NHS

University Hospitals Birmingham

NHS Foundation Trust

# Quality Account 2017/18

This annual report covers the period 1 April 2017 to 31 March 2018

# 2017/18 Quality Account

**Contents**

# 1 Chief Executive's Statement

University Hospitals Birmingham NHS Foundation Trust (UHB) maintained its focus on delivering high quality care and treatment to patients during 2017/18. In line with national trends, the Trust continued to see unprecedented Emergency Department attendances and hospital admissions which 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 UHB's robust approach to managing quality.

The Trust has made progress in relation to four of the six priorities for improvement set out in last year's Quality Report: reducing grade 2 pressure ulcers; improving patient experience and satisfaction; reducing harm from falls and timely treatment for sepsis. Performance for the remaining indicators: timely and complete observations, and reducing missed doses, has been mixed with further work required to improve performance in 2018/19. The Board of Directors has chosen to continue with these six priorities for improvement in 2018/19.

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 were reviewed in detail during 2017/18 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 those put forward by senior medical and nursing staff, e.g., individual wards selected for review, missed or delayed medication, serious incidents, serious complaints, infection incidents, incomplete observations and cross-divisional issues.

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

A key part of the Trust's commitment to quality is being open and honest with our staff, patients and the public, with published information not limited to good performance. The Quality web pages provide up-to-date information on UHB's performance in relation to quality: http://www.uhb.nhs.uk/quality.htm.

The Trust's 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 2017/18 Quality Report and undertaken testing for three indicators in line with the NHS Improvement guidance on external assurance:

1. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.
2. Reducing grade 2 hospital-acquired pressure ulcers (local indicator).
3. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

No significant issues were identified with the content review or the testing for the first two indicators. Deloitte has however issued a modified (qualified) opinion on the third indicator – 18 weeks (unfinished pathways) – and the Trust is currently reviewing the recommendations. The implementation of recommendations will be monitored via the Trust's Audit Committee. The report provided by our external auditor is included on page 53 of this report.

During 2017/18, UHB continued to support Heart of England NHS Foundation Trust (HEFT) in order to share learning and best practice. The work to bring the two trusts together was in progress for many months, and on 1 April 2018, the merger by acquisition of HEFT by UHB was formally agreed. The decision was approved by the trusts' respective Boards of Directors, with the decision cleared by both Councils of Governors. The enlarged organisation will use the University Hospitals Birmingham NHS Foundation Trust name.

2018/19 will be a very challenging year for the enlarged UHB as we focus on building healthier lives and achieving outcome and access targets alongside ever increasing demand for our services. 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 2018/19.

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, 2018

**Note regarding merger by acquisition of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust**

On 1st April 2018, the merger by acquisition of Heart of England NHS Foundation Trust (HEFT) by University Hospitals Birmingham NHS Foundation Trust (UHB) was formally agreed. The decision was made the Trusts' respective Boards of Directors, with the decision cleared by both Councils of Governors.

The enlarged Trust will use the University Hospitals Birmingham NHS Foundation Trust name (UHB). All individual hospital and clinic names will remain the same.

As this report is for 2017/18, i.e., pre-merger, it covers and refers to the 'old' UHB, and does not contain information from HEFT. Next year there will be one report, covering the enlarged UHB.

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

## 2.1 Priorities for Improvement

The Trust's 2016/17 Quality Report set out six priorities for improvement during 2017/18:

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

The Trust made progress in relation to four quality improvement priorities during 2017/18: Priority 1 - reducing grade 2 pressure ulcers, Priority 2 - improving patient experience and satisfaction, Priority 5 – reducing farm from falls and Priority 6 – timely treatment for sepsis.

There were, however, mixed results for the other two priorities. Performance for the first indicator (observations) in Priority 3 improved but did not achieve the end of year target. Performance for the second indicator (timely analgesia) remained steady throughout the year. Performance for Priority 4 (missed doses) decreased compared to 2016/17 so did not achieve the proposed improvement for 2017/18.

The Board of Directors chose to continue with the six priorities for improvement in 2018/19.

| | | |
|---|---|---|
| 1 | Reduce grade 2 pressure ulcers | New trajectory for 2018/19 agreed with CCG |
| 2 | Improve patient experience and satisfaction | New patient survey questions added, others removed due to achieving the 2017/18 target |
| 3 | Timely and complete observations including pain assessment | Targets to remain the same in 2018/19 after review of 2017/18 performance |
| 4 | Reducing missed doses | Targets to remain the same in 2018/19 after review of 2017/18 performance |
| 5 | Reducing harm from falls | Target for 2018/19 updated in line with 2017/18 performance |
| 6 | Timely treatment for sepsis | To report on performance against the CQUINs |

The improvement priorities for 2017/18 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.

The focus of the patient experience priority was decided by the Care Quality Group and the priorities for improvement in 2018/19 were then approved by the Board of Directors in March 2018. The priorities for 2018/19 will be presented to the Trust Partnership Team and cascaded to all staff via Team Brief in 2018.

They have also been discussed with various Trust groups including staff, patient and public representatives as shown in the table below.

| Date | Group | Key members |
|---|---|---|
| March 2018 | Care Quality Group | Executive Chief Nurse, Associate Directors of Nursing, Matrons, Senior Managers with responsibility for Patient Experience, and Patient Governors |
| April 2018 | 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 |
| May 2018 | Trust Partnership Team | Executive Directors, Directors, Human Resources Managers, Divisional Directors of Operations, Staff Side Representatives |
| 2018 TBC | 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 |

Although some of the 2018/19 priorities have been in place for a number of years, the specific focus and targets within each priority are regularly reviewed and updated in line with changes in performance and in response to priorities within the Trust.

The performance for 2017/18 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 2016/17.

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

**Background**
This quality improvement priority was first 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 tubing required for oxygen delivery.

Pressure ulcers are painful, may lead to chronic wound development and can have a significant impact on a patient's recovery from ill health and their quality of life. They are 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. |
| Ungradable (Depth unknown) | Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the wound bed. |
| Suspected Deep Tissue Injury (SDTI) (depth unknown) | Purple or maroon localized area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. |

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

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

Due to very low numbers of hospital-acquired grade 3 and grade 4 ulcers at UHB, the Trust focus is on further reducing grade 2 ulcers. This in turn should help towards aiming for zero avoidable hospital-acquired grade 3 and grade 4 ulcers, as grade 2 ulcers will be less likely to progress.

**Performance**
For 2016/17, UHB reported 71 patients with non-device-related, hospital-acquired avoidable grade 2 pressure ulcers, against the agreed reduction target of 125. This compares to 79 reported in 2015/16, and 144 reported in 2014/15.

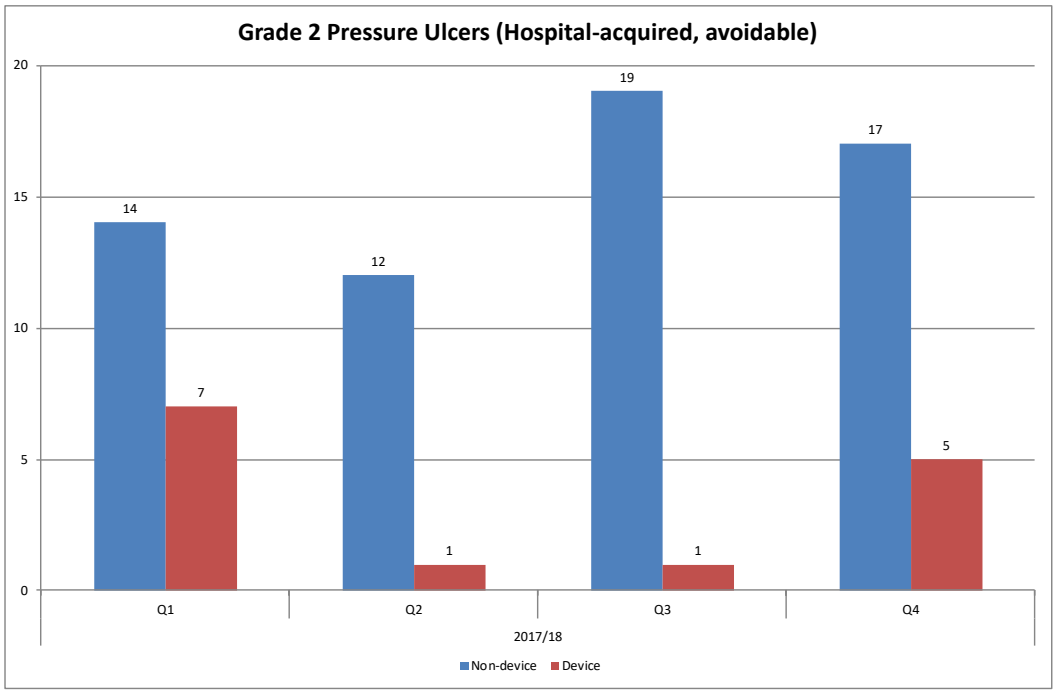
The target agreed with the CCG for 2017/18 was to "maintain current performance" – no more than 75 patients with these pressure ulcers.

During 2017/18, UHB reported 62 patients with non-device related, hospital-acquired avoidable grade 2 pressure ulcers.

The Trust also decided to report on device-related hospital-acquired avoidable grade 2 pressure ulcers. In 2016/17 UHB reported 28 patients with such ulcers, and the target set by the CCG for 2017/18 was no more than 42 patients.

During 2017/18, UHB reported 14 patients with device-related, hospital-acquired avoidable grade 2 pressure ulcers.

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




Note: End-of-year ratification means figures above may differ from those reported in the quarterly reports

**Initiatives implemented in 2017/18**
To improve the classification and grading of pressure ulcers across the trust through a variety of education and training programmes:

- The Tissue Viability Team took part in the International Stop the Pressure day, linking with partners in industry to provide education on repositioning across ward areas to a variety of staff
- Tissue viability link nurses and Skin Champions were released as part of their study days to visit ward areas and educate staff on the prevention of heel drag and to re-launch the React to RED strategies
- Accurate documentation of repositioning was promoted and monitored through educational campaigns, Tissue Viability Quality Audits, and Back to the Floor visits by senior nursing staff
- Ward teams were encouraged to develop a greater understanding of the causes of DTIs (deep tissue injuries) and ungradable pressure ulcers through completing mini RCAs (root cause analysis), and fed back at divisional preventing harm forums
- Trialling hybrid mattresses within a specific clinical specialty to evaluate their effect on pressure ulcer reduction and patient satisfaction
- Educational study days were revamped to include more interactive sessions including a 'crime scene'.
- All pressure ulcer education, audit tools and investigative paperwork (RCAs) were updated to reflect the new nursing documentation
- Pressure ulcer competency figures were monitored and uptake /review actively encouraged by senior nursing teams
- Timely risk assessments were monitored through QUORU (Quality and Outcomes Research Unit)

**Changes to improvement priority for 2018/19**
The 2018/19 targets agreed with Birmingham CrossCity Clinical Commissioning Group (CCG) for grade 2, avoidable, hospital-acquired pressure ulcers are:

- Device related – no more than 75 patients with such ulcers
- Non-device related – no more than 42 patients with such ulcers

These are the same as the targets set for 2017/18.

It should be noted that changes to some definitions are expected during 2018/19, which will affect reporting of pressure ulcers.

**Initiatives to be implemented during 2018/19**
To continue to build on the improvements seen in 2017/18, to further identify any commwon causes or reasons behind hospital-acquired pressure ulcers and to target training and resources accordingly. Initiatives to aid improvements include:

- Develop and launch seating leaflet and detailed seating guidelines in conjunction with Therapies
- Set up a task and finish group to determine the changes required to refocus on repositioning
- Ensure all wards have React to RED discs, key rings and grading cards
- Continue to promote the prevention of heel drag through educational activities and clinical practice
- To trial new and innovative pressure relieving equipment including mattresses, trolley mattresses and cushions through the Equipment Standardisation group
- To re-devise and re-launch the Equipment Selection Flowchart to promote effective utilisation of equipment
- Work in conjunction with other disciplines to link in with national campaigns e.g. "get up, get dressed, get moving".

**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 Preventing Harms meeting, 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 quality priority focuses on improving scores in our local surveys, and also takes into account national survey results and correlations with what ranks as most important to patients in giving a high rating of care.

**Patient experience data from local surveys**

| Survey | No. responses 2017/18 | Data up to |
|---|---|---|
| Inpatient | 10,875 | March 2018 |
| Emergency Department | 629 | March 2018 |
| Outpatient | 1,657 | Quarter 3 2017/18 |
| Discharge | 1,558 | Quarter 3 2017/18 |

In addition, UHB publishes findings from the National Inpatient Survey, run by the Picker Institute on behalf of the CQC – please see Part 3 of this Quality Account.

**Methodology**
Until Quarter 3 2017/18, the local inpatient survey was undertaken predominantly utilising the bedside TV system, allowing patients to participate in surveys at their leisure. Areas that did not have the bedside TVs used either paper or computer tablets for local surveys. During Quarter 3 the Trust decided not to renew the bedside TV survey contract with its external provider. Whilst exploring other electronic methods of feedback the Trust has implemented an interim solution using paper based surveys to replace those done on the bedside TV system. The Emergency Department survey is a paper-based survey, and the outpatient and discharge surveys are postal; both sent to a sample of 750 patients per month.

**Improvement targets**
For 2017/18, 2016/17 performance was reviewed for the questions set for this priority. Some of the questions that achieved or maintained their target during the previous year were replaced as part of the questions included within the Quality Account priority. The questions that were replaced as part of the priority will continue to be monitored as part of local surveys.

This improvement priority was agreed at the Trust's Care Quality Group meeting in February 2018, which is a Chief Nurse-led sub-committee of the Board, attended by clinical staff and also patient Governors who provide the patients' perspective. Rationale for keeping, removing or adding questions was included in the report to this committee. This was based on data available at that time (Quarter 3, 2017/18 data).

- **Questions carried forward** – targets carried forward from 2017/18
- **New questions with a 2017/18 baseline score from local surveys** – targets were set by the Care Quality Group
- **New questions without a 2016/17 baseline** – target to be set at Care Quality Group following collection of baseline data

**Results from local patient surveys**

This table shows results for 2016/17 and 2017/18 along with the status for each question. Below this are the new questions added for 2018/19.

| | 2016/17 | 2017/18 target | 2017/18 score | 2017/18 no. of responses | Plan for 2018/19 | 2018/19 Target | Rationale |
|---|---|---|---|---|---|---|---|
| 1. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you? | 8.8 | **9.0** | 8.6 | 9883 | Carry forward | 9.0 | Not met at Q3, carry forward |
| 2. During your time in hospital did you feel well looked after by hospital staff? | 9.5 | **9.7** | 9.6 | 9981 | Remove | NA | Target met at Q3 – remove from quality priority |
| 3. If you used the call bell, was it answered in a reasonable time? | 9.1 | **9.5** | 9.1 | 2548 | Carry forward but reword | To be set | Reworded for 2018/19 to match national survey, set new target. See new questions below for wording. |
| 4. Did you get enough help to eat your meals? | NEW | **9.3** | 9.0 | 733 | Remove | NA | Target met at Q3 – remove from quality priority |
| **Outpatient survey*** | | | | | | | |
| 5. How would you rate the courtesy of the reception staff during your time in the Outpatients Department? | 8.9 | **9.0** | 8.8 | 2090 | Remove | NA | Target almost met at Q3 and consistent all year – remove from quality priority |
| 6. Did the staff treating and examining you introduce themselves? | 8.8 | **8.9** | 8.8 | 2052 | Remove | NA | Target met at Q3 – remove from quality priority |
| 7. If you had important questions to ask the doctor, did you get answers that you could understand? | 8.9 | **9.0** | 8.9 | 1903 | Remove | NA | Target met at Q3 – remove from quality priority |
| **Emergency Department survey** | | | | | | | |
| 8. During your time in the Emergency Department did you feel well looked after by hospital staff? | 8.6 | **9** | 8.8 | 629 | Carry forward | 9 | Not met as at Q3, carry forward |
| 9. How would you rate the courtesy of the Emergency Department reception staff? | 8.5 | **9** | 8.7 | 597 | Carry forward | 9 | Not met as at Q3, carry forward |
| 10. Were you kept informed of what was happening at all stages during your visit? | 7.9 | **8.5** | 8.1 | 629 | Carry forward | 8.5 | Not met as at Q3, carry forward |
| **Discharge survey*** | | | | | | | |
| 11. Did a member of staff tell you about medication side effects to watch for when you went home? | 5.9 | **6.1** | 5.9 | 1434 | Remove | NA | Target met at Q3 – remove from quality priority |
| 12. Did you feel you were involved in decisions about going home from hospital? | 7.2 | **7.4** | 7.1 | 1850 | Carry forward | 7.4 | Not met as at Q3, carry forward |

