NHS

University Hospitals Birmingham

NHS Foundation Trust

Quality Report 2020/21

This annual report covers the period 1 April 2020 to 31 March 2021

2020/21 Quality Report

Contents

1 Chief Executive's Statement

At UHB, as with the wider NHS, 2020/21 was dominated by the Covid-19 pandemic. During the peak of the response, many activities had to be paused – primarily appointments and operations for many patients, but also some of the work in the background to measure and improve the quality of care. During the Covid-19 peaks of Spring 2020 and Winter 2020/21, staff from all disciplines supported ITU, wards, the vaccine programme and other key areas.

Despite the Covid-19 pandemic, maintaining high quality patient care through effective day-to-day operational and financial performance across our hospitals and services remained a key strategic priority during 2020/21. 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 2020/21. 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 seven quality improvement priorities set out for 2020/21 in the 2019/20 Quality Report has been mixed. The seven priorities were:

Priority 1: Reducing grade 2 pressure ulcers
Priority 2: Timely and complete observations including pain assessment
Priority 3: Reducing missed doses
Priority 4: Reducing harm from falls
Priority 5: Timely treatment for sepsis
Priority 6: Timely Medical Review
Priority 7: Freedom to Speak Up

The Board of Directors has chosen to refresh these priorities, and has selected a number of Quality Improvement Projects. One of the 2020/21 priorities (Freedom to Speak Up) will continue, and five new priorities are being introduced:

- Improving VTE prevention
- Improving ward rounds
- Improving diabetes management
- Improving nutrition and hydration
- Improving the safety of invasive procedures

Data for the discontinued Priorities is still collected, monitored and reported internally at the relevant Trust groups, for example the Chief Nurse's Care Quality Group.

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, it is chaired by a Deputy Divisional Director of Nursing 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 2020/21 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 Quality Reports.

As with 2020/21, 2021/22 will be another challenging year for UHB as we work towards achieving the ambitious priorities set out above in the context of the continuing Covid-19 pandemic. The Trust will continue working with health and social care providers, commissioners, regulators and other organisations to implement improved models of care delivery and further improvements to quality during 2021/22.

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

Dr David Rosser, Chief Executive
24 June 2021

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

2.1 Priorities for Improvement

The Trust's 2019/20 Quality Report set out seven priorities for improvement during 2020/21 (see table below).

Performance has been mixed for the priorities and across the different Trust sites during 2020/21.

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

The Board of Directors has chosen to continue with one of these overall priorities for improvement in 2021/22 and to introduce five new priorities:

2020/21	2021/22	Title of Priority	Notes
1	-	Reducing pressure ulcers	Discontinued
2	-	Timely and complete observations including pain assessment	Discontinued
3	-	Reducing missed doses	Discontinued
4	-	Reducing harm from falls	Discontinued
5	-	Timely treatment for sepsis	Discontinued
6	-	Timely Medical Review	Discontinued; will form part of new priority 3 for 2021/22
7	1	Freedom to Speak Up	To continue
-	2	Improving VTE prevention	New
-	3	Improving ward rounds	New
-	4	Improving diabetes management	New
-	5	Improving nutrition and hydration	New
-	6	Improving the safety of invasive procedures	New

The improvement priorities for 2020/21 were discussed and confirmed by the Trust's Clinical Quality Monitoring Group chaired by the Chief Medical Officer, following consideration of performance in relation to patient safety, patient experience and effectiveness of care.

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

Group	Key members
Joint Clinical Quality Assurance Group	Chief Medical Officer, Chief Nurse, Deputy Medical Officer, Deputy Chief Nurse, Head of Clinical Governance and Patient Safety, Chief Operating Officer, Deputy Director of Patient Experience, Director of Strategy and Quality Development
Care Quality Group	Trust Director of Nursing, Divisional Directors of Nursing, Matrons, Senior Managers with responsibility for Patient Experience, and Patient Governors
Council of Governors	Chair, Non-Executive Directors, Governors, Chief Executive, Directors and Senior Managers

The performance for 2020/21 and the rationale for any changes to the priorities are provided in detail below. It might be useful to read this report alongside the Trust's Quality Report for 2019/20.

Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

Background

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

They are categorised from 1 to 4 depending on their severity, 4 being the most severe. A new categorisation tool came into use from 2019:

Category	Description
1	Intact skin with non-blanching erythema (redness) of a localised area, usually over a bony prominence.
2	Partial-thickness loss of skin with exposed dermis.
3	Full thickness loss of skin.
4	Full thickness tissue loss with exposed tendon, muscle, bone or palpable bone.
Unstageable (depth un-known)	Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough or necrosis.
Deep Tissue Injury (DTI) (depth un-known)	Purple or maroon area of localised discoloured intact skin or blood-filled blister.

Improvement priority for 2020/21

At UHB, pressure ulcers are split into two groups: those caused by pressure from a medical device and those from pressure over a bony prominence. For 2020/21, the Trust is aiming to reduce the number of patients who develop category 2, device-related pressure ulcers.

Performance - Number of hospital-acquired device-related category 2 pressure ulcers

Quarter	Number
Q1	61
Q2	45
Q3	63
Q4	98
Total	**267**

The Trust had set a 5% reduction target for 2020/21 which equates to no more than 192 patients with category 2, device-related, pressure ulcers.

During the 1st and 2nd waves of the Covid-19 pandemic the recommended treatment for many ventilated patients was to nurse them in a proned position. Proning involves turning patients in a controlled manner onto their fronts to enable lung capacity to be released. When placing a patient into the prone position the risk of developing pressure ulcers to the front of the face and body, where risk is normally low, is significantly increased. These patients suffered from facial oedema and where often kept proned for weeks or even months at a time. These patients also had essential medical devices in situ, therefore the development of some pressure damage was inevitable and as a result the number of trust acquired device related pressure ulcers increased.

Initiatives carried out during 2020/21

- During 2020/21 the Tissue Viability (TV) Team continued to provide clinical advice and support for patients, staff and carers.
- Continued to align tissue viability practices and services across all hospital sites.
- Launched the MOVED resource pack as part of the National Stop the Pressure Day.
- Supported Divisions with RCA completion, complaints and Preventing Harms meetings, education as Covid restrictions allowed.
- During the second wave the TV Team were redeployed to support clinical areas and Critical Care.
- A poster was devised to promote standardised pressure ulcer prevention strategies in the proned patient and hands on/face to face education was delivered to the reservist workforce on critical care

- Formal educational activities were put on hold but alternative ways of delivery have been explored i.e. Moodle.
- The pressure ulcer steering group was put on hold during Covid.

Initiatives planned for 2021/22

- Carry out a service review in order to provide an equitable TV service across the organisation.
- Align policies/guidelines/documentation and practices
- Complete education packages on Moodle
- Redefine the Divisional offering/support
- Recommence the Pressure Ulcer Steering Group
- Carry out a Trust wide audit on foam mattresses and support equipment replacement programmes
- Standardise the Wound Product Formulary
- Review the pressure ulcer validation process to ensure consistent and accurate information is available to be used in relevant forums and reports.

How progress will be monitored, measured and reported

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

Priority 2: Timely and complete observations including pain assessment

Background – QEHB

At QEHB, all inpatient wards have been recording patient observations (temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness) electronically since 2011. The observations are recorded within the Prescribing Information and Communication System (PICS). In November 2020, Solihull Hospital also started using PICS.

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

The indicator looks for completeness of observation sets to within 6 hours of admission or transfer to a ward and also includes a pain assessment.

Performance – QEHB (plus Solihull from late November 2020)

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

None of the four quarters in 2020/21 met the 95% target, although performance for the first three quarters was within 1%.

Target	95%
Performance Q1	94.1%
Performance Q2	94.3%
Performance Q3	94.3%
Performance Q4	92.9%
2020/21	93.9%

Background – Heartlands, Good Hope and Solihull Hospitals

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

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

Although PICS was rolled out at Solihull Hospital in November 2020, the wards continued to complete the relevant nursing metrics audits in November and December 2020 for that period so their data is also included here. There is no data for Solihull Hospital for January – March 2021.

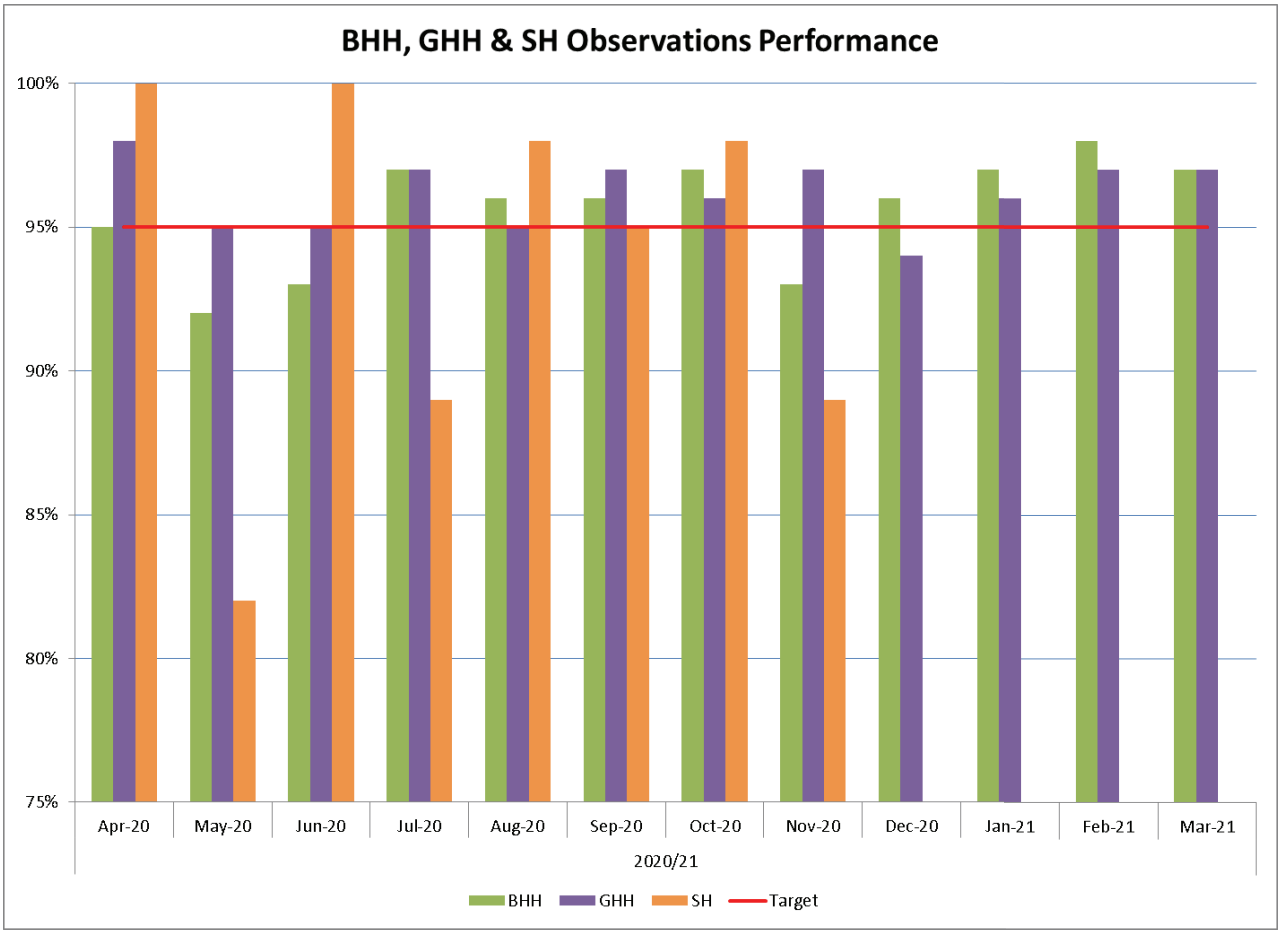
Performance – Heartlands, Good Hope and Solihull Hospitals

Observations

The target is 95%:

- Heartlands (BHH) – met the target for 9 of the 12 months.
- Good Hope (GHH) – met the target for 11 of the 12 months
- Solihull (SH) – met the target for 5 of the 8 applicable months – from Dec-20 PICS was in place and data was fed into the same system as the QEHB data (see above).

