University Hospitals Birmingham
NHS Foundation Trust

This annual report covers the period
1 April 2015 to 31 March 2016

Quality Account 2015/2016

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Quality Account 2015/2016

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 2015/16. In line with national trends, the Trust has again 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.

Staff have worked very hard to improve performance for two of the national cancer indicators – *31-day wait from diagnosis to first treatment: all cancers* and *31-day wait for second or subsequent treatment: surgery* – which have been achieved since July 2015. The Trust is continuing to do all it can to improve performance for the *62-day wait for first treatment from urgent GP referral: all cancers* and *Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge* indicators which are affected by late referrals from other trusts and ever increasing Accident and Emergency attendances respectively. It is very pleasing to see that patients and staff continue to recommend the Trust as a place to be treated in the 'Friends and Family' tests. The number of formal complaints reduced despite increases in activity and the number of compliments rose during 2015/16. The Trust also achieved its best ever performance in the 2015 Staff Survey.

The Trust has made excellent progress in relation to two of the five priorities for improvement set out in last year's Quality Report: reducing grade 2 pressure ulcers and improving patient experience and satisfaction. Performance for the remaining indicators – timely and complete observations, reducing medication errors and infection prevention and control – has been mixed with some key achievements and further work required to improve performance in 2016/17. The Board of Directors has chosen to continue with the five priorities for improvement in 2016/17 and has set ambitious improvement targets. The selection of local patient survey questions included in *Priority 2: Improve Patient Experience and Satisfaction* has been refreshed based on performance for 2015/16 by the Care Quality Group which has Governor representation.

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 2015/16 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 (SIs), 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 has developed an action plan and quarterly review process for monitoring progress over the next three years which will be published on the Trust's website.

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, 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: www.uhb.nhs.uk/quality.htm. The Trust has continued to publish monthly data during 2015/16 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 2015/16 Quality Report and undertaken testing for three areas in line with the Monitor guidance on external assurance: *18-week maximum wait from point of referral to treatment (incomplete pathways), Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge* and one local indicator. The Trust's Council of Governors selected one of the quality improvement priorities – *Priority 1: Reducing grade 2 hospital-acquired pressure ulcers* – as the local indicator to be audited. The Trust has been given a clean limited assurance opinion for the content of the Quality Report and the two nationally mandated indicators with a number of recommendations for improvement which will be implemented during 2016/17. There were no recommendations made for the local indicator. The report provided by the Trust's external auditor is included in Annex 3 of the Quality Report.

The Trust was last inspected in January 2015 by the Care Quality Commission (CQC) as part of the new, national inspection regime. The Trust was rated as Good overall with 85% of areas being rated as Good or Outstanding and 15% rated as Requires Improvement. Following a focussed inspection of the Trust's Cardiac Surgical Services undertaken in December 2015, the Care Quality Commission (CQC) placed additional conditions on the Trust's registration under Section 31 of the Health and Social Care Act 2008. These are explained in more detail in section 2.2.5 of the report. The Trust was required to submit specific outcome and performance information to the CQC on a weekly basis and to commission an external review of Cardiac Surgical Services. The Trust had already commenced a Cardiac Surgery Quality Improvement Programme (CSQIP) in advance of the CQC identifying concerns. The external review of the service was completed, and the CQC removed the conditions in May 2016. The Trust will continue to submit quarterly data to the CQC. A number of the actions identified by the external review were already incorporated in the CSQIP and any additional actions are being brought within its scope. The CQC has acknowledged that the data submitted to date shows an improvement in outcomes and the Trust's internal Cardiac Surgery Quality Improvement Programme continues.

The Five Year Forward View report was published in October 2014 and set out the changes and investment required to deliver an improved, more sustainable NHS and implement new models of care. The Trust became the prime provider for the new, fully integrated sexual health treatment and prevention programme called Umbrella from August 2015 which involves commissioning and providing services for the people of Birmingham and Solihull through two central sites, satellite clinics and community clinics. 2016/17 will be another very challenging year for UHB as we focus on delivering the best in care and achieving outcome/access targets alongside ever increasing demand for our services coupled with tighter financial constraints. The Trust will continue working with regulators, commissioners, healthcare providers and other organisations to influence future models of care delivery and deliver further improvements to quality during 2016/17.

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 23, 2016

Quality Account 2015/2016

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

2.1 Priorities for Improvement

The Trust's 2014/15 Quality Report set out five priorities for improvement during 2015/16:

- **Priority 1:** Reduce grade 2 pressure ulcers
- **Priority 2:** Improve patient experience and satisfaction
- **Priority 3:** Timely and complete observations including pain assessment
- **Priority 4:** Reduce medication errors (missed doses)
- **Priority 5:** Infection prevention and control

The Trust has made excellent progress in relation to two quality improvement priorities: reducing grade 2 pressure ulcers and improving patient experience and satisfaction. There has however been mixed performance for timely and complete observations, reducing medication errors and infection prevention and control during 2015/16.

Performance for both indicators within Priority 3 did not meet the agreed end-of year targets, although performance was higher than in 2014/15. The Trust has maintained performance for missed doses, but did not achieve the proposed reduction for missed non-antibiotics in 2015/16. The Trust missed the trajectory for zero Trust-apportioned MRSA bacteraemias but met the *C. difficile* infection trajectory during 2015/16.

The Board of Directors has chosen to continue with the five priorities for improvement in 2016/17.

1	Reduce grade 2 pressure ulcers	New trajectory for 2016/17 agreed with CCG
2	Improve patient experience and satisfaction	New patient survey questions added, others removed due to achieving the 2015/16 target
3	Timely and complete observations including pain assessment	Targets for 2016/17 updated in line with 2015/16 performance
4	Reduce medication errors (missed doses)	Targets and methodology kept the same for 2016/17
5	Infection prevention and control	Trajectories for 2016/17 agreed with CCG – same as 2015/16

The improvement priorities for 2016/17 were confirmed by the Trust's Clinical Quality Monitoring Group chaired by the Executive Medical Director, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. These were then discussed with various Trust groups including staff, patient and public representatives during Quarter 4 2015/16 as shown in the table below. The priorities for improvement in 2016/17 were also shared and discussed with interested parties outside the Trust including the Trust's lead Clinical Commissioning Group (CCG), Birmingham CrossCity CCG.

The focus of the patient experience priority was decided by the Care Quality Group and the priorities for improvement in 2016/17 were then finally approved by the Board of Directors in March 2016. The priorities for 2016/17 will finally be presented to the Trust Partnership Team and cascaded to all staff via Team Brief in May 2016.

Date	Group	Key Members
February 2016	Council of Governors	Chairman, Chief Executive, Executive Directors, Directors and Staff, Patient and Public Governors
March 2016	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 2016	Care Quality Group	Executive Chief Nurse, Associate Directors of Nursing, Matrons, Senior Managers with responsibility for Patient Experience, and Patient Governors
April 2016	UHB Contract Review Meeting	Various managers and clinical staff from Birmingham and CrossCity Clinical Commissioning Group and UHB
April 2016	Trust Partnership Team	Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives
May 2016	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 2015/16 and the rationale for any changes to the priorities are provided in detail below. It might be useful to read this report alongside the Trust's Quality Report for 2014/15.

Priority 1

Reduce grade 2 hospital-acquired pressure ulcers

Background

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

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair its blood supply (NICE, 2014).

They are also known as "bedsores" or "pressure sores" and they tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. Some pressure ulcers also develop due to pressure from a device, such as a urinary catheter.

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)

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

UHB has seen a continued decrease in the number of hospital-acquired pressure ulcers during 2015/16.

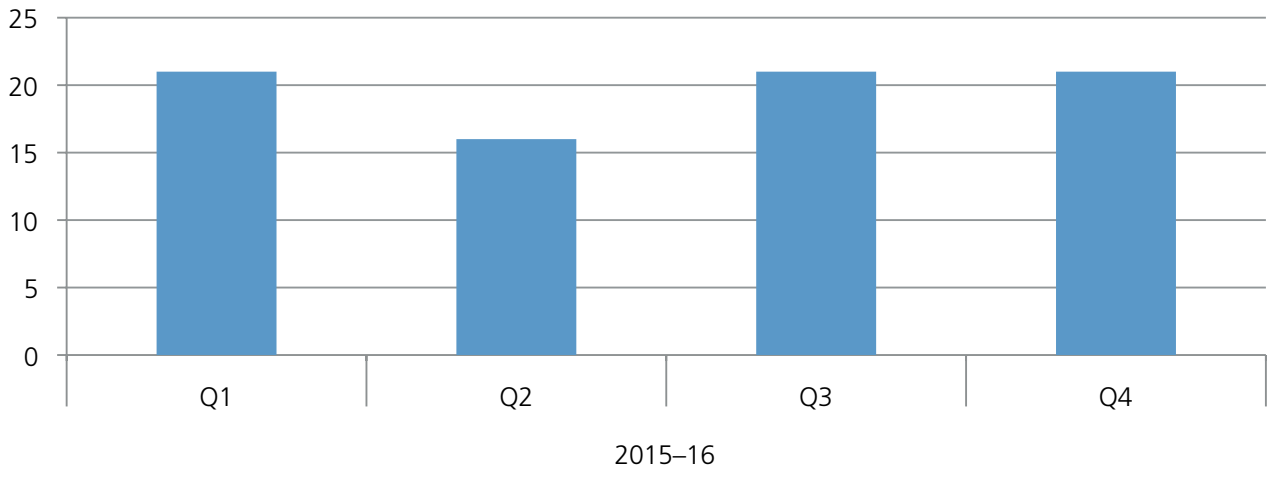
As there are now fewer hospital-acquired grade 3 and grade 4 ulcers at UHB, the Trust has chosen to focus on reducing grade 2 ulcers. This in turn should reduce the number of grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

Performance

The 2015/16 reduction target agreed with Birmingham CrossCity Clinical Commissioning Group (CCG) was 132 patients with non device-related, hospital-acquired avoidable grade 2 pressure ulcers.

For the period April 2015 to March 2016, UHB reported 79 patients with non device-related, hospital-acquired avoidable grade 2 pressure ulcers, against the agreed reduction target of 132. This compares to 144 reported in 2014/15.

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



Initiatives implemented in 2015/16

- Relaunched the 'React to RED' strategy through various forums including a link nurse study day and Practice Development. When a staff member identifies a potential pressure ulcer, they think "RED": Reposition, Equipment, Documentation.
- Updated the Back to the Floor audit to become the Tissue Viability Quality Audit; this involves each clinical area completing an audit form to assess five patients' pressure ulcer care and is fed back at the Preventing Harms meetings.
- Introduced a Skin Champions study day for nursing assistants with a keen interest in tissue viability.
- Held a Tissue Viability Conference to celebrate positive changes in pressure ulcer reduction in the Trust.
- Closer divisional working with Preventing Harms meetings regularly held; this provides a forum to discuss and address specific issues around pressure ulcers and any areas for concern.
- Improved documentation across Critical Care and held specific meetings for link nurses in these areas.
- Targeted education on the introduction of the new pressure ulcer grading system and updated the electronic resource for mandatory training on pressure ulcers.
- Carried out a Trust-wide chair audit, and a replacement programme of pressure reducing patient armchairs.
- Tissue Viability were invited to be part of the preceptorship programme and the pressure ulcer competencies have been incorporated in to the preceptorship book.
- Continued to provide a formal education programme which includes monthly pressure ulcer study days.
- Task and Finish groups looking at specific device related pressure ulcers i.e. anti-embolism stockings, plaster casts, catheters and endotracheal tubes.
- Continued to provide education for specific staff groups i.e. doctors' induction, Emergency Department and CDU (Clinical Decision Unit) rolling programme and student nurses.
- The Tissue Viability Team was shortlisted for the HSJ (Heath Service Journal) award for patient safety and was interviewed by a panel.
- The Lead Tissue Viability Nurse wrote and published a blog on pressure ulcer prevention strategies for the Royal College of Nursing.
- The Tissue Viability Team continue to review all patients with grade 2 and above hospital acquired pressure ulcers, or community-acquired grade 3 or 4 pressure ulcers, as well as any reported areas of concerns or potential for safeguarding.
- Worked closely with the Shelford group of hospitals and linked with West Midlands Tissue Viability Nurses.

Changes to improvement priority for 2016/17

The 2016/17 reduction target has been agreed with Birmingham CrossCity Clinical Commissioning Group (CCG) – no more than 125 patients to have an avoidable, hospital-acquired, non device-related grade 2 pressure ulcer. This is a 5% decrease on the reduction target set for 2014/15.

Initiatives to be implemented during 2016/17

To continue to build on the improvements seen in 2015/16, 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. This priority focuses on improving scores in our local surveys.

