Heart Of England NHS Foundation Trust

Quality Account 2014/15

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Introduction

All providers of NHS Services in England are required to produce an Annual Quality Account. The purpose of a Quality Account is to inform the public about the quality of services delivered by the Trust. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence based quality improvement and to explain progress to the public.

This account also forms part of the trust Annual Report which contains information which may be of interest including:

Workforce
Equality and diversity
Learning disability
Surgery reconfiguration
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Chief Executive's Statement

Welcome to Heart of England NHS Foundation Trust's Quality Account for 2014/15, the year in which we launched a public consultation on our plans to reconfigure surgical services for our 1.2m-strong community.

These plans are part of a wider strategy to create a fully integrated, modern healthcare organisation capable of delivering continuous improvements both to care outcomes and to patients' experiences of care - efficiently and sustainably.

2014/15 has been another challenging year for Heart of England, as it has for many other Trusts. We've struggled with a number of targets, notably with regard to patients with suspected cancer being first seen by a specialist within two weeks of an urgent referral, and also with the four-hour waiting time target in our Emergency Departments (EDs).

Since I've been in post I've seen how overcrowded our emergency departments can become, and it is clear to me that only building a new department at Heartlands Hospital will give us the long-term solution that our patients need. Nevertheless, there are things we can do differently to bring some improvements about sooner and I have started a programme of breakfast listening events to enlist frontline clinical teams in helping us to work on practical fixes. We have invested in much-needed new equipment and we are pushing ahead with plans to take pressure off the EDs by developing the urgent care facilities at Solihull, the AEC service at Heartlands, and the ambulatory care service at Good Hope which, I am pleased to report, has one of the best rates for treating patients without the need for admission to hospital in the country.

It has been disappointing that, between July 2014 and October 2014, we were unable to report on our performance with regard to all three standards for the referral to treatment (RTT) times due to migration to a new patient administration system (PAS). On return to reporting the admitted and non-admitted standards in November 2014, the Trust failed the admitted target. The non-admitted standard was achieved in quarter 1 but on return to reporting, and predominantly due to closure of legacy open clock pathways, the target was not achieved.

In 2014/15 our priorities were a continuation of those we had identified in 2013/14. We have gathered robust data throughout the year to monitor progress and measure improvements year on year.

Our headline priority was the fundamentals of care. Based on the National Care Campaign the work encompasses basics like pain management, communications, privacy and dignity, and nutrition. We have worked with external agencies to improve care fundamentals for several groups of patients with specific care needs – in particular, the end of life requirements of Muslim patients, and also strategies to prepare people with learning disabilities for their hospital admission and treatment.

We have also focused on evidence that we can gather closer to home, from patients and staff via friends and family test cards, analysing the data monthly and reporting it regularly to senior nurse managers and also to the CCG (Clinical Commissioning Group). Over the last year we have seen over and over again how important personal interactions can be in bringing about improvements to the fundamentals of care. Simple actions like dignity ward rounds and night ward rounds by senior nurses have resulted in easy but morale-boosting improvements such as the replacement of inferior razors with better ones so that patients no longer find themselves avoiding shaving.

Other important priorities include falls, pressure ulcers, strokes and fractured neck of femur. In this last area, it was clear from the 2013/14 Quality Account that we had a significant amount of work to do, and there has been much progress against some challenging targets:

In this we have been helped by the appointment of two additional trauma consultants, originally as interim support but now on permanent contracts. Additionally, we commissioned an external review of the fractured neck of femur treatment pathway and have implemented a range of recommendations including an expansion of the number of beds earmarked for these patients so that fewer will need to be admitted to non-trauma wards. In future, we'll see further improvements via a number of planned initiatives: perhaps the most significant benefits will be derived if the surgical reconfiguration plan proceeds as proposed. One aim of that proposal is to integrate trauma at a single site, which will increase both bed capacity and theatre availability.

In the past year we have, once again, been active in 400 or so ongoing research projects. Our research interests focus particularly on anaesthetics, critical care and resuscitation, diabetes, obstetrics and gynaecology, renal medicine and thoracic surgery. In addition, we have expanded this year into mental health research following the appointment of an academic research consultant specialising in dementia research, education and awareness. These research programmes reflect some of the specialties for which Heart of England is best known, and they are helping us to make sure we can remain at the forefront of developments in care in these areas.

I have only been at this Trust for a matter of months, but I would like to thank all the staff, volunteers and partners in the local health community for their hard work and commitment over the past year.

In making this statement I confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate.

Mr Andrew Foster
Chief Executive
26 May 2015

Part 2:

Looking back: Progress against 2014/15 priorities for quality improvement

The trust is required to set priorities for improvement for the Quality Account. These are issues which are considered to be important to patients, local communities and stakeholders.

We chose to continue focussing on all seven priorities from 2013/14 following consideration of performance in relation to patient safety, patient experience and effectiveness of care. This will ensure that quality will continue to be measured, maintained and developed in all of these areas. Each priority details how and where they are monitored.

Priority 1: Fundamentals of Care

What is the measure?

This priority looks at the fundamentals of care for patients to improve patient experience. It is based on the National Care Campaign and looks at communications; privacy and dignity; pain management; and nutrition.

How is this priority measured?

The patient metrics score card is now available on the back of the friends and family test card and captures the experiences of patients during their stay in hospital. This allows patients and carers to provide a first-hand account of their hospital experience.

The nursing metrics also audits nursing processes on ten patients on every ward each month. This is carried out objectively by peer review. The information gathered from the nursing metrics is presented at the Nursing Performance Committee on a monthly basis and is monitored via exception reports. This data also forms part of the nursing report which is presented and discussed at Trust Board.

What have we done to improve?

Communication

- We hosted a national 6Cs conference in October 2014 with over 250 attendees
- We continue to work closely with the National Council for Palliative Care and the Dying Matters Coalition on compassionate care and communication at end of life. At present, there is a focus on compassionate employers and how we can support staff when they face personal difficulties (e.g. bereavement)
- We have a 'carer's project' as part of a successful bid to Health Education West Midlands. This project looks at communication with patients and carers and the importance of listening to those who know the person best. The project hosts a carer's forum where carers discuss issues raised and provide advice and guidance for staff on patient and carer care
- The DVD entitled 'I didn't Know That' about end of life requirements from the Muslim perspective has been very well received by the local Muslim population and nationally via The National Council for Palliative Care
- We are also working in collaboration with Coventry & Warwickshire Partnership Trust to co-fund an acute liaison learning disability facilitator to support patients with learning disabilities

in preparation for their admission, during their hospital stay and planning for discharge. Pre admission visits to the ward/department are often arranged so that patients can meet the staff and familiarise themselves with the hospital environment.

Privacy and Dignity

- We monitor all ward areas for same sex breaches, where male and female patients are in the same bay overnight. Any breach is reported via Datix (the Trust incident reporting system) and a root cause analysis (RCA) is completed for each occurrence
- Dignity ward rounds continue to be undertaken by senior nursing staff. These rounds enable the senior nursing team to talk with patients and carers about their care and any issues they may have about privacy and dignity issues. For example following a recent round we have changed the supplier of razors as several gentlemen said that they would rather not shave as the razors available gave them cuts and grazes
- Patient safety walkabouts are undertaken by members of the executive team. They are undertaken to speak with front line staff and patients and hear their experiences and reflections about the care they provide, the area they work in and the organisation they work for. Any issues raised are highlighted to the managers and comments noted
- Night visits are also undertaken by the chief nurse, senior nursing and midwifery staff to ensure that care 24/7 is delivered to consistently high standards. These visits are also useful to gain an understanding of specific issues relating to care out of hours e.g. noise at night
- CCG and Community Health Care visits provide objective feedback on the quality of care provided including privacy and dignity issues

Pain Management

- A project is being undertaken by the pain team and anaesthetists to reduce post-operative breakthrough pain in elective orthopaedic surgery
- As part of the nursing metrics 10 patients per ward per month are audited for pain and appropriate pain control. Assurance that analgesia is prescribed as required is obtained through these checks
- The Anaesthetic Department also runs a trust wide pain clinic providing treatment plans and support for patients with acute and chronic pain
- A carer and users forum has been set up around medication to gain feedback from patients and carers re medication issues
- A trust wide review of the pain management care plan is currently being undertaken

Nutrition

- We are running a nutrition and hydration week in March 2015. The week will highlight key issues and considerations with nutrition and hydration e.g. encourage milky drinks between meals for patients with a poor appetite to increase protein and energy intake
- As part of the nutrition and hydration week 'Come dine with me' events are being held across the trust for staff to sample food from the new trust menu that was introduced in 2014
- We offer a wide range of special menus including vegetarian, Afro Caribbean, halal, kosher, puree etc
- The Eat, Drink Move project acknowledges the importance of keeping patients mobile to reduce the risk of pressure ulcers and hospital acquired pneumonias. Staff encourage and assist patients to walk to the toilet and also to the food trolley to choose meals
- We undertake an annual Essence of Care trust wide mealtime audit
- Plans are in progress to have a fruit and vegetable store outside the main entrance at Heartlands Hospital
- All patients on admission receive a nutritional screening and, if required, a full nutritional risk assessment is undertaken and management plan commenced

Future plans to improve compliance against the Trust targets

- On-going initiatives to embed the 6C's in the delivery of patient care. Compassion cards are going to be launched on International Nurses Day on the 12th May 2015. These can be presented to any member of staff who has gone above and beyond their normal role and will be an important part of a person's personal portfolio
- On-going monthly monitoring of pain management through nursing metrics and implementation of the findings of the review of the pain management care plan
- Sleep packs (including ear plugs and eye masks) will be piloted
- Schwartz rounds are meetings that enable healthcare professionals to share their experience for caring for patients, and to acknowledge and explore the pressures they face, in order to help them carry out their roles more effectively. The trust has just implemented these rounds and is part of the national review being undertaken by the Kings Fund.

Priority 2: Falls

What is the measure?

Reduction in the number of falls.

How is the priority measured?

All falls are reported via the DATIX and daily via the Daily Harm to alert staff a fall has been reported for their clinical area. The Daily Harm will indicate if any fall has been reported as injurious from the previous 24hr reporting period, this provides an alert to both the clinical team and the site team a patient has suffered harm as a result of a fall.

Weekly surveillance has also been introduced; this is a retrospective look at the previous week capturing all the reported falls, the report is sent out to the site head nurses and their deputies. The chief nurse or nominated deputy will hold a weekly conference call to discuss the harms identified for the respective sites.

All injurious falls require the completion of a RCA and these are presented at the site monthly forums, which are chaired by the site head nurse. All three hospital sites have an appointed falls lead and each site has a falls group to review learning from falls.

Falls rates are reported through the Trust Delivery Board, which provides assurance to the Executive Management Board regarding care delivery and harm associated with patient falls.

All injurious falls are reported externally to the CCG and copies of all completed RCA and the action plans are submitted.

We also complete the National Safety Thermometer (Department of Health Operating Framework for the NHS in England 2012-13). The audit is monthly point prevalence and captures any fall that has happened to inpatients in the preceding 72 hour period. The Trust has continued to show improvement, with March 2015 recording a 1.22% of falls happening within the preceding 72 hour reporting period.

Falls Nursing Care Indicator has shown an increase of 6% from quarter 3 to quarter 4 with a score of 92.3 %. Whilst this indicator has not achieved the standard of 95% the progress that has been made remains positive and reflects the changes within the falls bundle are being embedded into practice.

What have we done to improve?

We have contractual key performance indicators (KPI) set with our external stakeholders which is to measure the reduction in the number of falls and evidence from the nursing care indicator that we have compliance with the falls care bundle level 1. The year-end target was set at 95% compliance; the achieved rate was 97% by March 2015.

The agreed 20% reduction trajectory for all hospital falls was to achieve quarter 4 target of 6.4 per 1000 occupied bed days (OBD). The trust achieved 7.19 per 1000 OBD, which was outside of the trajectory however in comparison to 2013/14 this was an 18% reduction. The detail is shown in the chart below:

- The implementation of the new integrated Management and Prevention of Falls Policy was launched in May 2014 along with the new falls bundle to replace the stratify assessment. Improvement is now evident, partly due to the nursing risk assessment booklet being revised and the new falls bundle being included within the booklet
- The falls VITAL module remain available for both registered nurses and healthcare assistants with in excess of 1000 registered nurses having completed the module and approximately 300 healthcare assistants
- Successful appointment of an additional falls coordinator, with further recruitment planned
- Work is on-going for the falls web page development, with a target date for completion of July 2015
- The successful falls sharing event held during quarter 3 is being planned again with the intention to hold an additional two events in 2015/16
- We are committed to ensuring we have robust plans and lessons learnt when patients sustain an injurious fall and have set up a trust level scrutiny meeting with the medical director for patient safety, the deputy chief nurse and the lead nurse for falls

Future plans to improve compliance against trust targets include

We are committed to reducing the overall falls rate across the organisation and working with stakeholders to achieve the targets agreed. Future plans include:

- The falls sharing events will continue with a second planned for September 2015
- To support clinical staff with the RCA process, a new electronic RCA is being developed with a target completion date of July 2015
- With the new falls coordinators in post, the falls team intend to undertake work in the reduction of multiple fallers thus reducing the number of injurious falls as a consequence. Work will be ongoing throughout 2015/16

Priority 3: Pressure Ulcers

Pressure ulcers affect nearly 700,000 people a year, across all care settings, with approximately 186,617 patients developing a pressure ulcer in hospital each year and each pressure ulcer adds over £4,000 in additional costs to care. (NHS England Stop the Pressure Campaign).

Pressure ulcers can be extremely uncomfortable and in severe cases can result in irretrievable harm or even death. However, the vast majority of pressure ulcers are avoidable with the right procedures in place and when people are aware of what to do to prevent them. National Institute for Health and Care Excellence (NICE) Pressure Ulcer Prevention and Management of Pressure Ulcers (2014) provide key recommendations for preventing pressure ulcers. These include correct identification, robust risk assessment and appropriate preventative measure being implemented. We are committed to preventing harm to patients caused by pressure ulcers and therefore have implemented all of these recommendations.

What is the measure?

To achieve zero hospital acquired pressure ulcers.

How is the priority measured?

The "Daily Harm Alert" is now in place which informs clinical staff on a daily basis if a pressure ulcer has been reported for their clinical area.

Weekly surveillance has also been introduced; this is a retrospective look at the previous week capturing all the reported pressure ulcers. The report is sent out to the site head nurses and their deputies. The chief nurse, or nominated deputy, hold a weekly conference call to discuss the harms identified for the respective sites.

A monthly site pressure ulcer forum meet to determine the avoidability of each pressure ulcer following the completion of an RCA. These are chaired by the site head nurse. The sites are required to submit an exception report to the Nursing and Performance Committee for areas that are not achieving the required standard (95% required for tissue viability metric)

The tissue viability nursing care indicator has eight individual measures to achieve an overall score of 95% or above each month. Although the average score for quarter 4 was 91.3% and below the expected 95% it is over a 3% improvement from quarter 3. All individual indicators are required to achieve above 90% as per our KPI, only two of the eight indicators did not achieve this through the quarter but both made improvement with evidence of repositioning frequency being adhered to improving by 13%.

[2] Definition of Avoidable or Unavoidable pressure ulcers:

Unavoidable, the pressure ulcer has developed despite all preventative measures being in place. This can occur due to underlying /pre-existing health conditions or the patient simply chooses not to comply with care being provided or offered.

A pressure ulcer is deemed as avoidable if there has been an omission in the care provided or a failure to follow process has been the contributing factor in the pressure ulcer development.

In January 2015, a Tissue Viability Strategy Group was established which is chaired by the deputy chief nurse. The key objectives of this group are to set site trajectories for 2015/16.

The trajectories for 2015/16 are currently being developed and the proposal will be to have a 20% reduction on avoidable grade 2 pressure ulcers per site against the site's previous year's performance.

We have contractual key performance indicators (KPI) to be met through the CCG. The KPI is an agreed measurable numerator for avoidable pressure ulcers against the agreed defined categories.

Whilst the target set by the commissioners has not being met we have made improvement from the previous year with the number of avoidable grade 2 pressure ulcers for 2014/15 at 196 compared to 246 for the previous year. This relates to an improvement of 20.4% which clearly demonstrates an improvement in harm reduction. The avoidable grade's 3 have also reduced; although this was by only 2 from 63 to 61 we acknowledge there is still work to do to adhere to the agreed zero tolerance.

The National Safety Thermometer continues to be completed and submitted monthly; this provides a point prevalence snapshot of pressure ulcers and does not reflect the numbers that are submitted via the KPI source sheets. The pressure ulcers are defined as old or new, old are those pressure ulcers which developed prior to the patient being admitted and new are those that have developed since admission.

What have we done to improve?

- For 2014/15 we planned to implement a bespoke tissue viability risk assessment tool across midwifery. The tool has now been signed off and will be implemented from April 2015. The monitoring of the new tool will commence from June 2015
- The risk assessment tool for Intensive Care and High Dependency is on-going. We anticipate this will be completed by May 2015
- The introduction of the SSKIN Bundle in 2014 has remained a challenge. Education remains on-going with clinical teams to ensure they are completing the SSKIN tool
- The clinical nurse specialist for tissue viability, along with the tissue viability nurses, continue to deliver both ward based and classroom education to all grades of nursing staff. There are ten tissue viability study days a year that are available for registered nurses and the same for health care assistants with an annual update for the tissue viability link nurses. All clinical areas now have a minimum standard of one tissue viability link nurse who can be utilised as a resource for the clinical team
- We have also developed and implemented a trust wide electronic RCA which is the tool used to determine the avoidability of the pressure ulcer. The tool was designed in conjunction with user feedback and provides "drop down options" to support completion

Future plans to improve compliance against the Trust targets

- We are committed to reducing harm to patients caused by avoidable pressure ulcers. We are currently negotiating with the CCG regarding the KPI targets for 2015/16. Once these are agreed each site will have its own trajectory to achieve and this will be monitored via the Tissue Viability Strategy Group with a target date of May 2015
- The development of a tissue viability risk assessment tool for use within the renal dialysis unit is in development and has a target date for completion of May 2015
- To support accurate classification of pressure ulcers for the purpose of management and reporting, we intend to implement trust wide clinical photography of all pressure ulcers. To support this initiative the proposal is being presented to the trust clinical IT group in April.

Priority 4: Fractured Neck of Femur

Hip fractures are cracks or breaks in the top of the thigh bone (femur) close to the hip joint. Care of patients with hip fracture in the Trust is audited against 9 evidence based standards.

- Prompt admission to Orthopaedic care;
- **Surgery within 36 hours;**
- Nursing care aimed at minimising pressure ulcer incidence;
- **Routine access to ortho-geriatric medical care;**
- **Assessment and appropriate treatment to promote bone health and falls assessment;**
- Review at Multi-Disciplinary Team (MDT) meeting;
- **Assessment Mental testing (Dementia Screen) Pre-operative**
- **Assessment Mental testing (Dementia Scree n) Post-operative; and**
- Bone Density Testing.

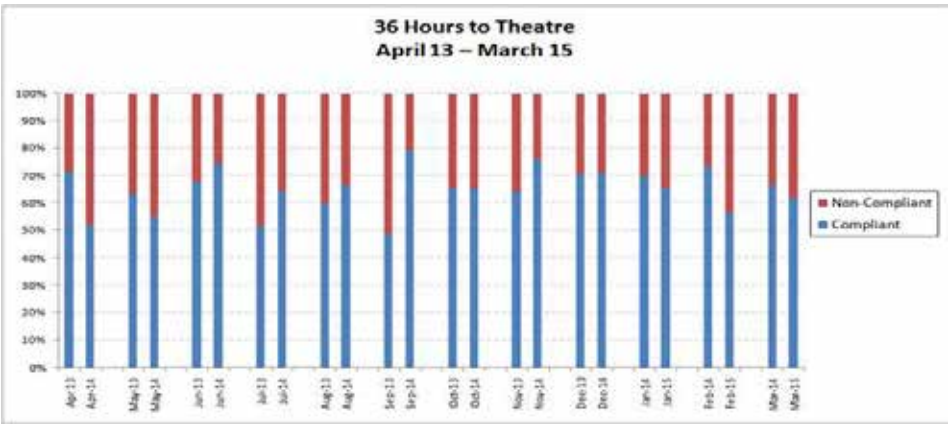
The national target to meet all elements of best practice pathway is 76.4%. Time to theatre target is 90% operated on within 36 hours (with a 10% tolerance for medically unfit patients). All other elements of the pathway have a target of 100%.

What is the measure?

We have chosen 5 indicators (highlighted in bold above) to monitor in more detail for this priority. This year, for the first time, routine access to ortho-geriatric medical care and assessment and appropriate treatment to promote bone health and falls assessment has been included. Both of these areas were seen as paramount to improving the quality of care of patients on the fractured neck of femur (NOF) pathway. The indicator 'review at multi-disciplinary (MDT)' has been dropped as a priority as the trust consistently achieves 99.5% - 100% and it can be confirmed that this has been maintained.

Time to Theatre Target 36 Hours

The tables below show the performance by site of the key indicators "surgery within 36 hours" which the Trauma and Orthopaedic Directorate has focused on during the past 12 months. The local target is that 90% of patients should be operated on within 36 hours of admission which at the end of 2014/15 66.2% was achieved. This is an improvement on the previous year of 60.3% in 2013/14. The graph below shows a month by month comparison.

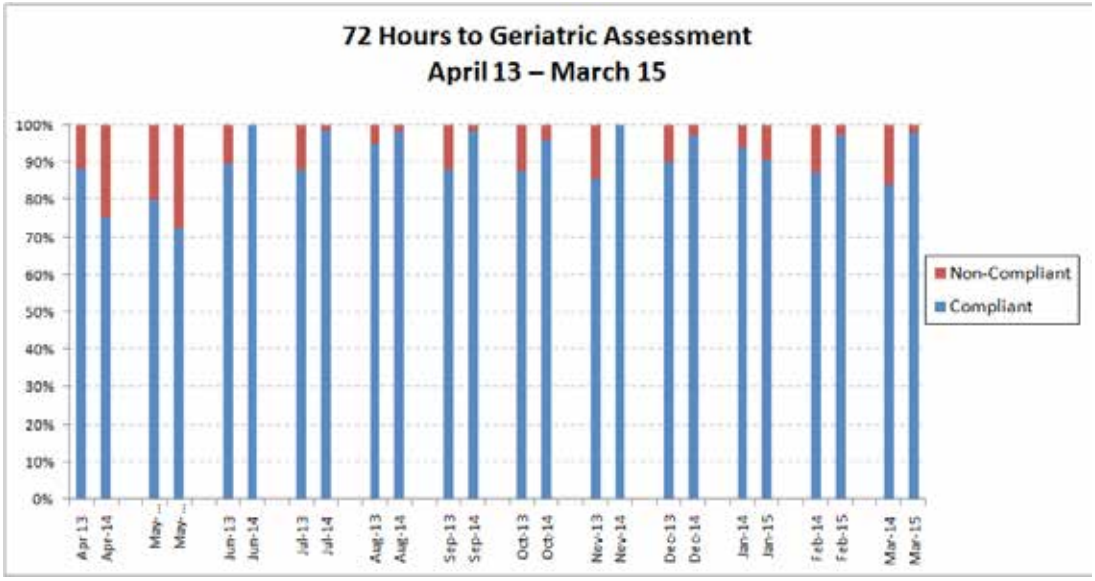


The graph shows across the trust, with the exception of April 2014, there has been a month on month improvement in time to surgery.