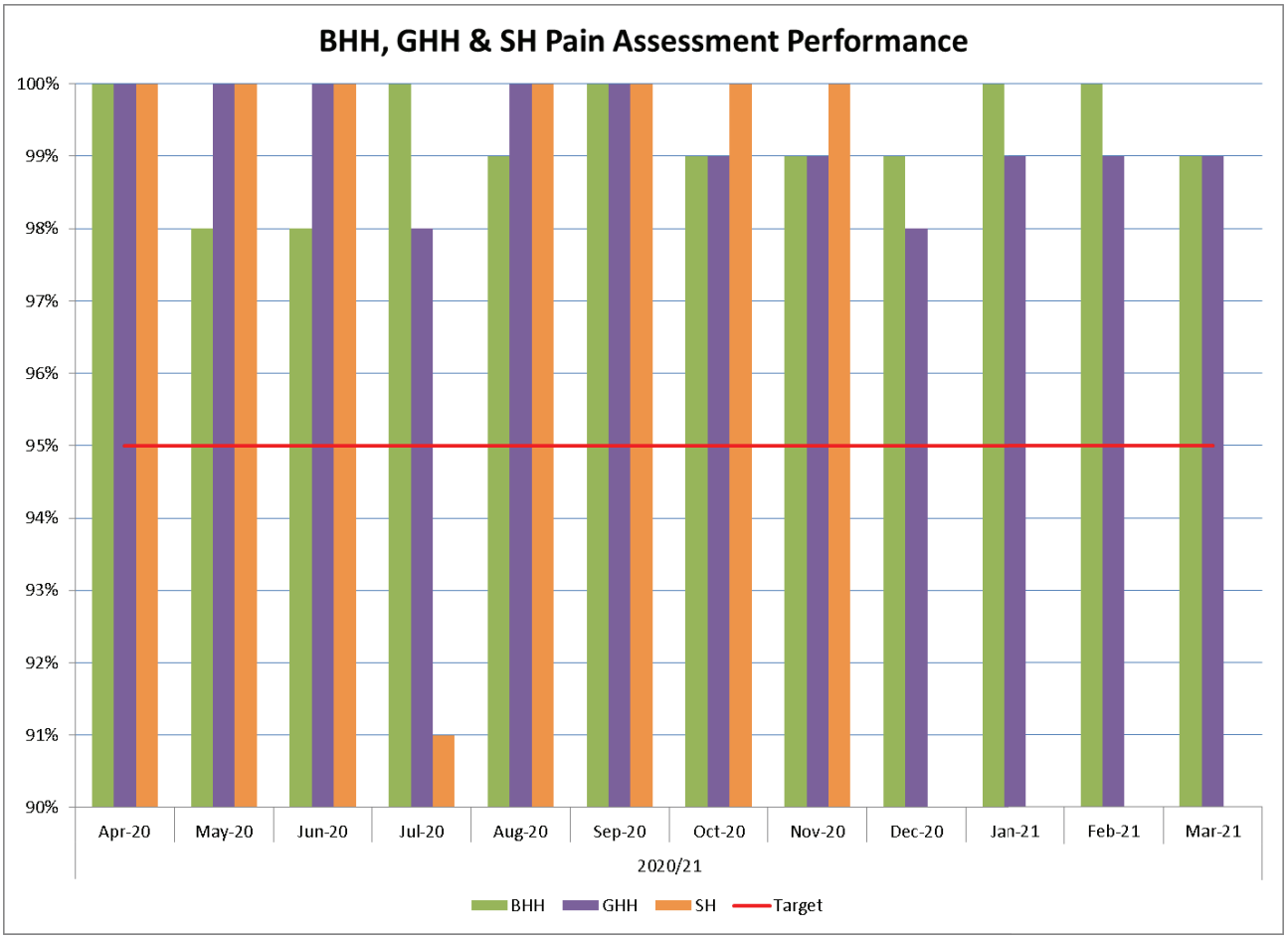
Performance is displayed in the graph below.



Pain assessment
The score is a composite score drawn from a number of questions in the monthly Nursing Metrics, and the target is 95%:

- Heartlands (BHH) and Good Hope (GHH) both met the target for all 12 months.
- Solihull (SH) – met the target for 7 of the 8 applicable months – from Dec-20 PICS was in place and data was fed into the same system as the QEHB data (see above).

Performance is displayed in the graph below.



Initiatives implemented in 2020/21

- Wards' performance is monitored at a divisional and Trust level. The Clinical Dashboard Review Group was established during 2019 – each month wards are selected based on their performance against certain indicators, including observations indicators.
- Wards complete a document that helps them review the causes of any misses, and breaks them down into issues they can resolve themselves, and those that are out of their control.
- For the issues they can resolve, they explain what they have already done, and what they plan to do.
- Examples of actions taken by individual wards at local level include:
  - Pain scores and clinical observations omissions discussed at handover from each shift.
  - Ensuring all bank staff are aware of trust expectations regarding patient admission.
  - PICS used during safety huddles and handovers to promote competency of the system.
  - Reminding staff of the correct order of actions on PICS when admitting a patient to their ward.

Initiatives to be implemented in 2021/22

- The refresh of the Clinical Dashboard continues, with associated indicators being reviewed and updated where required
- Continue to roll out PICS at Good Hope and the remaining Heartlands wards; indicators can then be drawn from the available data.

How progress will be monitored, measured and reported

- Wards performing below target will continue to be reviewed at the Clinical Dashboard Review Group (CDRG) meetings to identify where improvements can be made.
- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and Nursing Metrics. The Clinical Dashboard allows staff to compare their ward performance to the Trust as a whole, as well as seeing detailed data about which of the six observations or pain assessment were missed.
- Performance will continue to be measured using PICS data from the electronic observation charts, and data from the Nursing Metrics.

Priority 3: Reducing missed doses

Background

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

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

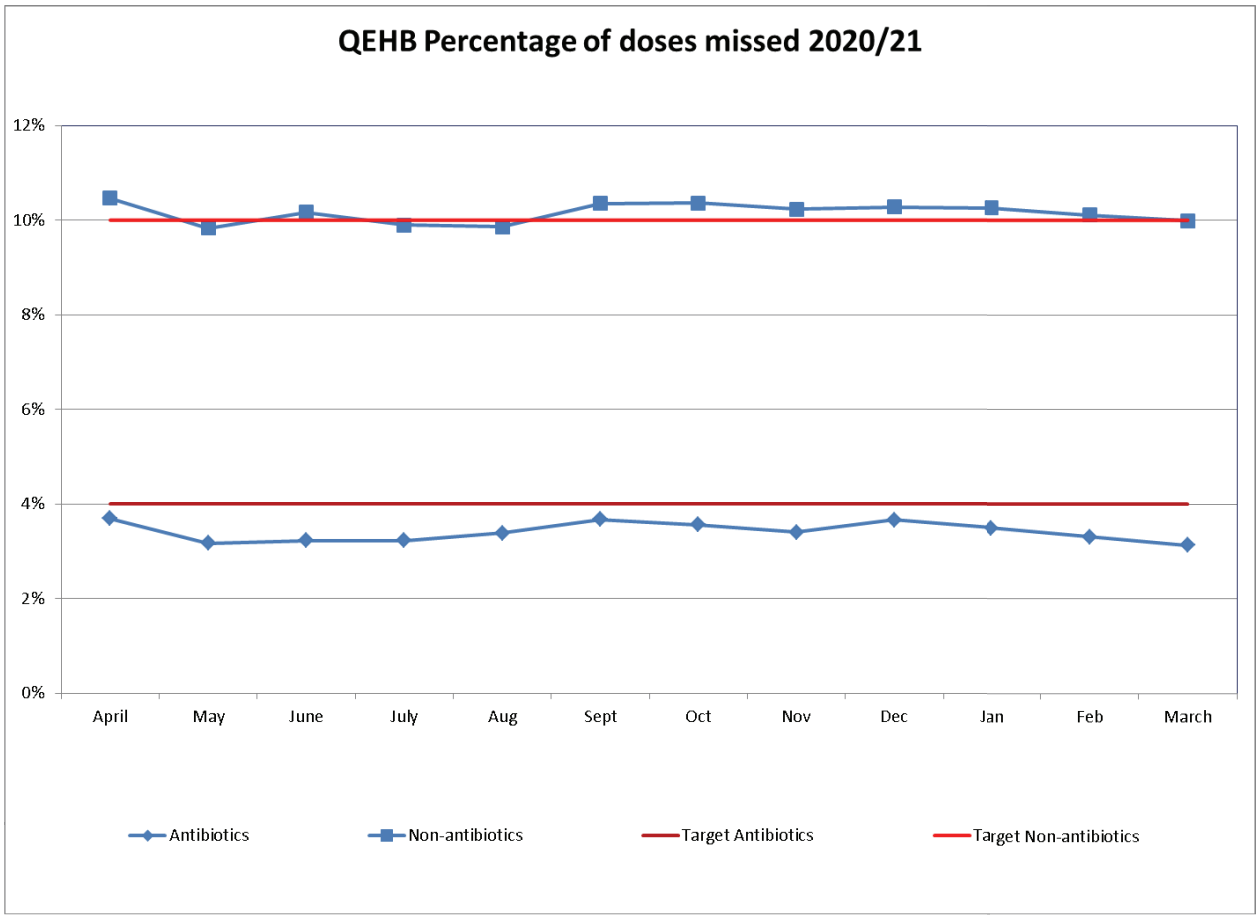
PICS was rolled out to the Solihull wards in November 2020.

Performance – QEHB (and Solihull from November 2020)

Solihull Hospital wards started using PICS in November 2020, so data for November 2020 to March 2021 also includes Solihull wards.

Antibiotics: in 2020/21 QEHB achieved 3.4% against a target of 4.0% or lower and also met the target every quarter.

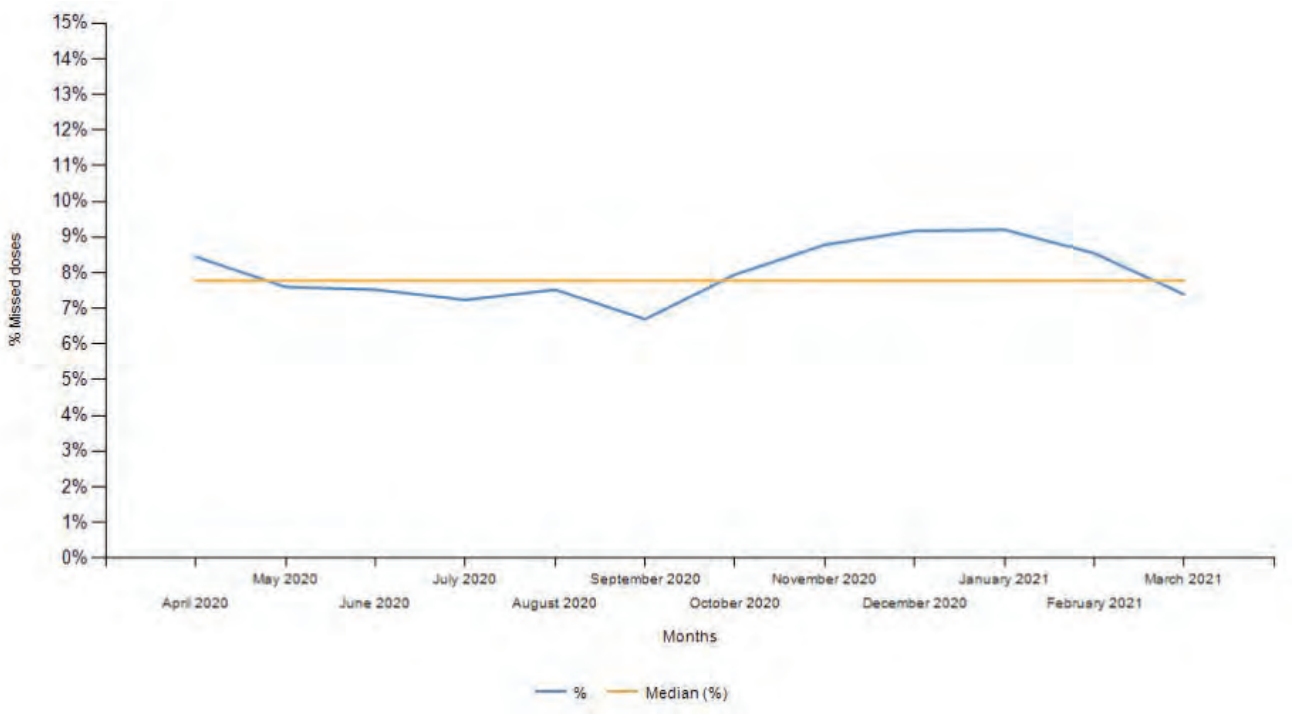
Non-antibiotics: in 2020/21 QEHB achieved 10.15% against a target of 10.0% or lower, all four quarters were slightly above the target.



	Antibiotics	Non-antibiotics
Target	**4% or lower**	**10% or lower**
Performance 2017/18	4.5%	11.3%
Performance 2018/19	3.9%	10.5%
Performance 2019/20	3.5%	10.0%
Performance 2020/21	3.4%	10.2%

Performance (Heartlands, Good Hope and Solihull Hospitals)
For Heartlands, Good Hope and Solihull Hospitals, the Trust chose to measure the percentage of missed doses of regular antibiotics. Performance was steady at around 7-9% for 2020/21.