Patient experience data from local surveys

During 2015/16, 22,572 patient responses were received to our local inpatient survey, 1,652 to the Emergency Department survey, 2,464 to the outpatient survey and 2,419 responses to our discharge survey.

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

Methodology

The local inpatient survey is undertaken, predominantly, utilising our bedside TV system, allowing patients to participate in surveys at their leisure. Areas that do not have the bedside TVs use either paper or tablets for local surveys. The Emergency Department survey is a paper-based survey, and the outpatient and discharge surveys are postal – both sent to a sample of 500 patients per month. Results of the postal surveys are given up to February 2016 as that is the latest data available at the time of compiling this report.

Improvement target for 2016/17

For 2016/17 we have reviewed 2015/16 performance for the questions set for this priority. Where these have achieved or maintained their target during the year they have been replaced with new questions. New questions have been chosen based on feedback we receive from patients about what really matters to them. Some of the new questions are already included on our surveys so have a baseline for 2015/16, some are new so will have a baseline set in quarter one. Where we have not quite achieved the targets set in 2015/16, these questions continue to be included in this priority for 2016/17.

- **Questions carried forward** – targets have been carried forward from 2015/16.
- **New questions with a 2015/16 baseline:**
  - Questions scoring 9 or above in 2015/16 are to maintain a score of 9 or above.
  - Questions scoring below 9 in 2015/16 are to increase performance by at least 5%, and/or achieve a score of 9.
- **New questions with no 2015/16 baseline** are to have a baseline set in Q1 2016/17. The above criteria will then apply.

This improvement priority was agreed at the Trust's Care Quality Group meeting in March 2016, which is a Chief Nurse-led sub-committee of the board, attended by clinical staff and also patient Governors to provide the patients' perspective.

The table below shows the results for 2015/16 and the status for each question. Below this are the new questions added for 2016/17.

Results from local patient surveys

	2014/15 Score	2015/16 Target	2015/16 Score	Status	2016/17 Target	2015/16 No. responses
Inpatient survey						
1. Did you find someone on the hospital staff to talk about your worries or fears?	8.4	8.8	8.5	Carry forward	8.8	8,575
2. Do you think that the ward staff do all they can to help you rest and sleep at night?	8.8	9	8.9	Carry forward	9	11,074
3. Have you been bothered by noise at night from hospital staff?	8.1	8.5	8.3	Carry forward	8.5	11,125
4. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	8.6	9	8.8	Carry forward	9	22,226
5. Did the staff treating and examining you introduce themselves?	8.9	9	9.1	Achieved	Removed	22,195
Outpatient survey						
6. Was your appointment changed to a later date by the hospital?	9	9	9.2	Achieved	Removed	2,411
7. Did the staff treating and examining you introduce themselves?	8.5	8.9	8.8	Carry forward	8.9	2,368
8. Did a member of staff tell you about medication side effects to watch out for?	6.7	7	7.3	Achieved	Removed	831
Emergency Department survey						
9. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.9	8.3	8.9	Achieved	Removed	1,605
10. Do you think the hospital staff did everything they could to help control your pain?	7.8	8.2	9.0	Achieved	Removed	1,472
11. Did the staff treating and examining you introduce themselves?	8.1	8.5	8.9	Achieved	Removed	1,515
Discharge survey						
12. Did a member of staff tell you about medication side effects to watch for when you went home?	5.8	6.1	5.7	Carry forward	6.1	1,738
13. Did you feel you were involved in decisions about going home from hospital?	7.0	7.4	7.2	Carry forward	7.4	2,193

New questions to be added for 2016/17

	2015/16 Score	Status	2016/17 Target
Inpatient survey			
During your time in hospital did you feel well looked after by hospital staff?	NA	NEW for 2016/17	To be set
Outpatient survey			
If you had important questions to ask, did you get answers that you could understand?	8.9	NEW for 2016/17	9
How would you rate the courtesy of the Outpatient reception staff?	8.9	NEW for 2016/17	9
Emergency Department survey			
During your time in the Emergency Department did you feel well looked after by hospital staff?	NA	NEW for 2016/17	To be set
How would you rate the courtesy of the Emergency Department reception staff?	NA	NEW for 2016/17	To be set
Were you kept informed of what was happening at all stages during your visit?	NA	NEW for 2016/17	To be set

How progress will be monitored, measured and reported

- This priority is measured using the local survey results as detailed in the methodology.
- The operational Patient Experience Group (reporting to the Care Quality Group) monitors this priority.
- Exception reports to Associate Directors of Nursing (ADNs) highlight individual wards not meeting the quality priority so that action can be taken. The new reporting format requires the ADNs to provide feedback on actions taken to the Care Quality Group.
- This patient experience quality priority is reported on the Clinical Dashboard so is always available for staff to view; updated monthly.
- Quarterly patient experience reports will be provided to the Care Quality Group (summarised to the Board of Directors) and the local Clinical Commissioning Group – this includes a gap analysis on the patient experience quality priority.
- Feedback will be provided by members of the Patient and Carer Councils as part of the Adopt a Ward / Department visits and via Governor drop-in sessions.
- Progress will also be reported via the quarterly Quality Report update published on the Trust Quality web pages.

Patient Experience initiatives implemented in 2015/16

- Food provision has continued to be monitored and improvements made in response to patient experience feedback received:
  - Menus are consistently reviewed and changes made to the dishes offered.
  - A beverage trolley has been implemented in outpatient waiting areas.
  - Brightly coloured Rio crockery (designed for the elderly or disabled) has been introduced across ten wards to aid independent eating, with further rollout planned for 2016/17.
  - Following a successful pilot, toast is being reintroduced to ward breakfast, this has resulted directly from feedback received from patients.
  - Texture modification diet descriptions are now included on the back of menu cards to assist staff and patients in choosing the correct modification required.
- Free WiFi has been introduced in key areas across the Trust to support patients and visitors with communication and internet access while using our services.
- Signage has been consistently reviewed to ensure that navigating around the hospital is made as easy and clear as possible.
- The Discharge Lounge was relocated in a newly refurbished location and relaunched to increase use. Patients using the Lounge are cared for in a comfortable, holistic environment whilst the last few preparations are made for their discharge. The Lounge includes access to a Pharmacy Technician who can

ensure that medication information is shared with the patient and their carer in a quiet, calm environment with plenty of opportunity for questions to be answered.

- Outpatient Pharmacy introduced in the atrium of the hospital.
- Feedback received via the NHS Friends and Family Test has been used to identify areas for improvement across the organisation; it is now embedded so patients have the opportunity to answer the question at any point of their journey.
- Artwork has been installed in a number of areas around the Trust to enhance the environment and make it more pleasant for patients, visitors and staff.
- A new Discharge Hub was set up, bringing together health and social care professionals involved in complex discharges. Cohorting staff together has improved communication, streamlined the discharge planning process and greatly enhanced the experience for this group of patients.
- The Communication Skills Task and Finish Group completed its remit by publishing the Trust's Communication Behaviours and the associated CommunicatingWell@UHB electronic information and training resource. The group has now been reformed as a Communication Skills Oversight Group which will monitor patient experience feedback around communication and use it intelligently to inform training needs of staff groups.
- A new Patient Experience Dashboard was launched and has been very well received by staff. Easier access to patient experience feedback results has enhanced staff engagement, enabling them to take ownership of their data. It has helped them to use their feedback to drive improvements and celebrate good practice. Further training is being delivered to continue to embed use of the dashboard across the Trust and ensure all relevant staff use it as a tool to support their patient experience needs.
- Ward/departmental workshop-based teaching on Patient Experience has been successfully implemented with a variety of staff groups. This approach to training and engaging staff seems to be popular and effective so will be rolled out further in 2016/17.
- Governor drop in patient experience visits were introduced to Inpatient areas to compliment those already carried out in Outpatient areas. These visits enable Governors to interact directly with patients, visitors and staff. There has been a wealth of rich qualitative information obtained that has been fed back in real-time to ward staff and senior nursing representatives meaning any immediate issues can be actioned without delay.

The Friends and Family Test

Response rates and positive recommendation percentages have been closely monitored throughout 2015/16 against internal targets set and tracked against national and regional averages to benchmark how we are doing against our peers.

The Friends and Family Test (FFT) asks patients the following question:

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

Patients can choose from six different responses as follows:

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

Methodology

Patients admitted as day cases, or staying overnight on an inpatient ward, were asked to complete the FFT on discharge from hospital; either on the bedside TVs, on paper or tablet. Those attending the emergency department were asked either on leaving (using a paper survey), or afterwards via an SMS text message. Outpatients are given the opportunity to answer the question whenever suits them best, either before they leave the department (paper or check in kiosk), or they can access the question online via the Trust website.

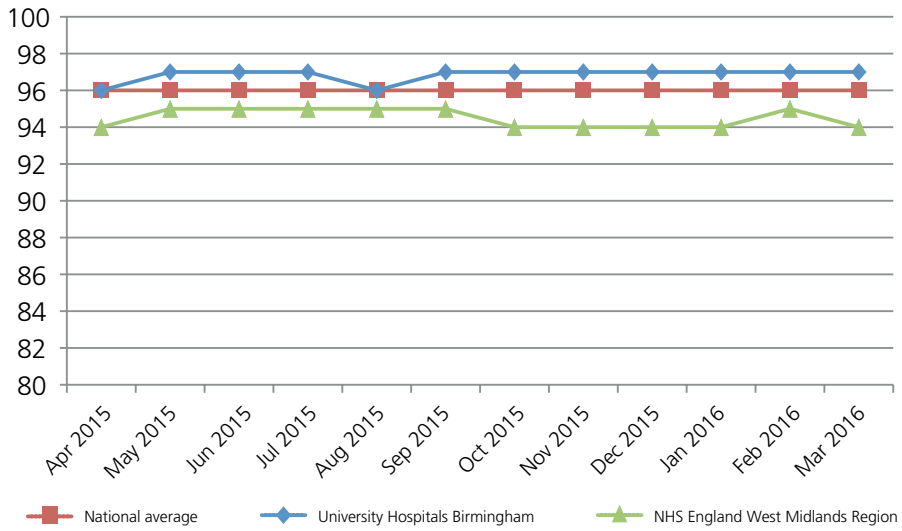
The Trust follows the national guidance for undertaking and scoring of the Friends and Family Test.

Performance

The charts opposite show benchmark comparisons for the positive recommendation percentages for the Friends and Family Test for Inpatients, A&E and Outpatients.

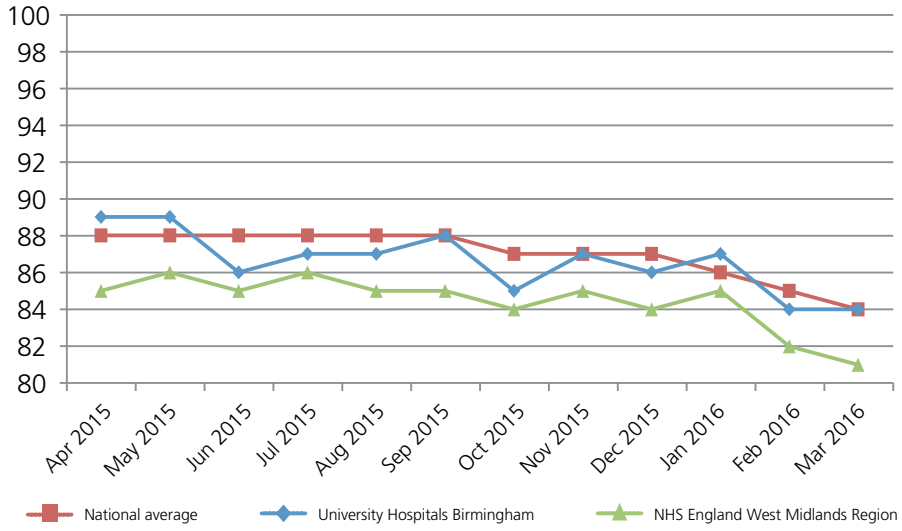
Inpatients

During 2015/16 the Trust has maintained a positive recommendation rate that is equal to or above the national average, and above the West Midlands rate.