*postal surveys – data is not complete due to time lag

### New questions to be added for 2017/18

| | 2017/18 score (as of Q3) | Status | 2018/19 target | 2017/18 No. responses |
|---|---|---|---|---|
| **Inpatient survey** | | | | |
| Do you think the hospital staff did everything they could to help control your pain? | 9.4 | NEW for 2018/19 | 9.6 | 8016 |
| Did you have confidence and trust in the nurses treating you? | New question | NEW for 2018/19 | To be set | NA |
| If you needed attention, were you able to get a member of staff to help you within a reasonable time? | N/A - new wording | Brought forward from 2017/18 but reworded | To be set | 1629 |
| **Outpatient survey** | | | | |
| How long after the stated appointment time did the appointment start? | 7.0 | NEW for 2018/19 | To be set | 2059 |
| If you had an intimate examination/procedure performed during your outpatient appointment, were you offered a chaperone? | New question | NEW for 2018/19 | To be set | NA |
| **Emergency Department survey** | | | | |
| Do you think the hospital staff did everything they could to help control your pain? | 8.2 | NEW for 2018/19 | 9.0 | 514 |

**How progress will be monitored, measured and reported**

- This priority is measured using the local survey results as detailed in the methodology
- The new questions 'confidence and trust in nurses' and 'offering a chaperone' will be added to the relevant local surveys and targets set once sufficient baseline data has been collected
- The call bell question will be reworded to match the new wording in the national inpatient survey for improved benchmarking. A target will be set once sufficient baseline data has been collected
- The operational Patient Experience Group (reporting to the Care Quality Group) monitors this priority
- Monthly exception reports to Associate Directors of Nursing (ADNs) highlight individual wards not meeting the quality priority so that action can be taken. This report is presented to the Care Quality Group and includes a section from each ADN with actions for their division
- This patient experience quality priority is also reported on the Clinical Dashboard so is always available for staff to view; updated monthly
- Quarterly patient experience reports, including progress on the patient experience quality priorities, are provided to the Care Quality Group (summarised to the Board of Directors) and the local Clinical Commissioning Group
- Feedback on patient experience is also provided by members of the Patient and Carer Councils as part of the Adopt a Ward / Department visits and via Governor drop-in sessions

### Update on Patient Experience initiatives in 2017/18

| Initiative planned | Update |
|---|---|
| Implement more flexible visiting times, with an increase from 2.30pm-7.30pm to 11am-8pm | Flexible visiting times were successfully implemented across the Trust along with a Visitor Charter setting out what visitors can expect from staff and sharing important information for visitors. When reviewed, overall this has had a positive impact for both patients and visitors. Patients report feeling more supported as they are able to spend more time with their family/friends, partner or spouse. Visitors have advised that it is easier to visit around their commitments and to access medical/nursing team members. The Trust will continue to monitor the experience of both patients and visitors over time. |
| Work with QEHB Charity to develop and implement a Pets in Hospital scheme | Introduction of a 'Pets in Hospital' scheme to enhance the patient experience is a step closer following approval of the initiative at board level and the development of procedural documentation. The Trust is working closely with Queen Elizabeth Hospital Birmingham Charity, who will run the scheme. |
| Pilot a renewed volunteer dining companions programme | Pilot wards have been identified, volunteers recruited and a training programme developed. This work will continue into 2018/19. |
| Undertake a baseline assessment of existing and ideal numbers and roles of volunteers to identify the Trust's volunteering needs and build a vacancy list | Priorities in the Voluntary Services Department had to switch to focus on maintaining the volunteer-force during a period of short-staffing in the department. The department is now back up to normal staffing levels and this project will continue. |
| Work with Harborne Academy on a pilot permitting younger volunteers (aged 16-17) into the Trust (currently minimum age is 18 years old) | The pilot proved successful with six health and social care students aged between 16 and 18 years of age volunteering each Wednesday afternoon. Following evaluation it was agreed to pilot for another year with some modifications to the process and programme. |
| Development of our patient experience collection, analysis and reporting system in conjunction with the Trust/ University of Birmingham PROMs group | Work continued on this long-term project throughout the year. A number of different software packages were installed and development groups set up. Research questions are being written and a first set of data has been analysed. |
| Work with the Young Persons' Council to develop mechanisms to increase feedback from young patients aged 16-24 | Following a successful pilot, the Young Person's Council (YPC) members were out and about on hospital wards through their 'Saturday Social' activity, engaging with and obtaining feedback from young patients in the 16 – 24 years age group. This was very successful as the council members were able to assist with completion of the survey if needed as they were not directly involved with the care of that patient. This will be further developed in 2018/19 and other methods of increasing feedback from this age group will be explored with the support of the YPC. |
| Develop a campaign to increase the number of patients reporting that their call bell was answered in a time reasonable for their needs | This piece of work is being conducted alongside the 'well looked after patient' project. Focused feedback obtained from patients provided insight into issues and staff insight was also sought to identify some of the reasons when call bells were not answered promptly enough. This work is ongoing. |
| Evaluate the pilot of an accessible feedback card and put methods in place to ensure that the opportunity to provide feedback is easy and accessible to all | Ongoing. This is part of a wider project ensuring that we listen to and obtain feedback from a range of hard to reach groups. The accessible feedback card pilot was evaluated and the card requires further work to make it suitable for patients with differing needs as it is not a 'one size fits all'. Existing surveys were simplified and shortened where possible and the use of volunteers was increased to support patients who need help to feed back via existing methods. Resources were developed to address the needs of visually impaired patients using larger font paper surveys. With the introduction of a new survey design system (planned for April 2018) the patient experience team will be able to customise all patient experience surveys to meet differing needs. Feedback was also obtained face to face from other patients falling into the hard to reach groups. This work will continue in 2018/19. |

**The Friends and Family Test (FFT)**
Response rates and positive recommendation percentages were closely monitored throughout 2017/18 against internal targets set and tracked against national and regional averages to benchmark against 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:

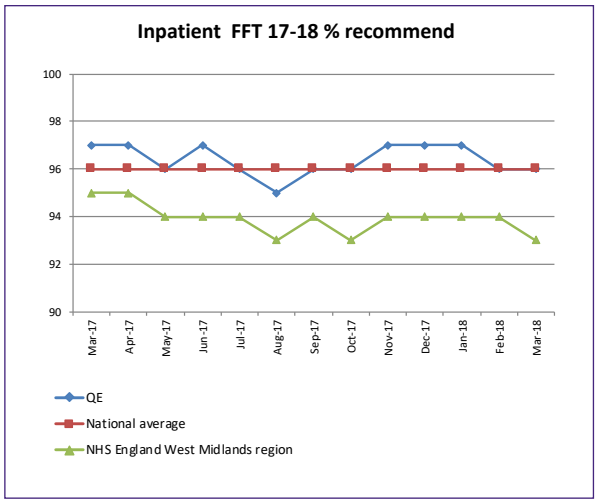
- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely Unlikely
- Don't know

**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.

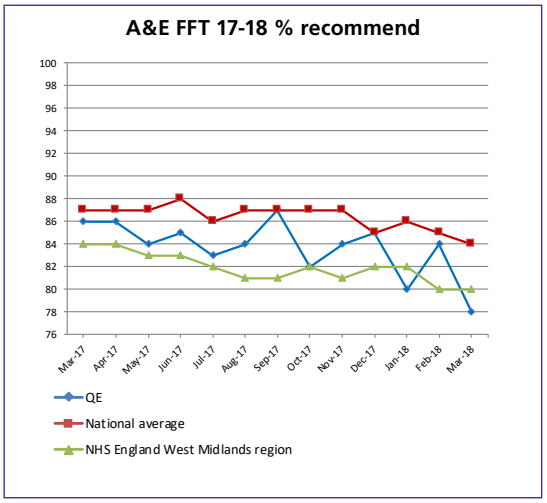
The Trust follows the national guidance for undertaking and scoring of the FFT.

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

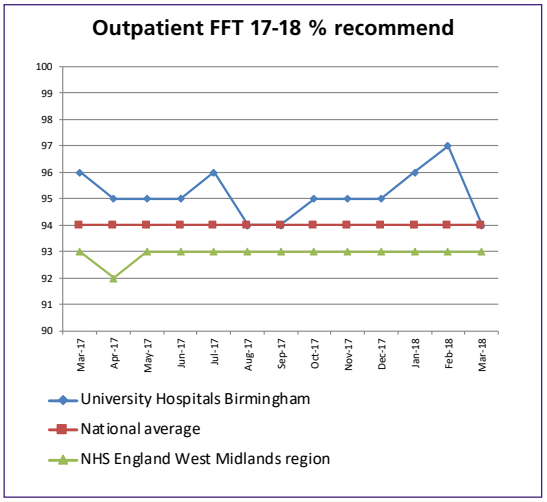
**Inpatients**: During 2017/18 the Trust maintained a positive recommendation rate that was above the West Midlands average and above or equal to the national average with exception of August 2017.




**A&E**: During 2017/18 the Trust's positive recommendation rate fluctuated. It remained below or equal to the national average, but above or equal to the West Midlands regional average with the exception of January 2018. Waiting times is often cited by patients as the reason for this reduction in score.




**Outpatients**: During 2017/18 the Trust maintained a positive recommendation rate, which is significantly higher than the West Midlands regional average, and higher or equal to the national averag




**Complaints**
The total number of all complaints received in 2017/18 was 660, a decrease of 15% on the 779 complaints received in 2016/17. The main subjects related to clinical treatment (188), communication (103) and attitude of staff (93), matching the top three subjects from the previous year.

| | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Total number of all complaints | 680 | 779 | 660 |

The table below compares complaints received against activity data. The number of inpatient, outpatient and emergency department complaints received in 2017/18 reduced compared to the previous year, whilst activity increased, resulting in a lower complaints-to-activity ratio.

| Rate of all complaints to activity | | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
| **Inpatients** | FCEs* | 129,574 | 135,216 | 142,264 |
| | Complaints | 345 | 327 | 296 |
| | Rate per 1000 FCEs | **2.7** | **2.4** | **2.1** |
| **Outpatients** | Appointments | 788,996 | 817,407 | 824,700 |
| | Complaints | 245 | 331 | 275 |
| | Rate per 1000 appointments | **0.3** | **0.4** | **0.3** |
| **Emergency Department** | Attendances | 108,463 | 115,226 | 117,513 |
| | Complaints | 90 | 121 | 89 |
| | Rate per 1000 attendances | **0.8** | **1.0** | **0.8** |

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

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

| Issue | Action taken |
|---|---|
| **Limited access to neuro-rehabilitation sessions** | The Trust now funds additional neuro-rehabilitation consultant sessions. Further, a Specialist Hyperacute Rehabilitation Team was set up to ensure improved surveillance of patients with prolonged disorders of consciousness. This means that they will be assessed more intensively; with an emphasis on responsiveness being recorded in a more accurate way. |
| **Appointment not received for follow up scan** | Repeat scan process reviewed and additional step introduced so that an additional, separate email is sent to the booking office to confirm that the follow up scan has been booked. |

More information around how learning is shared across the Trust can be found in the patient experience annual report.

**Accessible complaints process**
The Trust makes every effort to ensure that our complaints process is accessible to all. Complaints can be made by telephone, by email, via our website, in writing or in person (at the PALS office). Feedback leaflets with contact details are located on every ward and department. There is an easy read complaints leaflet, which explains the process in simple terms. When we are contacted by someone who has difficulties with the process, we provide clear contact details for the local NHS complaints advocacy service, who can support the individual and make the complaint on their behalf. We have provided complaints responses in alternative formats to accommodate specific requests including large font and braille.

**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 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Cases referred to PHSO by complainant for investigation | 28 | 28 | 13 |
| Cases which then required no further investigation | 0 | 0 | 1 |
| Cases which were then referred back to the Trust for further local resolution | 0 | 1 | 0 |
| Cases which were not upheld following review by the PHSO | 6 | 13 | 10 |
| Cases which were partially upheld following review by the PHSO | 11 | 12 | 8 |
| Cases which were fully upheld following review by the PHSO | 2 | 1 | 0 |

NB outcome numbers may not match the cases referred in any year as these may span different periods, e.g., cases received in one year may be finalised in another.

The total number of cases referred to the Ombudsman for assessment, agreed for investigation and ultimately upheld or partially upheld, remains relatively low in proportion to the overall level of complaints received by the Trust. There was a significant reduction in the number of cases investigated by the Ombudsman in 2017/18.

Eight cases were upheld or partially upheld by the Ombudsman in 2017/18, a reduction on the thirteen in the previous year. A further ten cases were not upheld by the Ombudsman, compared to thirteen last year. In every case, appropriate apologies were provided, action plans were developed where requested and learning from the cases shared with relevant staff.

**Compliments**

The majority of compliments are received in writing – by letter, card, email, website contact or via the Trust Patient Experience 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 recorded fewer formal compliments in 2017/18 than in 2016/17. 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 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Nursing care | 579 | 211 | 368 |
| Friendliness of staff | 84 | 90 | 130 |
| Treatment received | 1,290 | 1,582 | 1,210 |
| Medical care | 83 | 88 | 101 |
| Other | 24 | 18 | 22 |
| Efficiency of service | 268 | 275 | 157 |
| Information provided | 15 | 20 | 16 |
| Facilities | 6 | 2 | 2 |
| **Total** | **2,349** | **2,286** | **2,006** |

*data as of February 2018

**Examples of compliments received during 2017/18:**

"To each and every one of you a big thank you from all of us. Five weeks ago our world was turned upside down. Then we met all you wonderful people and you made part of our journey easier to cope with. Thank you for your kindness, understanding and the hugs when needed. Thank you for being a shoulder to cry on."

"Doctor and his team were excellent in their knowledge and expertise, from the initial prognosis to the operation and finally my aftercare."

"I cannot praise your staff enough, they are a brilliant team and nothing is too much trouble and I feel so cared for. They always have a smile and a kind word and are very, very professional. Also the hospital is so clean and the auxiliaries are just wonderful. I have had the best care and attention possible."

"She ensured that dad was moved to the ward as quickly as possible so that he could have a dignified and peaceful end. That is something myself and my family cannot express our gratitude enough for. She spoke to dad with such respect, even after he had passed away. She made an absolutely awful day that much easier to cope with."

**Feedback received through NHS Choices, Care Opinion and Healthwatch websites**

The Trust has a system in place to monitor feedback posted on three external websites; NHS Choices, Care Opinion and Healthwatch. 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.

Feedback received by this method has shown a significant increase of 45% during the year (from 126 in 2016/17 to 183 in 2017/18). Whilst more people are using this method to feed back, the numbers remain low in comparison to other methods used. Most feedback posted on these external websites is positive, concerns raised via this method reflect themes raised via more direct methods, for example via PALS, complaints or locally received verbal feedback.

**Initiatives to be implemented in 2018/19**

- Increased identification and support of carers driven by the recently introduced Carer Coordinator role.
- Further development of feedback methods to ensure 'hard to reach' groups have a voice and their views are listened to and acted on
- Develop work started around the use of chaperones, ensuring patients are informed and staff are educated to ensure chaperones are proactively offered and used appropriately in relevant situations (the patient experience team input into this will focus on monitoring the patient experience)
- Continued staff engagement in relation to patient experience, empowering multi-disciplinary team members to understand their role in influencing the overall patient experience, including production of a video highlighting the patient experience quality priorities
- Introduction of android tablets to all wards and some departments to make it easier for patients to feed back electronically
- Development of the information screen in the Emergency Department to include different pathways to help patients understand why they may wait different times, and the use of paracetamol as first line pain relief

## 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.

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

In addition, the Trust monitors the timeliness of analgesia (pain relief medication) following a high pain score. The pain scale used at UHB runs from 0 (no pain at rest or movement) to 10 (worst pain possible). Whenever a patient scores 7 or above, they should be given analgesia within 30 minutes. The indicator also includes patients who are given analgesia within the 60 minutes prior to a high pain score to allow time for the medication to work.

