University Hospitals Birmingham
NHS Foundation Trust

This annual report covers the period
1 April 2014 to 31 March 2015

Quality Account 2014/2015

Contents

Part 1: Chief Executive's Statement

University Hospitals Birmingham NHS Foundation Trust (UHB) has continued to focus on delivering high quality care and treatment to patients during 2014/15. In line with national trends, the Trust has seen unprecedented demand for its services with large increases in Emergency Department attendances and admissions which has put significant pressure on our ability to deliver planned treatments. The Trust's Vision is "to deliver the best in care" to our patients. The Trust's Core Purposes – Clinical Quality, Patient Experience, Workforce and Research and Innovation – provide the framework for the Trust's robust approach to managing quality. It is very pleasing to see that patients and staff would recommend the Trust as a place to be treated in the 'Friends and Family' tests. Furthermore, the number of formal complaints received remained stable and the number of compliments increased during 2014/15.

The Trust has made excellent progress in relation to two of the five priorities for improvement set out in last year's Quality Report: improving venous thrombo-embolism (VTE) prevention and completeness of observation sets. Performance for the remaining indicators – patient experience, reducing medication errors and infection prevention and control – has been mixed with some key achievements and further work required to improve performance in 2015/16. The Board of Directors has chosen to continue with four of the five priorities for improvement in 2015/16 and replace *Priority 1: Improving VTE Prevention* with a new priority proposed by the Trust's Council of Governors: *Reducing grade 2 hospital-acquired pressure ulcers*.

UHB's focused approach to quality, based on driving out errors and making incremental but significant improvements, is driven by innovative and bespoke information systems which allow us to capture and use real-time data in ways which few other UK trusts are able to do. A wide range of omissions in care have been reviewed in detail during 2014/15 at the regular Executive Care Omissions Root Cause Analysis (RCA) meetings chaired by the Chief Executive. Cases are selected for review from a range of sources including an increasing number put forward by senior medical and nursing staff: wards selected for review, missed or delayed medication, Serious Incidents Requiring Investigation (SIRIs), serious complaints, infection incidents, incomplete observations and cross-divisional issues.

The national Sign up to Safety campaign was launched in 2014 and aims to make the NHS the safest healthcare system in the world. The ambition is to halve avoidable harm in the NHS over the next three years. Organisations across the NHS have been invited to join the Sign up to Safety campaign and make five key pledges to improve safety and reduce avoidable harm. University Hospitals Birmingham NHS Foundation Trust joined the Sign up to Safety campaign in November 2014. As part of the campaign, UHB has made five Sign up to Safety pledges which closely align with the content of the Quality Report and are included in section 3.7 of the report. UHB is now working on an action plan and process for monitoring progress over the next three years.

Data quality and the timeliness of data are fundamental aspects of UHB's management of quality. Data is provided to clinical and managerial teams as close to real-time as possible through various means such as the Trust's digital Clinical Dashboard. Information is subject to regular review and challenge at specialty, divisional and Trust levels by the Clinical Quality Monitoring Group, Care Quality Group and Board of Directors for example. An essential part of improving quality at UHB continues to be the scrutiny and challenge provided through proper engagement with staff and other stakeholders. These include the Trust's Council

of Governors, Patient and Carer Council (Wards), General Practitioners (GPs) and local Clinical Commissioning Groups (CCGs).

A key part of UHB's commitment to quality is being open and honest with our staff, patients and the public, with published information not simply limited to good performance. The Quality web pages provide up to date information on the Trust's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm. The Trust has continued to publish monthly data during 2014/15 showing how each inpatient specialty is performing for a range of indicators on the dedicated *mystay@QEHB* website: infection rates, medication given, observations, clinical assessments and patient feedback.

The Trust's internal and external auditors provide an additional level of scrutiny over key parts of the Quality Report. The Trust's external auditor Deloitte has reviewed the content of the Trust's 2014/15 Quality Account and undertaken testing for three areas in line with the Monitor guidance on external assurance: 18 week referral to treatment times (unfinished pathways), 28 day readmissions and two local indicators. The Trust's Council of Governors selected two local pain indicators to be audited this year which will be measured as part of *Priority 3: Timely and complete observations including pain assessment* during 2015/16. No significant issues were identified with the content review or the testing for the 28 day readmission and two local pain indicators. Deloitte has however issued a qualified opinion on the 18 week referral to treatment time (unfinished pathways) indicator and the Trust is currently implementing the recommendations. The report provided by our external auditor is included in Annex 3 of the Quality Report.

The Trust was inspected in January 2015 by the Care Quality Commission (CQC) as part of the new, national inspection regime. The inspection involved around 60 inspectors observing the care and treatment provided across the Trust over 3 days, focusing on core services such as the Emergency Department and Critical Care, with an unannounced follow-up visit afterwards. The CQC focuses on assessing whether services are safe, effective, caring, responsive to people's needs and well led. The inspection included a Public Listening Event and voluntary drop-in sessions for various staff groups to provide feedback to the CQC. Trusts are given one of four overall ratings following inspection as well as separate ratings for each core service: Inadequate, Requires Improvement, Good or Outstanding. The Trust has been rated as Good overall with 85% of areas being rated as Good or Outstanding and 15% rated as Requires Improvement. The CQC found the Trust to be compliant with all Essential Standards and identified a small number of recommendations which will be taken forward during 2015/16.

The Five Year Forward View report was published in October 2014 and sets out the changes and investment required to deliver an improved, more sustainable NHS and implement new models of care. During 2014/15, the Trust successfully bid to become the prime provider for a new fully integrated sexual health treatment and prevention programme called Umbrella from August 2015. The contract will see UHB both providing and commissioning services for the people of Birmingham and Solihull through two central sites, satellite clinics and community clinics over the next five years.

2015/16 will be particularly challenging for UHB as we focus on delivering the best in care and achieving outcome/access targets alongside rising demand for our services and greater financial constraints. The Trust will continue working with commissioners, healthcare providers and other organisations to influence future models of care delivery and deliver further improvements to quality during 2015/16.

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.

Dame Julie Moore, Chief Executive

May 21, 2015

Section 3 | Quality Report

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

2.1 Priorities for Improvement

The Trust's 2013/14 Quality Report set out five priorities for improvement during 2014/15:

Priority 1: Improving VTE (venous thrombo-embolism) prevention
Priority 2: Improve patient experience and satisfaction
Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)
Priority 4: Reducing medication errors (missed doses)
Priority 5: Infection prevention and control

The Trust has made excellent progress in relation to two quality improvement priorities: improving venous thrombo-embolism (VTE) prevention and completeness of observation sets. There has however been mixed performance for patient experience, reducing medication errors and infection prevention and control during 2014/15.

The Trust received more compliments in 2014/15 compared to 2013/14 and the number of formal complaints received compared to activity remained stable. The improvement targets for the local patient survey questions were not achieved in 2014/15 for the majority of questions. The Trust has successfully maintained performance for missed antibiotics but performance for missed non-antibiotics deteriorated in 2014/15. The Trust missed the trajectory for zero Trust-apportioned MRSA bacteraemias but met the *C. difficile* infection trajectory during 2014/15.

The Board of Directors has chosen to continue with four of the five priorities for improvement in 2015/16 and replace priority 1 as follows:

No.	Priorities for Improvement	2014/15	2015/16	Detail
1	Improving VTE Prevention	Yes	No	Discontinued due to consistent high performance.
	Reducing grade 2 pressure ulcers	No	Yes	New priority proposed by Council of Governors to replace VTE.
2	Improve patient experience and satisfaction	Yes	Yes	Care Quality Group chose to keep the same questions due to performance issues and use scores to aid comparability with other trusts.
3	Timely and complete observations including pain assessment (previously called Electronic observation chart)	Yes	Yes	Changed to include pain assessment and timely administration of pain relief (analgesic medication).
4	Reducing medication errors (missed doses)	Yes	Yes	Remains a priority as non-antibiotic missed doses increased in 2014/15 rather than reduced as planned.
5	Infection prevention and control	Yes	Yes	Trajectories refreshed for 2015/16.

The improvement priorities for 2015/16 were initially selected by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then discussed with various Trust groups including staff, patient and public representatives during Quarter 4 2014/15 as shown in the table below. The priorities for improvement in 2015/16 were also shared and discussed with interested parties outside the Trust including the Trust's lead Clinical Commissioning Group (CCG): Birmingham and Cross-City CCG.

The focus of the patient experience priority was decided by the Care Quality Group and the priorities for improvement in 2015/16 were then finally approved by the Board of Directors in March 2015. The priorities for 2015/16 will finally be presented to the Trust Partnership Team and cascaded to all staff via Team Brief in May 2015.

Date	Group	Key Members
February 2015	Council of Governors	Chairman, Chief Executive, Executive Directors, Directors and Staff, Patient and Public Governors
February 2015	Care Quality Group	Executive Chief Nurse, Associate Directors of Nursing, Matrons, Senior Managers with responsibility for complaints, PALS (Patient Advice and Liaison Service), patient experience and governance
March 2015	Patient and Carer Council (Wards)	Patient and Carer Council Representatives, Associate Directors of Nursing, Matrons, Senior Managers with responsibility for complaints, PALS (Patient Advice and Liaison Service), patient experience and Human Resources
March 2015	Chief Operating Officer's Group	Executive Chief Operating Officer, Deputy Chief Operating Officer, Directors of Operations, Divisional Directors, Director of Operational Finance, Deputy Chief Nurse, Director of Patient Services, Director of Estates and Facilities, Director of IT Services plus other Managers
March 2015	UHB Contract Review Meeting	Various managers and clinical staff from Birmingham and Cross-City Clinical Commissioning Group and UHB
May 2015	Trust Partnership Team	Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives
May 2015	Chief Executive's Team Brief (cascaded to all Trust staff)	Chief Executive, Executive Directors, Directors, Clinical Service Leads, Heads of Department, Associate Directors of Nursing, Matrons, Managers

The performance for 2014/15 and the rationale for any changes to the priorities are provided in detail below. This report should be read alongside the Trust's Quality Report for 2013/14.

Priority 1: Improving VTE prevention

Background

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

Whilst many other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System (PICS) since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

During 2011/12, the Trust started to regularly monitor whether patients are given VTE prevention treatment, if required, following risk assessment. Performance for individual wards and the Trust overall is now available on the electronic Clinical Dashboard to allow real-time audit of performance by nursing and medical staff.

The Trust has performed consistently highly for completion of VTE risk assessments and therefore chose to focus on improving compliance with the outcomes of completed VTE risk assessments from 2012/13. This means improving VTE prevention through appropriate administration of preventative (prophylactic) treatment. Preventative treatments include anti-embolism stockings (AES) and/or enoxaparin medication used to reduce the risk of blood clots forming.

Performance

VTE Risk Assessment Completion

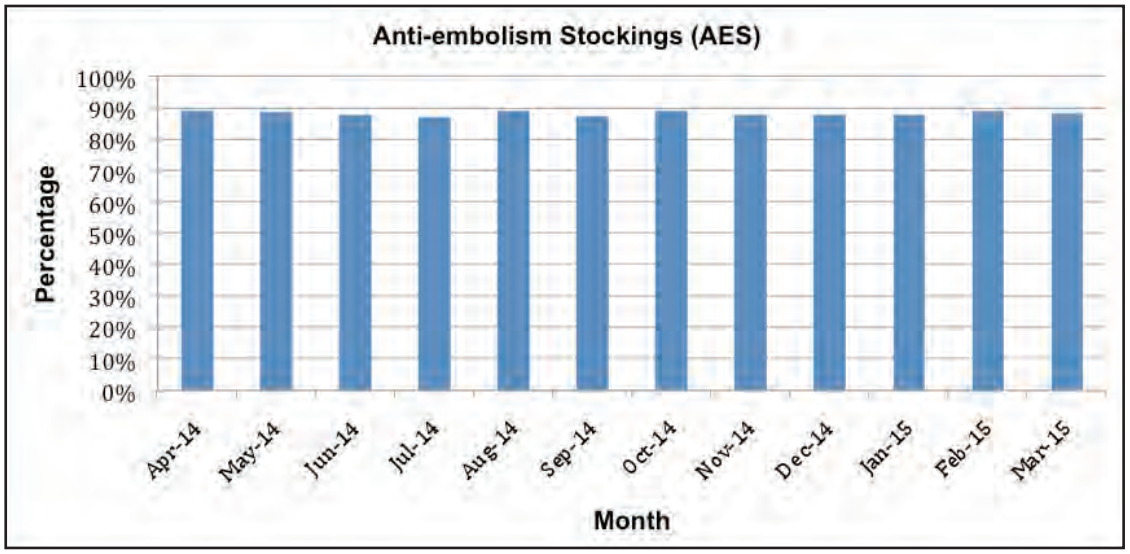
The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010 and 99% or over since June 2012. This is above the national average of 96% for NHS acute providers as published on the NHS England website (January 2015).

VTE Prevention – Anti-embolism Stockings

The graph below shows the percentage of anti-embolism stockings administered at least once by episode for those patients who require them as recorded in the electronic Prescribing Information and Communication System.

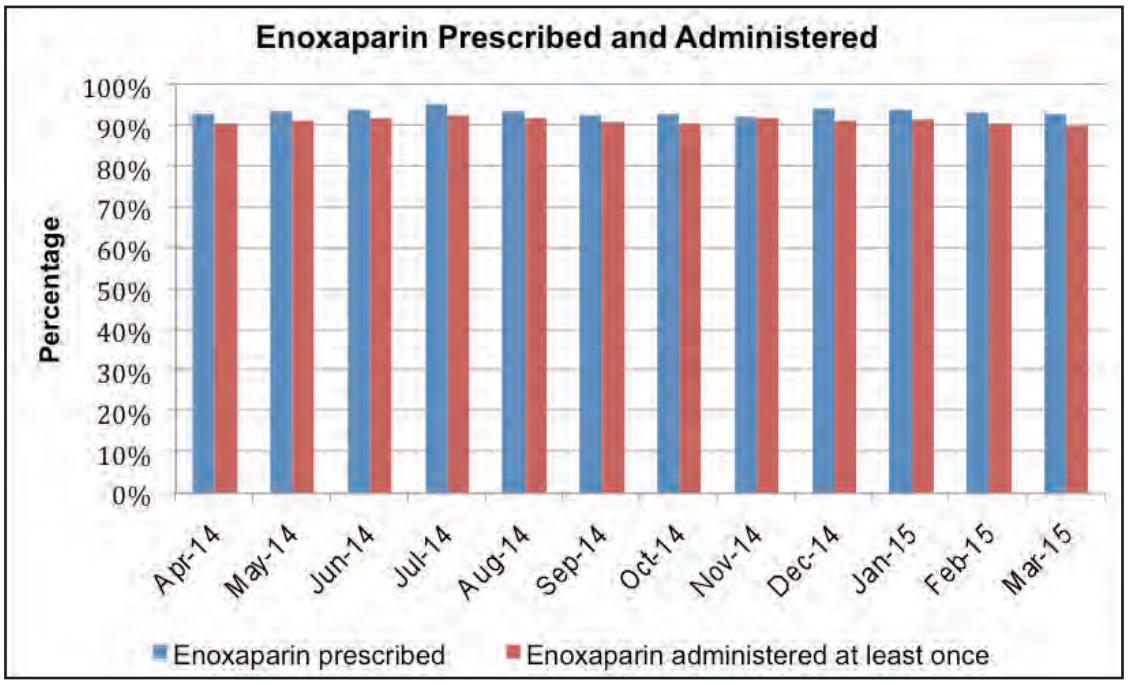
In the 2013/14 Quality Report, the Trust committed to maintaining performance for administration of anti-embolism stockings at 83% or above during 2013/14. Overall, 88.5% of anti-embolism stockings were administered at least once per episode during 2014/15.

One patient admission or spell in hospital can comprise a number of different episodes of care. If the outcome of a VTE risk assessment shows that a patient requires anti-embolism stockings, they are automatically prescribed by PICS. It is not always appropriate to administer anti-embolism stockings every day for a variety of reasons including patient choice and clinical contraindications such as sore or swollen skin for example. These two categories account for around two-thirds of the stockings not administered.



