University Hospitals Birmingham
NHS Foundation Trust

Quality Account 2021/22

This report covers the period 1 April 2021 to 31 March 2022

2021/22 Quality Report

Contents

1 Chief Executive's Statement

Since COVID-19 was first identified in December 2019, it has been an extraordinary journey for University Hospitals Birmingham NHS Foundation Trust (UHB), the NHS, the UK and the world at large. During this period, UHB has faced unprecedented challenges, being the hardest-hit Trust in the country, treating over 27,500 COVID-positive inpatients. This has significantly impacted UHB's ability to provide routine elective care over the whole period of the epidemic, with the Trust having significant numbers of patients who have waited extended periods for treatment.

During 2021/22, the Trust has worked with its partners across Birmingham and Solihull and beyond to ensure that the longest waiting patients are prioritised for treatment. This has resulted in a significant reduction in the number of patients waiting over 52 weeks for treatment since that number peaked in December 2021. Meanwhile the number of patients who have waited more than 104 weeks for treatment has more than halved with the Trust meeting the target reduction agreed with NHS England by 31 March 2022. Work continues to make progress toward the ambition set out in the 2022/23 national planning guidance that all waits of over 104 weeks should be eliminated by July 2022.

The Trust has focused on standardising high quality patient care across the four main hospital sites alongside digital and technological transformation. The implementation of common electronic systems such as the Oceano Patient Administration System (PAS) and the Prescribing Information and Communication System (PICS) across the sites continued in 2021/22. These systems will enable the quality of care to be measured, compared, monitored and improved in the same way across the hospital sites.

Performance for the six quality improvement priorities set out for 2021/22 in the 2020/21 Quality Report has been mixed. The six priorities were:

Priority 1: Freedom to Speak Up
Priority 2: Improving VTE prevention
Priority 3: Improving ward rounds
Priority 4: Improving diabetes management
Priority 5: Improving nutrition and hydration
Priority 6: Improving the safety of invasive devices

The Board of Directors has chosen to continue with five of these priorities for improvement and add a new one for 2022/23:

Priority 1: Freedom to Speak Up
Priority 2: Improving VTE prevention
Priority 3: Improving ward rounds
Priority 4: Improving nutrition and hydration
Priority 5: Improving the safety of invasive devices
Priority 6: Using real-time information to improve patient care

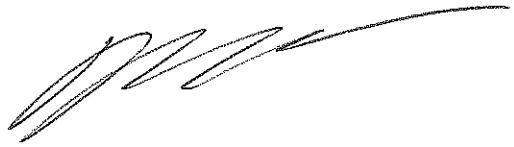
UHB's focused approach to quality, based on driving out errors and making incremental but significant improvements, is driven by innovative and bespoke information systems which allow us to capture and use real-time data in ways which few other UK trusts are able to do. The Clinical Dashboard Review Group was set up in August 2019 and continues to meet monthly. The group is chaired by the Deputy Chief Nurse and the 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 2021/22 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 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, and this was repeated for the 2020/21 and 2021/22 Quality Reports.

2022/23 will be another challenging year for UHB as we work towards achieving the ambitious priorities set out above in the context of recovering from the impact of the 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 2022/23.

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



Prof. David Rosser, Chief Executive
16 June 2022

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

2.1 Priorities for Improvement

The Trust's 2020/21 Quality Account set out six priorities for improvement during 2021/22 (see table below).

Performance has been mixed for the priorities and across the different Trust sites during 2021/22.

Further details for each priority are provided in the main body of the report.

The Board of Directors has chosen to continue with five of these priorities for improvement in 2022/23, one will be discontinued and a new one will be added:

2021/22	2022/23	Title of Priority	Notes
1	1	Freedom to Speak Up	To continue
2	2	Improving VTE prevention	To continue
3	3	Improving ward rounds	To continue
4	-	Improving diabetes management	To be discontinued
5	4	Improving nutrition and hydration	To continue
6	5	Improving the safety of invasive procedures	To continue
-	6	Using real-time information to improve patient care	New

The improvement priorities for 2022/23 were discussed and confirmed by the Trust's Clinical Quality Monitoring Group chaired by the Chief Medical Officer and at the Operational Care Quality Group, chaired by the Director of Nursing, following consideration of performance in relation to patient safety, patient experience and effectiveness of care.

The performance for 2021/22 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 Account for 2020/21.

Priority 1: Freedom to Speak Up

This quality improvement priority was first proposed by the Chief Executive and approved by the Board of Directors for inclusion within the 2019/20 Quality Account.

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 23 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 any concerns they may have which directly or indirectly impacts on patient safety or the capacity of staff to deliver quality care, if they feel unable to raise those concerns with their line managers. 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. They also have an important role in assisting the Trust in protecting staff from detriment as a consequence of raising concerns.

Speaking Up at UHB
Staff can contact the Freedom to Speak Up Guardian and the Confidential Contacts using a 24/7 telephone line (response 9am-5pm working days), a dedicated email address, and an internal webpage with further contact information for the Guardian and confidential contacts.

The Freedom to Speak Up Guardian and the Confidential Contacts meet quarterly, alternating between hospital sites or by videoconference, communicating 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 a summary of contacts (de-identified or attributable as required by the 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. The Guardian reports 6-monthly to the Trust Board and Board of Directors, and meets four-monthly with the Chair of the Trust Board. In addition, the Guardian meets quarterly with the Trust's Senior Independent Director (SID) who attends regular meetings with the Guardian and the Confidential Contacts to gain an overview of current themes and issues being raised.

Concerns raised via the Freedom to Speak Up process are also reported quarterly to the National Guardian's Office (housed at the Care Quality Commission which allows national data to be collated on the sources and types of concerns being raised.

Performance Metrics

The Trust monitors its Freedom to Speak Up culture through the following means:

- Number of contacts per quarter
- Typology of concerns
- Freedom to Speak Up index measured annually
- The percentage of respondents to the NHS staff survey giving an affirmative response to the statement: "I feel safe to speak up about anything that concerns me in this organisation"*
- 62% of UHB respondents answer this positively. The 'best' Trust has a positive response rate of 78%, and the lowest was 53%.

Number of contacts

Of the 22,000 staff at UHB, 79 (0.35%) have contacted the Speaking Up service during the financial year April 2021 – March 2022. Of the 79 contacts, 17 (21.5%) were nurses, and 22 (27.8%) were doctors, of whom 13 were consultants and 9 junior doctors. Fifteen (18.9%) contacts were managerial, and 7 were administrative or clerical staff. No concerns were raised anonymously. Four contacts were received from patients or relatives, who were directed to PALS.

Typology of concerns raised

Typology	Number (%)
Bullying, disrespect or harassment	26 (32)
Employment, HR, contract, personal health issues	20 (24.6)
Workload, resources, working environment	9 (11)
Patient safety	7 (8.6)
Discrimination: racial 3, gender/sexuality 4	7 (8.6)
Leadership, management or strategic issues	6 (7.4)
Probity, fraud, data manipulation	5 (6.1)
Staff safety	1
Total	**81**

Of the 81 concerns raised by the 79 contacts, problematic attitudes and behaviours remain the most common reason for staff to seek help, expressed as lack of respect ranging from micro-aggressions to overt bullying. One of the Trust's reconfigured values is kindness, and this quality of caring for each other would do much to improve staff experience in the workplace. Issues related to contractual, disciplinary or employment and redeployment concerns were the next most frequent. Patient safety was raised as a specific issue on 7 occasions, but could also be affected indirectly by many of the other concerns raised.

Freedom to Speak Up Index (2021)

The FTSU index for 2021 is based on data from the 2020-21 NHS Staff Survey. The Index is calculated as the mean of the sum of the percentages of staff agreeing or strongly agreeing with each of the following four statements in the NHS Staff Survey:

- • My organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- • My organisation encourages staff to report errors, near misses or incidents (question 16b)
- • If I were concerned about unsafe clinical practice, I would know how to report it (question 17a)
- • I would feel secure raising concerns about unsafe clinical practice (question 17b)
- UHB's FTSU Index for 2021 is 75.9%, higher than in 2020 (74.7%). The national range is from 66.6% (an ambulance Trust) to 87.6% (a community Trust).

Since 2020 the NHS staff survey has also included Q18F: "I feel safe to speak up about anything that concerns me in this organisation" which is reported to align well with the FTSU Index (data not provided). In the NHS Staff Survey 2021, 38% of UHB staff responded negatively or uncertainly to this statement (mean for all Trusts = 34.4%). In the national survey, ethnicity influences responses, with 37.9% of Black and minority ethnic staff responding negatively, compared with 33% of white staff.

Current Speaking Up Challenges:

- Fear of detriment is expressed by the majority of those contacting the speaking up service. However, very few contacts are anonymous, suggesting that those who do raise concerns have confidence in the service. The Guardian recognises that there will be other staff who lack confidence and do not speak up (see FTSU Index below). When detriment occurs, it is generally in the form of micro-aggressions from workplace colleagues or from those about whom allegations have been made. Middle management and opinion leaders including senior staff in frontline positions have an important role in modelling positive behaviours in this respect.
- Delays in addressing issues aggravate unhappiness and detriment to staff. The longer issues are left unaddressed, the more difficult it is to achieve resolution. Line managers and immediate colleagues are encouraged to adopt a proactive approach to identifying possible concerns or unsatisfactory behaviours and to use informal mechanisms early on before positions become entrenched.
- Responding to and learning from concerns is emotionally taxing for all participants. The Trust's Director of Human Resources is developing a methodology for balancing due process with compassion and support for individuals involved in disciplinary procedures or investigations, and for developing organisational learning, using the CAPA (corrective and preventative actions) framework. The Guardian has several examples of both exemplary and unsatisfactory responses by line managers to concerns raised by staff, and these are being developed as de-identified case histories for teaching and training.

Activities, Developments and Forward Plans

The Guardian now meets three times a year with the interim Chair of the Trust Board, Mr Harry Reilly, together with the Non-Exec Director for Speaking Up, Prof. Jon Glasby. This has been a very positive development. An annual appraisal was introduced in 2021/22 for the Guardian role with feedback sought from Executive colleagues, the Senior Independent Director and the Confidential Contacts to reflect on the previous year and agree priorities for the coming year.

The Guardian provides monthly induction training to all new consultants, and to international nursing students. Sister Liz Mitchell provides FTSU training for professional development nurses who can then act as additional champions and disseminators. Major Simon Roberts provides training in the military context. Lectures and seminars on speaking up are provided to departments on request (most recently to Human Resources, and to Unison). The Guardian delivered an annual seminar to the Trust's Board of Directors in May 2021 on the topic of speaking up. The Board of Directors recognised that while the majority of contacts received by the Freedom to Speak Up service do not relate to patient safety directly, it was important for staff to be able to raise any issues through this route.

The Guardian also provides a lecture as part of the Leadership series for all staff. In 2022, the Guardian and CCs will ask Divisional Management teams if they would like to meet with the FTSU service to allow an exchange of views and experiences relating to speaking up issues.

The Guardian and several of the confidential contacts are members of the Fairness Taskforce. Chaired by the Chief Executive, the taskforce is managed by two senior staff, both FTSU Confidential Contacts.

The Trust has yet to put in place a confidential database for recording speaking up contact activity. This aspect needs to be accorded a higher priority.

A Deputy FTSUG will be appointed during 2022 to assist the Guardian with all activities including the induction programme, and to raise the profile of the service across the Trust. Additional Confidential Contacts, and Speaking Up Champions, will also be appointed.

The Speaking Up service continues to support the Trust in developing a 'Just Culture', a restorative and forward-looking approach to addressing staff concerns based on reflective learning. In this respect the service is well-aligned with the Trust's new values, namely that staff are:

- Kind: We take a compassionate interest in others, and demonstrate behaviours which contribute to pride and pleasure in the workplace.
- Connected: We recognise that delivering quality care to our patients is a team effort. What we do, what we say, and how we behave has an impact on those around us: patients, relatives, and colleagues.
- Bold: It takes courage to undertake difficult

conversations, respond to concerns, and acknowledge our own fallibilities. It is our duty as responsible healthcare professionals to learn from both error and excellence.

2021 NHS Staff Survey Results for Questions on Raising Concerns

Year/ Question	2019			2020			2021		
	Number of Responses	UHB: % of staff selecting 'Agree'/'Strongly agree'	National: % of staff selecting 'Agree'/'Strongly Agree'	Number of Responses	UHB: % of staff selecting 'Agree'/'Strongly agree'	National: % of staff selecting 'Agree'/'Strongly Agree'	Number of Responses	UHB: % of staff selecting 'Agree'/'Strongly agree'	National: % of staff selecting 'Agree'/'Strongly Agree'
17a: I would feel secure raising concerns about unsafe clinical practice	6,958	68.7%	70.8%	7,324	69.9%	71.8%	7,173	70.2%	73.9%
17b: I am confident that my organisation would address my concern.	6,939	55.7%	59.1%	7,324	56.9%	59.1%	7,177	51.5%	57.6%
21e: I feel safe to speak up about anything that concerns me in this organisation*	N/a	N/a	N/a	7,288	61.2%	65.0%	7,093	53.8%	60.7%
17b: If I spoke up about something that concerned me I am confident my organisation would address my concern**	N/a	N/a	N/a	N/a	N/a	N/a	7,088	42.3%	47.9%

* This was a new question in the 2020 NHS Staff Survey so there is no data shown for 2019.
** This was a new question in the 2021 NHS Staff Survey so there is no data shown for 2020 or 2019.

Update on the Trust-wide Fairness Programme

Fairness Taskforce

The CEO's Fairness Taskforce continues to meet on a monthly basis, as well as a Core Group. Over the last quarter, the work programme of the Fairness Taskforce has developed further.

A Board Seminar, led by Roger Kline and Randeep Kular, was delivered in March 2022 and was well received. The Board was keen to see further progress and asked for future updates, including on the impact of the work programme. Furthermore, a presentation on the work of the Fairness Taskforce was delivered to the NHS Confederation representatives at a recent visit in April 2022.

Reciprocal Mentoring Programme

The UHB Reciprocal Mentoring Programme continues to be popular amongst staff, Cohort five of the UHB Reciprocal Mentoring Programme was launched at the end of March 2022, taking the participants number over 300. Further cohorts are planned to take place throughout the year.

Due to the success of the Programme, Reciprocal Mentoring is now embedded in the staff annual appraisal documentation and UHB is currently working with the University Hospitals Birmingham, to discuss the possibility of accreditation of the programme.

Finally, the evaluation of cohorts one – four is currently taking place via a questionnaire and will help to improve the offering.

Fairness RCAs
The Fairness RCA Reference Group, chaired by the Chief Strategy and Projects Officer, continues to meet on a fortnightly basis and reviews potential fairness cases for consideration. As part of the process, weekly Datix reports continue to be examined by members of the group and any actions required are taken or escalated via the appropriate forum, including to Executive level. The next Fairness RCA case is due to be presented at the Executive RCA Meeting in May 2022. In addition, work is ongoing to support case referrals that come from the Staff Network Chairs, Inclusion Team, Freedom to Speak Up Guardians and HR.

