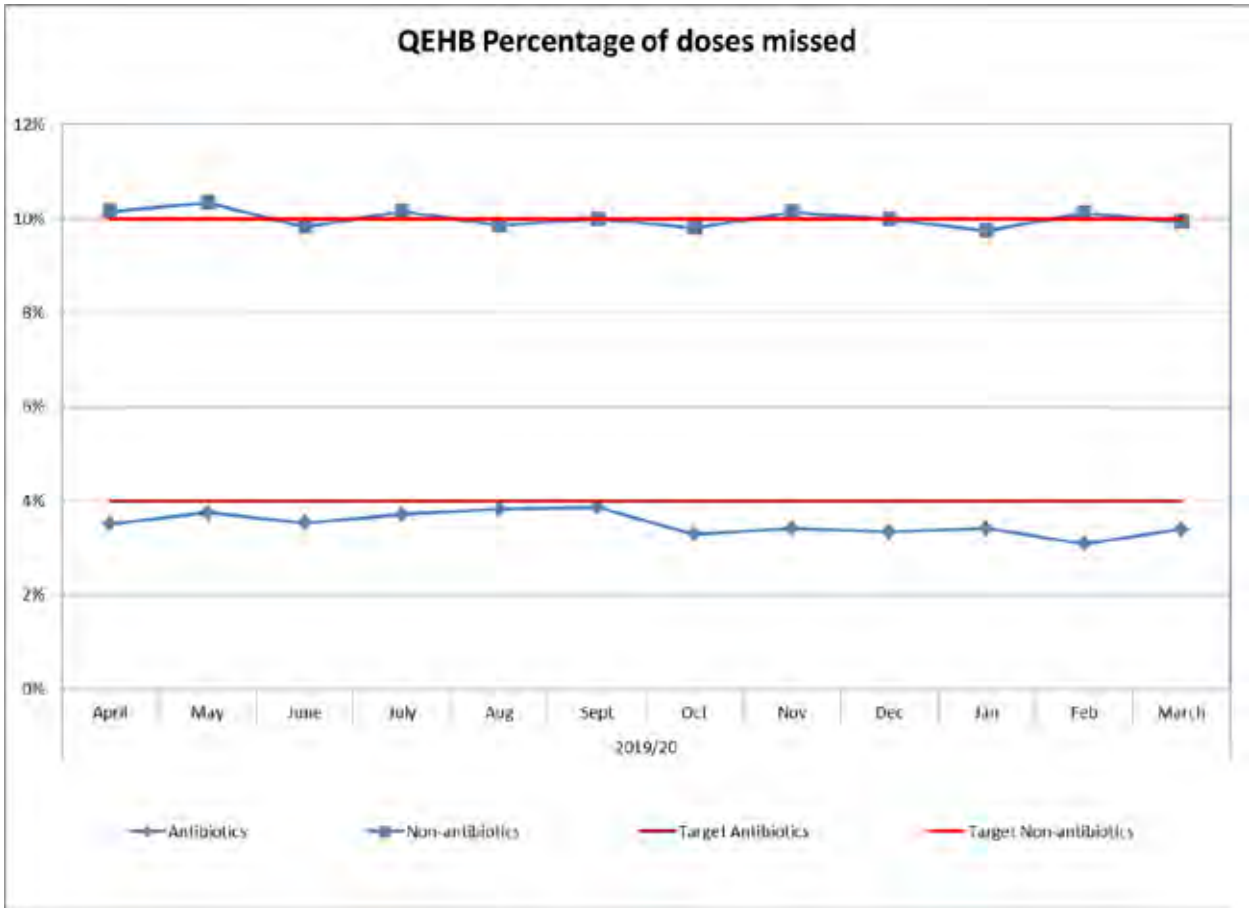
At Heartlands, Good Hope and Solihull Hospitals, drug prescriptions and administrations are recorded on a different electronic system, and the chosen indicator is the rate of missed doses of regular antibiotics.

Performance - QEHB
Antibiotics: in 2018/19 QEHB achieved 3.9% against a target of 4.0% or lower, and also met the target every quarter. In the 2018/19 Quality Report, UHB decided to keep this target and monitor the indicator internally, whilst considering other indicators such as consecutive missed doses, or missed doses of high risk medicines.

For information, performance for 2019/20 overall was 3.5%, the target was met every month, and the best month was February 2020 with 3.1%.

Non-antibiotics: in 2018/19 QEHB achieved 10.5% for the year, and Quarter 4 was 10.2%, against a target of 10.0% or lower. In the 2018/19 Quality Report, UHB decided to keep this target for 2019/20.

In 2019/20 QEHB achieved 10.0% for the year, meeting the target, with the best month being January 2020 with 9.8%.

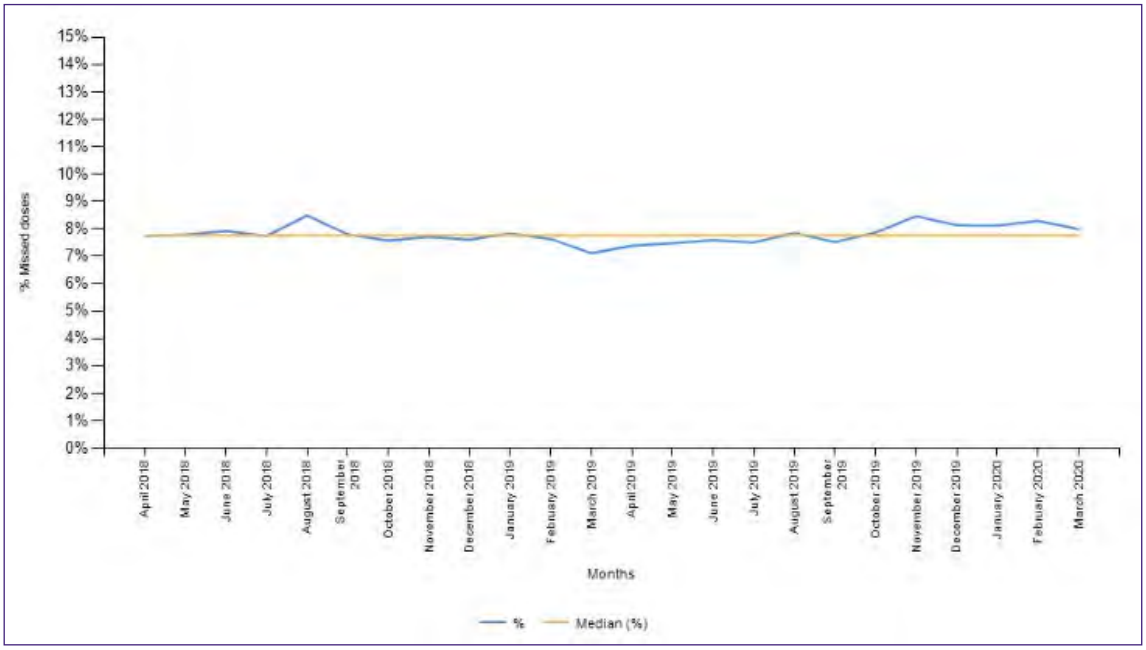


	Antibiotics	Non-antibiotics
Target	**4% or lower**	**10% or lower**
Performance 2017/18	4.5%	11.3%
Performance 2018/19	3.9%	10.5%
Performance 2019/20	3.5%	10.0%

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 7-9% for the last two years.

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



Initiatives implemented during 2019/20

- Wards' performance is monitored at a divisional and Trust level. The Clinical Dashboard Review Group was established during 2019/20 – each month wards are selected based on their performance against certain indicators, including indicators that look at the rate of missed doses.
- Wards complete a document that helps them review the reasons behind missed doses, and break them down into issues they can resolve themselves, and those that are out of their control.
- For the issues they can resolve, they explain what they have already done and what they plan to do.
- Examples of actions taken by individual wards at local level include:
  - A change in process to escalate patients who require cannulation to receive their IV medication.
  - Ensuring nursing staff have access to cannulation training, in order to reduce the wait times for a doctor to cannulate patients.
  - Issues arose from doctors not pausing or stopping prescriptions when they are no longer needed, Medical engagement was sought through the Clinical Service Lead, and discussed at a Consultants meeting.
  - Incorrect prescriptions were the cause for some missed doses, to rectify this new juniors have undergone further training from pharmacists.
  - Pharmacy Technicians now attend daily Multi Disciplinary Team meetings, to help address issues around administration for patients who lack capacity, or those with swallowing difficulties.
  - Weekly summary of the ward's Clinical Dashboard performance added into the staff "Focus of the Week" team meetings, to highlight issues and good practice to all ward staff.
  - Ward-organised monthly quality audits introduced, so that performance could be monitored closely and presented to staff to increase ownership of performance.