VTE Prevention – Enoxaparin Medication

The graph below shows the percentage of patients who required enoxaparin medication following VTE risk assessment and were prescribed it. In the 2013/14 Quality Report, the Trust committed to maintaining performance for enoxaparin prescription at 90% or above during 2014/15. Overall, 93.5% of patients who required enoxaparin following VTE risk assessment were prescribed it within 12 hours in 2014/15. Of the patients who were prescribed enoxaparin, 91.3% were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Initiatives implemented during 2014/15:

- Regular Junior Doctor review clinics continued during 2014/15 with a particular focus on improving timeliness of enoxaparin prescription for those patients who require it following VTE risk assessment

- The findings from root cause analysis (thorough investigation) of cases where patients developed VTE during their stay in hospital or within 3 months after discharge have been regularly reviewed

- The change made to the VTE risk assessment module in the Trust's Prescribing Information and Communication System (PICS) in January 2014 has been monitored to ensure the increase in performance was sustained. When a Doctor completes a VTE risk assessment and enoxaparin is required, the system automatically takes the Doctor to a blank prescription proposal for them to complete

Changes to Improvement Priority for 2015/16:

As performance has remained consistently high, the Trust has decided to discontinue this priority for improvement in 2015/16. Performance will continue to be monitored internally via the Clinical Dashboard, Thrombosis Group and regular Junior Doctor review clinics which focus on compliance with VTE risk assessment outcomes.

New Priority 1: Reducing grade 2 hospital-acquired pressure ulcers

This quality improvement priority was proposed by the Council of Governors and approved by the Board of Directors.

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.

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

Grade	Description
1	Skin is intact but appears discoloured. The area may be painful, firm, soft, warmer or cooler than adjacent tissue.
2	Partial loss of the dermis (deeper skin layer) resulting in a shallow ulcer with a pink wound bed, though it may also resemble a blister.
3	Skin loss occurs throughout the entire thickness of the skin, although the underlying muscle and bone are not exposed or damaged. The ulcer appears as a cavity-like wound; the depth can vary depending on where it is located on the body.
4	The skin is severely damaged, and the underlying muscles, tendon or bone may also be visible and damaged. People with grade 4 pressure ulcers have a high risk of developing a life-threatening infection.

(National Pressure Ulcer Advisory Panel, 2014)

UHB has seen a significant decrease in the number of hospital-acquired pressure ulcers during 2014/15, especially grade 3 and grade 4 ulcers. This is as a result of a number of initiatives:

- In April 2013, the Tissue Viability Service (TVS) was granted funding for additional specialist nurses which enables the Service to review every pressure ulcer that is reported as a grade 2, 3 or 4. This has allowed them to build up a clear idea of the true incidence of pressure ulcers, to assess educational requirements and tailor training to specific wards. It also means that the team can run a six-day service (a model of care not provided by any other regional providers)

- The Pressure Ulcer Action Group is a trust-wide group with a multi-disciplinary membership. The group hold monthly meetings chaired by the Deputy Chief Nurse, providing a forum to identify and address any key quality issues. Divisions complete action plans and present progress updates. There has been significant support from senior management which has ensured that ward staff are increasingly aware of how to prevent, identify, assess and manage pressure ulcers. The TVS provides a formal education programme on pressure ulcer prevention and treatment. Each clinical area has several Tissue Viability link nurses, and a member of the TVS is linked to each Division. All nursing staff are required to undergo mandatory pressure ulcer grading training

- UHB devised the "React to RED" preventative strategy: when a staff member identifies a potential pressure ulcer, they think "RED": Reposition, Equipment, Documentation

- The Waterlow assessment tool (an assessment of a patient's risk of developing a pressure ulcer) is recorded electronically in PICS, which means wards' use of this

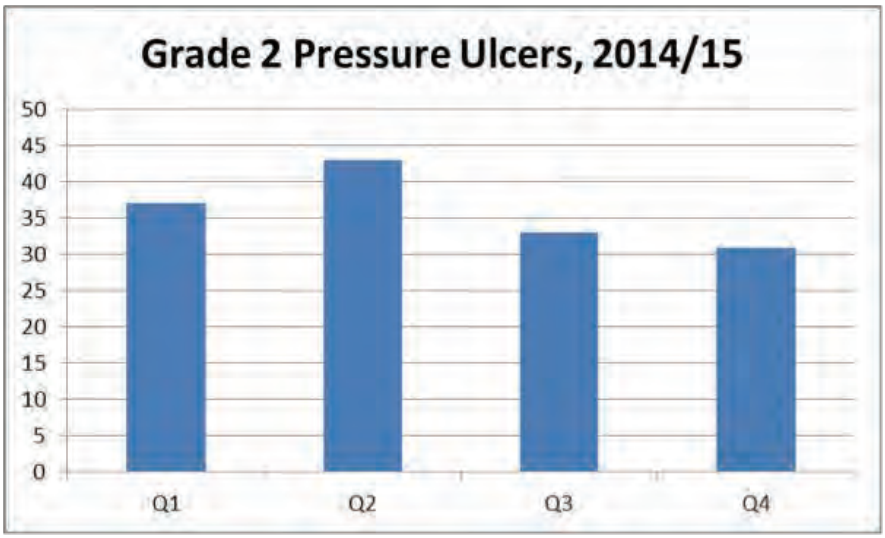
assessment tool can be easily monitored and reported. Repositioning is also recorded electronically

- The TVS are responsible for purchasing decisions for pressure relieving equipment, meaning choices are evidence-based, using the latest available research

As there are now fewer hospital-acquired grade 3 and grade 4 ulcers at UHB, the Trust has chosen to focus on reducing grade 2 ulcers. This in turn should reduce the number of grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

Performance

For the period April 2014 to March 2015, there were 144 non device-related grade 2 pressure ulcers reported at UHB, against a trajectory of 143.



The 2015/16 reduction target agreed with Birmingham Cross City Clinical Commissioning Group (CCG) is 132 non device-related grade 2 pressure ulcers.

Initiatives to be implemented during 2015/16

To continue to build on the improvements seen in 2014/15, to further identify any common causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly.

How progress will be monitored, measured and reported:

- All grade 2, 3 and 4 pressure ulcers are reported via the Trust's incident reporting system Datix, and then reviewed by a Tissue Viability Specialist Nurse

- Monthly reports are submitted to the Trust's Pressure Ulcer Action Group, which reports to the 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 can monitor the number and severity of pressure ulcers on their ward via the Clinical Dashboard

Priority 2: Improve patient experience and satisfaction

The Trust measures patient experience via feedback received in a variety of ways, including local and national patient surveys, the NHS Friends and Family Test complaints and compliments and online sources (e.g. NHS Choices). This vital feedback is used to make improvements to our services.

Patient Experience Data from surveys

Performance

During 2014/15, 25,960 patient responses were received to our local inpatient survey and 2265 responses to our discharge survey. The table below shows results to key questions for the past four financial years. The results show that since 2011/12 the Trust has made improvements across all areas of patient experience; however a slight decline was seen in completely positive responses during 2014/15, with an increase in partially positive responses and negative responses.

The Trust's latest National Adult Inpatient Survey results are shown in Part 3 of this report.

Methodology

From 2015/16 we are changing the way we report our patient experience results to match the national survey scoring method, which takes account of all responses received. This will allow transparency and comparison as well as simpler interpretation. In previous years we have reported the percentage of most positive responses received (calculated by dividing the number of positive responses, e.g. 'Yes, definitely', by the total number of applicable responses).

The data in the table for 2014/15 shows the new scoring system alongside the previous system for completeness.

The 2014 national survey scores for UHB have been included for information, but please note that these results are based on a smaller sample size than the local surveys (approximately 400, although this varies by question), hence the difference between the scores for each question.

Improvement target for 2015/16

The questions chosen for our improvement priority for 2014/15 included our lowest performing questions from our regular inpatient, outpatient, Emergency Department and discharge surveys. As we have not managed to show improvement in these areas during the year (see below table) we have decided to maintain this important improvement priority for 2015/16.

- Questions scoring 9 or above in 2014/15 are to maintain a score of 9 or above

- Questions scoring below 9 in 2014/15 are to increase performance by at least 5%, and/or achieve a score of 9

Results from local patient surveys

	Score		% most positive responses (local survey)		Target	No. responses (local survey)	UHB ranking in national survey compared to other Trusts	UHB National survey score (2014)
	2013/14	2014/15	2013/14	2014/15	2014/15	2014/15		
Inpatient survey								
1. Did you find someone on the hospital staff to talk about your worries or fears?	8.7	**8.4**	79.7%	**74.6%**	83.7%	10,913	About the same	6.1
2. Do you think that the ward staff do all they can to help you rest and sleep at night?	9.1	**8.8**	83.5%	**78.4%**	87.7%	14,633	Not applicable (local question)	
3. Have you been bothered by noise at night from hospital staff?	8.4	**8.1**	73.5%	**67.7%**	77.2%	14,697	About the same	8.2
4. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.6	**8.6**	77.3%	**76.6%**	81.2%	25,610	About the same	8
5. Did the staff treating and examining you introduce themselves?	New for 2014/15	**8.9**	New for 2014/15	**80.3%**	New for 2014/15	22,724	Not applicable (local question)	
Outpatient survey*								
6. Was your appointment changed to a later date by the hospital?	9.2	**9.2***	80.6%	**81.1%***	84.6%	2,186	No recent national survey	
7. Did the staff treating and examining you introduce themselves?	8.6	**8.5***	78.0%	**73.1%***	81.9%	2,144		
8. Did a member of staff tell you about medication side effects to watch out for?	6.6	**6.6***	54.9%	**52.6%***	57.7%	422		
Emergency Department survey								
9. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.1	**7.9**	68.8%	**67.4%**	72.2%	1,680	About the same	7.5
10. Do you think the hospital staff did everything they could to help control your pain?	8	**7.8**	70.3%	**69.6%**	73.8%	1,608	About the same	7.6
Discharge survey*								
11. Did a member of staff tell you about medication side effects to watch for when you went home?	5.9	**5.8***	47.3%	**48.3%***	49.7%	1,631	About the same	5.3
12. Did you feel you were involved in decisions about going home from hospital?	7.2	**7.0***	54.7%	**53.1%***	57.4%	2,085	About the same	7.2

*2014/15 data available for outpatient and discharge survey questions up to February 2015.

Friends and Family Question

The Trust has monitored performance for the Friends and Family Test question during 2014/15:

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

Patients asked the question could choose from six different responses as follows:

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

Patients staying overnight on an inpatient ward were asked on discharge from hospital. Those attending the emergency department were asked either on leaving, or afterwards via an SMS text message.

From 1st October 2014 the question was rolled out to include those attending as day cases and outpatients. Patients can choose to answer the question as they leave, or they can access the question online via the Trust website.

The required inpatient response rate target of 30% in Quarter 4 2014/15 has been met, and the additional target of 40% for March 2015 has also been met.

The response rate target for the A&E Friends and Family Test has proved challenging, but a sustained and collaborative focus has resulted in this target being met with a response rate for Quarter 4 of 20.8% against a target of 20.0%.

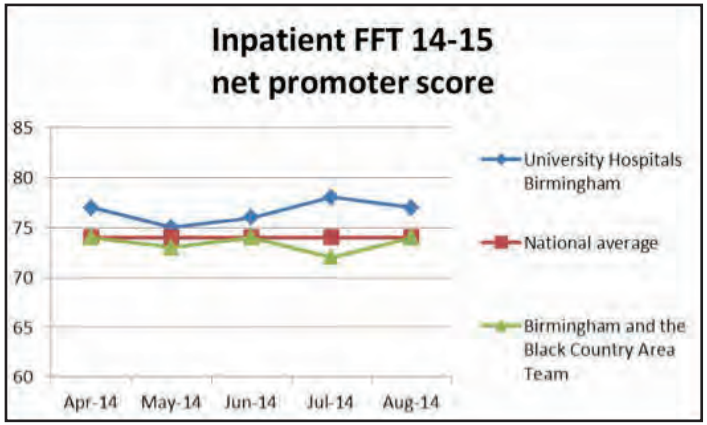
Methodology

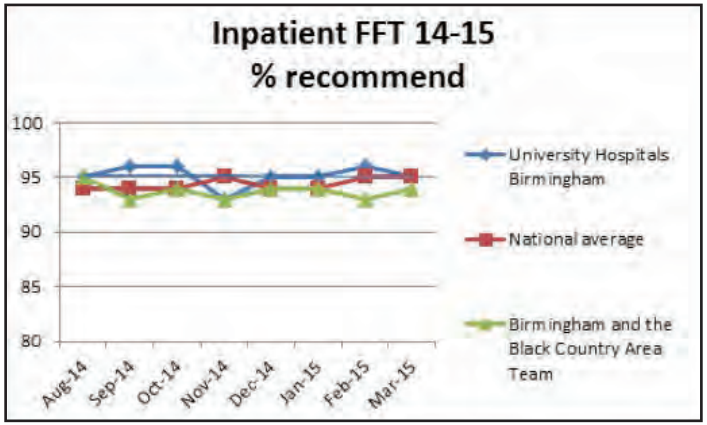
In 2014/15 there was a national change to the methodology for reporting results. From Quarter 3, rather than a net promoter score, results are shown as a percentage of those who 'would recommend' (those who answered 'extremely likely' or 'likely') and those who would not recommend' (those who answered 'unlikely' or extremely unlikely').

Although the net promoter score is no longer used, both ways of scoring are displayed in this report for completeness for the year.

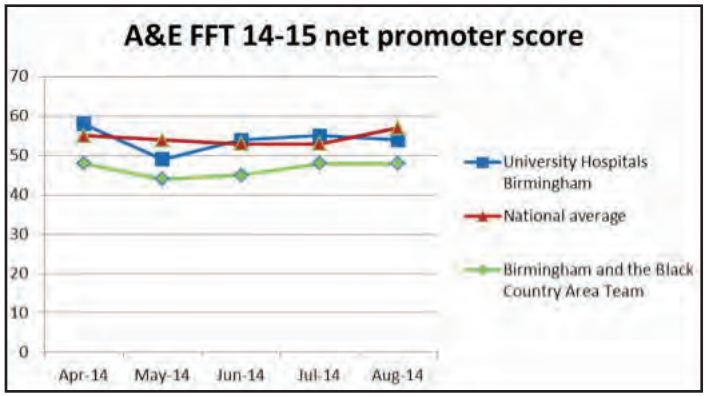
Performance and Response Rates

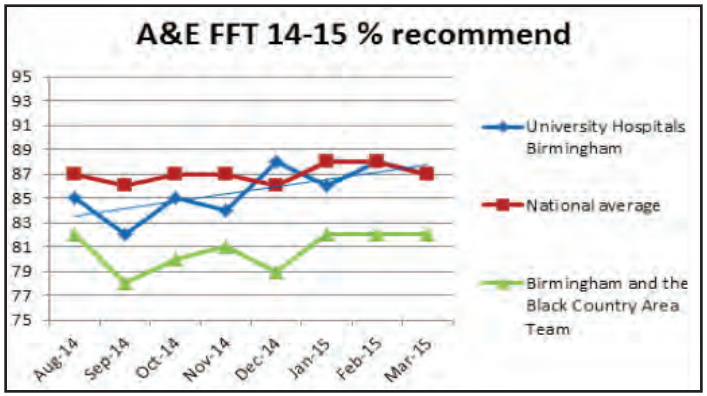
The charts below show comparisons for the net promoter scores, and the 'would recommend' percentages for the Friends and Family Test for Inpatients and for A&E. Two charts are shown for each area due to the change in scoring mechanism during the year.





Inpatients: During 2014/15 the Trust has maintained a score/positive recommendation rate that is equal to or above the national average, and above the Birmingham and Black Country regional score/positive recommendation rate.





A&E: During 2014/15 the Trust has increased its positive recommendation rate to fall in line with the national average, and has remained above the Birmingham and Black Country regional score/positive recommendation rate.

Complaints

The number of formal complaints received in 2014/15 was 654. A further 138 complaints were dealt with informally such as via a telephone call to resolve an appointment issue, without the need for formal investigation.

The top three main subjects of complaints received in 2014/15 related to clinical treatment (358), communication and information (83) and inpatient appointment delay/cancellation (80), matching the top three main subjects identified in 2013/14 complaints.

The rate of formal complaints received against activity across Inpatients, Outpatients and the Emergency Department has remained stable, despite an increase in activity in Outpatients and the Emergency Department.

	2011/12	2012/13	2013/14	2014/15
Total number of formal complaints	797	752	664	654

Rate of formal complaints to activity		2011/12	2012/13	2013/14	2014/15
Inpatients	FCEs*	118,504	126,309	132,280	127,204
	Complaints	434	428	379	371
	Rate per 1000 FCEs	**3.7**	**3.4**	**2.9**	**2.9**
Outpatients	Appointments**	544,876	585,488	729,695	752,965
	Complaints	289	214	200	201
	Rate per 1000 appointments	**0.5**	**0.4**	**0.3**	**0.3**
Emergency Department	Attendances	87,744	94,662	97,298	102,054
	Complaints	72	110	85	82
	Rate per 1000 attendances	**0.8**	**1.2**	**0.9**	**0.8**

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

** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech & Language Therapy and Occupational Therapy)

Learning from complaints

The table below provides some examples of how the Trust has responded to complaints where serious issues have been raised, a number of complaints have been received about the same or similar issues or for the same location, or where an individual complaint has resulted in specific learning and/or actions.