Recruitment, Retention and Progression
The Director of Workforce has outlined a new Trust-wide approach to ensuring fairness exists within all recruitment processes. One of the initiatives includes the development of a network of Fair Recruitment Experts to support recruitment panels to make appropriate decisions.

Improvement priority for 2022/23

The Trust will continue to monitor the Trust's Freedom to Speak Up culture using the number and type of contacts per quarter and the four questions on raising concerns in the annual NHS Staff Survey. It is difficult to set a target for the number of contacts 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.

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.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 2: Improving VTE prevention

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

Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs). VTE is associated with periods of immobility such as when a patient is in hospital. VTE can either develop during a patient's hospital stay or after they have left hospital.

The Trust has chosen to focus on reducing the number of hospital-associated thromboses (blood clots) because they cause considerable harm to patients and can often be avoided if appropriate preventative measures are taken. Preventative measures usually include compression stockings and/or medication to reduce the risk of blood clots forming. It is important to note that these preventative measures do not reduce the risk to zero; a few patients will still go on to develop VTE even when all appropriate measures have been taken.

The Trust has been using an electronic VTE risk assessment tool within its Prescribing Information and Communication System (PICS) for inpatients for over a decade on the Queen Elizabeth Hospital site. The tool provides tailored advice regarding preventative treatment based on the assessed risk. PICS was rolled out to the Solihull Hospital site in November 2020 and is currently being rolled out to Heartlands Hospital followed by Good Hope Hospital with the roll-out scheduled to complete by Summer 2022. In the meantime, any wards which do not have PICS are using a similar electronic form within the Concerto system.

Improvement priority for 2021/22

The Trust set up a quality improvement project in 2020/21 to improve VTE prevention and reduce the number of hospital-associated thromboses. The focus of this work is both on inpatients and patients who may not be admitted to hospital but are at risk of developing VTE such as those with lower limb fractures.

Performance

VTE risk assessment (National Key Performance Indicator)
The Trust has continued to exceed the national requirement for 95% of patients having a VTE risk assessment during their admission. Trust-level compliance has been above 96% every month during 2021/22. National reporting requirements were suspended during 2021/22 due to the Covid-19 pandemic.

Potentially preventable hospital-associated thromboses (blood clots)
The table below shows the number of preventable hospital-associated thromboses (HATs) which occurred at UHB during the period April-July 2021. These include thromboses which occurred in hospital and those which developed within three months of a patient leaving hospital. Unfortunately the anticoagulant medical and nursing teams have not been able to reliably complete the RCA process since August 2021 due to staffing shortages and the need to prioritise immediate clinical management of patients. This has been discussed and presented at the Trust's Clinical Quality Monitoring Group on several occasions.

Month	Number of HATs	Number potentially preventable	% potentially preventable
April 2021	23	4	17%
May 2021	39	2	5%
June 2021	36	0	0%
July 2021	27	1	4%

Number of Serious Incidents relating to hospital-associated thromboses
There was one Serious Incident relating to Hospital Acquired Thrombosis in 2021/22. This compares with one SI reported in 2020/21.

Progress during 2021/22

To develop inpatient VTE pathway indicators during Quarter 2 2021/22
Nine automated indicators along the VTE pathway have been developed so far and are currently being validated within newly purchased PowerBI software which allows better statistical analysis, triggers for escalation and drill down. Additional indicators are being scoped in line with recently released quality standards

It should be noted that some of the Trust and site level results will need to be interpreted with care during the roll out of PICS across Heartlands and Good Hope wards due to the impact, as new wards are added, on some of the time dependant indicators.

Missed doses of enoxaparin for any reason are measured within the ward Clinical Dashboard and lower performing wards attend the Clinical Dashboard Review Group to discuss their performance and improvement.

To develop lower limb VTE pathway indicators during Quarter 2 2021/22
Manual audit tools have been developed and the first audits and interventions have been undertaken.

To monitor and improve performance for the inpatient and lower limb pathway indicators during Quarter 3 2021/22
There has been a slight delay in publishing all the VTE data for inpatients as the basic functionality was being built and agreed within PowerBI. VTE risk assessment completion compliance was sent to the Divisional Medical Director in December and March. A full update on the VTE project will be included in the Divisional reports and data will start to be included in Q1 and 2 2022.

In the specialty reports there have been inclusions, where relevant, regarding the lower limb guidelines and VTE risk assessment implementations and an update this quarter regarding the next phase of the project being on inpatients. However no data has yet been included.

The draft indicators are being reviewed at the VTE QI project group and once validated by included within Divisional Quality reports and reviewed by the Thrombosis group

Reviewing ward level performance for the VTE indicators at the Clinical Dashboard Review Group (CDRG) to identify where improvements can be made and providing support to deliver these improvements

Ward and site level data for missed doses of enoxaparin data is monitored at CDRG and wards are selected to attend for further review. This ward level data is available to all ward managers who use the Prescribing Information and Communication System (PICS) via the Clinical Dashboard. The roll-out of PICS is continuing at pace with most wards at Heartlands and Good Hope due to go live by end of 2022.

- The VTE Lower Limb guidelines are now in place and on the guidelines page of the intranet.
- The UHB Lower Limb guidelines and changes are included in education and training sessions for staff in the Emergency Departments and Trauma and Orthopaedics.
- Patient information leaflets have been delivered to the relevant areas for issue to patients/carers and are available via an electronic system on the Heartlands, Good Hope and Solihull hospital sites.

Improvement priority for 2022/23 and initiatives to be implemented in 2022/23

The quality improvement project and associated initiatives will continue in 2022/23.

How progress will be monitored, measured and reported

- The VTE indicators will be included within existing performance dashboards such as the Clinical Dashboard and Junior Doctors' Dashboard. New performance dashboards may be developed as required.
- Expanded quarterly reports will be provided to the Clinical Quality Monitoring Group (CQMG) chaired by the Chief Medical Officer.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 3: Improving ward rounds

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 Trust set up a quality improvement project in 2020/21 to improve the consistency and effectiveness of ward rounds following a number of incidents and patient complaints relating to ward-based care. In January 2021, the Royal College of Physicians and the Royal College of Nursing published a report which sets out best practice for ward rounds: Modern ward rounds: Good practice for multidisciplinary inpatient review (Modern ward rounds | RCP London). Ward rounds are defined as 'the focal point for a hospital's multidisciplinary teams to undertake assessments and care planning with their patients'.

A number of standards for ward rounds and an implementation tool including the mnemonic 'REMIND' were developed and tested to support clinicians during ward rounds:

REMIND acronym	What does it stand for?	What does this mean?
R	ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)	Ensuring the ReSPECT process and form are completed. The ReSPECT process supports clinicians to have conversations with patients to understand their wishes about care and treatment in advance of an emergency situation occurring. The outcomes of such conversations are documented in the Trust's ReSPECT form.
E	Electronic prescribing	Ensuring the right medication is prescribed.
M	Mental capacity	Ensuring mental capacity is assessed and dementia risk assessments are completed for patients over 75
I	Investigations and tests	Ensuring the right investigations and tests are ordered and the results are followed up.
N	Nutrition and hydration	Ensuring patient's nutritional and hydration needs are assessed and met
D	DVT (Deep vein thrombosis)	Ensuring the risk of developing venous thromboembolism (blood clots) is assessed and appropriate preventative measures are taken.

The Trust was also selected as a trial site for the national improving ward rounds project being led by the Emergency Care Improvement Support Team (ECIST) which is part of NHS Improvement and NHS England.

Improvement priority for 2021/22

The Trust was aiming to develop a framework of local ward round standards and to set out an implementation plan during 2021/22. The Trust also planned to start measuring indicators linked to ward rounds to gauge their effectiveness as follows:

- All emergency admissions should be reviewed with 14 hours of admission by a Consultant
- All emergency admissions should be reviewed daily by a Consultant
- Timely VTE risk assessment completion
- Timely administration of preventative VTE medication if required
- ReSPECT form completion
- Dementia risk assessment completion for patients over 75
- Mental capacity assessment completion

Broader measures:

- Reduction in the number of serious incidents where ward rounds is a theme
- Reduction in complaints around ward based care
- Reduction in incidents related to nutrition and hydration
- Positive staff and patient survey responses
- Length of stay (LOS)
- Increased patient discharges before 11am

Progress during 2021/22

18 wards across different sites and a wide range of clinical specialties have been involved at various stages of the ward round quality improvement project during 2021/22.

Standards for a ward round

The following key elements of a ward round were agreed during 2021/22:

1. The ward round will occur every day.
2. The ward round will be multi-disciplinary.
3. The round will be undertaken with a board round, bedside ward round and a debrief.
4. The round will include prompts for each of the elements of the REMIND mnemonic.
5. The ward round will be clearly documented with actions recorded and handed over to relevant staff.
6. The ward rounds will be audited and improvements will be made based on audit findings.

'REMIND' mnemonic

The 'REMIND' mnemonic was expanded during 2021/22 to incorporate additional prompts for clinicians undertaking ward rounds:

R = Respect form and ceiling of treatment correctly completed.

E = Electronic prescribing up to date (antibiotics have end date, duration, IV/Po switch
Examination: abdominal, internal

M = Mental capacity, Dementia, mobility status (physiotherapy, occupational therapy)
MEWS/NEWS fluid balance
Management of cannula and catheter

I = Investigations and tests (post/pre-op X-rays and blood tests)

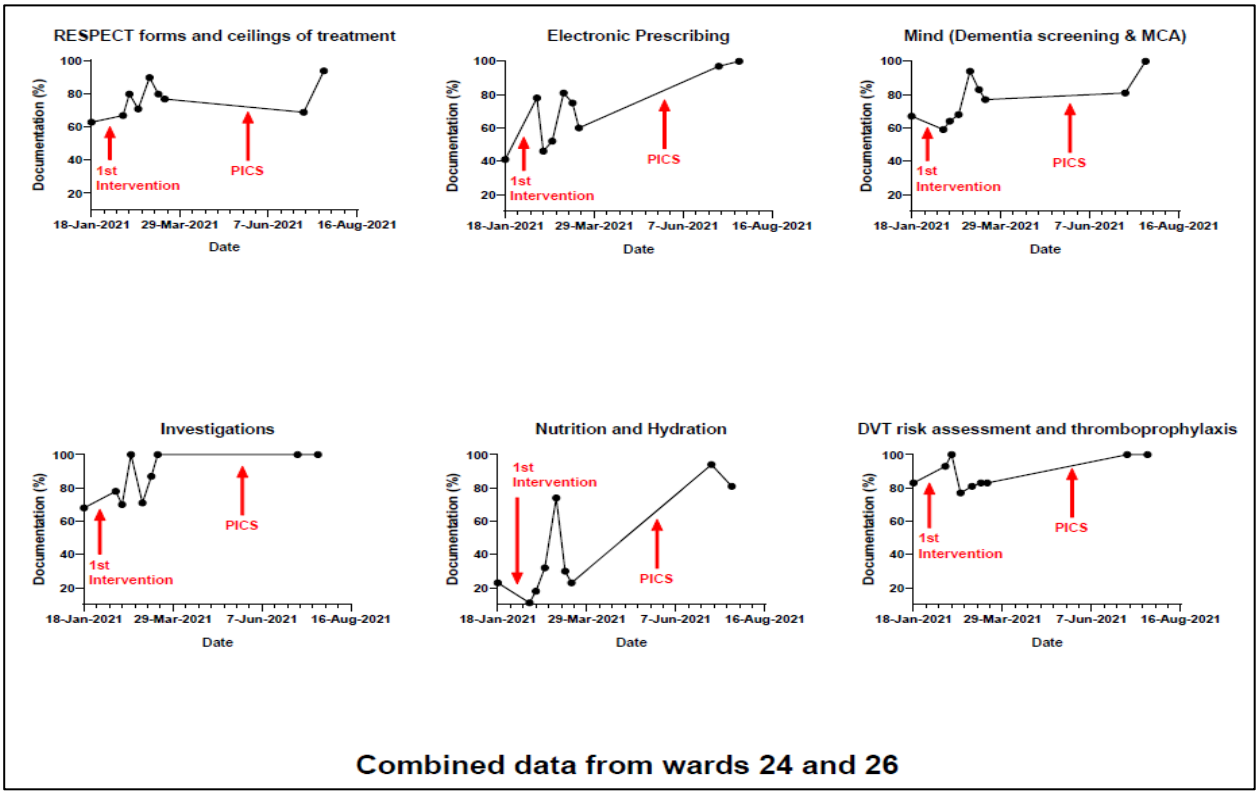
N = Nutrition and hydration (IV nutrition and hydration/fluid chart), nil by mouth status

D = DVT risk assessment and thromboprophylaxis
Discharge planning (date of discharge)
Discussion with patient regarding options and plans

- Work is underway with Health Informatics and the Quality Development Team to develop the above measures, some of which are already in place.
- A Clinical Governance Fellow has been recruited to support the project.
- Two Infectious Diseases wards at Heartlands Hospital and a Care of the Elderly ward at Good Hope Hospital are actively participating in the ECIST improving ward rounds project.
- The Trust received very positive feedback during a recent feedback session on the ECIST project.
- Key elements of a ward round training module using the Moodle platform have been developed and agreed.
- The project is focussing on effective communication between nursing and medical staff as achieving nurse presence on ward rounds is very challenging due to current staffing issues.
- Two respiratory wards have shown a significant increase in adherence to the REMIND process following the introduction of the Prescribing Information and Communication System (PICS).

Performance

Implementation of the ward round project and PICS on two respiratory wards at Heartlands Hospital (Wards 24 and 26):



Run charts for other wards and specialties will be developed and monitored once the project has been running for long enough in each area.

Improvement priority for 2022/23

- To involve at least 20 wards across the Trust in the improving ward rounds quality improvement project.
- To obtain longitudinal improvement data for at least 5 wards.

Initiatives to be implemented during 2022/23

- Widespread adoption of ward round champions.
- Establishment of a data dashboard to allow wards to benchmark against peers.
- Implementation of a system for annual peer review of ward rounds.
- Alignment of the ward round quality improvement project to sub-projects emerging from the NHS England & NHS Improvement review:
  - Estimated discharge date: to improve documentation and use of estimated discharge date by wards
  - Nurse led and therapy led discharge: to develop a standard operating procedure for nurse/therapy led discharge
  - Discharge bundle completion: to improve timely discharge via introduction of a discharge bundle comprising tick boxes for key aspects of the discharge process
  - Multi-disciplinary team (MDT) board round: to improve documentation of the board round by wards
- Implementation of a quality improvement intranet site for staff education and sharing of best practice.
- Development of a standard operating procedure, board round and discharge bundle paperwork
- Quality improvement prize to be developed and awarded via grand rounds, in order to raise the profile of quality improvement across the Trust.

How progress will be monitored, measured and reported

- Progress will be monitored through the Trust's ward rounds quality improvement project.
- Some indicators will be included within existing performance dashboards such as the Clinical Dashboard. New performance dashboards may be developed as required.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 4: Improving diabetes management

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 Trust chose to focus on reducing the number of patients who develop diabetic ketoacidosis (DKA) in hospital during 2021/22 based on recent incident data and the high number of diabetic patients we treat. Diabetic ketoacidosis is a serious problem that can happen in people with diabetes if their body starts to run out of insulin. When this happens, harmful substances called ketones build up in the body which can be life-threatening if not diagnosed and treated quickly. DKA mainly happens in people with Type 1 diabetes but can occur in Type 2 diabetes, especially during acute illness. DKA is generally preventable and therefore should not develop during a hospital stay when diabetes is well managed by clinical staff.