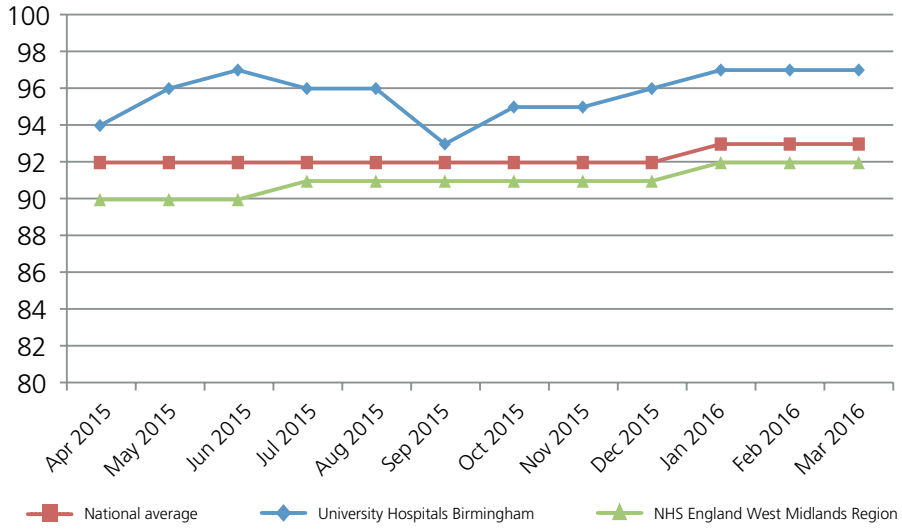
A&E

During 2015/16 the Trust's positive recommendation rate has fluctuated but has remained around the national average and above the regional average. Trust, national and regional averages are seeing a downward trend in this score with current pressures in A&E departments.



Outpatients

During 2015/16 the Trust has largely maintained a positive recommendation rate that is significantly higher than both the national average, and the West Midlands regional average.



Complaints

The number of formal complaints received in 2015/16 was 629. A further 51 complaints were dealt with informally, such as via a telephone call to resolve an appointment issue, without the need for formal investigation. The total number of complaints (formal and informal) received in 2015/16 was 14% lower than 2014/15.

The main subjects of complaints received in 2015/16 related to clinical treatment (281), communication and information (86), matching the top two main subjects in 2014/15, whilst attitude of staff (65) replaced inpatient delays/cancellations as the third most prevalent subject of complaints.

While the number of inpatient complaints received in 2015/16 reduced, there was a slight increase in the level of outpatient complaints. Emergency Department complaint numbers remained stable despite increased activity. The rate of formal complaints received against activity across inpatients, outpatients and the Emergency Department has remained relatively stable.

	2013/14	2014/15	2015/16
Total number of formal complaints	664	654	629

Rate of formal complaints to activity		2013/14	2014/15	2015/16
Inpatients	FCEs*	132,280	127,204	129,574
	Complaints	379	371	325
	Rate per 1000 FCEs	**2.9**	**2.9**	**2.5**
Outpatients	Appointments**	729,695	752,965	788,996
	Complaints	200	201	222
	Rate per 1000 appointments	**0.3**	**0.3**	**0.3**
Emergency Department	Attendances	97,298	102,054	108,463
	Complaints	85	82	82
	Rate per 1000 attendances	**0.9**	**0.8**	**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 by Complaints	Outcome
Level of complaints around cancelled/ delayed surgery	Number of complaints principally about this, especially during Quarter 1.	Details of trend highlighted in the Patient Relations reports to the Chief Executive's Advisory Group and the relevant Divisional Clinical Quality Groups. Separate report for particular specialties sent to relevant senior divisional staff for review and action.	• Action plan developed and is being monitored by the Operational Delivery Group which is chaired by the Executive Chief Operating Officer. • Improve the current escalation process to ensure where possible that all relevant patients are rescheduled within 48 hours of their procedure being cancelled and that the date of the rescheduled procedure is within 28 days.
Communication by medical staff with patients and their families	Level of complaints and PALS concerns	Details of trend and specific cases highlighted as part of reports provided to relevant senior Trust groups	• Issue reviewed in detail at the Trust's multi-disciplinary Communication Skills Group, where the Trust's approach to supporting staff around communication is reviewed and developed. • The Group has a management representative from Medical Education and a Consultant representative. • Case studies from complaints have been discussed in detail at this group. • One of the complaints was also discussed at an Executive Care Omissions Root Cause Analysis (RCA) meeting, where issues are critically reviewed by Board members and relevant senior staff. This case was also taken to the Patient Safety Group for review and presented to a meeting of Geriatricians. • A set of standards for communication between specialties by medical staff is being developed by one of the senior clinicians involved in the above case.
Issues around discharge	Level of complaints and PALS concerns	Details of trend highlighted in the Patient Relations reports to the Chief Executive's Advisory Group and the relevant Divisional Clinical Quality Groups.	• Discharge Steering Group meets monthly. • Use of Discharge Lounge being audited and reviewed. • 'Transfer of care referral' launched June 2015 for complex discharges. • Criteria led discharge being rolled out across all divisions. • 3pm 'board round' being trialled in Division C, with a multi-disciplinary presence to promote progress towards discharge. • 50% of discharge medication is now provided via the Outpatient Pharmacy (45 minutes turnaround).

* 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).

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 division's senior management team with details of every complaint for their division with actions attached, highlighting any 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 divisional Clinical Quality Group meetings. 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 Chair, 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. Significant complaints, especially those involving medical staff and cases upheld by the Parliamentary and Health Service Ombudsman are reviewed at the Trust's multi-disciplinary Patient Safety Group. A complaints actions learning sheet has recently been developed which will be produced quarterly to share actions from individual complaints across the Trust.

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 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.

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

PHSO Involvement	2013/14	2014/15	2015/16
Cases referred to PHSO by complainant for investigation	16	23	28
Cases which then required no further investigation	3	2	0
Cases which were then referred back to the Trust for further local resolution	1	1	0
Cases which were not upheld following review by the PHSO	2	5	6
Cases which were partially upheld following review by the PHSO	3	9	11
Cases which were fully upheld following review by the PHSO	0	0	2

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.

Thirteen cases were upheld or partially upheld by the Ombudsman in 2015/16, an increase on the nine 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 the Ombudsman found that the clinical team had not given the family a realistic picture of their relative's condition. Consequently, an apology letter was provided to the complainant as requested, informing them that the case had been reviewed at the Trust's Communication Skills Group and Patient Safety Group to ensure learning was shared.

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 team 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.

UHB consistently receives considerably more compliments than it does complaints. The Trust also recorded slightly more compliments in 2015/16 than in 2014/15. The Patient Experience team provide support and guidance to divisional staff around the collation and recording of compliments received directly to wards and departments.

Compliment subcategories	2013/14	2014/15	2015/16
Nursing care	424	242	579
Friendliness of staff	191	142	84
Treatment received	1,202	1,743	1,290
Medical care	79	56	83
Other	9	17	24
Efficiency of service	187	104	268
Information provided	27	12	15
Facilities	12	12	6
Total	**2,131**	**2,328**	**2,349**

Month received	Compliment
April 2015	Incredibly professional, caring and compassionate staff. Thank you.
May 2015	Thank you all so much for all your help, you all give so much and the care I received on this and other occasions has been exceptional.
July 2015	I have to let you know that the care I received as a patient on that day was outstanding.
July 2015	Excellent experience, I was put at ease and everything explained, all very caring.
Sept 2015	All marvellous, the service is second to none and everywhere is pristine clean
November 2015	I have had extraordinary care… all staff have listened and made sure we understood what is happening… staff clearly love their work and care deeply about their patients.
November 2015	We wish to express our sincere thanks for the way we have both been treated for our respective illnesses. Professionalism of all staff has been outstanding… thanks to consultants and staff for their exemplary care.
November 2015	Attention and care I received from all personnel at QEHB has been beyond reproach. Thanks to consultants, surgeons, physiotherapists and support staff…It would be impossible to find any negative comment about my hospital experience.
December 2015	Your staff were very competent but more than that they showed great humanity and compassion… I greatly appreciate the care your staff took of me.
February 2016	I do hope my sincere thanks can be passed on to all staff to say "You make a difference!" Your care and compassion make a huge difference when families are faced with scary times.
March 2016	You are all amazing. This hospital, in my experience, is the very pinnacle of patient care and efficiency. In tough times you continue to impress me on every visit.
March 2016	I wish to express my thanks and appreciation to all the staff. I have absolute admiration for the skills and dedication along with the friendly reassurance of all the staff encountered during my stay.

Feedback received through NHS Choices and Patient Opinion websites

The Trust has a system in place to 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, negative comments tend to be reflective of feedback received via more direct methods for example concerns raised via PALS, complaints or locally received verbal feedback.

Initiatives to be implemented in 2016/17

- Continued review and updating of the patient experience dashboard and reporting processes.
- Implement the use of patient stories as a feedback and training mechanism.
- Review of how patient experience data is monitored and used to drive improvements.
- Using a more focused project-based approach to tackle challenging aspects of the patient experience.
- Finalisation of the plans to implement an internal buggy system.
- Scope the potential implementation of therapeutic visits from trained and approved volunteers with pets.
- Increase number of guest beds to allow carers to stay overnight.
- Pilot a new ward booklet to give patients and visitors improved information.
- Additional wheelchairs for patient use.
- Implement updated survey system on bedside TVs to include free text comments.
- Review of complaints process to streamline and improve response time.
- Refresh the Friends and Family Test in outpatients to increase response rate.
- Implement new Learning from Complaints report to share learning Trust-wide.

Priority 3

Timely and complete observations including pain assessment

Background

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

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

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

In addition, the Trust is monitoring the timeliness of analgesia (pain relief medication) following a high pain score. Until December 2015, the pain scale used at UHB went from 0 (no pain) to 3 (severe pain at rest). Whenever a patient scores 3, they should be given analgesia within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work.

The new pain scale was introduced in December 2015 which runs from 0 to 10, instead of 0 to 3. A score of 7 or more is now classed as a high pain score.

Performance

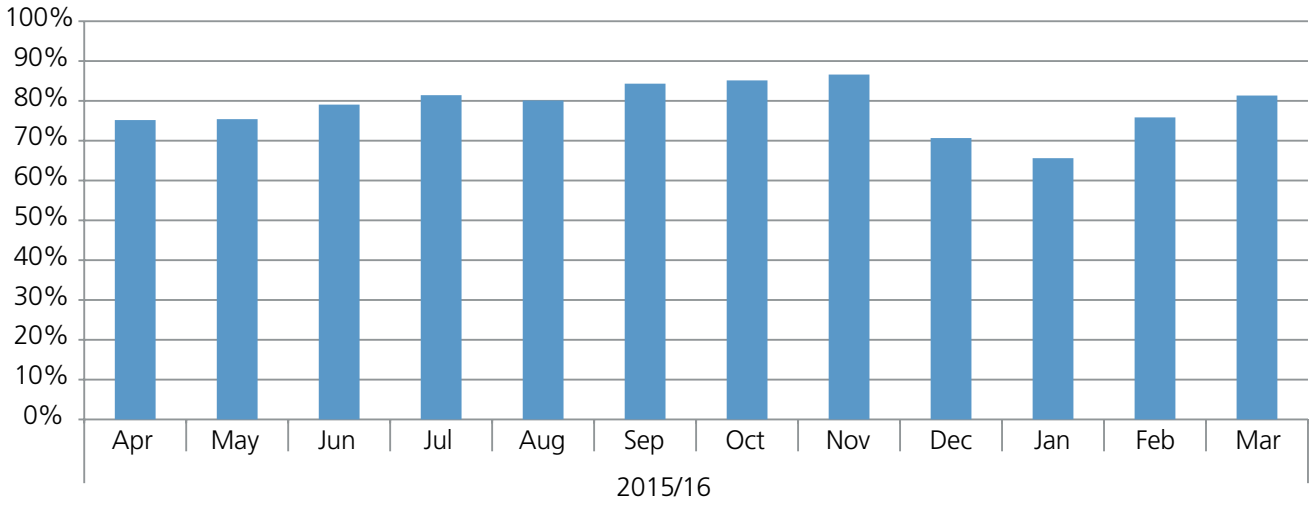
These were new indicators so challenging and ambitious improvement targets were set for the Trust to achieve by the end of 2015/16.

After the 2015/16 Quality Report, the methodology for the second indicator was reviewed in advance of the pain scale change. Baseline 2014/15 performance was higher than previously reported and the target was reviewed accordingly – the target was re-set to achieve 80% by the end of Quarter 4. This was signed off by the Executive Chief Nurse in January 2016.

Performance by month is displayed in the graphs and table below.