Routine Access to Ortho-geriatric medical care

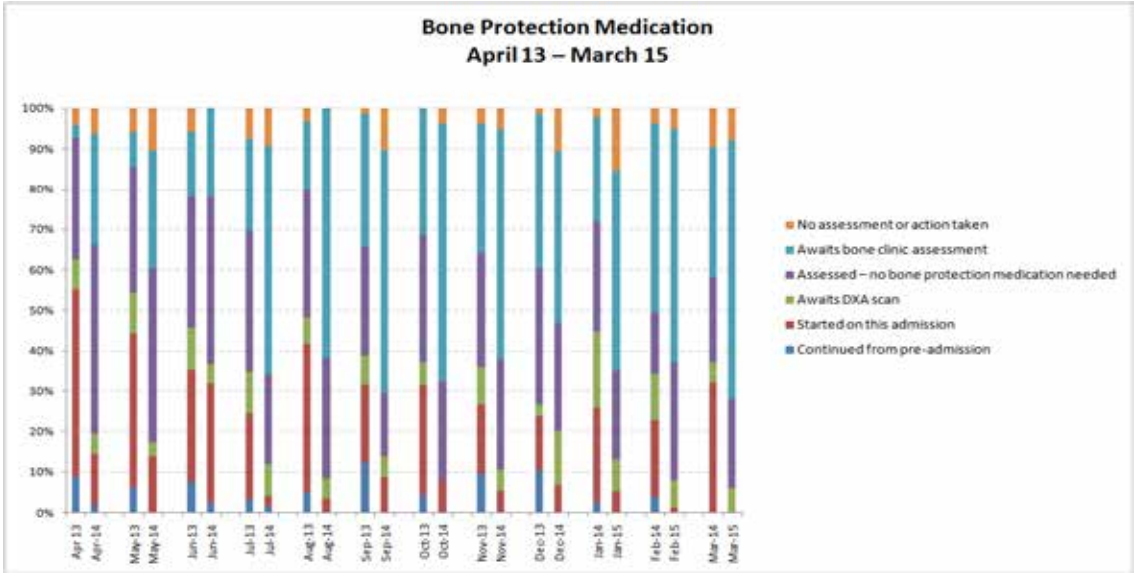
This indicator is included for the first time in the Quality Account for NOF pathway with a local standard of 72 hours. At year end 2014/15 we achieved 93.6% compliance compared with 2013/14 87.4%. Performance against this standard and the next three areas listed are dependant upon ortho geriatric resource being available which comes from outside the directorate.

Trust wide



The graph shows across the trust an improvement every month on the previous years performance.

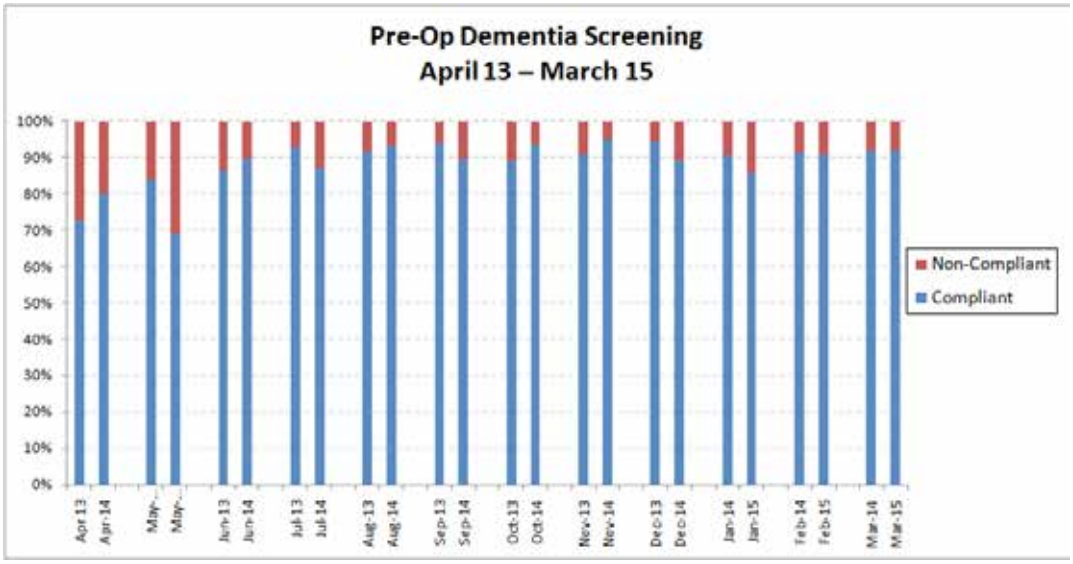
Assessment and appropriate treatment to promote bone health and falls assessment



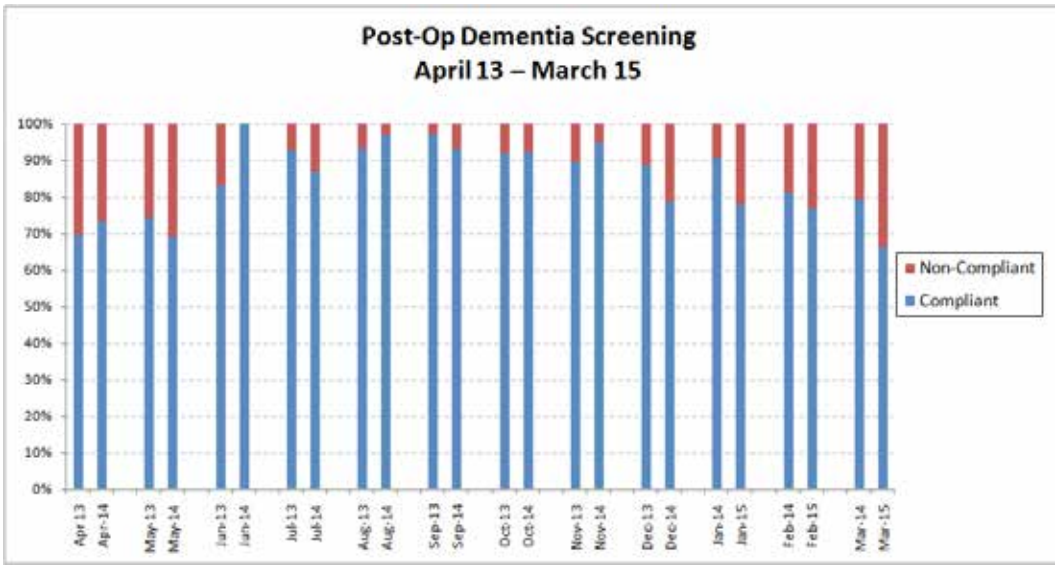
A risk assessment is completed on all patients for falls – which is audited vis the nursing metrics. A scrutiny forum is held monthly by the Head Nurse and a root cause analysis completed for all injurous falls.

Assessment Mental testing (Dementia Screen 1) Pre-operative and Assessment Mental testing (Dementia Screen 2) Post-operative

The Ortho-Geriatric Teams work closely with the Orthopaedic Team to ensure that all elements of the patient pathway, including dementia screening and multi-disciplinary team discussions take place.



At the end of 2014/15 the trust achieved 88.0% compared with 86.4% at the end of 2013/14 against a target of 90.0%.



The trust achieved 83.4% in 2014/15 compared with 72.8% at the end of 2013/14, against a target of 90%. The biggest improvement in performance can be seen in the pre operative dementia screening. Within the trust, dementia screening has been a major focus for all specialties, with great emphasis being placed on this indicator with ward staff and at junior doctor induction on rotation.

The directorate are reliant on manual data collection for Best Practice Tariff (BPT) and National Joint Register (NJR) from multiple hospital systems. In validating the data for this year's quality account, some data quality issues have been identified. The data has now been fully validated and the directorate have identified additional funding to address their data quality issues going forward.

Overall the trust's performance against this priority has improved by just over 10.0% achieving 50.3% across all the indicators at the end of this year compared with 39.7% in 2013/14. The directorate achieved the national overall target in year, but we were unable to sustain this.

How are these priorities measured?

- The data for these priorities is a subset of the extract from the NHFD from the fractured neck of femur best practice tariff monthly reports. It is widely distributed across the directorate and discussed in the following forums:
- Good Hope Hospital* Performance and Efficiency Meeting
- Good Hope Hospital Quality and Safety Meeting
- Birmingham Heartlands Hospital Trauma Action Group
- Directorate Business and Governance meetings

*Good Hope Hospital has responsibility for Trauma and Orthopaedics across the trust.

What have we done to improve?

- Establishment of two extended trauma theatre lists at Birmingham Heartlands Hospital
- It was identified that further capacity was required to prevent the admission of NOF patients to non trauma wards in 2013/14. This has been achieved at Heartland Hospital with the trust going at risk with the financial costs of this expansion to the bed base
- Temporary appointment of two trauma consultants from February 2014, two of which were made permanent in December 2014
- On the Heartlands site a multi-disciplinary NOF Group meet weekly to review the NOF patients
- Grand Consultant Ward Rounds have been introduced seven days a week at Heartlands Hospital
- The Heartlands site supported the appointment of an interim trauma manager for six months from October 2014
- A patient participation group was held for NOF patients at Heartlands Hospital. As a result actions have been taken to improve the patient experience
- The NOF pathway at Heartlands Hospital was reviewed by an external consultancy firm which produced a set of recommendations and action plan

Future plans to improve compliance against the Trust targets

- Re-launch of the Trauma Action Group which was temporarily suspended pending the appointment of the directorate clinical director
- A business case is being developed to implement a new trauma on call rota at Heartlands Hospital to increase the number of senior medical staff are available at the weekend.
- A business case is being developed to increase the trauma nurse coordinator role and for the permanent appointment of a trauma service manager as part of the directorate
- Further work is required to identify dedicated paediatric and adult day case theatre lists at Heartlands Hospital
- Work continues as part of Surgical Reconfiguration Programme to have trauma on one site with the increase in theatre/ bed capacity.
- In conjunction with Trust IT system services develop a Trauma & Orthopaedics database to meet the data requirements of national audits and enquiries i.e. National Hip Fracture Database, National Joint Registry

Priority 5: Stroke

Background Information

A review of stroke services across the Midlands and East of England in 2012 recommended that hyper-acute stroke services should be provided by services seeing at least 600 stroke patient admissions each year supported by a seven day a week specialist stroke workforce. The review has reached a pivotal phase of modelling the hyper-acute stroke service requirements across Birmingham and the Black Country. The general direction of travel is to have fewer units providing hyper-acute stroke care and a very detailed service specification has been published.

The regional modelling only includes one Hyper Acute Stroke Unit (HASU) within the trust and following an internal review of stroke service provision the trust agreed to reconfigure their services to provide one HASU at Heartlands Hospital and an Acute Stroke Unit (ASU) at Heartlands, Solihull and Good Hope Hospitals. As the single HASU hub, Heartlands Hospital will manage all the emergency stroke admissions across the trust. Once the hyper acute phase is over patients will be transferred to their local hospital if necessary to complete their treatment closer to home.

The timeline was as follows:

- Regional review of stroke services 2012
- Internal review of stroke services August 2012
- New Hyper Acute Stroke Unit was launched at Heartlands Hospital on 30th October 2014
- Hyper acute stroke service transferred from Solihull to Heartlands Hospital on 17th November 2014
- New Acute Stroke Unit was opened at Heartlands Hospital on 21st January 2015
- Hyper acute stroke service transferred from Good Hope to Heartlands Hospital on 2nd February 2015

These significant changes to the stroke service across the trust over the last year will affect the data presented below in a number of different ways.

Four specific measures have been chosen from the acute stroke pathway because they are considered good indicators of the quality of care received by patients. They are the same measures as previously reported. Where the previous year's figures are available, these have been put in brackets for comparison.

What is the measure?

Acute Stroke Patients Thrombolysed – Target ≥ 10%

- Focuses on the hyper-acute phase.
- The understanding of stroke as a medical emergency in the local community.
- Ambulance Service responses and assessments.
- Emergency Department (ED) performance in rapid stroke assessment and referral.
- The ability of the stroke service (medical and nursing) to respond with 7 day working patterns.

How is the priority measured:

This measure is collected as part of hyper acute stroke service measured nationally and reported through the Sentinel Stroke National Audit Programme (SSNAP).

	Percentage of patients who received thrombolysis			
	Q1 14/15 (13/14)	Q2 14/15 (13/14)	Q3 14/15 (13/14)	Q4 14/15 (13/14)
Heartlands (BHH)	4.4%	13.3%	11.2%	10.8% (9.3%)
Good Hope (GHH)	0.0%			N/A (5.3%)
Solihull (SH)	10.8%	6.5%	11.1%	N/A (2.2%)
Trust	5.1%			10.8%
Nationally	12.2%	11.7%	11.6%	Unknown

Due to the changes within the stroke service across the trust over the last 2 years the percentage of patients who received thrombolysis at the different sites has varied from quarter to quarter. During the year there has been a gradual increase in appropriate patients receiving thrombolysis across the trust.

The trust achieved the target for Q4.

This measure is reviewed weekly in the thrombolysis governance meeting at Heartlands Hospital

What have we done to improve?

Since Monday 2nd February 2015 when the hyper acute stroke service transferred from Good Hope Hospital all emergency stroke admissions across the trust are delivered to Heartlands Hospital and thrombolysis is only administered on this site. One of the main objectives of centralising the hyper acute stroke service including thrombolysis at Heartlands Hospital was to improve the quality of care through an increase in the concentration of specialist medical and nursing staff available 24/7.

At Heartlands Hospital there is now a stroke specialist nurse (SSN) team responding within 5 minutes and a supporting medical bleep holder responding within 15 minutes of a stroke alert 24/7.

There is a weekly thrombolysis governance meeting that scrutinises the process to ensure that opportunities to thrombolyse patients are not missed and that thrombolysis practice is safe. During this meeting there is a RCA process to look at any cases where thrombolysis door to needle time exceeds 1 hour or any cases where the reason to thrombolyse is not clear.

Future plans to improve compliance against the trust targets

With time the increased specialist workforce across medicine and nursing is expected to improve the efficiency of the pathway further and improve the quality of treatment received within the first 72 hours. Weekly meetings, RCA's and the concentration of expertise should lead to a greater proportion of people being eligible for thrombolysis and it will also ensure that all patients who are eligible receive the thrombolysis treatment.

In addition telemedicine will be available very shortly at Heartlands Hospital which will allow the SSN team and consultant on-call to interact with each other more efficiently and effectively.

What is the measure?

2. Direct Admission to stroke unit within 4 hours – Target 50%

- Focuses on the hyper-acute to acute phase
- ED performance in rapid stroke assessment and referral
- Hospital capacity and stroke unit capacity
- Bed management and protection

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This is possibly the single most evidence based intervention for stroke patients. An early admission to a stroke unit generally means early assessment by specialists and less variation in treatment and care.

How is the priority measured?

This measure is reported through best practice tariff (BPT) and nationally through SSNAP.

	Percentage of Patients Directly Admitted to Stroke Unit within 4 hours			
	Q1 14/15 (13/14)	Q2 14/15 (13/14)	Q3 14/15 (13/14)	Q4 14/15 (13/14)
Heartlands (BHH)	56.4% (44.4%)	53.8% (68.4%)	56.6% (64.2%)	57.9% (73.1%)
Good Hope (GHH)	50.0% (40.8%)	48.8% (58.4%)	39.5% (37.5%)	24.5% (46.6%)
Solihull (SH)	21.4% (18.7%)	35.5% (29.5%)	20.7% (38.3%)	31.6% (44.2%)
Trust	47.5% (35.4%)	49.3% (52.7%)	48.4% (44.8%)	48.2% (58.2%)

Performance for this measure is quite variable. Attendance in the ED and capacity throughout the 3 sites remains very challenging and this has a large impact on direct admissions. The stroke bed capacity on all three sites is sufficient, but some of these beds are occupied for long periods by non-stroke patients. At times this can make it difficult for patients to move through the ED into a stroke bed within 4 hours.

Solihull Hospital site performance is poor, however there are unique issues with the ED located in an Acute Medical Unit (AMU) which affects the urgency to move to a stroke specific bed and is likely to distort these figures.

This measure is monitored closely by the performance department and reviewed bimonthly at the stroke sub-directorate meeting. In validating the data for this year's quality account, some data quality issues have been identified and the final percentages for the year 2013/14 have been corrected and now show an improved performance on what we reported previously.

What have we done to improve?

With the reconfiguration of hyper acute services to Heartlands Hospital nearly all of the direct admissions are now on this site. Heartlands Hospital is currently the best performing site and the performance of Good Hope and Solihull Hospital will improve as they need to directly admit very few patients. The new designated HASU has increased capacity in real terms from 12 beds across the three sites to 16 beds at Heartlands Hospital and this has improved the ability to admit directly to a stroke bed.

The SSN team and medical bleep holder at Heartlands Hospital 24/7 provides support for the ED and attempts to ensure an efficient patient pathway. The new stroke repatriation policy has helped to ensure timely repatriation to the ASUs which has improved the access to HASU beds. Heartlands Hospital has maintained performance above 50% during an incredibly difficult period in terms of overall bed capacity.

Future plans to improve compliance against the trust targets

There is a need to further improve the protection of HASU beds from non-stroke patients to ensure consistent and rapid access for emergency stroke admissions.

We are also in the process of separating stroke on the three sites into a single directorate. One of the intentions of this will be to ensure a consistent and efficient approach to the management of stroke beds across the trust.

What is the measure?

3. Swallow Assessment for stroke patients within 4 hours – Target Q1 84% Q2 86% Q3 88% Q4 90%

- Focuses on the hyper-acute to acute phase
- ED performance in rapid stroke referral
- The ability of the stroke service (nursing) to respond with 7 day working patterns
- Focuses on stroke specific training and skill set

How is the priority measured?

This measure is part of our contracts and is reported as a key performance indicator (KPI) to the commissioners. It is also measured nationally through SSNAP.

	Percentage of Stroke Patients with a Swallow Assessment Completed within 4 hours			
	Q1 14/15 (13/14)	Q2 14/15 (13/14)	Q3 14/15 (13/14)	Q4 14/15 (13/14)
Heartlands (BHH)	86.0% (47.8%)	94.3% (61.4%)	93.5% (72.7%)	94.2% (83.8%)
Good Hope (GHH)	65.1% (73.9%)	82.9% (84.9%)	87.3% (75.0%)	72.1% (59.3%)
Solihull (SH)	72.7% (65.1%)	72.4% (64.4%)	46.4% (78.2%)	38.5% (81.0%)
Trust	75.1% (63.2%)	86.4% (74.2%)	85.0% (75.6%)	84.4% (75.5%)

This is a very good marker for the level and speed of initial specialist assessment. Swallow screens have to be taught as a competency and are usually only performed by stroke specialist / competent nurse.

The hyper acute stroke services transferred from Solihull to Heartlands Hospital during Q3 and this explains why the performance was significantly worse at Solihull Hospital during this quarter. The majority of the patients admitted initially to Solihull Hospital were not suspected to have had a stroke otherwise they would have been admitted directly to Heartlands Hospital. Patients who are not

diagnosed as stroke initially will not have a routine swallow screen unless they are observed to have swallowing difficulties; however they are included in the numbers.

This measure is monitored closely by the performance department and reviewed bimonthly at the stroke sub-directorate meeting.

What have we done to improve?

With the reconfiguration of hyper acute services to Heartlands Hospital nearly all of the swallow screens will be required on this site. At Heartlands Hospital there is a Stroke Specialist Nurse (SSN) team responding within 5 minutes to a stroke alert 24/7 and they are trained to perform the swallow screen. Heartlands Hospital is currently the best performing site and consistently achieves in excess of 90%.

Future plans to improve compliance against the trust targets

Many of the swallow screens that fail are patients who suffer their stroke while in hospital and there is often a delay before they receive the necessary specialist input. Although this is a national phenomenon, we have started to improve this situation within the trust through a variety of training sessions aimed at increasing staff knowledge of stroke and emphasising the importance of early interventions.

What is the measure?

4. 90% of Stay Spent in a Stroke Unit – Target 80% of patients

- Focuses on the acute to early rehabilitation phase
- Stroke unit capacity
- Bed management and protection

How is the priority measured?

This measure is part of our contracts and is reported as a KPI to the commissioners. It is also measured nationally through SSNAP.

Capacity throughout the 3 sites remains challenging which at times directly impacts on the performance to meet this target. Each site needs to continue to focus on keeping specialist capacity free to allow this performance to continue to improve.

	Percentage of Patients Spending 90% of stay in a Stroke Unit			
	Q1 14/15 (13/14)	Q2 14/15 (13/14)	Q3 14/15 (13/14)	Q4 14/15 (13/14)
Heartlands (BHH)	84.9%	84.9%	88.0%	93.5% (86.0%)
Good Hope (GHH)	79.8%	76.5%	77.1%	84.4% (78.4%)
Solihull (SH)	81.8%	82.9%	65.4%	85.0% (79.6%)
Trust	82.4%	81.5%	80.0%	89.6% (82.2%)

This is closely associated to the direct admission metric as anyone who has a short length of stay who is not initially admitted to a stroke unit is likely to fail this metric. As previously discussed the trust is underperforming on direct admission to a Stroke Unit and this will reduce the figures above. Heartlands Hospital is performing well and we have managed to maintain performance as a trust above the target despite an incredibly difficult period in terms of overall bed capacity.

This measure is monitored closely by the performance department and reviewed bimonthly at the stroke sub-directorate meeting.

What have we done to improve?

All three sites are aware of the importance of flow from HASU to ASU and looking after stroke patients at all stages of the pathway in stroke specific beds. The new stroke repatriation policy has helped to ensure timely repatriation to the ASUs which has improved the access to HASU beds for emergency stroke admissions.

There have been many initiatives to improve patient flow and facilitate discharge for all patients. Engagement with both social services and community health services in addition to a strengthened enhanced supportive discharge team has helped to reduce the length of stay across the trust for stroke patients. All this work has improved access to stroke specific beds and ensured that the performance has been maintained.

Future plans to improve compliance against the Trust targets

As already stated this measure is very closely linked to the 4 hour admission standard and plans to make improvements in that area will directly improve performance for this indicator too.

The bed model as part of the trust reconfiguration will mean there is enough capacity to deal with demand. This has been calculated and is sufficient to not only allow front door access, but also to allow stroke patients to be looked after by stroke specialist teams throughout their hospital stay. It is important to continue the good work that has been done already working closely with both social services and community health services to maintain good flow of patients through the stroke pathway.

As previously mentioned when the trust completes the process of separating stroke on the three sites into a single directorate this will facilitate an improvement in the management of stroke beds across the trust.

Priority 6: Dementia Care

What is the measure?

There has been a change in measurement standards for this year's submission, namely;

- S2: Every patient with newly diagnosed dementia to have communication with primary care teams (changed from every patient with potential dementia to have communication with primary care teams).
- S3: 'About me' tool in nursing notes to be completed by family / carer for every patient with known or newly diagnosed dementia (changed from joint elderly care medicine and old age psychiatry expertise to be routinely available on all three sites for older people in need).

After review of the quality account by the dementia strategy steering group the consensus was that the current account would no longer reflect quality of care and therefore changes were made to what was being measured. It was acknowledged that the standards chosen reflected the initial phases of introducing good dementia care. The trust strategy has moved on and these measures will be met as a default. It was therefore felt appropriate to change the standards to better reflect care quality. The changes, particularly the new standard 3, involve measuring activities known to improve dementia care.

Standard	Previous Position	Current Position	Future Aims
S1: Every unplanned admission for a patient aged over 75 to result in querying dementia as a known diagnosis within 72 hours following admission Target 90%	In March of 2014, the percentage of all patients aged over 75 years who had been screened following admission to hospital using the dementia screening tool was 69.5%.	Currently, trust performance is 92%. There are a variety of factors responsible for this, including increased focus on the 4 hour ED targets. A daily report is generated for all site leads who are individually managing this and we expect to consistently achieve 90% and above in the very near future.	Continuation of work with the faculty of education so that all staffs understand the importance of this work in the provision of quality care for patients. Further development of ward based metrics system for ward management Improve the use of IT systems
S2: Every patient with newly diagnosed dementia to have communication with primary care teams Target 100%	Standardised advice being given on how to communicate this. It was identified that further work was needed to develop robust data to measure compliance with this target.	All newly diagnosed patients have communication via the electronic discharge letter to GPs or the Mental Health computer system (RIO)	Integrate local IT system so information collected or patients with dementia or suspected dementia is automatically passed to primary care RIO performance at Solihull to be improved by appointment of new Consultant Psychogeriatrician for the Rapid Assessment Interface and Discharge team in March
S3: 'About me' tool in nursing notes to be completed by family / carer for every patient with known or newly diagnosed dementia	Sporadic performance mainly driven by relatives and pockets of good practice	Our standardised document has been developed along with community partners, the Alzheimers society and Alzheimers UK. This is currently being piloted and will be released trust wide in the next 1-2 months	The 'About Me' document will be available from the same IT source as staff currently use for the dementia assessment for Standard 1.