Changes to Improvement Priority for 2020/21

- 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 2020/21

- Wards performing below target will continue to be reviewed at the Clinical Dashboard Review Group (CDRG) meetings to identify where improvements can be made.
- The Clinical Dashboard refresh and associated indicators to be reviewed and updated where required.
- Development of missed doses indicators for the Heartlands, Good Hope and Solihull to align with those available at the QEHB site.
- Scoping and development of an IV antimicrobial specific indicator for all sites – this will include antifungal and antiviral drugs, as well as antibiotics.
- Continued work to roll out PICS at Heartlands, Good Hope and Solihull; indicators can be then be drawn from the available data.

How progress will be monitored, measured and reported

- The Clinical Dashboard Review Group (CDRG) meetings will continue to run and review wards' performance on missed doses.
- 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 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.

All falls RCAs that are scheduled for hearing at an HMS Coroner's inquest, are also presented and approved at CaPRI (Clinical and Professional Review of Incidents) chaired by the Executive Chief Medical Officer, before they are submitted to the HMS Coroner.

Falls prevention
All inpatients, regardless of age, should undergo a Falls Risk Assessment on admission/transfer to a ward; this is repeated every 7 days or and more frequently if their clinical condition changes. If a patient is found to be at an increased risk 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 and/or more visible bed space.

The Falls Team work closely with Therapy teams to ensure that patients are reviewed in accordance with their needs, in particular where walking aids might be required to assist with a patient's mobility.

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

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.

Performance
For 2019/20, the Trust chose to focus on reducing the overall number of patient falls that occur at UHB (the four hospital sites).

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

In 2019/20, 6336 patient falls occurred at UHB's four hospital sites, meaning the Trust did not meet the target. It should be noted that there was an increase in activity across the Trust, and this indicator cannot take account of this.

The Trust therefore also monitors the number of patient falls per 1000 occupied bed days (OBDs), does take account of activity levels. The Trust set an internal target of no more than 5.65 patient falls per 1000 OBDs, and performance for 2019/20 was 5.59 patient falls per 1000 OBDs which met the internal target.

Initiatives implemented during 2019/20
- The Trust Falls procedures and associated pathways have been fully aligned across the organisation. Therefore all staff have access to the same falls information and guidance regardless of which hospital site they work at.
- A Trust wide Falls Steering group was set up with membership from Divisions and specialities with direct association to falls prevention and management, e.g. Health and Safety Team, Manual Handling team and Therapies. This is driving a more unified and consistent approach to falls prevention, whilst embracing engagement and expertise from a wide range of specialities.
- Falls education and training has been standardised across the organisation and is available to access on the Trust wide Preventing Harm rolling programme.
- A Trust wide falls specific DATIX form was designed and is now in use. This ensures consistency in incident reporting and allows for more robust internal benchmarking of falls themes and trends across the organisation.
- The falls RCA process has been standardised across UHB, including RCA tools and the procedure for investigation. This has resulted in more robust interrogation of why falls occur, and is promoting a more consistent open and transparent culture of falls incident investigation.

Changes to Improvement Priority for 2020/21
The Trust has chosen to measure the number of patient falls per 1000 occupied bed days (OBDs), as this takes account of the levels of activity across the Trust. In 2019/20, there were 5.59 patient falls per 1000 OBDs at UHB.

However due to the change in patients admitted to UHB during the Covid-19 pandemic and the step down of elective activity, it has been agreed that it is not realistic to set a falls reduction target based on this time period. Also, performance will most likely change again as the number of Covid-19 admissions reduces and elective work is gradually stepped back up.

Data will be collected and monitored during 2020/21 and will be available at ward and Trust level. When at least three months of settled performance data is available, this will be reviewed and a reduction target considered. However it is currently not possible to say when this can take place as the recovery plans are still in the early stages and there is still the possibility of a second wave of Covid-19 cases.

Initiatives to be implemented during 2020/21
- The existing falls education and training offer will be extended to Falls link nurses, and the development of a falls Moodle package.
- The falls team will be focussing on seeking assurances that the newly merged falls procedures and associated pathways are being adhered to across the organisation, incorporating the use of audit and NICE guideline baseline tools etc.
- The falls team will be implementing the Trust Falls Prevention and Management Strategy for 2020-2023, which reflects and supports both the UHB

key priorities as outlined in the UHB Strategy for Building Healthier Lives, and also the Birmingham and Solihull Sustainability and Transformation plan.

How progress will be monitored, measured and reported

- Data on falls along with any themes and trends, and/or key learning points identified, will be presented to the Operational Quality Assurance Group on a quarterly basis by the Lead Nurse for Falls as part of the falls performance update. .
- Data on falls will also be presented to the monthly Chief Nurse's Care Quality Group as part of the monthly performance review.
- Ward-level and trust-level data on falls is available to clinical staff via electronic dashboards and reports. Divisional Directors of Nursing present these and any exceptions, at the monthly Operational Quality Assurance Group as part of their Divisional performance review.
- 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 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

See also *Quality Improvement Projects* below.

This quality improvement priority has continued during 2019/20.

Background

Sepsis is a life threatening condition. Almost 37,000 deaths are attributed to sepsis in England annually. Of these, it is estimated that 11,000 could have been prevented.

Sepsis was on the national agenda as a high priority area for the Commissioning for Quality and Innovation (CQUIN) system until the end of 2018/19. This changed to a composite key performance indicator (KPI) focussing on screening for sepsis of patients with deteriorating health conditions followed by timely and appropriate treatment where sepsis is identified.

The Trust's aim for 2019/20 was to improve the early recognition and management of patients with sepsis.

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

Performance

Indicator 1: Sepsis identification, screening and treatment for Service Users presenting as emergencies

This is a composite indicator.

Definition: Proportion of Service Users presenting as emergency admissions who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis undertaken as a quarterly audit of at least 50 emergency admissions

Target: 90%

Indicator 2: Sepsis identification, screening and treatment for inpatient service.

This is composite indicator.

Definition: Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis as a quarterly audit of at least 50 inpatient admissions.

Target: 90%

Indicator	Target	Q1*	Q2*	Q3	Q4
1 - Emergency patients undergoing sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	≥ 90%	82%*	84%*	92%	83%
2 - Inpatients undergoing sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	≥ 90%	59%*	71%*	82%	97%**

* Audit methodology found to be incorrect following review. This has been corrected in subsequent quarters.

** The Trust did not manage to audit at least 50 inpatient admissions in each quarter. The audits are labour intensive for medical staff and the Trust's Sepsis Steering Group has been focusing on increasing the number of inpatients audited. 37 patients were audited in Quarter 4. National submission of the data was then suspended during phase 1 of the pandemic.

Initiatives implemented during 2019/20

- The merged Trust Sepsis Group is chaired by a Deputy Medical Director and meets monthly. It has expanded its membership to include Divisional representation. Work has been undertaken to refine the audit methodologies, standards and education.
- At QEHB a screening question was implemented in PICS at the beginning of July 2018 and was updated in January 2019 with the introduction of the NEWS2 score – this continued into 2019/20.
- At Heartlands, Solihull and Good Hope Hospitals there was the successful roll-out of updated paper observation charts and associated education.
- In Quarter 3 following a change in methodology to capture all patients presenting to the Emergency Department (now including resuscitation cases), acute admissions have seen a marked improvement with 92% of 50 patients audited meeting the standard. The inpatient audit has been slower to progress and in Quarter 3 the Trust failed both the number requirement for the audit and compliance. The Trust Sepsis Group chair engaged with the Divisions to undertake weekly audits across all wards to help provide the Trust with a fuller picture of the quality of sepsis recognition and management. This was commenced in January 2020 but was slow to roll out and was further impacted upon by the Trust's response to COVID-19.
- Due to the complexities of COVID-19 and identification of sepsis, updated guidance on sepsis and antimicrobial management was rapidly produced for clinicians.
- The range of education material and tools were reviewed.