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



Initiatives implemented during 2020/21

- Wards' performance is monitored at a divisional and Trust level. The Clinical Dashboard Review Group was established during 2019 – each month wards are selected based on their performance against certain indicators, including indicators that look at the rate of missed doses.
- Wards complete a document that helps them review the reasons behind missed doses, and breaks them down into issues they can resolve themselves, and those that are out of their control.
- For the issues they can resolve, they explain what they have already done and what they plan to do.
- Examples of actions taken by individual wards at local level include:
  - A training program has been put it place for staff to become more familiar with using stock checker to borrow from other wards.
  - One ward have piloted having their own pharmacy technician.
  - Increase in staff training and competency for cannulation, reducing delays in waiting cannulas to be inserted and therefore delays in administering IV medication.
  - Working with doctors to edit, pause or end prescriptions, or to prescribe alternative routes, where needed.
  - Encouraging staff to do a walk-around handover with PICS, to highlight anything that needs doing e.g. picking up medicines for out of stock doses.

Initiatives to be implemented in 2021/22

- The refresh of the Clinical Dashboard continues, with associated indicators being reviewed and updated where required
- Continue to roll out PICS at Good Hope and the remaining Heartlands wards; indicators can then be drawn from the available data.

How progress will be monitored, measured and reported

- Wards performing below target will continue to be reviewed at the Clinical Dashboard Review Group (CDRG) meetings to identify where improvements can be made.
- Progress will be monitored at ward, specialty and Trust levels through the Clinical Dashboard and Nursing Metrics. The Clinical Dashboard allows staff to compare their ward performance to the Trust as a whole, as well as seeing detailed data about which medications have been missed and the reasons provided.
- Performance will continue to be measured using PICS data from the electronic drug charts, and data from the Nursing Metrics.

Priority 4 – Reducing harm from falls

Background

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital are the most common reported patient safety incident, with more than 247,000 reported in acute hospitals and Mental Health trusts in England alone every year (NHS Improvement). About 30% of people 65 years of age or older have a fall each year, this increases to 50% in people 80 years of age or older (NICE).

Falls prevention

All inpatients, regardless of age, should undergo a Falls Risk Assessment on admission/transfer to a ward; this is repeated every 7 days or and more frequently if their clinical condition changes. If a patient is found to be at an increased risk of falls, staff will identify the risk factors and the precautions that can be taken to reduce these risks. These may include a medication review by pharmacy staff, provision of non-slip socks, ensuring chairs are the correct height and width for the patient, or moving the patient to a height-adjustable bed and/or more visible bed space.

Changes to Improvement Priority for 2020/21

The Trust chose to measure the number of patient falls per 1000 occupied bed days (OBDs), as this takes account of the levels of activity across the Trust. In 2019/20, there were 5.59 patient falls per 1000 OBDs at UHB.

The impact of the COVID-19 pandemic

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

During the pandemic we have seen a significant increase in deconditioning leading to falls as a result of:

- A reduction in falls related services that people would otherwise access. For instance; falls clinics, physiotherapy and occupational therapy assessment including accessing strength and balance sessions (inpatient and community).
- National isolation and social distancing guidelines causing a reduction in social and physical activity amongst the general population, especially older adults considered to be most vulnerable.
- Increased frailty and worsening of chronic conditions in patients who have not been able to, or who have been reluctant to, seek advice/ support for their condition.

We have also experienced staffing challenges with ensuring adequate and consistent levels of supervision within inpatient areas where the number of patients with cognitive impairment who are at an increased risk of falling have increased, at the same time as staff sickness and shielding. In addition we have experienced an increase in sudden collapse caused by Covid-19 associated complications (hypoxia, pulmonary embolism and drop in blood pressure – postural hypotension).

As a result, falls rates have increased since the start of the pandemic and remain higher than pre-Covid levels. This is in line with national reporting of falls rates during COVID-19.

Performance

Data was to be collected and monitored during 2020/21 and made available at ward and Trust level. The plan was to consider a reduction target once at least three months of settled performance data was available. However this did not happen and it is currently not possible to say when this can take place as the recovery is still in the early stages and there is still the possibility of further waves of Covid-19.

Inpatient Falls: Falls Rate per 1,000 Occupied Bed Days (OBDs)

For 2020/21, the UHB rate was 7.41. The table below shows the breakdown by site and quarter.

	Q1	Q2	Q3	Q4
QEH	7.67	6.87	6.38	7.47
BHH	6.54	6.90	7.22	7.26
GHH	8.34	8.02	9.59	9.85
SH	5.91	2.75	2.77	8.05

Initiatives implemented during 2020/21, plans for 2021/22

- The existing falls education and training offer will be extended to falls link nurses, and the development of a falls Moodle package, along with a falls study day towards the end of the summer.
- A baseline review of NICE guideline compliance at the very beginning of the Pandemic highlighted that UHB are compliant with all but one recommendation. Work is underway to achieve 100 % compliance by way of upgrading the existing PICS falls risk assessment which moves away from falls risk prediction, but instead facilitates identification of risk factors present, and prompts appropriate action to mitigate these
- A Trust wide inpatient falls audit is being undertaken in Quarter 1 2021 in order to gain assurance of compliance with the inpatient falls procedures and associated pathways/guidance.

How progress will be monitored, measured and reported

- Data on falls along with any themes and trends, and/or key learning points identified, will be presented to the Divisions on a monthly and quarterly basis by the falls team as part of the falls Preventing Harm update.
- Data on falls will also be presented to the monthly Chief Nurse's Care Quality Group as part of the monthly performance review.
- Ward-level and trust-level data on falls is also available to clinical staff via electronic dashboards and reports.
- Falls data, themes and trends will also be reported to the Falls Steering Group on a quarterly basis in order to inform actions trust wide.
- Falls with specific outcomes, e.g., a fractured neck of femur (broken hip), will continue to be reported to the local Clinical Commissioning Group.

Priority 5 – Timely treatment for sepsis

Background

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

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

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

Performance

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

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

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

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

Period	Indicator 1 (ED / AMU)	Indicator 2 (In-patients)	Notes
Standard	≥90%		
2019/20 Q1	82%	59%	-
2019/20 Q2	84%	71%	-
2019/20 Q3	92%	82%	-

Period	Indicator 1 (ED / AMU)	Indicator 2 (In-patients)	Notes
Standard	≥90%		
2019/20 Q4	83%	97%	37 patients audited, national submission of data was then suspended during phase 1 of the pandemic
2020/21 Q1	90%	100%	The Trust did not manage to audit at least 50 inpatient admissions
2020/21 Q2	90%	100%	The Trust did not manage to audit at least 50 inpatient admissions
2020/21 Q3	84%	90%	The Trust did not manage to audit at least 50 inpatient admissions
2020/21 Q4	-	-	Audit data received, but as expected less than 50 cases have been audited and it yet to be validated by the Sepsis Leads

Initiatives implemented during 2020/21, plans for 2021/22

- Datix incidents will be completed for all identified instances of non-adherence to sepsis screening and delay in administration of antibiotics longer than 60 minutes, to allow more in-depth exploration and identification of the reasons.
- The Critical Care Outreach team enrolled a Sepsis Lead who commenced their role in Quarter 1 2020/21
- Sepsis champions have been enrolled across the Trust and they have completed the AIM (Acute Illness Management) course.
- Education working group to be convened to update the current training and modalities of delivery for doctors and nurses.
- An electronic sepsis dashboard has been developed to trial the automation of the KPI audit data and this will be enhanced later to capture data on the whole sepsis pathway. This is currently being trialled at QEHB prior to the roll out of PICS across the whole Trust.

How progress will be monitored, measured and reported

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

Priority 6 - Timely Medical Review

This quality improvement priority was agreed at the Clinical Quality Monitoring Group chaired by the Chief Medical Officer and approved by the Board of Directors, and first included in the 2019/20 Quality Report.

Background

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

1. Time to consultant review
2. Diagnostics
3. Interventions
4. On-going review

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

1. Time to consultant review

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

2. Diagnostics

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

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

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

Improvement priority for 2020/21
The Trust planned to focus on measuring and improving performance for two of the priority clinical standards in 2020/21 through development of indicators.

1. All emergency admissions should be reviewed with 14 hours of admission by a Consultant

2. All emergency admissions should be reviewed daily (or twice daily if HDU patient) by a Consultant

Performance
The national requirement to undertake audits relating to the Seven Day Services standards was suspended during the Covid pandemic and they have not yet restarted.

The Trust has developed the two indicators listed above in draft form but has not been able to validate them clinically due to the constraints caused by the pandemic. The Trust will validate these during Quarter 2 2021/22 and they will then be monitored as part of 'Priority 3: Improving ward rounds' during the rest of 2021/22. These indicators will cover those wards which have gone live with the Prescribing Information and Communication System (PICS) which currently includes the Queen Elizabeth Hospital, Solihull Hospital and eight wards at Heartlands Hospital. Manual audits will have to be undertaken for all other wards in line with national guidance on when these audits should begin again.

How progress will be monitored, measured and reported
Performance for the indicators and manual audit results will be reported as part of 'Priority 3: Improving ward rounds' during 2021/22.

Priority 7 (Priority 1 for 2021/22) - 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 Report.

Background - Encouraging staff to speak up
The appointment of Freedom to Speak Up Guardians was a recommendation of The Francis Report (Report of the Mid-Staffordshire NHS Foundation Trust public inquiry) published in February 2013. UHB's Freedom to Speak Up Guardian is Professor Julian Bion, Honorary Consultant in Critical Care Medicine. Professor Bion is supported by thirty-one Confidential Contacts from across the Trust who are also a point of contact for raising concerns.

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

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

The Freedom to Speak Up Guardian and the Confidential Contacts meet quarterly, alternating between hospital sites, 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 an anonymised summary of contacts and to discuss specific issues requiring the attention of the Trust leadership. The Freedom to Speak Up Guardian also meets every six months with the Head of Human Resources and the Head of Occupational Health to exchange insights.

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

Performance
The Trust used two methods in 2020/21 to monitor the Trust's Freedom to Speak Up culture:

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

Number of contacts

The Trust continued to measure the number and type of *Freedom to Speak Up* contacts made by different staff groups during 2020/21.

Freedom to Speak Up Contacts and Concerns, 1st April 2020 – 31st March 2021

Professional group	No. (%) of contacts)	No. of concerns raised	Issues raised				
			Patient Safety	Staff Safety	Disrespect, bullying, leadership / probity	Discrimination or racism	HR, contracts, disciplinary procedures, redeployment, service reconfiguration
Consultants	30 (25.6)	21	6	2	10		11
Junior doctors	26 (22.2)	7		1	8		4
Nurses Band 5-8	16 (13.6)	13	3		9	2	2
CNS/PAs	-	0					
AHPs	21 (17.9)	13			11	3	3
HCAs	1 (0.8)	1	1				
Tech/Sci	2 (1.7)	2			1	0	1
Pharm	2	2				1	1
Dentists	1	1			1		1
Domestic	1(+)	1			1		
Catering	1	1			1	1	0
Managers/ Corp	5 (4.2)	5			2	2	1
A&C	8 (6.8)	7		2	4	1	1
Porters	1	1			1		
R&D	1	1			1		
Unknown	-	2			2		
Anonymous	1	1			1		
TOTAL	**117**	**79**	**10**	**5**	**53**	**10**	**25**

Freedom to Speak Up Index

The Trust uses the Freedom to Speak Up Index to monitor the Trust's Freedom to Speak Up culture. The index is calculated as the mean average of responses to four questions from the NHS Annual Staff Survey (see table below).

UHB scored 75.5% (range across all healthcare Trusts in England is 68.5% to 86.6%) in the latest published Freedom to Speak Up Index. This percentage is based on data from the 2020 NHS Annual Staff Survey (see table below). This is a slight improvement from the 2019 Freedom to Speak Up Index which was 75% for UHB based on the 2018 NHS Annual Staff Survey. Areas for improvement are around staff feeling safe to raise concerns and believing that they will be treated fairly in the event of making a mistake.

Question	Number of Responses	Strongly agree %	Agree %	Neutral %	Disagree %	Strongly disagree %
16a: My organisation treats staff who are involved in an error, near miss or incident fairly	5764	9%	46%	35%	7%	3%
		Total agree 3133 (54%)			Total disagree 628 (10%)	
16b: My organisation encourages them to report errors, near misses or incidents	7069	25%	61%	10%	3%	1%
		Total agree 6048 (86%)			Total disagree 290 (4%)	
17a: If I were concerned about unsafe clinical practice, I would know how to report it	6420	Yes 93%			No 7%	
		Total agree 5979			Total disagree 441	
17b: I would feel secure raising concerns about unsafe clinical practice	7324	19%	50%	21%	7%	3%
		Total agree 5047 (69%)			Total disagree 725 (10%)	

Nationally, 59.7% of NHS staff survey respondents agreed their organisation treats staff who are involved in an error, near miss or incident fairly, and 71.7% said they would feel secure raising concerns about unsafe clinical practice.