Theme/Issue	Area of Concern	Action taken	Outcome
Level of complaints around the attitude of Imaging staff towards patients/ carers.	Relatively low but persistent level of complaints. Impact on patients/ carers already anxious about a procedure.	Details of trend highlighted in the Patient Relations report to the relevant Divisional Clinical Quality Group. Highlighted in a report and email to the Group Manager for Imaging. Head of Patient Relations delivered a programme of bespoke customer care training to Imaging staff, incorporating anonymised examples of the feedback received.	No complaints received about Imaging staff attitude relating to experiences since the time of the training. The level of complaints around this will continue to be closely monitored.
Level of complaints around Urology, especially around cystoscopy procedures.	Delays and cancellations of appointments, delaying procedures.	Trend highlighted in a report and email to the divisional Associate Director of Nursing. Head of Patient Relations met with the Associate Director of Nursing to discuss content of complaints and associated trends. Actions have been taken to address the underlying issues. Additional theatre time allocated to the specialty. Private sector theatre capacity secured. Process refinements on the main Urology ward had resulted in an increased throughput of patients.	Waiting list for patients awaiting the specific procedure has been dramatically reduced; impacting positively on the patient experience and the level of complaints received about this issue, which will continue to be monitored.
Personal hygiene needs neglected.	Four complaints received around this subject in one month.	Each complaint investigated and response including apology provided. Findings reviewed by members of the senior divisional management team. Details sent to the Senior Clinical Educator (Nursing) with anonymised details of the cases for incorporation into training sessions with nursing staff. The anonymised scenarios developed have been used in a number of training sessions. Details also shared with the Lead Nurse for Standards.	Complaints around this issue significantly reduced but this issue will continue to be closely monitored.

The Trust takes a number of steps to review learning from complaints and to take action as necessary. Related actions and learning from individual complaints are shared with the complainant in the Trust's written response or at the local resolution meeting where appropriate. All actions from individual complaints are captured on the Complaints database. A regular report is sent to each clinical division's senior management team with details of every complaint for their division with actions attached; highlighting any of those cases where any of the agreed actions remain outstanding.

Details of actions and learning from complaints are also shared in a wider Patient Relations report, which is presented at the relevant division's Clinical Quality Group meeting. This report provides detailed data on complaints, Patient Advice and Liaison Service (PALS) concerns and compliments, as well as highlighting trends around specific issues and/or wards, departments or specialties. Trends around staff attitude and communication for particular locations feed into customer care training sessions, which are delivered by the Head of Patient Relations to ward/department staff and include anonymised quotes from actual complaints about the specific ward/department. Complaints and PALS data is also shared in a broader Aggregated Report which is presented to the Clinical Quality Committee, chaired by the Trust's Chairman, on a quarterly basis and incorporates information on incidents and legal claims. Complaints and PALS data is reported monthly to the Care Quality Group as part of the Patient Experience report. A monthly complaints report is presented at the Chief Executive's Advisory Group meeting.

Serious Complaints

The Trust uses a risk matrix to assess the seriousness of every complaint on receipt. Those deemed most serious, which score either 4 or 5 for consequence on a 5 point scale, are highlighted separately across the Trust. The number of serious complaints is reported monthly to the Chief Executive's Advisory Group and detailed analysis of the cases and the subsequent investigation and related actions are presented to the Divisional Management Teams at their Divisional Clinical Quality Group meetings. It is the Divisional Management Teams' responsibility to ensure that following investigation of the complaint, appropriate actions are put in place to ensure that learning takes place and that every effort is made to prevent a recurrence of the situation or issue which triggered the complaint being considered "serious". A recent revision of the Terms of Reference for the Trust's Patient Safety Group allows for serious complaints, where there is potential for Trustwide learning, to be presented to the Group for consideration of how best to share that learning across the organisation.

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

PHSO Involvement	2011/12	2012/13	2013/14	2014/15
Cases referred to PHSO by complainant for investigation	16	16	16	23
Cases which then required no further investigation	8	9	3	2
Cases which were then referred back to the Trust for further local resolution	1	2	1	1
Cases which were not upheld following review by the PHSO	0	1	2	5
Cases which were partially upheld following review by the PHSO	1	1	3	9
Cases which were fully upheld following review by the PHSO	0	1	0	0

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

Nine cases were upheld or partially upheld by the Ombudsman in 2014/15, an increase on the three partially upheld in the previous year. Discussion with complaints leads elsewhere suggests that this trend is mirrored at many Trusts across the country, including the larger acute Trusts which form the Shelford Group. In every case, appropriate apologies were provided, action plans were developed where requested and the learning from the cases was shared with relevant staff. Among the learning identified and shared was a case where a chyle leak (a complication where there is a leak of fluid from the thoracic duct or one of the channels leading into it) had been conservatively managed by the surgical team. As a direct result of the complaint, a new protocol for the management of such leaks was developed and shared with the complainant and the Ombudsman.

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS), and also by the Patient Experience Team. PALS record any compliments they receive directly from patients and carers. The Patient Experience Team collates and records compliments received via all other sources. This includes those sent to the Chief Executive's office, the patient experience email address, the Trust website and those sent directly to wards and departments. Where compliments are included in complaints or customer care award nominations they are also extracted and logged as such.

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

The Trust recorded around nine per cent more compliments in 2014/15 than in 2013/14. The Patient Experience team have continued to provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments. In addition, they have been scoping additional methods of capturing positive feedback received.

Compliment Subcategories	2012/13	2013/14	2014/15
Nursing care	356	424	**242**
Friendliness of staff	207	191	**142**
Treatment received	766	1,202	**1,743**
Medical care	92	79	**56**
Other	38	9	**17**
Efficiency of service	151	187	**104**
Information provided	10	27	**12**
Facilities	24	12	**12**
Totals:	**1,644**	**2,131**	**2,328**

Examples of compliments received during 2014/15:

Date received	Compliment
April 2014	I… found that the nursing staff were exceptionally professional and couldn't do enough for me. Also the cleanliness was outstanding. I was very pleased with the food on offer and menu choice. The Porter was excellent and managed to make me feel relaxed and calm prior to my operation.
May 2014	Thank you for making today as comfortable and stress-free as possible, I have nothing but the greatest respect for your thoroughly professional team. From the very first engagement to post procedure care, I was treated extremely well by all the fantastic staff at QEH.
July 2014	Heart filled thank you and gratitude to you all for looking after me and for your patience and continuous care around the clock.
August 2014	Not only did she listen when I was panicking to help put me at ease she explained to me the reasons to the long waiting times… treated my granddad as a patient, not a number. She knew who I was talking about instantly which showed a customer rapport.
September 2014	Everyone was kind and thoughtful, explained everything clearly and allayed any concerns I had.
October 2014	My experience… has been second to none. I have been treated with the utmost efficiency, respect, and compassion by each and every one of the team.
December 2014	Your compassion has changed a situation I was dreading, into something I hardly gave a second thought to, and I really thank you for that.
February 2015	Thanking you making my stay a very pleasant experience under the circumstance. Your friendly faces and smiles helped a great deal.
March 2015	The best ever ward! You saved the family from disaster, thank you all for your hard work and help. Without your help and service our dad wouldn't be alive.

Feedback received through the NHS Choices and Patient Opinion websites

The Trust has a system in place to routinely monitor feedback posted on two external websites; NHS Choices and Patient Opinion. Feedback is sent to the relevant service/ department manager for information and action. A response is posted to each comment received which acknowledges the comment and provides general information when appropriate. The response also promotes the Patient Advice and Liaison Service (PALS) as a mechanism for obtaining a more personalised response, or to ensure a thorough investigation into any concerns raised. Whilst there has been a further increase in the number of comments posted on each of these two websites the numbers continue to be extremely low in comparison to other methods of feedback received. The majority of feedback received via this method is extremely positive.

Initiatives implemented in 2014/15:

The following initiatives were implemented during the year to help to improve the experience of patients, carers and visitors:

- The NHS Friends and Family Test question was expanded to include day case patients and those attending as an outpatient

- Feedback around food has been consistently evaluated via a variety of different methods and a number of touch points along the patient journey. This has enabled the catering team to be very responsive around making improvements. In particular they have been able to take an individualised approach, working directly with clinical areas to look at bespoke solutions for particular groups of patients

- A number of clinical areas have reviewed their individual needs around patient experience feedback and have introduced innovative ways of collecting feedback and displaying results, these areas include Ambulatory Care, East Block Day Unit and Therapies

- The Trust's first Patient Experience Conference titled 'Listen, Involve, Learn, Improve' was held in October 2014, with delegates coming from all parts of the country to see examples of good practice from this Trust and other organisations. The conference received excellent evaluations and is planned to be repeated in 2016

- Patient Experience team members have spoken at a number of national conferences and have shared some of the good practice that is evident across the organisation. They also bring back ideas for innovative ways to improve patient experience

- The Admissions Lounge has started to telephone patients the day before their admission to talk them through the admissions process and ensure they understand what will happen on the day of admission. It is a good opportunity to reiterate important information e.g. when to stop eating and drinking etc. An added benefit to patients is that they have an opportunity to discuss any last minute queries or anxieties they may have

- The trust has embraced the #*hellomynameis* initiative, a significant amount of work has been carried out to ensure staff introduce themselves properly to patients, a question relating to this was added to all relevant patient experience surveys so this can be monitored and areas where improvement is needed are identified

- In order to further improve communication generally and enhance the ability of staff to communicate effectively, a task and finish group looked at information and training requirements for staff around communication skills and then developed a toolkit. This will continue to be evaluated via the patient experience feedback mechanisms in place

- Helping patients to rest and sleep in hospital has been challenging this year, following previous improvements a decline in positive feedback was noted, this resulted in a further

trust-wide audit being undertaken (final analysis awaited). The process and stock availability of sleep kits has been improved and there is now a process in place to audit their use, and evaluate the impact they have on the patient experience. Adding sleep kits to our electronic prescribing system (PICS) as a prescribing option has also supported the organisation in its drive to reduce the amount of inappropriate night sedation prescribing

Initiatives to be implemented in 2015/16

- A review of our patient experience dashboard and reporting processes
- Launch of a dedicated Carers page on the Trust website
- Further work to reduce noise at night to be undertaken
- Use of patient stories as a feedback mechanism
- Development on an internal buggy system to complement the external buggy

How progress will be monitored, measured and reported

- Feedback rates and responses will continue to be measured and reported via the Clinical Dashboard
- Regular patient experience reports will be provided to the Care Quality Group and to the Board of Directors
- Performance will continue to be monitored as part of the Back to the Floor visits by Governors and the senior nursing team with action plans developed as required
- Feedback will be provided by members of the Patient and Carer Councils as part of the Adopt a Ward / Department visits
- Progress will also be reported via the quarterly Quality Report update published on the Trust Quality web pages

Priority 3: Timely and complete observations including pain assessment

Background

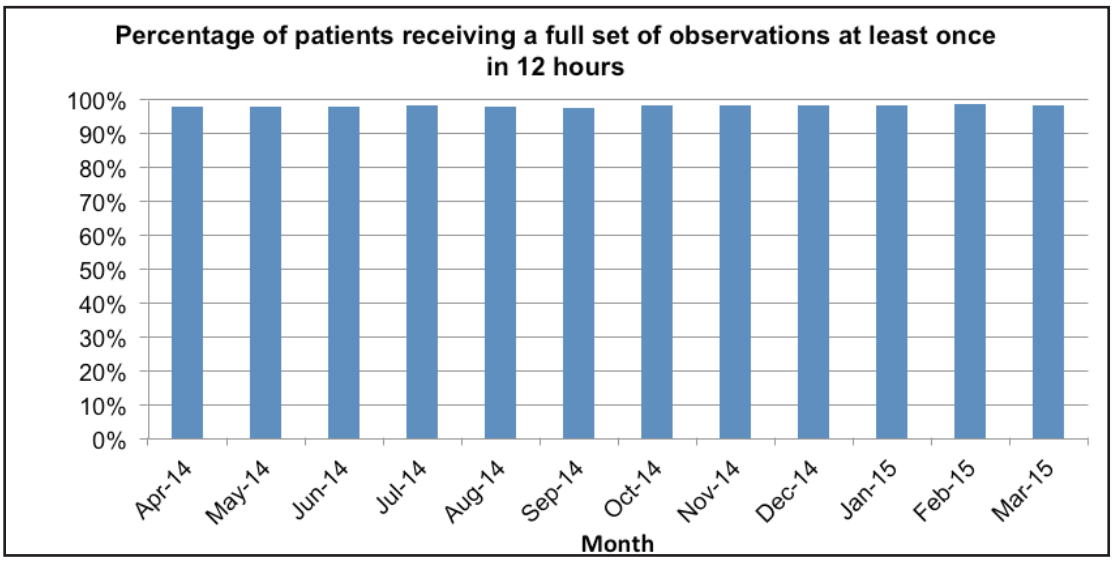
The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool enables an early warning score called the SEWS (Standardised Early Warning System) score to be triggered automatically if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible. This indicator measures the percentage of patients who receive at least one full set of observations in a 12-hour period.

All inpatient wards have been recording patient observations electronically since 2011/12. The four Critical Care areas have very different requirements for recording observations compared to the inpatient wards so do not currently record these on the standard electronic observation chart in PICS. A specific and detailed electronic observation chart has now been developed for Critical Care and is due to be implemented during 2015/16.

Performance

In the 2013/14 Quality Report, the Trust committed to all wards achieving at least 98.0% for completion of observations by the end of 2014/15. The Trust has maintained performance during 2014/15 with an overall completion rate of 98.3%. The vast majority of the Trust's wards achieved at least 98% with some observations appropriately missed due to patients being off the ward, in theatre or at the end of their life when a complete set of observations may not be clinically appropriate.



Initiatives implemented in 2014/15:

- Wards performing below the 98.0% target for observation completion have continued to be reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements could be made

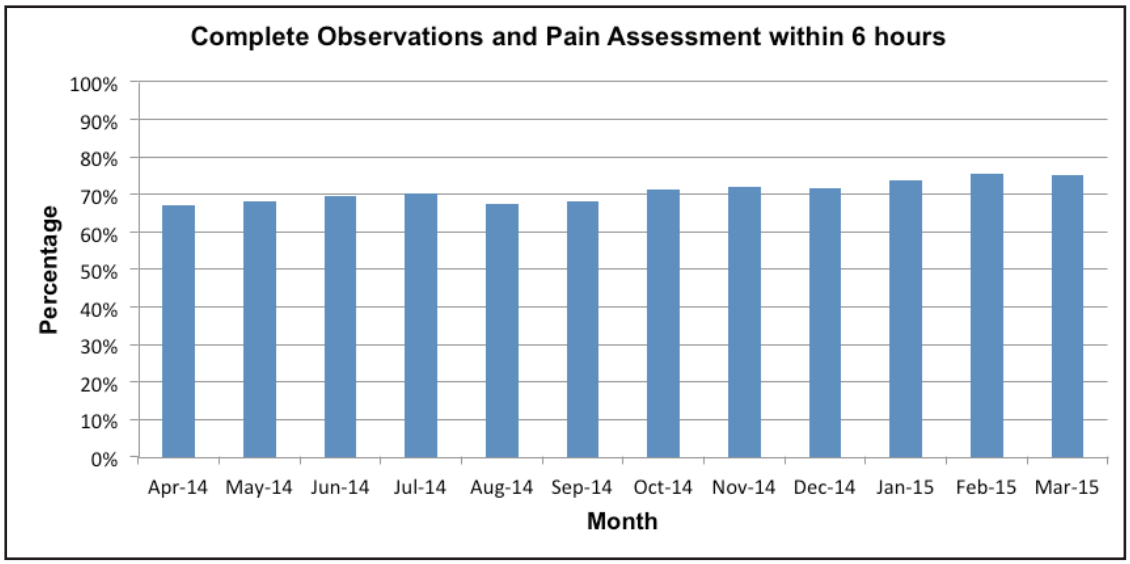
- Automatic incident reporting was implemented in September 2014 for 12 hour observation completion. If a patient receives an incomplete or late set of observations, PICS automatically notifies Datix, the Trust's incident reporting system. The Ward Sister is required to review any such incidents and implement remedial actions. Performance is monitored monthly via the Clinical Quality Monitoring Group chaired by the Executive Medical Director