How is this priority measured?

S1: Every unplanned admission for a patient aged over 75 to result in querying dementia as a known diagnosis within 72 hours following admission is measured by a dashboard that is able to drill down to specific patient / consultant level for highlighting off track areas. The target is 90% and the current performance is 90%. This has significantly improved since this was made mandatory. This data is discussed at the monthly dementia trust steering group meeting.

S2: Every patient with newly diagnosed dementia to have communication with primary care teams is measured by the presence of printed communication in the electronic record. This is hard to measure and relies on retrospective searching of data but shows a position above 90% at present. Future IT developments will make this easier and allow for real-time data.

S3: Once the tool is launched fully it will be possible to review the electronic records of all admitted patients and ensure 'about me' forms part of this.

What have we done to improve?

Since the last statement, what we feel to be the most comprehensive 'About Me' tool has been developed and is currently being piloted. All general surgical groups have had a presentation from the trust dementia lead at their meetings and the response has been positive. Communication of trust achievements around dementia has been improved by input from the communications team. Governor scrutiny has been invited, including an open presentation and a planned meeting with Governors and the Chairman. Carers and patients now have direct input into the strategy group via a dementia educator.

Future plans to improve compliance against the Trust targets

- 'About me' to be launched trust wide
- Improved IT links to make dementia tools more user-friendly and linked
- Improved IT data capture to produce real time data
- Further dementia and delirium education, with the development of a 5 credit masters level module (final testing March 2015)

Priority 7: Discharge Arrangements

What is the measure?

To improve communication relating to discharge arrangements for patients and relatives.

How is the priority measured?

Discharge arrangements are currently measured through the patient experience metrics relating to a patient knowing when they are going home.

What have we done to improve?

A Length of Stay (LOS) reduction project has commenced on all 3 sites, with particular focus on re-embedding SAFER and the use of JONAH. Project leads have been identified with a focus on 60-100 beds /site. There will be a rolling programme until all wards are involved.

The trust monitors progress against the numbers of patients given a predicted date of discharge within 48 hours of admission and the numbers of patients who go home on or before their date for discharge.

Future plans to improve compliance against the trust targets

We are aiming to increase the patient experience metrics relating to patients knowing when they are going home.

A significant amount of work has taken place on all 3 sites following a decrease in performance in quarter 2, which has resulted in all sites now achieving over 80% of patients being spoken to about expected date of discharge. This was achieved by the use of SAFER, daily board rounds and planned discharges for the following day, robust site meetings where discharges later in the week are discussed & planned as well as increased engagement from clinicians & community teams.

A discharge hub is now in place on all 3 sites, where complex discharges are discussed and planned with the multidisciplinary team as well as the patient and their family. This has had a positive impact on the patient and family experience.

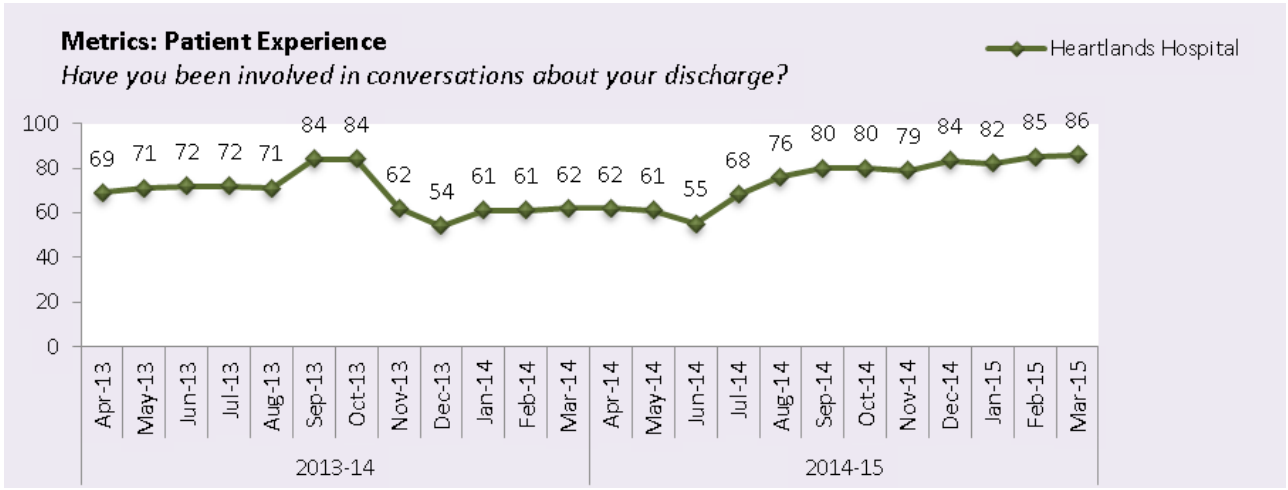
However, we have changed the way in which this data is collected and there are now 5 questions on the reverse of the Friends & Family Test cards, 1 which relates to discharge planning. This is instead of patients being asked directly. This has changed the percentage of respondents and further work is needed to embed this process and we will continue to monitor this. The results are shown in the table overleaf.

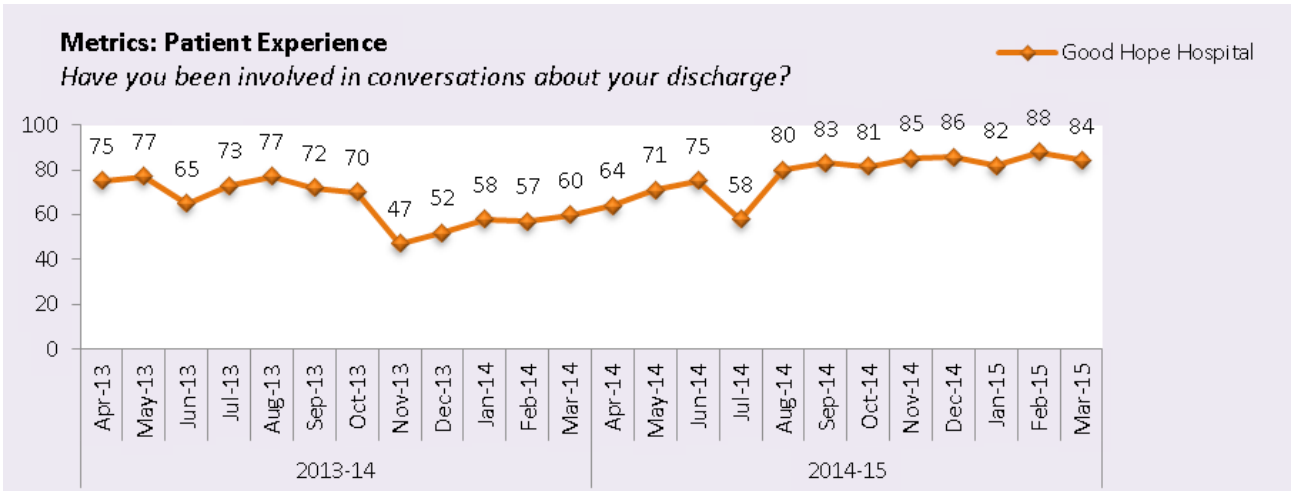
Ticket Home is being developed & piloted on Wards 9 & 14 at Good Hope Hospital site May 2015. This has had involvement from patients & carers about what they would like to see on the ticket home. This aims to inform the patient & carer/family about all aspects of their discharge, from the time of admission.

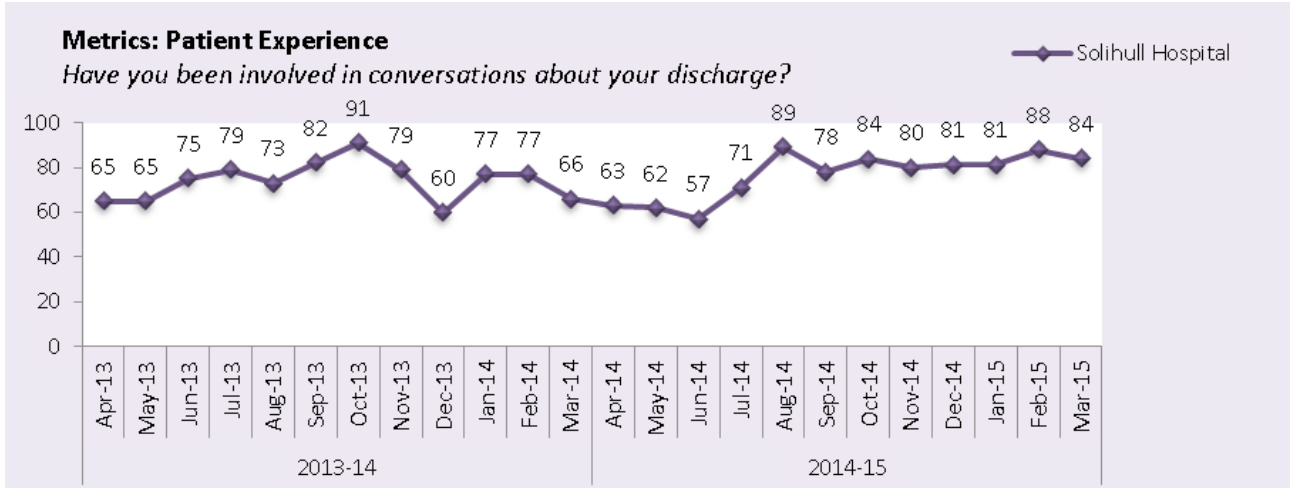
[3]Safe care means not keeping patient's in hospital any longer beyond the acute phase of their illness/surgical recovery. To enable teams to progress safe, timely care the Trust has established the SAFER flow bundle, this means:

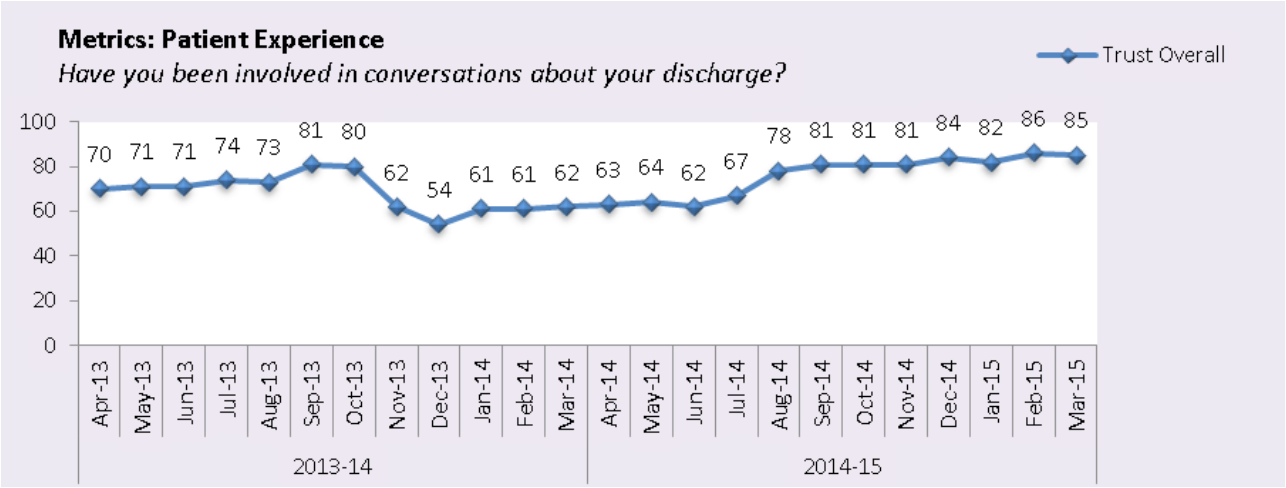
Senior Review: Consultant will conduct a daily ward round;
All: All patients will have a PDD (planned date for discharge) agreed within 24 hours of admission;
Flow: All wards should have capacity to "pull" a minimum of 1 patient from the assessment areas by 9am;
Early discharge: Wards teams should ensure that 50% of the total ward discharges have left the ward by 12 noon;
Review: Patients whose length of stay exceeds a 14 days will be reviewed weekly by a Site Team in collaboration with the Directorate and for the Hospital Discharge Hub.

Patient Experience Question: Have you been involved in conversations about your discharge from hospital?









The scoring model used above allows us to summarise and compare the results of any survey question to monitor our performance. Questions in the survey have varying numbers of response options, and it is difficult to evaluate and compare different combinations of response. Each question's multiple response options are summarised by a single number using an explicit weighting system. The single numeric score per question allows direct comparisons, taking account of all answer options.

For example, if the respondent ticks 'yes definitely' we will score 1 point, if they tick 'yes to some extent' we will scores 0.5 point and if they said 'no' we would not score any points. All of the scores are added together and divided by the total number of people who responded to the question. To achieve the maximum score of 100, all the respondents would have to ticked the top answer (yes definitely).

Part 2:

Going forward: Priorities for Quality Improvement 2015/16

The Board of Directors formally approved the priorities listed below. This was also agreed by the Patient Experience Committee, a sub-committee of the Council of Governors, which includes patient, public and staff governors.

Priorities 1, 2 and 4 have been carried over from 2014/15 and will continue to be measured in the same way as previously. This is detailed in each section. There will be a regular report to the Quality and Risk Committee regarding all of the priorities.

Priority 1 Reduction of grade 2 hospital acquired pressure ulcers

Rationale	We are proposing to change the way we look at pressure ulcers, with improvements in quality measures rather than solely measuring prevalence and incidence. We are therefore continuing to measure this as a priority to assess the impact of these changes
Monitoring	Trust Quality & Risk Committee

Priority 2 Reduction of incidence for patients who have multiple falls in hospital

Rationale	This is still the highest reported clinical incident within the trust. We are proposing to change the way we look at pressure ulcers, with improvements in quality measures rather than solely measuring prevalence and incidence. We are therefore continuing to measure this as a priority to assess the impact of these changes
Monitoring	Trust Quality & Risk Committee

Priority 3 Improvement in both response rates and overall scores of Friend and Family Test in the Emergency Department

Rationale	Addressing the pressures in our ED department continues to be a priority for the trust. By monitoring patient experience (via the Friends and Family Test) and acting upon the feedback we receive, we will be able to assess the impact of the wider initiatives within the trust in relation to ED and the urgent care pathway
Monitoring	Trust Quality & Risk Committee

Priority 4 An Improvement in response rates to stroke

Rationale	We have decided to continue stroke as a quality priority as we would like to demonstrate the impact of the major redesign that the stroke service has undergone over the past year
Monitoring	Trust Quality & Risk Committee

Part 2:

Review of Services/Statements of Assurance from the Board

The Trust is required to include statements of assurances from the Trust Board which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts

Service Income

During the 2014-15 the Heart of England NHS Foundation Trust provided and/or sub-contracted 114 relevant health services.

The Heart of England NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2014-15 represents 100% per cent of the total income generated from the provision of relevant health services by the Heart of England NHS Foundation Trust for 2014-15.

Clinical Audit

During 2014/15, 33 national clinical audits and 4 national confidential enquiries covered relevant health services that Heart of England NHS Foundation Trust provides.

During 2014/15, Heart of England NHS Foundation Trust participated in 97% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Heart of England NHS Foundation Trust was eligible to participate in during 2014/15 can be found in **Appendix 1.**

The national clinical audits and national confidential enquiries that Heart of England NHS Foundation Trust participated in during 2014/15 are shown in the second column in **Appendix 1.**

The national clinical audits and national confidential enquiries that Heart of England NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed in the third column in **Appendix 1** 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.

Reviewing reports of national and local clinical audits

The reports of 18 national clinical audits were reviewed by the provider in 2014/15 and Heart of England NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- As part of the National Cardiac Arrest Audit, individualised consultant feedback on 'Do Not Attempt Resuscitation' decisions can now be reviewed. To reduce cardiac arrests further, the trust is participating in NHS Quest quality improvement projects and resuscitation outcomes research
- The National Intermediate Care Audit revealed Solihull Intermediate Care Service had fewer beds or alternatives for patients than the national average. Thus, a Supported Integrated Discharge Service at Solihull has been developed, creating a further pathway for up to 500 patients per year. This is being audited and adapted in partnership with Solihull Metropolitan Borough Council and patient satisfaction is being evaluated
- As a result of the National Paediatric Diabetes Audit, the trust is working towards standardising care to improve overall diabetes control across all five sites and has introduced nurse led clinics on separate days from the multi-disciplinary paediatric diabetes clinics, to focus on those children on the high HbA1c pathway
- Following participation in the Falls and Fragility Fractures Audit Programme, the trust continues to review its performance against the Best Practice Tariff standards and address any issues. Poor recording of post-operative dementia at Good Hope Hospital prompted staff training to improve this measure. Time to surgery for fractured neck of femur patients is also monitored and as a result the theatre booking system has been amended at Heartlands Hospital to ensure patients are operated on in a timely fashion
- The Case Mix Programme provides quarterly comparative data which is used to monitor a variety of parameters including delayed discharges, ITU and post ITU mortality and standardised mortality ratios. Outlying data is being investigated on an individual basis
- The National Bowel Cancer Audit results highlighted higher than average readmission rates which prompted a detailed local audit of 90 day readmission rates. This revealed wound infections and chemotherapy complications as the main reasons for readmission which is being addressed
- Following participation in the Sentinel Stroke National Audit Programme (SSNAP), a regular mood screen for stroke patients has been implemented. Concise documentation by stroke nurses has improved data collection and communication between multi-disciplinary teams. A root cause analysis in door to needle time for thrombolysis has halved the time from 90 to 49 minutes. Ward staff have been trained to improve swallow screening within 4 hours and notices circulated to doctors and wards regarding immediate referral
- The Adult Community Acquired Pneumonia Audit findings, along with a local audit into antibiotic prescribing have highlighted the need to implement antibiotic prescribing protocols for respiratory conditions including community acquired pneumonia. ED staff have also been approached regarding prescribing antibiotics promptly and correctly
- As a result of the Pleural Procedure Audit, monthly chest drain insertion training sessions have been introduced for junior doctors. The trust pleural procedures guideline has also been updated to reflect these changes

The reports of 130 local clinical audits were reviewed by the provider in 2014/15 and Heart of England NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- An audit into the management of women presenting with vaginal bleeding in early pregnancy has resulted in a clerking proforma being developed for ED staff to provide consistency
- The findings from an ED audit into Troponin test requesting highlighted that a proforma document would be beneficial for potential acute coronary syndrome patients and is being developed to improve risk stratification and to ensure appropriate test requesting
- An initial baseline audit into Neutropenic Sepsis has revealed the need to improve the 'one hour door to needle time' target. To improve this, an ED acute oncology link nurse role has been established, monthly audits and process mapping around breaches has helped to identify pathway delays and is fedback at regular meetings with ED and AMU staff. An urgent care pathway has been developed by Acute Oncology at Good Hope Hospital and regular induction training is provided for all ED doctors and nurses
- Following an audit into the quality of electronic discharges in Thoracic Surgery, a change to the

doctors induction training was implemented to highlight that electronic discharge prescriptions need to be completed to a high quality
- The Community Acquired Pneumonia (CAP) Care Bundle audit has resulted in the CAP guideline being rewritten to reflect the new changes in practice. Stickers which detail the CAP care bundle have also been introduced within ED to improve the number of patients who receive antibiotics within 4 hours of admission
- An audit to review gout within Rheumatology highlighted that a target Serum Urate measurement must be documented in GP clinical letters for every gout patient
- Following an audit looking at equivocal results when screening patients for Chlamydia and Gonorrhoea the guideline was changed to reflect that it is not necessary for patients with equivocal results to be offered treatment and should instead be rescreened
- A regional audit looking at the transfer documentation for HIV Patients who are changing care centre has resulted in the development of a local proforma for transfer in/out of care to accompany the latest clinic letter

Research

Over 400 research projects are being undertaken across the trust in various stages of activity from actively recruiting patients into new studies to long-term follow-up. There are 26 departments across the trust currently taking part in research with between one and six research active consultants in each of these areas. During 2014/15 mental health research has become a new area of activity for the trust following the appointment of Professor George Tadros, Consultant in Old Age Liaison Psychiatry as an academic research consultant.

The number of patients receiving relevant health services provided or sub-contracted by Heart of England NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 5729.

Clinical trials remain the largest research activity performed at the trust, in terms of project numbers. We have a mixed portfolio of commercial studies and academic studies, the majority of which are adopted on to the National Institute for Health Research (NIHR) portfolio. Non-portfolio work is also undertaken and this comprises of commercial clinical trials, student based research or pilot studies for future grant proposals. During 2014/15 patient recruitment was highest in Anaesthetics, Critical Care and Resuscitation, Diabetes, Obstetrics and Gynaecology, Renal Medicine and Thoracic Surgery. Diabetes, Obstetrics and Gynaecology Renal Medicine have been particularly successful this year and have increased their recruitment of patients into the trust's portfolio as follows:

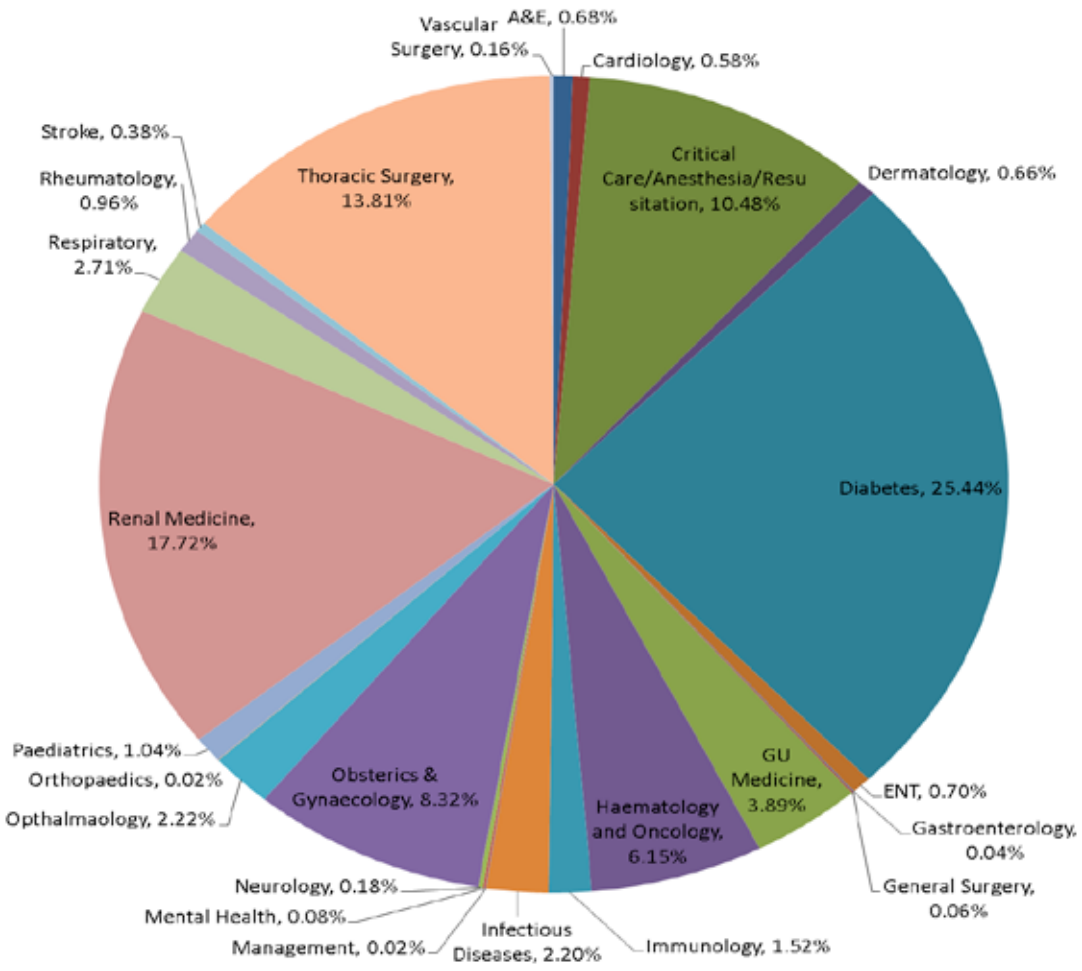
- Diabetes: 25.44% in 2013/14 compared to 14.84% in the previous year
- Obstetrics and Gynaecology: 8.32% in 2013/14 compared to 0.55% in the previous year
- Renal Medicine: 17.72% in 2013/14 compared to 2.16% in the previous year

The Guardian research table published annually, ranks trusts based on patient recruitment into trials. For an acute trust, we ranked 20/160 in 2013/14. In the previous year we ranked 24/69 for a large acute trust (NB the guardian league tables have not split trusts by size in 2013/14).