**Performance**

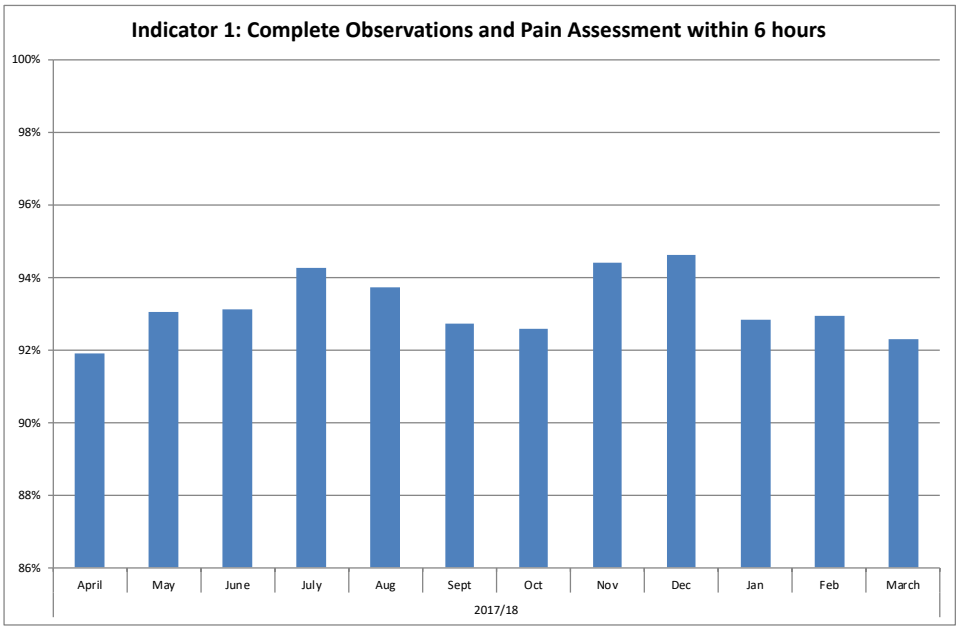
Indicator 1 had achieved the target during 2016/17, so the target was raised to 95% for 2017/18. Performance improved again during 2017/18 (reaching 93.8% during Quarter 3) but did not meet the final target.

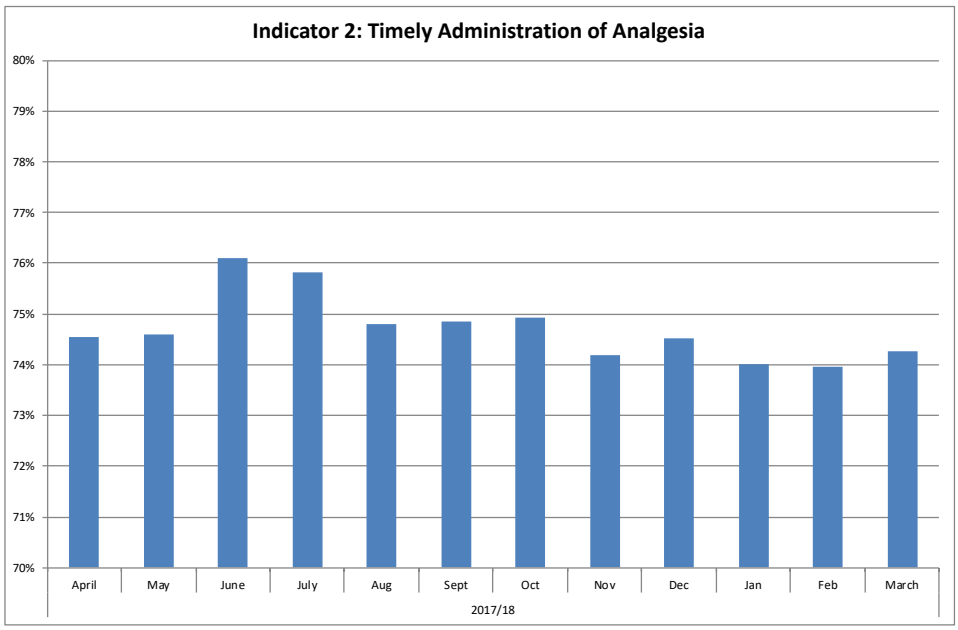
Indicator 2 had not achieved the target during 2016/17, so the same target was kept for 2017/18. Performance was again steady throughout the year, around 74% to 76% each month, however the target of 85% was not achieved.

**Table: Performance by quarter**

| | | Indicator 1 | Indicator 2 |
|---|---|---|---|
| | | Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward | Analgesia administered within 30 minutes of a high pain score |
| **Performance 2014/15** | | 71% | 64% |
| **Performance 2015/16** | | 79% | 76% |
| **Performance 2016/17** | | 90% | 75% |
| **2017/18** | **Target** | **95%** | **85%** |
| | **Q1** | 92.7% | 75.1% |
| | **Q2** | 93.6% | 75.2% |
| | **Q3** | 93.8% | 74.5% |
| | **Q4** | 92.7% | 74.0% |
| | **Year** | **93.1%** | **74.6%** |

**Graphs: Performance by month**



**Initiatives implemented in 2017/18**

- Wards' performance is monitored at a divisional and Trust level. Lower performing wards developed action plans to make improvements, and have been called to Executive Care Omissions Root Cause Analysis (RCA) meetings.
- Following these meetings, wards have taken actions at their local level; these include:
  - Development of a welcome letter for new staff, setting out clear expectations of which observations/assessments are due and when
  - Reinforced use of PICS during nursing handover to help monitor patients observations and assessments
  - Implementation of monthly assurance meetings where a ward presents their performance against a number of indicators, and talks about actions taken to make improvements. Attendees include senior nurses for the area, and lead nurses for Pharmacy and for Standards
- The Trust has another indicator that looks at whether patients receive a full set of observations every 12 hours. If this is missed, an incident is automatically generated in Datix. During 2017/18 Datix was updated to allow staff to choose the reason for the missed observations from a dropdown list of options. This has helped with data analysis and identification of problems
- A message was sent out via Team Brief, reminding wards of the importance of timely observations and assessments, and informing them of the new targets

**Changes to Improvement Priority for 2018/19**

Indicator 1 - as the performance improved but did not achieve the target at the end of 2017/18, the Trust has chosen to keep the target for 2018/19:

1. Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward: 95% by the end of the year.

Indicator 2 - as performance was steady throughout the year, meaning the target was not achieved, the Trust has chosen to keep the same target for 2018/19:

2. Analgesia administered within 30 minutes of a high pain score: 85% by the end of the year.

**Initiatives to be implemented in 2018/19**

- Wards performing below target will continue to be reviewed at the Executive Care Omissions Root Cause Analysis (RCA) meetings to identify where improvements can be made. Observations and pain assessment compliance will be monitored as part of the unannounced monthly Board of Directors' Governance Visits to wards.

**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. The Clinical Dashboard allows staff to compare their ward performance to the Trust as a whole, as well as seeing detailed data about which of the six observations or pain assessment were missed
- Performance will continue to be measured using PICS data from the electronic observation charts
- Progress will be reported monthly to the Clinical Quality Monitoring Group and the Board of Directors in the performance report. Performance will continue to be publicly reported through the quarterly Quality Report updates on the Trust's website

## Priority 4: Reducing 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.

In the absence of a national consensus on what constitutes an expected level of drug omissions, the Trust has set targets based on previous performance.

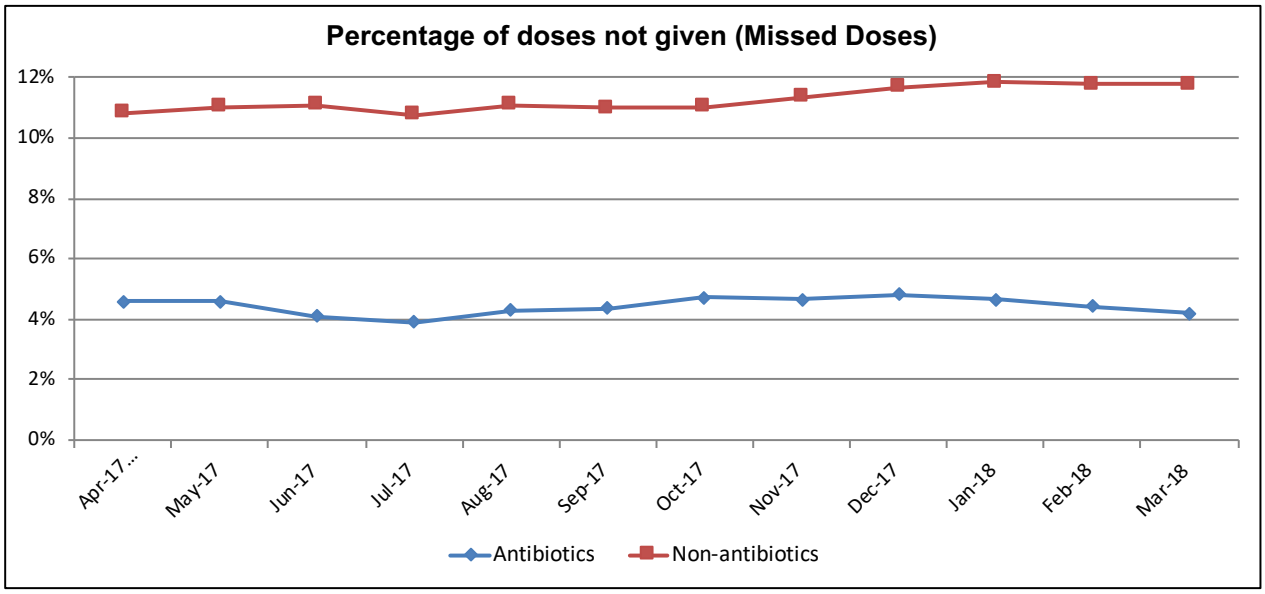
It is important to remember that some drug doses are appropriately missed due to the patient's condition at the time, and when a patient refuses a drug this is also recorded as a missed dose. The Trust has decided to record patient refusals as missed doses, as it is important for the staff looking after the patient to encourage them to take the medication, and to consider the reasons for refusal and whether a different medication would be more appropriate.

**Performance**

Rates of missed doses for antibiotics and non-antibiotics did not meet their targets for 2017/18.

Performance at the end of 2016/17 for missed doses of antibiotics was 4.1%, so in the 2016/17 Quality Report the Trust committed to reducing this to 4.0% by the end of 2017/18. The end of year performance was 4.4%.

Performance at the end of 2016/17 for missed non-antibiotics was 10.8%, so in the 2016/17 Quality Report the Trust committed to reducing this to 10.0% by the end of 2017/18. The end of year performance was 11.8%.




| | Antibiotics | Non-antibiotics |
|---|---|---|
| **Performance 2014/15** | 4.0% | 10.5% |
| **Performance 2015/16** | 3.9% | 10.5% |
| **Performance 2016/17** | 4.1% | 10.6% |

| | | | |
|---|---|---|---|
| **2017/18** | **Target** | **4% or lower** | **10% or lower** |
| | **Q1** | 4.4% | 11.0% |
| | **Q2** | 4.2% | 11.0% |
| | **Q3** | 4.7% | 11.3% |
| | **Q4** | 4.4% | 11.8% |
| | **Year** | **4.5%** | **11.3%** |

**Initiatives implemented during 2017/18, including learning from missed doses**

- A report which displays missed doses due to medication being intermittently out of stock continues to be used to identify cases for review at the Executive Care Omissions RCA meetings
- Wards that are identified as exceptions for missed doses have been called to the Executive Care Omissions RCA meetings, where they talk through their data, any problems identified and actions taken
- Following these meetings, wards have taken actions at their local level, these include:
  - Recruitment of a non-medical prescriber, to allow prompt changes to prescriptions when patients no longer require medications or require the medication via another route, amongst other reasons
  - Education of staff relating to how frequently some medications can be given
  - Review of training to increase the number of staff able to insert cannulas, to allow intravenous drugs to be given
  - Reminder of use of the dropdown box on the electronic drugs chart, to accurately record the reason for a drug being recorded as missed. This will help identify problems
  - Reminder that many medications do not need to be omitted if a patient is nil by mouth.
  - Looking at systems to ensure that when a patient is transferred to another ward, their drugs are transferred with them
  - Ward stock lists reviewed and updated
  - Education from Pharmacy on the ordering and tracking of drugs and the use of Stock Locator
  - Implementation of monthly assurance meetings where a ward presents their performance against a number of indicators, and talks about actions taken to make improvements. Attendees include senior nurses for the area, and lead nurses for Pharmacy and for Standards
- The Practice Development nurses have supported wards in conducting audits of drug rounds in order to identify common causes of missed doses

**Changes to Improvement Priority for 2018/19**

As the targets were not achieved for 2017/18, the Trust has decided to keep the same targets for 2018/19:

- missed doses of antibiotics to be 4% or less by the end of 2018/19
- missed doses of non-antibiotics to be 10% or less by the end of 2018/19

**Initiatives to be implemented in 2018/19**

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

**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).
- Data on missed drug doses is available to clinical staff via the Clinical Dashboard and includes a breakdown of the most commonly missed drugs and the most common reasons recorded for doses being missed. This is also 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 on the *mystay@QEHB* website

## Priority 5 – Reducing harm from falls

This quality improvement priority was proposed by the Council of Governors and approved by the Board of Directors. It was first included in the 2016/17 Quality Report.

**Background**

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital are the most common reported patient safety Incident, with more than 240,000 reported in acute hospitals and Mental Health trusts in England and Wales every year (Royal College of Physicians, *National Audit of Inpatient Falls, 2015*). About 30% of people 65 years of age or older have a fall each year, increasing to 50% in people 80 years of age or older (*National Institute of Health and Clinical Excellence - NICE*).

All falls can impact on quality of life; they can cause patients distress, pain, injury, prolonged hospitalisation and a greater risk of death due to underlying ill health. Falls can result in loss of confidence and Independence which can result in patients going into long term care. Falling also affects the family members and carers of people who fall.

When a fall occurs at UHB, the staff looking after the patient submit an incident form via Datix, the Trust's incident reporting system. All falls incidents are reviewed by the Trust's Falls Team, a team of clinical nurse specialists. The lead for the area where the fall happened, usually the Senior Sister / Charge Nurse, investigates the fall and reports on the outcome of the fall, and whether there is any learning or if any changes in practice / policy need to be made.

Most falls do not result in any harm to the patient. Any falls resulting in severe harm undergo an RCA (root cause analysis) process to identify any issues or contributory factors. Falls resulting in specific harm, e.g., a fractured neck of femur (broken hip), are also reported to the local Clinical Commissioning Group.

**Falls prevention**

All inpatients should undergo a Falls Assessment on admission/transfer to a ward or if their clinical condition changes. If a patient is found to be at an increased risk at of falls, staff will identify the risk factors and the precautions that can be taken to reduce these risks. These may include a medication review by pharmacy staff, provision of good-fitting footwear, ensuring chairs are the correct height and width for the patient, or moving the patient to a height-adjustable bed.

The Falls Team also receives information on patients who have fallen more than once during their hospital stay. These patients are reviewed, taking account of mobility, medication, continence and altered cognition. The Falls Team will make suitable recommendations to the ward staff around intervention and prevention of further falls.