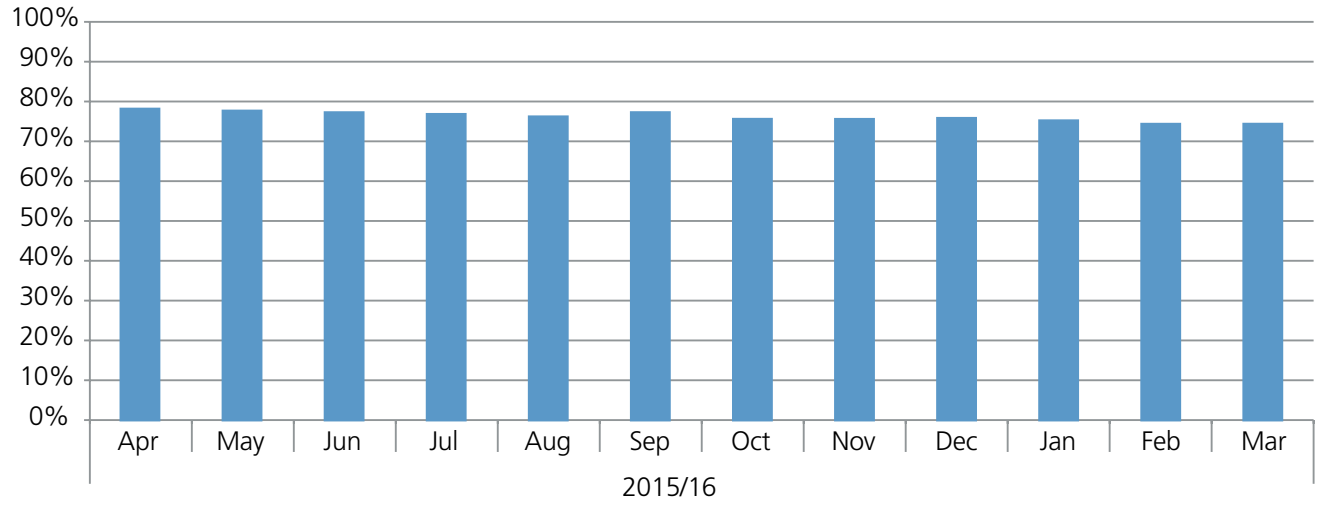
		2014/15	2015/16					
			Target	Q1	Q2	Q3	Q4	Year
1	Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward	71%	**85%**	75%	81%	81%	74%	**79%**
2	Analgesia administered within 30 minutes of a high pain score	64%	**80%**	78%	77%	76%	75%	**76%**

Indicator 1: Complete Observations and Pain Assessment within 6 hours



Performance increased until the new 0–10 pain scale was introduced in December 2015. Performance then started to increase again and reached 81% in March 2016.

Indicator 2: Timely Administration of Analgesia



Performance for this indicator remained stable throughout the year as the Trust focused on implementing the new pain scale and ensuring pain assessments are routinely carried out.

Initiatives implemented in 2015/16

- The pain assessment scale was changed to a 0-10 scale from the 0-3 scale to allow for more detailed assessment of patients' pain.
- A change was made to the electronic observation chart within the PICS to allow staff to more accurately record the reasons for incomplete observations. This allows 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.
- The Clinical Dashboard was reviewed and improved so that ward staff can see which of the six observations or pain assessment were missed and when, plus how their ward compares to Trust-wide performance.
- Staff can now see detailed data around timely analgesia including when the high pain score was recorded and when the analgesia doses were administered.

Changes to Improvement Priority for 2016/17

As the Trust was close to achieving the targets set for 2015/16, the Executive Medical Director and Executive Chief Nurse have chosen to increase the targets for 2016/17:

1. Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward: 90% by the end of the year.
2. Analgesia administered within 30 minutes of a high pain score: 85% by the end of the year.

Initiatives to be implemented in 2016/17

- To continue to pilot and implement the bespoke electronic observation chart for Critical Care within PICS.
- Wards performing below target for the two indicators will be reviewed at the Executive Care Omissions Root Cause Analysis (RCA) meetings to identify where improvements can be made. Observation and pain assessment 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

Reduce 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, or missed) to patients on the Prescribing Information and Communication System (PICS).

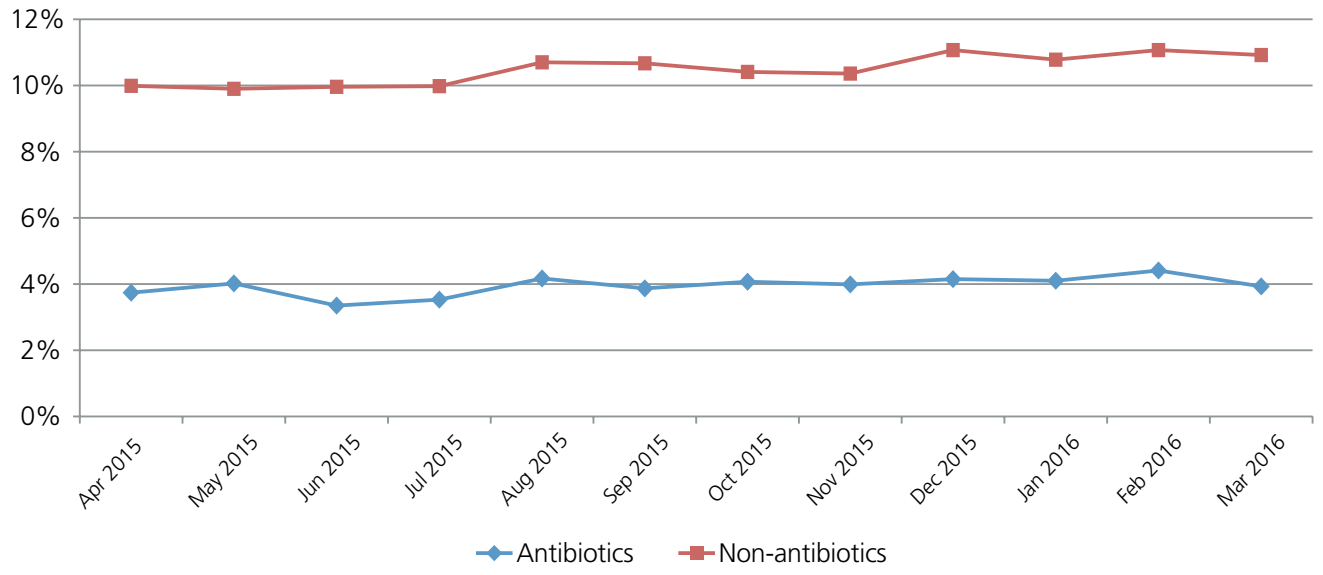
The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and when the Executive Care Omissions Root Cause Analysis (RCA) meetings started at the end of March 2010.

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.

It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time, and when a patient refuses a drug this is also recorded as a missed dose.

Performance

In the 2014/15 Quality Report, the Trust committed to maintaining performance for missed antibiotics at around 4.0% which has successfully been achieved with 2015/16 performance at 3.94%. The Trust was aiming to reduce the percentage of missed non-antibiotics by 10% in 2015/16, to 9.5%, however this has not been achieved. Performance was 10.5% for 2015/16 which is the same as 2014/15. It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time.



Initiatives implemented during 2015/16

- The updated Clinical Dashboard was rolled out which included updates to the missed doses indicators. Staff can easily see which drugs are being missed, the most common reasons for missed doses, when and by whom plus how their ward compares to Trust-wide performance.
- A new report has been developed to monitor missed doses due to medication being intermittently out of stock. Certain cases are reviewed by the Executive Care Omissions RCA meeting.
- Performance for missed doses by specialty continues to be published for patients and the public each month as part of the *mystay@QEHB* website.

Learning from missed doses

The Trust has identified key reasons for missed doses, this includes delays in converting prescriptions from regular doses (e.g. three times a day), to 'as required' (called PRN, *pro re nata*). This is often found in prescriptions for analgesia (painkillers) where the patient may refuse some or all of the doses if they do not need it. In these cases it can be preferable to use a PRN prescription, although this is a clinical decision and will depend on the patient's individual circumstances.

Review of missed doses for the Executive Care Omissions RCA group has led to certain drugs, e.g. ones used to manage Parkinson's Disease, being stocked in the emergency drug cupboards which ward staff can access when the medication is not available on their ward.

Following one Executive Care Omissions RCA case, the ward updated their nursing shift handover process to include a review of patients' missed doses, meaning actions can be taken sooner such as asking the doctors to review a prescription or contacting Pharmacy to request a re-stock.

Changes to Improvement Priority for 2016/17

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

The Trust is aiming to maintain missed doses of antibiotics at 4% or less, and to reduce missed doses of non-antibiotic to 10% or less by the end of 2016/17 as this was not achieved in 2015/16.

Initiatives to be implemented in 2016/17

- New reports will be developed to identify types and patterns of missed doses across the Trust.
- Individual cases will continue to be selected for further review at the Executive Care Omissions RCA meetings.
- The Corporate Nursing team and Pharmacy will work together to identify where improvement actions should be directed to try to reduce missed non-antibiotics.

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 2015/16 was to have zero avoidable MRSA bacteraemia. During the financial year 2015/16, there were eight MRSA bacteraemias apportioned to UHB.

All MRSA bacteraemias are subject to a post infection review (PIR) 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 three financial years:

Time Period	2013/14	2014/15	2015/16
Number of cases	5	6	8
Agreed trajectory	0	0	0

Clostridium difficile Infection (CDI)

The Trust's annual agreed trajectory was a total of 63 cases involving lapses of care during 2015/16. A lapse in care means that correct processes were not fully adhered therefore the Trust did not do everything it could to try to prevent a *C. difficile* infection. UHB reported 66 cases in total, of which 24 had lapses in care. The Trust uses a post infection review tool with the local Clinical Commissioning Group to identify whether there were any lapses in care which the Trust can learn from.

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

Time Period	2013/14	2014/15	2015/16
Lapses in care	16	17	24
Total number of Trust-apportioned cases	80	66	66
Agreed trajectory	56	67	63

Initiatives implemented in 2015/16

- Reintroduced routine screening for MRSA, and decolonisation where required, of all patients who go to Critical Care. The Trust has not had any further MRSA bacteraemias involving patients who have been to Critical Care since this change was implemented from December 2015.
- The consistency of MRSA screening has been improved; swabs are taken by nursing staff to ensure that they have been properly taken from the nostrils, groin and back of the throat plus any additional sites as required.
- Focused on raising the awareness of proper hand hygiene with staff, patients and visitors via articles in news@QEHB.

Changes to Improvement Priority for 2016/17

For 2015/16, the zero tolerance approach to avoidable MRSA bloodstream infections with timely post infection reviews will continue as previously. For 2015/16, the UHB trajectory for CDI cases deemed to have lapses in care will remain at 63.

Initiatives to be implemented in 2016/17

A robust action plan has been developed to tackle Trust-apportioned MRSA bacteraemias and *Clostridium difficile* infections:

- Strict attention to hand hygiene and the use of PPE (Personal Protective Equipment). Ensure all staff are compliant in performing hand hygiene and adhere to PPE policy.
- Ensuring all relevant staff understand the correct procedure for screening patients for MRSA before admission, on admission and the screening of long stay patients.
- Ensuring prompt identification of people who have or are at risk of developing infection so they receive timely, appropriate treatment and management to reduce risk of transmission to other people.
- Ensuring the optimal management of all patients with MRSA colonisation and infection, including decolonisation treatment, prophylaxis during procedures, and treatment of established infections.
- Ensure appropriate antimicrobial use, to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance through prudent antimicrobial prescribing and stewardship.

- Careful attention to the care and documentation of any devices, ensuring all procedures are being followed as per Trust policy.
- Ensure all relevant staff are performing Saving Lives (infection prevention and control) audits and acting on the results.
- Providing and maintaining a clean environment throughout the Trust. Ensure cleaning standards are reviewed and implemented.
- Ensure all staff are aware of their responsibility for preventing and controlling infection through mandatory training attendance.
- Ensure post infection review investigations are completed and lessons learnt are fed back throughout the Trust.
- Continuation of the rapid reviews by the Infection Prevention & Control team of any area reporting two or more cases of CDI.

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 2016/17 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 (SIs) to Birmingham CrossCity 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 2015/16 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 2015/16 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2015/16.

* 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 2015/16 32 national clinical audits and 4 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 94% (30 of 32) 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 2015/16 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in during 2015/16 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 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2015/16	Percentage of required number of cases submitted
National Vascular Registry (NVR)	Yes	>100%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Oesophago-Gastric Cancer Audit (NAOGC)	Yes	61–70%
Bowel Cancer (NBOCAP)	Yes	75%
NHS Blood And Transplant Audit Programme	Yes	N/A
Procedural sedation	Yes	100%
VTE Risk in Lower Limb Immobilisation	Yes	100%
Rheumatoid & Early Inflammatory Arthritis (EIA)	Yes	100%
Parkinson's Audit	Yes	100%
Emergency Oxygen Audit	Yes	100%
Cardiac Rhythm management	Yes	100%
Critical Care Case Mix Programme (ICNARC)	Yes	100%
Congenital Heart Disease Audit	Yes	81.1%
Acute Coronary Syndrome / Myocardial Infarction (MINAP)	Yes	100%
End of Life Care / National Audit of Care of the Dying	Yes	100%
Percutaneous Coronary Intervention (PCI)	Yes	100%
National Diabetes Audit	No	To start next financial year
Falls and Fragility Fractures Audit Programme	Yes	100%
Inflammatory Bowel Disease Programme	Yes	100%
National Lung Cancer Audit	Yes	100%
Trauma Audit & Research Network (TARN)	Yes	100%
National Adult Cardiac Surgery Audit	Yes	100%
National Cardiac Arrest Audit	No	Decision to not participate made at Executive Director level
National Chronic Obstructive Pulmonary Disease Audit Programme	Yes	100%
National Prostate Cancer Audit	Yes	>100%
Renal Registry – Renal Replacement Therapy	Yes	100%
SSNAP	Yes	100%
National Joint Registry – NJR	Yes	100%
Complicated Diverticulitis Audit	Yes	100%
National Emergency Laparotomy Audit	Yes	100%
National Heart Failure Audit	Yes	100%
National Ophthalmology Audit	Yes	Data collection to commence in September 2016.