Fixed rate intravenous insulin infusions are used to treat diabetic ketoacidosis. For wards currently using the Trust's electronic Prescribing Information and Communication System (PICS)*, there is an automated referral to the Diabetes Team for patients who have a fixed rate intravenous insulin infusion prescribed. In addition, the Trust's Diabetes Team has just launched an online insulin safety module via Moodle to educate staff.

* The Trust's electronic Prescribing Information and Communication System (PICS) is currently in use at the Queen Elizabeth, Solihull and Heartlands hospital sites site. PICS is being rolled out to the Good Hope hospital site with a planned completion date of September 2022.

This improvement priority builds on the work of the Trust's Diabetes Quality Improvement Project, supported by the Diabetes Steering Group which is jointly chaired by a Consultant and an Associate Director of Nursing.

Improvement priority for 2021/22

The Trust was aiming to reduce the number of patients who develop diabetic ketoacidosis whilst in hospital.

Performance

A new category of 'Diabetes' was added to the Trust's incident reporting system from 1st June 2020 and staff are required to categorise incidents according to the harm categories specified by the National Inpatient Diabetes Audit (NaDIA) of which DKA is one.

DKA incidents

Incident data has been validated against the NaDIA harms categories and is available from November 2021. This data will be used to monitor progress of the quality improvement project interventions. Cases are individually reviewed according to the Trust's Incident Management Policy.

Month	Total
Nov 2021	2
Dec 2021	1
Jan 2022	0
Feb 2022	2
Mar 2022	1

Measuring and reviewing ward level performance for missed background insulin doses which can lead to DKA is undertaken at the Clinical Dashboard Review Group.

Missed background insulin (all reasons)

This data comes from the Trust's Clinical Dashboard which displays up to date performance information for a range of patient care indicators and the original data source is PICS. It should be noted that PICS has been rolled out in stages to wards at Solihull, most of Heartlands and several GHH wards over 2021-22. As the wards start to use PICS, their data is included as per the table below:

Site	2021									2022			Ward Average (Apr 21 – Mar 22)
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
BHH	10.5%	6.0%	6.6%	5.2%	3.9%	6.2%	4.4%	5.6%	7.6%	7.2%	7.1%	6.9%	**6.2%**
GHH	-	-	-	-	-	-	-	-	-	-	4.0%	2.6%	**3.4%**
QE	4.6%	3.4%	4.2%	3.0%	4.1%	3.6%	3.7%	3.3%	4.5%	3.6%	4.0%	3.7%	**3.8%**
SOL	4.3%	0.0%	7.7%	5.5%	8.3%	4.5%	4.7%	7.6%	5.9%	4.0%	2.7%	2.0%	**4.9%**
Trust	4.6%	3.5%	4.4%	3.5%	4.1%	4.3%	3.9%	4.1%	5.3%	4.7%	4.9%	4.8%	**4.4%**

Progress with initiatives planned for 2021/22

- To develop an automated indicator to identify patients with DKA based on specific clinical parameters within the Prescribing Information and Communication System.
  - **Progress:**
    The Trust is currently unable to progress this automated indicator until ketone meters are rolled out across the Trust with real time connectivity. Although the ketone meters do not yet have IT connectivity, working with Point Of Care Testing team there is increased and improved availability and access to ketone meters across the sites – most clinical areas now have a ketone meter. Previously the majority of wards had to rely on urine testing for ketones.

- Automated referrals to the Diabetes team within PICS for patients who have a dose of background insulin missed as this can lead to patients developing DKA.
  - **Progress:**
    The diabetes team receive daily reports of missed doses of insulin across PICS areas and which now also includes Good Hope hospital. An audit of this referral data has shown that for the month of December 2021, there were 86 incidents of missed basal insulin but 46 of these were appropriately missed (40 were inappropriately missed). All patients who were alerted to the team were seen and appropriate action taken; there were no incidents of DKA caused by missed background insulin during this month.

- To develop mandatory training for inpatient-facing nurses and doctors to include: insulin hypoglycaemia/ hyperglycaemia, DKA and when to refer patients to the Diabetes Team.
  - **Progress:**
    Role specific training has been developed and is currently with the Moodle team to convert the education to online education.

- To develop a Trust-wide Standard Operating Procedure for monitoring of diabetes including glucose and ketone testing.
  - **Progress:**
    This is completed and available Trust-wide.

- To develop an indicator to measure whether ketones have been checked when a patient's blood glucose level is high.
  - **Progress:**
    This requires ketone meters to be in place as above so has not been possible to develop during 2021/22.
- A suite of automated diabetes measures for improvement have now been selected for development using PowerBI software which will provide statistical analysis and generate triggers for review and escalation.

Improvement priority for 2022/23

The Trust has decided to update the selection of priorities included the Quality Account for 2022/23 and this priority will be discontinued pending a refresh of the Diabetes Steering Group and associated work programme. Progress will continue to be reported internally to the Clinical Quality Monitoring Group chaired by the Chief Medical Officer.

Priority 5: Improving nutrition and hydration

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 Trust already has a safer swallow quality improvement project in place following previous serious incidents relating to this topic. The Trust chose to make improving nutrition and hydration a Trust-wide improvement priority during 2021/22 based on the number and types of incidents and complaints related to this topic. There have also been more serious cases that have been discussed at the Trust's Clinical Ethics Committee which reinforces the need to raise the profile of nutrition and hydration and clinical accountability for it across the Trust.

Improvement priority for 2021/22

Building on the existing safer swallow quality improvement project, the Trust decided to set up a new, overarching multidisciplinary group for nutrition and hydration during 2021/22 with senior clinical input.

Two areas of focus for this priority were:

1. Improving the management of patients who are nil by mouth (NBM):

There are two distinct groups of nil by mouth patients:

- Pre-operative patients who need to fast before their procedure
- Patients with dysphagia (difficulty in swallowing)

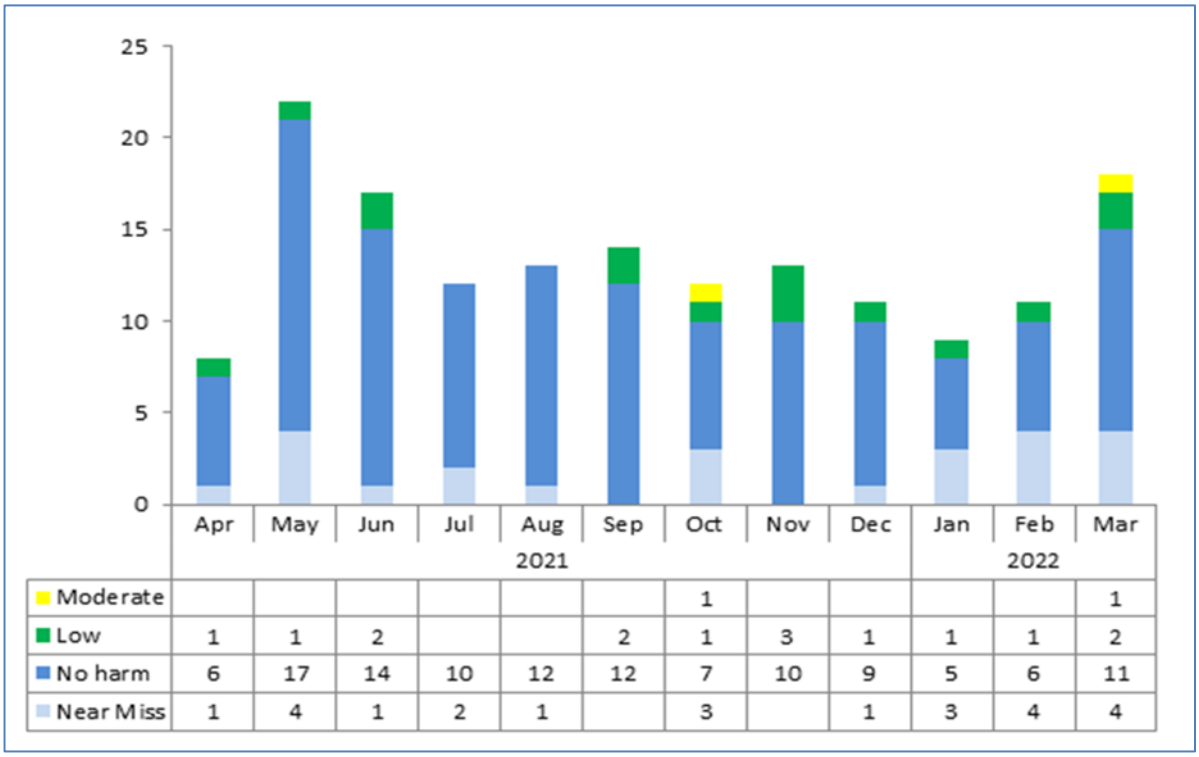
2. Ensuring patients' baseline and on-going weight and Malnutrition Universal Screening Tool (MUST) risk assessments are accurately completed.

The Trust aimed to standardise the approach to managing the two groups of nil by mouth patients, decision-making and nil by mouth signage across all hospital sites. The Trust also chose to focusing on ensuring patients received the right type of food (from a consistency perspective) at the right time.

Performance

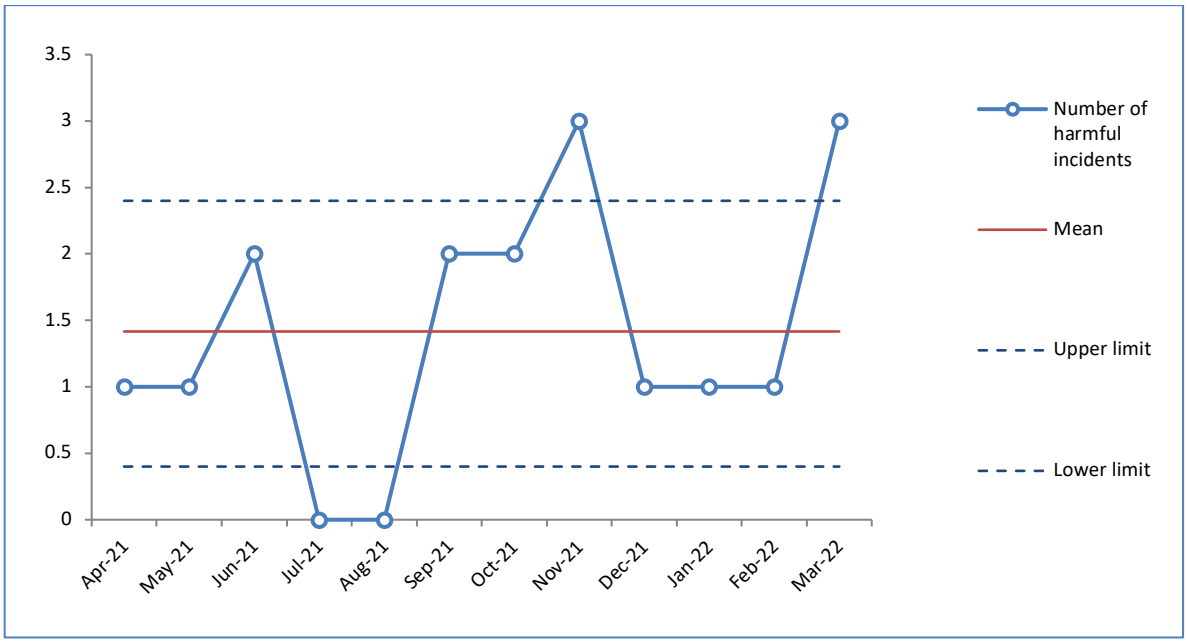
Incidents

The Trust has continued to monitor incidents relating to dysphagia/swallowing and nil by mouth issues during 2021/22. The table and graph below show the number of incidents reports and the level of harm.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2021									2022		
Moderate							1					1
Low	1	1	2			2	1	3	1	1	1	2
No harm	6	17	14	10	12	12	7	10	9	5	6	11
Near Miss	1	4	1	2	1		3		1	3	4	4

The graph below shows the number harmful incidents reported by month for the 2021/22. The total number of harm incidents reported during this period was 17. The number reported per month has fluctuated throughout the year. With the lowest at 0 harm incidents reported in July and August 2021



Complaints

The table below shows there were 76 instances relating to a wide variety of nutrition and hydration issues noted in complaints during 2021:

Nutrition/Hydration COMPLAINTS ISSUES 1/4/21 - 30/9/21	BHH	GHH	QEH	Total
EOL - Nutrition/Hydration	1	0	3	**4**
Facilities - Food - quality (non-clinical aspects only - see also Patient Care)	2	0	0	**2**
Facilities - Food - availability (non-clinical aspects only - see also Patient Care)- also includes non-patient	3	1	0	**4**
Food and Hydration - Failure to identify specific nutritional/dietary needs on admission	1	0	0	**1**
Food and Hydration - Failure to monitor food intake during period of admission	6	3	5	**14**
Food and Hydration - Failure to monitor fluid intake during period of admission	2	1	4	**7**
Food and Hydration - Failure to provide adequate fluids during period of admission	7	4	8	**19**
Food and Hydration - Failure to provide assistance with eating/drinking	1	1	3	**5**
Food and Hydration - Failure to provide appropriate foods linked to clinical need (e.g. diabetes, coeliac, texture modified/dysphagic)	1	1	2	**4**
Food and Hydration - Failure to provide appropriate foods linked to personal/ cultural need (e.g. vegan, halal)	0	0	1	**1**
Food and Hydration - food/drink left out of reach	2	3	0	**5**
Food and Hydration - Nil by mouth issues	2	1	6	**9**
Food and Hydration - Availability of drinking water (e.g. in A&E, Outpatient areas)	1	0	0	**1**
Total	**29**	**15**	**32**	**76**

Progress during 2021/22

- To set up a new, overarching multidisciplinary group for the nutrition and hydration quality improvement project.

A new Nutrition and Hydration Steering Group was set up in the second half of 2021/22 and is jointly chaired by the Deputy Chief Nurse and two Consultant Gastroenterologists. There are five sub-groups which report to the overall steering group:

- Safer Swallow
- Enteral Feeding
- Nutrition and Weight Assessment
- Parenteral Nutrition
- Eating Disorders and Disordered Eating
- To highlight within the Trust's electronic Prescribing Information and Communication System (PICS) how long patients have been nil by mouth for.

Updates to PICS are currently in development and will provide a single point of recording for when a patient is required to be nil by mouth. The system will record the time, date and rationale for the nil by mouth period so all clinicians are aware of a patient's nil by mouth status. An audit of patients who are nil by mouth is being undertaken to explore clinical decision-making and the duration patients remain nil by mouth for. The audit outcomes will be reported to the Nutrition and Hydration Steering Group and the Clinical Quality Monitoring Group. Standardised bed side signage is now in place across the Trust.