Initiatives to be implemented during 2020/21

- From Quarter 1 2020/21, Datix incidents will be completed for all identified instances of non-adherence to sepsis screening and delay in administration of antibiotics longer than 60 minutes, to allow more in-depth exploration and identification of the reasons.
- A business case was submitted for a member of the Critical Outreach team to have a sepsis educational role and this will start in June 2020.
- Education working group to be convened to update the current training and modalities of delivery for doctors and nurses.
- An electronic sepsis dashboard is underdevelopment to trial the automation of the KPI audit data and this will be enhanced later to capture data on the whole sepsis pathway. This will initially be trialled at QEHB prior to roll out of PICS across the whole Trust.
- A "Learning from Excellence" quality improvement project is being undertaken at Birmingham Heartlands Hospital Emergency Department to improve the timely recognition and treatment of sepsis

How progress will be monitored, measured and reported

- Performance against the KPIs will be reported to the Trust's Sepsis Group in addition to the Clinical Quality Monitoring Group, Chief Operating Officer Group, and the Clinical Commissioning Group.
- Progress will be publicly reported in the mid-year Quality Account update published on the Trust's quality web pages.
- Performance will be reported to the Clinical Quality Monitoring Group as part of the Quality Account update reports.

NEW Priority: Freedom to Speak Up

This quality improvement priority was proposed by the Chief Executive and approved by the Board of Directors.

Background - Encouraging staff to Speak Up

The appointment of Freedom to Speak Up Guardians was a recommendation of The Francis Report (Report of the Mid-Staffordshire NHS Foundation Trust public inquiry) published in February 2013. UHB's Freedom to Speak Up Guardian is Professor Julian Bion, Honorary Consultant in Critical Care Medicine. Professor Bion is supported by thirty-one 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. They provide confidential advice and support to staff in relation to concerns they may have about patient safety and/or the way their concern has been handled for example. 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 and ensure 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.

The Freedom to Speak Up Guardian and the Confidential Contacts meet quarterly, alternating between hospital sites, and communicate regularly in between. The list of Confidential Contacts is available on the Trust intranet.

The Freedom to Speak Up Guardian meets quarterly with the Chief Executive, Chief Medical Officer, Executive Chief Nurse and the Director of Corporate Affairs to present an anonymised summary of contacts and to discuss specific issues requiring the attention of the Trust leadership. The Freedom to Speak Up Guardian also meets every

six months with the Head of Human Resources and the Head of Occupational Health to exchange insights.

Concerns raised via the Freedom to Speak Up process are also reported quarterly to the Care Quality Commission which allows national data to be collated on the sources and types of concerns being raised.

Improvement priority for 2020/21
The Trust plans to use two methods in 2020/21 to monitor the Trust's Freedom to Speak Up culture:

- Number of contacts per quarter
- Freedom to Speak Up index measured annually

Performance

Number of contacts
The Trust intends to continue measuring the number of Freedom to Speak Up contacts made by staff each quarter. It is difficult to set a target as this stage as the Trust is continuing to promote the Freedom to Speak Up process and would view an increase in the number of contacts as positive evidence of an open culture. Over time the Trust may want to see a decrease in contacts as the culture matures and staff feel more able to use existing channels to raise issues.

Table 1: FTSU CONTACTS JANUARY 1ST TO JUNE 17th 2020	Period	
	Jan-March	April-June
Contacts' professional group:		
Consultants	8	2 (+1 external)
Junior doctors	-	4
Nurses:	1	-
Clinical Nurse Specialist:	1	1
Managerial/support staff:	2	1
Admin/clerical/secretarial	2	1
Catering	1	1
Not recorded	-	10 (via Well-being hubs)
Anonymous	-	1
Subtotal	**15**	**22**
Allegations or Issues (may be >1):		
Disparaging or disrespectful behaviours	10	1
Discrimination, racism	1	2
Dysfunctional relationships, cliques	3	1
Unfair treatment	4	1
PPE & personal safety	-	4
Probity	-	1
Redeployment ('repurposing') & Comms	0	14
Routes to resolution/outcome:		
Line manager informed	13	18
Resolved by contact without further help		3
Fear of detriment hampered resolution	2	2
Did not wish to proceed	1	-

Freedom to Speak Up Index
The Trust will be using the Freedom to Speak Up index to monitor the Trust's Freedom to Speak Up culture. The index is calculated as the mean average of responses to four questions from the NHS Annual Staff Survey:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

The 2019 Freedom To Speak Up Index Report used data drawn from the 2018 NHS Staff Survey, the link to the report is provided here:(https://www.nationalguardian.org.uk/wp-content/uploads/2019/10/ftsu-index-report-2019.pdf).

UHB's score was 75%.

The national range for all types of trust was 68% - 87%.

The average for Acute Trusts was 77%, and for Acute Specialist Trusts is was 81%.

How progress will be monitored, measured and reported

- Regular reports provided by the Freedom to Speak Up Guardian to the Board of Directors
- Regular discussions with the Freedom to Speak Up Guardian and senior leaders
- Freedom to Speak Up Index – national data is published annually.

NEW PRIORITY: Timely Medical Review

This quality improvement priority was agreed at the Clinical Quality Monitoring Group chaired by the Chief Medical Officer and approved by the Board of Directors.

Background
The NHS in England has been focusing on reducing variation in patient outcomes between patients admitted as emergencies to hospital at weekends compared to weekdays for a number of years. Variation has been seen in mortality rates, patient experience, length of hospital stay and re-admission rates with those patients admitted at the weekend faring worse. In 2013, ten clinical standards for Seven Day Services were developed, 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:

1. Time to 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.

2. 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.

3. 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.

4. 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.

Improvement priority for 2020/21
The Trust plans to focus on measuring and improving performance for two of the priority clinical standards in 2020/21:

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant

TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

UHB is developing two indicators to automatically pull data from the Trust's Prescribing Information and Communication System (PICS) to monitor the timeliness and frequency of senior medical review:

1. All emergency admissions should be reviewed with 14 hours of admission by a Consultant
2. All emergency admissions should be reviewed daily (or twice daily if HDU patient) by a Consultant

Indicator definitions will be agreed by the Chief Medical Officer before the indicators are implemented. PICS is currently in use at the QEHB site and will start to be rolled out to other sites from November 2020. Manual audit will therefore continue to be used to monitor performance for the two indicators on the Heartlands, Good Hope and Solihull hospital sites during 2020/21.

Performance
Baseline performance will be calculated for 2019/20 once the two indicators have been developed and performance will then be monitored on a quarterly basis during 2020/21.

How progress will be monitored, measured and reported

- Performance for the indicators and manual audit results will be reported in the Quality & Performance Reports to the Chief Executive's Advisory Group and the Board of Directors in line with national requirements.