National Confidential Enquiries (NCEPOD)

National Confidential Enquiries (NCEPOD)	UHB participation 2015/16	Percentage of required number of cases submitted
Mental Health	Yes	100%
Acute Pancreatitis	Yes	100%
Sepsis	Yes	100%
Gastrointestinal Haemorrhage	Yes	100%

Percentages given are the latest available figures.

The reports of 11 national clinical audits were reviewed by the provider in 2015/16 and UHB intends to take the following actions to improve the quality of healthcare provided: (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

The reports of 91 local clinical audits were reviewed by the provider in 2015/16 and UHB intends to take the following actions to improve the quality of healthcare provided (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

At UHB a wide range of local clinical audits are undertaken. This includes Trust-wide audits and specialty-specific audits that reflect local interests and priorities. A total of 504 clinical audits were registered with UHB's clinical audit team during 2015/16. Examples of some of the types of recommendations from these audits can be found in the table below. Of these audits, 136 were completed during the financial year (see separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm.)

2.2.3 Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by UHB in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was:

NIHR portfolio studies	5,051
Non-NIHR portfolio studies	1,977
Total	**7,028**

The total figure is based on all research studies that were approved during 2015/16. (NIHR: National Institute for Health Research).

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	2013/14	2014/15	2015/16
Total number of projects registered with R&D	306	307	361
Out of the total number of projects registered, the number of studies which were abandoned	39	56	70
Trust total patient recruitment	**10,778**	**11,400**	**7,028**

The table below shows the number of projects registered in 2015/16, by specialty:

Speciality	Number of Projects Registered
Non-Specific	36
Accident & Emergency	2
Anaesthetics	4
Audiology	3
Burns & Plastics	3
Cardiac Medicine	1
Cardiac Surgery	5
Cardiology	17
Clinical Haematology	7
Clinical Immunology	1
Critical Care	7
Dermatology	4
Diabetes	5
Elderly Care	3
Endocrinology	19
ENT (Ear, Nose & Throat)	6
General Medicine	1
General Surgery	4
Genito-Urinary Medicine	6
GI Medicine	13
Haematology	26
Histopathology	1
HIV	1
Imaging	4
ITU	3
Liver Medicine	32
Lung Investigation Unit	2
Maxillofacial	2
Microbiology	4
Neurology	5
Neurosurgery	4
Oncology	63
Ophthalmology	5
Pain Services	1
Palliative Care	1
Pharmacology	1
Radiotherapy	1
Renal Medicine	21
Renal Services	2
Renal Surgery	3
Respiratory Medicine	10
Rheumatology	9
Stroke Services	4
Trauma	1
Urology	5
Vascular Surgery	3
Total	**361**

Examples of research at UHB having an impact on patient care

UHB is the Chief Investigator site for the national Lung Matrix Trial. By creating a collaborative network to screen patients across the West Midlands, this trial has the potential to identify large numbers of patients with gene mutations that can be targeted by the trial's drugs and will change patient care by personalising medicine and finding the best treatment "fit" for a patient, based on the tumour's genetics. The design of the trial allows for the addition of trial "arms" as and when drug and mutation combinations have been identified with pharmaceutical companies, thus eliminating the need to start a trial set up from scratch and speeding up the timelines for patient access to trial drugs. This trial is also advancing the testing procedures undertaken for patients with lung cancer and has the potential to drive the integration of genomic medicine into standard patient care. Since the trial opened in April 2015, UHB has been the highest recruiter in the UK to date.

A key objective of the NIHR Surgical Reconstruction and Microbiology Research Centre was to transfer lessons learned from the military setting into civilian care for Trauma patients. The Major Trauma Centre at UHB had the highest rate of unexpected survivors in England in 2015/16. The 24/7 Trauma research team have extended their reach to recruit patients to clinical trials at point of presentation in the Emergency Department and the Intensive Care Unit. This team now recruited approximately 500 patients per year who present acutely with traumatic injury. The team have visited other NHS trusts and worked with NIHR Clinical Research Networks to share best practice and support adoption of a similar service in other hospitals.

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

UHB income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the

Commissioning for Quality and Innovation payment framework because the Trust was paid by commissioners based on the Default Rollover Tariff in 2015/16 and therefore was not eligible for CQUIN funding. The Trust received £10.9m in payment in 2014/15.

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 taken enforcement action against UHB during 2015/16 as a result of a focused inspection to Cardiac Surgery. Prior to the CQC inspection the Trust had established a Cardiac Surgery Quality Improvement Programme (CSQIP) to improve the service.

The CQC placed two conditions on the Trust registration following a focused inspection to Cardiac Surgery. The conditions require the Trust to submit weekly outcome data to the CQC and commission an external review. The external review was completed in March 2016 and actions to address the recommendations have been identified. Whilst the majority of the actions in response to the recommendations were already being progressed through the CSQIP, the additional actions identified have been added to the CSQIP and will be monitored on a weekly basis by the project group. Reports on progress against the project plan will continue to be provided to the Cardiac Surgery Steering Group and the Cardiac Surgery Oversight Group. In May 2016, the CQC removed the conditions on UHB's registration. Data will be submitted on a quarterly basis.

UHB has participated in special reviews or investigations by the Care Quality Commission and the Birmingham CrossCity Clinical Commissioning Group relating to the following areas during 2015/16 (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 31st March 2016 in taking such action (see table below).

Responding to Key National Recommendations

In September 2015 NHS England published the National Safety Standards for Invasive Procedures (NatSSIPs) to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. The NatSSIPs cover all invasive procedures including those performed outside of the operating department. In addition a 'Stage 2 – Resource' Patient Safety Alert was issued, The Alert requires each relevant organisation to take local action to put the standards in place, LocSSIPs (Local Safety Standards for Invasive Procedures). The requirements to ensure compliance were discussed at the Clinical Quality Monitoring Group, a gap analysis has been undertaken to identify the appropriate procedures and the Trust is developing a Human Factors Faculty that will support some aspects of the NatSSIPs work programme.

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.

Inspections/visits undertaken by the Care Quality Commission and Birmingham CrossCity Clinical Commissioning Group

Date	Type of inspection	Outcome	Actions taken
Birmingham CrossCity – Clinical Commissioning Group (CCG)			
21 January 2016	As per the contractual requirement, the CCG undertook a bi annual assurance review of the trust's systems and processes in place for managing the application of the Duty of Candour	The trust has a robust system in place for managing this process. During discussion with the Risk and Compliance team the CCG were made aware that further enhancements to the system will be undertaken in the near future. Clearly an effective training programme had been implemented across the trust with evidence of commitment across all disciplines of staff.	N/A
14 August 2015	An unannounced visit was conducted to look at patient experience. The review included wards 514, 411 and West 2	We spoke to several patients and overall the comments received were very positive. We gave feedback to the Deputy Chief Nurse who was aware of the concern relating to incident reporting on Ward W2 and is addressing this.	Incident was reviewed and actions implemented.
9 November 2015	Unannounced visit of the Emergency Department looking at patient experience and in particular vulnerable patients	Overall the CCG was satisfied and did not identify any improvement actions for UHB.	N/A
12 November 2015	This was an unannounced visit to wards 407, 409, 621 and 622 carried out with Birmingham South Central CCG.	Overall the visit was positive with some minor suggestions for improvement.	Feedback was shared with the wards involved and improvements are being monitored by the Corporate Nursing team.
Care Quality Commission (CQC)			
21–23 December 2016	Focused Inspection of Fundamental Standards relating to Cardiac Surgery	The CQC placed two conditions on the Trust registration. The conditions require the Trust to submit weekly outcome data to the CQC and commission an external review. The external review was completed in March 2016 and actions to address the recommendations have been identified. In May 2016, the CQC removed the conditions on UHB's registration. Data will be submitted on a quarterly basis.	Whilst the majority of the actions in response to the recommendations were already being progressed through the CSQIP, the additional actions identified have been added to the CSQIP and will be monitored on a weekly basis by the project group. Reports on progress against the project plan will continue to be provided to the Cardiac Surgery Steering Group and the Cardiac Surgery Oversight Group.

Care Quality Commission: Inspection Ratings Grid

The CQC carried out a focused inspection of the Trust in January 2015. As a result of the inspection the Trust was overall rated as 'good' and full details of the Trusts ratings are below.

Domain	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Requires Improvement	Good	Outstanding	Good	Good
Medical Care	Good	Good	Good	Good	Good	Good
Surgery	Good	Outstanding	Good	Requires Improvement	Good	Good
Critical Care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
End of Life Care	Good	Good	Good	Outstanding	Good	Good
Outpatient and diagnostic imaging	Good	N/A	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall Trust	Good	Good	Good	Good	Outstanding	Good

For the areas which were rated as 'requires improvement' the CQC provided recommendations the Trust must take to improve. An action plan was developed as a result of and is monitored by the Board of Directors on a quarterly basis.

2.2.6 Information on the quality of data

UHB submitted records during 2015/16 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:
  - 96.30% for admitted patient care;
  - 97.42% for out patient care; and
  - 97.30% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
  - 99.98% for admitted patient care;
  - 99.74% for out patient care; and
  - 99.99% for accident and emergency care.

UHB Information Governance Assessment Report overall score for 2015/16 was 72% and was graded green (satisfactory).

UHB was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

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.
- Implementation of a new integrated Trust-wide patient administration system which will simplify data entry, increase validation and reduce duplication of data entry.
- Ensure 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. The data quality policy for the Trust is under review with workstreams identified to enhance data quality compliance.
- 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. An 18 week RTT audit is scheduled to occur in 2016/17.

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

Quality Account 2015/2016

Part 3: Other information

3.1 Overview of quality of care provided during 2015/16

The tables below show the Trust's latest performance for 2015/16 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 2014/15 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 2015/16 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	2013/14	2014/15	2015/16	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*	**1.04**	**1.52**	**2.43**	**0.83**
Time period	2013/14	2014/15	April 2015 – January 2016	April 2015 – January 2016
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*	**1.04**	**1.52**	**2.44**	**0.98**
Time period	2013/14	2014/15	April 2015 – January 2016	April 2015 – January 2016
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
2(a). Patients with C. difficile infection/100,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**20.76**	**16.73**	**16.45**	**14.14**
Time period	2013/14	2014/15	April 2015 – January 2016	April 2015 – January 2016
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

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
2(b). Patients with C. difficile infection/100,000 bed days (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**20.89**	**16.82**	**16.53**	**17.27**
Time period	2013/14	2014/15	April 2015 – January 2016	April 2015 – January 2016
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
3(a) Patient safety incidents (reporting rate per 1000 bed days) *Lower rate indicates better performance*	**Not available (new measure)**	**47.2**	**63.3**	**37.2**
Time period		2014/15	2015/16	October 2014 – March 2015
Data source(s)		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 (non specialist) hospitals
3(b) Never Events *Lower rate indicates better performance*	**2**	**3**	**5**	**Not available**
Time period		2014/15	April 2015 – January 2016	April 2015 – January 2016
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)
Peer group				Acute trusts in West Midlands

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
4(a) Percentage of patient safety incidents which are no harm incidents *Lower rate indicates better performance*	**71.1%**	**81.0%**	**82.0%**	**74.3%**
Time period	2013/14	2014/15	2015/16	October 2014 – March 2015
Data source(s)	Datix (incident data)	Datix (incident data)	Datix (incident data)	NRLS website (Organisational Patient Safety Incidents Workbook)
Peer group				Acute (non specialist) hospitals
4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death *Lower rate indicates better performance*	**0.24%**	**0.12%**	**0.14%**	**0.50%**
Time period	2013/14	2014/15	2015/16	October 2014 – March 2015
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 (non specialist) hospitals
4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	**9,828**	**16,222**	**20,516**	**9.566 (6 months)**
Time period	2013/14	2014/15	2015/16	October 2014 – March 2015
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 (non specialist) hospitals

Notes on patient safety indicators

3(a): 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 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. The plan is to include other automated incidents such as 'complete set of observations plus pain assessment within 6 hours of admission to a ward' during 2016/17.