- Targeted education through an online Moodle module alongside ward based face-to-face training.

Safer swallow Moodle training is ongoing and available to all staff. 1,672 staff members accessed the Moodle package during 2021/22. Face-to-face rolling training from the speech and language therapy team to clinical and facilities staff is ongoing cross site. The content of the education packages are standardised cross site and specific for the grade and specialism of the staff receiving the training and is supported by the Education team.

A MUST Moodle training package has been developed and was launched Jan 2021 to provide easier access to MUST training. The Moodle can be accessed by all ward staff. Face-to-face training and informal support is also delivered at ward level to complement online training, mainly provided by the Dietetic team.

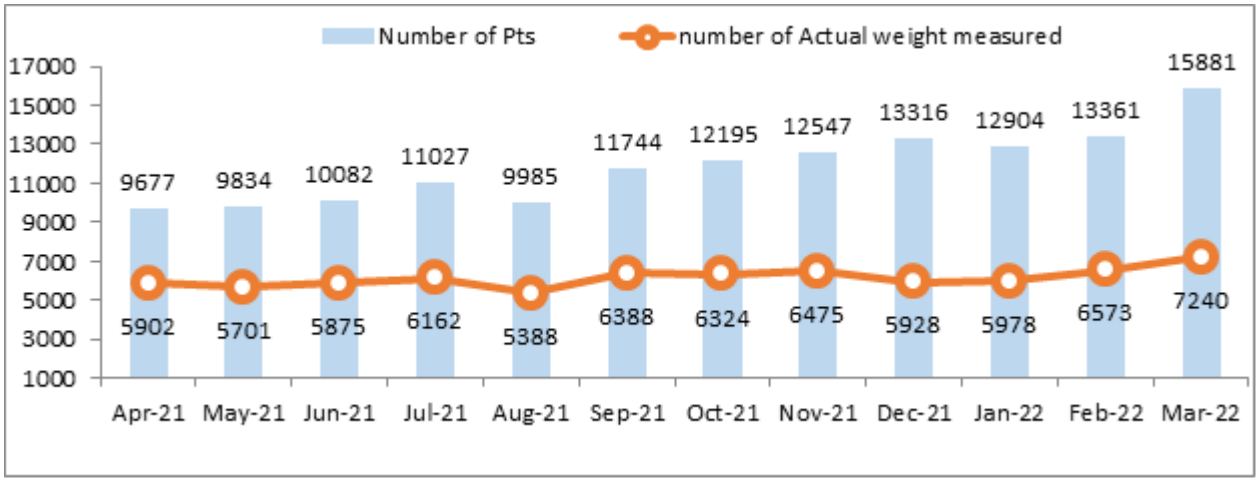
- Staff consultation and survey to understand what staff find difficult about managing patients' nutrition and hydration with a view to providing increased support in these areas and developing clinical cultures.

- Interviews and consultations with staff have taken place cross site, within ward environments and in focus groups. Information from these consultations identified ward-based challenges which were fed back to the Safer Swallow Group. Operational issues have been actioned via appropriate personnel who attend the group. The findings from these consultations have informed a research proposal exploring ways in which food and drink delivery may be improved within an acute Trust.

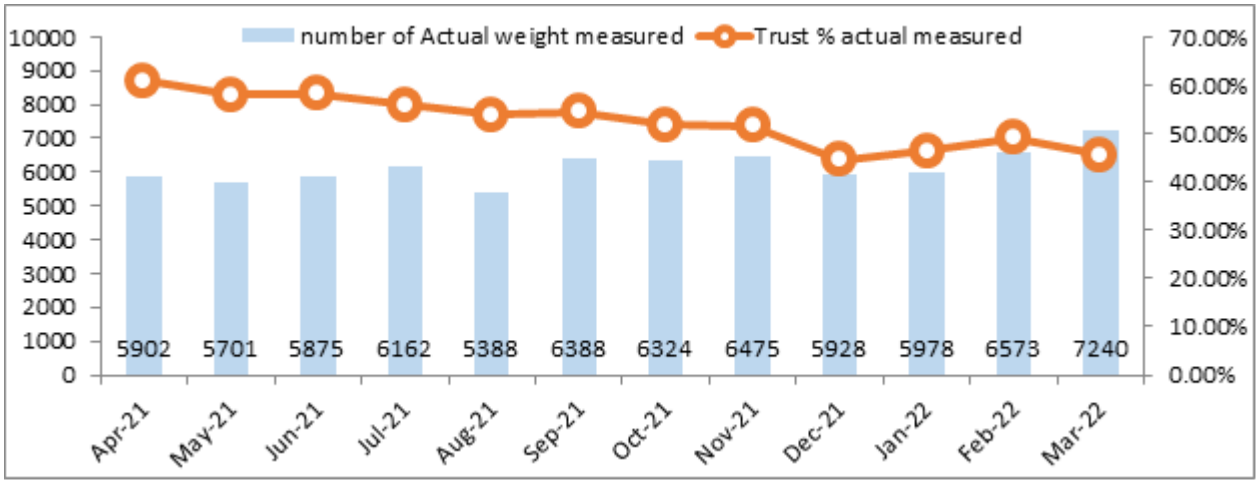
- Development of indicators and a programme of regular ward audits to measure performance:
  - Initial and on-going accurate weight details.
  - Initial and on-going MUST risk assessments. Weight is recorded as part of the MUST assessments and completion of MUST assessments within 6 hours of arrival or transfer to a ward is monitored via the Trust's Clinical Dashboard.
  - Daily nutrition and hydration assessments on patients identified as being at risk from initial screening.
  - Regular meal-time audits to check whether patients are being given the right type of food and drink as part of their care.
    Regular meal time audits exploring adherence to swallow recommendations have been undertaken by the Education team. These were completed twice weekly in Division 2 pre-Covid however these were stood down during Covid-19 peaks due to staffing issues. Facilities staff are also undertaking quarterly audits of nil by mouth signage to provide assurance around safe and consistent use of bed signs.
    Staff continued to report any issues with the wrong types of food and drink being provided to meet patients' dysphagia needs via Datix, the Trust's incident reporting system. A regular meal-time audit programme will be a priority for development in 2022/23
  - Percentage of patients who have an actual rather than estimated weight recorded.
    The percentage of patients who have an actual rather than estimated weight recorded within PICS has been monitored and reported to the Clinical Quality Monitoring Group monthly. In addition, a small audit of the accuracy of recorded weights was carried

out as part of Nutrition and Hydration week in March 2022. The audit results are being collated and will be shared with the Nutrition and Hydration Steering Group and the Care Quality Group.

Number of patients admitted to wards who had their actual weight recorded



Number and percentage of patients who had their actual weight recorded



Improvement priority for 2022/23 and initiatives to be implemented during 2022/23

The focus of this priority will remain on improving the management of nil by mouth patients and delivering the priorities of the five sub-groups:

1. Safer Swallow

- To improve clinical outcomes for patients who have swallowing problems within the trust.
- To devise strategies and structures to facilitate safe swallowing within the trust.
- Provide a forum for discussion and debate on issues related to safe swallowing within the trust.
- Review, critique and approve clinical guidelines, patient group directions, policies and procedures with impact on safe swallowing.
- To advise the Director for Nursing and Medical director on innovations, actions and outcomes of the group.
- Collaborate to streamline a MDT (multi-disciplinary team) workforce and approach to safer swallowing.
- To review clinical incidences that relate to safe swallow.

- To explore research opportunities to improve clinical outcomes related to people who have swallowing problems

2. Enteral Feeding
- Standardisation of Trust enteral feeding tube procedures via the application of evidence based practice and with reference to national best practice guidance
- Standardisation of Trust enteral feeding tube equipment
- Audit related to enteral feeding tube management and patient care
  - Nasogastric feeding tubes
  - PEG/RIG insertions including 30 day mortality
  - Displaced gastrostomy/jejunostomy feeding tube management
- Review of clinical incidents related to enteral feeding tubes, with a particular focus on fine bore nasogastric feeding tubes and displaced gastrostomy/jejunostomy tubes
- Identification of staff training needs in relation to enteral feeding tube management
- Identification of quality improvements in enteral feeding
- Report developments within the Enteral Feed tendering process

3. Nutrition and Weight Assessment
- Ensuring patients' baseline and on-going weight and Malnutrition Universal Screening Tool (MUST) risk assessments are accurately completed and actions are taken to support patients identified as at risk (monitored via PICS and through ward audits of completion and accuracy of MUST screening (including measurement of actual weight), and of action taken in response to screening).
- Promote and increase uptake of the online MUST Moodle training package.
- Ensure baseline and ongoing hydration screening is completed and appropriate monitoring of fluid intake is put in place for patients identified as at risk (monitor via audit of hydration assessment completion and appropriate use of food/fluid charts and fluid balance charts)
- Promote good practice at meal times as defined by compliance with Supportive Mealtimes Procedures and the 6 Step Mealtime Check (monitor via ward mealtime audit).
- To consider implementing a volunteer role of 'Dining Companion' to provide social contact and encouragement to eat and drink for patients as well as to assist staff at mealtimes. This will depend upon Covid-19 restrictions.

4. Parenteral Nutrition
- Implementation of the NHSE Specialised Commissioning contract for Severe Intestinal Failure (SIF) and Home Parenteral Nutrition (HPN) services
  a. Agreement of UHB intestinal failure catchment area
  b. Confirmation of specialised commissioning SIF funding stream 2022/2023
  c. Intestinal failure team expansion, to continue to meet the standards required within the contract
- Review and standardisation of in-patient parenteral nutrition regimens used across UHB
- Presentation of all UHB in-patient parenteral nutrition data within a single annual report
- Review of clinical incidents related to parenteral nutrition

5. Eating Disorders and Disordered Eating

How progress will be monitored, measured and reported

- Progress will be monitored and reviewed by the Nutrition and Hydration Steering Group.
- Progress will be reported to the Care Quality Group chaired by the Chief Nurse.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 6: Improving the safety of invasive procedures

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

NHS England* published a set of National Standards for Invasive Procedures (NatSSIPs) in September 2015 which were endorsed by all relevant professional bodies. The aim of the NatSSIPs is to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. Never Events are defined as 'Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers' (NHS England, January 2018). The NatSSIPs set out the minimum standards considered necessary for the delivery of safe care during invasive procedures as well as underpinning aspects of education and training.

NHS England then issued a Patient Safety Alert requiring trusts to review clinical practice and develop their own Local Safety Standards for Invasive Procedures (LocSSIPs) to improve patient safety. Since that time, the Trust has implemented a large number of LocSSIPs within a wide range of specialties.

The Trust has now incorporated this work within the Local Safety Standards for Invasive Procedures (LocSSIPs)/ World Health Organization (WHO) Safety Checklist quality improvement project.

No further national requirements or updates have been issued since the publication of the National Standards for Invasive Procedures.

* NHS Improvement and NHS England have worked together as a single organisation since 1 April 2019.

Improvement priority for 2021/22

The Trust planned to introduce new Local Safety Standards for Invasive Procedures into four additional clinical specialties: Critical Care, Endoscopy, Interventional Radiology and Cardiology.

Progress during 2021/22

- New Safety Standards for Invasive Procedures have been implemented in Critical Care, Endoscopy, Interventional Radiology and Cardiology as planned:

Specialty	LocSSIPs Implemented	Sites
Critical Care	1. Bronchoscopy 2. Leadercath Arterial Line Access 3. Chest Drain Insertion 4. Percutaneous Tracheostomy Tube Insertion 5. Changing a Tracheostomy 6. Serratus Anterior/Posterior Block 7. Vascular Access 8. Rapid Sequence Induction	All three sites: QEHB, BHH and GHH
Endoscopy	1. Colonoscopy 2. Gastroscopy	All four sites: QEHB, BHH, GHH and SH
Interventional Radiology	1. Simple interventional radiology procedures 2. Complex interventional radiology procedures (those requiring sedation)	All four sites: QEHB, BHH, GHH and SH
Cardiology	1. Catheter Lab procedures 2. Transoesophageal ECHO	All three sites: QEHB, BHH and GHH

- Specialties are auditing their Local Safety Standards for Invasive Procedures. These are presented to the LocSSIPs steering group and shared with Specialities and Divisions via the Quarterly Quality and Safety Report.
- The table below shows the most recent audit performance. The compliance column shows the percentage of required LocSSIPs that were completed. The 'correctly completed' column shows the percentage of completed LocSSIPs which were completed properly. Where there is poor compliance or LocSSIPs which are not being completed properly, discussions are held with departments to ensure remedial actions are put in place such as presentations at departmental governance meetings and teaching sessions for junior doctors.

Specialty	Compliance	Correctly Completed
Critical Care	QEHB: 12% BHH: 16% GHH: 12%	All three sites: QEHB, BHH and GHH
Endoscopy	All sites: 100%	All four sites: QEHB, BHH, GHH and SH
Interventional Radiology	67-100% across sites and departments	All four sites: QEHB, BHH, GHH and SH
Cardiology	Catheter Lab: 100%Transoesophageal ECHO: 100%	All three sites: QEHB, BHH and GHH

- LocSSIPs have also been implemented within the following specialties during 2021/22: Gynaecology, Ophthalmology, ENT, Vascular Surgery, Maxillofacial Surgery, Emergency Medicine and Neonates. The Trust has recently approved LocSSIPs for Breast Surgery and Trauma and Orthopaedics.
- Work is progressing on an educational package for staff using the Moodle platform with modules being developed on LocSSIPs and the WHO checklist. The training will be interactive using videos based on real incidents and Never Events, with a focus on human factors. The modules should be completed by July 2022 in time for the new rotation of junior doctors.
- There continues to be regular communication with staff following the development and implementation stages to ensure each LocSSIP is fit for purpose.

Improvement priority for 2022/23

The aim for 2022/23 is to continue to develop and implement LocSSIPs throughout the Trust. Work is in progress with Acute Medicine, Critical Care and Gastroenterology on cross-departmental LocSSIPs for procedures such as ascitic drain insertions and lumbar punctures.

How progress will be monitored, measured and reported

- Quarterly audits of compliance following the introduction of each Safety Standard.
- Quarterly progress updates to the Clinical Quality Monitoring Group (CQMG) chaired by the Chief Medical Officer.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Never Event data will continue to be regularly reported to the Board of Directors and Clinical Quality Group.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors.

New Priority: Using real-time information to improve patient care

Background

The Trust's Clinical Dashboard was first implemented at the Queen Elizabeth Hospital site in 2009. The dashboard provides clinical staff with up to date information about the care they are providing to patients for a range of clinical indicators. The dashboard covers most inpatient beds, medical and surgical assessment units, ambulatory care areas and critical care units. A wide range of clinical indicators are presented at ward and Trust level automatically without the need for staff to undertake manual audits. Staff are able to see how their own and other wards/areas are performing at a glance as well as being able to drill down to view which patients did not receive their medication, assessments or observations for example. Data is regularly refreshed and is drawn from various clinical IT systems, predominantly the Trust's Prescribing Information and Communication System (PICS).

The design and content of the Clinical Dashboard are regularly reviewed and updated together with clinical and technical staff. The most recent review took place in 2021 before the roll-out of the Clinical Dashboard to the Solihull and Heartlands hospital sites. The Clinical Dashboard is now being rolled out to the Good Hope hospital site with a provisional completion date of September 2022.