The Trust's Research Portfolio by Directorate

2014/15 has seen many new researchers lead grant applications and develop new research collaborations both within the Trust and with external partners. One new area of research development has been in the area of Mental Health with a strong focus on dementia research, education and awareness. This has also seen two research fellows, appointed last year, and from different clinical specialities working together to develop new research ideas and developing new researchers from their respective clinical areas. Applications for funding, either led by the trust or with trust co-applicants, continues to be made predominantly to the NIHR funding streams, and for the year 2014/15 totalled in excess of £15.5 million. To date much of this is still awaiting the outcome; with many NIHR funding streams taking in excess of 8 months to inform the researchers of the outcome of their application. We have seen an increase in enquiries for advice in the development local projects, which are part of further degrees, from junior doctors, nurses, midwives and allied health professionals.

In addition to clinical trials, the trust hosts academic appointments in partnership with three local Universities; Universities of Birmingham and Warwick and Aston University. In 2013/14 new appointments were made with the University of Warwick with the appointment of Professor Ivo Vlaev in Behavioural Science and Health. Prof Vlaev has begun working across the trust to develop research to improve the safety and quality of care for patients. With the University of Birmingham, new appointments have been made in Public Health, Professor Tom Marshall and Professor Debbie Carrick-Sen as the new Florence Nightingale Chair of Nursing. Professor Marshall is beginning work in the management of chronic diseases and in particular patients with atrial fibrillation and improving the ways in which they are medicated. With the arrival of the Chair in nursing work will begin on increasing the number of applications for post-doctoral fellowships. The support and nurturing of the junior doctors, nurses, midwives and allied health professional in developing their research skills and knowledge is essential for the encouraging and developing the researchers of the future, for changing practice and also in the potential of findings being used for further, larger research projects.



Following the trust investment in July 2013, we supported the development of NHS Consultant Fellowships. The three-year Fellowships offer funding for consultants to be bought out of clinical responsibilities, in order to use that part of their schedule as dedicated research time. Four appointments were made to Dr Mark Thomas (Renal Medicine), Dr Indy DasGupta (Renal Medicine), Dr Ed Nash (Respiratory Medicine) and Professor George Tadros (Mental Health).

Dr Thomas has begun work on his project, funded by the NIHR Research for Patient Benefit funding stream, on developing a system of alerts and to provide outreach to patients with Acute Kidney Injury and to achieve more consistent and more effective interventions in inpatients across the hospital.

Dr DasGupta has begun work on developing a pathway for investigations in patients with resistant hypertension and the use of urine drug assays to check for compliance. A second area of research attached to Dr Dasgupta's fellowship focuses on phosphate binders. These are drugs used to reduce the absorption into the blood of phosphate, which in patients with chronic renal failure can lead to bone pathology and cardiovascular complications. The medications bind phosphate to the gastrointestinal tract, rendering absorption impossible. Dr Dasgupta plans to develop a pragmatic trial to assess the hard outcomes of various phosphate binders available on the market.

Dr Nash has begun work on his project also funded by the NIHR Research for Patient Benefit funding stream, aiming to determine whether home monitoring of patients with Cystic Fibrosis helps to improve patient outcomes.

Professor Tadros has various projects being developing including finding innovative ways of training and up-skilling staff through an online resource designed to engage and appeal to staff, but provide the knowledge we have identified is often necessary on the front-line to deal effectively with patients with dementia. He has further develops in investigating delirium and understanding and minimising risk in those patients vulnerable to suicidal feelings.

Commissioning for Quality and Innovation (CQUINs)

A proportion of the Heart of England NHS Foundation Trust income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between the Heart of England NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available by contacting the head of performance at the trust. The CQUIN value within the contract was £11,436,628 of the Trust's income in 2014/15 (based on 2.5% of the contract value of £542,587 million). CQUINs encompass the Acute, Specialised services, Community Services and Public Health contracts and include the following CQUINs detailed below. For the contracting year ending March 2014 a sum of approximately £13.1 million was received for CQUINs.

Acute Contract

Goal Number	Performance Indicator	HEFT Achievements
1.1a Friends and Families Test (FFT) Implementation of Staff FFT	Demonstrate that staff FFT has been delivered across all staff groups. Reported June 2014	Achieved
1.1b Friends and Families Test Early Implementation	Early Implementation of patient FFT in outpatient and day case departments Implementation by 1st October 2014	Achieved
1.2 Friends and Family Test Increased Response Rate Inpatient Services	Increased response rate in Acute Inpatient Services and ED Inpatient 30% and ED 20% by year end	Achieved
1.3 Friends and Family Test Response Rate in Acute Inpatients	The response rate of 40% to be achieved for Acute Inpatient Services during March 2015	Achieved
2.1 Safety Thermometer Improvement Goal Specification	50% reduction in Pressure Ulcer Prevalence to 2.08 by 31st March 2015	Not achieved Although there has been an improvement on last year's outturn with a 14.4% reduction, the 50% reduction target has not been achieved. A tissue viability steering group has been established to further focus on improving performance
3.1 Dementia Find, Assess, Investigate, Refer	Achieve 90% or more for each of the following elements of Dementia Screening Find Assess Investigate Refer	Not achieved The 90% element was achieved for assessments only. Trust IT systems have been updated to facilitate improved data capture, which has led to significantly better performance for this CQUIN compared to 2013/14. Further automation is planned to further improve performance
3.2 Dementia Clinical Leadership	Identify a named Dementia Clinician lead and implement planned training programme by March 2015	Achieved

3.3 Dementia Supporting Carers of People with Dementia	Undertake an audit of carers of people with dementia to test whether they feel supported and report the results to the Trust's Board	Not achieved A 3 month long survey was undertaken instead of an audit. Unfortunately the response rate was extremely poor.
4.1 Safeguarding Learning from Safeguarding Concerns	Ensure that lessons learnt following a safeguarding event, are embedded into safeguarding practice	Achieved
4.2 Safeguarding Children/ Common Assessment Framework for Children	To increase the number of Common/Children Assessment Framework (fCAF) for Children. A total of 100 to be initiated and undertaken throughout 2014-15	midwives and other relevant staff to increase the number of fCAFs undertaken
5.1 Elimination Improved dignity and care for patients	To improve the quality of care and patient experience for patients with short term urinary incontinence	Achieved
5.2 Elimination Reduce Oral Laxative Use	Reduce the use of oral laxatives by encouraging a high fibre diet and fluid intake	Achieved
6.1 Deteriorating Patient – Escalation	Early identification and escalation of deteriorating patient. To include: Observations recorded and repeated at correct frequency Mews calculated and documented correctly Escalation as per policy	Achieved
6.2 Deteriorating Patient – Documentation and Communication of DNACPR	Clear documentation for DNACPR decisions and evidence of clear communication of the DNACPR to the patient and or relative	Achieved
6.3 Deteriorating Patient Improved management of severe sepsis	Where there is a diagnosis of severe sepsis, the sepsis 6 care bundle is used in accordance with protocol	Achieved

7.1 Leadership for Harm Free Care Transparent Care	The Trust publishes information at ward level across all sites with regards to the level of harm free care provided within the defined metrics agreed with commissioners	Achieved
7.2 Leadership for Harm Free Care Improving culture	Board Members to go back to the floor to engage with staff on patient safety concerns. All board members have undertaken at least one floor walk each month	Achieved
8.1 Cancer Survivorship Framework (wellbeing clinic)	Health and wellbeing advice and information is provided to a defined cohort of patients with cancer (breast and colorectal) and their families and carers as appropriate	Achieved
8.2 Cancer Survivorship framework (treatment summaries)	The trust develops and provides treatment summaries for patients with colorectal cancer	Achieved
9 Maternity low risk deliveries	Supporting low risk deliveries for women that are assessed as being low risk within the unified assessment criteria. Evidencing that women deemed low risk re having low risk births at time of delivery	Achieved

Community Services Contract

Goal Number	Performance Indicator	HEFT Achievements
1.1a Friends and Families Test Implementation of Staff FFT	Rollout of Friends and Family Test across all staff groups as determined by guidance	Achieved
1.1b Friends and Families Test Phased Expansion	Phase expansion of Friends and Family as per agreed service list. Full delivery of the nationally set milestone	Achieved
2.1 Safety Thermometer Reduction in Pressure Ulcers	50% reduction from baseline pressure ulcer prevalence	Not achieved Although there has been an improvement on last year's outturn with a 14.4% reduction, the 50% reduction target has not been achieved. A tissue viability steering group has been established to further focus on improving performance
3.1 Safeguarding Learning from Safeguarding Concerns	Ensure that lessons learnt following a safeguarding event, are embedded into safeguarding practice	Achieved
3.2 Safeguarding Children Common Assessment Framework	To improve the number of fCAFs/right Service Right Time assessments initiated by children's staff. A total of 100 to be initiated and undertaken throughout 2014-15	Not achieved The Safeguarding lead is working with Health Visitors, midwives and other relevant staff to increase the number of fCAFs undertaken
4 Elimination Improving the management of urinary incontinence in inpatients	Improve the quality of care and patient experience for patients with short term urinary incontinence	Achieved
5 Leadership for Harm Free Care Improving culture through board level ownership	Board members go back to the floor to engage with staff on patient safety concerns. Improving culture through board level ownership	Achieved
6 Dementia Champions Improving Care to dementia champions through dementia champions	Improve care to dementia sufferers through dementia champions. Develop and produce the CQUIN for 2015/16 to include the dementia training in community services and how champions will work to signpost patients and carers	Achieved

Specialised Services Contract

Goal Number	Performance Indicator	HEFT Achievements
1.1a Friends and Families Test (FFT) Implementation of Staff FFT	Demonstrate that staff FFT has been delivered across all staff groups. Reported June 2014	Achieved
1.1b Friends and Families Test Early Implementation	Early Implementation of patient FFT in outpatient and day case departments	Achieved
1.2 Friends and Family Test Increased Response Rate Inpatient Services	Increased Response Rate in Acute Inpatient Services and ED Inpatient 30% and ED 20% by year end	Achieved
1.3 Friends and Family Test Response Rate in Acute Inpatients	The response rate of 40% to be achieved for Acute Inpatient Services during March 2015	Achieved
2.1 Safety Thermometer Improvement Goal Specification	50% reduction in Pressure Ulcer Prevalence	Not achieved Although there has been an improvement on last year's outturn with a 14.4% reduction, the 50% reduction target has not been achieved. A tissue viability steering group has been established to further focus on improving performance
3.1 Dementia Find, Assess, Investigate, Refer	Achieve 90% or more for each of the following elements of Dementia Screening Find Assess Investigate Refer	Not achieved The 90% element was achieved for assessments only. Trust IT systems have been updated to facilitate improved data capture, which has led to significantly better performance for this CQUIN compared to 2013/14. Further automation is planned to further improve performance
3.2 Dementia Clinical Leadership	Named lead clinician and planned training programme implemented	Achieved

3.3 Dementia Supporting Carers of People with Dementia	Monthly audit of carers undertaken and results reported to Trust Board	Not achieved A 3 month long survey was undertaken instead of an audit. Unfortunately the response rate was extremely poor.
4 – A06 Shared Haemodialysis Care Friends and Families	To offer the choice to in-centre and satellite haemodialysis patients to become involved in tasks relating to their dialysis	Achieved
5 – A08 Faecal Incontinence Multidisciplinary Decision Making	Increased use of Multidisciplinary Meetings to support decision making prior to surgery for Faecal Incontinence	Achieved
6 – CB3 Patient Held Records	Encourage the use of patient held records by provider services for long term conditions eg HIV, haemophilia, cancer, infectious diseases and haemoglobinopathy	Achieved
7 – CB10 Investment in HIV IT	Development of HIV IT system to support implementation of ARV procurement programme	Achieved
Quality Dashboards	Quarterly submission of Clinical Dashboards for Specialised Services for the following: Cardiology Cystic Fibrosis Adult BMT (Bone Marrow Transplant) Neo Natal Intensive Care Unit (NICU)	Achieved

Care Quality Commission

Heart of England NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with seven compliance actions. Heart of England NHS Foundation Trust has the following conditions on registration:

Regulation 10	There was a lack of robust incident reporting feedback which could result in learning opportunities being lost; management of patient handover and timely assessments in ED; service delivery and improvement in outpatients with the use of management reporting data
Regulation 12	Within ED cleaning practices needed to improve. Within the Trust, staff were not adhering to Trust policy
Regulation 13	Where emergency medications were required within maternity they were not readily available, staff were unaware of its whereabouts and they had not been checked regularly to ensure that they were still in date and safe to use
Regulation 16	Lack of equipment and faulty equipment not being replaced in a timely fashion
Regulation 23	The appraisal rate for staff within the Trust was 38%. This rate had the potential to impact on the level of care patients received. Managers also lost the opportunity to support staff and identify areas where additional support was required. In addition the visibility of the head of midwifery continues to be an issue as identified during the previous inspection in November 2013.
Regulation 11	Safeguarding processes were not in place for people wearing mittens in the Trust
Regulation 22	Nursing staffing was insufficient in places having a direct impact on patients. For instance not being able to staff the second obstetrics theatre in maternity

(Note: the table above outlines the draft recommendations – prior to factual accuracy sign off by the Trust)

The Care Quality Commission has not taken enforcement action against Heart of England NHS Foundation Trust during 2014/15.

The trust was subject to an unannounced inspection in December 2014. The outcome of this review (included in the draft report) was summarised as follows:

Safe – Requires Improvement
Responsive – Requirement Improvement
Well-led – Requires Improvement

The Effective and Caring domains were not assessed during this inspection

The CQC key findings are outlined as follows:

- Widespread learning from incidents needs to be improved
- Appraisal rates need to be improved
- Staff sickness and attrition rates were impacting negatively on existing staff
- Poor patient flow mainly at BHH and GHH was having negative impacts across the core areas that were inspected
- Referral to Treatment times were not always met
- Discharge arrangements required improvement
- The care of deteriorating patients was generally managed well
- Arrangements for patients with reduced cognitive function was not always managed well
- The culture within the Trust was one of uncertainty due to the number of changes which had occurred
- Staff could not communicate the Trust vision or strategy
- Governance arrangements needed to be strengthened to ensure more effective delivery
- IT reporting needed to be improved

At the time of writing this Quality Account the CQC draft report is still undergoing factual accuracy checks with the Trust and CQC. An action plan to address issues identified in the report will be developed and monitored by the Executive Team and the Trust Quality & Risk Committee. Actions are already in being delivered as part of the Integrated Improvement Plan to address many of the issues raised including: developing and communicating the Trust strategic vision; governance arrangements; urgent care; culture and leadership and IM&T.

Heart of England NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2014/15: Maternity Services.

Heart of England NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

Review the maternity documentation to ensure that it adequately reflects significant chronological events and social risk factors; Ensure that routine inquiry in relation to domestic abuse is utilised in line with current policy and best practice guidance; review the personalisation of birth plans to ensure they are tailored to the needs of the individual; ensure that mechanisms are in place to monitor the attendance and provision at case conferences by midwives. In relation to Emergency Department: Ensure compliance with the safeguarding specific element of ED assessment; ensure that 16-18 year olds are reviewed using appropriate documentation which takes into account their legal status as a child; review the fitness of purpose of the discharge information from Eds to GPs to ensure it fully reflects risks identified; ensure that conversations with Social Workers in MASH are recorded in the ED assessment documentation; ensure a flagging system operates in the ED to makes staff aware of children subject to Child Protection or Child in Need Plans; Ensure that the Training requirements for Staff are developed in line with intercollegiate guidance; ensure that supervision is documented in records

Heart of England NHS Foundation Trust has made the following progress by 31st March 2015 in taking such action:

The Trust has implemented a new electronic recording system in Maternity Services which enhances assessment and chronology formation. The Trust has an audit programme continuously reviewing compliance with routine inquiry policy guidance and has delivered additional training to midwives about these requirements; the Trust is monitoring attendance of midwives at Case Conferences and their provision of reports; the Trust has a Supervision Policy outlining recording requirements, an Education and Development Policy, based on intercollegiate guidance and making training requirements clear for all our staff. The trust has an electronic flagging policy and currently flags children subject to Child Protection Plans and those children referred by our staff to Social Care. The Trust is working with partners on the implementation on the National CP-IS system; The Trust is enforcing compliance with existing documentation requirements and simultaneously re-designing ED assessment paperwork, and ensuring that this will be utilised for all children up to the age of18. The discharge information is under review and all relevant staff have received detailed feedback in relation to the CQC findings including what must be included in discharge summaries. The Trust has submitted supporting evidence to the CQC via the CCG supporting progress to date and will undergo assurance visit/ visits from CCG staff in the near future to evaluate the implementation of changes to date.

Solihull CCG has also carried out several quality visits throughout the trust over the previous year which includes:

Solihull Hospital:
- Ward 17 – May 2014 (Falls spot check)
- Ward 20a – May 2014 (Falls spot check)
- Whole site – June 14 (Hard truths workforce)
- Cardiology Rehabilitation Gym – October 2014 (on going assurance)
- Acute Medical Unit – January 2015 (Patient experience)
- Ward 18 – January 2015 (Patient experience)
- Arden Lea – February 2015 (Patient experience)

Good Hope Hospital:
- Ward 16 – June 2014 (Falls spot check)
- Cedarwood – 2 visits July 2014 (Review of compliance with quality standards of care)
- Ward 8 – September 2014 (Falls)
- Ward 8 and Ward 16 – March 2015 (Patient experience)

Heartlands Hospital
- Ward 24 – May 2014 (Falls spot check)
- Ward 8 – September 2014 (Patient experience and dementia)
- Ward 8 – March 2015 (Fundamentals of care)

Action plans following these visits are monitored by the individual sites.

Data Quality

The Heart of England NHS Foundation Trust submitted records during 2014/2015 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:

Valid NHS Number	%
Admitted patient Care	99.66
Outpatient Care	99.86
Emergency Care	98.27

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

Valid NHS Number	%
Admitted patient Care	99.90
Outpatient Care	100
Emergency Care	99.71

Information Governance Toolkit

Heart of England NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 68% and was graded green.

Details of the Level 2 Information Governance incidents are outlined in the Annual Report.

Clinical Coding Error Rate

Heart of England NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by Capita under the current Audit Commission framework. The audit took place in April 2015 with the final report and result unavailable until June 2015.

Taken from the Trusts internal Information Governance audit (and not undertaken by Capita under the Audit Commission Framework), the coding error rate for diagnoses and treatment coding (clinical coding) was:

	% procedures coded incorrectly		% diagnoses coded incorrectly	
	Primary	Secondary	Primary	Secondary
Overall	8.9	9.7	8.9	8.5

The audit touched on almost all specialties and covered 20 of the trust's coders across all sites. In total 950 Finished Consultant Episodes (FCEs) were audited, selected at random by the trust information team from our data submissions. The results should not be extrapolated further than the actual sample audited.

Improvement of Data Quality

Heart of England NHS Foundation Trust will be taking the following actions to improve data quality:

- A suite of data quality (DQ) indicators form part of monthly directorate reports and are a standing agenda item on performance meetings with action plans in place to improve on performance
- Reports monitoring the timeliness against the new target of within 2 hours for Admissions, Discharges & Transfers (ADT) have been set up with links on the DQ sharepoint site for use by all operational inpatient areas. A monthly DQ ADT matrix report detailing the top 3 areas of concern across all divisions is reported monthly to matrons and lead nurses and is monitored via the Nursing Performance Committee
- A Data Quality Strategy and Data Quality Steering Committee are currently being developed this committee will focus on areas of concern requiring improvement in data quality
- The trust employs a team of data quality staff within the Finance Performance Directorate who raise the importance of good data quality and also participates in the training of staff as it relates to data quality for the use of the trust's main systems

National Quality Indicators

A national core set of quality indicators has been jointly proposed by the Department of Health and Monitor for inclusion in trust Quality Reports from 2012/13. The data source for all the indicators is the Health and Social Care Information Centre (HSCIC) which has only published data for part of 2014/15 for some of the indicators. The trust's performance for the applicable quality indicators is shown in **Appendix 2** for the latest time periods available. Further information about these indicators can be found on the HSCIC website: www.hscic.gov.uk

Part 3:

Other Information

Below is an overview of some of the quality of care initiatives offered by the trust against indicators originally chosen by the Executive Management Board because of their importance regarding patient care. An update on the progress to embed these indicators is included below.

These are:

Patient Safety Indicators:	Medication safety Improving recognition and management of deteriorating patients (new) Infection control
Clinical Effectiveness Indicators:	Incident reporting, management and learning Serious incidents and never events Morbidity and mortality
Patient Experience Indicators:	Inpatient satisfaction Friends and family test Complaints

One of the patient safety indicators has been changed from that reported in 2013/14, from cumulative balance to deteriorating patients. This is to reflect trends in incidents and concerns that have been raised and also maps in with priorities agreed with our collaborative and regional partners.

Where applicable, these are governed by standard national definitions.