3(b): UHB had five Never Events in 2015/16:

- A guide wire was left in situ following insertion of a central venous catheter (CVC). A scan the next day found the guide wire and it was removed. No harm was caused to the patient as a result of this incident, a full investigation has been carried out and actions are being implemented including update of the relevant guidelines and documentation and education around CVC insertion.
- Laser Pan-Retinal Photocoagulation (PRP) treatment (an ophthalmology procedure) was carried out on an incorrect patient. After the procedure had commenced the staff realised and the procedure was stopped immediately. The patient was informed of what happened at the time of the incident and an apology was made. The patient has also since been contacted and informed that an investigation is taking place. There was no immediate harm to the patient, who will be closely monitored in clinic. Immediate precautionary measures have been put in place and the pre-operative checklist is to be adapted.
- Staff failed to check the position of a nasogastric (NG) tube after insertion by testing the pH and the tube was later found to be in the patient's lung instead of their stomach. A nursing alert has been sent out across the Trust reinforcing the Trust standards for management of NG feeding tubes.
- An anaesthetist gave a block on the wrong side for shoulder surgery. Checks prior to administration of the block were incomplete. This incident is subject to an ongoing investigation.
- A patient received four units of incorrect blood type due to an error in labelling. This Never Event occurred in March 2016 but was reported to Birmingham Cross-City Clinical Commissioning Group in early April 2016 once it had been confirmed as a Never Event. This incident is subject to an ongoing investigation.

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	2013/14	2014/15	2015/16	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*	**12.86%** **England: 13.51%**	**13.51%** **England: 13.88%**	**13.33%**	**13.82%** **England: 13.37%**
Time period	2013/14	2014/15	April – December 2015	April – December 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*	**12.80%** **England: 12.90%**	**13.48%** **England: 13.25%**	**13.30%**	**13.32%** **England: 13.37%**
Time period	2013/14	2014/15	April – December 2015	April – December 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 (%) (includes all bed days from all specialties) *Lower rate indicates better performance*	**10.25%**	**10.75%**	**10.64%**	**Not available**
Time period	2013/14	2014/15	April 2015 - February 2016	
Data source(s)	Lorenzo	Lorenzo	Lorenzo	
Peer group				

Indicator	2013/14	2014/15	2015/16	Peer Group Average (where available)
6. Falls (incidents reported as % of patient episodes) *Lower % indicates better performance*	**2.1%**	**2.2%**	**2.1%**	**Not available**
Time period	2013/14	2014/15	2015/16	
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*	Not Available	9.5%	5.0%	**Not available**
Time period		2014/15	2015/16	
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) *Lower % indicates better performance*	**89.0%**	**94.7%**	**97.5%**	**Not available**
Time period	2013/14	2014/15	2015/16	
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. Any changes in data since the previous Quality Report and due to updates made to the national HES data.

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. Any changes in previously reported data are due to long-stay patients being discharged after the previous years' data was analysed.

7: The data source for this indicator was changed in 2014; this means 2013/14 data has not been included as it is not directly comparable to subsequent years.

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 for this year.

Patient experience indicators

The results of the 2015 National Inpatient Survey reported that the Trust was 'better' than other Trusts in six questions (four in 2014): getting enough help from staff to eat meals, being given written or printed information about what to do/not do after leaving hospital, giving family/someone close all the information needed to care for the patient, telling patients who to contact if they are worried after leaving hospital, discussing with patient whether any further health or social care services were needed after leaving hospital, and asking patients during their stay about the quality of care they were receiving. All other questions scored 'about the same' as other trusts. This shows a continuous improvement from 2013 when the Trust was 'about the same' as other trusts in all questions.

	2013/14		2014/15		2015/16	
Patient survey question	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England
9. Overall were you treated with respect and dignity	9.1	About the same	9.2	About the same	9.2	**About the same**
10. Involvement in decisions about care and treatment	7.5	About the same	7.7	About the same	7.5	**About the same**
11. Did staff do all they could to control pain	7.9	About the same	8.1	About the same	8.2	**About the same**
12. Cleanliness of room or ward	9.3	About the same	9.2	About the same	9.2	**About the same**
13. Overall rating of care	8.3	About the same	8.3	About the same	8.4	**About the same**
Time period & data source	2013, Trust's Survey of Adult Inpatients 2013 Report, Care Quality Commission		2014, Trust's Survey of Adult Inpatients 2014 Report, Care Quality Commission		2015, Trust's Survey of Adult Inpatients 2015 Report, Care Quality Commission	

Notes on patient experience measures

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	
		2014/15	2015/16
C. difficile infection (post-48 hour cases) (Number of judged lapses in care)	2014/15: ≤ 67 2015/16: ≤ 63	17 judged lapses in care (66 total)	24 cases judged lapses in care (66 total)
62-day wait for first treatment from urgent GP referral: all cancers	85%	73.8%	72.2%
62-day wait for first treatment from consultant screening service referral: all cancers	90%	89.3%	92.8%
31-day wait from diagnosis to first treatment: all cancers	96%	91.9%	95.5%
31-day wait for second or subsequent treatment: surgery	94%	82.9%	93.2%
31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	98.5%	99.4%
31-day wait for second or subsequent treatment: radiotherapy	94%	98.0%	97.4%
Two week wait from referral to date first seen: all cancers	93%	95.1%	97.2%
Two week wait from referral to date first seen: breast symptoms	93%	99.9%	98.5%
18-week maximum wait from point of referral to treatment (incomplete pathways)[1,2,3]	92%	93.6%	95.0%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge [2]	95%	94.8%	91.9%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Certification made	**Certification made**

Notes

1: During the year the targets for an 18-week maximum wait from point of referral to treatment for admitted and non-admitted patients were removed from Monitor's Risk Assessment Framework. The target for an 18-week maximum wait from point of referral to treatment for incomplete pathways remains.

2: Indicators audited by the Trust's external auditor Deloitte as part of the external assurance arrangements for the 2015/16 Quality Report. Please see detailed notes below relating to the 18-week maximum wait from point of referral to treatment (incomplete pathways) indicator.

3: Information relating to the *18-week maximum wait from point of referral to treatment (incomplete pathways)* indicator:

Performance validation

In line with practices across many NHS Trusts and Foundation Trusts, the Trust has a month end validation process in place prior to the submission of Referral-to-Treatment (RTT) performance data. The Trust undertakes a range of validation primarily because of the volume of patients recorded as being on a RTT pathway, the volume of referrals accepted from other organisations and also because of the complexity of the patient pathways as a specialist tertiary centre.

The Trust concentrates its month end reporting validation on the incomplete pathways with a waiting time in excess of 18 weeks. Previously validation only focused on the less well-performing specialties and ceased once overall performance reached between 92%-95%. As a result of this validation process, there is a possibility we may have overstated the number of breaches. In such instances, our performance against the 92% target could have been greater than the levels identified in the table above. From March 2016, all incomplete pathways with a waiting time of 18 weeks or more are being validated, regardless of specialty or the level of performance reached.

A pathway compliance monitoring tool is in development and will be deployed from June 2016. This tool looks for common RTT pathway errors on a weekly basis, identifying individual users who make the most errors so that they can be targeted for training and support. The tool will allow pathway errors to be corrected as they are identified, rather than waiting until the pathway has exceeded 18 weeks and relying on the error being picked up during month end validation. Over time it is anticipated the number of pathways requiring month end validation will reduce, allowing the Trust to validate to 16 weeks and even earlier, as resources allow. This is a key shift from "back-stop" validation to prevention of errors at source or early detection and correction of errors before a breach arises.

A weekly RTT Assurance meeting is chaired by the Head of Service Improvement and is attended by operational managers representing all specialties. Key themes that emerge from the month end validation process are discussed at the meeting, for example the validation process may have identified an increase in the number of missed clock stops for first treatment in outpatients. This discussion and subsequent rectification action planning ensures that key messages are disseminated and learning from validation is shared within the organisation. Output from the pathway compliance monitoring tool will also be reviewed at the weekly RTT Assurance meeting from June 2016.

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; and
- "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 the 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 began 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 standard 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.

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.

3.3 Mortality

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

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

Summary Hospital-level Mortality Indicator (SHMI)

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.[1] An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model but may still be within the control limits. A SHMI above the control limits should be used as a trigger for further investigation.

The Trust's latest SHMI is 99.55 for the period April – December 2015 which is within tolerance. The latest SHMI value for the Trust, which is available on the HSCIC website, is 95.51 for the period April – September 2015. 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 105.31 for the period April 2015 – January 2016 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

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

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

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

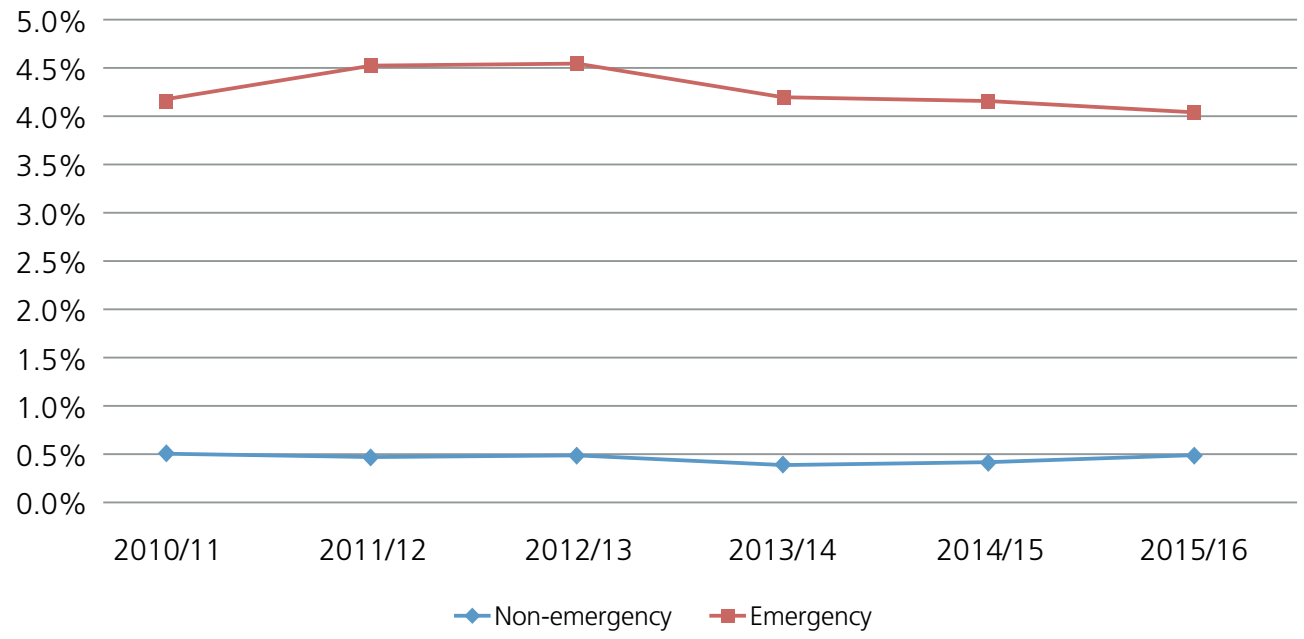
national debate and is largely discredited.[2,3] The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

Crude Mortality

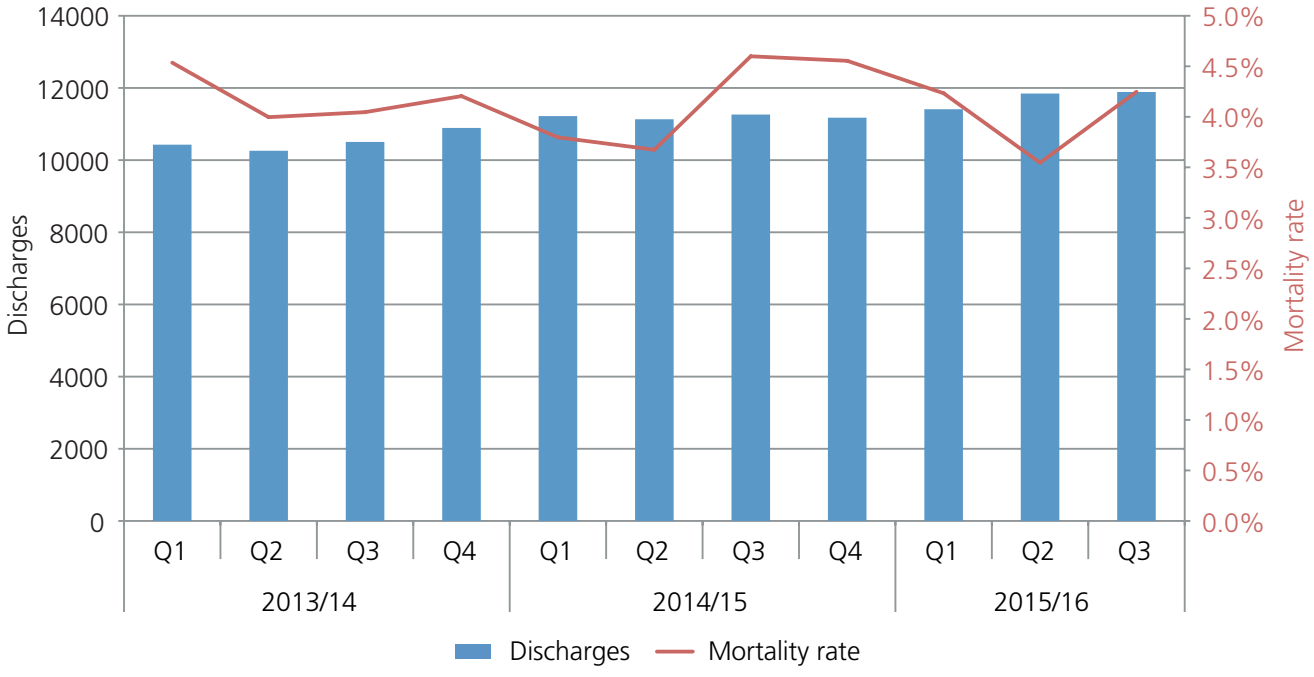
The first graph shows the Trust's crude mortality rates for emergency and non-emergency (planned) patients. The second graph below shows the Trust's overall crude mortality rate against activity (patient discharges) by quarter for the past two calendar years. The crude mortality rate is calculated by 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 2015/16 (3.04%) is very similar to 2014/15 (3.05%).