As the roll-out of the Clinical Dashboard to all four hospital sites will be completed during 2022/23, it is the right time to begin comparing performance and supporting clinical staff to make improvements.

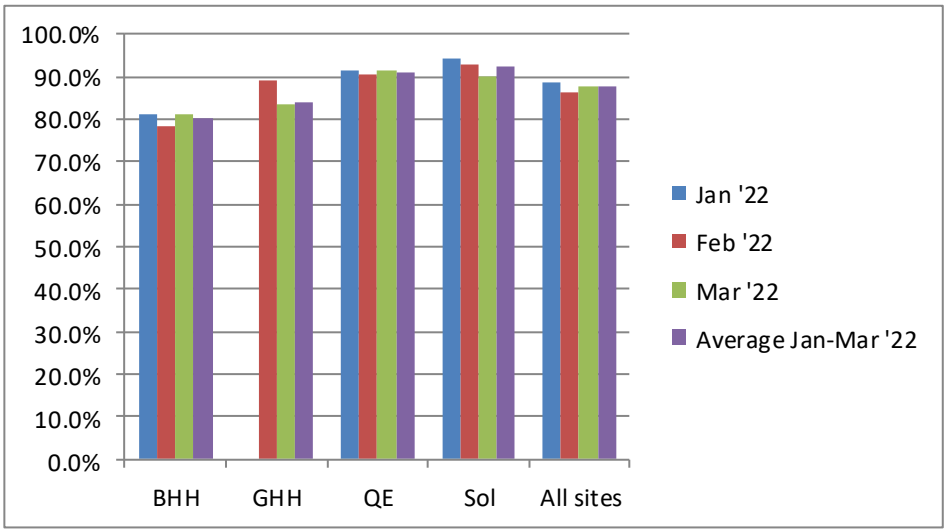
Improvement priority for 2022/23

To improve performance and reduce variation across the four hospital sites for five of the indicators on the Clinical Dashboard selected by Matrons:

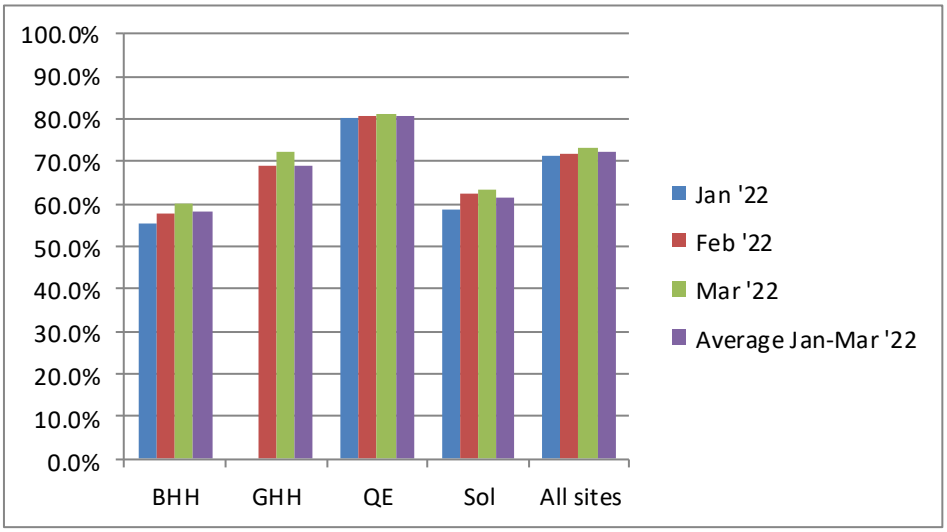
No.	Indicator Title	Notes	Target	Higher or lower is better
1	Full set of observations and pain assessment within 6 hours of admission or transfer to a ward (%)	A full set of observations includes: › Alertness (using ACVPU scale) › Temperature › Heart rate › Blood pressure › Respiratory rate › Oxygen saturation Plus pain assessment	95%	Higher
2	MUST assessment completed within 6 hours of admission or transfer to a ward (%)	The Malnutrition Universal Screening Tool (MUST) is used to assess individual patients' risk of malnutrition.	95%	Higher
3	Missed doses of antimicrobials (%)	Missed antimicrobials include antibiotics, antivirals and antifungals	2%	Lower
4	Electronic wristband identity check before administration of medication (%)	Staff are expected to check each patient's identity by scanning their electronic wristband before giving medication.	95%	Higher
5	PICS document archive print (%)	Each ward/area must have an archive printer which can be used if the electronic Prescribing Information and Communication System (PICS) ever goes down. Staff are expected to print out one document such as a drug chart each day to ensure they know what to do if PICS goes down.	96%	Higher

Baseline performance:
Baseline data is shown in the graphs below for each of the five selected Clinical Dashboard indicators by hospital sites for the period January-March 2022.

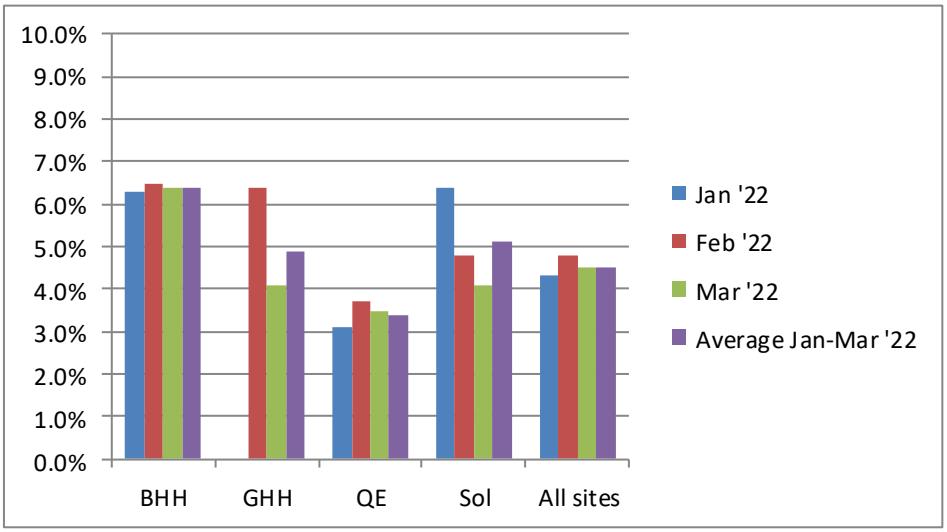
Graph 1: Full set of observation and pain assessment within 6 hours of admission or transfer to a ward (%) – Target 95%



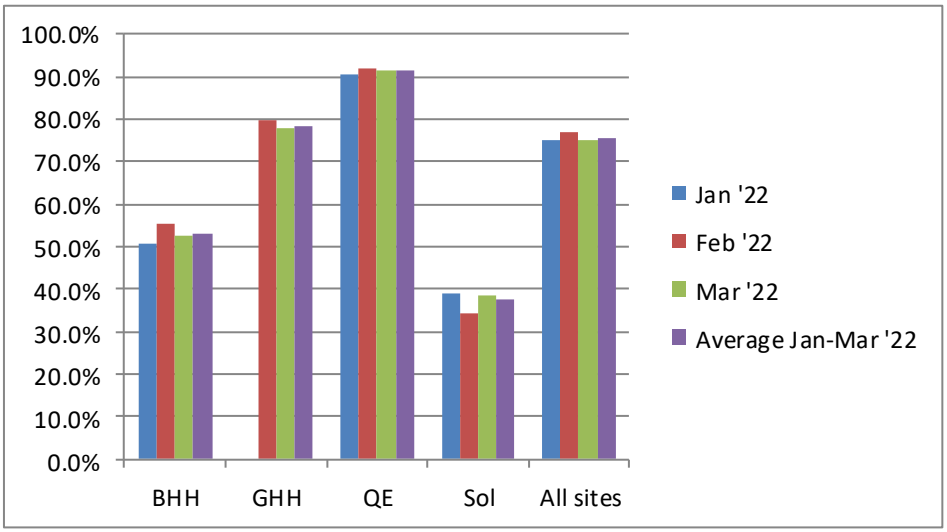
Graph 2: MUST assessment completed within 6 hours of admission or transfer to a ward (%) – Target 95%



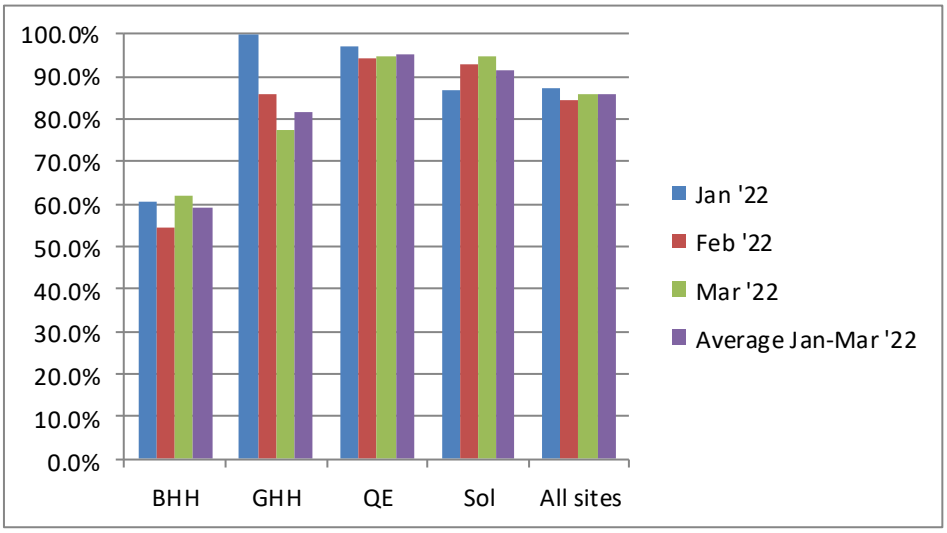
Graph 3: Missed doses of antimicrobials (%) – Target 2%



Graph 4: Electronic wristband identity check before administration of medication (%) – Target 95%



Graph 5: PICS document archive print (%) – Target 96%



Initiatives to be implemented during 2022/23

- PICS and the Clinical Dashboard will be rolled out to the remaining areas of Good Hope hospital by September 2022.
- To continue to deliver face-to-face and online training sessions to clinical staff on how to use the Clinical Dashboard to improve patient care.
- To continue to review low and high performing wards at the Clinical Dashboard Review Group and share learning across the hospital sites.
- To work with the Health Informatics team to ensure clinical staff have the information they need to improve performance at ward level.
- To work with the IT and Procurement teams to ensure staff have the right equipment in place to deliver excellent care to their patients.
- To set up a Clinical Dashboard working group with clinical staff to regularly review and update the selection of indicators and targets included within the dashboard.
- To work with clinical staff to design a new Clinical Dashboard using the PowerBI software.

How progress will be monitored, measured and reported

- Performance for the Clinical Dashboard indicators will continue to be reviewed monthly at the Clinical Dashboard Review Group jointly chaired by the Deputy Chief Nurse and Director of Strategy and Quality Development.
- Performance exceptions will be reported to the Joint Clinical Quality Assurance Group chaired by the Chief Medical Officer and Chief Nurse.

Other Quality Improvement (QI) Projects

In addition to the Trust's Quality Improvement Priorities listed above, the Patient Safety Team holds a register of Quality Improvement (QI) Projects. This table provides details on these.

Multi-Disciplinary Team (MDT) / Multi-Disciplinary Meeting (MDM) Review	
Project Aims	To reduce the preventable harm and improve the consistency and quality of care for patients being referred to and managed within cancer MDTs.
Project Measures	› Reduction in serious incident themes and trends that involve the cancer MDT process › Percentage of clinicians referring to cancer MDTs that have knowledge of their responsibilities under the newly developed SOP (target TBC)
Project Update	› SOP for cancer MDT referral finalised and uploaded to the intranet. › Explanation of the process and links emailed to all consultants on behalf of the Chief Medical Officer. › A Trust wide Patient Safety Notice has been issued explaining the process and responsibilities. › PICS has been updated and includes a function to refer to cancer MDMs directly, matching the iCare process at BHH, GHH and SH. Once PICS is rolled out across all Trust sites, the iCare function will be removed and the PICS referral will be the only accepted method of referring to a Cancer MDM. › New Work stream: MDT group working with cancer team to implement RMS (remote monitoring system) within Somerset

End of Life Care/DNACPR	
Project Aims	To improve the standard of end-of-life advanced care planning and to reduce incidents/ complaints related to end-of-life care.
Project Measures	› % of deaths with a valid DNAR › % of all inpatients with a valid DNAR › Months since last SI › Number of complaints related to EOL care
Project Update	› Digitalisation of RESPECT/ TEAL, on-going with PICS team. › Moodle educational package being updated to be more interactive for staff. › Work on the validation of first indicators commenced
NEWS2	
Project Aims	Implement NEWS2 scoring across UHB, integrated into PICS for automated alerting Trust wide.
Project Measures	› Ongoing compliance will continue to be monitored via ward data on the Clinical Dashboard › Informatics will supply stats on numbers of alerts to Outreach triggered as PICS goes live
Project Update	› Nursing and Medical Clinical Decision Advisory Groups (CDAG), Sepsis group, and Outreach teams all sites consulted and agreed NEWS2 threshold for alerting within PICS. › Chief Executive Advisory Group (CEAG) approved NEWS2 implementation › UHB NEWS2 Procedure updated › Outreach teams nomenclature rebranded 'Critical Care Outreach Team' Trust wide › Trust wide communications issued › RCP training package customised and included in Moodle. › NEWS2 replaced SEWS in PICS, NEWS2 help panel created, included and launched 15th December 2021 › Patient Safety Notice highlighting the change to NEWS2 issued Trust wide, to be discussed at every handover and displayed on Patient Safety Boards across the Trust
Discharge	
Project Aims	To improve the patient experience of discharge
Project Measures	› Time of discharges › Reduction in CQC and safeguarding alerts relating to poor discharge › Reduction in concerns and complaints about discharge › Reduction in discharge incidents › Time to discharge from when patient told they are medically fit › Increased compliance against policy/procedure – discharge planning and on the day
Project Update	› National survey results published 19/10/21 has 10 discharge related questions. Leaving hospital was one of the Trust's highest ranking sections. › NHSE/I bid granted for focussed piece of work on involvement of carers in the discharge process › Masters nursing students project underway › Junior doctor survey developed › Scoping the use of volunteers in supporting the discharge process and the roles that could be undertaken
Communication	
Project Aims	To improve standards of communication, attitudes and behaviours across the organisation to improve the patient experience and reduce complaints
Project Measures	› Reduction in rates of complaints and concerns about communication, attitudes and behaviours. › Increase in Friends and Family Test scores. › Increased participation in communication skills training. › Increased participation in diversity/inclusion training
Project Update	› Two focus groups with administrative/secretarial staff have taken place to hear suggestions of how communication with patients, relatives and carers can be improved from this staff group's perspective. Focus groups with Therapies staff are planned. › One national survey question relating to communication in the 'worse' than others category. › Video of a patient story completed and will be used as a resource. A review of communication training has been undertaken. › The group will have a new lead/Chair for 2022.