Patient Safety

Medication Safety

In 2013 improving medication safety, by reducing avoidable harm from missed and delayed doses, was identified as a trust safety priority. Antibiotics were agreed as the first medication priority as:

- There is considerable evidence to show that prompt delivery of antibiotics reduces harm
- Trust data suggested that the scale of the impact (with approximately 75 STAT (immediate) antibiotic doses prescribed each day at the trust) could be significant

During 2014/15 the antibiotic safety team have rolled out the antibiotic dashboard across all three hospital sites. The dashboard shows staff how wards or departments are performing in two key areas:

- Compliance with 1 hour target of STAT antibiotic administration
- Compliance with 100% target for all antibiotic prescriptions to have a STOP date

Figure 1: STOP DATES compliance before the dashboard – 1st November 2013 to 31st December 2013

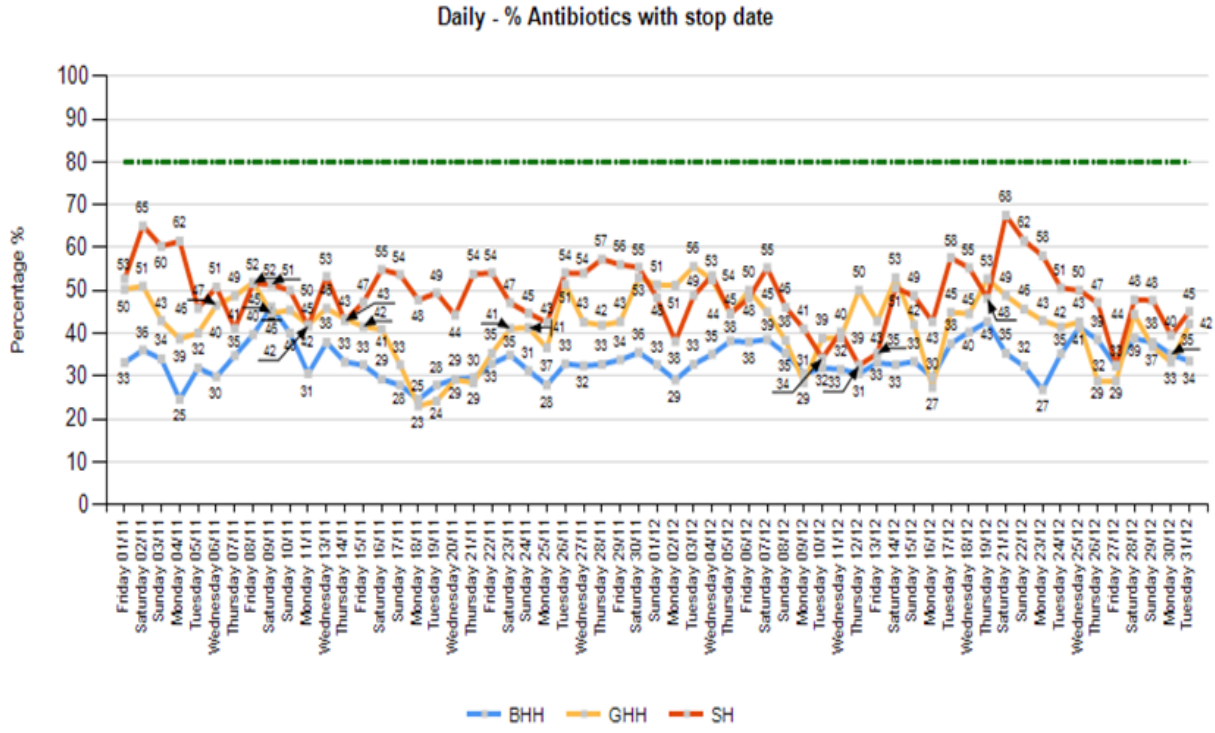
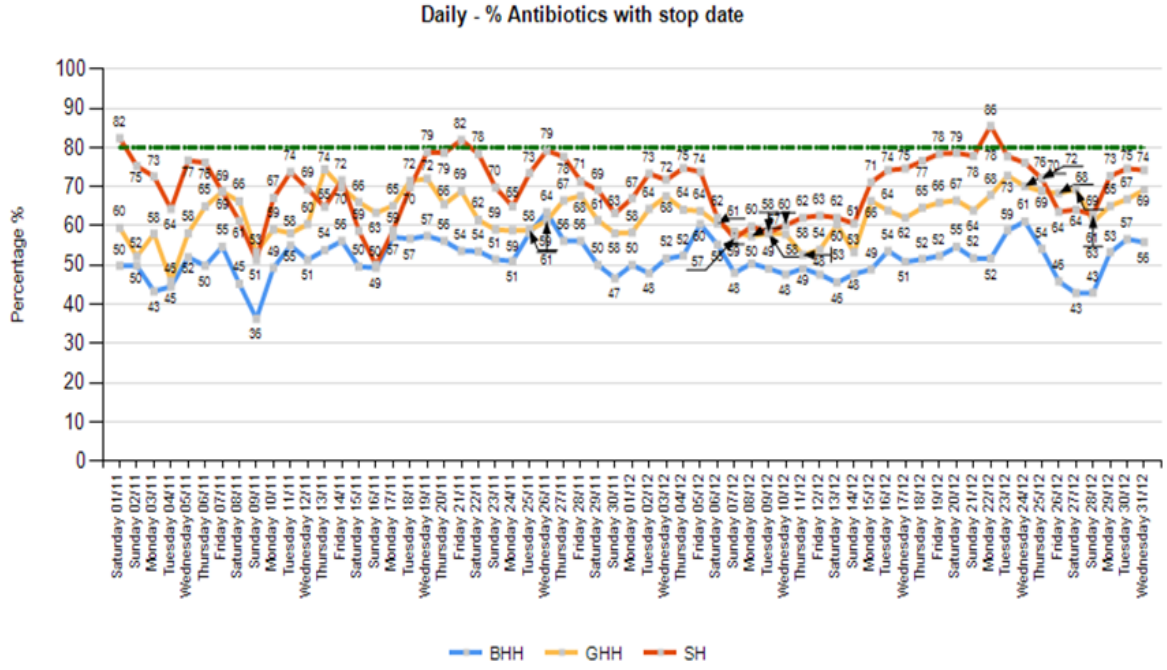


Figure 2: STOP DATES compliance one year on – 1st November 2014 to 31st December 2014



The figures above compare compliance with one of these key areas, compliance with STOP dates, before and after the dashboard was introduced and clearly illustrate a Trust wide improvement.

A Key Performance Indicator (KPI) has been agreed in relation to STOP dates, in line with overall safety strategy to reduce antibiotic resistance.

Since January 2014 the dashboard has undergone further refinements including the development of a 'LIVE' tab. The LIVE tab has enabled targeted work with acute admission areas which prescribe the largest proportion of STAT doses in the Trust.

A novel 'real time' STAT IV antibiotic bleep is being piloted in AMU areas which provides a simple prompt to alert nursing staff when an IV STAT dose has been prescribed.

The aim is that this simple solution will overcome known problems with communication about STAT doses as well as build resilience into the system.

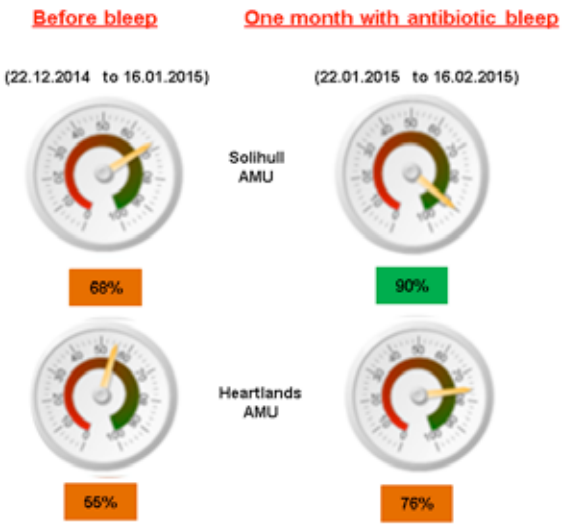


figure 3: Compliance with 1 hour target
before and after introduction of antibiotic bleep

Although the bleep trial is in its infancy, positive clinician feedback and site performance, illustrated below indicates that the bleep is a useful technological intervention to support sustained improvement.

Educational resources to support antibiotic safety

- **Antibiotic safety video:** The antibiotic safety team have developed an educational video, showcasing the antibiotic dashboard, which is being in Trust wide educational programmes. The video has generated interest from JAC, the trusts' electronic prescribing system provider who have uploaded it onto the customer portal as an exemplar of good practice to demonstrate to other trusts how electronic prescribing system data can be used to drive safety improvements.

- **Lesson of the Month:** A lesson of the month has been launched reminding staff of the importance of prompt STAT antibiotic administration and outlining responsibilities of prescribers, administrators and ward based pharmacy staff. From February 2015 wards will be monitored against the target of 80% STAT IV Antibiotic administrations in the new ward performance framework.

- **Recognition of success:** The success of the antibiotic safety project has been acknowledged both internally and externally. The antibiotic safety team won the trust Patient Safety Award at the 2014 staff recognition awards the team; they were also shortlisted as a finalist for the National Safety and Care awards 2014.

Regional Safety Collaborative

We have also recently joined the West Midland Patient Safety Collaborative hosted by the West Midland Academic Health Science Network (WMASN). The aims are to improve safety and continually reduce avoidable harm by supporting organisations in working together to develop, implement, share and spread proven safety interventions that are based on rigorous, evidence-based scientific methodologies. They are working on a number of region wide projects which the trust will contribute to and these include:

- A review of SCRIPT training for Foundation Doctors
- Development of Electronic Prescribing SPACE (Sharing Practice and Continuing Education) website for non-medical prescribers
- Improvements to the implementation of the 'Green Bag Scheme' to help patients to bring medicines into hospital and support transfer between wards and on discharge

We have also proposed a new project to the WMASN for consideration: the standardisation of cardiac arrest/ emergency boxes across the region following local anaphylaxis improvement work.

Improving recognition and management of Deteriorating Patients

Improving the recognition and management of deteriorating patients remains a trust priority and in February 2014 the Trust Deteriorating Patient Recognition Group (DPRG) was reconvened. This is a new indicator in the quality account and therefore previous data is not available. This group monitors and co-ordinates activity aimed at improving recognition and management of deteriorating patients. A number of work streams are underway. These include:

NHS QUEST

In March 2014 the trust was invited to become a member of NHS QUEST. NHS QUEST is a new model of collaborative working that is breaking down traditional boundaries and focussing on networking like-minded organisations across England around a set of shared ambitions with a strategic focus on improving safety and quality. Clinical engagement, use of quality improvement (QI) methodologies and adoption of sustainability model are core features of the Quest approach.

For year one, the priorities that the Quest members have agreed to work on are:

- Improved compliance with severe sepsis bundle
- Reduction in cardiac arrest rates

These priorities are in line with trust safety strategy and it is anticipated that being an active member of this collaborative will facilitate improvements with recognition and management of deteriorating patients. Pilot areas for improvement include:

- Early identification and escalation of deteriorating patient
- Documentation and communication of DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)
- Improving compliance with sepsis six bundle

Sepsis: Work has started with Acute Medicine Assessment and Surgical Assessment Units; a revised sepsis screening tool has been developed and is being piloted and refined. This tool has been aligned to the revised National guidelines for recognition and management of severe sepsis. Engagement with front line clinicians is key to the success of these projects and staff are piloting new 'innovative' solutions such use of a designated sepsis trolley and use of an automated bleep system to improve antibiotic delivery.

Surgical escalation cards: In June 2014 the Surgical Directorate developed and rolled out a surgical escalation prompt cards. The cards provide guidance and support staff within surgical teams in the escalation of deteriorating surgical patients.

Winter poster campaign: During January 2015 a Deteriorating Patient winter poster campaign was launched. This was a priority identified by DPRG and also in response to a series of Serious Untoward Incidents (SUI) relating to deteriorating patients.

This campaign was aimed at educating and supporting staff to 'do the right thing' and the response from front line staff to the campaign has been extremely positive.

Initially the campaign was aimed at general wards, however, interest spread to other specialist areas (e.g. paediatrics and maternity) who have asked if they can adapt the posters for their areas

Deteriorating Patient and eObs project posts: In January 2015 we appointed a deteriorating patient CQUIN project nurse to lead improvement work associated with the local deteriorating patient CQUIN. In addition to this a clinical project lead for electronic observations has also been appointed.

Infection Control

This year a trajectory of zero post 48 hour MRSA bacteraemias was set. One has been recorded and this was deemed to be avoidable. It had been 383 days since the previous MRSA bacteraemia within the Trust. There have been no MRSA bacteraemias at Solihull Hospital for over three years. The Trust acknowledges that improvements can still be made.

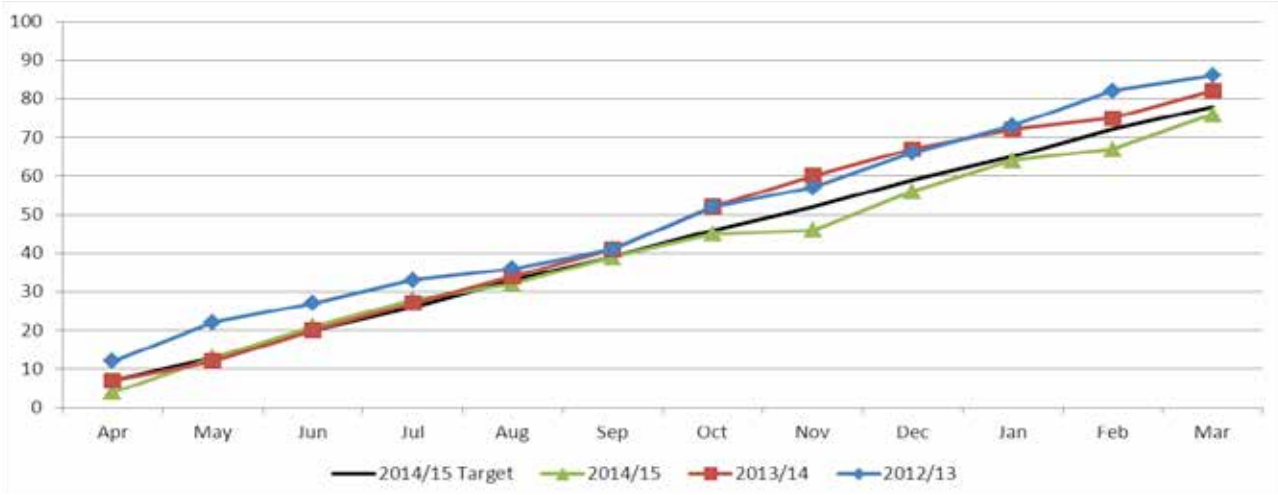


Figure 1. HEFT MRSA bacteraemia cases for April 2014 to March 2015, with the annual threshold shown

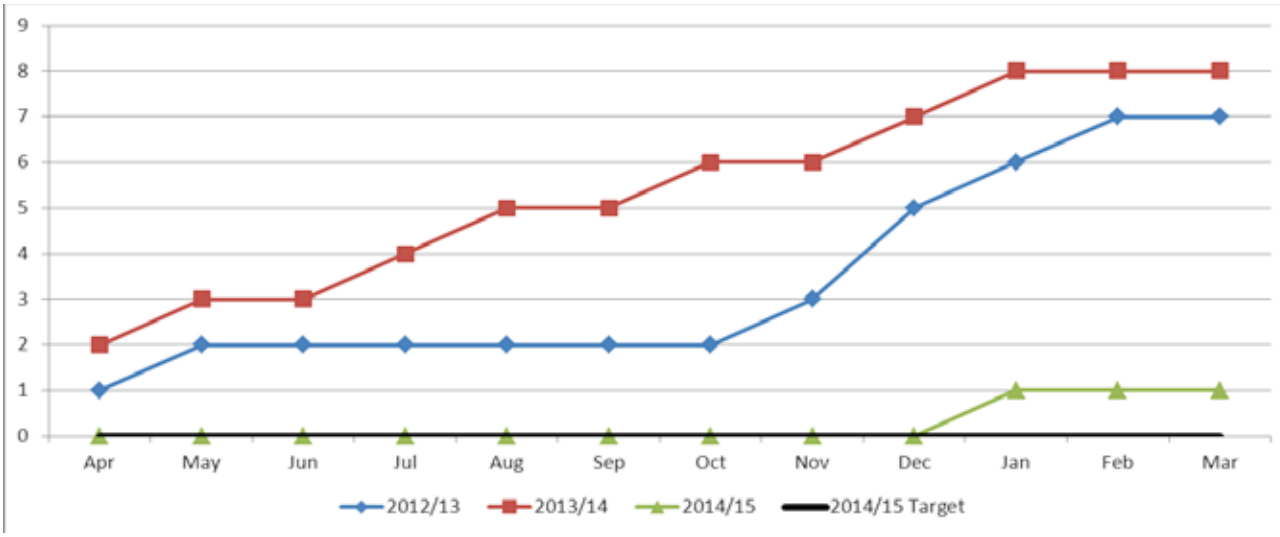


Figure 2 HEFT C. difficile toxin-positive post-48 hour cases from April 2014 to March 2015, with the annual threshold shown

A very challenging trajectory of 78 Clostridium difficile cases was set this year. The trust has remained within this with a total of 76 cases. A number of these cases were considered unavoidable and it is likely that an irreducible minimal has now been achieved.

Clinical Effectiveness

Incident Reporting, Management and Learning

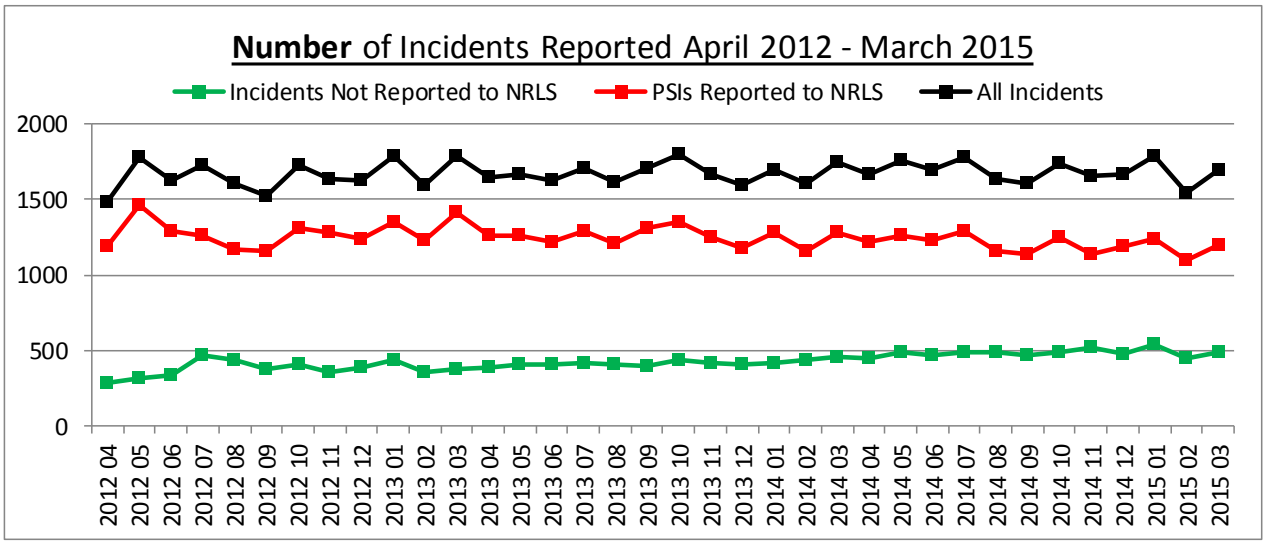
We actively encourage the reporting of all types of incidents to ensure that lessons can be learnt from such occurrences. We continue to consider a high level of incident reporting as an indication of a good safety culture.

When staff report an incident they are asked to consider the level of harm to the person, property or services that has occurred, in summary the level can be:

- Catastrophic/death: Death directly attributed to the incident / multiple permanent injuries or irreversible health effects;
- Severe: Causing permanent and significant harm;
- Moderate: Causing significant but not permanent damage;
- Low: Requiring extra observation or minor treatments; and
- No harm: Any incident that caused or resulted in no harm done.

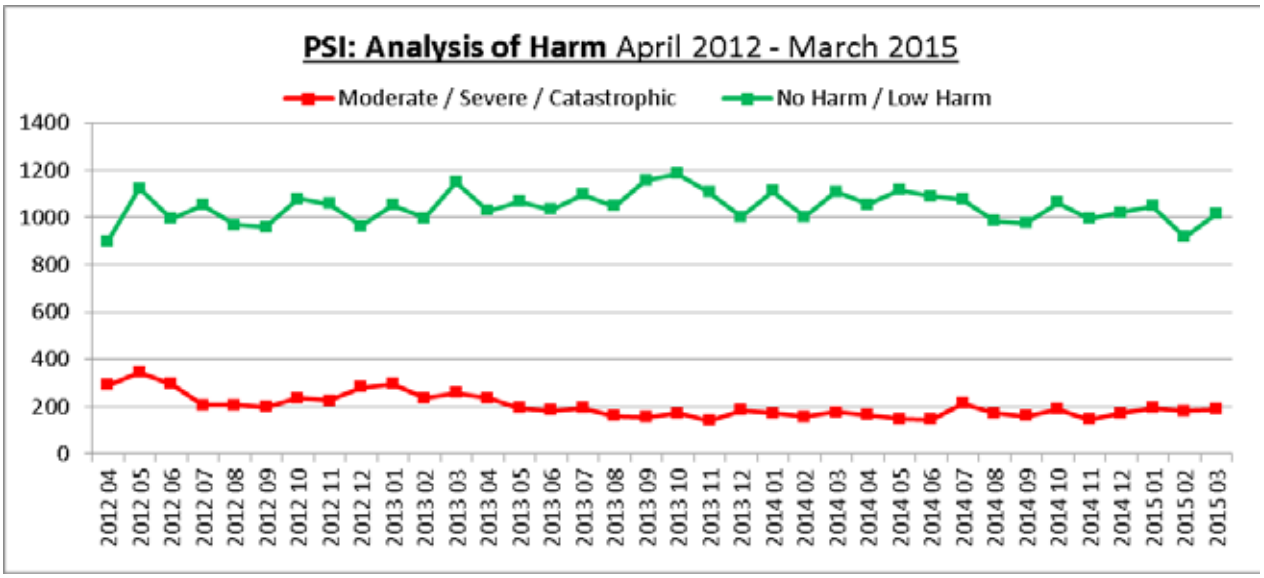
Whilst this can only be a very subjective assessment at the time of the incident, and may change as more is learned about the incident or outcome of the incident, this grading is used to identify the incidents that are to be investigated using RCA to identify learning.
Patient Safety Incidents (PSI's) are broadly defined as any incident causing or having the potential to cause harm to a patient receiving services from the trust. These incidents are reported to the National Reporting and Learning System (NRLS) to support national data analysis, comparison and learning.

Incident Reporting



[4]The definition of an incident is very broad and can be considered as any event which causes or has the potential to cause any of the following:

- Harm to an individual;
- Financial loss to an individual or the Trust;
- Damage to the property of an individual or the Trust;
- Disruption to services provided by the Trust;
- Damage to the reputation of the Trust.

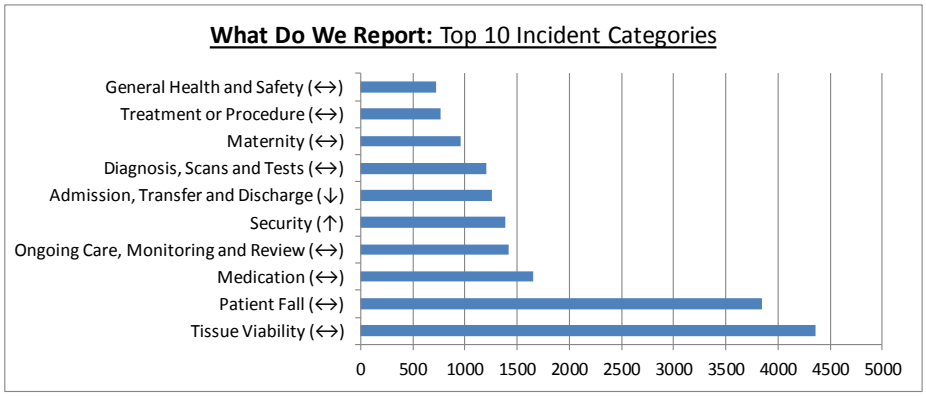


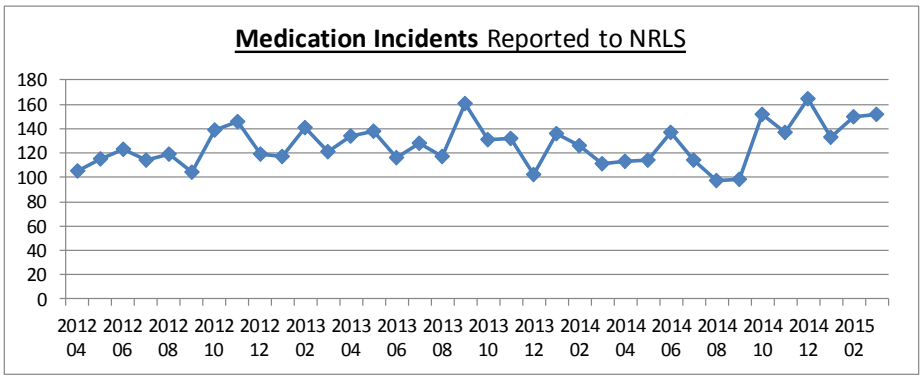
The incident profile that we see this year remains relatively static and is broadly the same as last year. In summary it shows us:

We have reported over 20,000 incidents this financial year. Of those almost 14,500 are PSI's and have been reported to the NRLS.