Improvement priority for 2020/21
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 annual Freedom to Speak Up Index. 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 Report Update to the Board of Directors and the Council of Governors.

New 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

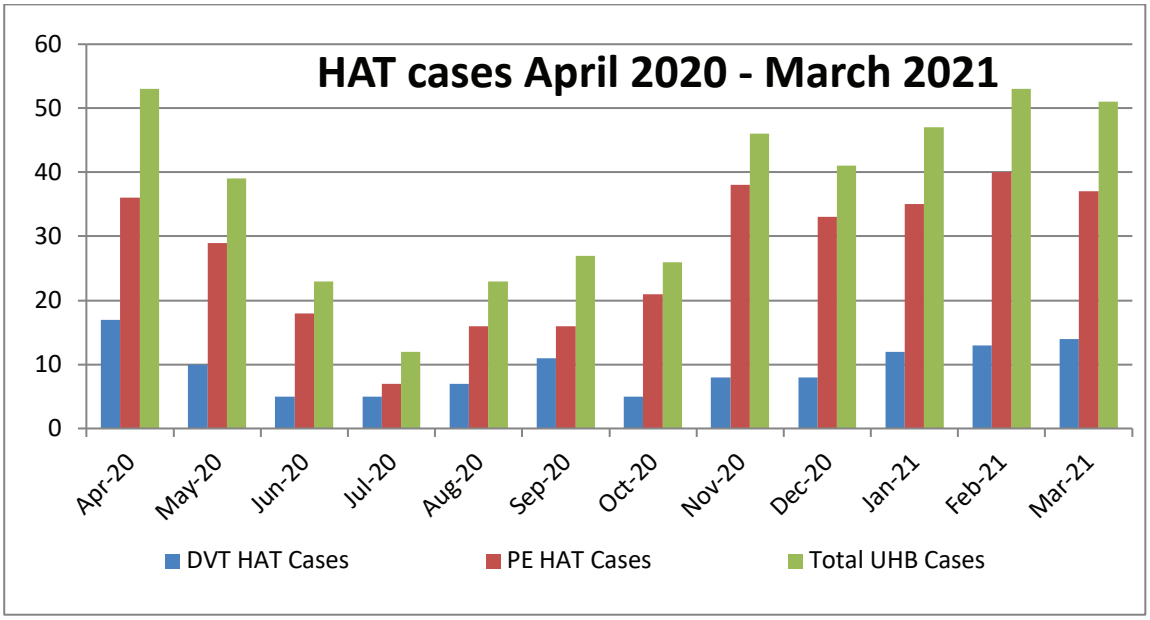
The Trust set up a quality improvement project in 2020/21 to improve VTE prevention and reduce the number of hospital-associated thromboses. The focus of this work is both on inpatients and patients who may not be admitted to hospital but are at risk of developing VTE such as those with lower limb fractures.

The quality improvement project will continue in 2021/22. The focus will be on developing a suite of indicators to measure whether patients are promptly assessed for their risk of VTE and receive any recommended preventative treatments at the right time.

Performance

Table 1 shows the number of hospital-associated thromboses (blood clots) which occurred at UHB during the period 1st April 2020-31st March 2021. These include thromboses which occurred in hospital and those which developed within three months of a patient leaving hospital.

Table 1



Notes:

HAT = hospital-associated thromboses (blood clots)

DVT = deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs)

PE = pulmonary embolism (blood clot which has travelled through the blood and lodged in the lungs)

Initiatives to be implemented during 2021/22

- To develop inpatient VTE pathway indicators during Quarter 2 2021/22
- To develop lower limb VTE pathway indictors during Quarter 2 2021/22
- To monitor and improve performance for the inpatient and lower limb pathway indicators during Quarter 3 2021/22.
- 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.
- Reviewing specialty level and individual doctors' performance for the VTE indicators at the Junior Doctor Clinics to identify where improvements can be made and providing support to deliver these improvements.

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 Report Update to the Board of Directors and the Council of Governors.

New 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 acronym 'REMIND' have been 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	E-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 has been 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. Two wards at Heartlands Hospital have been chosen to participate in the pilot during 2021/22: Ward 28 (Infectious Diseases) and Ward 21 (Healthcare of Older People).

Improvement priority for 2021/22

The Trust is aiming to develop a framework of local ward round standards and to set out an implementation plan during 2021/22. The Trust is also planning 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

Initiatives to be implemented during 2021/22

- To creating an electronic ward round tool within the Prescribing Information and Communication System (PICS) to support clinicians to undertake effective ward rounds.
- To participate in the ECIST improving ward rounds pilot on wards 28 and 21 at Heartlands
- To encourage and measure nursing attendance at ward rounds.
- To develop and report on a suite of indicators to gauge the effectiveness of ward rounds 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 and Junior Doctors' 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 Report Update to the Board of Directors and the Council of Governors.

NEW 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 has chosen to focus on reducing the number of patients who develop diabetic ketoacidosis (DKA) in hospital 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 Queen Elizabeth Hospital and Solihull Hospital site plus eight wards have recently gone live at Heartlands Hospital. PICS will be rolled out to the remaining wards at Heartlands Hospital and Good Hope Hospital by Summer 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 is 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.

The table below shows the number of diabetic ketoacidosis incidents reported by site over a nine month period from 1st June 2020 to 31st March 2021:

Site	Number of DKA incidents
Queen Elizabeth Hospital	5
Heartlands Hospital	14
Good Hope Hospital	5
Solihull Hospital	0
Solihull Community	1
Offsite/ Other Sites	1
Total	**26**

Initiatives to be implemented during 2021/22
- To continue monitoring the number of reported diabetic ketoacidosis incidents as an overall measure of success in line with the harm data collected by the National Diabetes In-Patient Audit (NaDIA).
- To develop an automated indicator to identify patients with DKA based on specific clinical parameters within the Prescribing Information and Communication System.
- To continue measuring and reviewing ward level performance for missed background insulin doses which can lead to DKA at the Clinical Dashboard Review Group.
- To consider implementing 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.
- 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.
- To develop a Trust-wide Standard Operating Procedure for monitoring of diabetes including glucose and ketone testing.
- To develop an indicator to measure whether ketones have been checked when a patient's blood glucose level is high.

How progress will be monitored, measured and reported
- Performance for the DKA indicators and incident data will be reviewed at each Diabetes Steering Group meeting.
- Progress will be reported quarterly to the Clinical Quality Monitoring Group.
- 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 Report Update to the Board of Directors and the Council of Governors.

NEW 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 has chosen 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 will be setting up a new, overarching multidisciplinary group for nutrition and hydration during 2021/22 with senior clinical input. Two areas of focus will be:

1. Improving the management of patients who are nil by mouth (NBM).
2. Ensuring patients' baseline and on-going weight and Malnutrition Universal Screening Tool (MUST) risk assessments are accurately completed.

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)

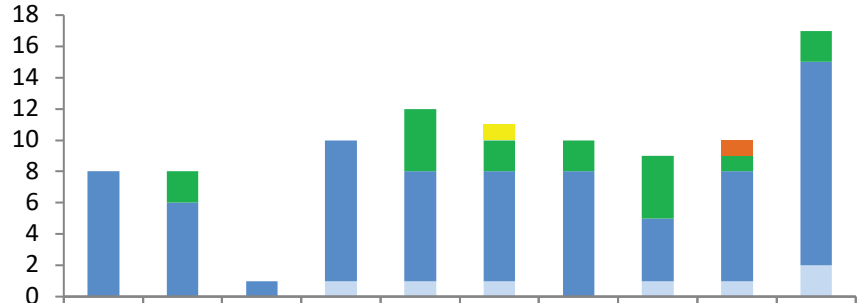
The Trust is aiming to standardise the approach to managing the two groups of nil by mouth patients, decision-making and nil by mouth signage across all hospital sites. The Trust is also focusing on ensuring patients receive the right type of food (from a consistency perspective) at the right time.

Performance

Incidents

The Trust has continued to monitor incidents relating to dysphagia/swallowing and nil by mouth issues during 2020/21. There were a total of 96 incidents reported during 2020/21. No incidents were reported during the months of April and May 2020 relating to swallowing/dysphagia or nil by mouth issues. There were fewer incidents reported during 2020/21 than the previous year due in part perhaps to lower reporting during the Covid pandemic.

The table below shows the total incidents each month relating to patients with swallowing difficulties, dysphagia or recommended for nil by mouth because of dysphagia:



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2020							2021		
Catastrophic / Death									1	
Moderate						1				
Low		2			4	2	2	4	1	2
No harm	8	6	1	9	7	7	8	4	7	13
Near Miss				1	1	1		1	1	2

Complaints

The table below shows there were 73 instances relating to a wide variety of nutrition and hydration issues noted in complaints during 2020/21:

Nutrition & Hydration Complaints 2020/21 SUB-SUBJECTS/SITE	QEH	BHH	GHH	SOL	Total
End of life - Nutrition/Hydration	2	0	1	0	**3**
Facilities - Food - choice	0	0	0	1	**1**
Facilities - Food - availability	0	1	1	1	**3**
Food and Hydration - Failure to weigh on admission	1	0	0	0	**1**
Food and Hydration - Failure to identify specific nutritional/dietary needs on admission	2	0	2	0	**4**
Food and Hydration - Failure to monitor food intake during period of admission	4	7	2	0	**13**
Food and Hydration - Failure to monitor fluid intake during period of admission	2	4	1	0	**7**
Food and Hydration - Failure to provide adequate fluids during period of admission	4	6	6	0	**16**
Food and Hydration - Failure to provide assistance with eating/drinking	0	3	5	0	**8**
Food and Hydration - Failure to provide appropriate foods linked to clinical need (e.g. diabetes, coeliac, texture modified/dysphagic)	1	0	1	1	**3**
Food and Hydration - Failure to provide appropriate foods linked to personal/ cultural need (e.g. vegan, halal)	0	1	0	0	**1**

Nutrition & Hydration Complaints 2020/21 SUB-SUBJECTS/SITE	QEH	BHH	GHH	SOL	Total
Food and Hydration - food/drink left out of reach	0	6	2	0	**8**
Food and Hydration - help not given to open packaging	1	0	0	0	**1**
Food and Hydration - failure to provide nutritional advice	0	0	1	0	**1**
Food and Hydration - failure to identify food allergy	2	1	0	0	**3**
Total	**19**	**29**	**22**	**3**	**73**

Initiatives to be implemented during 2020/21

- To set up a new, overarching multidisciplinary group for the nutrition and hydration quality improvement project.
- To highlight within the Trust's electronic Prescribing Information and Communication System (PICS) how long patients have been nil by mouth for.
- Targeted education through Moodle module alongside ward based face-to-face training.
- 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.
- 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.
  - Percentage of patients who have an actual rather than estimated weight recorded.
  - 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.

How progress will be monitored, measured and reported

- Progress will be monitored and reviewed at the new overarching group for nutrition and hydration.
- 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 Report Update to the Board of Directors and the Council of Governors.

New 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.

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

Improvement priority for 2021/22

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

Initiatives to be implemented during 2021/22

- Introduction of new Safety Standards for Invasive Procedures within Critical Care, Endoscopy, Interventional Radiology and Cardiology.
- Development and implementation of a staff education module via Moodle with oversight from the Theatre Standards Group.
- Introduction of a staff feedback form to ensure each new safety standard meets the needs of the staff involved.
- The number of Never Events and near miss incidents related to invasive procedures will continue to be regularly reviewed.

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 Report Update to the Board of Directors.

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.

Learning Disabilities (LD)	
Project Aims	Improve safety and quality of care for patients with a learning disability and addressing issues from past and current serious incident investigations.
Project Status	Most components of the change package related to the team's aim are implemented for the population of focus/area of the organization. There is evidence of breakthrough improvement in outcome measures, with the team at least halfway toward accomplishing all of their goals. Plans for spread, consistent with the team's aim, are in place.
Progress	The multi-disciplinary QI group links with the vulnerabilities steering group and the ward round QI project. The lead nurse for vulnerabilities has led on the majority of the improvement work and the implementation of the LD standards. The QI group have reviewed the compliance data against the Learning Disability standards and it will be proposed to the Vulnerabilities Steering Group that the LD group is stood down. On-going work with the LD standards will be monitored by the Vulnerabilities Steering Group. Compliance/ Audit of Mental Capacity Act (MCA) and Best Interests (BI) via the Trust Mental Health Group and work in regard to Mouth Care Matters via the IPC (Infection Prevention and Control) meetings.
Project Measurables	Improved compliance with LD standards Reduction in the number of harmful incidents and serious incidents Reduction in complaints relating to vulnerable patients Increase in positive patient and carer feedback
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 Status	Initial plans for the project have been made. Team actively engaged in development, information gathering, and discussions, but no changes have been tested.
Progress	Multidisciplinary QI group established, focussing on Cancer MDTs. A SOP (Standard Operating Procedure) for MDM's has been written, this has been reviewed by the group and changes have been agreed. This is being updated and will be progressed. A PICS referral form into MDTs is in development, further work is required on a dropdown list to support the referral process. A new system RAD Alert has been tested in urology, further discussions are planned to decide how best to utilise and implement this system. Each MDM Serious Incident (SI)/Root Cause Analysis (RCA) is reviewed by the group qualitatively, considering options for improvement, with the intended outcome of a reduction in SI's relating to MDM.