Patient Property	
Project Aims	To improve the management and safeguarding of patient property on Trust premises
Project Measures	› PALS/Complaints reduction › Reduction in contacts from the police regarding thefts
Project Update	› Core group meeting fortnightly. › IT solution likely via PICS for recording patient property and updating for each move to create an audit trail. › Baseline audit of ward safes underway to ascertain gaps. Early findings would indicate big gaps in availability of safes and variable practice in usage/documentation. › Draft documentation under review.
Consent	
Project Aims	To ensure a robust consent process is in place, addressing the actions from previous incidents and issues raised in the Learning from Deaths programme. This project will be launched pending the new UHB consent procedure.
Project Status	Procedure launched. Consent documentation audit tool piloted and to be disseminated trust-wide in early 2022. QI aims to be developed pending Consent audit findings

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2021/22 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 2021/22 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2021/22.

* 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 2021/22, 40 national clinical audits and 3 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 38 (95%) national clinical audits and 3 (100%) 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 2021/22 are as follows (see table below).

The national clinical audits and national confidential enquiries that UHB participated in during 2021/22 are as follows: (see table below).

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2021/22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2021/2022	Percentage of required cases submitted
Case Mix Programme	Yes	100%
Cleft Registry and Audit Network	Yes	100%
Chronic Kidney Disease Registry	Yes	100%
Emergency Medicine QIPS	Yes	Pain in Children – 100% Severe Sepsis & Septic Shock – 100% Infection prevention and control V2 –100%
Inflammatory Bowel Disease Audit	No	Not participating
Learning Disabilities Mortality Review Programme	Yes	100%
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	100%
National Adult Diabetes Audit	Yes	2. National Pregnancy in Diabetes Audit data collection – 100% 3. National Diabetes Footcare Audit data collection – 100% 4. National Inpatient Diabetes Audit (including NADIA Harms) data collection – 100%
Falls and Fragility Audit Programme	Yes	1. Fracture Liaison Service - 100% 2. National Audit of Inpatient Falls – 100% 3. National Hip Fracture Database Jan 2019 to Dec 2019 National Standard – 100% QEH – 101% BHH -111.8% GHH – 112.8%

National Audit UHB eligible to participate in	UHB participation 2021/2022	Percentage of required cases submitted
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Yes	1. Paediatric Asthma Secondary Care data collection –0% 2. Adult Asthma Secondary Care - 22% (1st October 2019 - March 2022) 3. Chronic Obstructive Pulmonary Disease Secondary Car - 100% 4. Pulmonary Rehabilitation- Organisational and Clinical Audit data collection – 100%
National Audit of Breast Cancer in Older People	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Cardiovascular Disease Prevention	Yes	100%
National Audit End of Life Care	Yes	100%
National Audit of Dementia	Yes	No data national data collection during 2021/22
National Audit of Pulmonary Hypertension	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	No	Not participating
National Cardiac Arrest Audit	Yes	100%
National Cardiac Audit Programme	Yes	1. National Audit of Cardiac Rhythm Management - Data collection 100% 2. Myocardial Ischaemia National Audit Project – 100% 3. National Audit Cardiac Surgery Audit – 100% 4. National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) – 100% 5. National Heart Failure Audit 100% 6. National Congenital Heart Disease Data collection 100%
National Child Mortality Database	Yes	100%

National Audit UHB eligible to participate in	UHB participation 2021/2022	Percentage of required cases submitted
National Comparative Audit of Blood Transfusion	Yes	1. 2021 Audit of Patient Blood Management & NICE Guidelines Data collection 04/10/2021-31/12/2021 QEH – 100% HGS – 100%
National Early Inflammatory Arthritis Audit	Yes	100%
Emergency Laparotomy Audit (NELA)	Yes	QEH – 97.7% BHH – 100% GHH – 100%
Gastro-Intestinal Cancer Audit Programme	Yes	National Oesaphago-gastric Cancer (NOGCA) April 2017 to Mar 2019 UHB - 75-84% National Bowel Cancer Audit (NBOCA): Apr 2018 to Mar 2019 QEHB - Case Ascertainment: 86.50% BHH - Case Ascertainment: 90.00%
National Joint Registry	Yes	April 2019 - April 2020 National Standard: >95% GHH - 87.50% BHH - 87.50% QEH - 87.50%
National Lung Cancer Audit	Yes	100%
National Maternity and Perinatal Audit	Yes	2017/18: 0%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%
National Paediatric Diabetes Audit	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	Jan 2019 to Dec 2019 National Standard: 90% Case Ascertainment [Abdominal Aortic Aneurysm]: 80%

National Audit UHB eligible to participate in	UHB participation 2021/2022	Percentage of required cases submitted
Neurosurgical National Audit Programme	Yes	100%
Respiratory Audits	Yes	National Outpatient Management of Pulmonary Embolism – Data collection: 100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	QEH – 90%+ BHH – 90%+ GHH - 90%+ SHH – Too few to report
Serious Hazards of Transfusion Scheme (SHOT)	Yes	100%
Society for Acute Medicine Benchmarking Audit	Yes	100%
Trauma Audit and Research Network	Yes	100%+
Cystic Fibrosis Registry	Yes	100%
Urology Audits	Yes	1. Cytoreductive Radical Nephrectomy Audit – 100% 2. Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit) – 100%

National Confidential Enquiries (NCEPOD)

National Confidential Enquiry (NCEPOD)	UHB participation 2021/2022	Percentage of required number of cases submitted
Epilepsy	Yes	100%
Transition	Yes	100%
Crohn's	Yes	100%

Percentages given are the latest available figures.

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 974 clinical audits were registered with UHB's clinical audit team during 2021/22. Of these audits, 328 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

This year has seen the research portfolio at its recovery stage; teams have been working with Sponsors and Trust service support departments to ensure research activity can be delivered. They have looked at strategically planning their future research portfolio, as well as ensuing the on-going care and follow up of their research patients.

There is still a COVID research portfolio; this is alongside the wider speciality research portfolio. The Total number of UHB patients recruited into all studies open, (including Covid-19 and non-Covid-19 studies) at the Trust during 2021/22 was:

NIHR Portfolio Recruitment	10, 287
Non-NIHR Portfolio Recruitment	893
Total Patient Recruitment	**11, 180**

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

The CQUIN policy was suspended from Quarter 4 of 2019/20 onwards as a result of the pandemic. No CQUIN schemes were agreed and no payment was received specifically in relation to CQUIN.

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 currently has no conditions on the registration status.

The Care Quality Commission has not taken enforcement action against UHB during 2021/22.

UHB has not participated in any special reviews or investigations by the CQC during 2021/22.

No visits were conducted by Birmingham and Solihull Clinical Commissioning Group during 2021/22.

CQC Inspection Ratings Grids

Throughout June 2021, the CQC undertook a number of inspections across services at University Hospitals Birmingham. These inspections covered a variety of core services and across all hospital sites, as follows:

- Urgent and Emergency Care Core Services at Heartlands Hospital, Good Hope Hospital and Queen Elizabeth Hospital
- Medical Services at Good Hope Hospital
- Cancer Services at Queen Elizabeth Hospital
- Surgical Services at Queen Elizabeth Hospital
- Well Led (Trust-wide review of leadership, governance, management and culture)

The final report confirms the following ratings have been given to the Trust for the services inspected:

Overall Trust Rating

	Safe	Effective	Caring	Responsive	Well-led	Overall
Trust Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Ratings for Core services by Site

QEHB

Core service	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Cancer Services	Good	Good	Good	Requires Improvement	Good	Good
Surgery	Requires Improvement	Good	Not inspected	Not inspected	Good	Good
Overall	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

BHH

Core service	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Inadequate	Good	Requires Improvement	Inadequate	Requires Improvement	Inadequate
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

GHH

Core service	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Urgent & Emergency Care	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

2.2.6 Information on the quality of data

Secondary Uses Service data
UHB submitted records during 2021/22 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS Number was:
- 99.02% for admitted patient care
- 99.02% for outpatient care
- 98.7% for accident and emergency care

Which included the patient's valid General Medical Practice Code was:
- 100% for admitted patient care
- 99.06% for outpatient care
- 99.6% for accident and emergency care

(All Apr 21- Mar 22).

Data Security & Protection Toolkit (formerly Information Governance Assessment Report)
The Data Security and Protection Toolkit (DSPT) for 2020/21 was submitted in June 2021. The Trust achieved status 'Approaching Standards'.

The baseline for the DSPT 2021/22 was submitted in February 2022 and The Trust is in the process of completing the Toolkit by 30 June 2022. Owing to annual changes in mandatory requirements, the Trust expects to submit at a level which requires some further work by the Trust to demonstrate good progress being made to comply with all requirements. An outcome of internal audit by KPMG was due to be presented to the Audit Committee at the end of April.

Payment by Results clinical coding audit
UHB was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

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

Actions to improve data quality
- A Data Quality Issues Log group was established in November 2021. There are TOR for this group and the chair is the head of health informatics. This group report in to the IGG quarterly. The DQIG are responsible for monitoring and recording data quality issues identified in the Organisation and for ensuring action plans are in place to address issues identified. The DQIG have established processes for DQ issues to be raised within the Organisation.
- The DQIG review the issues and prioritise them on the DQ issues log which is held on the Health Informatics compliance share point site The compliance team hold action plans for DQ issues and manage progress against these action plans
- Quality monitoring checks are in place for inpatient records and ward clerk team leaders across the QEH site validate circa 7,000 records per month. Compliance is checked against 13 indicators to assess the quality of the information on our PAS systems in relation to inpatients. Plans are in place to roll these checks out to the other hospital sites
- The Health Informatics Compliance Team check NHS digital DQMI (Data Quality Maturity Index) and SUS dashboards once per month to identify any areas of concern. Any issues identified are flagged to DQMI and action plans put in place to address.
- The Clinical Coding team carry out the DSPT required audit annually. This is an audit of 200 FCES and is carried out by the Trusts internal clinical coding auditor.
- A programme of continuous improvement audits on Clinical Coding is in place and monthly audits take place.
- The Trusts internal Clinical Coding trainer delivers the following training: Coding Standards, Refresher and Exam Revision using NHS digital approved material. Classification Updates, Adhoc issues that arise from validation and audit.
- Clinical Coding reports are in place to ensure quality of coding is maintained and continually approved - examples include HED Report, MHA, SHMI, Palliative Care and the Sepsis Dash Board.
- The Trusts Data Quality policy is in place and was reviewed in February 2022 to ensure the DQIG processes are reflected and that we continue

to 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

UHB has been an 'early adopter' of the Medical Examiner role. UHB currently has a team of Medical Examiners who 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.

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 (CQMG) where a decision will be made on whether further review or investigation is required.

1.	During 2021/22 5617 UHB patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: › 1214 in the first quarter; › 1358 in the second quarter; › 1585 in the third quarter; › 1460 in the fourth quarter.
2.	Up to 7th April 2022, 4677 case record reviews and 55 investigations have been carried out in relation to 5617 of the deaths included in item 1. In some 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: › 974 in the first quarter; › 1164 in the second quarter; › 1279 in the third quarter; › 1260 in the fourth quarter.
3.	Twenty seven deaths, representing 0.5% 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: › 7 representing 0.6% for the first quarter; › 7 representing 0.5% for the second quarter; › 8 representing 0.5% for the third quarter; › 5 representing 0.3% 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: › Speciality to ensure that discharge documentation is completed for every patient and share all relevant information including any outstanding referral to a specialist service on discharge › Review the process for externally referred cases that require referral to MDT but no immediate clinical action › Encourage consistent use of prescription notes on the electronic prescription system (PICS) when prescribing antimicrobials › Ensure Hand Hygiene data collection is concordant with WHO standards › Ensure staff check venous access devices eight hourly and when accessing lines. › Disseminate knowledge of a rare condition through grand round presentation (cross-site) and governance newsletters
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.	No case record reviews and 14 investigations completed after 1st April 2021 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.	No patient deaths during 2020/21 were subsequently reviewed and judged to be more likely than not to have been due to problems in the care provided to the patient.

3 Part 3: Other information

3.1 Overview of quality of care provided during 2021/22

The tables below show the Trust's latest performance for 2021/22 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 2020/21 Quality Account 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	2019/20	2020/21	2021/22	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)	**1.39**	**0.28**	**1.01** (Apr-21 to Feb-22)	**0.73** 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)	**1.31**	**0.29**	**1.06** (Apr-21 to Feb-22)	**0.87** Acute trusts in West Midlands
2a. Patients with C. difficile 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)	**17.59**	**21.10**	**21.71** (Apr-21 to Feb-22)	**18.74** 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)	**16.66**	**22.01**	**22.65** (Apr-21 to Feb-22)	**22.36** Acute trusts in West Midlands
3a. Patient safety incidents Reporting rate per 1000 bed days › Higher rate indicates better reporting	› Trust MRSA data reported to PHE, › HES data (bed days)	**58.1**	**70.2**	**72.1**	**58.4** Apr-20 – Mar-21 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), › Bed days data	**9**	**12**	**4**	Not available
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	› Datix › (incident data)	**84.24%**	**80.94%**	**78.95%**	**72.7%** Apr-20 – Mar-21 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
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)	**0.40%**	**0.47%**	**0.41%**	**0.44%** Apr-20 – Mar-21 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Indicator	Data source	2019/20	2020/21	2021/22	Peer Group Average (where available)
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	› Datix › (patient safety incidents reported to the NRLS)	**44,275**	**35,754**	**49,198**	**12,502** Apr-20 – Mar-21 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Clinical Effectiveness Indicators

Indicator	Data source	2019/20	2020/21	2021/22	Peer Group Average (where available)
5a. Emergency readmissions within 28 days (%) Elective and emergency admissions aged >17 › Lower % indicates better performance	› HED data	**13.29%**	**0.28**	**15.08** (Apr-21 to Feb-22)	**13.69%** Apr-20 to Dec-20 University hospitals
5b. Emergency readmissions within 28 days (%) All specialties › Lower % indicates better performance	› HED data	**13.41%**	**14.04%**	**14.70** (Apr-21 to Feb-22)	**12.86%** Apr-20 to Dec-20 University hospitals

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:

- 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:

- This is based on incident date between 01 April 2021 and 31 March 2022 and reported to STEIS as per the published NHS Never Events data. The national data is based on the incident date during and reported to STEIS by a particular date.
- UHB had four Never Events during 2021/22 in the following categories: Overdose of insulin; Retained foreign object post procedure; Wrong implant / prosthesis; Blood product/ transfusion.

4c:

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

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

In the 2020 report, the authors stated "Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month".

Therefore, although results from 2018 and 2019 are included for information, it is not possible to say if there has been an improvement or decline.