- The minimum observation requirements have been agreed for Harborne ward which cares for patients who are waiting to be discharged from the Trust. A full set of observations, excluding blood pressure which can be distressing for patients with dementia for example, is required at least once every 24 hours on this ward

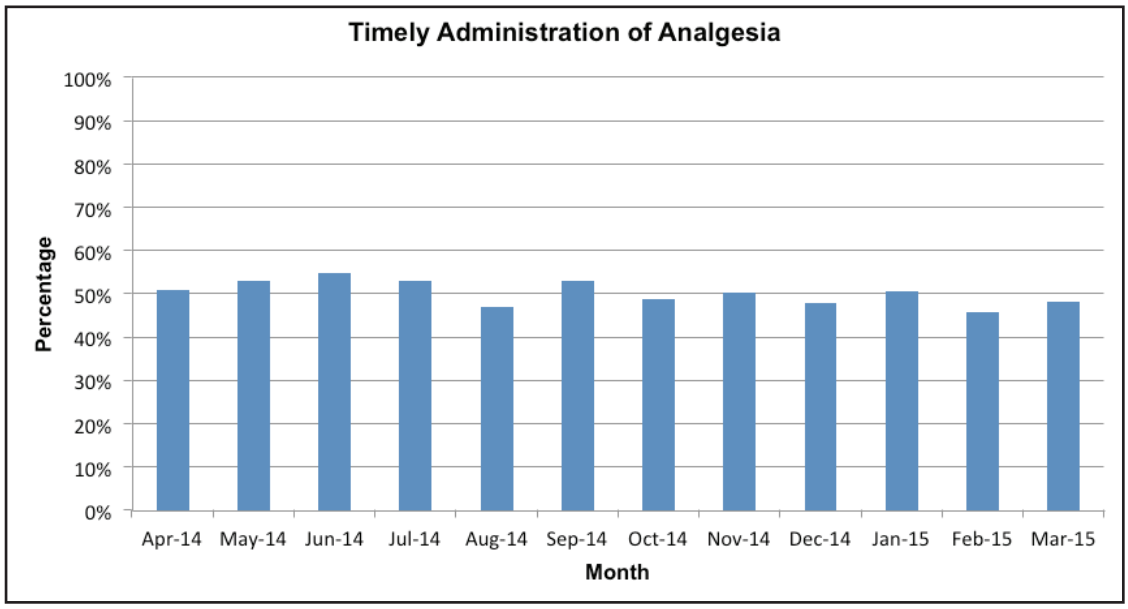
Changes to Improvement Priority for 2014/15:

The Board of Directors has chosen to tighten the timeframe for completeness of observation sets to within 6 hours of admission or transfer to a ward and to include pain assessment. Baseline data for 2014/15 is shown in the graph below: 71% of patients had a full set of observations plus a pain assessment done within 6 hours of admission or transfer to a ward during 2014/15.

This is a new indicator so a challenging improvement target of 85% has been set for the Trust to achieve by the end of 2015/16.



In addition, the Trust will monitor the timeliness of analgesic (pain relief) medication following a high pain score of 3. The pain score used at UHB runs from 0 (no pain) to 3 (severe pain at rest). Whenever a patient scores 3, they should be given analgesic medication within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work. Baseline data for 2014/15 is shown in the graph below: 50% of patients received timely pain relief following a high pain score in 2014/15. This is a new indicator so an ambitious improvement target of 75% has been set for the Trust to achieve by the end of 2015/16.



Initiatives to be implemented in 2015/16:

- A change will be made to the electronic observation chart within the PICS to allow staff to more accurately record the reasons for incomplete observations. This will allow us to understand the reasons for incomplete or delayed observations in more detail and to focus on those observations which should not have been missed
- To implement a bespoke electronic observation chart for Critical Care within PICS
- The Clinical Dashboard will be reviewed and improved so that ward staff can see which of the six observations are being missed and when, plus how they compare to Trust-wide performance
- Wards performing below target for 6 hour observation completion and pain assessment or timely analgesia administration will be reviewed at the Executive Care Omissions Root Cause Analysis meetings to identify where improvements can be made
- Observation compliance will be monitored as part of the unannounced Board of Directors' Governance Visits to wards which take place each month

How progress will be monitored, measured and reported:

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

Priority 4: Reducing medication errors (missed doses)

Background

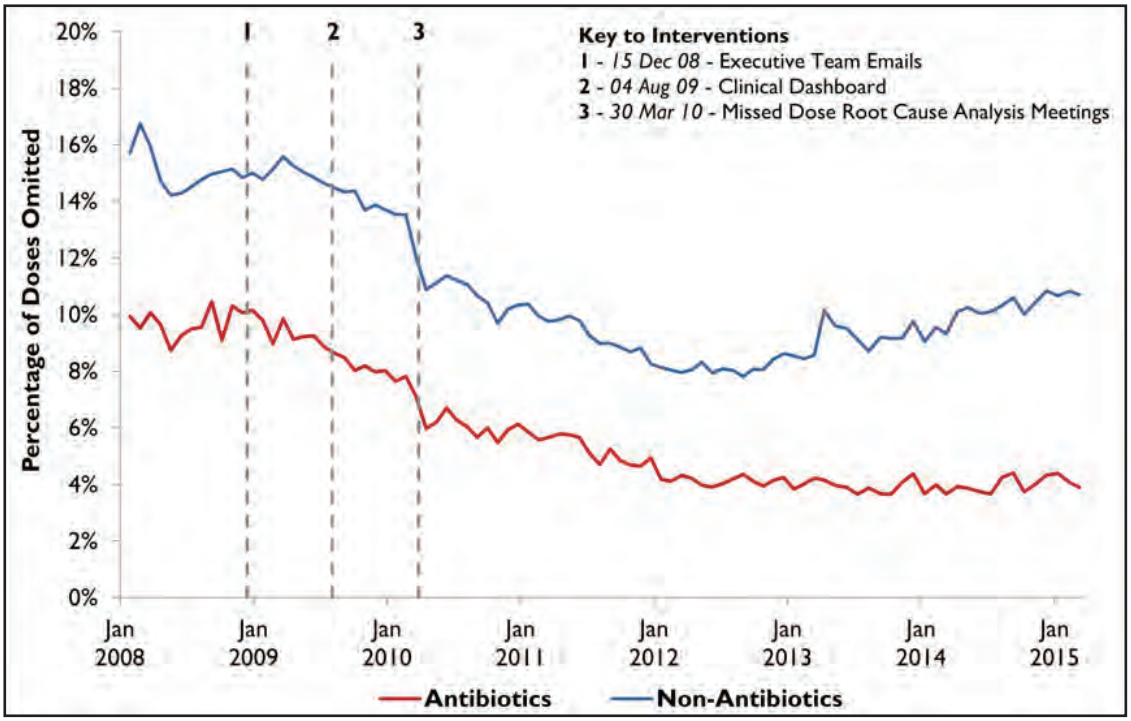
Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System (PICS).

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

The Trust has chosen to focus on maintaining performance for missed antibiotics and reducing non-antibiotic missed doses in the absence of a national consensus on what constitutes an expected level of drug omissions.

Performance

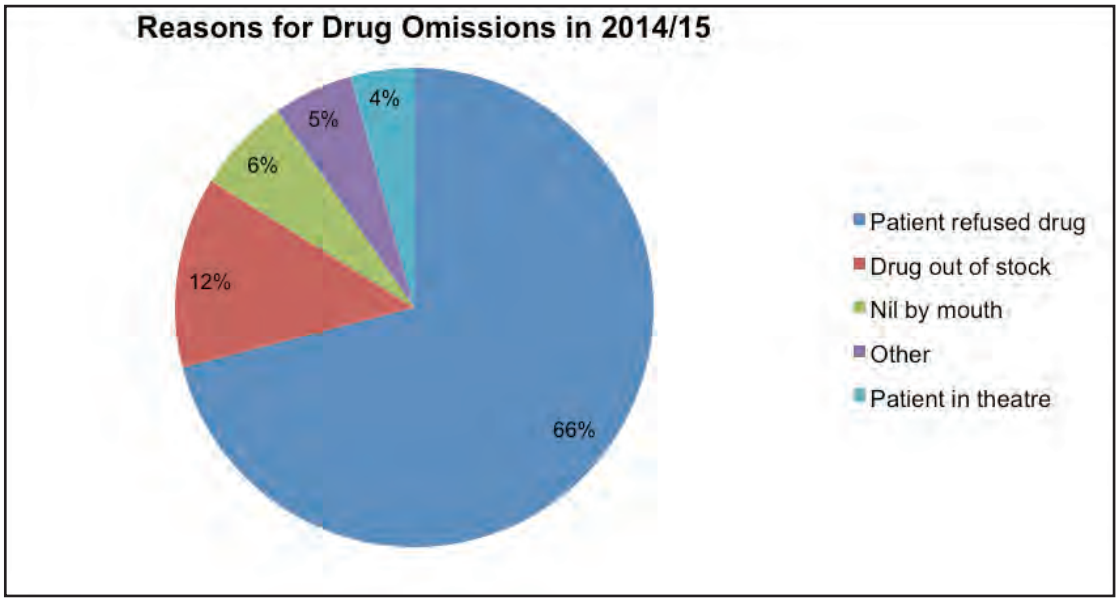
The graph below shows performance for missed antibiotics and non-antibiotics for the past seven years. In the 2013/14 Quality Report, the Trust committed to maintaining performance for missed antibiotics at around 4.0% which has successfully been achieved. The Trust was aiming to reduce the percentage of missed non-antibiotics by 10% in 2014/15 compared to 2013/14 however this has not been achieved. The percentage of missed non-antibiotics was 10.5% for 2014/15 and 9.3% for 2013/14. It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time.



The pie chart below shows the main reasons recorded for missed antibiotic and non-antibiotic doses in 2014/15. The most common reason recorded for doses being missed was due to patients refusing their medication. Certain medications such as pain-relief, anti-sickness and other symptomatic treatments tend to be regularly prescribed in case patients require it which can result in a high number of patient refusals. Patients may also refuse medication because they do not like the side effects or the route of administration e.g., injection. Medical staff are expected to promptly review prescriptions where the patient has refused two or more doses. There may be a different way of giving the same medication to a patient or another medication which can be given instead.

The Trust has greatly improved stock availability with nursing staff expected to go to adjacent wards or other areas should the medication they require be out of stock on their ward. It is therefore disappointing to see 12% again being recorded as being out of stock in 2014/15. 'Query not administered' means that nursing staff have not recorded whether the drug dose was given or not. There are a number of other reasons recorded for drug omissions included in the 'Other' category such as patient unable to take medication due to vomiting or drowsiness.

In 2015/16, the Trust will focus on trying to reduce missed non-antibiotics across the Trust particularly those due to patient refusals, medication being out of stock on the ward and nil by mouth. Wards which perform better than average will be asked to share best practice with others to ensure learning is widely known and acted upon.



Initiatives implemented during 2014/15:

- Patient refusal rates for missed doses were reviewed at ward level to ensure all our clinical staff do their best to encourage patients to take the medication they need
- Work was undertaken to review the medications most commonly recorded as being out of stock in the Clinical Decisions Unit. These include specific types of inhaler, emollient creams and eye drops which can only be used on an individual patient basis
- Performance for missed doses by specialty has been published for patients and the public each month from September 2013 as part of the new mystay@QEHB website
- The Executive RCA group have begun to look at patients who had intermittent missed doses of non-antibiotics, where the reason was recorded as 'drug out of stock', this will continue in 2015/16

Changes to Improvement Priority for 2015/16:

The Trust has chosen to focus on maintaining performance for missed antibiotics and reducing non-antibiotic missed doses in the absence of a national consensus on what constitutes an expected level of drug omissions. The Trust is aiming for a 10% reduction in missed non-antibiotic doses by the end of 2015/16 as this was not achieved in 2014/15.

Initiatives to be implemented in 2015/16:

- New reports will be developed to monitor consecutive missed doses of non-antibiotics, repeated patient refusals and intermittently out of stock medication
- Wards with the highest percentage of consecutive missed doses, patient refusals or out of stock medication will be selected for review at the Executive Care Omissions Root Cause Analysis meetings to identify where changes need to be made
- Automated incident reporting from PICS to Pharmacy will be implemented for drugs which are recorded as out of stock
- The Clinical Dashboard will be reviewed and improved so that ward staff can easily see which non-antibiotics are being missed, when and by whom plus how they compare to Trust-wide performance

How progress will be monitored, measured and reported:

- Progress will continue to be measured at ward, specialty, divisional and Trust levels using information recorded in the Prescribing Information and Communication System (PICS)
- Missed drug doses will continue to be communicated daily to clinical staff via the Clinical Dashboard (which displays real-time quality information at ward-level) and monitored at divisional, specialty and ward levels
- Performance will continue to be reported to the Chief Executive's Advisory Group, the Chief Operating Officer's Group and the Board of Directors each month to ensure appropriate actions are taken
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages. Performance for missed doses by specialty will continue to be provided to patients and the public each month on the mystay@QEHB website

Priority 5: Infection prevention and control

Performance

MRSA Bacteraemia

The national objective for all Trusts in England in 2014/15 was to have zero avoidable MRSA bacteraemia. During the financial year 2014/15, there were six MRSA bacteraemias apportioned to UHB.

All MRSA bacteraemias are subject to a post infection review by the Trust in conjunction with the Clinical Commissioning Group. MRSA bacteraemias are then apportioned to UHB, the Clinical Commissioning Group or a third party organisation, based on where the main lapses in care occurred. Trust-apportioned MRSA bacteraemias are also subject to additional review at the Trust's Executive Care Omissions Root Cause Analysis meetings chaired by the Chief Executive.

The table below shows the Trust-apportioned cases reported to Public Health England for the past four financial years:

Time Period	2011/12	2012/13	2013/14	2014/15
Actual performance	4	5	5	6
Agreed trajectory	7	5	0	0

Clostridium difficile Infection (CDI)

The Trust's annual agreed trajectory was a total of 67 cases for 2014/15. The Trust uses a review tool with the local Clinical Commissioning Group to establish whether cases were avoidable or unavoidable, so that the Trust could focus on reducing avoidable (preventable) cases. The majority of the Trust's CDI cases were deemed to be unavoidable following this joint review.

The table below shows the total Trust-apportioned cases reported to Public Health England for the past four financial years:

Time Period	2011/12	2012/13	2013/14	2014/15
Actual performance	85	73	80	66
Agreed trajectory	114	76	56	67

Initiatives implemented in 2014/15:

- Maintained improvements in patient safety through a robust Infection Prevention and Control surveillance programme, including all alert organisms, urinary catheter associated infection, and the identification and management of multi-drug resistant microorganisms
- Continued monthly prevalence audit of urinary tract infections as part of the nationally agreed CQUIN (Commissioning for Quality and Innovation Indicator)
- Continued to minimise the risk from healthcare associated infections to patients through better management of invasive devices

Changes to Improvement Priority for 2015/16:

For 2015/16, the zero tolerance approach to avoidable MRSA bloodstream infections with timely post infection reviews will continue as previously. For CDI, the national approach will expand on what was done at UHB during 2014/15 with a system of joint reviews with commissioners to assess cases where there have been "lapses in care" and those cases will count towards penalties based on breaching trajectory. For 2015/16 the UHB trajectory will be 63.

Initiatives to be implemented in 2015/16:

- Deliver further improvements to antimicrobial prescribing through a system of audits, feedback to teams and educational initiatives
- Build on the work undertaken last year to refine the review process for CDI cases
- Continue to support reductions in surgical site infections through improving the process of surveillance and feedback to surgical teams
- Further address improvements to urinary catheter care by developing a group to focus on data collection, awareness raising, audit and feedback
- Continue to improve systems for surveillance of alert organisms including timely feedback to clinical teams

How progress will be monitored, measured and reported:

- The number of cases of MRSA bacteraemia and CDI will be submitted monthly to Public Health England and measured against the 2015/16 trajectories
- Performance will be monitored via the Clinical Dashboard. Performance data will be discussed monthly at the Board of Directors, Chief Executive's Advisory Group and Infection Prevention and Control Group meetings
- Any death where an MRSA bacteraemia or CDI is recorded on part one of the death certificate will continue to be reported as serious incidents requiring investigation (SIRIs) to Birmingham Cross City Clinical Commissioning Group (CCG)
- Post infection review and root cause analysis will continue to be undertaken for all MRSA bacteraemia and CDI cases
- Progress against the Trust Infection Prevention and Control delivery plan will be monitored by the Infection Prevention and Control Group and reported to the Board of Directors via the Patient Care Quality Reports and the Infection Prevention and Control Annual Report. Progress will also be shared with Commissioners

2.2 Statements of assurance from the Board of Directors

2.2.1 Information on the review of services

During 2014/15 the University Hospitals Birmingham NHS Foundation Trust* provided and/or sub-contracted 63 relevant health services.