Incidents are reported from all the locations where trust services are provided including primary care settings and patients' own homes. The profile of where incidents are reported from remains broadly similar to last year, with the majority of incidents reported from Heartlands Hospital, Good Hope Hospital and Solihull Hospital, reflecting where the trust provides most of its services.

The top 10 categories of reported incidents has not changed since last year, although the order of some of them has changed marginally, illustrated by the arrows.





[5]An investigation process to determine high level information about the reported incident including the actual level of harm caused and the level of investigation recommended.

Much work, described elsewhere in this document continues to ensure reporting and learning from tissue viability incidents and patient falls.

This year we have developed a framework to support the reporting, investigation and learning from medication incidents which includes a bespoke root cause analysis tool and is supported by two contractual indicators:

- All medication incidents resulting in severe or catastrophic harm are reported on STEIS within 48 hours of the incident being identified. This financial year we have "scoped " 20 medication incidents and followed 6 of these with RCA investigation. We have not always managed this within the 48 hour target but continue to work on the quality, timeliness and learning from these investigations

- Increase reporting of medication-related incidents to NRLS: The graph below suggests that the number of incidents we report to the NRLS has remained broadly static; we will need to watch this trend over the next financial year to see if increased focus on medication incidents can be reflected in this way.

Serious Incidents and Never Events[6]

The trust uses incident severity as one way to identify the most serious of incidents and decide how an incident should be investigated.

In 2014/15 we have "scoped" over 137 reported severe harm incidents, leading to

- 25 investigations in line with the trust's serious untoward incident policy (SUI). See the table below for details
- 60 local level RCAs with oversight / review from investigation team

This process reflects a conscious intent to lower the threshold, (and therefore increase the number) of incidents being investigated in line with the trust's SUI policy and thereby increase the learning and quality improvement opportunities from the incidents.

Site	10/11	11/12	12/13	13/14	14/15
BHH	8	11	7(2xN)	7 (1xN)	17 (1xPN)
GHH	5	1	3 (1xN)	4 (2xN, 1xPN)	6
SH	-	5	1	3 (2xN)	2 (1xN)
Other	-	-	-	1	-
Total	14	17	11	15	25

[6]'Never Events' are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. Each year the Department of Health updates the list of Never Events and the associated guidance to prevent or minimise the risk of such an event.

To be a Never Event, an incident must fulfil the following criteria:

- The incident has clear potential for or has caused severe harm/death;
- There is evidence of occurrence in the past (i.e. it is a known source of risk);
- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation;
- The event is largely preventable if the guidance is implemented; and
- Occurrence can be easily defined, identified and continually measured.

This is reflected in the numbers above which shows a 66% increase in the total number of SUI's from 2013/14 to 2014/15. Whilst the proportion of incidents that have occurred at Heartlands Hospital has increased slightly there is no obvious trend or pattern in these incidents.

This year we have had:

- One Never Event: Wrong implant (ophthalmology)
- One Prevented Never Event: Opioid overdose of opioid I patient (paediatrics)

Whilst we have continued to actively share and disseminate learning from SUIs with 'Safety Lessons of the Month', doctors ''Risky Business Forum' and 'SUI: At a glance' reports and trust-wide cascade process our recent main areas of focus, which will carry over into the next financial year, have been:

Support and training: The term ""RCA" still strikes fear into the heart of some of our staff, we cannot hope to increase our learning from incidents without demystifying the incident reporting and investigation tools and processes. We have had the opportunity to invest in some new staff and develop some new training and resource packages. So far we have held 3 RCA training events and already have a waiting list for future events.

Quality improvement plans: With the complexity and constantly changing workforce of our organisation, one of our constant challenges is how to embed sustainable learning from incidents. We have recently established an assurance panel, chaired by our deputy chief nurse and deputy medical director, to examine progress with, and effectiveness of, quality improvement plans from all incidents investigated in line with the SUI Policy.

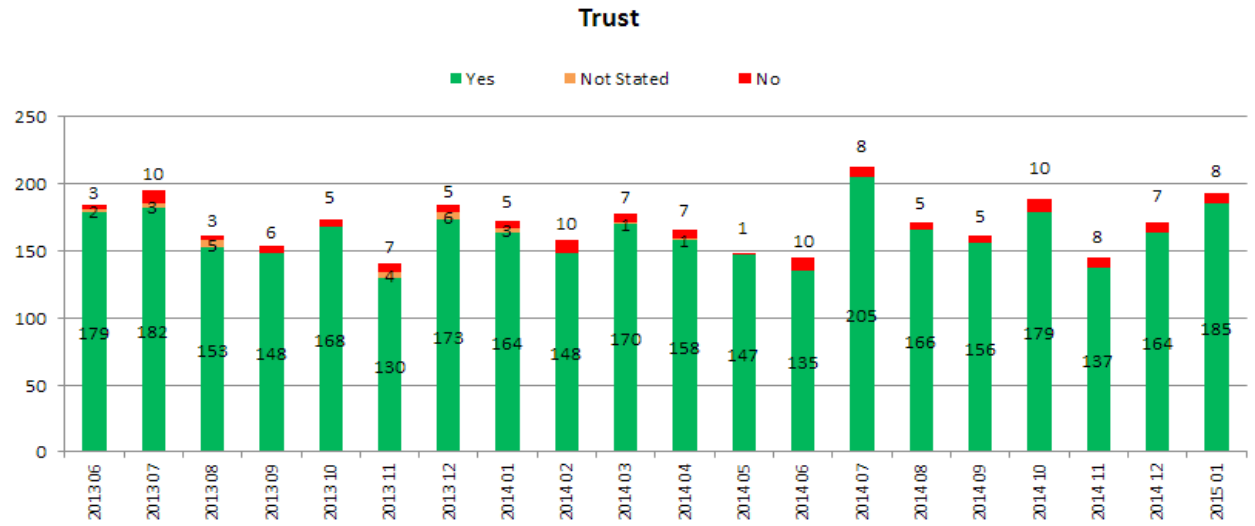
We are also continuing to work with our commissioners to establish a regional group to share learning from incidents and best practice in incident management across the local healthcare economy.

Duty of Candour

From November 2014, NHS England required a contractual duty of openness to be included in all commissioning contracts, called 'duty of candour'. This meant that NHS organisations were contractually required to tell patients about adverse events where moderate, severe or catastrophic harm has occurred, and ensure that lessons are learned to prevent them from being repeated.

These principles are not new, and are outlined in the trust's 'being open' policy which has been in place since 2008. The essence of being open is that patients, relatives and carers should receive the information they need to understand what has happened, receive an apology, details of the investigation into the incident and reassurance that lessons will be learned to help prevent the incident reoccurring.

This year we used the incident reporting process to record and monitor how this duty is being fulfilled and share this information with the trust's CCG commissioners. The results of this monitoring are illustrated below.



With the introduction of the statutory duty of candour we will be reviewing the way that we implement this duty and working with our commissioners and regional colleagues to develop consistent processes to measure compliance.

Learning from incidents

Anaphylaxis: During the period of September 2013-2014 there were five incidents involving incorrect treatment of anaphylaxis. Analysis of incidents showed that administration of wrong dose and wrong route of adrenaline was a common theme.

The patient safety team; resuscitation and pharmacy teams have worked together during 2014/15 to bring about a number of trust wide changes to help reduce risk of further incidents occurring. These included:

- Improved labelling of red emergency drugs boxes- to signpost staff to the correct box to use in anaphylaxis emergency
- Inclusion of resuscitation council guidelines for anaphylaxis in red emergency drugs boxes
- Development of a "moodle" education package for anaphylaxis
- Trust wide communications and dissemination of a "lesson of the month" to raise awareness about the incidents and improved systems
- Since October 2014 no further incidents of incorrect treatment of anaphylaxis have been reported.

Management and treatment of inpatient diabetes: We are also working closely with the multidisciplinary diabetes team to run a month of simple messages about diabetes management and treatment. These lessons and key messages will be based on learning following concerns raised recently about diabetes management/knowledge in the trust. The current plan is to commence this at the end of April with a lesson of the month and then cascade weekly lessons throughout the month of May.

Incidents and errors

The learning lessons survey was launched on the 13th January 2015. This survey is the third to be cascaded and ensures that we continue to regularly evaluate if our learning lessons initiatives are effective and helps us improve our dissemination and cascade systems.

This year there are two learning lessons surveys: The first survey is very similar to the previous surveys and is generic for all staff to complete.

The second is a survey has been specifically devised for CD's, matrons, ward managers and governance leads. This survey is designed to gather feedback from senior staff who handle and manage incidents and will enable us to identify any gaps relating to feedback to frontline staff and also assess

knowledge and awareness related to our learning lessons initiatives.

Both surveys have been cascaded via multimodal methods to gather feedback from as many staff as possible. This also includes walking wards and departments with ipads, taking the survey directly to staff in clinical areas and providing hard copies to areas such as Theatres/ITU/ED and clinics.

The survey results will be posted on the intranet along with any improvements taken in response.

Lesson of the month

The 'Lesson of the month' initiative continues to work well and shares a different lesson each month. The lessons can be either proactive or reactive and depend upon incident themes and trends of concerns raised. The aim is to continue to increase the profile of specific incidents and relay key guidance to all staff.

The lessons of the month have generated good engagement from clinicians across the organisation. There have been a total of 29 lessons shared to date and currently there are a further 21 topics for the lessons of the month initiative.

Morbidity and Mortality

We monitor our mortality rates on a monthly basis using the Hospital Standardised Mortality Rate (HSMR) available from Dr Foster and on a quarterly basis using the Summary Hospital Level Mortality Indicator (SHMI) produced and published by the Health and Social Care Information Centre.

Both of these indicators are a ratio of observed number of deaths over expected number of deaths given the characteristics of the patients being treated by the trust.

We are also trialling the use of the CRAB tool (Copeland Risk Adjusted Barometer) looking at surgical outcomes and complications and along with triggers to identify potential (similar to the global trigger tool).

The outcomes of the National Audits and surgeon specific data are also reviewed.

Our multidisciplinary Mortality and Morbidity Performance Group meets monthly to review, analyse, interpret and request action upon mortality data on behalf of the Trust.

A quarterly report goes to the Trust Board level committee Quality and Risk and mortality data is also reported to Trust Board in the monthly Safety SITREP. Trust level mortality data forms part of the Delivery Unit report and the new/integrated governance report which go to Board level committees Finance and performance, quality and risk along with Trust Board for discussion.

Care Quality Commission Mortality Outlier Reports

One diagnosis, patients with an admission diagnosis of urinary tract infection and one procedure, therapeutic upper gastrointestinal endoscopy were identified as mortality outliers by the CQC requiring further investigation under their mortality outlier programme but covered periods within 13/14. These were investigated during 2014/15.

Outcome of these reviews:

Urinary tract infections (UTI). It was not possible to identify why there had been an increase during July to November 2013. The most recent data demonstrates that following the rise across all three sites, this has now returned to previous levels. Although in the majority of cases, overall care was felt to be good, even where UTI was not felt to be the correct diagnosis, there were a number of opportunities identified where we can improve both the diagnosis and treatment of UTI and other aspects of care.

- DNAR orders – improvements in several cases identified around documentation, communication and timing of DNAR. We are currently auditing DNAR orders and they form part of a CQUIN.
- Prescription and administration of antibiotics for UTI/sepsis. Although none of the patients were admitted with severe sepsis with organ failure, research shows that mandating antibiotics in one hour improve survival. Management of the deteriorating patient and patients with severe sepsis form part of this year's local CQUIN. These subjects also form part of an improvement project with the NHS Quest collaborative (see below)

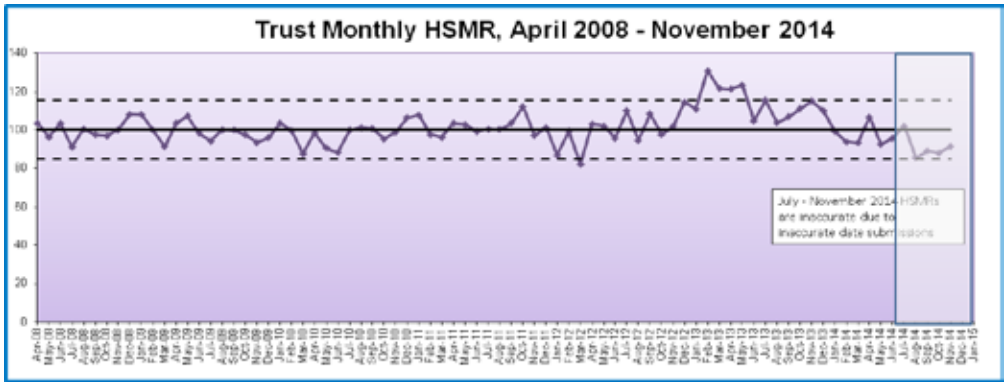
Therapeutic endoscopic procedures on upper GI tract (September to December 2013)

All deaths were anticipated and these patients had either advanced malignancies (eight) or significant co-morbidities (decompensated liver disease, cardiac, kidney and/or advanced age). The therapeutic endoscopic procedures were appropriate for palliative management (stents or percutaneous endoscopic gastrostomy) or control of bleeding.

There were some opportunities for improvement identified:

- All patients calculated as "high risk" upper GI bleed should have their gastroscopy test within 24-48 hours depending on the severity of the GI bleed. High risk upper GI re-bleed patients should be managed in a gastroenterology ward for regular specialist review, an earlier decision on ceiling for escalation of care or alternative therapy and specialist nursing care as per NICE.
- All decompensated liver disease patients should be seen by a Gastroenterologist within 24-48 hours of admission and managed in a gastroenterology ward as per NCEPOD recommendations

HSMR



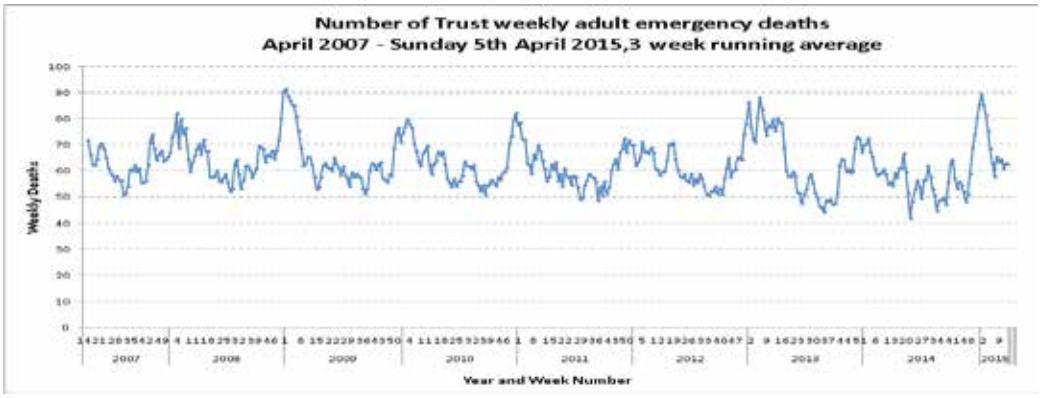
Dr Foster HSMR, December 2012 – November 2014 (rebased using 13/14 benchmark)

Dr Foster HSMR 2010/11 to April – Nov 2014

Site	2010/11 (rebased)	2011/12 (rebased)	2012/13 (rebased)	2013/14 (rebased)	2014/15 YTD (2013/14 base)
Trust Wide	98.6	98.5	107.9	107.9	97.4
Heartlands Hospital	97.7	101.2	109.3	112.4	107.0
Good Hope Hospital	103.3	98.5	108.4	106.7	97.3
Solihull Hospital	93.0	93.1	104.2	100.6	76.6

As can be seen from the graphs above, the trust has seen a steady decline in its monthly HSMR over the last year compared with the previous year 2013/14. We remained an outlier once Dr Foster recalculated their annual benchmark data from all Trusts for 2013/14. This suggested that other Trusts are improving more than we are. It should be noted that following the move to a new patient administration system in July 2014 it was identified that there was a period of inaccurate inputting of the type of admission with more patients be coded as emergency rather than elective admissions. As a result the HSMR and SHMI may be affected and is not reliable for mortality measurement.

We moved to monitoring of weekly crude numbers of deaths over the winter period in order to track mortality. There was a marked rise in the weekly number of deaths over December which peaked at the end of December/beginning of January. This was associated with increased congestion in patient flow and also mirrors the Flu A spike – this is in line with the findings of the Public Health England (PHE) report into seasonal flu. There was a decline in crude numbers of deaths throughout January which has stabilised at a slightly higher number than the pre-winter level, possibly associated with a minor rise in Flu B positive cases since the start of February



Although our SHMI continues to be raised our figures put us in band 2 "within expected" band.

Period	Measure	Band
Jan 12-Dec12	103.0	Band 2 within expected
Apr 12-Mar13	107.9	Band 2 within expected
Jul 12-Jun 13	108.6	Band 2 within expected
Oct 12-Sept 13	108.8	Band 2 within expected
Jan13-Dec 13	109.9	Band 2 within expected
April 13-Mar14	108.2	Band 2 within expected
Jul 13- Jun 14	109.2	Band 2 within expected

What are we doing to reduce our mortality further?

In the autumn of 2014 the Board commissioned an external review of mortality by Mr Silverman, deputy medical director of the Trust Development Authority. This report produced a number of recommendations and these have been combined with other mortality reduction initiatives into an overarching plan to reduce mortality.

Below are a number of initiatives that we are currently undertaking to reduce mortality and improve the quality of care. This list is not exhaustive.

Development of a combined quality improvement plan to include:

- improving mortality governance,
- service transformation to address congestion,
- staff engagement,
- improving coding and data quality within the clinical record and mortality quality improvement projects
- quality improvement projects :
    - Improving time of STAT dose antibiotics,
    - Reinstatement of the deteriorating patient recognition group to focus on sepsis, MEWS escalation, electronic observation systems, cardiac arrest and Do not attempt resuscitation (DNAR).
    - CQUIN for deteriorating patient
    - NHS Quest breakthrough series collaborative for deteriorating patient
    - Sepsis quality improvement work
- continue to monitor, review and explore our mortality data to help focus any improvement activities including the trial of the CRAB data analysis tool

Patient Experience

The Trust is committed to ensuring patients have a positive experience of care, listening to their views is key to making improvements in the areas that matter most. The trust uses a range of local and national measures which allow performance to be monitored and focus on areas which require attention. Findings are crucial in helping us to understand the patient experience and monthly satisfaction reports presented to the Board of Directors and site leads.

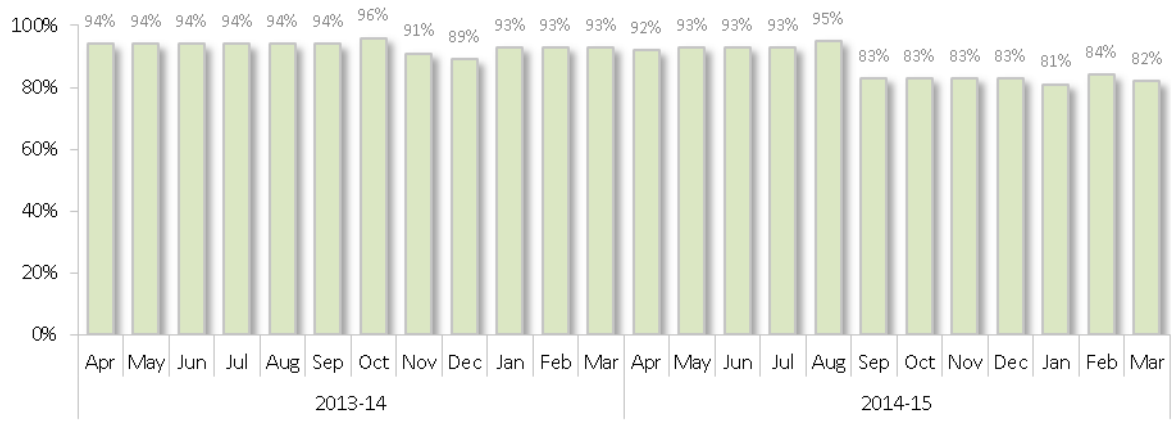
Since developing the inpatient metrics as described below, we are receiving an unprecedented amount of qualitative feedback from patients about what we did well and what we have done better. This particular data source will be developed over the coming year to help us make improvements for patients, carers and relatives.

Inpatient Satisfaction

The Head of Patient and Public Engagement carried out an appraisal of the Patient Metrics Programme. The main conclusions of this review were to reduce the number of measures and change the way the feedback was collected. In the past, the team interviewed patients at their bedside (face to face surveys); this process can be time consuming and consequently a maximum of 15 patients gave feedback per ward each month. Additionally we were asking questions which were no longer relevant and are being measured in other ways. With fewer questions, they could be added to the friends and family postcard. By increasing the amount of patients who responded each month, the results would be more representative of the population as a whole.

In August 2014, a new programme for collating in patient experience was introduced; it is well documented that face to face surveys produce results that are more positive than those that are completed anonymously and as a result, overall satisfaction levels fell in September when the new methodology was introduced (see figure 1 below).

Figure 1: Overall satisfaction inpatient survey (April 2013 – March 2015)



The two tables below represent two different periods; before and up to when the inpatient experience metrics were reviewed and updated (April – August 2014) and the period after (from August 2014 onwards). The tables are organised into colour coded sections showing the upper and lower ranges of scores achieved, the highest scores (green) are on the left and the lowest are on the right (red).

Figure 2: New inpatient survey (August 2014 – March 2015)

Felt cared for	Staff talk in front of me	Pain control	Medication side effects	Call buzzer	Informed about going home	Involved in decisions	Noise at night
92.9	89.5	88.9	85.1	82.5	82.3	81.9	62.6
Top 20% of highest scores		Scores in the intermediate 60% of scores				Bottom 20% of scores	

Figure 2a: Inpatient face to face survey (April 2014 – August 2014)

Help eating meals	Regularly checks if comfortable	Mixed sex bay	Hand hygiene	Respect & dignity	Cleanliness	Felt cared for	Privacy discussing condition	Pain control	Medication side effects	Involved in treatment decisions	Discuss worries or concerns	Would recommend ward to others	Call buzzer response	Informed about going home
99	99	99	99	98	98	97	97	96	96	94	93	90	84	63
of highest scores				Scores in the intermediate 60% of scores								of scores		

Friends and family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The survey team ensure the Friends and Family Test (FFT) is fully implemented for inpatients, the emergency department and maternity services. In real terms, for this measure alone we have increased the number of patients who gave feedback from 27,000 in 2013 to 39,000 respondents in 2014.

Table 1: Percentage of responses for the Friends and Family Test (April 2014 – March 2015)

FFT Response	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Inpatient	14%	14%	17%	36%	37%	30%	30%	38%	28%	37%	32%	41%	29%
Emergency	19%	19%	18%	17%	17%	17%	18%	17%	17%	18%	22%	21%	18%
Maternity	11%	15%	13%	16%	6%	9%	3%	6%	2%	2%	3%	4%	8%

The NHS England review recommended the introduction of a simpler scoring system in order to increase the relevance of the FFT data for NHS staff, patients and members of the public. The trust presents results as a percentage of respondents who would recommend the service to their friends and family. The graphs below shows the percentage of patients who would recommend our services to friends and family, the grey dotted line shows the percentage of NHS patients in England.