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

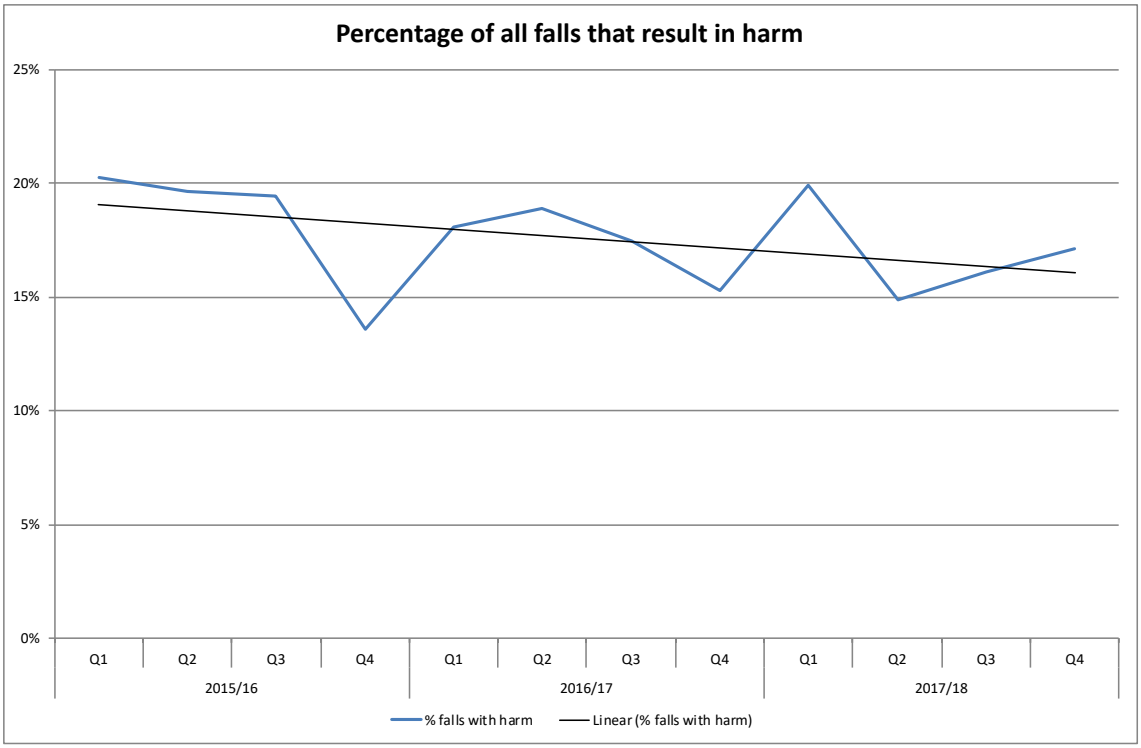
**Performance**

The Trust has chosen to measure 'percentage of falls resulting in harm'.

While staff take precautions to prevent falls from occurring, it is not possible to prevent all falls, therefore it is also important to attempt to minimise the harm that occurs due to falls.

Data for the last three years is presented below:

| Year | Quarter | Percentage of falls with harm |
|---|---|---|
| **2015/16** | Q1 | 20.2% |
| | Q2 | 19.6% |
| | Q3 | 19.5% |
| | Q4 | 13.6% |
| | **Year** | **18.1%** |
| **2016/17** | Q1 | 18.1% |
| | Q2 | 18.9% |
| | Q3 | 17.4% |
| | Q4 | 15.3% |
| | **Year** | **17.4%** |
| **2017/18** | Q1 | 19.9% |
| | Q2 | 14.9% |
| | Q3 | 16.1% |
| | Q4 | 17.1% |
| | **Year** | **17.0%** |




The target set for 2017/18 in the previous Quality Account was to reach 16.5%. This target was met during Quarters 2 and 3 2017/18, however for Quarters 1 and 4, and 2017/18 overall, the target was not reached.

However, for 2017/18 overall, the harm rate was slightly lower than 2016/17, and was below that seen during most of the quarters of 2015/16 and 2016/17. The trend line in the graph above demonstrates the overall improvement.

For 2018/19, the Trust has decided to set a target of 16.9% by the end of 2018/19 – this is a 1.5% reduction on the Quarter 4 2017/18 data.

**Initiatives to be implemented during 2018/19**

- A new Lead Nurse for Falls, to continue to identify and implement improvement plans with the aim of achieving further reductions in falls with harm during 2018/19
- Continue to work with Divisions on their plans for 2018/19. Key focus will be on post fall care/ management, and driving compliance in the completion of lying and standing blood pressure measurement
- Continue to raise the profile of the Trust Falls Prevention Team, for example by ensuring active engagement in Back to the Floor (BTTF) visits, attendance at Divisional Preventing Harm meetings, supporting clinical staff in implementing falls prevention strategies, audit of falls assessment compliance and interventions, problem solving, and RCA completion and action planning
- Continue providing Falls training to all Divisions on their mandatory training days, FY1 (junior doctor) training induction days, new starters on the HPIP course and bespoke training for teams in critical care
- Collaborate with HGS colleagues to explore the potential for providing a joint falls study day and joint falls prevention initiatives
- Work with the patient experience team to explore how to capture and use patient stories in education, training and reports
- Work in collaboration with the Health and Safety team and HGS to update the Trust's falls procedures
- Work with a nominated Consultant in Geriatric Medicine to implement actions following the Royal College of Physicians' National Audit of Inpatient Falls in May 2017
- Re-evaluate the Trust compliance with NICE guidelines CG161 and Falls Quality Standards 2017, and implement any actions identified
- Assist with the development and implementation of a combined UHB/HEFT falls Datix and RCA tool, and explore how to further improve SI learning and sharing across teams

**How progress will be monitored, measured and reported**

- Data on falls is presented to the monthly Trust Preventing Harm group, which reports to the Chief Nurse's Care Quality Group. Data on falls is also provided to the Medical Director's monthly Clinical Quality Monitoring Group
- Ward-level and trust-level data on falls is available to clinical staff via the Clinical Dashboard
- Falls with specific outcomes, e.g., a fractured neck of femur (broken hip), are reported to the local Clinical Commissioning Group
- Progress will be publicly reported in the quarterly Quality Report updates published on the Trust's quality web pages

## Priority 6 – Timely treatment for sepsis

This quality improvement priority was proposed by the Clinical Quality Monitoring Group, agreed by the Council of Governors and approved by the Board of Directors.

**Background**
Sepsis is a potentially life-threatening condition which is the result of a bacterial infection in the blood. It affects an estimated 260,000 people per year in the UK and is a significant cause of preventable mortality. Approximately 44,000 people die each year as a result of sepsis; a quarter of which are avoidable.

Although there are certain groups in whom sepsis is more common, the very young and very old, people with multiple co-morbidities, people with impaired immunity and pregnant women, it can occur in anybody, regardless of their age or health status.

Though sepsis is common, it is poorly addressed. It is important to understand that if sepsis is recognised early and appropriately managed it is treatable. However, if recognition is delayed and appropriate treatment not instituted (usually oxygen, intravenous fluids and antibiotics), significant harm or even death can occur.

Sepsis has been on the national agenda as a high priority area for the Commissioning for Quality and Innovation (CQUIN) system. In 2016/17 certain trusts had a key target to implement systematic screening for sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. This CQUIN has been extended in the 2017–19 plan, which UHB is participating in.

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

The Trust's aim for 2017/18 was to improve the early recognition and management of patients with sepsis.

**Performance**
Indicator 2a: Quarterly audit of 300 patients (150 emergency admissions and 150 inpatients) that meet the criteria for screening for sepsis (e.g., for inpatients this is a SEWS trigger of 4 and above). Target: over 90% of patients to have evidence of screening for sepsis using the Trust screening tool.

Indicator 2b: Quarterly audit of patients identified as having sepsis from part 2a above. Time between diagnosis of sepsis and antibiotics administered is then assessed. Target: over 90% to be given with 60mins.

| | Indicator 2a Timely identification of sepsis in emergency departments and acute inpatient settings | Indicator 2b Timely treatment of sepsis in emergency departments and acute inpatient settings |
|---|---|---|
| **Quarter 1** | 59% | 74% |
| **Quarter 2** | 82% | 76% |
| **Quarter 3** | 98.5% | 82% |
| **Quarter 4** | 100% | 69% |

For 2018/19, the Trust will continue to aim to meet the targets set out in the serious infection CQUIN, which have been agreed with the CCG.

**Initiatives implemented during 2017/18**
- A sepsis screening tool has been implemented in PICS for inpatients. A new paper-based screening tool is due to be rolled out in ED. Both of these are to help staff quickly identify patients who at risk, or who have developed sepsis, and also provide clear instruction on how to treat them and what further tests are required
- A Sepsis sub-group meeting has been set up, chaired by the Head of Education
- Nurses and doctors are undergoing "Peer 1 sepsis training". Further work undertaken to develop more detailed Sepsis training (Tier 2) for staff to be rolled out to staff in 2018
- The antimicrobial guidelines were reviewed and updated. Launched April 2018
- 'THINK SEPSIS' is an ongoing national campaign aiming to raise awareness of sepsis. In April 2017, UHB held a Sepsis Awareness week, to raise awareness of the THINK SEPSIS campaign and to provide information and advice of how to recognise the symptoms, how to screen and how to treat red flag sepsis. On the first day there was a stall with information and a presentation from Dr Ron Daniels BEM, Chief Executive of the UK Sepsis Trust and Global Sepsis Alliance, and also Clinical Advisor (Sepsis) to NHS England. On the following days a multi-disciplinary Sepsis Team visited wards across the hospital site
- Sepsis audit results feedback to an away day for Clinical Service Leads in March 2018

**Initiatives to be implemented during 2018/19**
- Roll out of updated Sepsis training (Tier 2) to nursing staff and doctors
- 10 day rolling audit in Emergency department (ED) by consultant to identify and feedback to staff patients that did not receive antibiotics within 60 minutes
- PICS implementation of Sepsis screening question in June 2018. This will allow staff to record patients with Sepsis to help prioritise treatment promptly

**How progress will be monitored, measured and reported**
- Performance against the CQUINs is reported to the Antimicrobial stewardship and sepsis group (ASSG), Chief Operating Officer Group, CQUIN tracker meeting and the Clinical Commissioning Group
- Progress will be publicly reported in the quarterly Quality Account updates published on the Trust's quality web pages
- Performance will be reported to the Clinical Quality Monitoring Group as part of the quarterly Quality Account update reports

## 2.2 Statements of assurance from the Board of Directors

### 2.2.1 Service income

During 2017/18 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 2017/18 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2017/18.

* 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 2017/18, 41 national clinical audits and 6 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 95% (39 of 41) national clinical audits and 83% (5 of 6) 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 2017/18 are as follows: (see tables below).

The national clinical audits and national confidential enquiries that UHB participated in during 2017/18 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 2017/18, 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 2017/18 | Percentage of required number of cases submitted |
|---|---|---|
| Adult Cardiac Surgery | Yes | 100% |
| BAETS - Endocrine and Thyroid National Audit | Yes | 100% |
| Cardiac Rhythm Management | Yes | <80% |
| Congenital Heart Disease | Yes | 99.7% |
| Critical Care Case Mix Programme (ICNARC) | Yes | 100% |
| Cystectomy Audit | Yes | 100% |
| Falls and Fragility Fractures Audit Programme | Yes | 100% |
| Fractured Neck of Femur | Yes | 100% |
| Head and Neck Cancer Audit | Yes | 100% |
| Inflammatory Bowel Disease programme | Yes | 100% |
| Learning Disability Mortality Review Programme (LeDeR Programme) | Yes | 100% |
| Myocardial Ischaemia National Audit Project (MINAP) | Yes | 100% |
| National Bowel Cancer Audit | Yes | 36% |
| National Cardiac Arrest Audit (NCAA) | No | 0% |
| National Audit of Percutaneous Coronary Interventions | Yes | 100% |
| National Audit of Breast Cancer in Older Patients (NABCOP) | Yes | 100% |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit programme | Yes | 100% |
| National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery | Yes | 100% |
| National Diabetes Audit | No | 0% |
| National Emergency Laparotomy Audit | Yes | 100% |
| National Heart Failure Audit | Yes | 74% |
| National Hip Fracture Audit | Yes | 91.0% |
| National Inpatient Audit (Diabetes) | Yes | 100% |
| National Joint Registry (NJR) | Yes | 100% |
| National Lung Cancer Audit | Yes | 100% |
| National Neurosurgery Audit Programme | Yes | 100% |
| National Ophthalmology Audit | Yes | 100% |
| National Prostate Cancer Audit | Yes | 100% |
| National Vascular Registry | Yes | 87% |
| Nephrectomy audit | Yes | 100% |
| Oesophago - Gastric Cancer Audit | Yes | 72% |
| Parkinson's Audit | Yes | 100% |
| Percutaneous Nephrolithotomy (PCNL) | Yes | 100% |
| Procedural Sedation in Adults | Yes | 100% |
| Radical Prostatectomy Audit | Yes | 100% |
| Renal Replacement Therapy (Renal Registry) | Yes | 100% |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Yes | 100% |
| Sentinel Stroke National Audit programme | Yes | 100% |
| Stress Urinary Incontinence Audit | Yes | 100% |
| TARN - Major Trauma Audit | Yes | 100% |
| Use of Blood Audit Programme | Yes | 100% |

### National Confidential Enquiries (NCEPOD)

| National Confidential Enquiries (NCEPOD) | UHB participation 2017/18 | Percentage of required number of cases submitted |
|---|---|---|
| Chronic Neurodisability | Yes | 100% |
| Young People's Mental Health | No | Insufficient cases and available information to participate. |
| Cancer In Children, Teens and Young Adults | Yes | 100% |
| Acute Heart Failure | Yes | 100% |
| Perioperative Diabetes | Yes | On-going Study – 75% completed |
| Pulmonary Embolism | Yes | On-going Study – commenced March 2018. Datasheet submitted ready for patient selection. |

Percentages given are the latest available figures.

The reports of 16 national clinical audits were reviewed by the provider in 2017/18 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 159 local clinical audits were reviewed by the provider in 2017/18 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 738 clinical audits were registered with UHB's clinical audit team during 2017/18. Of these audits, 159 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 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was:

| | |
|---|---|
| NIHR portfolio studies | 6,682 |
| Non-NIHR portfolio studies | 1,572 |
| **Total** | **8,254*** |

*Data available up to February 2018

The total figure is based on all research studies that were approved during 2017/18. (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 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Total number of projects registered with R&D | 361 | 266 | 270 |
| Out of the total number of projects registered, the number of studies which were abandoned | 70 | 115 | 72 |
| **Trust total patient recruitment** | **8,493** | **8,813*** | **8,254**** |

* This figure has been updated since the 2016/17 Quality Account, as the full year's data is now available.
** Data available up to February 2018

The table below shows the number of projects registered in 2017/18, by specialty:

| Specialty | No. of projects registered |
|---|---|
| Non-specific | 31 |
| A&E | 1 |
| Anaesthetics | 3 |
| Audiology | 2 |
| Breast Services | 1 |
| Burns & Plastics | 7 |
| Cardiology | 8 |
| Clinical Haematology | 5 |
| Clinical Immunology | 1 |
| Clinical Psychology | 1 |
| Critical Care | 4 |
| Dermatology | 5 |
| Diabetes | 2 |
| Elderly Care | 2 |
| Endocrinology | 23 |
| ENT | 4 |
| General Medicine | 1 |
| General Surgery | 4 |
| Genito-Urinary Medicine | 4 |
| GI Medicine | 18 |
| GI Surgery | 2 |
| Haematology | 6 |
| HIV | 1 |
| Imaging | 6 |
| ITU | 2 |
| Liver Medicine | 13 |
| Liver Surgery | 1 |
| Lung Investigation Unit | 2 |
| Microbiology | 3 |
| Neurology | 16 |
| Neuroradiology | 4 |
| Neurosurgery | 5 |
| Oncology | 43 |
| Ophthalmology | 2 |
| Palliative Care | 1 |
| Physiotherapy | 1 |
| R&D | 1 |
| Renal Medicine | 11 |
| Respiratory Medicine | 8 |
| Rheumatology | 3 |
| Stroke Services | 2 |
| Trauma | 8 |
| Urology | 2 |
| **TOTAL** | **270** |

**Examples of research at UHB having an impact on patient care**

Three research studies were recently featured in the BBC2 Surgeons documentary filmed at UHB last summer:

**The Cochlear Implant Study:** six patients at UHB have taken part in a trial testing if a middle ear microphone will be of benefit and improve hearing in comparison to the normal cochlear implant microphone. Mr Richard Irving (Consultant ENT Surgeon) was the surgical lead who secured £1million of NIHR research funding which has allowed six patients to undergo experimental surgery to implant the in-ear microphone for six months. The episode focused on one patient, a 63 year old caretaker who, when the middle ear microphone was turned on, said his hearing had "more clarity than I've had in 20 years." The surgery works by connecting the microphone to the middle ear, allowing for better hearing, with an invisible hearing aid (as it is in an individual's head). The trial is nearly complete with data and results currently being collected.

**Liver Transplant Reperfusion Study:** Richard Laing (Liver Research Fellow) is the lead on a liver trial using the ORGANOX machine, which could help make "unsuitable" livers suitable for transplant. Currently, 400 livers are considered unsuitable for transplantation each year, and therefore disregarded. Being able to use these additional livers would be a great help, considering liver disease death has soared by 40% in the last decade. The ORGANOX machine restores the liver to the best possible state through perfusion, supplying it with blood, nutrients and oxygen. In the programme, Richard Laing and transplant surgeon Mr Thamara Perera were filmed in the operating theatre undertaking a liver transplant for a patient who had had problems with her liver for many years. Even with ORGANOX, transplantation must be complete within 13 minutes of the liver coming out of the machine. The study is now complete and the team are delighted with the results so far.