Time period	2018		2019		2020	
Data source	Trust's Survey of Adult Inpatients 2018 Report, CQC		Trust's Survey of Adult Inpatients 2019 Report, CQC		Trust's Survey of Adult Inpatients 2020 Report, CQC	
Patient survey question	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	8.8	About the same	8.8	About the same	9.1	About the same
Involvement in decisions about care and treatment	7.2	About the same	7.1	About the same	7.1	About the same
Did staff do all they could to control pain	7.9	About the same	7.8	About the same	8.8	About the same
Cleanliness of room or ward	8.7	About the same	8.6	About the same	9.1	About the same
Overall rating of care	8.0	About the same	7.8	About the same	8.1	About the same
Response rate	30% (360 respondents) National: 45%		38% (464 respondents) National: 45%		38% (450 respondents) National: 46%	

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

Indicator	Target	Performance		
		2019/20	2020/21	2021/22
A&E: maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	67.3%	77.6%	57.0%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	82.8%	58.4%	42.8%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer1	85%	60.4%	42.6%	40.9%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	66.6%	69.6%	59.2%
Maximum 6-week wait for diagnostic procedures	99%	97.4%	60.6%	63.0%
Venous thromboembolism (VTE) risk assessment	95%	98.3%	97.8%	97.1%

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

"*C. difficile*: variance from plan" is no longer part of the NHS Improvement Single Oversight Framework

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.

Measure	Value	Data period
SHMI, calculated by UHB Informatics	101.05 - within tolerance	2021/22 (Apr-21 – Feb-22)
SHMI, from NHS Digital website	101.06 - within tolerance	2020/21 (Apr-20 – Jan-21)
HSMR, calculated by UHB Informatics	108.34 - outside tolerance	2021/22 (Apr-21 – Mar-22)

SHMI: Summary Hospital-level Mortality Indicator

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.

HSMR: Hospital Standardised Mortality Ratio

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.

[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.

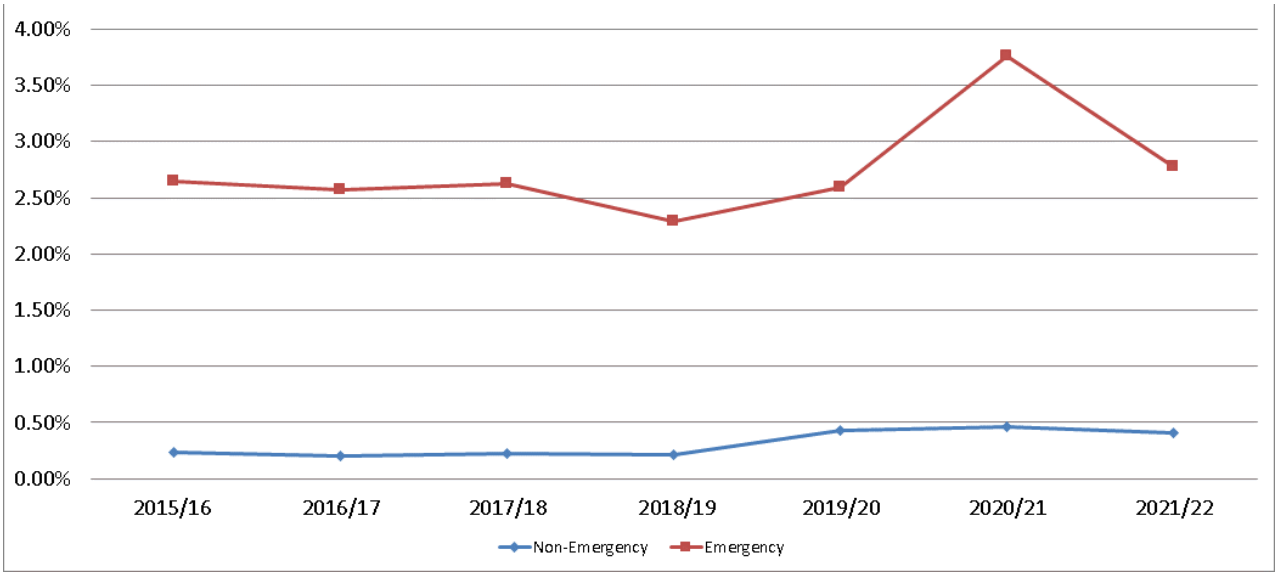
[3] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Crude Mortality

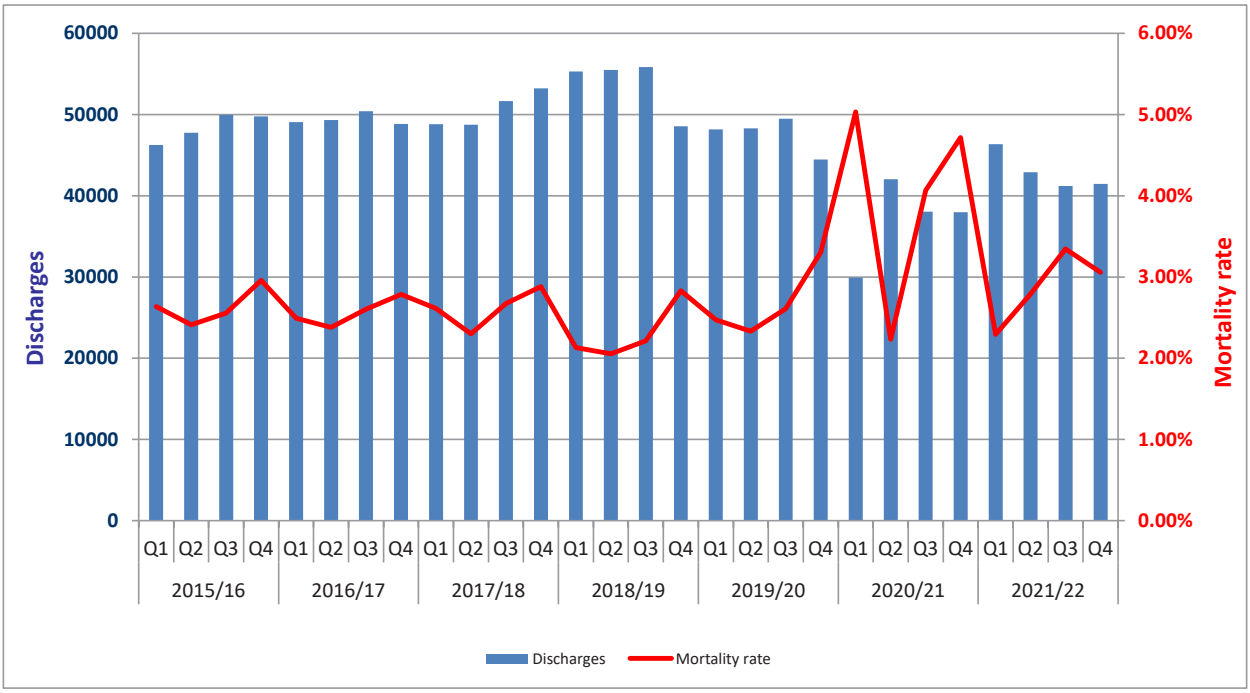
The first graph below shows crude mortality rates for emergency and non-emergency (planned) patients. The second graph shows the overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number 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 2021/22 is 2.78%, which has decreased when compared to 2020/21 (3.76%), but is a slight increase from 2019/20 (2.60%).

Emergency and Non-emergency Mortality Graph



Emergency Crude Mortality Graph



3.4 Statement regarding junior doctor rota

Guardian of Safe Working: Quarter 2 Report (2021/22)

Date period 01/11/21 - 31/01/22

It remains a requirement of the 2016 Junior Doctor contract for the Trust Guardian of Safe Working (GSW) to hold responsibility for ensuring that issues of compliance with safe working hours are addressed in accordance with the terms and conditions of the Junior Doctor contract - this includes 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 ERs submitted by junior doctors with an extended Annual Report to the Trust Board. Quarterly reports are presented through the Performance Report structure. A final Annual Report at the end of each academic year will be produced to coincide with major house change.

Summary of junior doctor exception reports in period

Junior Doctor Exception Reports (ERs) for Q2 period are summarised in table 1 below.

TABLE 1: Exception Reports Q2 combined (2021-2022)

	HGS	QEHB	Total
Hours	29	14	43
Education	5	6	11
Pattern of work	0	2	2
Service Support	6	12	18
Total ERs for period Q2 21/22	**40**	**34**	**74**

Immediate Safety Concerns (ISCs)

QEHB	BHH	GH/SOL	Other
11	4	0	0

ISCs were addressed on site by the junior doctors at the time of incidence and escalated accordingly - junior doctors have also been instructed to submit safety concerns via the standard Datix mechanism.

GSW Penalty Fines

When a junior doctor exception report is found to breach contractual hours, a Guardian of Safe Working (GSW) penalty fine applies for the period of time that leads to the 'breach'. The junior doctors are paid for the additional hours at the penalty rate set out in Annex A (TCS) and the GSW will levy a fine on the department employing the doctor for those additional hours worked at the rates also set out in Annex A. The 'fine' monies are distributed in agreement with the Guardian Exception Reporting Group. In Q2 there were 7 concluded occurrences of GSW divisional penalty fines as follows:

Rota code	Spec	Level	Breach	Penalty to Div £
BHH-015 Gen Surg F1	Urol	F1	Max 13 hrs	27.22
BHH-015 Gen Surg F1	Vasc	F1	Max 13 hrs	27.22
BHH-015 Gen Surg F1	Vasc	F1	Max 13 hrs	136.10
QEHB-037 Onc/Haem CT/F	Onc	F2	Max 13 hrs	125.98
QEHB-037 Onc/Haem CT/F	Onc	F2	Max 13 hrs	34.48
QEHB-038 Haem ST3+	Haem	ST5	5 hrs contin rest	472.30
QEHB-041 Onc ST3+	Onc	ST5	5 hrs contin rest	472.30
TOTAL				**£1,295.60**

Areas of significant trend/concern in period

Rota code	Key Concerns and work schedule reviews
BHH-015 Gen Surg F1	ERs against this rota appear to be related to the Covid "surge" period and the change of purpose on ward 4 to a medical Covid function. The ward has now reverted to vascular surgery - ERs will be monitored to see if there is improvement. The majority of ERs are linked to vascular. Deputy Guardian has asked for input from the Vascular CSL and rota lead.
BHH-030 O&G ST3	Steady flow of ERs against this rota however there remains concern that ER reporting system is underused. Concerns relating to the holding of multiple bleeps (due to low staffing) and lack of educational experience are thematic. O & G has been subject to a recent HEE review and improvement measures. Deputy Guardian will meet the junior doctors to discuss ER and potential positive benefits of consistent reporting.
GHH-004 Gen Med ST1/2/FY2	The frequency of ER has reduced recently. This may reflect discussions between GSW, JDMO and the service rota leads regarding appropriate distribution of JDs across the medical wards at GHH and improved understanding of the requirements and benefits of ER process amongst juniors and supervisors. Situation to be monitored through ER. The standard day template end-time is also under review.
QEHB037 Onc/Haem CT/F QEHB041 Oncology ST3+	Oncology at QEHB continues to report insufficient medical workforce for the intensity and number of ill inpatients. Further GSW fines have been incurred during this quarter. The CSL and educational leads have issued guidance on rest following busy StR non-resident overnight on call - this is being disseminated as an interim measure to improved rest. The StR rota is expected to move to resident shift from August 2022. Mr. Mike Hallissey and Ms Vicky Race are leading a workforce review within this priority area.

Guardian exception reporting review group (GERRG)

A virtual 'teams' meeting of the group took place on 15/02/2022 to cover the reports generated in Q2.

High level data

Doctors/dentists in training	Ref: Med Resourcing
Doctors/dentists in training on 2016 TCS	Ref: Med Resourcing
Time available in job plan for GSWs	GSW/Dep 3 PAs
Admin support provided to the GSWs	Manager 0.3 wte, B3 Admin 1.5 wte
Job-planned time for Ed. Supervisors	25 PAs per trainee within agreed job plans

GSW analysis/comments

The Omicron wave in December 2021/January 2022 saw significant medical staffing challenges due to staff sickness. Local solutions for cross cover were put in place and the situation has much improved as the Trust emerged from the peak of the wave. During this period, suspension of new requests for annual leave and pre-existing study leave also resulted in challenges to achieve leave prior to rotation, once the embargo was lifted at the end of January 2022. Individual grievances highlighted to the GSW were dealt with via Medical Workforce. There was a reduction in the number of ERs submitted at the QEHB site compared to the preceding quarter.

The use of the GSW penalty monies accrued to date is under consultation with doctors in training representatives. Catering and social gatherings were not thought to be compatible with current infection control policy. Proposals include the offer of travel or educational bursaries and food and beverage vouchers. The GSW will respond when feedback on the survey is concluded.

The Director of Medical Education has issued guidance on Self-Development time (SDT). These are likely to be clustered into 3 nominated days in a 4-month placement and will be more formally incorporated into rosters from August 2022 onwards. This has been communicated to the doctors in training and the relevant stakeholders.

Significant staffing pressures remain in Haematology and Oncology at the QEHB sites. The GSW is working with the CSL and educational leads within these two specialties to enable effective work schedule review. Mr Mike Hallissey and Ms Vicky Race are leading on urgent workforce review in these specialties as priority areas. A timeline is also being set out for the transition to resident shift patterns for the StR doctors.

Incorporating the requirements for GIM accreditation for IMT doctors into rotas is currently being scoped. This presents challenges for the specialty rotas, particularly at QEHB including the balance of exposure to GIM versus specialty training, out of hours rota cover and expansion of 'individualised' rotas (in place of multi doctor cyclical rotas) for doctors. The matter of agreeing balance of training requirements remains under discussion with HEE.

The Trust has commenced discussions to extend the Exception Reporting process to all other non-HEE doctors in training (junior and senior JSDs) to ensure access for all training grade doctors at the Trust.

Dr Jason Goh, Guardian of Safe Working

Dr David Sandler, Deputy Guardian of Safe Working

February 2022

3.5 Glossary of Terms

Term	Definition
A&E	Accident & Emergency, also known as the Emergency Department (ED)
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
BAUS	British Association of Urological Surgeons
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark / -ing	A method for comparing (e.g.) different hospitals
BHH	Birmingham Heartlands Hospital
Cannula	A tube that can be inserted into the body, often for the delivery or removal of fluid or for the gathering of samples
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
CEAG	Chief Executive's Advisory Group
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 aspects of clinical quality
CDRG	Clinical Dashboard Review Group – reviews ward performance against certain care indicators
Commissioners	See CCG
Concerto	Computer system showing patient details, hospital stays etc
COVID-19	A disease caused by a strain of Coronavirus, the cause of the current pandemic
CQC	Care Quality Commission: independent regulator of health and social care in England
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
Datix	Database used to record incident reporting data
Deloitte	The Trust's external auditor
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
DNAR	Do not Attempt Resuscitation
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
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
EOL	End of Life Care
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
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.
FTSU INDEX	Freedom To Speak Up Index

Term	Definition
GHH	Good Hope Hospital
GP	General Practitioner
GSW	Guardian of Safe Working
HCA	Health Care Assistants
HDU	High Dependency Unit
Healthwatch	An independent group who represent the interests of patients
HED	Healthcare Evaluation Data
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
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
JDMO	Junior Doctors Monitoring Office
KPI	Key performance indicator: a measurable value demonstrating how effectively targets are being met
KPMG	Trust Auditors
LOS	Length of Stay
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 for obtaining training courses and information
Mortality	A measure of the number of deaths compared to the number of admissions
MRSA	Meticillin-resistant staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
NBM	Nil by mouth
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
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 merged with NHS England
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System

Term	Definition
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
PAS	Oceano - Patient Administration System
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
PICS	Prescribing Information and Communication System
Pulmonary Embolism	Blocked blood vessel in your lungs.
QEHB / QE / QEH	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
R&D	Research & Development
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)
Sepsis	A potentially life-threatening condition resulting from a bacterial infection of the blood
SEWS	Standardised Early Warning System – similar to NEWS 2
SH / SHH / SOL	Solihull Hospital
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SOP	Standard Operating Procedure
STEIS	Strategic Executive Information System - used to report and monitor the progress of Serious Incident investigations across the NHS
TEAL	Treatment Escalation and Limitation
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
WHO	World Health Organisation

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

The Trust has shared its 2021/222 Quality Account with:

- Birmingham and Solihull Clinical Commissioning Group
- Birmingham Health & Social Care Overview and Scrutiny Committee
- Solihull Health & Social Care Overview and Scrutiny Committee <check name>
- Healthwatch Birmingham
- Healthwatch Solihull

These organisations have provided the statements below.