Other Quality Improvement (QI) Projects

In addition to the Trust's Quality Improvement Priorities, the Trust's Patient Safety Team holds a register of Quality Improvement (QI) Projects underway at UHB, details are provided below:

Diabetes	
Project Aims	Diabetes Steering Group established to provide a review of all diabetes related incidents, to identify key themes and implement effective strategies, processes and resources that prevent such incidents from occurring again. Incorporates numerous QI projects.
Progress	› Additional field added to Datix to help capture diabetes management incidents. › A monthly report covering diabetes incidents, RCA actions and mortality review findings goes to the Diabetes QI group. › Procedures and policies are being reviewed, agreed and published (topics include steroid-induced hyperglycaemia, hypoglycaemia, diabetic ketoacidosis (DKA) and management of surgical inpatients). › Business case being written to expand the Clinical Nurse Specialist (CNS) service to 7 days at BHH; this is already in place at QEHB and has been recently established at GHH. › Insulin Self Administration Pilot being planned. › Patient Safety Notice focussing on 'Withdrawing Insulin from Pen Devices' and an Insulin Safety Poster has been disseminated across Trust. › Learning from investigations is being incorporated into education packages. › A Hypoglycaemia Simulation Project is being planned, this would involve a simulation of common clinical situations where staff members rehearse their management skills in their normal working environment (e.g. on a ward). The plan is for junior doctors to support the delivery of this training as part of their own educational development. Key diabetes staff members have been trained in simulation skills and are completing the process to unify the hypoglycaemia guidance cross site. › A dedicated Diabetes area on the Junior Doctors Moodle site (training / education site) is being developed which will include case studies and links to policies / protocols / flow charts. › New clinical Indicators are being developed, and existing ones are being reviewed and refined.
Project Measurables	Reduce the number and frequency of incidents relating to the management of diabetes. Standardise approach to diabetes care across the organisation. Standardise investigation of serious incidents relating to the care of patients with diabetes. Improve education relating to diabetes across the organisation.

Ward Rounds	
This links in with section "Timely Medical Review" above.	
Project Aims	Improve consistency and efficacy of ward rounds, ensuring key issues identified such as Learning Disability, VTE prophylaxis. Improve team working and safety culture amongst the whole professional group.
Progress	A multi-disciplinary QI group has been established, supported by the Associate Medical Director for Governance and the Deputy Chief Nurse. Terms of Reference have been agreed and regular monthly meetings are in progress. National Standards and templates used locally have been reviewed. A UHB auditable proforma, to include core basic assessments, is being developed. Pilot areas have been identified in orthopaedics, orthogeriatrics and gynaecology across all sites. Staff engagement events to launch the project with pilot areas are being arranged. A staff survey is in progress to gain feedback on safety briefings/huddles; experience of how these function in clinical areas and views on a standardised approach to safety briefings at UHB.
Project Measurables	Reduction in number of serious incidents where ward rounds is a theme. Reduction in complaints around ward based care. Positive staff and patient survey responses. Impact on length of stay.
Sepsis	
This links in with section "Priority 6: Sepsis" above.	
Project Aims	To reduce patient harm associated with sepsis via implementation of sepsis 6 bundle.
Progress	Timely recognition and treatment for sepsis is also a national KPI. Compliance with the use of sepsis screening and sepsis 6 and identification of areas for improvement is currently assessed via manual audits. An automated sepsis dashboard is also being developed. Areas for improvement from the audit are feedback to the clinicians. The group has also worked on the development of sepsis guidance during COVID and more recently a reminder to take blood cultures. In collaboration with UHB education faculty, a sepsis education subgroup has been established to enhance a MDT educational programme for identification and management of sepsis in UHB clinical areas. To raise awareness of sepsis in the Trust, the group plans to celebrate World Sepsis Day on 11th September. A new Critical Care Outreach team sepsis lead has been appointed.
Project Measurables	Increased adherence to sepsis screening and management guidelines. Improvement in Trust's outcome for administration of antibiotics intravenously within 1 hour of diagnosis of sepsis. Data of automated reports from PICS are currently being validated.
Learning Disabilities (LD)	
Project Aims	Improve safety and quality of care for patients with a learning disability and addressing issues from past and current serious incident investigations.
Progress	A multi-disciplinary QI group has been established supported by the Associate Medical Director for Governance and the Deputy Chief Nurse. Terms of Reference have been agreed. Regular monthly meetings are in progress. The group links with the vulnerabilities steering group and the ward round QI project. The lead nurse for vulnerabilities has led on the majority of the improvement work, new LD standards have been launched, there will be a benchmark against the standards at the end of October 2020. Improvement measures established to reduce the number of harmful incidents and serious incidents. Reduce complaints and increase positive patient and carer feedback. Monthly incident data is reviewed by the group; no catastrophic or severe harm incidents have been reported since December 2019. Quarterly Patient Relations activity data around vulnerable patients will also be reviewed by the group.
Project Measurables	Improved compliance with LD standards. Reduction in the number of harmful incidents and serious incidents. Reduction in complaints. Increase in positive patient and carer feedback.

MDT / MDM Review	
Project Aims	To ensure high quality, safe MDM/MDTs addressing issues from past incidents.
Progress	Initial meeting planned to establish a core QI group supported by the Associate Medical Director for Governance, to agree Terms of Reference and priorities for this work in collaboration with the Quality Development team.
Project Measurables	Reduction in incident themes and trends.
RESPECT / End of Life Care (EOL)	
Project Aims	To provide a review of the related incidents, to identify key themes and implement effective strategies, processes and resources that prevent such incidents from occurring again.
Progress	A core QI group has been agreed supported by the Associate Medical Director for Governance. An initial meeting has been planned to agree Terms of Reference and a QI plan for RESPECT and end of life care.
Project Measurables	Reduction in incidents and serious incidents related to RESPECT and EOL care.

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2019/20 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 2019/20 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2019/20.

* 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 Chief Medical Officer.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2019/20, 43 national clinical audits and 4 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2019/20 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in during 2019/20 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 2019/20, 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 (where known).

There remains a number of outstanding reports from the national teams therefore some of this information is unavailable pending receipt of these.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2019/2020	Percentage of required cases submitted
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	Yes	Awaiting report for details
Care in Emergency Departments (3 work streams)	Yes	Awaiting report for details
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	Yes	Awaiting report for details
BAUS Urology Audits - Radical Prostatectomy Audit	Yes	2016-2018: QE: 103% BHH: 103%
BAUS Urology Audits - Cystectomy	Yes	2016-2018: QE: 104% BHH: 91%
BAUS Urology Audits - Nephrectomy Audit	Yes	2016-2018: QE: 102% BHH: 90%
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	UHB: 100%
Case Mix Programme (CMP)	Yes	QE: 50% (Area D not eligible to participate) BHH: 100% GHH: 100%
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	UHB: 103.9%
Inflammatory Bowel Disease (IBD) Audit	Yes	UHB: 100%
Endocrine and Thyroid National Audit	Yes	UHB: 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	UHB: 100%
Mental Health (Care in Emergency Departments)	Yes	Awaiting report for details
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Yes	UHB: 100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	UHB: 98%
National Audit of Care at the End of Life (NACEL)	Yes	UHB: 100%
National Audit of Dementia (care in general hospitals)	Yes	UHB: 100%
National Audit of Pulmonary Hypertension (NAPH)	Yes	UHB: 100%
National Audit of Seizure management in Hospitals (NASH)	Yes	Awaiting report for details
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Awaiting report for details
National Cardiac Arrest Audit (NCAA)	Yes	Data collection on-going
National Cardiac Audit Programme (NCAP)	Yes - multiple work streams	Heart Failure: QE: 100% GH: 100% SH: 69% Myocardial Ischaemia: QE: 99.2% GH: 109.1% SH: 109.1% Cardiac Surgery: QE: 1705 cases
National Audit of Cardiac Rehabilitation (NACR)	Yes	UHB: 100%

National Audit UHB eligible to participate in	UHB participation 2019/2020	Percentage of required cases submitted
National Diabetes Audit	Yes – with the exception of one work stream	UHB: 100% Note: UHB did not participate in one of the work streams (audit of primary care and specialist diabetes services)
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	UHB: 100%
National Emergency Laparotomy Audit (NELA)	Yes	GH: 91.9% BHH: 100% QE: 94.1%
National Gastro-intestinal Cancer Programme	Yes - 2 work streams	Oesophago-gastric Cancer- UHB: 61-70% Bowel Cancer - UHB: 105%
National Joint Registry (NJR)	Yes	QE: 83.23% BHH: 81.8% GH: 81.8% SH: 81.8%
National Lung Cancer Audit (NLCA)	Yes	UHB: 100%
National Maternity and Perinatal Audit (NMPA)	Yes	UHB: 100.68%
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	Yes	UHB: 100%
National Ophthalmology Audit (NOD)	Yes	UHB: 99%
National Paediatric Diabetes Audit (NPDA)	Yes	BHH: 300 cases GH: awaiting report for details
National Prostate Cancer Audit	Yes	UHB: 96.6%
National Smoking Cessation Audit 2019	Yes	Awaiting report for details
National Vascular Registry	Yes	UHB: 96%
Neurosurgical National Audit Programme	Yes	UHB: 100%
Sentinel Stroke National Audit programme (SSNAP)	Yes	UHB: 100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	UHB: 100%
Surgical Site Infection Surveillance Service	Yes	UHB: 100%
Trauma Audit & Research Network (TARN)	Yes	BHH: 59.4 - 69.4% QE: 100%
UK Cystic Fibrosis Registry	Yes	BHH: 325 Cases
UK Parkinson's Audit	Yes	UHB: 100%

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2019/20	Percentage of required number of cases submitted
Out of Hospital Cardiac Arrest	Yes	95%
Dysphagia	Yes	100%
Acute Bowel Obstruction	Yes	100%
Long term Ventilation	Yes	100%

Percentages given are the latest available figures.