Project Measurables	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). Further measures to be developed once SOP approved and information systems allow.
RESPECT / End of Life Care (EOL)	
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 Status	Initial plans for the project have been made. Team actively engaged in development, information gathering, data collection, and discussions, but no changes have been tested.
Progress	Multi-disciplinary QI group established and regular meetings in progress. Main aim is for RESPECT to be built into PICS and available Trust wide. Efforts are being made with the PICS team to prioritise this build, aiming for completion before June 2021. Currently QEHB / Solihull / Elderly care wards at BHH are running a dual system – paper RESPECT, alongside TEAL in PICS. Some areas of BHH / GHH remain paper RESPECT only. Communications have been issued and will be re-issued as the PICS roll out progresses. Patient criteria for RESPECT and prompts on PICS will be explored with the PICS team. Plans are in place for educational comms and a short Moodle module to support the proper use of RESPECT / TEAL. Outcome measures for % of inpatients and death with a valid DNAR (Do Not Attempt Resuscitation), is being explored with Informatics, the data provided requires validation.
Project Measurables	% of deaths with a valid DNAR % of all inpatients with a valid DNAR Months since last SI Number of complaints related to EOL care.
Consent	
Project Aim and Status	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.

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2020/21 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 2020/21 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2020/21.

* 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 2020/21, 41 national clinical audits and 1 national confidential enquiry covered relevant health services that UHB provides. During that period UHB participated in 37 (90%) national clinical audits and 1 (100%) national confidential enquiry which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2020/21 are as follows: (see tables below). Due to the Covid-19 pandemic, a number of National Audits and National Confidential Enquiries into Patient Death and Outcome (NCEPOD) studies were placed on hold- information on this is included in the below tables.

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (where known).

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2020/2021	Percentage of required cases submitted
Antenatal and Newborn National Audit Protocol	Yes	UHB: 100%
BAUS Urology Audits	Yes	Cystectomy: BHH: 84.61% QEH: 64.34% Nephrectomy: BHH: 121% QEH: 74% Percutaneous Nephrolithonomy: 100%* Radical Prostatectomy: BHH: 132.9% QEH: 75.69% Stress Urinary Incontinence: 100%* Bladder Outflow Obstruction (BOO): 100%* The Management of the Lower Ureter in Nephroureterectomy: Data Collection Period Still Open Renal Colic: Data Collection Period Still Open
British Spine Registry	Yes	UHB: <50%
Case Mix Programme	Yes	UHB: 100%*
Cleft Registry and Audit Network	Yes	UHB: 100%*
Emergency Medicine QIPS	Yes	Fractured Neck of Femur: Data Collection Closed April 2021- Awaiting Outcomes Infection Control: Data Collection Closed April 2021- Awaiting Outcomes Pain in Children: Data Collection Period Still Open
Falls and Fragility Audit Programme (FFFAP)	Yes	Hip Fracture Database: BHH: 108% GHH: 88% QEH: 98%
Inflammatory Bowel Disease Audit	No- Currently Awaiting Divisional and Executive Sign off	
Mandatory Surveillance of HCAI	Yes	UHB: 100%*

National Audit UHB eligible to participate in	UHB participation 2020/2021	Percentage of required cases submitted
National Asthma and COPD Audit Programme	Yes	Chronic obstructive pulmonary disease: UHB: 38% Adult Asthma: UHB: 22% Paediatric Asthma: Not Yet Available Pulmonary Rehabilitation: 100%*
National Audit of Breast Cancer in Older People	Yes	UHB: 100%*
National Audit of Cardiac Rehabilitation	Yes	UHB: 100%*
National Audit End of Life Care	Paused Nationally	
National Audit of Dementia	Paused Nationally	
National Audit of Pulmonary Hypertension	Yes- Shared Centre with Sheffield Teaching Hospitals NHS Foundation Trust	UHB: 100%*
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes- part of Birmingham Regional Paediatric Neurology Forum	UHB: 100%*
National Bariatric Surgery Register	Yes	UHB: 100%*
National Cardiac Arrest Audit	Yes	BHH: 100% QEH: 100% GHH: 100%
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	Paused Nationally	
National Diabetes Audit	No- Trust Participation Paused with the approval of the Chief Medical Officer	
National Early Inflammatory Arthritis Audit	No- Data Collection Nationally Paused March 2020. Now resumed, the Team is seeking Divisional and Executive Approval to continue the pause, with an aim to scope feasibility to continue data collection November 2021.	
Emergency Laparotomy Audit (NELA)	Yes	BHH: 99% GHH: 100% QEH: 86.4%
Gastro-Intestinal Cancer Audit Programme	Yes	NOGCA: UHB: 85-100% NBOCA: BHH: 106% QEHB: 95%
National Joint Registry	Yes	UHB: 81.84%

National Audit UHB eligible to participate in	UHB participation 2020/2021	Percentage of required cases submitted
National Lung Cancer Audit	Yes	UHB: 100%*
National Maternity and Perinatal Audit	Yes	BHH: 100.68% GHH: 100.68%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	UHB: 100%
National Ophthalmology Audit Database	Yes	UHB: 99%
National Paediatric Diabetes Audit	Yes	BHH:83.5% GHH: 91.3%
National Prostate Cancer Audit	Yes	UHB: 100%*
Sentinel Stroke National Audit Programme (SSNAP)	Yes	BHH: 90%+ QEH: 90%+ GHH: 90%+ SHH: 90%+
Serious Hazards of Transfusion Scheme (SHOT)	Yes	UHB: 100%*
Society for Acute Medicine Benchmarking Audit	Paused Nationally	
Surgical Site Infection Surveillance	Yes	UHB: Data Collection Period Still Open
Trauma Audit and Research Network	Yes	UHB: 100%
Cystic Fibrosis Registry	Yes	Data Completeness omitted from National reports. Some units have been unable to participate in 'data cleaning' due to frontline pressures.
UK Registry of Endocrine and Thyroid Surgery	Yes	UHB: 100%*
UK Renal Registry National Acute Kidney Injury programme	Yes	BHH: 76.5% QEH: 100%
Neurosurgical National Audit Programme	Yes	UHB: 100%*
National Vascular Registry	Yes	UHB: 79%

National Audit UHB eligible to participate in	UHB participation 2020/2021	Percentage of required cases submitted
Cardiac Audit Programme	Yes	Heart Failure: BHH:69% QEH:90% GHH:69% SHH: 69% Myocardial Ischaemia: BHH: 109.1% QEH: 99.2% GHH: 109.1% Cardiac Surgery: QEH: 100%* Congenital Heart Disease: QEH: 87.25% Cardiac Rhythm Management: QEH: 84.6% GHH: 95.7% SHH: 97.2% Percutaneous Coronary Interventions: 100%
Learning Disability Mortality Review Programme	Yes	UHB: 100%*
Perioperative Quality Improvement Programme	No- Trust Participation Paused with the approval of the Chief Medical Officer	
Elective Surgery (PROMS)	Yes	UHB: 100%*
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	UHB: 100%*
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections.	Paused Nationally	

*Case ascertainment for this project is not measured against expected cases.

National Confidential Enquiries (NCEPOD)

Please note that NCEPOD has been on hold throughout the pandemic, resuming with the below short survey/project:

National Confidential Enquiries (NCEPOD)	UHB participation 2020/2021	Percentage of required number of cases submitted
Alcohol Related Liver Disease (2013)	Yes	Ongoing – NCEPOD have designed a short survey based on the principal recommendations to look at what improvements have been implemented and where change is still needed since the published report in 2013.

Percentages given are the latest available figures.

The reports of 47 published national clinical audits were reviewed by the provider in 2020/21 and UHB intends to take the following actions to improve the quality of healthcare provided: (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

At UHB a wide range of local clinical audits are undertaken. This includes Trust-wide audits and specialty-specific audits which reflect local interests and priorities. A total of 1113 clinical audits were registered with UHB's clinical audit team during 2020/21. Of these audits, 207 were completed during the financial year (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

The outcomes of 181 local clinical audits were reviewed by the provider in 2020/21 and UHB intends to take the following actions to improve the quality of healthcare provided (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

2.2.3 Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was:

Portfolio recruitment	12,908
Non-Portfolio Recruitment	2,151
Total	**15,059**

The Trust's extensive Research, Development and Innovation portfolio was paused during the pandemic which impacted on a range of commercial and non-commercial partners across a range of specialties. Clinical trials which provided no other treatment options for patients did remain open for whom conventional treatments might have failed or where treatment options are limited.

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 2020/21.

UHB has not participated in any special reviews or investigations by the CQC during 2020/2021.

No visits were conducted by Birmingham Cross City Commissioning Group during 2020/2021.

CQC Inspection Ratings Grids

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

In December 2020 the CQC inspected the Safe Domain across the Medical Care Core Service at Queen Elizabeth Hospital, Good Hope Hospital and Heartlands Hospital. The Service scored 'Requires Improvement,' meaning that the rating remained the same as previously scored.

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

CQC Inspection Ratings Grids

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

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

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

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

2.2.6 Information on the quality of data

Secondary Uses Service data
UHB submitted records during 2020/21 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:
- 94.4% for admitted patient care
- 97.0% for outpatient care
- 98.7% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
- 99.95% for admitted patient care
- 99.67% for outpatient care
- 99.6% for accident and emergency care.

Data Security & Protection Toolkit (formerly Information Governance Assessment Report)
The Data Security and Protection Toolkit (DSPT) for 2019/20 was submitted in September 2020. The Trust achieved status 'Standards Met' and is fully compliant with the DSPT 2019/20.

The baseline for the DSPT 2020/21 was submitted in February 2021 and The Trust is in the process of completing the Toolkit by 30 June 2021. Owing to some new mandatory requirements, the Trust expects to submit at a level which requires some further work by the Trust to maintain its fully compliant status with all requirements. An Action Plan is in the process of being agreed. 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 2020/21 by the Audit Commission.

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

Actions to improve data quality
UHB takes / will take the following actions to improve data quality:
- Training programs are in place for Clinical Coders.
- Engagement with Clinicians for validation of coding, this currently takes place electronically.
- Audits of Clinical Coding. There is a programme for audits and validation in place internally and an external audit was carried out in July 2020. Quality assurance of data takes place supported by regular validation reports on key data items and missing data.
- Use of national benchmarking data such as the SUS Benchmarking & Data Quality Maturity Index tool to ensure correct and full data completion.
- Continue to monitor data quality through the Ward Clerk quality monitoring and management programme linking into DSPT requirements
- Ensure continued compliance with the DSPT minimum Level 2 for data quality standards. The annual Clinical Coding /Data Quality audit was provided for submission for the 20/21 DSPT
- 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.

The Trust updated the Reviewing Inpatient Deaths Policy and associated procedure in March 2021. All deaths must be given a stage one review by a Medical Examiner, except for those meeting the Coroner's referral criteria.

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 2020/21 6341 UHB patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: › 1635 in the first quarter; › 1054 in the second quarter; › 1693 in the third quarter; › 1959 in the fourth quarter.
2.	By 21st June 2020, 4061 case record reviews and 54 investigations have been carried out in relation to 6341 of the deaths included in item 1. In 54 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: › 854 in the first quarter; › 997 in the second quarter; › 1189 in the third quarter; › 1021 in the fourth quarter.
3.	Thirty six deaths, representing 0.6% 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: › 4 representing 0.2% for the first quarter; › 9 representing 0.9% for the second quarter; › 16 representing 0.9% for the third quarter; › 7 representing 0.4% 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: › If a patient is booked for a procedure, there must be a clinical discussion with the Consultant responsible for the patient prior to the cancellation of the patient's procedure. › Post Fall management needs to be communicated at handover to ensure continuity of performing post fall observations › Reminder to all clinicians that the SBAR system should be used for all interdepartmental referrals for inpatients › Review and clarification of the liver/gastro MDT process and distinguish subsequent ownership of patient after MDT and the process of informing the requesting clinician. › Guidelines for management of cerebrospinal fluid drainage systems to be updated to clarify the responsibility for surgeons to review such devices post-operatively when the patient is transferred from the operating theatre.
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 two investigations completed after 1st April 2020 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 2019/20 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 2020/21

The tables below show the Trust's latest performance for 2020/21 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 2019/20 Quality Report to enable patients and the public to understand performance over time.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible.