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

The income generated by the relevant health services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2014/15.

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

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

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

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2014/15 33 national clinical audits and 5 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 87.9% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2014/15 are as follows: (see tables below). The national clinical audits and national confidential enquiries that UHB participated in during 2014/15 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

Audit UHB eligible to participate in	UHB participation 2014/15	Percentage of required number of cases submitted
Part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP)		
Inflammatory bowel disease (IBD)	Yes	75% of those completed, as of February 2015
Oesophago-gastric cancer	Yes	100%
Bowel cancer (NBOCAP)	Yes	100%
Adult cardiac surgery	Yes	100%
Heart failure	Yes	On target to be 100% by the data submission date
Myocardial infarction (MINAP)	Yes	N/A no required case target.
Cardiac rhythm management (Pacing / Implantable Defibrillators)	Yes	95% submission rate, 5% admitted due to patient choice of non-surgical management
Congenital heart disease (children and adults) / Paediatric cardiac surgery	Yes	100%
National Vascular Registry (CIA, National Vascular Database, AAA, Peripheral Vascular Surgery / VSGBI Vascular Surgery Database)	Yes	100%
Lung Cancer	Yes	Data collection for 2014 is still ongoing via Somerset database
Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
Rheumatoid and early inflammatory arthritis	Yes	100%, 2-3 patients per week on average
National Diabetes Audit	Yes	N/A no required case target
Head and Neck Cancer (DAHNO)	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP) – includes National Hip Fracture Database (NHFD)	Yes	Data collection due to commence May 2015
SSNAP (Sentinel Stroke National Audit Programme)	Yes	100% (more cases actually submitted than required)
National Emergency Laparotomy Audit (NELA)	Yes	Target 100%, submitted 97%
National Joint Registry	Yes	79% cases submitted to date, against a target of 75%
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%

Audit UHB eligible to participate in	UHB participation 2014/15	Percentage of required number of cases submitted
Medical and Surgical Clinical Outcome Review Programme *(also known as NCEPOD, or Confidential Enquiries)*	Yes	See National Confidential Enquiries table below
National Audit of Dementia	Yes	Pilot began in January 2015. Data collection will take place in 2016 from April with local reporting in early 2017.
National Ophthalmology Audit	Yes	N/A no required case target confirmed
National Prostate Cancer Audit	Yes	100%
Not part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP)		
National Cardiac Arrest Audit	No	N/A
ICNARC - Adult Critical Care Case Mix Programme	No	Working towards 100% with a rectification plan in place which has been agreed by UHB CQMG and ICNARC.
PROMs	Yes	66.4% Pre-operative questionnaire completion for groin hernias and varicose veins as published on the HSCIC website. Data covers April-September 2014. Participation in PROMS by patients is voluntary.
Major Trauma - TARN (Trauma Audit and Research Network)	Yes	100%
CEM Mental Health (care in ED)	Yes	100%
CEM Older People (care in ED)	Yes	100%
Adult Community Acquired Pneumonia	Yes	100% (data collection underway, deadline 31/05/15)
Pleural Procedures	Yes	100%
National Comparative Audit of Blood Transfusion programme	No	N/A
British Society for Clinical Neurophysiology & Association of Neurophysiological Scientists: Standards for Ulnar Neuropathy at Elbow testing	No	N/A

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2014/15	Percentage of required number of cases submitted
Acute pancreatitis	Yes	Data submitted, awaiting the questionnaires for the study.
Avoidable death review	Yes	100%
Sepsis	Yes	100%
Gastrointestinal Haemorrhage	Yes	100%
Lower Limb Amputation	Yes	100%

Percentages given are the latest available figures.

The reports of 13 national clinical audits were reviewed by the provider in 2014/15 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 audit is undertaken in clinical specialties and across the Trust. These may be highly specialised audits examining whether treatments or services for specific medical conditions, such as diabetes, are meeting standards of best practice; or they may be broader audits of particular aspects of services, such as monitoring staff hand hygiene. A total of 808 clinical audits were registered with UHB's clinical audit team as having commenced or been completed at UHB during 2014/15.

The reports of 137 local clinical audits were reviewed by the provider in 2014/15 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 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 11,400. The total figure is based on all research studies that were approved during 2014/15.

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

Reporting Period	2012/13	2013/14	2014/15
Total number of projects registered with R&D	286	306	307
Out of the total number of projects registered, the number of studies which were abandoned	27	39	56
Trust total patient recruitment	**8,598**	**10,778**	**11,400**

The table below shows the number of projects registered in 2014/15 split by specialty:

Specialty	Number of projects registered
Accident & Emergency	2
Anaesthetics	4
Audiology	1
Breast Services	2
Burns & Plastics	3
Cardiac Surgery	1
Cardiology	20
Clinical Haematology	2
Critical Care	5
Dermatology	5
Diabetes	5
Emergency Medicine	1
Endocrinology	16
ENT	8
General Medicine	1
General Surgery	4
Genito-Urinary Medicine	6
GI Medicine	8
GI Surgery	1
Haematology	13
HIV	2
Imaging	6
ITU	2
Liver Medicine	24
Liver Surgery	2
Lung Investigation Unit	3
Neurology	15
Neuroradiology	2
Neurosurgery	6
Non-specific	37
Oncology	45
Ophthalmology	6
Oral Surgery and Orthodontics	1

Specialty	Number of projects registered
Palliative Care	1
Radiotherapy	2
Renal Medicine	13
Renal Services	1
Renal Surgery	1
Respiratory Medicine	9
Rheumatology	8
Stroke Services	5
Trauma	2
Urology	5
Vascular Surgery	1
Total	**307**

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

A proportion of UHB income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between UHB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at http://www.uhb.nhs.uk/quality.htm.

The amount of UHB income in 2014/15 which was conditional upon achieving quality improvement and innovation goals was £10.7m*. The Trust received £12.6m in payment in 2013/14. Final payment for 2014/15 will not be known until June 2015.

* This figure has been arrived at as a percentage of the healthcare income which will be included within the Trust's 2014/15 accounts and does not represent actual outturn (as an estimate has to be included for March 2015 income). The actual figure will not be known until the final position has been reconciled with Healthcare Commissioning Services (HCS).

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

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

The Care Quality Commission has not taken enforcement action against UHB during 2014/15.

UHB has participated in special reviews or investigations by the Care Quality Commission and the Birmingham Cross City Clinical Commissioning Group relating to the following areas during 2014/15 (see table below). UHB intends to take the following action to address the conclusions or requirements reported by the CQC (see table below). UHB has made the following progress by 31 March 2015 in taking such action (see table below).

Responding to Key National Recommendations

During 2014/15 the Trust responded to the consultation by the Department of Health on the new regulations to replace the CQC's Essential Standards with Fundamental Standards, as recommended by Sir Robert Francis. The new Fundamental Standards come into effect from 1 April 2015, in preparation for this the Trust has reviewed the new requirements and is putting in place appropriate actions to ensure it is complaint with the new requirements.

In response to the new and revised regulations that came into effect on 27 November, which sets out the new statutory duty of candour, the Trust is updating its policies and processes in order to comply with the new requirements. In February 2015 the Freedom to Speak Up review was published. In the report Sir Robert Francis sets out 20 Principles and Actions which aim to create the right conditions for NHS staff to speak up, share what works right across the NHS and get all organisations up to the standard of the best and provide redress when things go wrong in future. The proposed recommendations were discussed at the Patient Safety Group and work is underway to implement the relevant recommendations.

UHB is committed to providing the best in care and there are a wide range of measures in place to improve the quality of services provided to patients as detailed within this Quality Report.

Date	Type of inspection	Outcome	Actions taken
Birmingham Cross City - Clinical Commissioning Group			
07/07/14 & 03/09/14	Review of compliance with quality standards of care to ensure that all actions are taken to reduce harm form falls.	The report concluded that 'Overall the findings from the review have been very positive with no major concerns identified. The Trust has a very robust falls prevention agenda with engagement from the medical teams, therapy groups, pharmacy, all nursing groups and various other professionals. There is clear ownership right up at Trust board level that support the agenda and gain frequent assurances'.	There were some minor recommendations made which have been incorporated into an action plan and are monitored by the Lead Nurse for Falls.
20/10/14	Review of Radiology Services to review actions implemented within the department following a cluster of UHB radiology reported Serious Incidents (SIs) regarding delayed imaging/diagnosis.	CCG advised that there have not been any recent serious incidents in relation to delayed imaging/diagnosis indicating the new process is working well. No further actions were identified.	No further action required
12/11/14	Review of UHB's Duty of Candour and WHO checklist processes.	Reviewed our processes for both Duty of Candour and WHO checklist and considered that the Trust is compliant.	No further action required

Date	Type of inspection	Outcome	Actions taken
Care Quality Commission			
28/11/14	Unannounced inspection of Core Essential Standards.	Outcome 16: Assessing and Monitoring the Quality of Service Provision to follow up on previous inspection 22-24 July 2013. CQC report deemed the Trust fully compliant: People were safe and benefited from appropriate arrangements to assess their needs and plan, provide and regularly review care and treatment that met their needs and protected their rights. The provider had effective systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service.	Continue to complete monthly audits and for these to be reviewed at the Care Quality Group.
28/01/15	Announced inspection of Core Essential Standards.	Overall the Trust was rated as Good with 85% of areas being rated as 'good' or 'outstanding' and 15% of areas rated as 'requires improvement'. The CQC found the Trust to be compliant with all the Essential Standards and identified a small number of recommendations.	The CQC report was published on 15 May 2015. The recommendations will be contained in an action plan and an appropriate lead and Director will be identified for each action. Overall compliance with the action plan will be monitored by the Director of Corporate Affairs' Governance Group and compliance will be reported to the Board of Directors via the quarterly compliance reports.

2.2.6 Information on the quality of data

UHB submitted records during 2014/15* to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was:
99.0% for admitted patient care;
99.3% for out patient care; and
97.0% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
99.9% for admitted patient care;
99.8% for out patient care; and
100% for accident and emergency care.

* Percentages shown are for the period April 2014 to

February 2015. Data for the whole year will be available by mid May 2015.

UHB Information Governance Assessment Report overall score for 2014/15 was 76% and was graded green (satisfactory).

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

	Diagnoses Incorrect		Procedures Incorrect	
	Primary	Secondary	Primary	Secondary
Digestive System Procedures and Disorders	3.0%	3.9%	4.1%	3.1%
Orthopaedic Non-Trauma Procedures	6.0%	12.4%	3.1%	20.6%

* CHKS undertook the Payment by Results clinical coding audit in 2014/15 on behalf of Monitor.

The results should not be extrapolated further than the actual sample audited. The two areas reviewed within the sample were Digestive System Procedures and Disorders and Orthopaedic Non-Trauma Procedures. The audit results were good and met Information Governance Standard Level 2, specifically related to Clinical Coding Audit. Whilst we cannot compare directly by specialty because only some trusts are audited and on different areas, overall we rate better than average for the trusts audited.

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

- Continue to drive forward the strategy of the West Midlands Clinical Coding Academy to further improve training and clinical coding across the West Midlands
- Continue to provide a robust programme of internal audit and training, which is undertaken by the Trust's own Accredited Auditor and Trainer
- Implementation of a new integrated Trustwide patient administration system which will simplify data entry, increase validation and reduce duplication of data entry
- Ensuring continued compliance with the Information Governance Toolkit minimum Level 2 for data quality standards
- Reinforce the embedded data quality culture by ensuring senior staff are informed of the importance of data accuracy and the Trust Data Quality Policy
- Continue to reinforce the embedded data quality culture by challenging data at monthly executive forums and investigating any potential issues
- Implementation of a quality assurance programme ensuring key elements of information reporting including data assurance, presentation and validation
- Continue to improve the data quality in relation to 18 week referral to treatment time (RTT) through audit, validation and education of both clinical and non-clinical teams

2.3 Performance against national core set of quality indicators

A national core set of quality indicators was jointly proposed by the Department of Health and Monitor for inclusion in trusts' Quality Reports from 2012/13. The data source for all the indicators is the Health and Social Care Information Centre (HSCIC) which has only published data for part of 2014/15 for some of the indicators. The Trust's performance for the applicable quality indicators is shown in Appendix A for the latest time periods available. Further information about these indicators can be found on the HSCIC website: www.hscic.gov.uk

Part 3: Other Information

3.1 Overview of quality of care provided during 2014/15

The tables below show the Trust's latest performance for 2014/15 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 2013/14 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 for 2014/15 is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance is monitored and challenged during the year by the Clinical Quality Monitoring Group and the Board of Directors.

Patient safety indicators

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
1(a). Patients with MRSA infection/ 100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**1.41**	**1.04**	**1.21**	**0.84**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands
1(b). Patients with MRSA infection/ 100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**1.42**	**1.04**	**1.21**	**0.99**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
Data source(s)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)	Trust MRSA data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
2(a). Patients with *C. difficile* infection /100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**20.31**	**20.76**	**16.98**	**13.38**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA
2(b). Patients with *C. difficile* infection /100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**20.44**	**20.89**	**17.01**	**16.34**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
Data source(s)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)	Trust CDI data reported to PHE, HES data (bed days)
Peer group				Acute trusts in West Midlands

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
3(a,i) Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**10.4**	**10.7**	**16.7**	**8.7**
Time period	2012/13	2013/14	2014/15	Oct 2013 - March 2014
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
3(a,ii) Patient safety incidents (reporting rate per 1000 bed days) *Higher rate indicates better reporting*	Not available (new measure)	Not available (new measure)	**47.2**	**35.9**
Time period			2014/15	April - September 2014
Data source(s)			Datix (incident data), Trust admissions data	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute (non specialist) hospitals

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
3(b) Never Events *Lower number indicates better performance*	**0**	**2**	**3**	*Not available*
Time period	2012/13	2013/14	2014/15	
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				
4(a) Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**64.4%**	**71.1%**	**81.0%**	**73.7%**
Time period	2012/13	2013/14	2014/15	April - September 2014
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death *Lower % indicates better performance*	**0.27%**	**0.24%**	**0.12%**	**0.5%**
Time period	2012/13	2013/14	2014/15	April - September 2014

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
Data source(s)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	Calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	**9,536**	**9,828**	**16,222**	**4,196**
Time period	2012/13	2013/14	2014/15	April - September 2014
Data source(s)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	Datix (patient safety incidents reported to the NRLS)	Average number of patient safety incidents reported calculated from data on NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute teaching hospitals

Notes on patient safety indicators

3(a,i) & 3(a,ii): NHS England recently changed the methodology for calculating incident reporting rates from 'per 100 admissions' to 'per 1000 bed days', so both measures are presented here for completeness. For 2015/16 onwards, UHB will report against the new measure of 'per 1000 bed days'.

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.

In January 2014, the Trust implemented an automatic incident reporting process whereby incidents are directly reported from the Trust's Prescribing Information and Communication System (PICS). These include missed observations and patients who need to be discharged off PICS. The plan is to include other automated incidents such as consecutive missed drug doses during 2015/16. The Trust's incident reporting rate has therefore increased and this trend is likely to continue. The purpose of automated incident reporting is to ensure even small errors or omissions are identified and addressed as soon as possible.

3(b): The Trust reported three Never Events in 2014/15: a guide wire was left in situ, a swab was retained after a procedure and an incorrect site was biopsied. All incidents have been investigated as serious incidents and remedial actions put in place to prevent recurrence.

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

Clinical effectiveness indicators

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
5(a) Emergency readmissions within 28 days (%) (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**12.65%** **England: 13.39%**	**12.86%** **England: 13.50%**	**13.50%**	**13.53%** **England: 13.82%**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(b). Emergency readmissions within 28 days (%) (all specialties) *Lower % indicates better performance*	**12.62%** **England: 12.75%**	**12.85%** **England: 12.89%**	**13.48%**	**13.11%** **England: 13.26%**
Time period	2012/13	2013/14	April 2014 – January 2015	April 2014 – January 2015
Data source(s)	HES data	HES data	HES data	HES data
Peer group				University hospitals
5(c). Emergency readmissions within 28 days of discharge (%) *Lower % indicates better performance*	**9.87%**	**10.25%**	**10.68%**	*Not available*
Time period	2012/13	2013/14	2014/15	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				

Indicator	2012/13	2013/14	2014/15	Peer Group Average (where available)
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	**2.2%**	**2.1%**	**2.2%**	*Not available*
Time period	2012/13	2013/14	2014/15	
Data source(s)	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				
7. Stroke in-hospital mortality *Lower % indicates better performance*	*Data collected as part of national audit from April 2013*	**8.7%**	**8.5%**	*Not available*
Time period		2013/14	April 2014 - February 2015	
Data source(s)		SSNAP data	SSNAP data	
Peer group				
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**96.4%**	**89.0%**	**94.7%**	*Not available*
Time period	2012/13	2013/14	2014/15	
Data source(s)	Trust PICS data	Trust PICS data	Trust PICS data	
Peer group				

Notes on clinical effectiveness indicators

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

5(a), 5(b): The methodology has been updated to reflect the latest guidance from the Health and Social Care Information Centre. The key change is that day cases and regular day case patients, all cancer patients or patients coded with cancer in the previous 365 days are now excluded from the denominator. This indicator includes patients readmitted as emergencies to the Trust or any other provider within 28 days of discharge. Further details can be found on the Health and Social Care Information Centre website.