The reports of 11 national clinical audits were reviewed by the provider in 2019/20 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 770 local clinical audits were reviewed by the provider in 2019/20 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 839 clinical audits were registered with UHB's clinical audit team during 2019/20. Of these audits, 649 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 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was:

NIHR portfolio studies	11,754
Non-NIHR portfolio studies	1,545
Total	**13,299**

NB data was drawn from the NIHR Open Data Platform (ODP) which the Trust uses to benchmark against other trusts of similar population/ attendance rates. The data contained above lags behind real-time Edge recruitment figures while Sponsors upload data to ODP. The COVID-19 pandemic has impacted on the reconciliation of recruits and the Trust can expect to see a small uplift of recruitment figures on ODP (around 80 – 100 patients at the most).

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 2019/20 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 2019/20 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 2019/20 which was conditional upon achieving quality improvement and innovation goals was £15.2m*. Final payment for 2019/20 will not be known until August 2020.

* 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 2019/20.

A proportion of UHB income in 2018/19 was conditional on achieving quality improvement and innovation goals. The Trust received £25.1m in payment for 2018/19.

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 (CQC) and its current registration status is registered with conditions. The conditions imposed are in respect of Diagnostic and Screening Procedures at Good Hope Hospital under Section 31 of the Health and Social Care Act 2018. The conditions specify that the Trust must report the following to the CQC each month until further notice:

i. The actions taken to ensure that there is an effective system implemented across the department;

ii. Action taken to ensure the system is being audited, monitored and continues to be followed;

iii. Inclusion of the results of any monitoring data and audits undertaken

The Care Quality Commission has not taken enforcement action against UHB during 2019/20.

UHB has not participated in any special reviews or investigations by the CQC during 2019/20.

Information on visits conducted by Birmingham Cross City Commissioning Group is provided in the table below:

Inspections/visits undertaken by Birmingham Cross City Clinical Commissioning Group

Date	Type of inspection	Premise of Visit	Outcome	Actions taken
29/04/19	Announced Visit	This was a visit to the Tissue Viability Team at QEHB to discuss the rise in grade 2 hospital acquired pressure ulcers.	The CCG were assured by the actions taken by the Trust and no further actions were required.	No actions were identified.
02/09/19	Unannounced Visit	The main focus of this visit was to gain assurance around the appropriateness of the management of Learning Disability (LD) and other vulnerable patients through their journey in ED.	Two recommendations were identified: ▸ A Trust member to present the trust's strategy at Transforming Care advisory board in order that other stakeholders are sighted on what is going on in within the trust and how they are trying to develop support for individuals with LD. ▸ It is recommended that the trust system for flagging LD patients is extended across the organisation as soon as possible.	Actions are now complete.

CQC Inspection Ratings Grids

The CQC last carried out a yearly inspection of some of the Trust's Core Services during October 2018 and concluded with a well-led review in November 2018. The Trust received a rating of 'good' for each key question (are services safe, effective, caring, responsive) giving the Trust an overall quality rating of 'good'. The Trust received a rating of 'outstanding' for the well-led element; this is a standalone rating and does not take into account aggregated core service well-led ratings as it did previously.

Full details of each site'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 2019/20 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:
  - 99.47% for admitted patient care;
  - 99.78% for outpatient care; and
  - 98.2% for accident and emergency care.
- - which included the patient's valid General Medical Practice Code was:
  - 99.92% for admitted patient care;
  - 99.5% for outpatient care; and
  - 99.92% for accident and emergency care.

Heartlands, Good Hope and Solihull Hospitals
- - which included the patient's valid NHS Number was:
  - 99.78% for admitted patient care;
  - 99.94% for outpatient care; and
  - 99% for accident and emergency care.
- - which included the patient's valid General Medical Practice Code was:
  - 99.99% for admitted patient care;
  - 99.99% for outpatient care; and
  - 99.81% for accident and emergency care.

Data Security & Protection Toolkit (formerly Information Governance Assessment Report)
The Data Security and Protection Toolkit (DSPT; formerly known as Information Governance Toolkit) is an online annual self-assessment tool that enables organisations to measure their performance against the national data security and information governance standards.

In light of COVID-19 events, NHSX recognises that it will be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. Therefore the final deadline for DSP toolkit submissions was moved to 30 September 2020. In the interim, UHB submitted its improvement plan setting out the steps which will be taken to meet the toolkit standard.

Payment by Results clinical coding audit
UHB was not subject to the Payment by Results clinical coding audit during 2019/20 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:
- Training programmes are in place for Clinical Coders.
- Engagement with Clinicians for validation of coding takes place currently electronically.
- Audits of Clinical Coding. There is a programme for audits and validation in place internally and in Summer 2020 an external audit will also be carried out.
- Quality assurance of data takes place supported by regular validation reports on key data items and missing data.
- Data Quality improvement Plans are in use in some areas within the Trust. A review of this approach will take place.
- Use of national benchmarking data such as the SUS Benchmarking & Data Quality Maturity Index tool to ensure correct and full data completion.
- Continue to monitor data quality through the Ward Clerk quality monitoring and management programme linking into DSPT requirements
- Ensure continued compliance with the DSPT 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).

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 2019/20 5580 of UHB patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: › 1326 in the first quarter; › 1239 in the second quarter; › 1424 in the third quarter; › 1591 in the fourth quarter.
2.	By 1st April 2020, 3715 case record reviews and 28 investigations have been carried out in relation to 3727 of the deaths included in item 1. In 16 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: › 784 in the first quarter; › 891 in the second quarter; › 1074 in the third quarter; › 994 in the fourth quarter.
3.	Five deaths, representing 0.09% 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: › 2 representing 0.15% for the first quarter; › 2 representing 0.16% for the second quarter; › 1 representing 0.07% 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 on-going 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. › This case should inform the Trust MDT Improvement Project and other work on processes for internal referrals. › A monthly audit of the TAVI (Transcatheter Aortic Valve Implantation) database should take place. This will form part of a Quality Indicator. › Consider changes to PICS to implement a prompt to complete a mandatory VTE assessment if oral anticoagulants are stopped during a patient's hospital admission. › There must be Consultant review of all patients waiting to be seen in the Emergency Department (pre-clerking) when the department is overcrowded and there are indications to suggest increased vulnerability and that earlier review is required. › This case should be presented to the Care of the Older Person & Acute Medicine Mortality & Morbidity meeting to ensure learning from this case.
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.	35 case record reviews and six investigations completed after 1st April 2019 which related to deaths which took place before the start of the reporting period.