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

Patient safety indicators

Indicator	Data source	2018/19	2019/20	2020/21	Peer Group Average (where available)
1a. Patients with MRSA infection / 100,000 bed days › Includes all bed days from all specialties › Lower rate indicates better performance	› Trust MRSA data reported to PHE, › HES data (bed days)	**0.53**	**1.39**	**0.30** (Apr-20 to Feb-21)	**0.61** Acute trusts in West Midlands
1b. Patients with MRSA infection / 100,000 bed days › Aged >15, excluding elective orthopaedics › Lower rate indicates better performance	› Trust MRSA data reported to PHE, › HES data (bed days)	**0.56**	**1.31**	**0.31** (Apr-20 to Feb-21)	**0.66** Acute trusts in West Midlands
2a. Patients with C. difficile infection / 100,000 bed days › Includes all bed days from all specialties › Lower rate indicates better performance	› Trust CDI data reported to PHE, › HES data (bed days)	**17.38**	**17.59**	**19.92** (Apr-20 to Feb-21)	**17.18** 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)	**16.41**	**16.66**	**20.79** (Apr-20 to Feb-21)	**18.57** Acute trusts in West Midlands
3a. Patient safety incidents › Reporting rate per 1000 bed days › Higher rate indicates better reporting	› Datix (incident data), › Bed days data	**68.3 (QEHB)** **46.7 (HGS)**	**58.1**	**70.2**	**50.66** Oct-19 – Mar-20 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)	**9**	**9**	**12**	Not available
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	› Datix › (incident data)	**88.9% (QEHB)** **97.7% (HGS)**	**84.24%**	**80.94%**	**74.2%** Oct-19 – Mar-20 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Indicator	Data source	2018/19	2019/20	2020/21	Peer Group Average (where available)
4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death › Lower % indicates better performance	› Datix › (patient safety incidents reported to the NRLS)	**0.26% (QEHB)** **0.64% (HGS)**	**0.40%**	**0.47%**	**0.30%** Oct-19 – Mar-20 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	› Datix › (patient safety incidents reported to the NRLS)	**26,342 (QEHB)** **21,811 (HGS)**	**44,275**	**35,754**	**6,502** (6 months) Oct-19 – Mar-20 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)

Clinical Effectiveness Indicators

Indicator	Data source	2017/18	2018/19	2019/20	Peer Group Average (where available)
› **5a. Emergency readmissions within 28 days (%)** › **Elective and emergency admissions aged >17** › **Lower % indicates better performance**	› HED data	**13.73%**	**13.29%**	**15.43%** (Apr-20 to Jan-21)	**16.32%** Apr-20 to Jan-21 University hospitals
› **5b. Emergency readmissions within 28 days (%)** › **All specialties** › **Lower % indicates better performance**	› HED data	**13.77%**	**13.41%**	**14.15%** (Apr-20 to Jan-21)	**13.75%** Apr-20 to Jan-21 University hospitals
› **6. Stroke in-hospital mortality** › **Lower % indicates better performance**	› SSNAP data	**12.6% (QEHB)** **10.8% (HGS)**	**11.1% (QEHB)** **10.9% (HGS)**	**6.6% (QEHB)** **8.6% (HGS)**	**13.4%** 2017/19 England & Wales SSNAP crude mortality data
› **7. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG)** › **Higher % indicates better performance**	› Trust PICS data	**92.6%**	**94.3%**	TBC – data not yet validated	Not available

Notes on patient safety & clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that not all hospitals within the Trust undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection, for example, and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

1a, 1b:
- Peer group figures are not final.

1a, 1b, 2a, 2b:
- 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 2020 and 31 March 2021 and reported to STEIS by 12 April 2021 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 twelve Never Events during 2020/21 in the following categories: Transfusion or transplantation of ABO incompatible blood components or organs (4), Retained foreign object post procedure (3), Wrong implant/ prosthesis (2), Wrong site surgery (3).

4c:
- The number of incidents shown only includes those classed as patient safety incidents and reported to the National Reporting and Learning System.

6 HGS:
- The data was calculated by downloading available number of cases from SSNAP web-tool (Sentinel Stroke National Audit Programme), however there is a number of cases where stroke patients were admitted to different wards who do not feature on SSNAP. The Stroke Unit at Solihull closed in April 2020 and the status of the BHH stroke unit changed from hyper-acute to rehabilitation. The hyper-acute Stroke Unit was moved to QEHB.

7:
- QEHB indicator only as cardiac surgery is not carried out at the other sites.
- Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.

Patient experience indicators

The National Inpatient Survey is run by the Picker Institute on behalf of the Care Quality Commission (CQC); UHB's results for selected questions are shown below. The 2018 survey was the first to cover the newly merged Trust; data from the 2017 survey is split between the two former Trusts. The 2020 survey was delayed due to the Covid-19 pandemic and is the report is expected in November 2021.

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

Patient survey question	Site/s	2017/18		2018/19		2019/20	
		Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England
Overall were you treated with respect and dignity	QEHB	9.2	About the same	8.8	About the same	8.8	About the same
	BHH/GHH/SH	8.8	About the same				
Involvement in decisions about care and treatment	QEHB	7.4	About the same	7.2	About the same	7.1	About the same
	BHH/GHH/SH	7.0	About the same				
Did staff do all they could to control pain	QEHB	8.0	About the same	7.9	About the same	7.8	About the same
	BHH/GHH/SH	7.6	Worse				
Cleanliness of room or ward	QEHB	9.1	About the same	8.7	About the same	8.6	About the same
	BHH/GHH/SH	8.6	About the same				
Overall rating of care	QEHB	8.3	About the same	8.0	About the same	7.8	About the same
	BHH/GHH/SH	8.0	About the same				
Response rate		QEHB: 37% (441 respondents) BHH/GHH/SH: 30% (368 respondents)		30% (360 respondents) National: 45%		38% (464 respondents) National: 45%	
Time period & data source:		2017 Trust's Survey of Adult Inpatients 2017 Report, CQC		2018 Trust's Survey of Adult Inpatients 2018 Report, CQC		2019 Trust's Survey of Adult Inpatients 2019 Report, CQC	

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

Indicator	Target	Performance		
		2018/19	2019/20	2020/21
A&E: maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	76.7%	67.3%	77.6%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	88.2%	82.8%	58.4%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer1	85%	78.9%	60.4%	42.6%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	91.2%	66.6%	69.6%
Maximum 6-week wait for diagnostic procedures	99%	99.5%	97.4%	60.6%
Venous thromboembolism (VTE) risk assessment	95%	98.3%	98.3%	97.8%

Performance in late 2019/20 and 2020/21 was affected by the COVID-19 pandemic which increased pressure on emergency services and led to the cancellation of elective surgery and appointments.

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

"*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 (UHB)	Data period
SHMI, calculated by UHB Informatics	93.16 - within tolerance	2020/21 (Apr-20 – Nov-20)
SHMI, from NHS Digital website	94.42 - within tolerance	2020/21 (Apr-20 – Jan-21)
HSMR, calculated by UHB Informatics	104 - within tolerance	2020/21 (Apr-20 – Feb-21)

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.

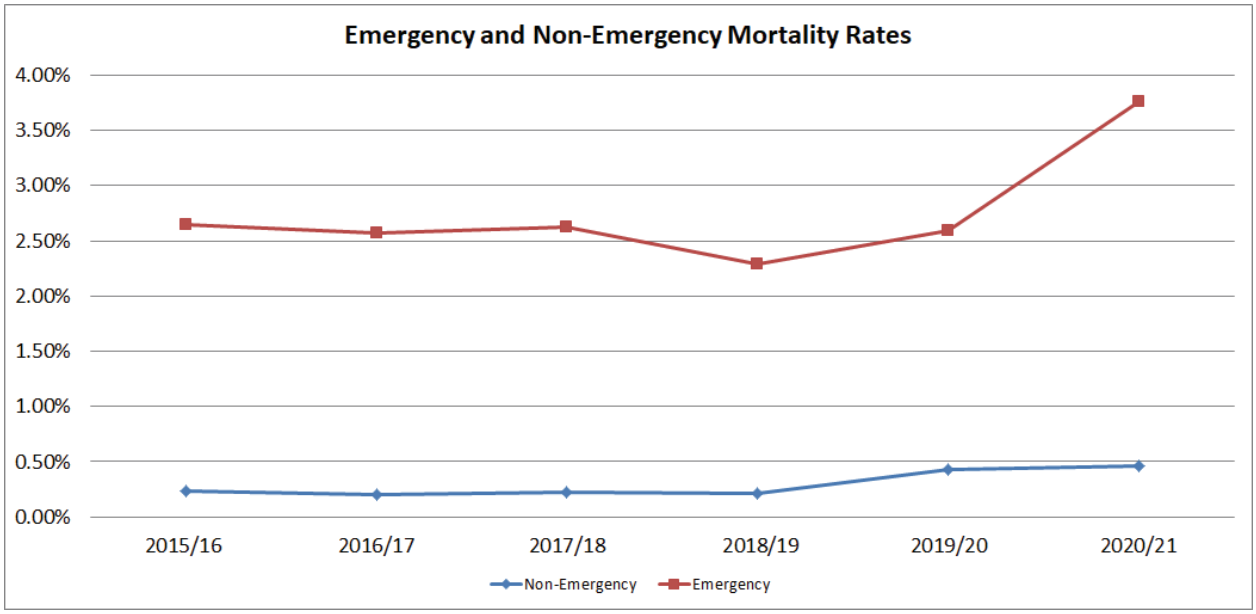
[3] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Crude Mortality

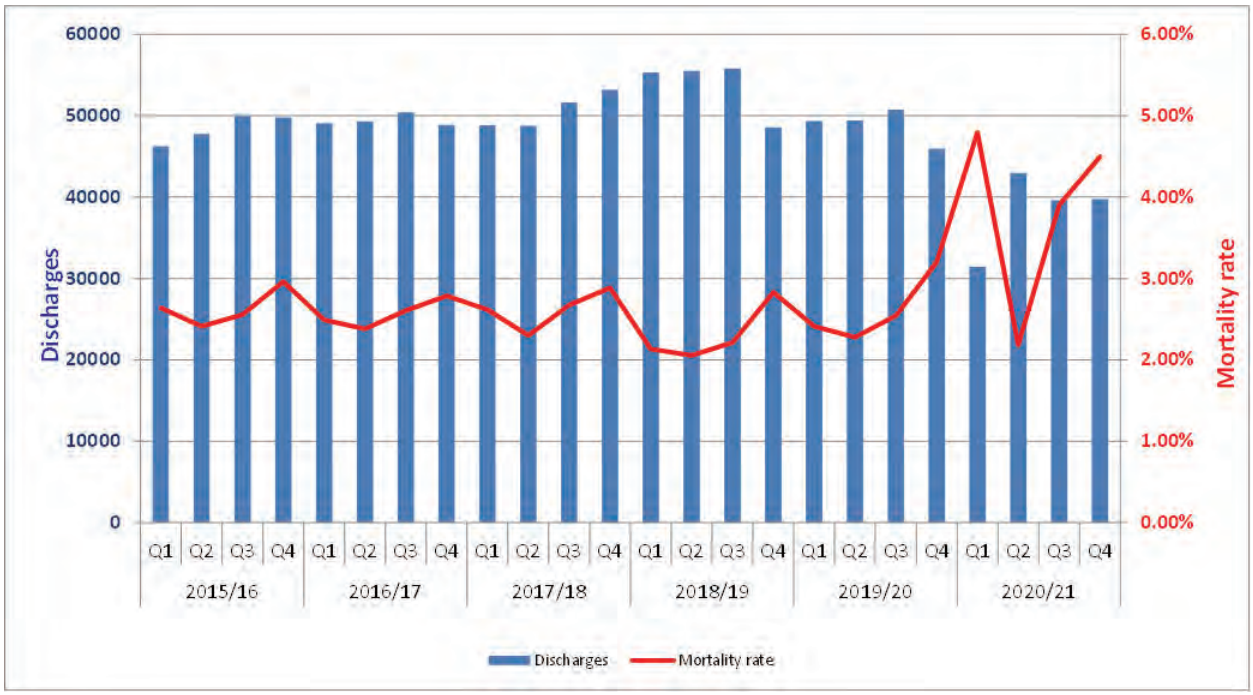
The first graph below shows crude mortality rates for emergency and non-emergency (planned) patients. The second graph shows the overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number 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 2020/21 is 3.76%, which has increased when compared to 2019/20 (2.60%) and 2018/19 (2.29%).

Emergency and Non-emergency Mortality Graph



Emergency Crude Mortality Graph



3.4 Statement regarding junior doctor rota

The Trust has appointed a Guardian of Safe Working (GSW), an experienced consultant who is supported by the Junior Doctors Monitoring Office (JDMO). The JDMO administers the following functions, amongst others:

- Junior doctor rota templates (as issued with work schedules)
- Hours of work/working patterns
- Exception reporting (e.g. if doctors experience differences in hours of work / rest breaks / the work pattern itself)

It is a requirement of the 2016 Junior Doctor contract that the GSW holds responsibility for ensuring that issues of compliance with safe working hours are addressed in accordance with the terms and conditions of the new Junior Doctor contract - this includes the overall responsibility for overseeing the Junior Doctors' Exception Reporting (ER) process. The GSW is required to submit a report at least quarterly, on the analysis of the exception reports submitted by junior doctors. A final extended Annual Report is presented at the end of each academic year to the Trust's Board of Directors.