Figure 3: Percentage of inpatients who would recommend our services (April 2014 – March 2015)*

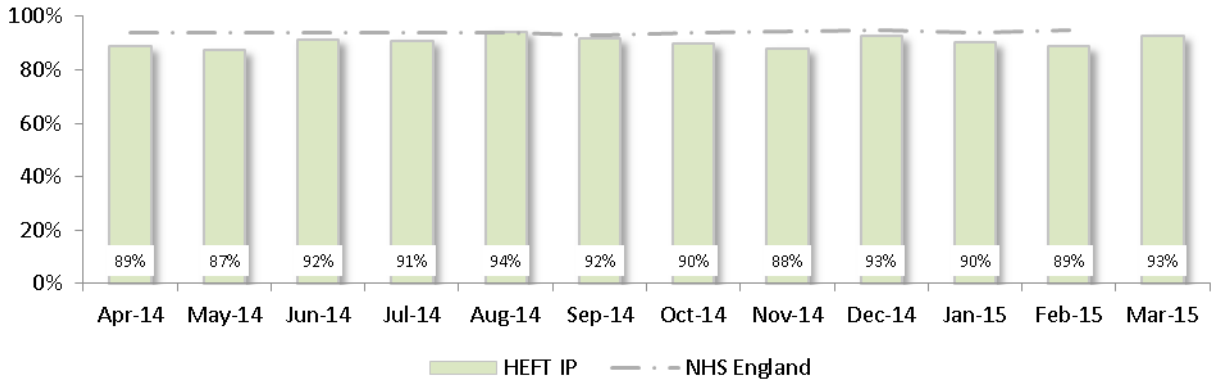


Figure 3a: Percentage of emergency patients who would recommend our services (April 2014 – March 2015)*

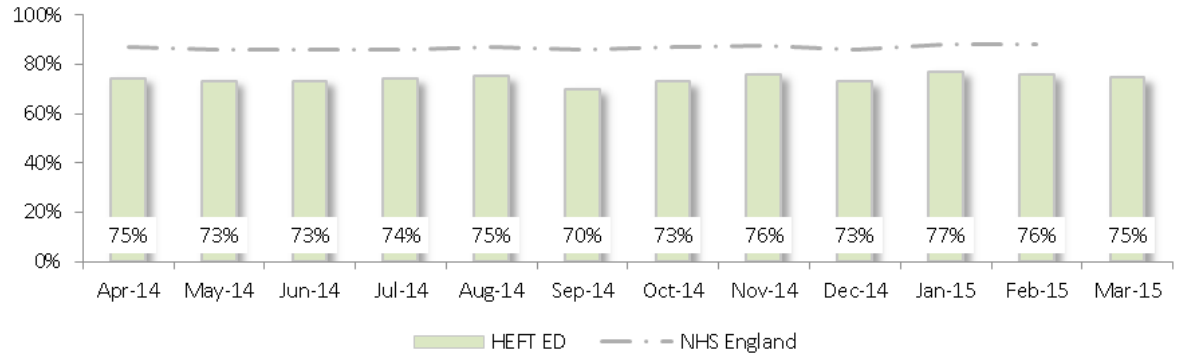


Figure 3b: Percentage of community patients who would recommend our services (April 2014 – March 2015)

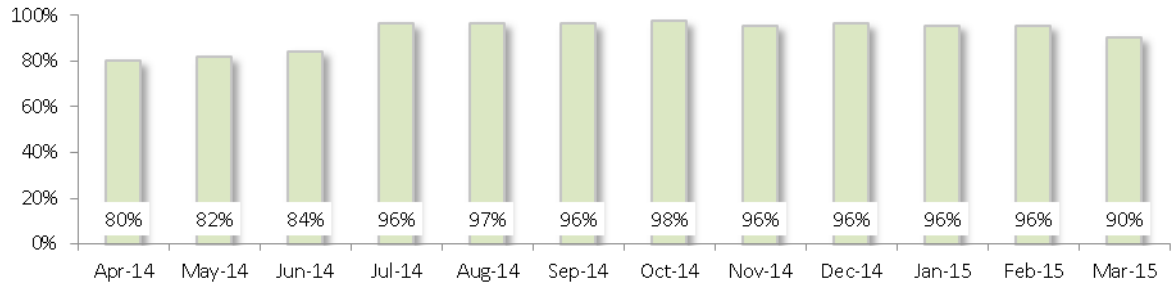
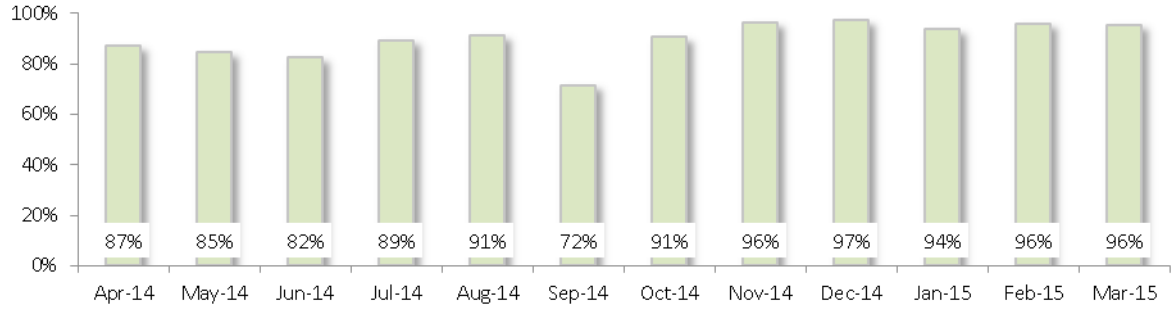


Figure 3c: Percentage of maternity patients who would recommend our services (April 2014 – March 2015)



The survey team is responsible for conducting our patient experience surveys on behalf of the trust, in real terms we have increased the number of patients asked to give feedback by 13,000 during 2014 (see table 2 below). The main projects are summarised in table 2a below:

Table 2: Yearly comparison of patient surveyed and the number of compliments and improvement comments (2012-2015)

Comparison of patients surveyed and quality comments between 2011-2015							
Year	Patients sampled	Total Responses		Compliments		Improvement	
		n	%	n	%	n	%
2014-15	280,297	64,616	23%	20,552	70%	8,720	30%
2013-14	213,464	41,813	20%	14,503	69%	6,435	31%
2012-13	148,483	30,570	21%	2,958	62%	1,795	38%
2011-12	38,795	14,650	38%	1,598	52%	1,500	48%

Table 2a: Breakdown of surveys from April 2014 to March 2015

Title	sample	Response	Compliments	Improvement
National Inpatient Survey	850	305	104	90
National Emergency Survey	850	227	44	32
National Cancer Survey	1,491	886	498	290
Inpatient Metrics Programme	24,332	13,685	N/A	N/A
Inpatient Friends & Family Test (FFT)	60,830	17,681	10,147	5,139
Emergency Department FFT	149,156	27,135	8,079	2,762
Maternity Services FFT	34,636	2,588	1,163	321
Community Services	8,152	2,109	517	86
Total	280,297	64,616	20,552	8,720

National Survey Programme

The trust carried out three national patient experience surveys (inpatient, emergency services and cancer) during 2014-15 on behalf of the Care Quality Commission (CQC). The inpatient and emergency surveys results were comparable to previous results; performance was about the same as most other in the country. The results from the cancer survey showed some significant improvements:

- We are one of the most improved trusts in the country in 2014. Results show significant improvements over time, 10 questions improved during 2013-14, 28 scored questions improved during 2010-14
- The Clinical Nurse Specialist (CNS) is the single variable associated with high scores by patients in every tumour group
- Patients entering through ED much less likely to be positive than those entering through other pathways (matched data from 2010 CPES with NCIN RTD data)
- Patients with recurrence of cancer or those who have had ineffective treatment give poorer scores than others

Table 3: National inpatient survey yearly comparison (April 2012 to March 2015)

National Patient Survey Programme	2012-13	2013-14	2014-15	Trend 2014-15
Length of time on waiting list	8.3	8.7	7.9 ↓	-0.8
Treated with respect & dignity	8.9	8.5	8.6 ↑	0.1
Staff did all they could to control your pain	7.8	7.4	7.9 ↑	0.5
Overall inpatient satisfaction	7.9	7.9	7.7 ↓	-0.2
Given the right amount of information	7.4	7.8	7.6 ↓	-0.2
Areas of concern				
Q49. Fully involved in decisions about discharge	*6.5*	*6.6*	*6.6* →	*0*
Q60. Staff took home situation into account when planning discharge	*7.1*	*6.3*	*7.0* ↑	*0.7*
Q52. Discharge delayed due to wait for medicines/doctor/ambulance	*5.3*	*5.3*	*5.4* ↑	*0.1*
Q59. Told about danger signals to watch out for at home	*5.1*	*4.6*	*4.8* ↑	*0.2*
Q56. Told about medication side effects to watch out for at home	*4.5*	*4.4*	*4.7* ↑	*0.3*
Q70. Informed about how to complain about care	*1.9*	*2.5*	*2.4* ↓	*-0.1*
Q69. Asked to give views whilst in hospital	*1.6*	*1.6*	*2.1* ↑	*0.5*

Patient Stories

Patient comments are recorded and monitored by the survey team on behalf of the trust. Some good examples are listed below:

Positive Feedback

"I think the ED at Good Hope Hospital was brilliant on this occasion. I was treated excellently in by the medical team. Thank you. I was put at ease very quickly and made to feel comfortable and relaxed. Once seen by the doctor in ED my condition was quickly diagnosed and I was moved to resus. The medical staff was very professional and kept me informed about the treatment I needed to have. (Name removed) in rhesus is fantastic!! He is able to explain exactly what needs to be done to correct my heart condition. He is very down to earth and brilliant is his job which is what I appreciated. (Name removed) is very knowledgeable and he is happy to share his expertise with trainee staff and students whilst they are training to gain their qualifications. Thanks (Name removed) you're a star. I would just like to say a huge THANK YOU for helping me get back home quickly. Keep up the good work." (emergency patient, October 2014)

"Nursing staff were all very polite, kind and very understanding of my situation. As a member of staff I was well cared for. A well run ward." (inpatient, April 2014)

"All staff on the Maple ward was absolutely fantastic! Very friendly, a very clean hospital and the surgery staff for my C-section were amazing. A big special mention for (name removed). She was amazing through my surgery and with my after care." (maternity patient May 2014)

"Really lovely with our little boy, we were seen quickly and given good information and advice! Children's AE section is great; I think (Name removed) just thought he was play group with all the toys, not scared at all! Thank You!" (parent of paediatric patient, July 2014)

"Overall, the care I received over the last year was outstanding in all areas. The doctors and nurses were excellent and made my journey of finding out I had cancer loads better for me. I was treated at Solihull, Good Hope, Walsgrave, and Heartlands. All hospitals offered outstanding care and support to me and my family. I would just like to thank the NHS for everything they done for me. My daughter has now decided to become a nurse and hopes to help other people and look after them like I was. Thank you." (cancer patient, June 2014)

How the trust is using this

We have embarked on a huge programme of staff engagement to change the culture of the organisation. Our feedback, including complaints, tells us that a large proportion of patient experience improvements centre around how well we communicate with patients, relatives and carers and how we build our systems with the patient in mind. If we can improve on our staff engagement we believe that we will drastically improve patient experience and prevent complaints from happening.

Additionally over the last year we have recruited our Citizens' Assembly. This is a group of members of the public, not necessarily with an attachment to healthcare services to support the trust's longer term strategic plans so that we can include patients and the public at an early stage in service planning. This is in addition to our network of patient groups, one of which routinely visits and inspect wards each month and whilst these are largely positive, they highlight where we can make some short term improvements.

Complaints

Complaints are one of many ways which we use to better understand the experiences patients, relatives and carers have.

In 2013/2014 a pilot study at Solihull Hospital was introduced whereby complaints staff became case managers responsible for reviewing the complaint from the beginning to the final response, with continuous liaison with the complainant. This same system has now been adopted by general surgery, urology and gastroenterology at Heartlands Hospital, having a dedicated team working closely with

the directorate to improve the complaints process. After an initial period of integrating these new systems we are now seeing improvements in process and we will continue to refine these over the coming months to improve the way complaints are handled for patients, carers and relatives.

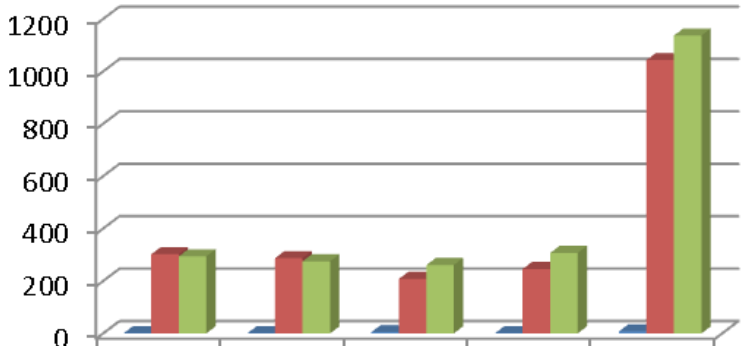
We are currently reviewing the entire process, both centralised and directorate led and consultation and discussions are underway to inform the organisation of the best systems and structures with which to manage complaints.

Comparison Complaints Data

Although complaint numbers remain consistent, the number of concerns that are raised, dealt with and resolved at an early stage has increased, reducing the number of potential formal complaints. The data for formal complaints and informal is used in conjunction with each other to identify themes and trends across the trust.

The information below excludes concerns raised by GP's regarding services.

Complaints and Concerns raised for all sites April 2014 – March 2015



	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	Totals:
Formal Complaint With HMC Interest	1	1	5	1	8
Formal Complaint	302	287	208	246	1043
Informal Complaint	294	275	261	307	1137

Complaints Reporting

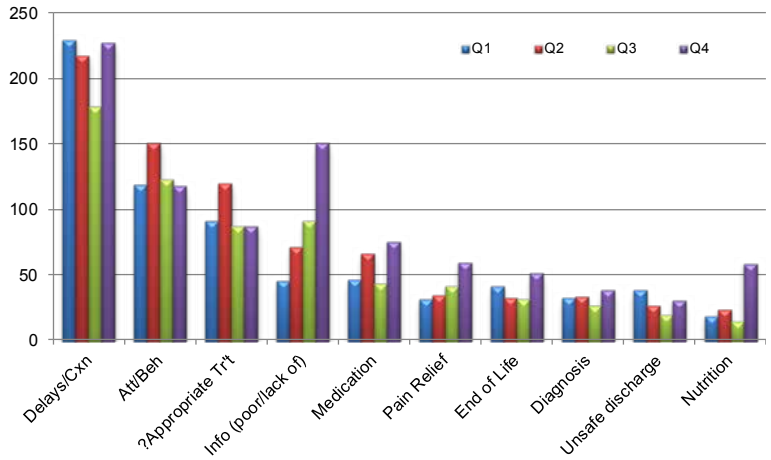
The themes of both formal and informal complaints are reported to the Quality and Risk Committee, detailed below are extracts from the Complaints Report April 2014 – March 2015.

The ratio of individuals registering complaints (both formal and informal) per 1000 patients is shown by site below.

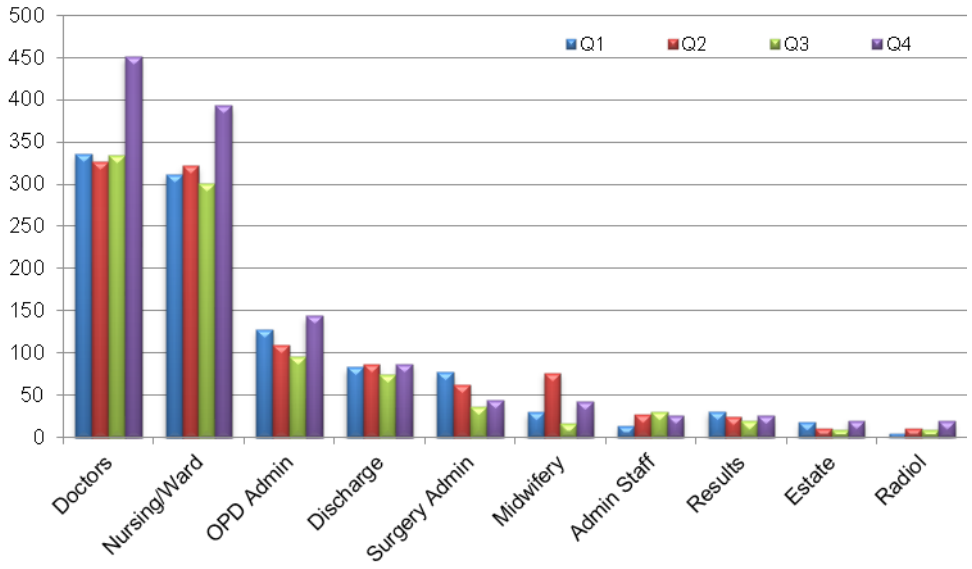
HEFT Complaints Against Activity												
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Site	Number of individual complaints	Site Activity/No patients	Ratio of complaints per 1000 patients	Number of individual complaints	Site Activity/No patients	Ratio of complaints per 1000 patients	Number of individual complaints	Site Activity/No patients	Ratio of complaints per 1000 patients	Number of individual complaints	Site Activity/No patients	Ratio of complaints per 1000 patients
BHH	276	76877	3.59	263	77820	3.38	241	78333	3.08	277	88166	3.14
GHH	216	56127	3.85	226	55750	4.05	193	56278	3.43	247	61026	4.05
SOL	129	51927	2.48	96	52103	1.84	96	51282	1.87	116	53912	2.15
COMMUNITY	13	18871	0.69	10	24984	0.40	7	22271	0.31	6	15365	0.39
TOTAL	634	203802	3.11	595	210657	2.82	537	208164	2.58	646	218469	2.96

The charts and tables below show the number of issues identified in complaints as opposed to the number of individuals contacting the service. For example, one complainant may raise several issues of concern in the one complaint.

The graph below shows the ten most prevalent of the themes across all staff types and areas. These accounted for 69.1% of all concerns or themes identified.



The graph below shows the areas and staff groups where themes most commonly occurred.



Patient Services

There is a need to develop the function of how we resolve and respond to informal complaints further and we are looking closely at how we utilise the patient services staff to ensure that a proactive five day service is available at each site. Currently the patient services team cover all three main sites. Having dedicated patient services support working on one site creates an in-depth knowledge and skill base of each of the sites and builds closer working relationships between wards and patient services which in turn helps to resolve issues early on identifying when a concern should be responded to as formal complaint and providing advocacy for the complainant throughout the complaints process.

Parliamentary Health Service Ombudsman (PHSO)

The PHSO provides a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service.

The aim of the PHSO is to provide an independent high quality complaint handling service that rights individual wrongs, drives improvement in public services and informs public policy.

During 2014/15 the PHSO requested information regarding 32 complaints, an increase on previous years. The increase is attributed to a change in PHSO practices in its review of individual cases; more scrutiny is now applied in the initial scoping of cases. 4 of these cases had elements which the PHSO partially upheld. The remainder were either not upheld, not investigated or are in the process of being scoped by the PHSO.

We either have action plans in place to address these issues or have acted in accordance with PHSO advice.

Local and National Priorities

Description of Target	Target 2014/15	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15 Month Period
Reduction of incidence of Clostridium (post 48 hours)*.	78	171	123	86	82	75	Apr-Mar 15
Reduction of incidence of MRSA bacteraemia (post 48 hours).	0	9	8	7	8	1	
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat – Surgery modality.	>=94%	98.43%	97.10%	97.42%	98.44%	98.79%	Apr 14-Jun14 &October 14-Mar 15
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat – Anti cancer drug modality.	>=98%	100%	100%	99.72%	100%	100.00%	
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat – Radiotherapy	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Patients receiving their first definitive treatment for cancer within 2 months (62 days) of GP or dentist urgent referral for suspected cancer. Ⓐ	>=85%	85.62%	85.44%	86.35%	86.33%	85.22%	Apr 14-Jun14 &October 14-Mar 15
Patients receiving their first definitive treatment for cancer within 2 months (62 days) of urgent referral from the National Screening Service.	>=90%	99.44%	98.16%	99.13%	97.00%	90.65%	

Admitted Patients Treated within 18 Weeks of Referral	>=90%	NA	90.00%	92.03%	89.39%	81.21%	Apr 14-Jun14 & Nov 14 – Mar15
Non-Admitted Patients Treated within 18 Weeks of Referral	>=95%	NA	97.82%	96.85%	96.29%	92.54%	
18 week incomplete pathways Ⓐ	>=92%	NA	NA	95.57%	94.21%	94.41%	Apr 14-Jun14
Patients receiving their first definitive treatment within 1 month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer.	>=96%	98.62%	97.42%	96.92%	97.92%	97.99%	Apr 14-Jun14 &October 14-Mar 15
Patients first seen by a specialist within 2 weeks when urgently referred by their GP or dentist with suspected cancer.	>=93%	94.04%	94.50%	93.66%	92.86%	84.42%	Apr 14-Jun14 &October 14-Mar 15
Patients first seen by a specialist within 2 weeks when urgently referred by their GP with any breast symptom except suspected cancer.	>=93%	94.81%	94.79%	94.64%	93.20%	79.18%	
Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge	>=95% target	95.41%	95.97%	93.13%	93.02%	90.38%	Apr 14-Mar 15

2013/14						2014/15	
	Target 2014/15	Qtr1	Qtr2	Qtr3	Qtr4	Qtr4	
Community Services Data completeness: Referral to treatment	50.00%	85.00%	96.32%	96.67%	84.10%	100.00%	Apr14 – Mar 15
Community Services Data completeness: Referral information	50.00%	89.10%	97.71%	99.98%	97.01%	97.27%	
Community Services Data completeness: Treatment activity	50.00%	99.80%	99.99%	99.80%	91.80%	99.91%	
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	out of 6 criteria	6	6	6	6	6	

Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge

A combination of an increased demand for urgent care, limited capacity in A&E and variable flow through the inpatient and discharge processes has resulted in delays. These delays have resulted in more patients spending longer than 4 hours in the A&E Departments.

We are implementing our Urgent Care Improvement Plan which has a range of measures, including:

- Delivery of an improved discharge process to significantly reduce the variability of inpatient discharges through each day and through the week
- Ensure that assessment areas move rapidly to a position where more than 50% of patients are appropriately assessed, treated and discharged within 72 hours
- Continue to develop models of Ambulatory Care across the Trust such that only those patients who must be admitted as inpatients access our beds.
- Work with Primary Care, Social and Community Services and developing models for care of frail patients such that this vulnerable group of patients only access inpatient care when absolutely necessary.

Two week wait Cancers and Breast Symptomatic

We are currently undertaking the following actions to improve these services by:

- Increasing capacity, both in terms of workforce and out patients clinic and diagnostic capacity to achieve 93% 2ww standard
- Improve referral guidance to reduce inappropriate GP referrals

- Increase awareness to patients via GPs of the reason for their referral and the importance of attending within 2 weeks of referral
- Undertaking on-going review of the growth in referrals using a forward look approach to ensure adequate capacity is planned.