5(c): This indicator only includes patients readmitted as emergencies to the Trust within 28 days of discharge and excludes UHB cancer patients. The data source is the Trust's patient administration system (Lorenzo). The data for previous years has been updated to include readmissions from 0 to 27 days and exclude readmissions on day 28 in line with the national methodology.

7: Stroke in-hospital mortality – data is one month in arrears due to the nature of the indicator methodology.

8: Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions. During 2014/15 there was a small adjustment to the methodology of this indicator, resulting in a very small change to the indicator results.

Patient experience indicators

The results of the 2014 National Inpatient Survey reported that the Trust was 'better' than other Trusts in four questions: specialists having all required information from referrer, being given written or printed information about what you should/should not do after leaving hospital, being given clear written or printed information about medicines and being asked to give views on the quality of care. We scored about the same as other trusts in all other questions. This is an improvement on 2013 when the Trust was 'about the same' as other trusts in all questions.

Patient survey question	2012/13	Comparison with other NHS trusts in England (2012/13)	2013/14	Comparison with other NHS trusts in England (2013/14)	2014/15	Comparison with other NHS trusts in England (2014/15)
9. Overall were you treated with respect and dignity	**8.9**	**About the same**	**9.1**	**About the same**	**9.2**	**About the same**
Time period & data source	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission
10. Involvement in decisions about care and treatment	**7.5**	**About the same**	**7.5**	**About the same**	**7.7**	**About the same**
Time period & data source	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission
11. Did staff do all they could to control pain	**8.0**	**About the same**	**7.9**	**About the same**	**8.1**	**About the same**
Time period & data source	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission

Patient survey question	2012/13	Comparison with other NHS trusts in England (2012/13)	2013/14	Comparison with other NHS trusts in England (2013/14)	2014/15	Comparison with other NHS trusts in England (2014/15)
12. Cleanliness of room or ward	**9.3**	**About the same**	**9.3**	**About the same**	**9.2**	**About the same**
Time period & data source	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission
13. Overall rating of care	**8.2***	**About the same**	**8.3***	**About the same**	**8.3**	**About the same**
Time period & data source	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2012, Trust's Survey of Adult Inpatients 2012 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission	2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission

*The rating for this question changed in 2013/14 to a ten point scale and so is not comparable to previous years.

Notes on patient experience measures:

9-13: The style of the survey reports produced by the Care Quality Commission for individual trusts benchmark report presents the data as a score out of 10; the higher the score for each question, the better the Trust is performing.

3.2 Performance against indicators included in the Monitor Risk Assessment Framework

Indicator	Target	Performance		
		2012/13	2013/14	2014/15
C. difficile infection (post-48 hour cases)	2012/13: 76 2013/14: 56 2014/15: 67	73	80 (16 cases judged avoidable)	**66** (17 cases judged avoidable)
62-day wait for first treatment from urgent GP referral: all cancers	85%	86.2%	79.5%	**73.8%**
62-day wait for first treatment from consultant screening service referral: all cancers	90%	95.2%	95.3%	**89.3%**
31-day wait from diagnosis to first treatment: all cancers	96%	97.2%	95.9%	**91.9%**
31-day wait for second or subsequent treatment: surgery	94%	96.8%	96.2%	**82.9%**
31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	99.8%	99.3%	**98.5%**
31-day wait for second or subsequent treatment: radiotherapy	94%	99.3%	95.1%	**98.0%**
Two week wait from referral to date first seen: all cancers	93%	96.3%	97.1%	**95.1%**
Two week wait from referral to date first seen: breast symptoms	93%	98.2%	97.1%	**99.9%**
18-week maximum wait from point of referral to treatment (admitted patients)*	90%	94.9%	91.4%	**88.9%***
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	99.1%	98.1%	**96.1%**
18-week maximum wait from point of referral to treatment (incomplete pathways)	92%	95.7%	94.6%	**93.6%****
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	94.95%	95.2%	**94.8%**
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Certification made	Certification made	**Certification made**

* The target for an 18-week maximum wait from point of referral to treatment for admitted patients was subject to a national 'managed fail' sanctioned by Monitor and NHS England for 8 months of 2014/15.

** This indicator was audited by the Trust's external auditor Deloitte as part of the external assurance arrangements for the 2014/15 Quality Report. Further detail about their findings is provided below.

1. Unknown clock starts

The Trust is required to report performance against three indicators in respect of 18 week Referral-to-Treatment targets. For patient pathways covered by this target, the three metrics reported are:

- "admitted" – for patients admitted for first treatment during the year, the percentage who had been waiting less than 18 weeks from their initial referral
- "non-admitted" – for patients who received their first treatment without being admitted, or whose treatment pathway ended for other reasons without admission, the percentage for the year who had been waiting less than 18 weeks from the initial referral
- "incomplete" – the average of the proportion of patients, at each month end, who had been waiting less than 18 weeks from initial referral, as a percentage of all patients waiting at that date

The measurement and reporting of performance against these targets is subject to a complex series of rules and guidance published nationally. However, the complexity and range of the services offered by the Trust mean that local policies and interpretations are required, including those set out in the Trust Access Policy. As a specialist tertiary provider, receiving onward referrals from other trusts, a key issue for our Trust is reporting pathways for patients who were initially referred to other providers.

Under the rules for the indicators, the Trust is required to report performance against the 18 week target for patients under its care, including those referred on from other providers. Depending on the nature of the referral and whether the patient has received their first treatment, this can either "start the clock" on a new 18 week treatment pathway, or represent a continuation of their waiting time which begun when their GP made an initial referral. In order to accurately report waiting times, the Trust therefore needs other providers to share information on when each patient's treatment pathway began.

Although providing this information is required under the national RTT rules, and there is a standardly defined Inter Provider Administrative Data Transfer Minimum Data Set to facilitate sharing the required information, the Trust does not usually receive this information from referring providers. This means that for some patients the Trust cannot know definitively when their treatment pathway began. The national guidance assumes that the "clock start" can be identified for each patient pathway, and does not provide guidance on how to treat patients with "unknown clock starts" in the incomplete pathway metric.

The Trust's approach in these cases, where information is not forthcoming after chasing the referring provider, is to treat a new treatment pathway as starting on the date that the Trust receives the referral for the first time. Rather than spend a significant amount of time chasing clock starts for tertiary referrals, the main focus is on recording receipt of the referral and ensuring timely appointments are made. This approach means that all patients are included in the calculation of the reported indicators, but may mean that the percentage waiting more than 18 weeks for treatment is understated as we cannot take account of time spent waiting with other providers which has not been reported by them. Due to how data is captured, it is not practicable to quantify the number of patients this represents for the year. However, the findings of the audit overall indicated the Trust was more likely to be overstating the number of breaches than understating them. An internal audit carried out by the Trust in December also found waiting time was more likely to be overstated than understated overall. Both audits recognised the positive patient safety features in place to ensure that any incomplete data entry does not result in patients being missed for RTT purposes.

The absence of timely sharing of data by referring providers impacts the Trust's ability to monitor and manage whether patients affected are receiving treatment within the 18 week period set out in the NHS Constitution, and requires significant time and resource for follow-up.

2. Data assurances

Data assurances and actions for improvement

The assurance work undertaken by Deloitte LLP in respect of the Quality Report 2014/15, led to a qualified conclusion in relation to the data quality of the

incomplete pathway indicator for 18-weeks Referral to Treatment. This finding is consistent with many other providers.

The Trust has put in place an action plan to address these concerns. This plan includes a review of the procedures required to achieve good data quality at the point of entry. In addition, the plan outlines initiatives to enhance skills and training of the clinical and administrative teams who are involved with RTT pathway management. By getting this right first time, we will reduce the validation burden down-stream.

The Trust's Service Improvement Team completed a detailed and larger audit involving 800 patients across admitted, non admitted and unfinished 18 week pathways during 2014/15 at the request of the Executive Chief Operating Officer. At any one time, UHB has around 30,000 patients on an 18 week pathway. The findings of this audit concluded that the Trust was putting patients onto an 18 week pathway and then removing them through validation rather than risk not tracking large numbers of patients. The Trust is currently implementing a number of actions in response to the internal review many of which are consistent with the Deloitte recommendations.

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.

UHB proactively contacted the CQC in December 2014 relating to a Burns diagnosis groups for which there appeared to be a higher than expected mortality rate. This diagnosis group was fully investigated by the Trust and no concerns were identified.

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

Summary Hospital-level Mortality Indicator (SHMI)

The Health and Social Care Information Centre (HSCIC) 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 Summary Hospital-level Mortality Indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care[3]. 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.

The Trust's latest SHMI is 102.21 for the period April – December 2014 which is within tolerance. The latest SHMI value for the Trust, which is available on the HSCIC website, is 95.81 for the period April – June 2014. This is within tolerance.

The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 98.95 for the period April 2014

3 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.
4 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.
5 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.

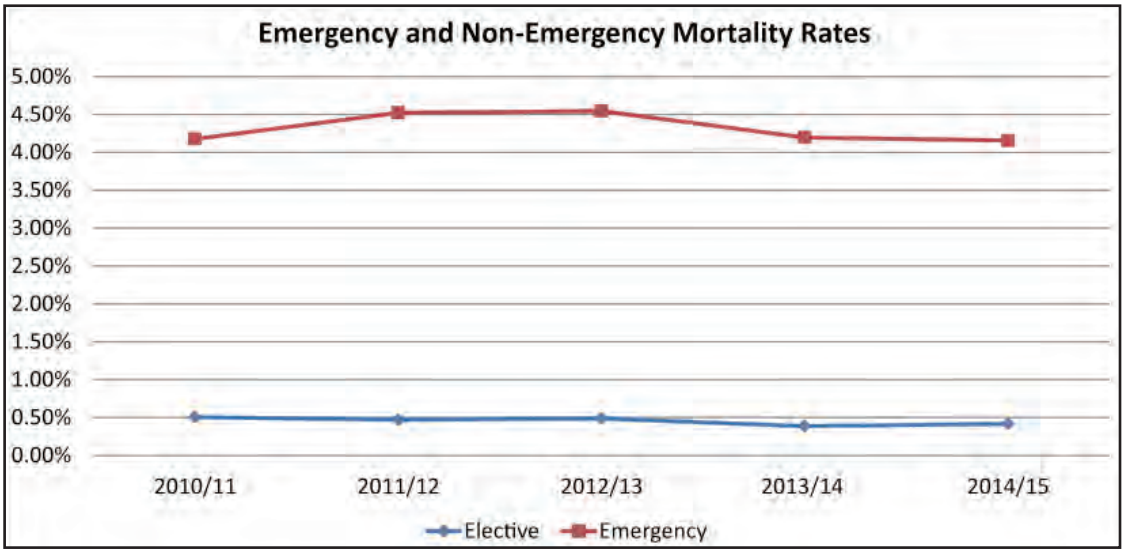
– January 2015 as calculated by the Trust's Health Informatics team. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited[45]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

Crude Mortality

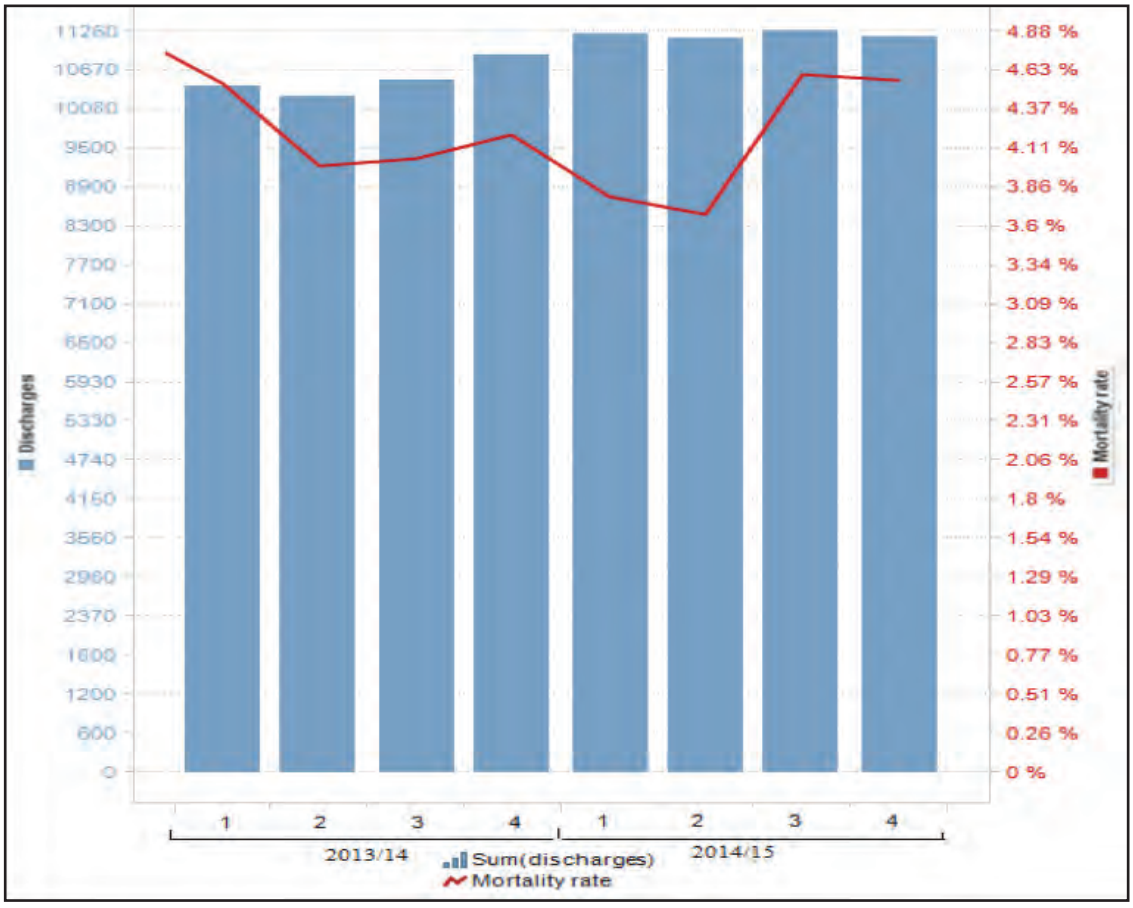
The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated by 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 Trust's overall crude mortality rate for 2014/15 (3.045%) is very similar to 2013/14 (3.052%).

Emergency and Non-emergency Mortality Graph



Overall Crude Mortality Graph



3.4 Safeguarding

The Trust's framework for safeguarding adults at risk is based on national guidance arising from the Health Service Circular 2000/007 'No Secrets' on developing inter-agency policy and procedures for safeguarding vulnerable adults; and has been updated to include changes introduced in the Care Act 2014

UHB has continued to ensure that safeguarding of adults at risk remains a high priority within the Trust. The aim of safeguarding is to ensure that there is a robust policy with supporting procedural documents which allow a consistent approach to the delivery of safeguarding principles across the Trust. Level 2 Adult safeguarding training has been mandatory for all patient-facing staff in 2014/15. Factsheets on numerous types of abuse are now available to support staff and a patient information leaflet for adults is available in all clinical areas. Two study days for Clinical Champions (one from each clinical area) have been held to improve knowledge across the Trust. A new domestic abuse page is available on the intranet for all staff.

The policy provides a framework that can be consistently followed, reinforced by training and support, to enable all clinical staff to recognise and report incidence of adults who are at risk, ensuring that patients receive a positive experience, including support in relation to safeguarding where necessary. Further information can be found in the Trust's Annual Report for 2014/15: www.uhb.nhs.uk/reports.htm.

3.5 Staff Survey

The Trust's Staff Survey results for 2014 show that performance was average or better for 25 of the 29 key findings and below average for 4 key findings, when compared to other acute trusts. The results are based on responses from 467 staff which represents a small decrease in response rate from 60% last year to 56% this year, however this response rate is in the highest 20% of acute trusts in England.