**Gene therapy for Prostate Cancer:** Mr Prashant Patel, Consultant Urological Surgeon, is the lead on a prostate cancer gene therapy trial (run jointly by UHB and University of Birmingham – Birmingham Health Partners). The trial injects patients with a genetically modified virus to target and kill their cancer cells, whilst having less unpleasant side effects compared to chemotherapy/radiotherapy. The episode focused on the twelfth patient on this trial, a 79 year old gentleman, who had had a recurrence of prostate cancer. The two-stage trial sees a "common cold" modified virus injected into the prostate cancer cell areas – this sample is localised, and changes the biochemistry of the cancer cells. 48 hours later, a second injection kills off the changed cancer cells. The trial is still ongoing, but early results are promising.

Also featured in the surgeons documentary was Lt Col Steven Jeffery (Consultant Plastic Surgeon) who used a revolutionary device that detects bacteria quickly (in real time). Faster, more accurate diagnosis helps lead to quicker treatment for infected burns wounds. This work forms part of the research programme for both military and civilian trauma patients treated at UHB testing novel

treatments and devices to further improve survival and rehabilitation post trauma injury.

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

A proportion of UHB income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between UHB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at http://www.uhb.nhs.uk/quality-reports.htm

The amount of UHB income in 2017/18 which was conditional upon achieving quality improvement and innovation goals was £12.7m*. Final payment for 2017/18 will not be known until June 2018.

* This represents the amount of income achievable based on the contract plans for NHS England and West Midlands CCGs. It isn't a precise figure for the following reasons;

- CQUIN would also be payable on any over-performance against these contracts
- CQUIN is also payable on out of area contracts
- A provision has been made in the accounts for non-delivery of some CQUINS
- CQUIN adjustments will also be applied for any adjustments made to the final outturn positions agreed with commissioners for 2017/18.

A proportion of UHB income in 2016/17 was conditional on achieving quality improvement and innovation goals. The Trust received £11.5m in payment for 2016/17.

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

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

The Care Quality Commission has not taken enforcement action against UHB during 2017/18.

UHB has not participated in any special reviews or investigations by the CQC during 2017/18.

During 2017/18, the Secretary of State for Health commissioned the CQC to carry out a whole system review of older people's services in England, by looking at twelve local health and social care systems. Birmingham was one of the areas chosen; the review (Birmingham Local System Review) took place in January 2018, it was led by the council and UHB contributed along with partners including the CCG. The review's focus was on how well people move through the health and social care system, including where there are delayed transfers of care, and what improvements could be made. The CQC's recommendations will be built into "Ageing Well" – one of the Priority Work Programmes in the Sustainable and Transformation Partnership (STP).

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

| Date | Type of inspection | Outcome | Actions taken |
|---|---|---|---|
| 31/05/2017 | The CCG carried out an unannounced visit to ED that focused on Patient Experience and Safeguarding. The outcome was positive with no immediate risks identified. | Four minor issues were raised:<br>1. Is the use of trolleys to manage capacity in ED on the local risk register and how is it mitigated?<br>2. How is safeguarding flagged in ED and information shared when patients are transferred?<br>3. Children in play area are not visible to staff.<br>4. Toilet doors could be utilised to display important local telephone numbers. | All four issues raised have been addressed and assurance has been provided to the CCG. |
| 16/06/2017 | An unannounced inspection was carried out the CCG, they assessed the following areas:<br>1. Staffing levels and associated safety issues<br>2. Infection Prevention Standards<br>3. Hand hygiene compliance<br>4. Saving Lives audit compliance<br>5. Cleanliness | There were nine minor issues addressed in the report received from the CCG. Two regarding decontamination, three regarding Infection Prevention and Control, one for Hand Hygiene, two for cleanliness and one for management of sharps. | All issues raised by the CCG have now been addressed and assurance has been provided to the CCG. |

**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 |

### 2.2.6 Information on the quality of data

UHB submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was*:
  - 99.16% for admitted patient care;
  - 99.57% for outpatient care; and
  - 96.78% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was*:
  - 99.81% for admitted patient care;
  - 99.72% for outpatient care; and
  - 98.90% for accident and emergency care.

*Figures cover the latest available period: 1st April 2017 to 28th February 2018.

UHB Information Governance Assessment Report overall score for 2017/18 was 71% and was graded green (satisfactory).

UHB was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

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

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

- Continue to drive forward the UHB Coding Training programme to further improve training
- Continue to provide training for clinical coding across the West Midlands for Trusts that do not have their own trainers.
- Continue to monitor data quality through the Ward Clerk quality monitoring and management programme.
- Ensure continued compliance with the Information Governance Toolkit minimum Level 2 for data quality standards.
- Review the Data Quality Policy and develop associated procedures.
- Continue to support improvement of the data quality programme for the operational teams by providing data in relation to 18 week referral to treatment time (RTT).

### 2.2.7 Learning from deaths

During 2017/18, there has been a national drive to improve the processes trusts have in place for identifying, investigating and learning from inpatient deaths. Since January 2014, UHB has taken part in an 'early adopter' project involving the introduction of the Medical Examiner role at the Trust. UHB currently has a team of Medical Examiners who are Consultant-level staff and are required to review the vast majority of inpatient deaths. The role includes reviewing medical records and liaising with bereaved relatives to assess whether the care provided was appropriate and whether the death was potentially avoidable.

The Trust implemented the *Reviewing Inpatient Deaths Policy* and associated procedure in October 2017. All deaths must be given a stage one review by a Medical Examiner except for those meeting defined exception criteria such as forensic deaths where the medical records will not be available to Trust staff.

Any death where a concern has been raised by the Medical Examiner will be escalated to the specialty mortality and morbidity meeting for in-depth specialist review (stage two). The outcomes of stage two reviews are reported to the Trust's Clinical Quality Monitoring Group where a decision will be made on whether further review or investigation is required.

Data on learning from deaths is shown in the table below for Quarters 3 and 4 2017/18. Data is not included for previous quarters or financial years as trusts were only required to collate this information from September 2017 onwards.

| | |
|---|---|
| 1. | During Quarters 3 and 4 2017/18 1073 of UHB's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:<br>› 519 in the third quarter;<br>› 554 in the fourth quarter. |
| 2. | By 31/03/2018, 952 case record reviews and 12 investigations have been carried out in relation to 954 of the deaths included in item 1. In 4 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:<br>› 455 in the third quarter;<br>› 509 in the fourth quarter. |
| 3. | One, representing 0.09%, of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:<br>› 1 representing 0.19% for the third quarter;<br>› 0 representing 0% for the fourth quarter.<br><br>These numbers have been estimated using the processes outlined in the Trust's *Reviewing Inpatient Deaths Policy* and related procedure. Thorough independent investigations of all deaths considered to be potentially avoidable after case record review have been undertaken using recognised root cause analysis techniques. |
| 4. | As part of every investigation, a detailed report that includes all learning points and an in-depth action plan is produced. Each investigation can produce a number of recommendations and changes, and each individual action is specifically designed on a case by case basis to ensure that the required changes occur. The implementation of these actions and recommendations is robustly monitored to ensure ongoing compliance. Similarly, the outcomes of every case record review are monitored with ongoing themes and trends reported and escalated as required to ensure all required changes are made.<br><br>The following specific actions are being implemented following the death identified in 3. above:<br>› To hold mandatory refresher educational sessions on imaging of acute bleeding for all Consultant and Registrar Radiologists.<br>› To reinforce requirement to discuss imaging concerns at Consultant-to-Consultant level where differences of opinion arise.<br>› To remind Radiologists to compare scans to previous imaging.<br>› To ensure there is a robust Cardiology imaging archive. The Royal College of Radiologists recommends that all imaging is archived for retrospective review.<br>› Staff must take a 'stop moment' when applying the resuscitation system to ensure optimum positioning.<br>› All relevant staff to receive refresher training on the resuscitation system settings and potential complications of using the device.<br>› Cardiology and Cardiothoracic Mortality and Morbidity Meeting to discuss the risks associated with carrying out ablation procedures.<br>› All pericardial drain placements to be carried out under ultrasound guidance which will require appropriate training. |
| 5. | As described above, each investigation involves the creation of a detailed, thorough action plan which will involve numerous actions per investigation. These actions are specifically tailored to individual cases and monitored on an ongoing basis to ensure the required changes have been made. |
| 6 | All actions are monitored to ensure they have had the desired impact. If this has not happened, actions will be reviewed and altered as necessary to ensure that sustainable and appropriate change has been implemented. |

## 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 (now NHS Improvement) for inclusion in trusts' Quality Reports from 2012/13. The data source for all the indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC). 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 NHS Digital website: http://content.digital.nhs.uk/

# 3 Other information

## 3.1 Overview of quality of care provided during 2017/18

The tables below show the Trust's latest performance for 2017/18 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 2016/17 Quality Report to enable patients and the public to understand performance over time.

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

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

## Patient safety indicators

| Indicator | Data source | 2015/16 | 2016/17 | 2017/18 | Peer Group Average (where available) |
|---|---|---|---|---|---|
| **1(a) Patients with MRSA infection/100,000 bed days**<br>› (includes all bed days from all specialties)<br>› *Lower rate indicates better performance* | › Trust MRSA data reported to PHE<br>› HES data (bed days) | **2.06** | **1.01** | **0.00**<br>April–Dec 2017 | **0.38**<br>April–Dec 2017<br>Acute trusts in West Midlands |
| **1(b) Patients with MRSA infection/100,000 bed days**<br>› (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics)<br>› *Lower rate indicates better performance* | › Trust MRSA data reported to PHE<br>› HES data (bed days) | **2.07** | **1.01** | **0.00**<br>April–Dec 2017 | **0.42**<br>April–Dec 2017<br>Acute trusts in West Midlands |
| **2(a) Patients with *C. difficile* infection/100,000 bed days**<br>› (includes all bed days from all specialties)<br>› *Lower rate indicates better performance* | › Trust CDI data reported to PHE<br>› HES data (bed days) | **16.76** | **21.73** | **18.41**<br>April–Dec 2017 | **13.40**<br>April–Dec 2017<br>Acute trusts in West Midlands |
| **2(b) Patients with *C. difficile* infection/100,000 bed days**<br>› (aged >15, excluding Obstetrics, Gynaecology and elective Orthopaedics)<br>› *Lower rate indicates better performance* | › Trust CDI data reported to PHE<br>› HES data (bed days) | **16.84** | **21.85** | **18.50**<br>April–Dec 2017 | **14.84**<br>April–Dec 2017<br>Acute trusts in West Midlands |
| **3(a) Patient safety incidents**<br>› (reporting rate per 1000 bed days)<br>› *Higher rate indicates better reporting* | › Datix (incident data)<br>› Trust admissions data | **63.3** | **63.6** | **65.4** | **62.3**<br>April–Dec 2017<br>Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook) |
| **3(b) Never Events**<br>› The number of Never Events that occurred during the time period<br>› *Lower number indicates better performance* | › Datix (incident data) | **5** | **1** | **6** | *Not available* |
| **4(a) Percentage of patient safety incidents which are no harm incidents**<br>› *Higher % indicates better performance* | › Datix (incident data) | **82.0%** | **83.1%** | **85.1** | **90.3%**<br>April – Sep 2017<br>Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook) |

| Indicator | Data source | 2015/16 | 2016/17 | 2017/18 | Peer Group Average (where available) |
|---|---|---|---|---|---|
| **4(b) Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death**<br>› *Lower % indicates better performance* | › Datix (patient safety incidents reported to the NRLS) | **0.14%** | **0.12%** | **0.22%** | **0.26%**<br>April – Sep 2017<br>Acute (non specialist) hospitals<br>NRLS website (Organisational Patient Safety Incidents Workbook) |
| **4(c) Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)** | › Datix (patient safety incidents reported to the NRLS) | **20,516** | **22,532** | **24,568** | **11,792**<br>(6 months)<br>April – Sep 2017<br>Acute (non specialist) hospitals<br>NRLS website (Organisational Patient Safety Incidents Workbook) |

## Clinical effectiveness indicators

| Indicator | Data source | 2015/16 | 2016/17 | 2017/18 | Peer Group Average (where available) |
|---|---|---|---|---|---|
| **5(a) Emergency readmissions within 28 days (%)**<br>› (Medical and surgical specialties – elective and emergency admissions aged >15) %<br>› *Lower rate indicates better performance* | › HED data | **13.86%**<br>**England: 13.50%** | **14.14%**<br>**England: 13.57%** | **13.53%**<br>Apr–Nov 2017<br>**England: 13.52%** | **13.58%**<br>April–Nov 2017<br>University hospitals |
| **5(b) Emergency readmissions within 28 days (%)**<br>› (all specialties)<br>› *Lower % indicates better performance* | › HED data | **13.84%**<br>**England: 11.24%** | **14.10%**<br>**England: 11.38%** | **13.50%**<br>Apr–Nov 2017<br>**England: 11.35%** | **11.42%**<br>Apr–Dec 2017<br>University hospitals |
| **5(c) Emergency readmissions within 28 days of discharge (%)**<br>› *Lower % indicates better performance* | › Lorenzo / Oceano | **10.68%** | **10.80%** | **10.71%** | *Not available* |
| **6 Falls (incidents reported as % of patient episodes)**<br>› *Lower % indicates better performance* | › Datix (incident data),<br>› Trust admissions data | **2.1%** | **2.2%** | **2.2%**<br>Apr 2017 - Feb 2018 | *Not available* |
| **7 Stroke in-hospital mortality**<br>› *Lower % indicates better performance* | › SSNAP data | **5.0%** | **1.8%** | **5.7%** | *Not available* |
| **8 Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG)**<br>› *Higher % indicates better performance* | › Trust PICS data | **97.5%** | **97.4%** | **94.8%** | *Not available* |

### Notes on patient safety & clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that 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.

- **1a, 1b, 2a, 2b**
  - These indicators uses HES data for the bed days, as this allows trusts to benchmark against each other. UHB also has an internal measure of bed days which uses a different methodology, and this number may be used in other, similar, indicators in other reports.
  - Receipt of HES data from the national team always happens two to three months later, these indicators will be updated in the next quarterly report.

- **3a**
  - The NHS England definition of a bed day ("KH03") differs from UHB's usual definition. For further information, please see this link:
  - http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/.
  - NHS England have also reduced the number of peer group clusters (trust classifications), meaning UHB is now classed as an 'acute (non specialist)' trust and is in a larger group. Prior to this, UHB was classed as an 'acute teaching' trust which was a smaller group.

- **3b**
  - UHB had six Never Events during 2017/18, (five wrong site surgery and one retained swab). All have been investigated, and the patients have received the correct procedures where appropriate. Two misplacements of an NG tube had previously been reported and managed as Never Events, however these two have since been downgraded following further investigation.

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

- **5a, 5b**
  - Data for these indicators has been taken from UHB's own data tool (HED), as the HES data has not been made available. Data for previous years has also been updated to allow for comparison in this report, so will not match data in the previous Quality Reports. This change also means that indicator 5a looks at readmissions for patients >17, instead of the previous >15.

- **5c**
  - 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, replaced by Oceano during 2017/18). 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.

- **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.

### Patient experience indicators

The National Inpatient Survey is run by the Picker Institute on behalf of the CQC; the UHB results of selected questions are shown below. The 2017 survey report has not been published at the time of writing, so the text and table below refer to the latest available results, which are from the 2016 survey. Information on the 2017 results will be added to the published Quality Account once it is available. Alternative patient experience data and indicators are also available in Priority 2: Improving patient experience above, these are taken from the Trust's local patient surveys.