Emergency and Non-emergency Mortality Graph



Overall Crude Mortality Graph



3.4 Safeguarding

The Trust underwent a Care Quality Commission (CQC) inspection in January 2015 which included safeguarding practice. The report, which was published in May 2015, was very positive in relation to safeguarding practice, training and leadership.

In October 2015, the Birmingham Safeguarding Children Board chair visited the Trust to carry out a review of safeguarding processes and procedures. A child's pathway was followed to ensure the appropriate response and documentation was in evidence and recorded. Verbal feedback from the review was very positive which also noted innovative ideas being adopted in the Trust.

The Lead Nurse for Safeguarding receives details of relevant incidents on a daily basis and initiates follow up actions where necessary. The Lead Nurse for Safeguarding also receives any complaints or concerns raised via the Patient Advice and Liaison Service (PALS) relating to safeguarding which are also followed up.

The Trust's framework for safeguarding adults and children is based on national guidance arising from the Care Act 2014 and the Working Together to Safeguard Children 2015 guide, which promotes development of inter-agency working to safeguard vulnerable adults and children.

UHB has continued to ensure that safeguarding of adults and children remains a high priority. The aim of safeguarding is to ensure that there are robust policies with supporting procedural documents which allows a consistent approach to the delivery of safeguarding principles across the Trust. Level 2 Adult and Children Safeguarding training is a combined session and has been mandatory for all patient-facing staff in 2015/16. Further factsheets on types of abuse are now available to support staff and a patient information leaflet for children 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. The domestic abuse information page which is available on the intranet for all staff has been developed along with a page containing information on Female Genital Mutilation to enhance staff members' awareness, knowledge and skills.

The Safeguarding Team have developed a questionnaire for adult patients who pass through the safeguarding process to obtain their views on the process.

The policy provides a framework that can be consistently followed, reinforced by training and support, to enable all clinical staff to recognise and report adults and children 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 2015/16: http://www.uhb.nhs.uk/reports.htm.

3.5 Staff Survey

The Trust's Staff Survey results for 2015 show that performance was average or better for 30 of the 32 key findings and below average for 2 key findings, when compared to other acute trusts.

The results are based on responses from 418 staff which represents a small decrease in response rate from 56% last year to 50% this year; however this response rate remains 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 satisfaction with the quality of work and patient care they are able to deliver (see Question 1 below).
- Percentage of staff agreeing their role makes a difference to patients (see Question 2 below).
- Staff recommending the Trust as a place to work or receive treatment (see Question 3 below).

In the previous report (2014), the Trust was 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 did 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 continued to encourage staff to report all incidents including minor incidents and near misses, and the results for 2015 have improved from 83% to 92%, putting UHB above average compared to other acute trusts.

Key Finding from Staff Survey	2013/14	2014/15	2015/16	Comparison with other acute NHS trusts 2015/16
1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (KF2)	**85%**	**82%**	**NA**	**NA**
1. Staff satisfaction with the quality of work and patient care they are able to deliver (KF2)	**NA**	**NA**	**4.16**	**Highest (best) 20%**
2. Percentage of staff agreeing their role makes a difference to patients (KF3)	**94%**	**90%**	**93%**	**Highest (best) 20%**
3. Staff recommendation of the trust as a place to work or receive treatment (KF1)	**4.04**	**3.96**	**4.02**	**Highest (best) 20%**
4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (KF29)	**86%**	**83%**	**92%**	**Above (better than) average**
5. Effective use of patient / service user feedback (KF32)	**NA**	**3.76**	**3.77**	**Highest (best) 20%**
6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26) (Lower score is better)	**23%**	**22%**	**27%**	**Average**
7. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion (KF21)	**92%**	**88%**	**88%**	**Above (better than) average**
Time period & data source	Trust's 2013 Staff Survey Report, NHS England	Trust's 2014 Staff Survey Report, NHS England	Trust's 2015 Staff Survey Report, NHS England	

Notes on staff survey
1: The scoring method changed in 2015/16 to a score (1–5) instead of a percentage – both have been displayed for completeness
1 & 3: Possible scores range from 1 to 5, with a higher score indicating better performance.
5: This was a new question for the 2014 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 2015/16 includes 69 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: http://www.uhb.nhs.uk/quality.htm

The Trust's clinical and management teams improved performance for 21% of the indicators during 2015/16 with support from the Quality and Informatics teams. Performance for 66% stayed about the same (including 7 indicators which were already scoring the maximum and continued to do so). Performance for 13% of the indicators deteriorated during 2015/16. The remaining 2 indicators do not yet have any data for 2015/16 so cannot be compared to 2014/15 performance. The majority of the 69 indicators have a goal; 63% of those with a goal met them in 2015/16, compared to 54% in 2014/15.

Table 1 shows performance for selected specialty quality indicators where the most notable improvements have been made during 2015/16. The Dermatology indicator has improved greatly since the 2014/15 report and is now performing well above the goal. 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 2015/16.

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

Table 1

Specialty	Indicator	Goal	Percentage Apr 13 – Mar 14	Percentage Apr 14 – Mar 15	Numerator Apr 15 – Mar 16	Denominator Apr 15 – Mar 16	Percentage Apr 15 – Mar 16	Data Sources
Stroke Medicine	In hospital mortality following stroke	< 20%	NA*	8.5%	27	535	5.0%	• SSNAP
Dermatology	Suspected cancer cases seen within 2 weeks by a Consultant	> 93%	97.9%	83.2%	2474	2501	98.9%	• Lorenzo • PICS
Imaging	Outpatients who have report turnaround time of less than or equal to 14 days for MRI	> 75%	NA*	79.0%	20749	24154	85.9%	• CRIS

Table 2

Specialty	Indicator	Goal	Percentage Apr 13 – Mar 14	Percentage Apr 14 – Mar 15	Numerator Apr 15 – Mar 16	Denominator Apr 15 – Mar 16	Percentage Apr 15 – Mar 16	Data Sources
Colorectal Surgery	Clexane medication after elective colorectal surgery (excluding day cases)	> 95%	89.2%	94.2%	203	225	90.2%	• Lorenzo • PICS
Heart Failure	Patients with a primary diagnosis of acute heart failure who had an echocardiogram (ECHO) within 3 months prior to discharge, or 1 month post discharge	100%	67.4%	67.4%	471	762	61.8%	• Lorenzo • PICS • PRISM
Surgery – Emergency	Perianal abscess operations should take place on the day of admission or the next day	> 90%	85.8%	94.4%	95	114	83.3%	• Lorenzo

* data not available for 2013/14 as methodology updated for 2014/15 onwards, so results not directly comparable

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. UHB joined the campaign in November 2014 and 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.

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.

UHB's Sign Up to Safety action plan can be found on the Trust intranet: http://www.uhb.nhs.uk/sign-up-to-safety.htm

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

3.8 Duty of Candour

When a patient has been affected by an incident, staff have a duty to inform the patient and/or their relatives or carers as appropriate, of what happened, to provide reasonable support and an apology when things go wrong. This is known as Duty of Candour and ensures trusts are open and transparent with patients, relatives and carers.

When these conversations take place at UHB, staff complete a form including the patient's details, where the incident occurred, what happened and details of the conversation. These forms are logged against the Trust-wide Duty of Candour tracker, which is monitored by the Clinical Risk & Compliance department, and also contains information on actions taken. If an incident has led to further investigation then details of the investigation will also be recorded.

The Duty of Candour process at UHB was audited by Birmingham CrossCity CCG in January 2016 and the process was deemed compliant and the tracker content was deemed to be of a high standard.

The Trust is planning to use the incident reporting system, Datix, to record Duty of Candour information against specific incidents in the future. Datix has been reviewed to ensure that it can record the information currently captured by the Duty of Candour forms. An education scheme is being planned to ensure all staff receive the appropriate training before this is launched. The Duty of Candour / Being Open Policy will be reviewed to reflect the new processes.

3.9 Glossary of Terms

Term	Definition
A&E	Accident & Emergency – also known as the Emergency Department
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
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
CABG	Coronary artery bypass graft procedure
CCG	Clinical Commissioning Group
CDI	*C. difficile* infection
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 assesses the quality of care, mainly nursing
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
Datix	Database used to record incident reporting data
Day case	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
Deloitte	UHB's external auditors
Division	Specialties at UHB are grouped into Divisions
Echo / echocardiogram	Ultrasound imaging of the heart
ED	Emergency Department (previously called Accident and Emergency Department)
Elective	A planned admission, usually for a procedure or drug treatment

Term	Definition
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.
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
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
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
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
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.

Term	Definition
Peri-operative	Period of time prior to, during, and immediately after surgery
PHE	Public Health England
PICS	Prescribing Information and Communication System
Plain imaging	X-ray
PRISM	Cardiology System which records information on ECGs and Echoes
PROMs	Patient Reported Outcome Measures
Prophylactic / prophylaxis	A treatment to prevent a given condition from occurring
QEHB	Queen Elizabeth Hospital Birmingham
QuORU	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
SEWS	Standardised Early Warning System
SHMI	Summary Hospital Mortality Indicator
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
Trajectory	In infection control, the maximum number of cases expected in a given time period
Trust apportioned	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

For indicator 3 below, the data available on the HSCIC website below has not been updated since the 2014/15 Quality Accounts, so the information presented is the same.

1 Mortality

	Previous Period (October 2013–September 2014)	Current period (October 2014–September 2015)				Comment
			National performance			
	UHB	UHB	Overall	Best	Worst	
(a) Summary Hospital-level Mortality Indicator (SHMI) value	1.01	**1.02**	—	0.65	1.17	The Trust considers that this data is as described for the following reasons as this is the latest available on the HSCIC website. The Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the technical approach UHB takes to improving quality detailed in this report. The Trust does not specifically try to reduce mortality as such but has robust processes in place, using more recent data, for monitoring mortality as detailed in Part 3 of this report. It is important to note that palliative care coding has no effect on the SHMI.
(a) SHMI banding	2	**2**	—	3	1	
(b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level	31.6	**26.4**	—	0.18	53.5	

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

	Previous Period (April 2014 – March 2015)	Current period (April – September 2015)				Comment
			National performance			
	UHB	UHB	Overall	Best	Worst	
(i) Groin hernia surgery	0.069	**0.080**	0.087	0.135	0.008	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. Figures for UHB for Varicose Vein Surgery are not available as insufficient responses were received.
(ii) Varicose vein surgery	—	—	0.103	0.129	0.037	
(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. 3(i) is not applicable to UHB as the Trust does not provide a Paediatrics service.
(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 (2013/14)	Current period (2014/15)				Comment
			National performance			
	UHB	UHB	Overall	Best	Worst	
Trust's responsiveness to the personal needs of its patients – average weighted score of 5 questions from the National Inpatient Survey (Score out of 100)	72.2	**72.0**	68.9	86.1	59.1	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 (2014)	Current period (2015)		Comment
			National performance	
	UHB	UHB	Average (median) for acute trusts	
Staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends.	82%	**82%**	70%	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 2015/16)	Current period (Q3 2015/16)				Comment
			National performance			
	UHB	UHB	Overall	Best	Worst	
Percentage of admitted patients risk-assessed for VTE	99.4%	**99.5%**	95.6%	100%	78.5%	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.