The results for the key findings of the Staff Survey which most closely relate to quality of care are shown in the table below. UHB performed in the highest (best) 20% of trusts for staff recommending the Trust as a place to work or receive treatment (see Question 3 in the table below). It is disappointing to see that the Trust is again in the lowest (worst) 20% of trusts reporting errors, near misses or incidents witnessed in the last month (see Question 4 in the table below). This does not accord with the Trust's high incident reporting rate and the high percentage of no harm incidents reported (see indicators 4(a) and 4(c) in section 3.1 of this report). UHB will continue to encourage staff to report all incidents including minor incidents and near misses.

Key Finding from Staff Survey	2012/13	2013/14	2014/15	Comparison with other acute NHS trusts 2014/15
1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver Time period & data source	**86%** Trust's 2012 Staff Survey Report, Department of Health	**85%** Trust's 2013 Staff Survey Report, NHS England	**82%** Trust's 2014 Staff Survey Report, NHS England	**Highest (best) 20%**
2. Percentage of staff agreeing their role makes a difference to patients Time period & data source	**94%** Trust's 2012 Staff Survey Report, Department of Health	**94%** Trust's 2013 Staff Survey Report, NHS England	**90%** Trust's 2014 Staff Survey Report, NHS England	**Average**
3. Staff recommendation of the trust as a place to work or receive treatment Time period & data source	**3.93** Trust's 2012 Staff Survey Report, Department of Health	**4.04** Trust's 2013 Staff Survey Report, NHS England	**3.95** Trust's 2014 Staff Survey Report, NHS England	**Highest (best) 20%**
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month Time period & data source	**92%** Trust's 2012 Staff Survey Report, Department of Health	**86%** Trust's 2013 Staff Survey Report, NHS England	**83%** Trust's 2014 Staff Survey Report, NHS England	**Lowest (worst) 20%**
5. Percentage of staff agreeing feedback from patients / service users is used to make informed decisions in their directorate / department Time period & data source	New question for 2014 survey	New question for 2014 survey	**61%** Trust's 2014 Staff Survey Report, NHS England	**Above (better than) average**

Notes on staff survey

Key Finding 3: Possible scores range from 1 to 5, with a higher score indicating better performance.

Key Finding 5: This is a new question for the 2014 Staff Survey, and has replaced the previously reported question about hand-washing materials being available, which is no longer in the Staff Survey.

3.6 Specialty Quality Indicators

The Trust's Quality and Outcomes Research Unit (QuORU) was set up in September 2009. The unit has linked a wide range of information systems together to enable different aspects of patient care, experience and outcomes to be measured and monitored. The unit continues to provide support to clinical staff in the development of innovative quality indicators with a focus on research. In August 2012, the Trust implemented a framework based on a statistical model for handling potentially significant changes in performance and identifying any unusual patterns in the data. The framework has been used by the Quality and Informatics teams to provide a more rigorous approach to quality improvement and to direct attention to those indicators which may require improvement.

Performance for a wide selection of the quality indicators developed by clinicians, Health Informatics and the Quality and Outcomes Research Unit has been included the Trust's annual Quality Reports. The selection included for 2014/15 includes 74 indicators covering the majority of clinical specialties and performance for the past three financial years is included in a separate appendix on the Quality web pages: www.uhb.nhs.uk/quality.htm

The Trust's clinical and management teams improved performance for 34% of the indicators during 2014/15 with support from the Quality and Informatics teams. Performance for 43% stayed about the same (including 6 indicators which were already scoring the maximum and continued to do so). Performance for 15% deteriorated during 2014/15. The remaining 8 indicators were new or updated during 2014/15 so previous years' data is not available for comparison. The majority of the 75 indicators have a goal; 55% of those with a goal met them in 2014/15.

Table 1 shows performance for selected specialty quality indicators where the most notable improvements have been made during 2014/15. The data has been checked by the appropriate clinical staff to ensure it accurately reflects the quality of care provided

Table 2 shows performance for selected indicators where performance has deteriorated during 2014/15. Performance for the Dermatology indicator has improved greatly since September 2014 however the performance shown is for the year to date.

Performance for the remaining indicators can be viewed on the Quality web pages: www.uhb.nhs.uk/quality.htm.

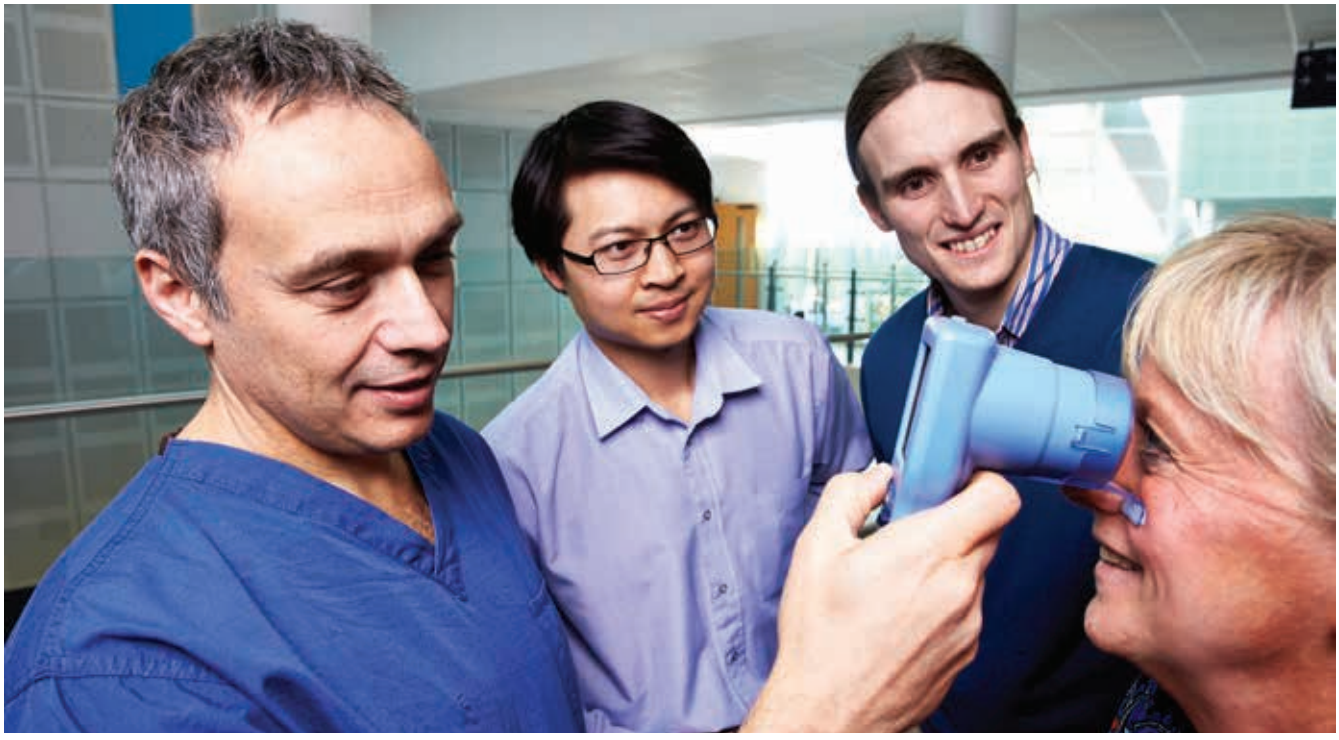


Table 1

Specialty	Indicator	Goal	Percentage Apr 12 - Mar 13	Percentage Apr 13 - Mar 14	Numerator Apr 14 - Mar 15	Denominator Apr 14 - Mar 15	Percentage Apr 14 - Mar 15	Data Sources
Imaging	Proportion of Inpatients who have report turnaround time of less than or equal to 4 days for MRI	>85%	90.0%	92.2%	4305	4438	97.0%	CRIS
Surgery – Emergency	Perianal abscess operations should take place on the day of admission or the next day	>90%	90.7%	85.8%	101	107	94.4%	Lorenzo
Upper Gastrointestinal Medicine	Emergency patients admitted with gall stone diseases who had an ultrasound within 24 hours of admission	>90%	62.6%	74.6%	174	208	83.7%	Lorenzo PICS

Table 2

Specialty	Indicator	Goal	Percentage Apr 12 - Mar 13	Percentage Apr 13 - Mar 14	Numerator Apr 14 - Mar 15	Denominator Apr 14 - Mar 15	Percentage Apr 14 - Mar 15	Data Sources
Dermatology	Suspected cancer cases seen within 2 weeks by a Consultant	>93%	97.9%	97.9%	1595	1950	81.8%	Lorenzo Somerset
Imaging	GP direct access patients who have report turnaround time of less than or equal to 7 days for plain imaging	>99%	97.7%	92.6%	27279	31937	85.4%	CRIS
Pathology	Turnaround time: Urine within 48 hours	>90%	82.0%	79.9%	35577	50164	70.9%	Telepath

3.7 Sign up to Safety

The national Sign up to Safety campaign was launched in 2014 and aims to make the NHS the safest healthcare system in the world. The ambition is to halve avoidable harm in the NHS over the next three years. Organisations across the NHS have been invited to join the Sign up to Safety campaign and make five key pledges to improve safety and reduce avoidable harm. University Hospitals Birmingham NHS Foundation Trust joined the Sign up to Safety campaign in November 2014. As part of the campaign, UHB has made the following five Sign up to Safety pledges:

1. Put safety first.

Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

We will:

- reduce medication errors due to missed drug doses
- improve monitoring of deteriorating patients through completeness of observation sets
- reduce hospital acquired grade 3 and 4 pressure ulcers
- reduce harm from falls
- reduce the risk of venous thrombo-embolism through increased prescription and administration rates of prophylactic medication for those patients who require it

2. Continually learn.

Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

We will:

- better understand what patients are telling about us about their care through continuous local patient surveys, complaints and compliments
- review the Clinical Dashboard to ensure clinical staff have the performance and safety information they need to improve patient care

3. Honesty.

Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

We will:

- improve staff awareness and compliance with the Duty of Candour
- communicate key safety messages through regular staff open meetings and Team Brief
- make patients and the public aware of safety issues and what the Trust is doing to address them

4. Collaborate.

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

We will:

- work closely with our partners to:
  - make improvements for patients in relation to mental health and mental health assessment.
  - develop clearer and simpler pathways around delayed transfers of care, safeguarding, end of life care and falls.
  - implement electronic solutions such as the 'Your Care Connected' project to improve patient safety by sharing key information

5. Support.

Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

We will:

- improve the learning and feedback provided to staff from complaints and incident reporting
- enable Junior Doctors to understand how they are performing and how they can improve in relation to key safety issues such as VTE prevention through the Junior Doctor Monitoring System
- recognise staff contribution to patient safety through the Best in Care awards

The Trust will now turn the above actions into a safety improvement plan to show how we intend to save lives and reduce harm to patients over the next three years.

Further information about Sign up to Safety can be found on the NHS England website: http://www.england.nhs.uk/signuptosafety/

3.8 Glossary of Terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department
AAA	Abdominal aortic aneurysm. This occurs when the large blood vessel that supplies blood to the abdomen, pelvis, and legs becomes abnormally large or balloons outward and can rupture if left untreated.
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
Administration	When relating to medication, this is when the patient is given the tablet, infusion or injection. It can also mean when anti-embolism stockings are put on a patient.
Alert organism	Any organism which the Trust is required to report to Public Health England
Analgesia	A medication for pain relief
Bacteraemia	Presence of bacteria in the blood
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark	A method for comparing (e.g.) different hospitals
Betablockers	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
Birmingham Health & Social Care Overview Scrutiny Committee	A committee of Birmingham City Council which oversees health issues and looks at the work of the NHS in Birmingham and across the West Midlands
BTS	British Thoracic Society
CABG	Coronary artery bypass graft procedure
CIA	Carotid Interventions Audit – this looks at Carotid Endarterectomy (a surgical procedure used to prevent stroke by correcting narrowing in the common carotid artery)
CCG	Clinical Commissioning Group
CDI	*C. difficile* infection
CEM	College of Emergency Medicine
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
Clinical Quality Committee	A committee led by the Trust's Chairman which reviews clinical quality in detail
Commissioners	*See CCG*
Congenital	Condition present at birth
Contraindication	A condition which makes a particular treatment or procedure potentially inadvisable
CQC	Care Quality Commission
CQG	Care Quality Group - a UHB group chaired by the Chief Nurse, which assess the quality of care, mainly nursing

Term	Definition
CQMG	Clinical Quality Monitoring Group - a UHB group chaired by the Executive Medical Director, which reviews the quality of care, mainly medical
CQUIN	Commissioning for Quality and Innovation payment framework
CRIS	Radiology database
Cystoscopy	A procedure where a camera is inserted into the bladder via the urethra
DAHNO	National Head and Neck Cancer Audit
Datix	Database used to record incident reporting data
Daycase	Admission to hospital for a planned procedure where the patient does not stay overnight
DCQG	Divisional Clinical Quality Group - the divisional subgroups of the CQMG
Division	Specialties at UHB are grouped into Divisions
ED	Emergency Department (previously called Accident and Emergency Department)
Elective	A planned admission, usually for a procedure or drug treatment
Enoxaparin	An anticoagulant drug used to treat or prevent venous thrombo-embolism (blood clots)
ENT	Ear, Nose and Throat
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
FCE	Finished/Full Consultant Episode - the time spent by a patient under the continuous care of a consultant
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.
Francis Report	The report by Robert Francis QC on the failings at Mid Staffordshire NHS Foundation Trust, published in February 2013
GI	Gastro-intestinal
GP	General Practitioner
HCS	Healthcare Commissioning Services
Healthwatch Birmingham	An independent group who represent the interests of patients and the public.
HES	Hospital Episode Statistics
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
Informatics	UHB's team of information analysts
IT	Information Technology
ITU	Intensive Treatment Unit (also known as Intensive Care Unit, or Critical Care Unit)
Lorenzo	Patient administration system
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts

Term	Definition
Mortality	A measure of the number of deaths compared to the number of admissions
MRI	Magnetic Resonance Imaging – a type of diagnostic scan
MRSA	Meticillin-resistant *Staphylococcus aureus*
Myocardial Infarction	Heart attack
mystay@QEHB	An online system that allows patients to view information / indicators on particular specialties
NaDIA	National Diabetes Inpatient Audit
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure
NHS	National Health Service
NHS Choices	A website providing information on healthcare to patients. Patients can also leave feedback and comments on the care they have received
NRLS	National Reporting and Learning System
NVR	National Vascular Registry
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
PALS	Patient Advice and Liaison Service
Patient Opinion	A website where patients can leave feedback on the services they have received. Care providers can respond and provide updates on action taken.
Peri-operative	Period of time prior to, during, and immediately after surgery
PHE	Public Health England
PHSO	Parliamentary and Health Service Ombudsman
PICS	Prescribing Information and Communication System
Plain imaging	X-ray
PROMS	Patient Reported Outcome Measures
Prophylactic / prophylaxis	A treatment to prevent a given condition from occurring
Pulmonary embolism	A blood clot in the blood vessels of the lungs
QEHB	Queen Elizabeth Hospital Birmingham
QuORU	Trust's Quality and Outcomes Research Unit
R&D	Research and Development
RCA	Root cause analysis
Readmissions	Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days
Safeguarding	The process of protecting vulnerable adults or children from abuse, harm or neglect, preventing impairment of their health and development.
Safety Thermometer	A system for monitoring harm across NHS organisations

Term	Definition
SEWS	Standardised Early Warning System
SHMI	Summary Hospital Mortality Indicator
SIRI	Serious incident requiring investigation
Spell	The time period from a patient's admission to hospital to their discharge. A spell can consist of more than one episode if the patient moves to a different consultant and/or specialty.
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit and Research Network
Thrombosis	A blood clot
Trajectory	In infection control, the maximum number of cases expected in a given time period
Trust assigned	A case (e.g. MRSA or CDI) that is deemed as 'belonging' to the Trust in question
Trust Partnership Team	Attendees include Staff Side (Trade Union representatives), Directors, Directors of Operations and Human Resources staff. The purpose of this group is to provide a forum for Staff Side to hear about and raise issues about the Trust's strategic and operational plans, policies and procedures.
TVS	Tissue Viability Service
UHB	University Hospitals Birmingham NHS Foundation Trust
VTE	Venous thromboembolism – a blood clot

Appendix A: Performance against core indicators

The Trust's performance against the national set of quality indicators jointly proposed by the Department of Health and Monitor is shown in the tables below. There are eight indicators which are applicable to acute trusts. The data source for all the indicators is the Health and Social Care Information Centre (HSCIC) which has only published data for part of 2014/15 for some of the indicators. Data for the latest two time periods is therefore included for each indicator and is displayed in the same format as the HSCIC. National comparative data is included where available. Further information about these indicators can be found on the HSCIC website: www.hscic.gov.uk

1. Mortality

	Previous Period (April 2013 – March 2014)	Current period (July 2013 – June 2014)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
(a) Summary Hospital-level Mortality Indicator (SHMI) value	1.05	**1.03**	-	0.54	1.20	The Trust considers that this data is as described for the following reasons as this is the latest available on the HSCIC website.
(a) SHMI banding	2	**2**	-	1	3	The Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the technical approach UHB takes to improving quality detailed in this report. The Trust does not specifically try to reduce mortality as such but has robust processes in place, using more recent data, for monitoring mortality as detailed in Part 3 of this report. It is important to note that palliative care coding has no effect on the SHMI.
(b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level	29.3	**30.5**	-	0	49.0	

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

	Previous Period (April 2013 – March 2014)	Current period (April – September 2014)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
(i) Groin hernia surgery	0.068	**0.039**	0.081	0.125	0.009	The Trust considers that this data is as described for the following reasons as it is the latest available on the HSCIC website. The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to focus on improving participation rates for the pre-operative questionnaires which we have control over. Participation is shown in Part 2 as part of the audit section of this report.
(ii) Varicose vein surgery	-	-	0.100	0.142	0.054	
(iii) Hip replacement surgery	Not applicable to UHB					
(iv) Knee replacement surgery	Not applicable to UHB					

3. Readmissions to hospital within 28 days

	Previous Period (April 2010 – March 2011)*	Current period (April 2011 – March 2012)*				Comment
			National Performance			
	UHB	UHB	Overall (England)	Best (Acute teaching providers)	Worst (Acute teaching providers)	
(i) Patients aged 0-15 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	-	-	10.01	5.86	12.50	The Trust considers that this data (standardised percentages) is as described for the following reasons as this is the latest available on the HSCIC website. UHB is however unable to comment on whether it is correct as it is not clear how the data has been calculated. The Trust intends to take the following actions to improve this data (standardised percentages), and so the quality of its services, by continuing to review readmissions which are similar to the original admission on a quarterly basis. UHB monitors performance for readmissions using more recent Hospital Episode Statistics (HES) data as shown in Part 3 of this report.
(ii) Patients aged 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust (Standardised percentage)	11.60	11.54	11.45	10.64	13.55	

* The Trust has included the latest data available on the HSCIC website.