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

1.1 Birmingham and Solihull (BSol) Clinical Commissioning Group (CCG) as coordinating commissioner for University Hospitals Birmingham (UHB), welcomes the opportunity to provide this statement for inclusion in the Trust's 2021/22 Quality Account.

1.2 A draft copy of the Quality Account was received by the CCG on 19th May 2022 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.

1.3 The information provided within this account presents a detailed and balanced report of the healthcare services that UHB provides. The services detailed 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 the 2021/22 priorities whilst also working towards Quality Improvement issues highlighted in the most recent Care Quality Commission report (CQC). 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 2022/23.

1.4 At the time of completing this statement the CCG has not reviewed Part 1: Chief Executive's statement as in draft format and therefore unable to comment on this element of the account

1.5 The CCG recognises that the Trust continues to address review and harmonise its systems and processes across the four hospital sites.

1.6 The report describes the six quality priorities, including the addition of a new priority: "Using Real-Time Information to Improve Patient Care". It further confirms the discontinuation of the priority: "Improving Diabetes Management". This will now become business as usual. Five priorities from 2021/22 will continue into 2022/23.

1.7 The quality priorities for 2022/23 reflect areas where improvement is required and take into consideration areas for improvement that the Trust has recognised during the previous year. The CCG is supportive of the Trust's quality priorities for 2022/23. The Trust has identified six priorities for improvement. It has been difficult for the CCG to review a number of initiatives to be implemented during 2022/23 from this account, however the CCG continues to be include in the UHB Quality Improvement agenda within UHB via other forums.

1.8 Freedom to speak up continues into 2022/23 and has been a trust priority since 2019/20. The CCG is encouraged to see that regular discussions with Freedom to Speak Up Guardians and senior leaders are now embedded with regular reports to support any actions necessary.

1.9 The CCG is pleased to review that the Trust continue to exceed the national requirement of 95% of all patients having a VTE assessment and the trust-level compliance has been above 96% every month during 2021/22. It is noted that the rollout of PICS continues at Heartlands and Good Hope Hospitals with a go live aspiration of end of 2022. This will enable the trust to improve on the missed doses of enoxaparin. The CCG feels it is a positive step to have one system across all sites.

1.10 The CCG agrees that the priority of Improving ward rounds needed to remain as the trust continues with recovery programmes post Covid-19 pandemic. The CCG notes that the trust is a trial site for the national improving ward rounds project being led by the Emergency Care Improvement Support Team (ECIST) and feels this will aid current priorities within the trust.

1.11 The CCG is encouraged by the improvement projects that link into the priority Improving nutrition and hydration. It is a priority that will continue into 2022/23 as the trust feel that they have seen a number of serious cases that require the trust to raise the profile of nutrition and hydration. It is noted that the incident and

complaints data for the full 2021/22 year will be included in the final report and as such the CCG has not had the opportunity to review this data.

1.12 The CCG has worked closely with the trust on the priority of improving the safety of invasive procedures. We are satisfied that the trust has implemented a large number of Local Safety Standards for Invasive Procedures (LocSIPPs) and also the World Health Organisation (WHO) checklist. This continues to feed into the Quality improvement plans that the trust has in this area. It is again noted by the CCG that the initiatives to be implemented during 2022/23 will be include in the final report and a mid-year Quality Account update will be available to review.

1.13 The trust was inspected on a number of occasions throughout June 2021 and covered a number of core services across all hospital sites with a number of elements requiring improvement and areas which were rated inadequate. The CCG has engaged and offered support to the trust to implement and roll out improvement plans to address required actions. The CCG recognises the difficulties the trust has faced and continues to support.

1.14 As an organisation we, the CCG have worked closely with UHBFT over the course of 2021/22, meeting with the Trust regularly to review the organisation's 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 2022/23 and into the ICS in support of the best possible care and outcomes for patients and citizens whilst ensuring services are designed and delivered to meet the different needs of the different communities we serve.

Karen Helliwell
Interim Accountable Officer
Birmingham and Solihull CCG

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

On 19th May 2022, it was confirmed that Birmingham Health and Social Care O&S Committee will not be in a position to comment on the UHB Quality Report this year as, due to the all out local election, they do not have a constituted committee until ratified at City Council.

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

The Solihull Health and Adult Social Care Scrutiny Board welcome the opportunity to comment on the Quality Account for 2021-22 for University Hospital Birmingham (UHB) NHS Foundation Trust. The Board would like to put on record its sincere thanks to all UHB staff for all their hard work and commitment over the last 12 months. It is recognised the last year has been incredibly demanding, with the focus upon the restoration of services, whilst also coping with the ongoing impact of the pandemic. It is also recognised the next 12 months will continue to be extremely challenging.

The Board also welcomes that the introduction of the Trust's Prescribing Information and Communication System (PICS) has been a great success in ensuring accurate dispensing of prescribed drugs and promises a considerable performance improvement going forward.

In considering the report, the Board wishes to raise the following points:

- It is noted that multiple items within the report require update prior to publication.
- The Board also notes that, as part of the Freedom to Speak Up Index, UHB is performing below the national average for the questions posed in the NHS Staff Survey. Members recognise it is crucial for staff to have the confidence to raise any concerns and are also confident that any matters identified are addressed. The Board would welcome further information upon what measures UHB are undertaking to improve performance here.
- It is queried why electronic wristband identity checks before administration of medication for Solihull Hospital are notably lower when compared with the other Hospital sites.
- The Board raises its particular concerns that, as part of the Care Quality Commission (CQC) inspections, Birmingham Heartlands Hospital has received an overall rating of inadequate for its Urgent and Emergency Care service. It Board recognises it is essential this service is a critical area of focus for the Trust going forward, over the next 12 months. Again, the Board would

welcome further information upon the measures UHB are undertaking here, to ensure improved outcomes for patients.

Going forward, the Board welcomes the six priorities for improvement during 2021/22, as set out by the Trust.

Statement provided by Healthwatch Birmingham and Healthwatch Solihull (joint statement)

Healthwatch Birmingham and Healthwatch Solihull welcome the opportunity to provide our statement on the Quality Account for University Hospital Birmingham (UHB) NHS Foundation Trust for 2021/22. We are pleased to see that there is an open evaluation of the Trusts performance between 2021 and 2022. There is a clear identification of areas where the Trust has done well and areas where further improvements are needed. We acknowledge that Covid-19 continues to have a significant impact on the Trusts activities. Consequently, the Trust is facing significant backlogs that have impacted waiting times, with patients waiting longer to access care. We would have liked to see this as one of the priorities for 2022/23 as delayed care has an impact on patients' wellbeing and outcomes.

We are aware through our work with the Trust that plans are already being implemented to tackle waits which include increasing the capacity of the hospital sites and transforming the way care is delivered. The Quality Account presents an opportunity for the Trust to show the work being undertaken to improve the care of patients as this continues to be a concern. Indeed, the experiences we have heard point to concerns about waiting times following referral and cancer waiting times.

Having spent 17 months on a waiting list for urgent procedures without any notification of appointment nor indeed any acknowledgement whatsoever from the QE, despite numerous letters from my GP and my Consultant, I've been forced to spend nearly £4000 on private health care.

Very long waiting times for cancer treatment. Poor communication leading to more stress and anxiety.

The individual's daughter has Acute Lymphoblastic Leukaemia. There have been delays in treatment along the way. Took over six days to receive echo. Phone call wasn't answered when the caller tried to contact hospital for a delayed period of time. Hasn't received chemotherapy yet despite requiring it.

A referral was sent pre pandemic to Urologists. Another sent April 2021. My GP has escalated it 4 times. I received a letter to book. I couldn't. When I finally got through on the phone I was told it was a minimum 52 week wait. Due to the issues I have with my bowel & bladder I am now unable to leave my home & had to engage with the Bladder & Bowel community for help and advice. I am still waiting for an appointment.

However, we also note the excellent work the Trust has carried out during this period and the positive impact on patients. People have shared positive experiences of accessing varied services provided by the Trust.

Sheldon Unit looked after my partner during lockdown, diagnosed with funicular cancer, professionalism beyond reproach, kindness and understanding, explaining everything that was happening. Aftercare and genuine concern and consideration for both my partner and myself was both heart-warming and much appreciated in such difficult and challenging times.

I had surgery there, 3 days in ITU and 2 on a ward. Extremely caring staff no matter what their role. Caring, compassionate and very person centred. Hard working and committed. I could not fault the care I received, I felt confident I was in safe hands from start to finish.

Amazing staff who made us feel completely at ease during one of the most traumatic experiences in our lives when my eldest son nearly lost his life due to undiagnosed type one diabetes. Ever since leaving the hospital they have always been at the other end of the phone no matter what time of the day or night, they also make sure my son is the centre of every appointment and make sure he feels 100% involved in his care. The selection box they sent him at Christmas is just a small thing that meant so much to him. Dr and his whole team are amazing.

Very professional even though they were extremely busy. Made sure I was sent home with all tests clear.

I have been an in-patient for cancer surgery in 2016 and have been followed up regularly every 3-6 months since. At all times the service has been exemplary and I have had excellent care throughout.

Throughout the past year and two months of the pandemic, they have not failed to keep in touch by phone, and to do all they can to maintain my medication regime and their advice and support.

Healthwatch Birmingham agrees with the priority areas for the Trust for 2022/23. We recognise the potential impact these have for patient experience. We note the progress made in improving VTE

prevention. We are pleased that the Trust has exceeded the national requirement for 95% of patients having a VTE risk assessment during their admission. In addition, that Trust-level compliance has been above 96% every month during 2021/22.

We are pleased to see continued focus on the 'Freedom to speak up' priority. This is important as the NHS staff survey shows that the percentage of staff that feel safe to speak about their concerns (54%) and those believing that their concerns would be addressed (42%) is much lower than the national average. Staff have also indicated the challenges they face in contacting the speaking up service. We ask that as the Trust continues to monitor the Freedom to Speak Up priority in 2022/23, that there is further engagement with staff. In particular, collaborate with staff to develop solutions to address the challenges they face. For instance:

Delays – engage staff to understand what the underlying concerns are with delays (whether they understand the process – in terms of timelines, what can be done as they wait, what information do they need when they are waiting etc.)

Fear of detriment – we note that there is an email contact that is confidential for the Speak Up contacts. The Trust needs to understand if this is providing the confidentiality that staff are seeking. The Trust need to explore with staff what can be done to increase confidentiality and reduce the fear of detriment from contacting the Speak Up service.

In our response to the 2021/22 Quality Account, we noted that there was not much focus on the role of service users in decision-making, implementation, and evaluation of services. We asked to see the role of service user experiences, insight and experiences become more central and evidence of use of this and impact, much better presented in the Quality Account. We note that two focus groups took place with staff as part of the 'communication' quality improvement project that the Trust has been focusing on in addition to the main priorities. The aim was to hear suggestions of how to communicate with patients, relatives, and carers. Although staff perspectives are important, it would be more useful if this was complemented by insight from patients, carers, and relatives. The Trust should consider holding similar engagement with patients.

CQC Rating

Although, we appreciate the massive pressure Covid-19 pandemic has put on the Trust over the past few years, we are concerned that the Trust's overall CQC rating has been downgraded from 'good' to 'requires improvement'. It is worrying that the 'safe domain' still remains 'requires improvement' alongside the 'responsive domain'. Healthwatch Birmingham and Healthwatch Solihull will continue to support the Trust in implementing actions to make improvements in these areas. To reiterate what the Chair of Healthwatch Birmingham and Healthwatch Solihull said when the CQC report was published "so many people across Birmingham, Solihull and beyond owe their lives to the care and expertise of people working across UHB's four hospitals. The trust should take pride in what they do, but this CQC report must also be a wake-up call for trust leaders to improve specific areas of care and to address the other concerns that it contains."

Patient Experience Indicators

We note that similar to the Quality Account report of 2020/21, apart from the VTE risk assessment indicator, the Trust is way below meeting the target in the other five indicators reported in the 2021/22 Quality Account report (p51). We note particularly the 18 weeks waiting time from referral to treatment performance is now at 42.9% (58.4% in 2020/21) against a target of 92%; All cancers maximum 62 day wait from urgent GP referral is at 40.7% (42.6% in 2020/21) against a target of 85%; All cancers maximum 62 day wait for first treatment is at 59.5% (69.6% in 2020/21) against a target of 90%. Whilst we still appreciate the impact that the COVID-19 pandemic has had on these numbers, it is worrying that the performance indicators for these areas continues to decrease. We also note that for A & E waiting times (4 hour from arrival to admission/transfer or discharge) performance is at 57% against a target of 95%, and performance for the maximum 6 week waiting time for diagnostic procedure is at 63.6% against a target of 99%.

As we indicated in our response to the 2020/21 Quality Account, this performance is of great concern to Healthwatch Birmingham and Healthwatch Solihull, especially considering the impact on outcomes and quality of life of patients. We will continue to work with the Trust and monitor the Trust's action plans implemented to make improvements. We will continue to share with the Trust feedback we receive from service users, carers, and the public on the Trust's services to inform improvements.

Andy Cave
CEO, Healthwatch Birmingham

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

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 Accounts (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 Account.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the content of the Quality Account meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for Quality Accounts 2019/20
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2021 to May 2022
  - papers relating to Quality Account to the board over the period April 2021 to May 2022
  - feedback from the commissioners dated 06/06/2022
  - feedback from governors dated 26/05/22
  - feedback from local Healthwatch organisations dated 14/06/22
  - feedback from Overview and Scrutiny Committee dated 14/06/22 (Solihull) and 19/05/2022 (Birmingham)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, due to be published mid-2022
  - the 2020 national patient survey 19/10/2021
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 11/06/2021
  - CQC inspection report dated October 2021
- the Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Account 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 Account.

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

By order of the board

Date: 27 June 2022 Signed .....Chair

Date: 27 June 2022 Signed.....Chief Executive

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

NHS England and NHS Improvement has advised that trusts' external auditors are not required to provide assurance on the 2021/22 Quality Accounts.