8.	None 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 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

3 Other information

3.1 Overview of quality of care provided during 2019/20

The tables below show the Trust's latest performance for 2019/20 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 2018/19 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

Indicator	Data source	2017/18	2018/19	2019/20	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	› Trust MRSA data reported to PHE, › HES data (bed days)	**0.0 (QEHB)** **0.4 (HGS)**	**0.53**	**1.39**	**0.89** Acute trusts in West Midlands
1b. Patients with MRSA infection / 100,000 bed days › Aged >15, excluding elective orthopaedics › Lower rate indicates better performance	› Trust MRSA data reported to PHE, › HES data (bed days)	**0.0 (QEHB)** **0.4 (HGS)**	**0.56**	**1.31**	**0.81** Acute trusts in West Midlands
2a. Patients with C. difficile infection / 100,000 bed days › Includes all bed days from all specialties › Lower rate indicates better performance	› Trust CDI data reported to PHE, › HES data (bed days)	**19.1 (QEHB)** **12.4 (HGS)**	**17.38**	**17.59**	**15.86** Acute trusts in West Midlands
2b. Patients with *C. difficile* infection / 100,000 bed days › Aged >15, excluding elective orthopaedics › Lower rate indicates better performance	› Trust CDI data reported to PHE, › HES data (bed days)	**18.9 (QEHB)** **13.8 (HGS)**	**16.41**	**16.66**	**14.45** Acute trusts in West Midlands
3a. Patient safety incidents › Reporting rate per 1000 bed days › Higher rate indicates better reporting	› Datix (incident data), › Bed days data	**65.4 (QEHB)** **49.3 (HGS)**	**68.3 (QEHB)** **46.7 (HGS)**	**58.7** April – December 2019	**49.8** April – September 2019 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
3b. Never Events › Number of Never Events that been reported on STEIS during the time period › Lower number indicates better performance	› Datix › (incident data)	**6 (QEHB)** **8 (HGS)**	**9**	**9**	Not available
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	› Datix › (incident data)	**85.1% (QEHB)** **97.6% (HGS)**	**88.9% (QEHB)** **97.7% (HGS)**	**84.24%**	**75.2%** April – September 2019 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Indicator	Data source	2017/18	2018/19	2019/20	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	› Datix › (patient safety incidents reported to the NRLS)	**0.22% (QEHB)** **0.84% (HGS)**	**0.26% (QEHB)** **0.64% (HGS)**	**0.40%**	**0.31%** April – September 2019 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	› Datix › (patient safety incidents reported to the NRLS)	**24,568 (QEHB)** **19,664 (HGS)**	**26,342 (QEHB)** **21,811 (HGS)**	**44,275**	**6,276** (6 months) April – September 2019 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Clinical Effectiveness Indicators

Indicator	Data source	2017/18	2018/19	2019/20	Peer Group Average (where available)
5a. Emergency readmissions within 28 days (%) › **Elective and emergency admissions aged >17** › **Lower % indicates better performance**	› HED data	**12.72%**	**13.73%**	**13.29%**	**11.76%** 2019/20 University hospitals
5b. Emergency readmissions within 28 days (%) › **All specialties** › **Lower % indicates better performance**	› HED data	**12.69%**	**13.77%**	**13.41%**	**11.61%** 2019/20 University hospitals

Indicator	Data source	2017/18	2018/19	2019/20	Peer Group Average (where available)
6. Stroke in-hospital mortality › **Lower % indicates better performance**	› SSNAP data	**5.9% (QEHB)**	**12.6% (QEHB)**	**11.1% (QEHB)**	**13.7%** 2016/17 England & Wales SSNAP crude mortality data
		12.2% (HGS)	**10.8% (HGS)**	**10.9% (HGS)**	
7. 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**	› Trust PICS data	**94.8%**	**92.6%**	**94.3%**	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 2019/20 in the following categories: wrong site (including wrong patient) (4), wrong implant (3), retained foreign object post procedure (1), and transfusion or transplantation of ABO-incompatible blood components or organs (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.

5a, 5b:

- 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.

6:

- 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 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 onwards reflects this.

7:

- 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); UHB's results for selected questions are shown below. The 2018 survey was the first to cover the newly merged Trust; data from the 2017 survey is split between the two former Trusts.

Further patient experience activity is detailed in the Trust's 2019/20 Annual Report.

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	2017/18		2018/19		2019/20	
		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	8.8	About the same	8.8	About the same
	BHH/GHH/SH	8.8	About the same				
Involvement in decisions about care and treatment	QEHB	7.4	About the same	7.2	About the same	7.1	About the same
	BHH/GHH/SH	7.0	About the same				
Did staff do all they could to control pain	QEHB	8.0	About the same	7.9	About the same	7.8	About the same
	BHH/GHH/SH	7.6	Worse				
Cleanliness of room or ward	QEHB	9.1	About the same	8.7	About the same	8.6	About the same
	BHH/GHH/SH	8.6	About the same				
Overall rating of care	QEHB	8.3	About the same	8.0	About the same	7.8	About the same
	BHH/GHH/SH	8.0	About the same				
Response rate		QEHB: 37% (441 respondents) BHH/GHH/SH: 30% (368 respondents)		30% (360 respondents) National: 45%		38% (464 respondents) National: 45%	
Time period & data source:		2017 Trust's Survey of Adult Inpatients 2017 Report, CQC		2018 Trust's Survey of Adult Inpatients 2018 Report, CQC		2019 Trust's Survey of Adult Inpatients 2019 Report, CQC	

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

Indicator	Target	Performance		
		2017/18	2018/19	2019/20
A&E: maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	80.8%	76.7%	67.3%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	91.6%	88.2%	82.8%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer[1]	85%	80.8%	78.9%	60.4%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	94.9%	91.2%	66.6%
C. difficile: variance from plan	2019/20: no more than 250 trust apportioned cases	139	153	256
Maximum 6-week wait for diagnostic procedures	99%	99.4%	99.5%	97.4%
Venous thromboembolism (VTE) risk assessment	95%	98.3%	98.3%	98.3%

Performance towards the end of 2019/20 was affected by the COVID-19 pandemic which increased pressure on emergency services and led to the cancellation of elective surgery and appointments.

For the SHMI, please refer to the Mortality section of this Quality Report (3.3).

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 . 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 . UHB continues to robustly monitor mortality in a variety of ways as detailed above.

Measure	Value (UHB)	Data period
SHMI, calculated by UHB Informatics	98 - within tolerance	2019/20
SHMI, from NHS Digital website	97.5 - within tolerance	2019/20
HSMR, calculated by UHB Informatics	104 - within tolerance	2019/20

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

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

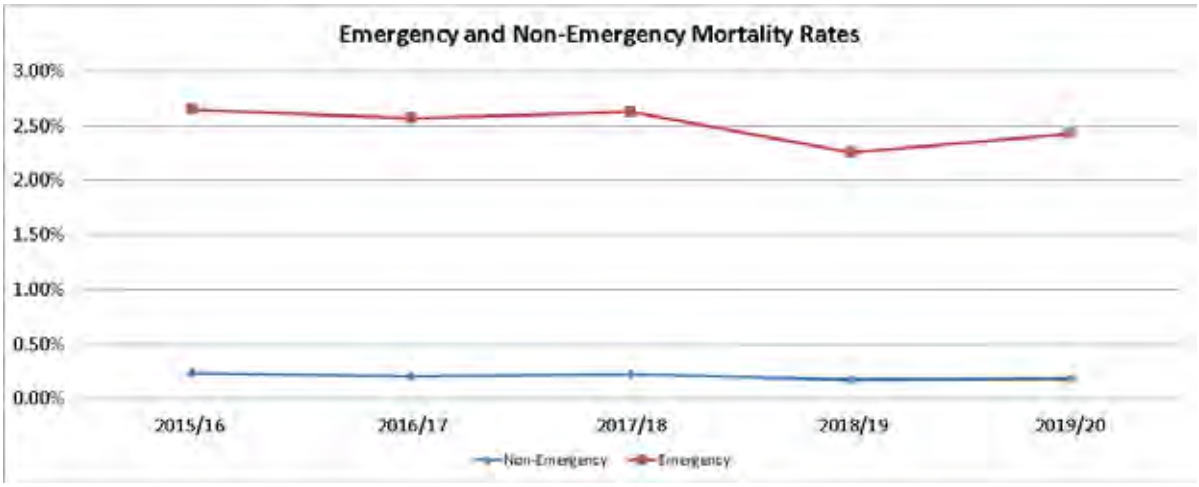
3 Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Crude Mortality