4. Responsiveness to the personal needs of patients

	Previous Period (2012/2013)	Current period (2013/14)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
Trust's responsiveness to the personal needs of its patients – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	72.4	**72.2**	68.7	84.2	54.4	The Trust considers that this data is as described for the following reasons as it is the latest available on the HSCIC website. It is pleasing to note that UHB continues to improve patient experience in the National Inpatient Survey. The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to collect real-time feedback from our patients as part of our local patient survey. The Board of Directors has again selected improving patient experience and satisfaction as a Trust-wide priority for improvement in 2015/16 (see Part 2 of this report for further details).

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

	Previous Period (2013)	Current period (2014)				
			National Performance			
	UHB	UHB	Average score for 4th quartile	Best	Worst	Comment
Staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends. Performance shown is based on staff who agreed or strongly agreed.	82	**82**	67	93	35	The Trust considers that this data (scores) is as described for the following reasons as it is the latest available on the HSCIC website and performance for 2014 is consistent with 2013. The Trust intends to take the following actions to improve this data, and so the quality of its services, by trying to maintain performance for this survey question.

6. Venous thromboembolism (VTE) risk assessment

	Previous Period (Q2 2014/15)	Current period (Q3 2014/15)				
			National Performance			
	UHB	UHB	Overall	Best	Worst	Comment
Percentage of admitted patients risk-assessed for VTE	99.24%	**99.34%**	95.95%	100%	81.19%	The Trust considers that this data (percentages) is as described for the following reasons as UHB has consistently performed above the national average for the past few years. The Trust intends to take the following actions to improve this data, and so the quality of its services, by continuing to ensure our patients are risk assessed for venous thromboembolism (VTE) on admission. Further details on UHB's VTE prevention performance are shown under Priority 1: *Improving VTE prevention* in this report.

7. *C. difficile* infection

	Previous Period (2012/13)	Current period (2013/14)				
			National Performance			
	UHB	UHB	Overall (England)	Best	Worst	Comment
C. difficile infection rate per 100,000 bed-days (patients aged 2 or over)	20.9	**21.9**	17.3	0	37.1	The Trust considers that this data is as described for the following reasons as it is the latest available on the HSCIC website. The Trust intends to take the following actions to improve this rate, and so the quality of its services, by continuing to reduce *C. difficile* infection through the measures outlined for Priority 5: *Infection prevention and control* in this report.

8. Patient Safety Incidents

	Previous Period (April – September 2012)	Current period (October 2012 – March 2013)				
			National Performance (Acute Teaching Providers)			
	UHB	UHB	Overall	Best	Worst	Comment
Incident reporting rate per 100 admissions	10.85	**11.00**	-	13.7	3.2	The Trust considers that this data is as described for the following reasons as the data is the latest available on the HSCIC website. UHB is however unable to comment on whether it is correct as it is not clear how the numerator (incidents) and denominator (admissions) data has been calculated. The Trust intends to take the following actions to improve this data and so the quality of its services, by continuing to have a high incident reporting rate. The Trust routinely monitors incident reporting rates and the percentage of incidents which result in severe harm or death as shown in Part 3 of this report.
Number of patient safety incidents that resulted in severe harm or death	77	**11**	-	74	2	
Rate of patient safety incidents that resulted in severe harm or death (per 100 admissions)	0.18	0.03	-	0.08	0.00	

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

The Trust has shared its 2014/15 Quality Report with Birmingham Cross City Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee.

Birmingham Cross City Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee have reviewed the Trust's Quality Report for 2014/15 and provided the statements below.

Statement provided by Birmingham Cross City Clinical Commissioning Group

University Hospitals Birmingham NHS Foundation Trust

Quality Account 2014/2015

Statement of Assurance from Birmingham CrossCity CCG May 2015

1.1 As coordinating commissioner Birmingham CrossCity CCG has welcomed the opportunity to provide this statement for the University Hospitals Birmingham NHS Foundation Trust's (UHB) Quality Account for 2014/15. The review of this Quality Account has been undertaken in accordance with the Department of Health guidance and Monitor's requirements. The statement of assurance has been developed in consultation with neighbouring CCGs, the Birmingham, Solihull and Black Country Area Team and the Birmingham CrossCity CCG Patient Council.

1.2 Ensuring high quality care for all is a fundamental component of improving patient outcomes and experiences, and therefore Birmingham CrossCity CCG is committed to working with providers such as UHB to drive forward best practice in respect to clinical quality, patient safety and patient experience. Hence during 2014/15 we have continued to work closely with the Trust's clinicians and managers, monitoring the delivery of care within clinical areas through undertaking Quality Assurance visits. We have also reviewed quality and performance through the monthly Clinical Quality Review Group meetings, addressing any issues around the quality and safety of patient care with the Trust, as and when they have occurred.

1.3 In reviewing this Quality Account we were disappointed that the Trust declined to include the locally agreed priorities for Quality Accounts into their Quality Account document for 2014/2015, for example information on Commissioning for Quality and Innovation (CQUINs) and equality performance. However, we acknowledge that the Trust produces this information in other formats regularly throughout the year as part of on-going performance reports.

1.4 We noted that the Trust has made considerable efforts to improve its services and the quality of the care it provides, notable examples include the excellent work that has taken place in respect to reducing avoidable harm from venous thrombo-embolism (VTE) and avoidable Grade 3 and 4 pressure ulcers. We are pleased that the Trust will now be focussing on reducing grade 2 hospital-acquired pressure ulcers as one of its targets for 2015/2016.

1.5 During 2014/2015 Friends and Family' test data indicates how patients and staff recommended the Trust as a place to be treated in. It was also positive that the number of formal complaints has remained stable. However whilst the Trust has seen an overall increase in the number of compliments received, there are two critical areas where

numbers of responses have declined: nursing staff and friendliness of staff.

1.6 We welcomed how the Trust had included examples of what patients had actually said within the compliments received and felt that this added a greater dimension to understanding of the patient's journey within the services the Trust provides.

1.7 We noted the examples of innovative practice such as the inclusion of sleep kits into the electronic prescribing system (PICS) as a prescribing option to reduce the amount of inappropriate night sedation prescribing, and were pleased to learn about the Trust's first Patient Experience Conference entitled 'Listen, Involve, Learn, Improve' which shared good practice from both the Trust and other organisations.

1.8 Whilst reviewing the Quality Account it was noted that there were some issues which were either not covered, or adequately explored. For example, frequent reference was made to the importance of investigation and learning lessons from adverse events, however the Trust did not offer any details of the learning from the three Never Events reported during 2014/15 and what measures had been taken to reduce the risks of future reoccurrence.

1.9 The Quality Account also contains details of the comprehensive range of audits and research projects that the Trust took part in during 2014/2015, however there are no specific details offered as to how such audit and research has impacted onto patient care and the key messages.

1.10 There was minimal reference to medicines management and how the Trust is learning from issues such as medication errors, and in a similar vein, safeguarding children is not mentioned. There was no reference to the children and young people who are seen in the Trust, despite the fact that the Emergency Department within the Trust was included in the CQC review of health services for Children Looked After and Safeguarding in September 2014.

1.11 There was also no detail offered in respect to how the Trust was working to tackle the issue of cancer waits, little mention in respect to staffing/workforce management and the delivery of the 6C's which supports the development of a nursing workforce which promotes: Care - Compassion – Competence – Communication – Courage – Commitment.

1.12 In response to discussions with the Trust, information has been included in the Quality Account on the Trust membership of the national Sign up to Safety Campaign. The Trust has made five pledges around:

- Putting safety first;
- Continually learning;
- Being honest and transparent when something goes wrong;
- Making improvements across all local services patients use;
- Being supportive.

These pledges are now being worked on to turn the actions into a Safety Improvement Plan.

1.13 In summary, we welcomed the opportunity to comment on the Trust's Quality Account which overall provided a balanced and accurate summary of the work of the Trust. The Quality Account provides description of a number of positive developments and innovative improvements made during the year, although in some areas the document lacked the necessary detail.

1.14 The Quality Account does however demonstrate the Trust commitment to making year on year improvement to patient experience and clinical quality, and we shall continue to work in partnership with the Trust to deliver the quality agenda in 2015/2016.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group

Statement provided by Healthwatch Birmingham

Comment from Healthwatch Birmingham regarding the University Hospitals Birmingham NHS Foundation Trust Quality Account 2014/15. 20 May 2015

We would firstly like to thank you for sending a copy of 2014/2015 Quality Account Report, highlighting your proposed vision and focus for quality improvement for UHB Trust.

Your vision to deliver best outcomes to patients sits well with our own philosophy of key principles, bringing quality to the forefront of practice.

Healthwatch Birmingham holds firm to this notion of thought and consider our dual role will be fundamental to the promotion of shaping future health services, through good consultation with the users of our services.

Your collective priorities for 2014/2015 reflect your strategic plans around governance. We are mindful that some of your priorities around quality have not been met and are now continuing with new initiatives set for the existing priorities. We trust that your predicted measures and outcomes around quality improvement will be met sufficiently in line with your CQC ratings and CQUIN agreed targets.

We would wish to draw reference to two of your five priorities in terms of responding to the overall quality.

It is refreshing to see improvements can be seen in Priority area 1 – Improving VTE Prevention. We trust that these improvements will be seen as a continuing feature of future research, and monitoring. We note that the trust has received a risk assessment rate of 98% allowing the trust to put mechanisms in place to reduce risks in this area. The assessment of risk allows the trust to monitor service provision levels against risk and level of improvement. During the process of reviewing your account information, we understand that the above priority is now replaced by a new priority; we too look forward to seeing similar decreases in cases and greater emphasis on risk elimination and preventative measures.

Under the four current tiers of managing quality set by the trust for this year; includes the quality management arrangements for governing patient experience. It is positive to see 'The Care Quality Board' is made up of key personnel including a patient representative member. We trust the long term arrangements of managing quality for patients, works in tangent with the recommendations of the Francis report, offering three main objectives of listening, understanding and responding to the needs of patients.

We welcome your new approach on the direct reporting protocols for addressing patient experience Priority 2 – Improve patient experience and satisfaction. The results from 'The Real Time Survey' highlight the need for this area to be addressed in a way that fully represents patient's feedback. The patient influx for the current year including inpatient, outpatient and A & E attendees appears to have increased in capacity. Your report references high levels of attendees for all three separate areas compared to previous years. It would therefore prove beneficial, if patient satisfaction levels were equally reflected in this transitional growth during the next reporting period. We particularly welcome the launch of the carer's page and website. The use of patient's satellites as a feedback mechanism allows progress to be monitored, measured and reported on, promoting 'Bespoke' services for the trust.

Alongside patient experience we have reviewed your complaints information, we note that responses to complaints and levels of satisfaction fluctuate. We see that there have been increases in cases referred to the Parliamentary Ombudsman. Although, some of these cases have been resolved at local level, we would hope for some redress to be taken in the future to address the way complaint handling is monitored, to prevent matters escalating to an external level unduly.

Thank you for providing an update on 'The Real Time Survey Model', we are aware this model is still being tested, we note that it is proving to be a highly effective model. Again, listening to patient's voice and building trust will be fundamental to the process of building wider participation forums; as is the need for building and restoring public confidence around these priorities.

We look forward to the transformation of your services and future integrated models of care delivery, which we believe will indeed govern the improvement of quality under your priorities. We are happy to see a number of initiatives implemented already, with a view of working through each priority; with agreed actions.

Thank you for giving us the opportunity to review the Trust's Quality Account.

Yours sincerely,
Candy
Candy Perry
Interim Director, Healthwatch Birmingham.

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

The Birmingham HOSC has indicated that it is not in a position to provide a statement on the 2014/15 draft Quality Report.

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- 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 2014 to May 2015
  - papers relating to Quality reported to the Board over the period April 2014 to May 2015
  - feedback from the commissioners dated 21/05/2015
  - feedback from governors dated 23/02/2015
  - feedback from local Healthwatch organisations dated 20/05/2015
  - feedback from Overview and Scrutiny Committee dated 12/05/2015
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/05/2015
  - the 2014 national patient survey 14/04/2015
  - the 2014 national staff survey 24/02/2015
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 21/05/2015
  - CQC Intelligent Monitoring Report dated December 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

21/5/15 .....Date.....Chairman

21/5/15 .....Date.....Chief Executive

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

2014/15 limited assurance report on the content of the quality report and mandated performance indicators

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

We have been engaged by the council of governors of University Hospitals Birmingham NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Birmingham NHS Foundation Trust's quality report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of University Hospitals Birmingham NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Birmingham NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Birmingham NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week referral to treatment – incomplete pathway; and
- Emergency readmissions within 28 days of discharge from hospital.

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

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

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified below:
    - board minutes for the period April 2014 to March 2015;

- papers relating to quality reported to the board over the period April 2014 to March 2015
- feedback from Commissioners, dated 21/05/2015;
- feedback from governors, dated 23/02/2015;
- feedback from local Healthwatch organisations, dated 20/05/2015;
- feedback from Overview and Scrutiny Committee, dated 12/05/2015;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 07/05/2015
- the national patient survey, dated 14/04/2015;
- the national staff survey, dated 24/02/2015;
- Care Quality Commission Intelligent Monitoring Report dated December 2014;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 21/05/2015; and
- any other information included in our review.

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

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

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

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

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- Reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and the explanation of the basis of preparation of the 18 week Referral-to-Treatment incomplete pathway indicator set out in the Quality Report which sets out the approach the Trust has taken to patients with "unknown" clock start dates.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion – 18 week Referral to Treatment Indicator
The "maximum time of 18 weeks from point of referral to treatment – patients on an incomplete pathway" indicator requires that the Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in national guidance.

During our sample testing, we found that:

- for a sample of our patient records' tested, one or both of the start and end date of treatment were not accurately recorded;
- for a sample of our patient records' tested, one or both of the start and end activity treatment were not accurately recorded; and

The "Performance against indicators included in the Monitor Risk Assessment Framework" section on page 162 of the Trust's Quality Report summarises the actions that the Trust is taking post year end to resolve the issues identified in its processes.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2015. We are unable to quantify the effect of these errors on the reported indicator.

Qualified Conclusion
Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2014/15; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Deloitte LLP
Chartered Accountants
Birmingham
26 May 2015