The results of the 2016 National Inpatient Survey for UHB were based on answers from 436 respondents, which is a response rate of 36% (compared to a national response rate of 44%). The findings report that the Trust was 'better' than other Trusts in two questions in the 2016 report (six in 2015, four in 2014): being given written or printed information about what to do/not do after leaving hospital, and being informed of any danger signals to watch for after going home. The remaining questions scored 'about the same' as other trusts, and none scored 'worse' than other Trusts.

| | 2014/15 | | 2015/16 | | 2016/17 | |
|---|---|---|---|---|---|---|
| Patient survey question | Score | Comparison with other NHS trusts in England | Score | Comparison with other NHS trusts in England | Score | Comparison with other NHS trusts in England |
| Overall were you treated with respect and dignity? | **9.2** | About the same | **9.2** | About the same | **9.2** | About the same |
| Involvement in decisions about care and treatment | **7.7** | About the same | **7.5** | About the same | **7.4** | About the same |
| Did staff do all they could to control pain? | **8.1** | About the same | **8.2** | About the same | **8.3** | About the same |
| Cleanliness of room or ward | **9.2** | About the same | **9.2** | About the same | **9.2** | About the same |
| Overall rating of care | **8.3** | About the same | **8.4** | About the same | **8.3** | About the same |
| Time period & data source | 2014, Trust's Survey of Adult Inpatients 2014 Report, CQC | | 2015, Trust's Survey of Adult Inpatients 2015 Report, CQC | | 2016, Trust's Survey of Adult Inpatients 2016 Report, CQC | |

Note: Data is presented 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 NHS Improvement *Single Oversight Framework*

| Indicator | Target | Performance | | |
|---|---|---|---|---|
| | | 2015/16 | 2016/17 | 2017/18 |
| A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge[1] | 95% | 91.9% | 81.8% | 82.9% |
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway[1,2] | 92% | 95.0% | 92.5% | 92.3% |
| All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer | 85% | 72.2% | 75.4% | 70.4% |
| All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral | 90% | 92.8% | 96.2% | 92.6% |
| *C. difficile* – meeting the *C. difficile* objective | ≤ 63 cases judged to be lapses in care | 24 judged lapses in care (66 total) | 31 judged lapses (92 total) | 8 judged lapses[3] (76 total) |
| Maximum 6-week wait for diagnostic procedures | 99% | 98.4% | 99.6% | 99.6% |
| Venous thromboembolism (VTE) risk assessment | 95% | 99.4% | 99.5% | 99.4% |

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

**Notes**:
**1**: Indicators audited by the Trust's external auditor Deloitte as part of the external assurance arrangements for the 2017/18 Quality Report.

**2**: Data assurances and actions for improvement
The assurance work undertaken by Deloitte LLP in respect of the Quality Report 2017/18 led to a modified opinion with respect to the accuracy of the reported 18 week Referral to Treatment incomplete pathway indicator.
The Trust has put in place an action plan in order to address the concerns identified. This plan includes a review of the procedures required to achieve good data quality at the point of entry. In addition, the plan outlines initiatives to enhance skills and training of the clinical and administrative teams who are involved with RTT pathway management. By getting this right first time, we will reduce the potential for errors and the need for any corrections down-stream. A detailed action plan, alongside progress reports, will be reported through the Trust's Audit Committee. The accountable lead for the delivery of this action plan will be the Chief Operating Officer. The majority of the data quality issues identified (relating to 25 out of 28 data errors observed) have no risk of impact on patients' clinical care and are administrative only. The only area where there is a small potential for an effect on the patient's clinical management has already been subject to additional reporting and monitoring but, as a result of this year's audit, this will be developed further and enhanced

accordingly. To date there is no indication that patient care has been affected by the recording or reporting of data for the measurement of access times in the RTT performance measure. The primary mechanism for the management of patient pathways remains outwith the RTT monitoring and reporting processes, and therefore remains unaffected by data quality issues.
**3**: Another 7 still to be determined

## 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, now NHS Digital) first published data for the Summary Hospital-level Mortality Indicator (SHMI) in October 2011. This is the national hospital mortality indicator which replaced previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The 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 96 for the period April – November 2017 this implies the mortality numbers are lower than expected but remain within tolerance control limits. The latest SHMI value for the Trust, which is available on the NHS Digital (formerly HSCIC) website, is 99 for the period April – September 2017. This is within tolerance.

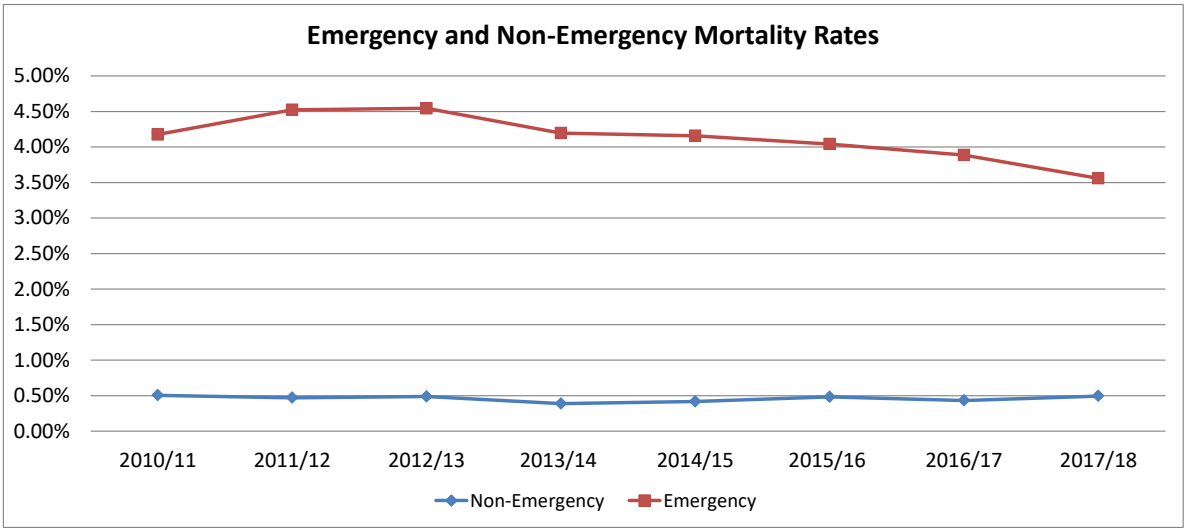
The Trust has concerns about the validity of the Hospital Standardised Mortality Ratio (HSMR) which was superseded by the SHMI but it is included here for completeness. UHB's HSMR value is 106 for the period April – December 2017 as calculated by the Trust's Health Informatics team. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited[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. 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 2017/18 is 2.85%, which is a small decrease compared to 2016/17 (2.96%) and 2015/16 (3.04%).

**Emergency and Non-emergency Mortality Graph**

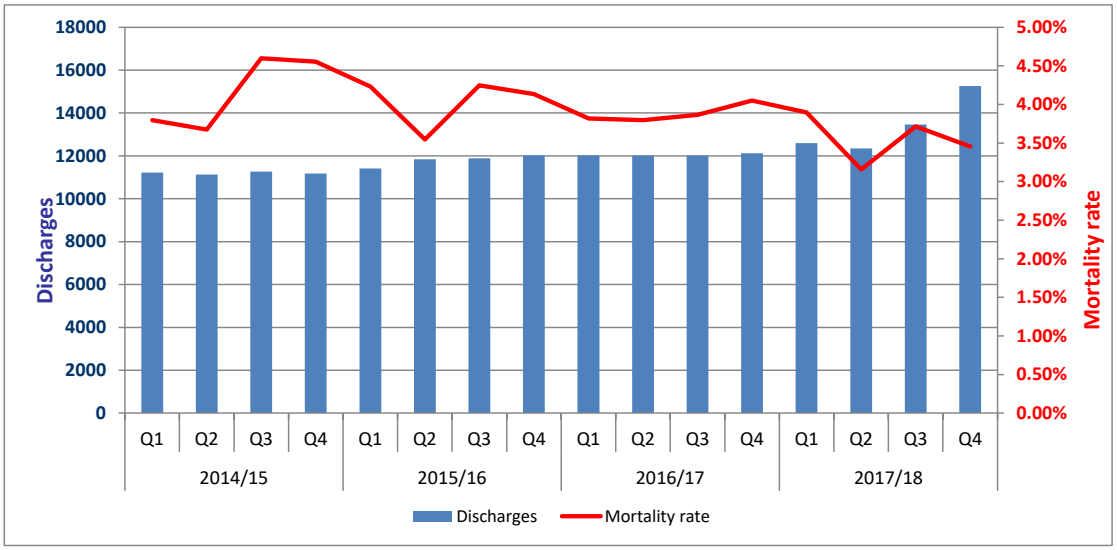



1 Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.

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.

**Overall Crude Mortality Graph**




## 3.4 Safeguarding

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.

University Hospitals Birmingham NHS Foundation Trust (UHB) has continued to ensure that the safeguarding of adults and children at risk remains a high priority within the Trust. The aim is to ensure that there is a robust safeguarding policy, with supporting procedural documents, which allows a consistent approach to the delivery of the Safeguarding Principles across the Trust. The policy provides a framework that can be followed, encourages the challenge of practise where appropriate, and is reinforced by training and support. It enables all clinical staff to recognise and report incidents where adults and children are at risk. It ensures that patients receive a positive experience, with support when necessary, in relation to safeguarding issues highlighted.

There is a robust collection of safeguarding activity in the Trust each month. This influences training, education, and patient resources.

Level 2 Adult and Children Safeguarding training is a combined session and has been mandatory for all patient-facing staff in 2017/18. A further two study days for Clinical Champions (one from each clinical area) have been held during this year to improve knowledge across the Trust.

Level 3 Adult and Children Safeguarding training is provided in key areas for staff identified as part of a training needs analysis. Compliance with training is 96%. Sessions on Child Sexual Exploitation, Domestic Abuse, Female Genital Mutilation, Sudden Death and Violence Reduction are provided and supplemented by e-learning sessions accessible via the intranet.

The safeguarding team provides supervision within the Emergency Department and Sexual Health services which is proving to be beneficial to clinical staff.

PREVENT training is delivered at Trust induction for new starters and in those areas identified in the training needs analysis; the Trust has achieved 90% compliance.

The Trust intranet pages for safeguarding are kept updated to reflect changes in legislation and updates to policy and procedures.

Mental Capacity Assessments are now documented on the Trust's Prescribing, Information and Communication System (PICS), ensuring that they are available to be viewed by all staff involved in that person's care.

The Making Safeguarding Personal (MSP) initiative is embedded across the Trust through Level 2 training and a flowchart to support staff is available on the Intranet and in each clinical area. To evaluate the effectiveness of the initiative, the safeguarding team has developed a questionnaire for adult patients who pass through the safeguarding process, to obtain their views on the process and the support that they have received from the safeguarding team. The aim is to ensure that the safeguarding process is personal for every patient. The results have been extremely positive, showing that patients feel that they are involved in the safeguarding process, receiving assurance that it is person-centred.

The use of 'the patient story' is embedded into the Trust Safeguarding Group to ensure that the divisional representatives are able to feedback to their clinical areas.

The Trust is committed to listening to the voice of the child and the safeguarding team visit all child admissions (16 and 17 year olds) to ensure they are being supported appropriately. The safeguarding team has produced a questionnaire on the patient experience whilst in hospital for 16-24 year olds. The results are evaluated and comments are taken into account when planning training and service changes.

The Trust approaches safeguarding using an integrated 'Right Help Right Time' model. At all times staff are encouraged to think about the impact their patients'

needs may have on children or vulnerable adults in their care and if an Early Help response may be helpful.

Further information can be found in the Trust's Annual Report for 2017/18: http://www.uhb.nhs.uk/reports.htm.

### 3.5 Staff Survey

The Trust's Staff Survey results for 2017 show that performance was above average or top 20% for 24 of the 32 key findings when compared to other acute trusts.

The results are based on responses from 3906 staff which represents an increase in response rate from 41% last year to 44% this year; this is average for acute trusts in England (also 44%).

The results for five key findings of the Staff Survey which most closely relate to quality of care are shown in the table below, along with two that have been included based on previous national guidance.

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)
- Staff recommending the Trust as a place to work or receive treatment (see Question 3 below)
- Percentage of staff reporting errors, near misses or incidents witness in the last month (see Question 4 below)
- Staff satisfaction with resourcing and support

To target lower performing areas identified by the survey, each Division has an action plan which looks at the key findings where they scored lowest. These also have actions based on staff groups, e.g., increase participation in the survey, or areas where a specific staff group have scored low. The action plans are monitored by the Chief Operating Officer.

Last year, the Trust focussed on addressing bullying and harassment, and staff health and wellbeing. An action arising from the divisional action plans was to ensure that staff were aware of the channels available for raising concerns about harassment, bullying or abuse, the support available, and increase awareness of the staff counselling service, staff support.

A trust-wide action was to focus on staff health and wellbeing; we already offer a number of initiatives but are aware that awareness of these is low. A marketing campaign was launched, using posters, leaflets and digital communication to raise awareness of the health and wellbeing initiatives available for staff such as staff physiotherapy, counselling, the staff well clinic, the Morris Centre, and psychological support such as Stress Management courses and mindfulness.

The Staff Survey results for 2017 have again highlighted these two areas, and actions arising from this year's survey will further address these areas. Ensuring staff feel safe and well at work is vital to support staff to deliver high quality care.

| Key Finding from Staff Survey | 2015/16 | 2016/17 | 2017/18 | Comparison with other acute NHS trusts 2017/18 |
|---|---|---|---|---|
| 1. Staff satisfaction with the quality of work and patient care they are able to deliver *(KF2)* | 4.16 | 4.08 | 4.02 | Highest (best) 20% |
| 2. Percentage of staff agreeing their role makes a difference to patients *(KF3)* | 93% | 92% | 90% | Above (better than) average |
| 3. Staff recommendation of the trust as a place to work or receive treatment *(KF1)* | 4.02 | 3.97 | 3.98 | Highest (best) 20% |
| 4. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(KF29)* | 92% | 91% | 91% | Above (better than) average |
| 5. Effective use of patient/service user feedback *(KF32)* | 3.78 | 3.76 | 3.72 | Average |
| 6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months *(KF26)* (Lower score is better) | 27% | 23% | 23% | Below (better than) average |
| 7. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion *(KF21)* | 88% | 86% | 85% | Average |
| *Data source* | Trust's 2015 Staff Survey Report, NHS England | Trust's 2016 Staff Survey Report, NHS England | Trust's 2017 Staff Survey Report, NHS England | |

**Notes on staff survey**

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

5: In the 2015 report, the 2015 score was reported as 3.77, but the latest report has it as 3.78 - this was due to a data cleaning exercise by the Picker Institute, which was done for all organisations.

## 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 2017/18 includes 65 indicators covering the majority of clinical specialties. 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

This analysis is based on data for April 2017 to March 2018 for most indicators. Some run one to two months in arrears and this is indicated where relevant.

The majority of the 65 indicators have a goal; 54% of those with a goal met it in 2017/18, compared to 62% in 2016/17 and 63% in 2015/16.

The Trust's clinical and management teams improved performance for 9% of the indicators during 2017/18. Performance for 77% stayed about the same (including eight indicators which were already scoring the maximum and continued to do so). Performance for 11% of the indicators deteriorated during 2017/18.

Two indicators have been decommissioned to avoid duplication, as the data is collected and monitored via other systems at the Trust.

Two further indicators do not yet have any data for 2017/18 so have not been included in the analysis (this data is sourced nationally).

Table 1 below shows performance for selected specialty indicators where the most notable improvements have been made during 2017/18.

Table 2 below shows performance for selected indicators where performance has deteriorated during 2017/18.