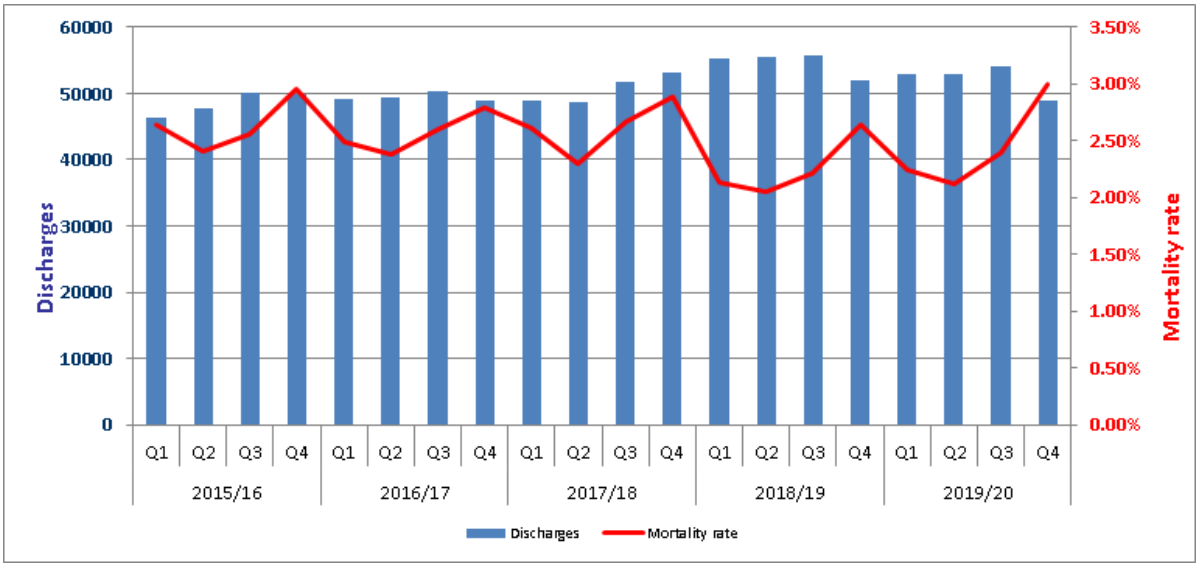
The first graph below shows crude mortality rates for emergency and non-emergency (planned) patients. The second graph shows the overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number 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.

The emergency crude mortality rate for 2019/20 is 2.34%, which is a decrease compared to 2018/19 (2.25%) and 2017/18 (2.62%).

Emergency and Non-emergency Mortality Graph



Overall Crude Mortality Graph



3.4 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.

3.5 Glossary of Terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department (ED)
ACP	Advanced Clinical Practitioners: healthcare professionals, educated to Master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
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
CABG	Coronary Artery Bypass Graft: a surgical procedure used to treat coronary heart disease
CaPRI	Clinical and Professional Review of Incidents Group
CCG	Clinical Commissioning Group: a clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area
CDI	*Clostridium difficile* infection
Cessation	To end or stop something
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
CDRG	Clinical Dashboard Review Group – reviews ward performance against certain care indicators
CNS	Clinical Nurse Specialist: an expert nurse in a particular specialty area.
Commissioners	See CCG
COVID-19	A disease caused by the new strain of Coronavirus, currently instigating a Pandemic
CQC	Care Quality Commission: independent regulator of health and social care in England
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 Chief Medical Officer, which reviews the quality of care, mainly medical
CQUIN	Commissioning for Quality and Innovation payment framework
CSL	Clinical Service Lead – the lead doctor for a particular specialty
Cystectomy	Surgical removal of the urinary bladder
Datix	Database used to record incident reporting data
Deloitte	The Trust's external auditor
Dermis	the thick layer of living tissue below the epidermis which forms the true skin
Division	Specialties are grouped into Divisions
DKA	Diabetic ketoacidosis: a serious condition that can lead to diabetic coma or even death. When cells don't get the glucose they need for energy, the body begins to burn fat for energy, producing ketones
DSPT	Data Security and Protection Toolkit: an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards
DTI	Deep tissue injury

Term	Definition
Dysphagia	Swallowing difficulties - some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all
ED	Emergency Department (also known as A&E)
Elective	A planned admission, usually for a procedure or drug treatment
Endocrine	Relating to hormones
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
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
GP	General Practitioner
Healthwatch	An independent group who represent the interests of patients
HEE	Health Education England: a public body who provide national leadership and coordination for the education and training within the health and public health workforce within England
HEFT	Heart of England NHS Foundation Trust
HES	Hospital Episode Statistics
HGS	"Heartlands, Good Hope, Solihull" – refers to the former-HEFT hospital sites
HSMR	National Hospital Mortality Indicator
Hyperglycaemia	An excess of glucose in the bloodstream
Hypoglycaemia	Deficiency of glucose in the bloodstream
Informatics	Team of information analysts
IT	Information Technology
ITU	Intensive Therapy Unit
JCC	Joint Consultative Committee
KPI	Key performance indicator: a measurable value demonstrating how effectively targets are being met
LFE	Learning From Excellence – a positive reporting system
LD	Learning Disability: A learning disability affects the way a person understands information and how they communicate
M+M meeting	Mortality and Morbidity meeting: a forum where adverse outcomes can be discussed
MDT / MDM	Multi-disciplinary Team / Meeting – where patients are discussed and plans of care made
Mealtime Council	A group that promotes and improves operational processes in relation to nutrition and hydration practices
Medical Examiner	Senior doctors who review deaths that occur in hospital
Missed Dose	A dose of prescribed medication not given to the patient
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
MRSA	Meticillin-resistant staphylococcus aureus
Myocardial Infarction	Heart attack
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure
Neonatal	Newborn
Nephrectomy	Surgical removal of the kidney

Term	Definition
Never Event	An incident that has the potential to cause serious harm/death
NHS	National Health Service
NHS Digital	A library of NHS data and reports (Formerly HSCIC - Health and Social Care Information Centre.)
NHS England	Now a merged organisation with NHS Improvement
NHS Improvement	The national body that provides the reporting requirements and guidance for the Quality Report. Now a merged organisation with NHS England
NHSX	A unit driving the digital transformation of care
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
Non-blanching erythema	Redness present on the skin
NRLS	National Reporting and Learning System
Nursing Metrics	Performance measure of multiple ward indicators gathered from monthly audits of nursing note
OBDs	Occupied Bed Days
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
Percutaneous nephrolithotomy (PCNL)	Removal of a kidney stone via a cut in the back
Perinatal	Relating to the time, usually a number of weeks, immediately before and after birth
PHE	Public Health England
Physicians Associates	Medically trained, generalist healthcare professionals, who work alongside doctors
PICS	Prescribing Information and Communication System
Pressure Ulcers	Area of damaged skin also known as pressure sores or bedsores
Proning	The position of a patient on their front for extended period of time.
Prostatectomy	Surgical removal of the prostate gland
QEHB / QE	Queen Elizabeth Hospital Birmingham
QIPs	Quality Improvement Priorities / Quality Improvement Projects
Radical	Surgery that is more extensive than 'conservative' surgery
RCA	Root Cause Analysis: a method of problem solving used for identifying the root causes of faults or problems
Readmissions	Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment: a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices
RTT	Referral to Treatment – the time elapsed between a patient being referred, and commencing treatment (or making the decision not to receive treatment)
Safety Thermometer	A point of care survey instrument providing a check on harm
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 – similar to NEWS 2
SH	Solihull Hospital
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident

Term	Definition
Slough	Nutrient laden material found within a wound that prolongs the inflammatory phase an impairs healing
SSNAP	Sentinel Stroke National Audit Programme
STEIS	Strategic Executive Information System - used to report and monitor the progress of Serious Incident investigations across the NHS
TAVI	Transcatheter Aortic Valve Implantation
Team Brief	Meeting open to all staff, where directors present information to staff, and information is then cascaded to colleagues
Tubing	Medical equipment required for the delivery of oxygen therapy for patients
TV / TVT / TVN	Tissue viability / Tissue Viability Team / Tissue Viability Nurses
UHB	University Hospitals Birmingham NHS Foundation Trust
Vascular	Relates to blood vessels, or sometimes other tubes in the body
VTE	Venous thromboembolism, also known as a blood clot
Ward clerk	A member of staff who provides general administrative, clerical, and support services for a ward

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

The Trust has shared its 2019/20 Quality Report with

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

These organisations have provided the statements below.