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

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

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

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

Recent actions taken to address rota gaps include:

- Recruitment of locum staff and junior specialist doctors.
- Review of rotas by Senior Responsible Clinicians at each site to ensure that work patterns match clinical need.
- Consideration of appointment of Advanced Clinical Practitioners (ACPs) and Physicians Associates to take on some of the junior doctors' work.
- Coaching on 'handover' techniques to reduce the amount of time staff need to work over at the end of a shift.

3.5 Glossary of Terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department (ED)
A&C	Administrative & Clerical Staff
ACP	Advanced Clinical Practitioners: healthcare professionals, educated to Master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
AHPs	Allied Health Professionals, for example physiotherapists, occupational therapists.
AIM course	Acute Illness Management
BAUS	British Association of Urological Surgeons
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark	A method for comparing (e.g.) different hospitals
Beta blockers	A class of drug used to treat patients who have had a heart attack, also used to reduce the chance of heart attack during a cardiac procedure
BHH	Birmingham Heartlands Hospital
BI	Best Interests - An act done or a decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his or her best interest
CABG	Coronary Artery Bypass Graft: a surgical procedure used to treat coronary heart disease
Cannula / cannulae	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
Cessation	To end or stop something
CEAG	Chief Executive's Advisory Group
Chief Operating Officer Group	An internal group for senior management staff
Clinical Audit	A process for assessing the quality of care against agreed standards
Clinical Coding	A system for collecting information on patients' diagnoses and procedures
Clinical Dashboard	An internal website used by staff to measure various aspects of clinical quality
CDRG	Clinical Dashboard Review Group – reviews ward performance against certain care indicators
CNS	Clinical Nurse Specialist: an expert nurse in a particular specialty area.
Commissioners	See CCG
Concerto	Computer system showing patient details, hospital stays etc
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	A disease caused by the new strain of Coronavirus, currently instigating a Pandemic
CQC	Care Quality Commission: independent regulator of health and social care in England
CQG	Care Quality Group; a group chaired by the Executive Chief Nurse, which assesses the quality of care, mainly nursing
CQMG	Clinical Quality Monitoring Group; a group chaired by the Executive Chief Medical Officer, which reviews the quality of care, mainly medical
CQUIN	Commissioning for Quality and Innovation payment framework
CSL	Clinical Service Lead – the lead doctor for a particular specialty
Cystectomy	Surgical removal of the urinary bladder

Term	Definition
Datix	Database used to record incident reporting data
Deloitte	The Trust's external auditor
Dermis	the thick layer of living tissue below the epidermis which forms the true skin
Division	Specialties are grouped into Divisions
DKA	Diabetic ketoacidosis: a serious condition that can lead to diabetic coma or even death. When cells don't get the glucose they need for energy, the body begins to burn fat for energy, producing ketones
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
DTI	Deep tissue injury
Dysphagia	Swallowing difficulties - some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all
ED	Emergency Department (also known as A&E)
Elective	A planned admission, usually for a procedure or drug treatment
Endocrine	Relating to hormones
EOL	End of Life Care
Epilepsy12	National Audit of Seizures and Epilepsies in Children and Young People
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
FFAP	Falls and Fragility Fractures Audit programme
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
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
Hypoxia	Tissues of the body do not receive sufficient oxygen supply
Huddles	Short multidisciplinary briefings to identify potential problems or safety issues, such as challenges to the safe flow of patients across a department or hospital
IBD	Inflammatory Bowel Disease
Informatics	Team of information analysts
IPC	Infection Prevention and Control
IT	Information Technology

Term	Definition
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
LD	Learning Disability: A learning disability affects the way a person understands information and how they communicate
LOS	Length of Stay
M+M meeting	Mortality and Morbidity meeting: a forum where adverse outcomes can be discussed
MCA	Mental Capacity Act
MDT / MDM	Multi-disciplinary Team / Meeting – where patients are discussed and plans of care made
Mealtime Council	A group that promotes and improves operational processes in relation to nutrition and hydration practices
Medical Examiner	Senior doctors who review deaths that occur in hospital
Missed Dose	A dose of prescribed medication not given to the patient
Moodle	A digital learning platform used for obtaining training courses and information
Mortality	A measure of the number of deaths compared to the number of admissions
MOVED	A campaign to increase movement and repositioning of patients to reduce pressure ulcers
MRSA	Meticillin-resistant staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
Myocardial Infarction	Heart attack
NABCOP	National Audit of Breast Cancer in Older People
NACEL	National Audit of Care at the End of Life
NACR	National Audit of Cardiac Rehabilitation
NAPH	National Audit of Pulmonary Hypertension
NASH	National Audit of Seizure management in Hospitals
NBM	Nil by mouth
NCAA	National Cardiac Arrest Audi
NCAP	National Cardiac Audit Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure
Necrosis	Death of most or all of the cells in an organ or tissue due to disease, injury, or failure of the blood supply
NEIAA	National Early Inflammatory Arthritis Audit
NELA	National Emergency Laparotomy Audit
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 a merged organisation with NHS England
NHSX	A unit driving the digital transformation of care
NICE	The National Institute for Health and Care Excellence

Term	Definition
NIHR	National Institute for Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme – Neonatal Intensive and Special Care
NOD	National Ophthalmology Audit
Non-blanching erythema	Redness present on the skin
NPDA	National Paediatric Diabetes Audit
NRLS	National Reporting and Learning System
Nursing Metrics	Performance measure of multiple ward indicators gathered from monthly audits of nursing note
OBDs	Occupied Bed Days
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
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
Physicians Associates	Medically trained, generalist healthcare professionals, who work alongside doctors
PICS	Prescribing Information and Communication System
Postural Hypotension	Form of low blood pressure that happens when you stand up from sitting or lying down
PPCI	Primary Percutaneous Coronary Intervention
Pressure Ulcers	Area of damaged skin also known as pressure sores or bedsores
Proning	The position of a patient on their front for extended period of time.
Prostatectomy	Surgical removal of the prostate gland
Pulmonary Embolism	Blocked blood vessel in your lungs.
QEHB / QE	Queen Elizabeth Hospital Birmingham
QIPs	Quality Improvement Priorities / Quality Improvement Projects
RAD Alert	A system of sending out radiology/imaging reports to clinicians
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)
SAMBA	Society for Acute Medicine's Benchmarking Audit
SRC	Senior Responsible Clinicians – a lead doctor overseeing each hospital site at UHB
Sepsis	A potentially life-threatening condition resulting from a bacterial infection of the blood
SEWS	Standardised Early Warning System – similar to NEWS 2

Term	Definition
SH	Solihull Hospital
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
Slough	Nutrient laden material found within a wound that prolongs the inflammatory phase an impairs healing
SOP	Standard Operating Procedure
SSNAP	Sentinel Stroke National Audit Programme
STEIS	Strategic Executive Information System - used to report and monitor the progress of Serious Incident investigations across the NHS
TARN	Trauma Audit & Research Network
TAVI	Transcatheter Aortic Valve Implantation
TEAL	Treatment Escalation and Limitation
Tubing	Medical equipment required for the delivery of oxygen therapy for patients
TV / TVT / TVN	Tissue viability / Tissue Viability Team / Tissue Viability Nurses
UHB	University Hospitals Birmingham NHS Foundation Trust
Vascular	Relates to blood vessels, or sometimes other tubes in the body
VTE	Venous thromboembolism, also known as a blood clot
Ward clerk	A member of staff who provides general administrative, clerical, and support services for a ward
WHO	World Health Organisation
Wound Product Formulary	Formulary that outlines the wound care products that are recommended for use by all Practitioners within the Trust

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

The Trust has shared its 2020/21 Quality Report with

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

These organisations have provided the statements below.

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

1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as coordinating commissioner for University Hospitals Birmingham NHS Foundation Trust (UHB), welcomes the opportunity to provide this statement for inclusion in the Trust's 2020/21 quality account.

1.2 A copy of the quality account was received by the CCG on the 25th June 2021 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 balanced report of the healthcare services that UHB provides. The range of services described and priorities for improvement are representative based on the information that is available to us. The report demonstrates the progress made by the Trust against most of the 2020/21 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2021/22.

1.4 This is the third quality account for the merged Trust. It is to be noted that the Trust continues to review and harmonise its systems and processes across the four hospital sites. Commissioners are pleased to note the planned implementation of Oceano Patient Administrative Systems (PAS) has now been completed. The Prescribing Information System (PICS) at Heartlands, Good Hope and Solihull Hospitals has still yet to be rolled out fully. The CCG are satisfied with the plans for Trust wide implementation to be complete by the end of 2021/22.

1.5 The report describes the five new quality priorities with one priority of; freedom to speak up to continue into 2021/22. The CCG also notes that a priority from 2020/21 timely medical review has been discontinued but will form the priority Improving Ward Rounds for 2021/22.

1.6 The quality priorities for 2021/22 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 Trusts quality priorities for 2021/22. The Trust has made a decision to work with six priorities for improvement. All targets for these priorities have been reviewed and the CCG supports the Trust's review of progress and setting of either revised or continuation of targets.

1.7 The CCG acknowledges the difficulty the Trust have had with the priority to reduce its target of reducing grade 2 hospital-acquired pressure ulcers due to recommended treatment of ventilated patients suffering from Covid-19. The CCG notes an improvement in the tissue viability service by the Tissue Viability Nurses (TVNs) from Queen Elizabeth, Heartlands,

1.8 Good Hope and Solihull hospital. The CCG recognises that there is a planned service review planned for 2021/22 and the continued importance of aligning services and expects to see continued improvements in accordance with these initiatives.

1.9 Against the priority to timely and complete observations including pain assessment, whilst targets for indicator 1 were not achieved the CCG acknowledges that for the first three quarters the performance was within 1% and overall stood at 93.9% against a target of 95% which given the significant pressure the Trust has been under due to Covid-19. Against pain scoring indicator, the CCG notes the explanation for non-achievement of the target at Solihull and expects the formal roll out of PICS to correct this in due course.

1.10 The CCG recognises that the priority of reducing missed doses has been impacted by the difficulty in the trust wide roll out of the PICS system, and the ability to utilise uniformed system across all sites for medicines management. Whilst it is noted that this may have had an impact, the CCG would expect

to see a marked improvement on this area and will closely monitor the current PICS roll out plan. Although the priority has been discontinued into 2021/22 the CCG does not expect the rationale for missed doses to be attributable to computer systems in the future. The CCG is however pleased that the Trust continues to utilise and refresh the clinical dashboard.

1.11 The CCG understands that the pandemic saw a significant increase in deconditioning of patients leading to increased falls which was not anticipated when initial performance measures were agreed. Staffing levels have also been noted as a contributory factor, one which the CCG expects to be addressed with the staffing model that UHB has in place. The CCG acknowledges that the issues contained in this priority were also felt nationally. The CCG is pleased to see that there will be a Trust wide inpatient falls audit in the first Quarter of 2021/22, to gain assurance of compliance with the inpatient falls procedures, associated pathways and guidance.

1.12 The priority of timely treatment for sepsis has either been met or missed. In Quarters 1 and 2 the Trust met the target in both areas of this priority however note that the audit did not manage to audit at least 50 inpatient admissions in any quarter. It is noted that in Quarter 3 the target set was narrowly missed. Quarter 4 data is not included so the CCG is unable provide opinion on the achievement of the indicator at this point. It is encouraging to see that the Trust have enrolled Sepsis champions across the Trust and that the Critical Care outreach team have a dedicated Sepsis lead.

1.13 The CCG is pleased to see that the Trust has decided the priority of a timely medical review will form part of the 2021/22 priority Improving ward rounds. The Trust had two indicators and have not been able to validate them clinically due to the constraints caused by the pandemic. The CCG acknowledges that the indicators and audits will now be reported as part of the new priority Improving ward rounds.

1.14 The Trust has continued with the Freedom to Speak Up priority into 2021/22. The Trust used two methods to monitor the culture of the number of contacts per quarter with the Freedom to Speak Up index measured annually. The CCG accepts and understands that this priority is difficult to set a specific target against the number of contacts made and an increase in contacts should be seen as a positive open culture, The CCG fully supports this staffing approach

1.15 The CCG have worked closely with UHB over the course of 2020/21. In line with Government recommendations, the CCG has been restricted to virtual meetings during the pandemic to reduce the footprint across the Trust. Meetings face to face are planned to recommence in Quarter 2 2021/22. The Trust and CCG will continue to regularly review the organisation's progress in implementing its quality improvement initiatives. The CCG are committed to engaging with the Trust in an inclusive and innovative manner and are pleased with the level of engagement from the Trust and hope to continue to build on these relationships as we move forward into 2021/22. The challenges surrounding Covid-19 threw up significant challenges in the way the Trust and CCG engaged during 2020/21

Paul Jennings
CEO
Birmingham and Solihull CCG

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

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

The Birmingham Health and Social Care O&S Committee (HOSC) recognises the challenges faced by the Trust over the past 12 months to maintain services whilst coping with the extra demands resulting from the Covid-19 pandemic. The committee would like to put on record its sincere gratitude to the staff who have worked tirelessly to meet the needs of the people of Birmingham. We also recognise that the coming year will be equally challenging in restoring services and reducing waiting lists for elective surgery whilst coping with the ongoing impact of the pandemic.