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 15 – Mar 16 | Percentage Apr 16 – Mar 17 | Numerator Apr 17 – Mar 18 | Denominator Apr 17– Mar 18 | Percentage Apr 17 – Mar 18 | Data Sources |
|---|---|---|---|---|---|---|---|---|
| Dementia | Percentage of patients with Dementia who died and had at least 3 out of the following 4 medications prescribed to be taken as required during their stay in hospital: analgesics, sedation to reduce agitation, anti-emetics (anti-sickness) and anti-secretory medication | > 90% | 69.6% | 66.5% | 240 | 304 | 78.9% | Lorenzo / Oceano, PICS |
| Gastro-enterology | Patients with inflammatory bowel disease admitted under the care of Gastroenterology Consultants who receive low molecular weight (LMW) heparin medication | > 90% | 95.0% | 94.4% | 57 | 57 | 100% | Lorenzo / Oceano, PICS |
| Imaging | GP direct access patients who have report turnaround time of less than or equal to 7 days for plain imaging | > 99% | 84.4% | 59.7% | 21412 | 29202 | 73.3% | CRIS |

Table 2

| Specialty | Indicator | Goal | Percentage Apr 15 – Mar 16 | Percentage Apr 16 – Mar 17 | Numerator Apr 17 – Mar 18 | Denominator Apr 17 – Mar 18 | Percentage Apr 17 – Mar 18 | Data Sources |
|---|---|---|---|---|---|---|---|---|
| Dermatology | Suspected cancer cases seen within 2 weeks by a Consultant | > 93% | 98.9% | 96.4% | 2442 | 2671 | 91.4% | Lorenzo / Oceano, Somerset |
| Maxillofacial Surgery | Percentage of emergency admissions with fractured mandible (lower jaw) who are operated on the same or next day | >90% | 76.1% | 77.4% | 515 | 749 | 68.8% | Lorenzo / Oceano |
| Ear, Nose & Throat (ENT) Surgery | All patients undergoing cochlear implantation should have a post operative skull x-ray or CT Scan | 100% | 100% | 96.0% | 68 | 86 | 79.1% | Lorenzo / Oceano, PICS |

## 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 adversely affected by an incident, staff have a duty to inform the patient, relatives and / or carers as appropriate. This may fall under the Being Open process or Duty of Candour (DoC), depending upon the level of harm or potential for harm to the patient, and must include details of what happened and what is being done in response. Provision of reasonable support and an apology when things go wrong must also be addressed. This ensures that not only does the Trust meet its Duty of Candour statutory requirements, but that staff are open and transparent, honouring the Trust vision and values of providing the best in care and honesty to patients and service users.

When Duty of Candour is identified as being applicable, the risk team works with staff to support the process and provide expert advice as required. Conversations are recorded on a standard form which includes specific details of who is to be contacted for future feedback and who will undertake this feedback. These forms are logged against the trust-wide Duty of Candour tracker, which is monitored by the Clinical Risk and 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 and information reconciled. The risk team work closely with the investigations team and complaints department to ensure that details are co-ordinated, providing patient focused feedback that is appropriate and timely, as well as meeting statutory deadlines.

The risk team support staff in understanding the process and how to complete Duty of Candour, as well as ensuring regulatory compliance. The risk team have embedded Duty of Candour into the investigation procedure to ensure timely recognition and facilitation of the Duty of Candour process.

A revised Duty of Candour pro-forma has been designed to improve quality of information and understanding of the process.

An education scheme is being planned to ensure all staff receive appropriate training before this is launched, and will be supported by ongoing education and training.

The Duty of Candour / Being Open Policy is currently being reviewed in conjunction with colleagues at HGS to ensure a clear and aligned process.

## 3.9 Statement on the implementation of the priority clinical standards for seven day hospital services

The Academy of Medical Royal Colleges have agreed a number of principles which are set out in three patient-centred standards to deliver consistent inpatient care irrespective of the day of the week. Sir Bruce Keogh, NHS England's National Medical Director, set out a plan to drive seven day services across the NHS, starting with urgent care services and supporting diagnostics.

Ten clinical standards have been identified, of which four are priority standards:

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

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

**Provision for consultant review**
Consultant job planning in the trust makes provision for a consultant-led ward round on every ward every day through formal provision which includes on-call OOHs.

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

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

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

## 3.10 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. |
| ADN | Associate Directors of Nursing – now known as Divisional Heads of Nursing |
| ADT | Admissions, discharges and transfers |
| Alert organism | Any organism which the Trust is required to report to Public Health England |
| AMU | Acute Medical Unit |
| Analgesia | A medication for pain relief |
| Bed days | Unit used to calculate the availability and use of beds over time |
| Benchmark | A method for comparing (e.g.) different hospitals |
| Beta blockers | A class of drug used to treat patients who have had a heart attack, also used to reduce the chance of heart attack during a cardiac procedure |
| BHH | Birmingham Heartlands Hospital |
| Birmingham Health & Social Care Overview Scrutiny Committee (OSC) | 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 |
| BTTF | Back to the Floor; Senior members of staff taking on junior, patient facing roles for a shift or period of time |
| CABG | Coronary Artery Bypass Graft |
| CCG | Clinical Commissioning Group |
| CDI | *Clostridium difficile* infection |
| Chief Executive's Advisory Group | An internal group, chaired by the Chief Executive |
| Chief Operating Officer's Group | An internal group for senior management staff |
| Clinical Audit | A process for assessing the quality of care against agreed standards |
| Clinical Coding | A system for collecting information on patients' diagnoses and procedures |
| Clinical Dashboard | An internal website used by staff to measure various aspects of clinical quality |
| CMP | Case Mix Programme |
| Commissioners | See CCG |
| Congenital | Condition present at birth |
| COPD | Chronic Obstructive Pulmonary Disease |
| CQC | Care Quality Commission |
| CQG | Care Quality Group; a group chaired by the Chief Nurse, which assesses the quality of care, mainly nursing |
| CQMG | Clinical Quality Monitoring Group; a group chaired by the Executive Medical Director, which reviews the quality of care, mainly medical |
| CQUIN | Commissioning for Quality and Innovation payment framework |
| CRAB | Copeland's Risk Adjusted Barometer; demonstrates quality of medical and ward based care |
| CRIS | Radiology database |
| CRM | Cardiac Rhythm Management |
| Datix | Database used to record incident reporting data |
| Day case | Admission to hospital for a planned procedure where the patient does not stay overnight |
| DDI | Decision to Deliver Interval |
| Deloitte | The Trust's external auditors |

| Term | Definition |
|---|---|
| Division | Specialties are grouped into Divisions |
| DQ | Data Quality |
| DOLs | Deprivation of Liberty Safeguards; Provide protection for vulnerable people who lack capacity to consent to care |
| DTI | Deep Tissue Injuries |
| Duty of Candour | Requirement for Trusts to be open and transparent with services users about care and treatment, including failures |
| Echo / echocardiogram | Ultrasound imaging of the heart |
| ED | Emergency Department (also known as A&E) |
| Elective | A planned admission, usually for a procedure or drug treatment |
| EP | Electronic Prescribing system |
| Episode | The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell |
| Equipment Selection flowchart | Promotes effective utilisation of equipment |
| Equipment Standardisation Group | An Internal group dealing with trialling new and innovative equipment |
| FCE | Finished/Full Consultant Episode – the time spent by a patient under the continuous care of a consultant |
| FFFAP | Falls and Fragility Fractures Audit Programme |
| FFT | The Friends and Family Test; a questionnaire to determine how likely a patient is to recommend the services used |
| Foundation Trust | Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities. |
| FY1 | Junior Doctor |
| GI | Gastro-intestinal |
| GP | General Practitioner |
| HANA | Head and Neck Cancer Audit |
| Healthwatch | An independent group who represent the interests of patients |
| HEFT | Heart of England NHS Foundation Trust |
| HEFT infection control group | Formally known as Infection prevention committee |
| HES | Hospital Episode Statistics |
| HPIP | Healthcare Practitioner Induction Programme |
| HSCIC | Health and Social Care Information Centre – now known as NHS Digital |
| HSMR | National Hospital Mortality Indicator |
| ICNARC | Intensive Care National Audit & Research Centre |
| Infection Prevention Committee | An internal committee focusing on the reduction of infection within the hospital, now known as HEFT infection control group |
| Informatics | Team of information analysts |
| IT | Information Technology |
| ITU | Intensive Treatment Unit (also known as Intensive Care Unit, or Critical Care Unit) |
| IV | Intravenous |
| LeDeR | Learning Disability Mortality Review Programme |
| LfE | Learning From Excellence; a system to identify, capture and celebrate excellent performance |
| Lorenzo | Patient administration system, replaced by Oceano during 2017/18 |
| LMW | Low Molecular Weight |
| MEWS | Modified Early Warning System |
| MINAP | Myocardial Ischaemia National Audit Project |

| Term | Definition |
|---|---|
| Monitor | Independent regulator of NHS Foundation Trusts – now replaced by NHS Improvement |
| 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* |
| MSP | Making Safeguarding Personal; Initiative to ensure the safeguarding process is personal for every patient |
| Myocardial Infarction | Heart attack |
| mystay@QEHB | An online system that allows patients to view information / indicators on particular specialties |
| NABCOP | National Audit of Breast Cancer in older Patients |
| NBSR | National Bariatric Surgery Registry |
| NBOCAP | National Bowel Cancer Audit Project |
| 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 |
| NELA | National Emergency Laparotomy Audit |
| Never Events | Has the potential to cause serious harm/death |
| NCEPOD | National Confidential Enquiries |
| 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 |
| NHS Digital | Formerly HSCIC - Health and Social Care Information Centre. A library of NHS data |
| NHS Improvement | The national body that provides the reporting requirements and guidance for the Quality Accounts |
| NICE | The National Institute for Health and Care Excellence |
| NIHR | National Institute for Health Research |
| NJR | National Joint Registry |
| NLCA | National Lung Cancer Audit |
| NNAP | National Neonatal Audit Programme |
| NPDA | National Paediatric Diabetes Audit |
| NRLS | National Reporting and Learning System |
| Observations | Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature |
| Oceano | Patient administration system, replaced Lorenzo during 2017/18 |
| Octenisan | Antimicrobial hair and body wash |
| OOH | Out Of Hours |
| OT | Occupational Therapy |
| PALS | Patient Advice and Liaison Service |
| Patient Experience Group | Internal committee to evaluate and improve patient experience |
| 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. |
| PCI | Percutaneous Coronary Interventions |
| PCP | Patient Community Panels |
| PD | Parkinson's Disease |
| Peri-operative | Period of time prior to, during, and immediately after surgery |
| PHE | Public Health England |
| PHSO | Parliamentary and Health Service Ombudsman |
| PICS | Prescribing Information and Communication System |
| PIR | Post Infection Review |
| PLACE | Patient Led Assessments of the Care Environment |

| Term | Definition |
|---|---|
| Plain imaging | X-ray |
| PPCI | Primary Percutaneous Coronary Intervention; a surgical treatment for myocardial Infarction (heart attack) |
| PPE | Personal Protective Equipment |
| Preventing Harms Meeting | Internal group to review incidents reported through Datix |
| PRN | Pro Re Nata; The administration of prescribed medication where timing is not fixed or scheduled |
| 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 | Route Cause Analysis |
| Readmissions | Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days |
| RTT | Referral to Treatment |
| Safeguarding | The process of protecting vulnerable adults or children from abuse, harm or neglect, preventing impairment of their health and development |
| Sepsis | A potentially life-threatening condition resulting from a bacterial infection of the blood |
| SEWS | Standardised Early Warning System |
| SHMI | Summary Hospital-level Mortality Indicator |
| SHOT | Serious Hazards of Transfusion |
| SMPG | Safer Medicines Practice Group |
| SSI | Surgical Site Infections |
| SSNAP | The Sentinel Stroke National Audit Programme |
| Trajectory | In infection control, the maximum number of cases expected in a given time period |
| Divisional triumvirates | A group within a Division consisting of the most senior managers (Divisional Director, Director of Operations, Head of Nursing) |
| 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. |
| UHB | University Hospitals Birmingham NHS Foundation Trust |
| UTI | Urinary Tract Infection |
| VTE | Venous thromboembolism – a blood clot |
| WHO | World Health Organisation |
| YPC | Young Person's Council |

# 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 (now NHS Improvement) is shown in the tables below. There are eight indicators which are applicable to acute trusts. The data source for all the indicators is NHS Digital (formerly the Health and Social Care Information Centre, or HSCIC) and the indicators below have been updated to the most recent data available. Data for the latest two time periods is therefore included for each indicator and is displayed in the same format as NHS Digital. National comparative data is included where available. Further information about these indicators can be found on the NHS Digital website: http://content.digital.nhs.uk/qualityaccounts

1. **Mortality**

| | Previous Period (Apr 2016 - Mar 2017) | Current period (Jul 2016 - Jun 2017) | | | |
|---|---|---|---|---|---|
| | UHB | UHB | National Performance | | |
| | | | Overall | Best | Worst |
| (a) Summary Hospital-level Mortality Indicator (SHMI) value | 1.04 | **1.05** | 100 | 0.72 | 1.16 |
| (a) SHMI banding | 2 | **2** | - | 3 | 1 |
| (b) Percentage of patient deaths with palliative care coded at diagnosis or specialty level | - | **30.35** | 30.49 | 11.09 | 56.88 |

**Comment**
The Trust considers that this data is as described for the following reasons as this is the latest available on the NHS Digital (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.

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

| | Previous Period (Apr 2015 - Mar 2016) | Current period (Apr 2016- Mar 2017) | | | |
|---|---|---|---|---|---|
| | UHB | UHB | National Performance | | |
| | | | Overall | Best | Worst |
| (i) Groin hernia surgery | 0.081 | **0.098** | 0.086 | 0.135 | 0.006 |
| (ii) Varicose vein surgery | Insufficient patient numbers | | | | |
| (iii) Hip replacement surgery | Not applicable to UHB | | | | |
| (iv) Knee replacement surgery | Not applicable to UHB | | | | |

**Comment**
The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (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.

3. **Readmissions to hospital within 28 days**

| | Previous Period (Apr 2010–Mar 2011)* | Current period (Apr 2011–Mar 2012)* | | | |
|---|---|---|---|---|---|
| | | | 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 |
| (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 NHS Digital/HSCIC website.

**Comment**
The Trust considers that this data (standardised percentages) is as described for the following reasons as this is the latest available on the NHS Digital (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.

4. **Responsiveness to the personal needs of patients**

| | Previous Period (2015/16) | Current period (2016/17) | | | |
|---|---|---|---|---|---|
| | | | 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) | 71.7 | **72.5** | 68.1 | 85.2 | 60 |

**Comment**
The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.
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 2018/19 (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 (2016) | Current period (2017) | |
|---|---|---|---|
| | UHB | UHB | National Performance |
| | | | Average (median) for acute trusts |
| Staff who would recommend the trust as a provider of care to their family and friends. Performance shown is based on staff who agreed or strongly agreed. | 81% | **81%** | 71% |

**Comment**
The Trust considers that this data (scores) is as described for the following reasons as it is the latest available on the NHS Digital (HSCIC) website.
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. For more information on response to staff feedback, see the Staff Survey section in Part 3.

6. **Venous thromboembolism (VTE) risk assessment**

| | Previous Period (Q2 2017/18) | Current period (Q3 2017/18) | | | |
|---|---|---|---|---|---|
| | UHB | UHB | National Performance | | |
| | | | Overall | Best | Worst |
| Percentage of admitted patients risk-assessed for VTE | 99.36% | **99.37%** | 95.35% | 100% | 76.08% |

**Comment**
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 using the PICS electronic system.

7. ***C. difficile* infection**

| | Previous Period (2015/16) | Current period (2016/17) | | | |
|---|---|---|---|---|---|
| | UHB | UHB | National Performance | | |
| | | | Overall (England) | Best | Worst |
| *C. difficile* infection rate per 100,000 bed-days (patients aged 2 or over) | 17.39 | **24.44** | 13.19 | 0 | 82.71 |

**Comment**
The Trust considers that this data is as described for the following reasons as it is the latest available on the NHS Digital (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 in Priority 5: *Infection prevention and control* in in the previous Quality Report (2016/17).

8. **Patient Safety Incidents**

| | Previous Period (Oct 2016 - Mar 2017) | Current period (Apr 2017 – Sept 2017) | | | |
|---|---|---|---|---|---|
| | UHB | UHB | National Performance (Acute Teaching Providers) | | |
| | | | Overall | Best | Worst |
| Incident reporting rate per 1,000 bed days | 59.06 | **62.25** | - | 23.47 | 112 |
| Number of patient safety incidents that resulted in severe harm or death | 15 | **21** | - | 0 | 121 |
| Rate of patient safety incidents that resulted in severe harm or death rate per 1,000 bed days* | - | **-** | - | - | - |

*at the time of writing, the Trust was not able to find the bed days data to make this calculation

**Comment**

The Trust considers that this data is as described for the following reasons as the data is the latest available on the NHS Digital (HSCIC) website.

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 by actively encouraging staff to report both clinical and non-clinical incidents. Although this table refers to 'best' and 'worst', a high incident reporting rate can be reflective of a good, open reporting culture. 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.

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

The Trust has shared its 2017/18 Quality Report with Birmingham and Solihull Clinical Commissioning Group, Healthwatch Birmingham and Birmingham Health & Social Care Overview and Scrutiny Committee.

These organisations have provided the statements below.