7 *C. difficile* infection

	Previous Period (2013/14)	Current period (2014/15)				Comment
			National performance			
	UHB	UHB	Overall (England)	Best	Worst	
C. difficile infection rate per 100,000 bed-days (patients aged 2 or over)	21.9	**17.7**	15.1	0	62.2	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

Since the 2014/15 report, the rate for this indicator has changed to 'per 1000 bed days' from 'per 100 admissions'.

	Previous Period (April – September 2014)	Current period (October 2014 – March 2015)				Comment
			National Performance (Acute Teaching Providers)			
	UHB	UHB	Overall	Best	Worst	
Incident reporting rate per 1,000 bed days	37.1	**11.0**	—	3.6	108.5	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	12	**11**	—	0	128	
Rate of patient safety incidents that resulted in severe harm or death rate per 1,000 bed days	0.06	**0.06**	—	0.00	0.12	

Quality Account 2015/2016

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

The Trust has shared its 2015/16 Quality Report with Birmingham CrossCity Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee.

Birmingham CrossCity Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee have reviewed the Trust's Quality Report for 2015/16 and provided the statements below.

Statement provided by Birmingham CrossCity Clinical Commissioning Group

University Hospitals Birmingham NHS Foundation Trust

Quality Account 2015/16

Statement of Assurance from Birmingham CrossCity CCG May 2016

1.1 As coordinating commissioner Birmingham CrossCity Clinical Commissioning Group (BCC CCG) has welcomed the opportunity to provide this statement for the University Hospitals Birmingham NHS Foundation Trust (UHB) Quality Account for 2015/16. The review of this Quality Account has been undertaken in accordance with the Department of Health guidance and Monitor's requirements, and the statement of assurance has been developed in consultation with neighbouring CCGs, NHS England (West Midlands) and the Birmingham CrossCity CCG People's Health Panel.

1.2 The report accurately outlines the structures and frameworks around safeguarding which the Trust has put in place. However, it does not fully reflect or emphasis the work it is delivering around the 'Making Safeguarding Personal' agenda and to support staff in delivering person centred practice. We are aware that the Trust has reconfigured and strengthened its dedicated safeguarding resource and is committed to approaching safeguarding as an integrated 'think family' model rather than separate silos for adults and children.

1.3 The Trust reported 4 never events to commissioners during 2015–16 (not the 5 contained in the report); whilst one incident occurred in March 2015 it was reported in April 2016. The Patient Safety Indicators table requires amending.

1.4 There is a defined rationale for the selection of improvement priorities, and it is evident that patients and governors have been consulted as part of that process. The account is also very clear about the background to the priorities and the performance in 2015/16.

1.5 It has been noted, however, that for the past five years' Quality Accounts the priorities have included 'improved patient experience and satisfaction', 'reduce medication errors', 'infection prevention and control' and a priority around 'observations'. Whilst it is appreciated that an improvement priority may need more than one year to embed and show progress, and that the focus each year may have moved it is disappointing that the Trust has not identified any new priorities.

1.6 The Trust is commended on its comprehensive approach to measuring patient experience and there are some good examples of initiatives implemented during 2015/16. It has been noted that the questions in the Local Patient surveys are changed each year, with those achieved being removed from the survey; assurance is required on how the Trust maintains those standards.

1.7 The Trust's approach to learning from complaints and taking action is comprehensive and demonstrates a real commitment to improving patient experience and outcomes.

1.8 It is recommended that the Trust reports on and sets targets against 'avoidable missed doses', excluding those doses refused by patients (which can be clinically acceptable i.e. the patient does not need a painkiller).

1.9 It would have been expected that the account would contain information on how the Trust is progressing on the reduction of serious harms due to medication errors.

1.10 The opportunity to involve and educate patients on the importance of completing courses of antibiotics could have been included in the Trust's initiatives and supported the achievement of their avoidable missed doses target.

1.11 It is pleasing to note the progress made by the Trust in achieving a significant reduction in grade 2 pressure ulcers (non-device-related) in 2015/16 (79 down from 144 in previous year, against a target of 132) and we look forward to further reductions in 2016/17.

1.12 An explanation for the rise in MRSA Bacteraemia and *Clostridium difficile* infection has not been provided and so it is unclear if the new initiatives for 2016/17 are based on learning from 2015/16 cases.

1.13 The vast majority of the account is well presented, structured and reader friendly, with a glossary helpfully included. The exceptions being the use of technical language, for example when referring to the action undertaken by the Care Quality Commission (CQC). This section needs to be more explicit to ensure that patients and the public know exactly why the CQC placed two conditions on the Trust's registration following a focused inspection to cardiac surgery, and what action is being taken to address the issues. Other improvements could include considering a reduction in the amount of information on internal processes and groups and ensuring that all tables and graphs are labelled and accompanied by an explanatory narrative.

1.14 It was pleasing to read that performance was average or better for 30 of the key findings of the NHS Staff Survey; the account could have been enhanced by provision of information on what actions are to be undertaken as a result of the survey and inclusion of details of the two areas which were below average would have increased transparency of this report.

1.15 An omission has been noted in the table containing the list of inspections/visits – a joint BCC CCG and Birmingham South Central CCG visit to a number of wards was carried out on 12th November 2015.

1.16 It is positive to note that staff achievements are celebrated in the publication, in particular the work completed by the Tissue Viability team for the Royal College of Nursing and the Health Service Journal.

1.17 It is also positive to note the changes that the new discharge lounge has provided for patients, providing a quiet and calm environment and access to a Pharmacist to give the important details of medications on discharge.

1.18 It is interesting to read that the Communication Skills Task and Finish Group completed its remit and have published the Trust's Communication Behaviours and the CommunicatingWell@UHB electronic information and training resource, more information on what this actually means in practice would be useful to the reader and further celebrate this achievement.

1.19 Really encouraging was the positive quotes sent from patients within the compliments section, this may be more reader friendly if they were presented pictorially such as within speech bubbles.

Barbara King

Accountable Officer

Birmingham CrossCity Clinical Commissioning Group

Statement provided by Healthwatch Birmingham

Comment from Healthwatch Birmingham regarding the University Hospital Birmingham NHS Foundation Trust Quality Account 2015/16

17 May 2016

University Hospitals Birmingham NHS Foundation Trust

Thank you for sending us a draft copy of University Hospital Birmingham NHS Foundation Trust Quality Account 2015/16.

At Healthwatch Birmingham we are passionate about putting patients, public, service users and carers (PPSuC) at the heart of service improvement in health and social care in the City of Birmingham. In line with our new strategy, we are focused on helping drive continuous improvement in patient and public involvement (PPI) and patient experience. We also seek to champion health equity so that PPSuC consistently receive care which meets their individual and collective needs. We have therefore focused our comments on aspects of the Quality Account which are particularly relevant to these issues.

Local Surveys and FFT

The draft Quality Account shows the Trust is using a diversity of tools to understand patient experience. This includes: the local inpatient, emergency departments, outpatient and discharge surveys; the Friends and Family Test (FFT); and complaints and compliments. It is excellent to see the Trust analysing evidence from all these sources in its Quality Account, and using this analysis to inform its actions going forward. We also support the use of 'governor drop ins' in inpatient and outpatient settings as an additional way of understanding patient experience at the Trust. Whilst patient surveys are an important way of gauging experience across the patient population, it is important to supplement this with more qualitative information. It is therefore heartening that Governors at the Trust directly interact with patients and visitors to understand their experiences, and we hope to see this type of initiative continue.

With regards to the local inpatient, outpatient, emergency department and discharge survey results, we note that the Trust has achieved 6 of its 13 targets and has carried over the remaining 7. It is positive to see that none of the scores for the 13 indicators have gone down since last year. It is also good to see that, where the Trust has achieved its targets, it is introducing new questions based on feedback received from patients. We also appreciate the Trust providing a clear account of its methodology, improvement targets, and how progress is monitored.

With regards to the Friends and Family Test (FFT), it is disappointing to see that the Trust's score for A&E has decreased over the course of the year. However, we note that the Trusts score remains around the national average, and above the NHS England West Midlands region average. We also note that the inpatient FFT has remained stable over the year, whilst the outpatient FFT score has increased.

As mentioned previously, one of Healthwatch Birmingham's focuses is on promoting health equity in the City. In next year's Quality Account we would value any information on how the Trust has monitored and improved the experience of 'hard to reach groups' (e.g. people with learning disabilities, people with mental health problems, minority ethnic groups etc.).

Patient experience initiatives

We congratulate the Trust on all of the patient experience initiatives that have been implemented over the past year. For example, it is excellent to read that the Trust is running ward/ departmental workshop based teaching on patient experience, has launched a CommunicatingWell@UHB electronic information and training resource, and has taken steps to make the Trust a more pleasant environment for patients. We are also happy to see a large number of initiatives planned for the coming year, such as the implementation of patient stories as a feedback and training mechanism, the use of a more focused approach to tackle challenging aspects of patient experience, and improved information for patients and visitors. We look forward to learning about the success of these initiatives in next year's Quality Account.

Complaints and compliments

We are happy to see an in-depth consideration of the complaints the Trust has received over the course of the year. It is heartening to see examples of where the Trust made changes in response to complaints around cancellations, communications and discharge. It is also good to receive information on the compliments received by the PALs and Patient Experience teams. We would particularly like to congratulate the Trust on the number of compliments given about nursing care and treatment received.

Whilst it is useful to be provided with information on the volume of complaints the Trust has received, we would caution the Trust against placing too much emphasis on the extent to which complaints have decreased. Whilst a decrease in complaints can be indicative of improvements in care and experience, this is not necessarily the case. Across the country many patients who have had negative experiences do not feed this back. When this happens, important opportunities to listen and improve services are lost. We would therefore ask the Trust to regularly review its complaints system to ensure it is accessible to all patients, including seldom heard and 'hard to reach' groups. If this already takes place at the Trust, we would value more information on this in the Quality Account.

Patient and Public Involvement (PPI)

Whilst the draft Quality Account provided to us provides ample detail on how patient feedback is gathered at the Trust, there is limited information on how the Trust engages and involves PPSuC when developing or redesigning services. We would therefore value more detail on this in the Quality Account.

CQC and never events

It is concerning to see that the CQC has taken enforcement action against the Trust during 2015/16 as a result of a focused inspection to Cardiac Surgery. It is also concerning that there were five never events at the Trust in 2015/16. We hope to see improvements in respect to these two areas next year.

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

Yours Sincerely

Jane Upton PhD
Head of Evidence

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

The Birmingham Health & Social Care Overview and Scrutiny Committee has confirmed that it is not in a position to provide a statement on the 2015/16 Quality Report.

Quality Account 2015/2016

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

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

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 2015/16 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 2015 to May 2016
  - papers relating to Quality reported to the Board over the period April 2015 to May 2016
  - feedback from the commissioners dated 25/05/2016
  - feedback from governors dated 16/02/2016
  - feedback from local Healthwatch organisations dated 17/05/2016
  - feedback from Overview and Scrutiny Committee dated 26/04/2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26/04/2016
  - the 2015 national patient survey (not due to be published until 08/06/2016)
  - the 2015 national staff survey 23/02/2016
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 23/05/2016
  - CQC Intelligent Monitoring Report dated May 2015

- 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

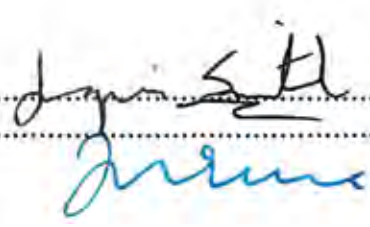
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- 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 manual and supporting 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

23rd May 2016 Date.....  .....Chairman

23rd May 2016 Date..... .....Chief Executive

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

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

We have been engaged by the Council of Governors of University Hospitals Birmingham NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Birmingham NHS Foundation Trust's quality report for the year ended 31 March 2016 (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 2016, to enable the Council of Governors to demonstrate that 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 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18-week maximum wait from point of referral to treatment (incomplete pathways); and
- Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge.

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 2015 to March 2016;
    - papers relating to quality reported to the board over the period April 2015 to March 2016;
    - feedback from the Commissioners dated 25 May 2016;
    - feedback from the governors dated 16 February 2016;
    - feedback from local Healthwatch organisations, dated 17 May 2016;
    - feedback from Overview and Scrutiny Committee, dated 26 April 2016;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26 April 2016;

- the national staff survey dated 23 February 2016;
- Care Quality Commission Intelligent Monitoring Report dated May 2016;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 19 May 2016; 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 (collectively the 'documents').

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

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

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the Monitor 2015/16 Detailed guidance for external assurance on quality reports; 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
United Kingdom
25 May 2016