It is evident that the Covid-19 pandemic has also hampered progress against some of your priorities including reducing grade 2 hospital-acquired pressures ulcers and reducing harm from falls both of which increased due to treatment and associated complications experienced by patients.

We fully support the continued roll-out of the Prescribing Information and Communications System (PICS) across the Trust which is pivotal for capturing real-time performance data and note that completion of the roll-out is scheduled for Summer 2022. It is also noted that further tools within PICS are being developed to measure performance against priorities e.g. reducing missed doses and supporting clinicians to undertake effective ward rounds.

Last year the committee was pleased to see the introduction of the 'Freedom to Speak Up' indicator and acknowledge the Trusts score of 75.5% against the range of 68.5% to 86.5% for all healthcare Trusts in England as published in the Freedom to Speak Up Index, which is based on the 2020 NHS Annual Staff Survey, and showed a slight improvement from the previous year. Noting the exceptional workplace pressures staff will have experienced in the past year and currently, we welcome the decision to continue this indicator. We believe it will be essential for performance on this to increase further, if possible, to a level above the 80% level which would then reflect high relative performance for the sector.

The committee supports the new priorities around improving ward rounds and improving nutrition and hydration both of which have been chosen based on incidents and complaints received relating to those topics. Furthermore, the actions being taken to improve data quality around clinical coding are particularly welcomed. This committee has previously been told that clinical coding is weak across the health system which has impeded identifying health inequalities across the city.

It is also encouraging to see that UHB is an 'early adopter' of the Medical Examiner role to review inpatient deaths and assess whether the care provided was appropriate and whether the death could potentially have been avoided.

Referring to the CQC Inspection grids we note with some concern that the 'safe' assessment is rated 'requires improvement' in all four domains at Heartlands and Good Hope, and for three domains at Solihull. The prevalence of this rating across such a substantial proportion of the UHB estate is of some concern to us and we would wish to gain some understanding of the factors behind this pattern and the actions being taken to remediate these ratings.

It is also of concern under paragraph 3.2 performance Indicators, to note the decline in the second (RTT 18 week wait) and third (62 days from urgent referral to first cancer treatment) indicators. While we appreciate that this is likely to be an unavoidable direct result of the pressures from Covid admissions, we are equally aware that the substantial reduction and shortfall against target risks a future rise in preventable cancer deaths. We regard it as a significant future priority that the resources required to re-set the performance towards the desired targets are made available as soon as possible.

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

The Solihull Health and Adult Social Care Scrutiny Board welcomed the opportunity to comment on the Quality Accounts. We welcome the steps taken to meet the priorities set out in the report, and look forward to engaging in the future to drive improvements in services and outcomes for local residents. Members are also grateful for the candour of the report and its clear identification of the challenges faced by the Trust. The Board wishes to place on record its thanks to the staff at UHB for their hard work and commitment over a very challenging 12 months.

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. As we give our comments to UHB's 2020/21 Quality Accounts, we recognise the tremendous challenges and difficulties Covid-19 has presented as the Trust carried out its work throughout the year. The importance of the NHS, and indeed our hospital Trusts in Birmingham, has never been more visible than at this time. Indeed, feedback from service users has highlighted the commitment and hard work of the staff at UHB during this period:

From my initial diagnosis to being given the all clear the QEHB have been truly excellent. The level of care has been outstanding. I have had three in patient stays and cannot find any fault in the standard of treatment I have received which has been brilliant. From my consultant downwards the entire team have been absolutely amazing and I cannot believe the treatment I have received in such difficult times I cannot thank QEHB enough.

The infectious disease department at Heartlands Hospital worked really well during the lockdown.

I was sent there by my G.P. The service I received was first class from start to finish. I was treated with the utmost respect and good humour, and left there feeling very reassured (Good Hope Hospital)

I had Covid and it was bad, ended calling 111 they send 2 ambulances as my wife had it too only she has terminal lung cancer and COPD, she was ok but I was rushed to the Queen Elizabeth hospital in Birmingham, rite from the get go in A & E to leaving 4 days later the staff from the cleaner to the doctor could not have done more. I hated having to press the call button but I had to at times and it was no trouble for anyone to see to my needs THANK YOU to everyone at that hospital.

We note the work that the Trust has carried out over the past year in standardising the quality of patient care across the four main hospitals. In addition to digital and technological transformation to enable quality of care to be measured, compared, monitored and improved across the Trust. We look forward to reading in the 2021/22 Quality Account a significant improvement in the adoption of the use of digital and technology, particularly at Good Hope, Heartlands and Solihull. For instance, the use of PICS for timely and complete observations including pain assessment is not fully adopted across the Trust. Indeed that some sites are still recording observations on paper and we wonder the extent to which these sites are able to provide timely and appropriate clinical treatment to all patients without the prompt that PICS offers staff. We note and welcome plans to continue to roll out PICS at Good Hope and remaining Heartlands ward.

Over the past year, we have been pleased with how the Trust has responded and acted on patient feedback Healthwatch Birmingham and Healthwatch Solihull has shared through our research reports and our right to respond program. More recently, we have collaborated on a project to improve the health information that the Trust provides to its Romanian and Urdu/ Mirpuri speaking patients. In addition, we have worked together to improve communication with patients about waiting times following the pausing of appointments and operations during the pandemic. We note that throughout the Quality Account and the priorities set for 2021/22, there is not much focus on the role of service users in decision-making, implementation and evaluation of services. We welcome that the Trust recognises that an essential part of improving quality continues to be the scrutiny and challenge provided, through proper engagement with staff and other stakeholders. We would like the role of service user experiences, insight and experiences to be much more explicit and evidence of use of this and impact, much better presented in the Quality Account.

Therefore, we would like to see this focus on service user engagement, use of their feedback, experiences and insight, as a signal for quality of care in 2021/22. In particular, we would like to read in the 2021/22 Quality Account how service user experiences and feedback are informing improvement in the priorities from last year and this year, and core quality indicators, especially those where the Trust needs further improvement. We would like to read in the 2021/22 Quality Account, how feedback and experiences are being used to understand and act on:

- Reducing harm from falls including identifying risk factors, reasons for falls and prevention.
- Improving VTE prevention – to what extent will the actions under this priority include the role of patients and their families/carers in preventing VTE, this can include understanding whether those at risk understand what they can do to help/support staff to prevent VTE and educating them on their role.
- Improving ward rounds (including timely medical review) – how will service users and their carers/ families be involved in the development of a framework for local ward round standards. This could include understanding the impact of these changes for service users, their families and carers.
- Improving nutrition and hydration – is an issue that we hear about from service users, especially those nil by mouth. Although we would like to read about the numbers of staff trained in the 2021/22 Quality Account, we would also like to read about the impact of this on practice. For instance, service user's experiences and whether this is changing following the training. In addition, consultations to understand the difficulties staff face in managing patient's nutrition and hydration should include service user insights.
- Improving the safety of invasive procedures - Indeed the staff view is critical but the patients/ carer/families view can add to progress on these measures, for instance, through audits of compliance following the introduction of safety standards.
- DNAR – we note plans to ensure the validity of DNARs and consent given. The feedback we have heard around DNARs shows that there needs to be a clear process, engagement and communication with families on this issue. We believe it is important that actions taken to address this should include the insights of families/carers and in some cases, service users.

CQC

We are pleased to see that the Trust has retained its overall rating of good and has not had conditions on its registration with the CQC. However, we are concerned that the Trust has a rating of 'requires improvement for the safe

domain following a CQC inspection in December 2020. We would have liked to see outlined in the 2020/21 Quality Account specific actions to be taken across the four sites to make improvement in this area. We would like to read in the Quality Account 2020/21 what these areas are and the specific actions that were taken to enable Healthwatch Birmingham and Healthwatch Solihull to support the Trust. The service user experiences we hear throughout the year can potentially inform the work that the Trust is implementing. As the Trust continues to see an increase in the number of patient safety incidents[4] , we would like to read about the impact of the actions taken on patient experience in the 2021/22 Quality Account.

Performance against indicators included in the NHS Improvement Single Oversight Framework and Outcomes for Patients

Healthwatch Birmingham and Healthwatch Solihull note that apart from the VTE risk assessment indicator, the Trust is way below meeting the target in the other five indicators reported on p55. We note particularly the 18 weeks waiting time from referral to treatment performance is at 58.4% against a target of 92%; All cancers maximum 62 day wait from urgent GP referral is at 42.6% against a target of 85%; All cancers maximum 62 day wait for first treatment is at 69.6% against a target of 90%. We understand and appreciate the role that COVID-19 has played in this and impacted on these numbers. We would have liked to see in this report a statement on the measures being taken to address this.

This is of great concern to Healthwatch Birmingham and Healthwatch Solihull, especially considering the impact on outcomes for patients. Through listening to patient and user feedback we have identified issues around communication between the Trust and patients. In particular around delayed treatment and cancelled appointments causing high levels of anxiety for patients, and little ongoing support to manage conditions whilst they wait for treatment. Central to all the patient outcome concerns is how the Trust will recover and restore services post the pandemic. We fully understand how the pandemic has hit the hospital, and understand that UHB has been the hardest hit Trust. Undoubtedly this has had an impact on patient care and waiting lists. In a recent meeting with UHB we were informed about plans to reduce waiting lists and recover from the pandemic. We would like to continue supporting the Trust in 2021/22 to develop a robust prioritisation system, that effectively reduces the waiting lists to pre-pandemic levels.

[4] An increase in the number of never events from 9 to 12; increase in patient safety incidents standing at 70.2 compared to a peer average of 50.66; an increase in percentage of patient safety incidents resulting in severe harm or death from 0.40% to 0.47% and higher than the peer group average of 0.30%.

Data Quality and FFT

Healthwatch Birmingham and Healthwatch Solihull have taken note of the actions to be carried out in 2021/22 in relation to data quality. We particularly welcome plans to review the Data Quality Policy and develop associated procedures. We believe that good quality data is crucial for understanding quality of care and variability in care for some groups. We therefore ask that the data quality policy review includes a look into the use of a wide range of demographic data to enable a more extensive deep dive and understanding of needs.

Equality and Diversity

The unequal impact of Covid-19 on people with a disability and Black, Asian and Ethnic Minority groups has further highlighted the important role of health and social care organisations in promoting equality for everyone. As the Nuffield Trust highlighted in their report, inequalities persisted during the Covid-19 pandemic with some groups facing poorer mental health and barriers to accessing services. It is disappointing not to see a commitment from the Trust to inclusion and equality in the 2020/21 Quality Account. We believe that a focus on inequality is ever more important as the Trust works to restore services if it is to reduce variability. It will be important for the Trust to understand the various experiences of discrimination that lead to health inequality and use this to inform restoration of services. We believe that Covid-19 has changed how health and social care collects and uses feedback, and public health data to understand the community it serves. We believe that this should be a critical focus of the Trusts priorities. Healthwatch Birmingham recently shared our 'Health Inequalities: Somali people's experiences of health and social care services in Birmingham' with the Trust. We would like to know how the findings of this report are continuing to inform the Trusts health inequalities work; how the Trust is improving its knowledge about the issues facing minority ethnic groups, improving engagement with ethnic minority groups, and how it is designing and delivering services in a manner that addresses issues of discrimination and stigma. For instance, we note the number of speak up contacts and issues raised under the freedom to speak priority for 2020/21. We would like to read examples of actions taken to address issues around disrespect, bullying, leadership/probity and discrimination or racism.

Andy Cave
CEO

Annex 2: Statement of directors' responsibilities for the quality report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2020 to May 2021
  - papers relating to quality reported to the board over the period April 2020 to May 2021
  - feedback from the commissioners dated 27/07/2021
  - feedback from governors dated 20/05/2021
  - feedback from local Healthwatch organisations dated 30/07/2021
  - feedback from Overview and Scrutiny Committee dated 28/07/2021 (Solihull) and 29/07/2021 (Birmingham)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2021
  - the 2019 national patient survey 02/07/2020
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 11/06/2021
  - CQC inspection report dated February 2021
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date: 28 June 2021 ..... Chair

Date: 28 June 2021 ..... Chief Executive

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

NHS England and NHS Improvement advised that the Trust's External Auditors, Deloitte, are not required to provide assurance on the Quality Report 2020/21.