### Statement provided by Birmingham CrossCity Clinical Commissioning Group

1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as coordinating commissioner for University Hospitals Birmingham NHS Foundation Trust (UHB) welcomes the opportunity to provide this statement for inclusion in the Trust's 2017/18 Quality Account.

1.2 A draft copy of the quality account was received by the CCG on the 27th April 2018 and this statement has been developed from the information presented to date.

1.3 In the version of the quality account we viewed, some full year data was not yet available, and so we have not been able to validate those areas; we assume, however, that the Trust will be populating these gaps in the final published edition of this document.

1.4 In compiling this quality account the Trust has provided the reader with a well laid out and clear picture regarding performance against 2017/2018 priorities, which describes initiatives implemented, identifying any changes to the priority and further actions to be undertaken going forward.

1.5 The Trust has made a decision to continue with the six priorities for improvement previously identified in 2017/2018. All targets for these priorities have been reviewed and the CCG supports the Trust's review of progress and setting of either revised or continuation of targets.

1.6 The Trust is to be congratulated on the improvement in Priority 2: Improve the patient experience and satisfaction, especially on the reduction in the number of complaints overall during 2017/2018, and in the reduction of those upheld or partially upheld by the Ombudsman. It is acknowledged that this improvement has been made at a time when patient activity across inpatients, outpatients and the emergency department has increased.

1.7 The CCG found it pleasing to note that the Trust have embedded patient experience throughout the quality account with evidence of learning and outcomes shown.

1.8 The CCG supports the introduction of the new questions to the patient surveys, particularly the questions relating to patients receiving attention within a reasonable time, and the ambitious target set for pain control within the emergency department.

1.9 It has been noted that the Trust did not meet the target it set for Priority 4, reducing missed doses, as these have not been achieved the targets will remain the same for 2018/2019.

1.10 The quality account outlines the national clinical audits undertaken within the Trust, there were some audits where the required number of cases submitted would have been useful.

1.11 It was noted that section 2.2.7 Learning from deaths was missing from the draft quality account. The CCG acknowledges that the Trust has a process in place for learning from deaths and that this will be included in the final version of the report.

1.12 The CCG felt the quality account gave little information about the challenges regarding managing patients with cancer, given the Trust's ongoing capacity challenges it would be helpful to add in the robust and regular oversight by the clinical leads to ensure that patients are managed in the best way possible.

1.13 The CCG would have liked the quality account to include more information regarding the improvements made from serious incidents for example the work around diabetes, and provision of safer care for patients which has been rolled out across the Trust.

1.14 Commissioners have noted the increase in reporting of patient safety incidents for 2017/18 and the associated increase in no harm, however it would be helpful to understand the small rise in severe harm in more detail and the actions that the Trust are taking.

1.15 The number of never events has increased from one in 2016/17 to six in 2017/18; it would have been appropriate to include some more narrative to explain what learning was gained from reviewing the events and how this has been embedded across the Trust.

1.16 More of an explanation is required with regards to Stroke in-hospital mortality, as it is not clear how this compares across current peer groups and similar hospitals.

1.17 As Commissioners we have worked closely with UHB over the course of 2017/2018, meeting with the Trust regularly to review the organisations' progress in implementing its quality improvement initiatives. We are committed to engaging with the Trust in an inclusive and innovative manner and are pleased with the level of engagement from the Trust. We hope to continue to build on these relationships as we move forward into 2018/2019.

**Paul Jennings**
**Chief Executive Officer**

### Statement from Healthwatch Birmingham

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for University Hospital Birmingham NHS Foundation Trust. We are pleased to see that the Trust has taken on board some of our comments regarding the previous Quality Account. For example, the Trust has:

- Provided details of how it makes the complaints process accessible to all
- Given some examples of learning from complaints and other priority areas such as missed doses etc.
- Ensured that patients are able to give reasons for their choice of the score in the Friends and Family Test, thus collecting qualitative data to complement the quantitative data.

**Patient and Public Involvement**

It is positive to see that the Trust continues to use varied methods to measure patient feedback in order to improve services. This includes local and national patient surveys, the NHS Friends and Family Test, complaints and compliments. In addition, the use of online sources, including not only NHS choices but feedback received by Patient Opinion and local Healthwatch. We note that the Trust has made improvements in four of the six priorities it set out in the 2016/17 Quality Account, for 2017/18. In particular, that the Trust made improvement in priority two – improve patient experience and satisfaction.

We welcome the questions that will be carried over and the new questions that have been added to the local patient survey for 2018/19. Based on the feedback we receive about the Trust we believe that the questions added to the local survey are important. We hear both positive and negative feedback about discharge assessment and involvement of patients, inconsistent messages from staff, accessing emergency services, pain control and outpatient appointments. Healthwatch Birmingham also continues to hear feedback about poor communication; patients are not kept informed at all stages during their visit. In one case, a patient was waiting for a scheduled operation for twenty hours and was not updated about what was happening. In another, a patient with hearing problems was given no information following a major operation, even when he requested an interpreter.

In our response to the 2016/17 Quality Accounts, we asked the Trust to demonstrate how patient feedback and experiences are used to understand barriers different groups face and how feedback is used to make changes or improvements to services. We are pleased to read about the initiatives that the Trust has implemented over the year.

Firstly, the implementation of more flexible visiting times, which has resulted in patients being more supported by family members, and visitors able to fit visits within time schedules. We note that a 'visitor charter' has been developed, which sets out what visitors can expect from staff and the process for sharing important information with visitors.

Secondly, the continued development of the patient experience collection, analysis and reporting system in conjunction with the University of Birmingham PROMs group. We note that software packages have been installed, research questions are being written and the first set of data has been analysed. We would like to read in the 2018/19 Quality Account how this initiative has enabled the Trust to focus on areas of patient's concern. Also, we would like to read more, in the 2018/19 Quality Account, about the themes drawn from the data that the Trust has analysed and solutions developed.

Thirdly, we welcome plans to evaluate the pilot of an accessible feedback card and plans to put methods in place to ensure that opportunities to provide feedback are easy and accessible to all. Ensuring that health and social care organisations are addressing health inequality is a key priority for Healthwatch Birmingham. We are pleased to see that this is part of a wider project to ensure that the Trust is listening to and obtaining feedback from a range of hard to reach groups. We note the work performed to ensure that feedback cards are accessible, such as shortening surveys to make them easier to read and using larger font paper surveys for visually impaired patients. We look forward to reading in the 2018/19 Quality Account how the new survey design system has enabled the Trust to meet patient's differing needs.

We would also like to read more about the impact of feedback, and how the Trust communicates with patients about how they are using their feedback to make changes. At Healthwatch Birmingham, we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback. We note the patient feedback pages on the Trust's website and we believe this is a good way, among others, of sharing with patients, the feedback you are collecting. The Trust should consider including on individual feedback page (i.e. pain management feedback page) the actions taken and the changes or improvements to service or practice made as a result. We believe this will encourage patients to provide feedback as they will know that their views matter and lead to actual improvement to services.

Regarding the Friends and Family Test (FFT) scores, in our response to the 2016/17 Quality Account we expressed concern that the positive response rate for A & E was inconsistent and below the national average, whilst that for inpatients and outpatients was above the regional and national levels. Based on the data provided in the 2017/18 Quality Account, we note that the situation remains the same. Thus, patients are continuing to have different experiences depending on how they have accessed the service. We note that waiting times are often cited by patients as the reason for giving a low score for A & E services. We welcome the Trust's plans to introduce an information screen in A & E to include pathways that will explain waiting times. We look forward to reading about the impact of this in the 2018/19 Quality Accounts.

It is positive to see that the number of compliments the Trust receives is more than the number of complaints. We note the examples of compliments provided in the Quality Account. The Trust should consider demonstrating how it uses compliments to share good practice across the Trust.

A new requirement for the 2017/2018 Quality Account was to provide information on how the Trust learns from deaths. We notice that this information is not yet available in the draft, but that the Trust will include this in the final Quality Accounts. We ask that the Trust follows the NHS National Guidance on Learning from Deaths regarding family and friends. The guidance states: "*Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken*"

Involving families and carers in case reviews and investigations offers a more rounded view and understanding of patient experience. We would like to read in the 2018/19 Quality Accounts, how families and patients have been involved in various stages of case reviews and investigations. In addition, how the Trust weights families and patient's views, compared with how they weight the views of clinical staff.

**Learning from complaints and patient safety incidents**

In our response to the Trust's 2016/17 Quality Accounts, we expressed concern that whilst the number of complaints about inpatients was reducing, complaints about outpatients and A & E was increasing. We welcomed the Trust's planned actions to learn from complaints. We are pleased to see that there has been a reduction in the number of complaints about inpatients, outpatients and the emergency department. In addition, the overall number of complaints has decreased by 15% from 779 (2016/17) to 660 (2017/18). However, the top three issues patients complain about remain clinical treatment (188), communication (103) and attitude of the staff (93).

We welcome that the Trust is demonstrating that it is learning from complaints and taking action in response to complaints. In particular, review of the repeat scan process and the introduction of emails to booking office when follow-up scans have been booked, and funding additional neuro-rehabilitation consultant sessions to improve access. We acknowledge the many ways the Trust ensures that the complaints process is accessible to all including the provision of alternative formats for complaints materials (large font or braille) and the provision of an easy read complaints leaflet. We believe that the Trust should consider collecting feedback from complainants about the complaints process in order to make changes that meet identified needs. A recent investigation by Healthwatch Birmingham into 'patient involvement and the complaints system' looked at the barriers to and benefits of using complainant's feedback to improve the quality of complaints systems.

Regarding patient safety incidents, the 2017/18 Quality Accounts has stated that the Trust has had six never events[4]. In addition, the percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) has increased from 0.12% in 2016/17 to 0.22% in 2017/18. We acknowledge that the Trust has investigated all never events, and the patients have received the correct procedures. We also welcome plans to improve learning and feedback provided to staff from complaints and incident reporting. We would like to read more about the impact of this in the 2018/19 Quality Accounts. The Trust should also consider reporting on how it involves patients, carers and families in the review or investigation process.

## The Trust's Priorities for 2018/19

**Observations and Pain Assessment**

In our response to the 2016/17 Quality Accounts, we expressed concern that the Trust had not met its target to increase the percentage of patients receiving pain medication (analgesia) within 30 minutes of a high pain score. We noted that this meant that those receiving pain medication within 30 minutes are accessing a better quality of care and consequently better health outcomes than those that are not. We welcomed the Trust's plans to increase the target for observations and pain assessment to 95% and 85% respectively.

We note that the Trust did not meet the target set for Indicator One[5] and Indicator Two[6]. However, performance for Indicator One has progressively increased since 2015 whereas, for Indicator Two, this has been variable. We welcome that these remain priorities for 2018/19 and look forward to reading the impact the various actions being implemented have had on performance.

**Reducing Missed Doses**

We note that the target for rates of missed doses for antibiotics and non-antibiotics has not been met. Missed doses for both antibiotics and non-antibiotics have steadily increased and stand at 4.5% for antibiotics (against a target of 4%) and 11.3% for non-antibiotics (against a target of 10% or lower). We welcome that this continues to be a priority for 2018/19. We recognise the actions that the Trust has outlined to address these issues. We particularly welcome the Trusts plans to consider new reports to identify types and patterns of missed doses across the Trust. This will help the Trust to come up with actions specific to identified problems.

**Timely Treatment of Sepsis**

We are concerned that the 2017/18 Quality Account shows that the timely identification of sepsis in emergency departments and acute inpatient settings was 59%; well below the target of 90% for Quarter 1. Although this has picked up to 98.5% for Quarter 3 (Indicator 2a). Equally, the timely treatment of sepsis in emergency departments and acute inpatient settings has been variable and below the target set. We welcome the Trust's identification of the potentially

[4] Never events - five wrong site surgery/procedure, one retained swab.
[5] Full set of observations plus pain assessment recorded within 6 hours of admission or transfer to a ward)
[6] Analgesia administered within 30 minutes of a high pain score

fatal impact on patients this might have and the plans put in place to address this. In particular, training on sepsis, audits and PICS implementation of screening question in June 2018. We agree that properly recording patients with sepsis will enable staff to prioritise patients appropriately. We would like to read more on the impact of these actions in the 2018/19 Quality Account.

**Patient Experience**
Healthwatch Birmingham has taken note of the Trust's priorities for 2018/19 relating to patient and public engagement. We would like to read more about the following initiatives to be implemented in 2018/19:

- Increased identification and support for carers
- Develop feedback methods to give a voice to hard to reach groups
- Continued staff engagement in relation to patient experience
- Introduce Android tablets to wards for patients to feedback more easily
- Information screen in A & e to include pathways that will explain waiting times.

We believe that continued focus on the involvement and engagement of families and carers when undertaking various activities, such as risk assessments and care planning, is important. As are plans to engage with staff on patient experience. It is important that staff understand what their role is in relation to patient experience, insights and feedback, and how this informs decision-making within their service area.

Healthwatch Birmingham has been working in partnership with the Trust through our 'Patient and Public Involvement Quality Standard'. Through this project, Healthwatch Birmingham is supporting providers in Birmingham to meet their statutory role of consulting and engaging with patients and the public. Consequently, we are helping Trusts ensure they are using public and patient feedback to inform changes to services, improve the quality of services and understand inequality in access to services and health outcomes. We have worked with the Trust to review their patient and public involvement processes (PPI), identify areas of good PPI practice and recommended how they can make PPI practice more effective. We look forward to continuing our working partnership with the Trust on PPI and building best practice.

To conclude, Healthwatch Birmingham would like to commend the Trust for taking action in response to our comments on the 2016/17 Quality Accounts. It is positive to see how the Trust uses feedback to develop actions and improve services. As well as using patient experience, feedback and insight to understand and address issues of health inequality. It is our wish to see further improvements in this area.

**Andy Cave**
**CEO**
Healthwatch Birmingham

## 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 2017/18 Quality Report.

# Annex 2: Statement of directors' responsibilities for the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 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 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to May 2018
  - feedback from the commissioners dated 16/05/2018
  - feedback from governors dated 27/03/2018
  - feedback from local Healthwatch organisations dated 16/05/2018
  - feedback from Overview and Scrutiny Committee dated 22/03/2018
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
  - the 2016 national patient survey June 2017; this is the latest available survey.
  - the 2017 national staff survey March 2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 17/05/2018
  - CQC inspection report dated 15/05/2015
- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

23 May 2018 ..... Date.....  .....Chair

23 May 2018 ..... 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 2018 (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 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and University Hospitals Birmingham NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Scope and subject matter**

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- number of patients on incomplete pathways who have been waiting no more than 18 weeks, as a percentage of the total number of patients on incomplete pathways; and
- percentage of patients with a total time in A&E of four hours or less 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 NHS Improvement.

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' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:
    - Board Minutes for the period April 2017 to April 2018;
    - Papers relating to the quality report reported to the board over the period April 2017 to March 2018;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2018;
    - The latest National Patient Survey results dated June 2017;
    - The latest National Staff Survey 2017 results dated March 2018;
    - The head of internal audit's annual opinion over the trust's control environment dated 17 May 2018;
    - The latest Care Quality Commission Inspection Report dated 15 May 2015;
    - Feedback from the commissioners dated May 2018;

- Feedback from governors dated 27 March 2018;
- Feedback from local Healthwatch organisations dated 16 May 2018; and
- Feedback from Overview and Scrutiny Committee dated 22 March 2018.

- 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 supporting guidance, 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' and supporting guidance.

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

**Basis for qualified conclusion**

***Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period***

The "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target.

Our procedures included testing a risk based sample of 60 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified the following errors:

- in 18.3% of items tested, one or both of the start and end date of treatment were not accurately recorded;
- in 5.0% of items tested, there was inappropriate reporting of breaches and non breaches; and
- in 23.3% of items tested, there was incorrect reporting of open pathways within the monthly submissions.

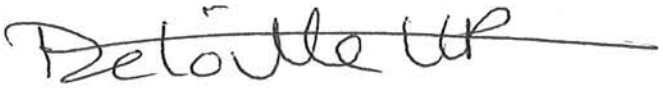
As a result of the issues identified, we have concluded that there are errors in the calculation of the "Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

The "Audited Indicators" section on page 48 of the Trust's Quality Report summarises the actions that the Trust is taking post year end to resolve the issues identified in its processes.

**Qualified conclusion**

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 'NHS Improvement Detailed requirements for external assurance for quality reports 2017/18' for foundation trusts; 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' and supporting guidance.



Deloitte LLP
Birmingham
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24 May 2018