Statement provided by Birmingham and Solihull Clinical Commissioning Group (CCG)

Statement of Assurance from NHS Birmingham and Solihull CCG, November 2020

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 2019/20 quality account.

1.1 A draft copy of the quality account was received by the CCG on the 29th October 2020 and the review has been undertaken in accordance with the Department of Health and Social Care guidance. This statement of assurance has been developed from the information provided to date.

1.2 The information provided within this account presents a balanced report of the healthcare services that UHB provides. The range of services described and priorities for improvement are representative based on the information that is available to us. The report demonstrates the progress made by the Trust against most of the 2019/20 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2020/21.

1.3 This is the second quality account for the merged Trust, it is to be noted that the Trust continues to review and harmonise its systems and processes across the four hospital sites. Commissioners are pleased to note the planned implementation of Oceano Patient Administrative Systems (PAS) and Prescribing Information System (PICS) at Heartlands, Good Hope and Solihull Hospitals in early 2021 and plans for trust wide quality indicators by the end of 2020/21.

1.4 The report describes the six quality priorities with an additional two new priorities of; Freedom to speak up and Timely medication reviews, the initiatives which have been implemented, and identified areas where the Trust requires further improvement and how the Trust aims to achieve the priorities for 2020/21.

1.5 The quality priorities for 2020/21 reflect areas where improvement is required. The CCG is supportive of the priority to embed quality improvements to improve. The Trust has made a decision to continue with five priorities for improvement previously identified in 2019/20. 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.

1.6 It is difficult to see and reflect on whether the trust has reduced its target of reducing grade 2 hospital-acquired pressure ulcers due to the reporting of data when Covid19 issues began. The CCG notes an improvement in the tissue viability service by the Tissue Viability Nurses (TVNs) from Queen Elizabeth, Heartlands, Good Hope and Solihull hospital. It is encouraging to read that the trust reviewed the Tissue Viability (TV) service provision for the whole of UHB to ensure it was equitable and met the needs of the organisation. The CCG recognises the importance of aligning services and expects to see improvements in accordance with these initiatives. The CCG plans to closely monitor this priority and expects to be in a position to report on the impact of these changes towards the middle of 2021.

1.7 It is encouraging to see the efforts taken to improve Patient Experience. Commissioners note the focus on Nutrition and Hydration and Pain Control in Emergency Departments. Whilst targets for pain score recording were not achieved, the Trust demonstrates in the report that there are improvements needed and new initiatives and measures are in place for 2020/21.

1.8 The CCG acknowledges the Trust's continued performance against targets for the recording of full set of patient observations, reaching 93.7.% against a target of 95%, and is supportive of

UHBs plans for further improvement and inclusion as a continued quality priority for 2020/21.

The CCG recognises that changes to the improvement priority for 2020/21 require monitoring with individual sites as well as the trust as a whole with the introductions of the two new systems PAS and PICS in 2021.

1.9 The CCG recognises that the priority of reducing missed doses has been affected by the trust introducing the PICS system to provide a uniformed system across all sites for medicines management. Whilst it is noted that this may have had an impact the CCG would expect to see a marked improvement on this priority into 2020/21 the CCG does not expect rationale for missed doses to be attributable to computer systems in the future. The CCG acknowledges and accepts that the system for monitoring and recording will differ for the 2020/21 data although this does make it difficult for the CCG to seek assurance in this priority for Heartlands, Good Hope and Solihull hospitals. The CCG is keen to understand the governance around the new systems and looks forwards to assurance.

1.10 The CCG is pleased to see that the trust continues to make good progress in the reduction of falls, and has shown ongoing improvement. The CCG notes the number of patient falls occurring at UHB's four hospital sites meant that the Trust did not meet their target.

It is also noted that the Trust monitors the number of patient falls per 1000 occupied bed days (OBDs), and takes account of activity levels and the CCG is pleased to see the trust met the internal target which is very positive.

1.11 It is difficult for the CCG to fully understand or to see how the priority of timely treatment for sepsis has either been met or missed. In Quarters 1 and 2 the trust failed to meet the target in both areas of this priority, it is recognised that that the methodology used for Quarters 1 and 2 against the indicators was found to be wrong, secondly it is also noted that quarter 4 data is not included in the report. The CCG accepts the trusts explanation around quarter 4 data due to the National submission of data suspension due to the pressures of COVID-19

The CCG acknowledges that the trust was unable to demonstrate achievement of this priority but is encouraged by the 2020/21 initiatives such as "Learning from Excellence" as a quality improvement project which will feed into the 2020/21 ongoing priority

1.12 As Commissioners we have worked closely with UHB over the course of 2019/20, 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 2020/21. The challenges surrounding Covid19 have thrown up significant challenges in the way the Trust and CCG engaged towards the end of 2019/20, continued productive working relationships are essential to the continued compliance and constant improvement quality care that the trust provides.

Paul Jennings
Chief Executive Officer
BSol CCG

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

Statement from Councillor Rob Pocock on behalf of the Health & Social Care O&S Committee

Based on the draft Quality Report on which we were invited to comment, we fully support the steps being taken to extend the previous UHB/QE electronic monitoring and alignment of reporting and processes across the Trust which is fundamental to standardising the real-time capture of data.

We note that you do not intend to continue to use improving patient experience and satisfaction as a priority for improvement in 2020/21 but will continue to monitor through the Patient Experience Group. We assume priorities for further improvement will continue through this route. Further we note that the satisfaction scores are reported as the average score. In hindsight, might it have been more intuitive to report percentage of responses <5 as this more closely reflects the minority who have had the worst experience. Given the average score was reported per quarter, it would be expected that this was a statistically 'skewed' distribution with a high proportion at the top end and a small proportion at the lower end i.e. <5 where the verdict is poor. The proportions giving this rating are in our view a better indicator of the extent to which improvements may be needed.

It has also been shown that most organisations who use the Friends and Family Test well, do so by extracting the small proportions of respondents who say 'no' and following up with a qualitative 'why not? question' to help shape and drive improvement. In future reports, we would like to see evidence that UHB is deploying this approach.

Finally, we welcome the introduction of the new 'Freedom to Speak Up' indicator and look forward to seeing it analysed and actions taken.

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

The Solihull Health and Adult Social Care Scrutiny Board welcomes the opportunity to comment on the UHB Quality Accounts 2019-20. The reorganisation of services due to Covid-19 has clearly proved challenging for some audit activity and the high number of critically ill patients has had an impact on some data sets. The progress of the 19/20 priorities against targets has been mixed, but it is encouraging that the Trust has a robust plan of initiatives to be implemented going forwards. It is good to see a greater focus on outcome metrics rather than process metrics in the proposals for 20/21. The inclusion of the Freedom to Speak Up priority for 20/21 shows the organisation's commitment to its staff and is to be commended as an important step in ensuring staff feel supported when concerns are flagged. The Board look forward to working closely with UHB on their priorities during the year ahead.

Statement provided by Healthwatch Birmingham

Healthwatch Birmingham have confirmed that they are not in a position to provide a statement this year.

Statement provided by Healthwatch Solihull

Healthwatch Solihull have confirmed that they are not in a position to provide a statement this year.

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 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- 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 2019 to October 2020
  - papers relating to quality reported to the board over the period April 2019 to October 2020
  - feedback from the commissioners dated 01/12/20
  - feedback from governors dated 26/11/20
  - feedback from local Healthwatch organisations dated 30/11/20 (Solihull) and 30/11/20 (Birmingham)
  - feedback from Overview and Scrutiny Committee dated 04/12/20 (Solihull) and 27/11/20 (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 2019 national patient survey 02/07/2020
  - the Head of Internal Audit's annual opinion of the trust's control environment dated April 2019
  - 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: 22 October 2020 ..... Chair

Date: 22 October 2020 .....Chief Executive

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

Due to the COVID-19 pandemic, NHS England and NHS Improvement advised that the Trust's External Auditors, Deloitte, are not required to provide assurance on the Quality Report 2019/20.