All other pathways

We are currently undertaking the following actions to improve the quality of these services by:

Admitted:

- Increase capacity, in terms of workforce, diagnostics and available operating time to achieve 90% 18 week standard.
- Continue to use additional capacity including mobile theatre unit, mobile MRI scanner and private sector capacity in addition to increasing theatre availability on all 3 sites.
- Increase endoscopy capacity further from Q2 with a mobile endoscopy unit
- Develop trajectories that illustrate a reduction in backlog and a return to compliance
- Centralise waiting list management
- Continue to apply an approach of continuous improvement and training to all staff groups in particular medical secretaries and consultants, regarding waiting list management including active management of patients whose "clock" is open pending clinical decision.
- Identify in partnership with CCG improvements in pathway management across primary and secondary care

Non Admitted:

- Increase capacity, both in terms of workforce, out patients clinic and diagnostic capacity to achieve 95% 18w standard
- Continue to provide additional capacity to reduce wait to 1st OPA to 5 weeks for >80% of patients
- Continue to use additional capacity including mobile MRI scanner in addition to increasing endoscopy capacity further from Q2 with use of a mobile endoscopy unit.
- Continue to apply an approach of continuous improvement and training to all staff groups in particular medical secretaries and consultants, regarding waiting list management including active management of patients whose "clock" is open pending clinical decision.
- Identify in partnership with CCG improvements in pathway management across primary and secondary care

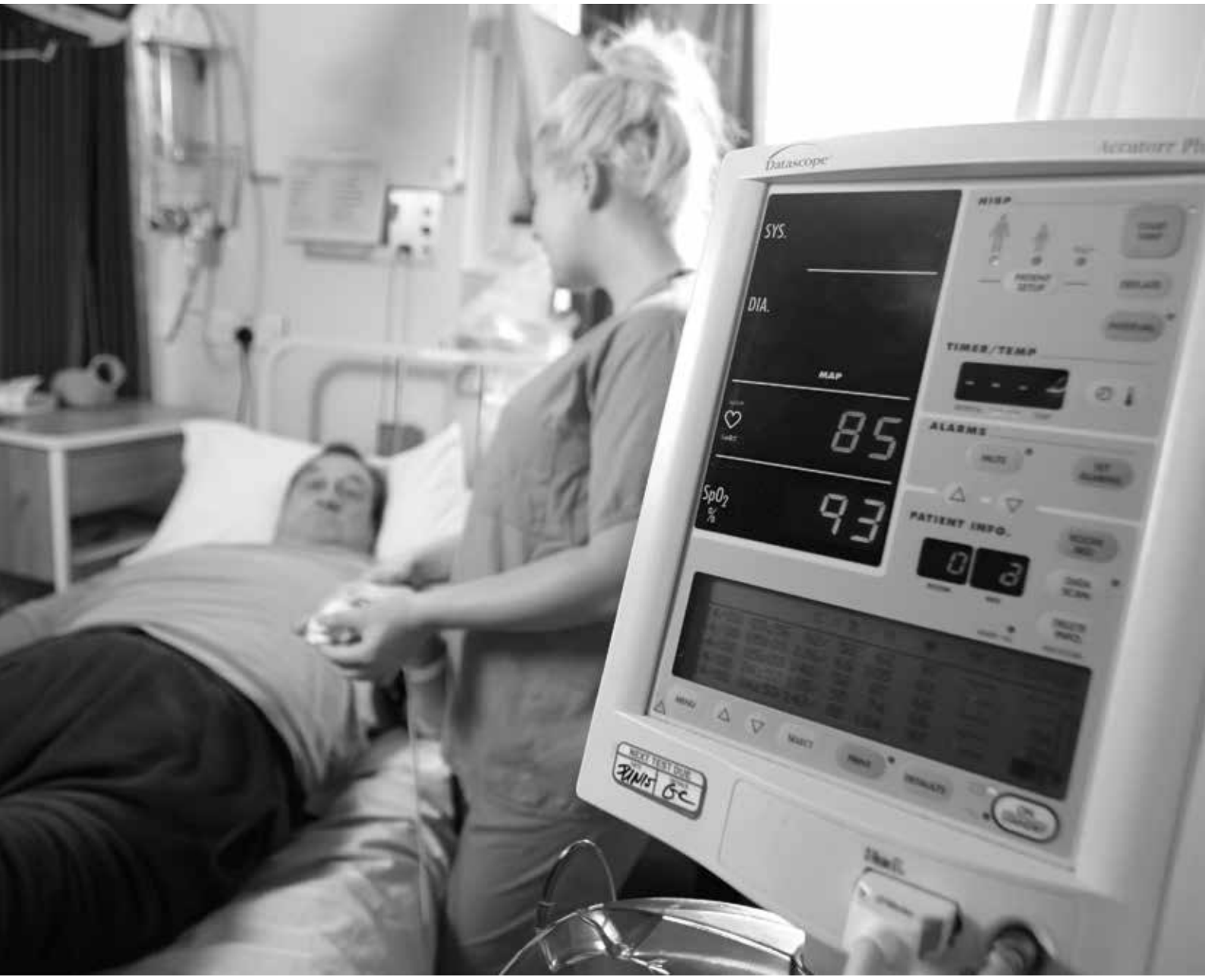
Referral to treatment (RTT):

The last monthly RTT position that was reported externally was in June 2014. The reported June position was compiled from HISS (patient system), and was externally audited and given a 'fit for purpose' status in a very detailed CCG-led audit.

In the first week of July 2014, the trust implemented a new PAS (patient system) system, PMS2, which was designed to provide a 'real time' RTT position, as the 18 week pathway calculations were designed within the system itself. The transfer of data from the legacy system resulted in further work being undertaken to ensure the information and reporting from the new system was complete and accurate. Validation of legacy 'open clocks', relating to patients currently on incomplete pathways (of which there were more than 100,000), formed a part of this work, and was completed with guidance from IMAS, and with weekly progress updates provided to Monitor.

This validation work has now been completed, and the Trust is now able to return to reporting its RTT position for incomplete pathways from April 2015.

Target	Definition	Criteria
Patients receiving their first definitive treatment for cancer within 2 months of GP or dentist urgent referral for suspected cancer Ⓐ	Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	• the indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period; • the indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2014 to March 2015; • the clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and • the indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.
8 week complete pathways Ⓐ	Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	· the indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; · an urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant; · the indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); · the clock start date is defined as the date that the referral is received by the Trust; and · the clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.


Datascope
SYS.
DIA.
MAP
85
SpO2
%
93
NIBP
TIMER/TEMP
ALARMS
PATIENT INFO.

Part 3:

In other news...

There are always a number of initiatives going on throughout the trust to enhance the quality of care patients receive. Below we've included a flavour of these quality initiatives.

6cs Programme for Health Care Assistants

Solihull identified the potential to engage with health care assistants (HCA) across the hospital and community services through a programme of work designed around the' 6Cs' that were launched by the chief nursing officer. The 6Cs reflect the expectations of fundamental care within nursing and describe an approach to care that is relevant regardless of role. The 6Cs are – Care; Compassion; Competence; Communication; Courage; and Commitment.

The Solihull HCAs 6Cs programme ran as a series of 2 hour sessions, with each session focusing on one of the 6Cs. Each session was facilitated by either the head nurse or associate head nurse with co-facilitators for each session identified from relevant areas of practice within the trust. HCAs were encourage to attend all sessions, although some staff attended only those sessions they felt were particularly relevant to their area of work. Approximately a dozen staff went through the first programme. Evaluation for each of the sessions was undertaken and staff rated the programme good to excellent, with some sessions rated as excellent by all staff in attendance, with comments such as:

"fantastic, informative insight into a very important aspect of care"
"great that appropriate to area of work, able to voice opinions, concerns"
"makes you realize what an individual may feel like in an unusual environment".

Whilst the initial plan was to run a second programme of sessions it has been identified that for some areas it is difficult to release HCAs for 2 hours at a time and it has therefore been agreed the 6Cs programme will be used to deliver a 1 day event that incorporates all the individual elements with a view to securing HCAs from a broader range of areas.

Dementia and Delirium Outreach Team

People with dementia will have changes in how they interpret what they see, hear taste, smell and feel. The manifestations are unique to the individual so it can be difficult to interrupt and offer a uniformed plan of care. The one size fits all approach cannot be applied to patients with dementia but it is acknowledged that all patients with dementia will find admission to hospital challenging as they will struggle with orientation to an unfamiliar environment. Patients with dementia in hospital are more likely to have an increased length of stay, fall and sustain injury, dehydration and development of pressure sores.

The dementia and delirium outreach team was established in November 2014 as part of Solihull's commitment towards developing a dementia friendly hospital and improving the experience of patients with dementia in the acute environment. The team operates as both a reactive (patients referred to the team) and proactive (team actively seeks out patients with dementia and delirium within the hospital). The team provides practical advice and support to staff for enhanced observation. Current data suggests that there are between 30-45 patients with a diagnosis of dementia in Solihull Hospital at any one time. Data is currently being collected to start evaluation but this initiative is very much around quality and it can be difficult to quantify outcomes.

The team also supports the transfer of patients to Ardenlea Grove where we have eight dementia assessment beds. These beds are also supported by the virtual ward community matron, an older adult

psychiatrist and an enhanced assessment Band 7 registered mental health nurse from Birmingham and Solihull Mental Health Trust, a GP, an allocated social worker and an acute geriatrician. The concept being that the assessment process is undertaken away from the acute environment and enables patients to return their own homes whenever possible. This is a totally integrated service which is currently being evaluated by Solihull CCG.

Maternity Services

In 2012 the trust agreed to explore how it might invest in future facilities for women and babies at Heartlands hospital.

Many staff (over 400) who work in maternity and neonatal services were consulted along with patients and key stakeholders to determine the scope of the project. It was broadly agreed that this was not simply about building a new facility but that this was an opportunity to look at how care for women and their families needed to be developed in the coming years and therefore understanding what the facilities at Heartlands Hospital would need to offer to deliver that care.

Several sub projects were agreed and progressed, these included the development of a transitional care facility; the development of an information system that allowed for good reliable information to be available to staff who manage patient care and a post natal pathway for women that gave some standardisation to how care was delivered across all three sites.

With a visit from the president of the royal college of midwives in the summer of 2014 midwives, obstetricians and representation from the maternity liaison committee held a workshop to consider ways of working in the proposed new facility. The professional debate lead to a set of care principles that have been used to influence the design of an "alongside maternity unit" offering both midwifery led and obstetric led care.

In terms of the new facility an options appraisal process has been undertaken to establish the best design solution capable of delivering the required number of births focusing on the labour ward, bereavement facilities and neonatal unit.

Babies flourish on new Blossom Unit

Mums and their babies are benefitting from a new Unit at Heartlands Hospital, just one of the areas of work completed as part of Project Pelican, which is dedicated to transforming our women's and children's services.

The Blossom Transitional Care Unit has been designed to provide care for babies that are well but require some extra support with for example, extra observations or antibiotics. The team of neonatal nurses and midwives on the Unit are also on hand to help mums care for their babies. This reduces any unnecessary separation of mums, improving the experience and quality of care they receive.

Over 100 babies have been on the Unit since it opened its doors earlier this year, including Claire Worrall and daughter, Poppy Worrall-Bhasin who were among the first patients on the Unit. Claire said: "The Blossom Unit was a nice, quiet and relaxed Unit. There was plenty of staff on standby from the neonatal unit due to Poppy being a premature baby. She had been in critical care with lots of machines wired to her. I benefited from staying there and getting the support and reassurance that I was doing everything right."

For further information about Blossom Unit or any other aspects of Project Pelican email: projectpelican@heartofengland.nhs.uk

Part 4:

Statements from stakeholders

Statement from Solihull Clinical Commissioning Group

1. Commissioners acknowledge that this has been an extremely challenging year for Heart of England Foundation Trust (HEFT) in terms of performance and quality of care, particularly in relation to the ED. The Trust is subject to MONITOR enforcement undertakings and there have been a number of senior leadership changes.
2. The Trust account provides a reasonably balanced reflection of the year experienced and commissioners believe it demonstrates both the recognition of the need, and, the will to implement improvements and to more importantly sustain those improvements going forward. We are however disappointed that the account does not reflect detailed information on community services as required stated in the MONITOR NHS Foundation Trust annual reporting manual 2013/14. In addition there is very little information in relation to maternity or paediatric services in light of the fact that both services have undergone peer review during the year.
3. A significant focus during the year was on the Trusts headline priority 'fundamentals of care'. As clinical commissioners, our aim is to ensure that our patients receive the best care they can, therefore we support this aim and through our programmes of announced, unannounced and fundamentals of care visits, we have tested the experience and the views of patients first-hand. The outcomes of these visits have not been reflected in the Quality Account.
4. It would have been helpful to have had an overview of workforce recruitment, deployment and retention as this has been a challenge for the Trust. It is encouraging that staff engagement will be a key objective for 15/16 as a positive staff experience leads to a positive patient experience. The Trust has reflected on a number of mechanisms to gain patient experience feedback and there are some positives identified through the national patient surveys especially in relation to cancer care. Commissioners look forward to the Trust building on this programme of work to improve the experience for patients especially in the Emergency Departments which have traditionally highlighted a less positive patient experience.
5. Many of the areas of focus demonstrate some improvements towards the end of the year. This is evident in the work relating to falls reduction and demonstrated through the challenge in achievement of some of the CQUINs.
6. We support the Trust's future plans to continue to reduce falls rates and acknowledge the additional clinical investment of a further falls co-ordinator. The Trust recognises that they have not achieved the required improvements in pressure ulcer and falls reduction. Commissioners are concerned that we are still seeing relatively high levels of pressure ulcers and falls. We hope that the newly established Tissue Viability Strategy Group and the appointment of the additional falls specialists, with senior clinical leadership through the Deputy Chief Nurses, will drive the improvements required.
7. Care of individuals with dementia is a clear priority within the NHS supported by Commissioners. We recognise that the Trust participated in the national dementia CQUIN and participated in a dementia summit held in Solihull, however, further work is required to find and refer dementia patients. Dementia 'Discharge to Assess' beds have been commissioned and this has resulted in people being discharged home following additional support.
8. The Trust has continued to place focus on discharge arrangements and has implemented a number of systems to improve arrangements and ensure patients are discharged in a timely manner. It is noted through the patient experience work-streams that patients still feel that there could be improved communication in relation to discharge arrangements however the discharge hubs now in place across all 3 inpatient sites should help to further facilitate improvements. Patient experience needs to be integrated into the discharge plans to ensure on going sustainable improvements.
9. **Patient safety** is of key importance to Commissioners and the Trust's Quality Account details some

of the work-streams undertaken. Reference is made to the Trust's commissioned mortality review which identified some shortfalls in governance. Additionally a governance review undertaken by Deloittes made reference to a number of shortfalls in governance systems. It is disappointing that some of the more clinically driven CQUINs (eg sepsis care and management of deteriorating patients) did not yield the benefits anticipated and again commissioners' reflection is that these were not fully focussed on until the latter part of the year. The Trust has reported one never event during 2014/2015 which is a significant improvement on the previous year.

10. Equality & diversity – Commissioners are disappointed that the Quality Account omits to detail the equality and diversity systems and framework the Trust has to ensure that it can effectively meet the needs of individuals with protected characteristics however it is evident that there has been some specific work with the local Muslim community and to support the requirements of individuals with Learning Disabilities.
11. Safeguarding – There is little information in relation to Safeguarding. The Trust was involved in a CQC review of Safeguarding for Solihull during February 2014 and a CQC review of Safeguarding for Birmingham September 2014. Both reviews highlighted good areas of practice for example the Female Genital Mutilation (FGM) clinics and processes for identifying children at risk however it was recommended that systems at Good Hope Hospital needed to be strengthened. The Trust has also participated in the development of the Birmingham Multiagency Safeguarding Hub (MASH) and are currently working with Solihull to implement a similar service.
12. We support the priorities for quality improvement although we would have liked a broader approach to capturing and acting on patient feedback to improve patient experience in the Emergency Department in addition to the Friends and Family Test.
13. Commissioners are sighted on the breadth of challenges the Trust faces during 2015/16 to make the improvements required. Commissioners will work collaboratively with the Trust providing challenge as appropriate to ensure that the quality of care provided meets required standards.

[7]The manual states that 'where an NHS Foundation Trust has provided and/or subcontracted community health services during 2013/14, the NHS Foundation Trust should include such community health services in the review of services in the quality report

Further to receipt of the statement above, we have now expanded the introduction of this document to include a list of selected contents of the Annual Report (of which the Quality Account forms part of). This signposts to some of the topics the commissioners would have liked to have seen in this account (specifically covering points 4 and 10 above).

We have also added details regarding the visits carried out throughout the trust by the CCG into the Care Quality Commission section.

Statement from Birmingham Healthwatch Organisation

Healthwatch Birmingham continues to work in partnership with stakeholders to contribute towards the outcomes for quality improvement in order to enhance the provision of services for patients. This is further evidenced in the current programme of activity we are completing around patient care.

The initiatives captured from the outset of the Heart of England NHS Foundation Trust Draft Quality Account 2014/2015 report highlight the progress made by the Trust in this area. The privacy, dignity and well-being of patients referenced throughout the report represents good communication and will ultimately lead to user-led outcomes in service delivery. The report further sets out a clear pathway around this by taking account of the key indicators and mechanisms to support change & improvement.

We would like to commend the actions and developments of the chief executive, staff, and all contributors to date. We look forward to seeing further evidence of outcomes for the people of Birmingham and the future of this vibrant city.

Statement from Solihull Healthier Communities Board

We, as a Scrutiny Board, considered the draft Quality Account at the formal Scrutiny Board meeting that took place on Tuesday 31st March 2015. At the meeting we were made aware that some of the content of the draft Quality Account was mandated and therefore was in a less accessible format. We were also advised that over the forthcoming 12 months, the Trust had made the conscious decision to only focus on four key improvement priorities and that work on existing priorities would be channelled through other strategies.

In terms of style and structure, we felt that more work needed to be undertaken to make the Quality Account more accessible to the public, for example by including an Executive Summary which pulls out the key messages and an acronyms, glossary and key definition section to make the document easier to understand. They also felt that some of the graphs / charts (e.g.in respect of Stroke) were difficult to decipher and would benefit from some better contextual and explanatory information.

We noted that there was some under-performance in respect of health professionals completing a Common Assessment Framework (CAF) within the seven day statutory timescales and that the Trust was struggling with filling out all of the associated paperwork. We hope that the development of the more simplified Early Help systems will help to boost performance over the next 12 months.

We are aware that there have been some leadership and governance issues within the Trust this year, which has affected progress being made on key programmes such as progressing the development of the Urgent Care Centre (UCC) on the Solihull Hospital site and we had to write to the Trust about some of our concerns. However, we are now pleased to note that the CCG and the Trust are working together on taking forward the development of the UCC and we will continue to have oversight of its development over the next 12 months.

We note there is a lot of work being undertaken led by the new Interim Chief Executive to listen to staff and this is encouraging. We urge the Senior Management Team to take forward key actions/ issues raised by staff such as moving forward with the establishment of a fruit and veg stall outside Heartlands Hospital for the benefit of patients, staff and visitors to the Hospital.

We probed about the fundamental of care and the need to maintain sufficient staffing at evenings and weekends and we told that there was regular reviews/e-rostering to manage staff capacity and ensure that it is responsive to need. We also feel that the proposed medium term plans to create more capacity in A & E at Heartlands Hospital is a step in the right direction and we look forward with interest to see how this develops as we are mindful about the sustainability of managing a congested service over a prolonged period of time.

As a Board we felt that work needs to be undertaken in the following areas;

- Improving patient experience – we noted the low satisfaction levels and wish for this to be looked at and addressed.
- Ensuring that handover to hospital times is significantly improved. We note that there is currently a review of the HALO service that helps deal with this and we urge you to carefully consider any adverse effects if you decide not to sustain this service.
- Improving current hospital discharge arrangements. We hope that the proposed re-opening of the discharge lounges and workforce co-ordination will have a positive effect.
- Improving quality of care through strengthening Patient Voice and proactively embedding the Nursing Code of Conduct.

Overall, we welcome the opportunity to comment on the Trust's Quality Account and look forward to working with the Trust over the next 12 months. In particular, we are keen to see the findings of the recent CQC Inspection and what action the Trust is going to take on identified areas for improvement.

Directors Statement of Responsibilities

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

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

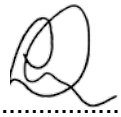
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2014 and up to the date of signing this limited assurance report (the period);
  - papers relating to the Quality Report reported to the Board over the period April 2014 to the date of signing this limited assurance report;
  - feedback from the Commissioners Solihull Clinical Commissioning Group dated 22 April 2015;
  - feedback from Local Healthwatch organisation, Healthwatch Birmingham, dated 1 April 2015;
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – KO41A dated May 2015;
  - feedback from other named stakeholders, Solihull Health and Wellbeing Scrutiny Board, dated 21 April 2015;
- the 'Care Quality Commission – Patient survey report 2014 - Survey of adult inpatients 2014 Heart of England NHS Foundation Trust' latest national and local patient survey dated 2014;
- the '2014 National NHS staff survey – Brief summary of results from Heart of England NHS Foundation Trust' latest national staff survey dated 2014;
- the Care Quality Commission Intelligent Monitoring Report – Draft Report on Heart of England NHS Foundation Trust dated May 2015; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 22 April 2015.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

NB: sign and date in any colour ink except black



27 May 2015 .....Date.....Chairman

27 May 2015 .....Date.....Chief Executive

Appendices

Apendix 1: Clinical Audit

Audit Title	Participation in 2014-2015	% of cases submitted
Acute care		
Adult Community Acquired Pneumonia	✓	100%
Case Mix Programme (CMP)	✓	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	✓	63.5% (no concerns as in line with national average)
National Emergency Laparotomy Audit (NELA)	✓	65% (limited participation due to resource issues
National Joint Registry (NJR)	✓	100%
Pleural Procedure	✓	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme	x	Agreed non-participation as first pilot year
Cancer		
Bowel cancer (NBOCAP)	✓	100%
Head and neck oncology (DAHNO)	✓	100%
Lung cancer (NLCA)	✓	100%
Oesophago-gastric cancer (NAOGC)	✓	100%
Prostate cancer	✓	100%
Heart		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	100%
Cardiac Rhythm Management (CRM)	✓	100%
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	x	N/A
Coronary Angioplasty/National Audit of PCI	✓	100%
National Adult Cardiac Surgery Audit	x	N/A
National Cardiac Arrest Audit (NCAA)	✓	100%
National Heart Failure Audit	✓	10-56% (limited participation due to resource issues)
National Vascular Registry	✓	100%
Pulmonary Hypertension (Pulmonary Hypertension Audit)	x	N/A
Long term conditions		
Chronic Kidney Disease in primary care	x	N/A
Diabetes (Adult)	✓	In progress
Diabetes (Paediatric) (NPDA)	✓	100%

Inflammatory Bowel Disease (IBD) programme	✓	52% (All eligible patients were submitted, however this falls short of the figure the audit provider requested.)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓	30-67% (Selection bias against Good Hope Hospital (30%). Staffing and difficulties in reviewing notes.)
Renal replacement therapy (Renal Registry)	✓	100%
Rheumatoid and Early Inflammatory Arthritis	✓	100%
Mental Health		
Mental Health (care in emergency departments)	✓	100%
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	×	N/A
Prescribing Observatory for Mental Health (POMH)	×	N/A
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP)	✓	100%
Older people (care in emergency departments)	✓	100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	100%
Other		
Elective surgery (National PROMs Programme)	✓	100%
National Audit of Intermediate Care	✓	100%

Indicator	Jan 2013 – Dec 2013	Apr 2013 – Mar 2014	Trust performance Latest Jul 2013 – Jun 2014	National Average	Lowest reported Trust	Highest Reported Trust
The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period	1.099	1.082	1.0916 (band 2)	1.0000	0.541 (RKE)	1.198 (RPA)
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	13.6%	17.5%	20.9%	24.6%	0% (RKE)	49% (RM3)

British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	×	N/A
Women's & Children's Health		
Epilepsy 12 audit (Childhood Epilepsy)	✓	100%
Fitting child (care in emergency departments)	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	✓	100%
Neonatal Intensive and Special Care (NNAP)	✓	100%
Paediatric Intensive Care Audit Network (PICANet)	×	N/A
National confidential enquiries (NCEPOD)		
NCEPOD Gastrointestinal Haemorrhage Study)	✓	100%
NCEPOD Sepsis study	✓	in progress
Lower Limb Amputation	✓	100%
Tracheostomy Care	✓	100%

Apendix 2: National Quality Indicators

Data correct up to Feb 2015

SHMI : The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

The SHMI is provided by the Health and Social Care Information Centre. During the period February to May 2013 the Trust experienced a marked spike in hospital mortality as measured by both HSMR and SHMI for this period. The SHMI remains within the 'expected band' (band 2).
The SHMI is a complex measure and can be influenced by many factors. During the period in question there was:

- a marked increase in 'winter pressures' on the Trust as reflected in a deterioration in the 4 hour ED performance standard
- a rise in influenza cases across the health economy.
- an increase in the number of elderly patients admitted- who are generally the sickest of our patients – with often with complex comorbidities.
- during late 2012, and into 2013, a significant reduction in patients coded as palliative care which with risk adjustment affects HSMR although not SHMI
- admission avoidance schemes introduced, so only the sicker patients were admitted(with an attendant impact on case mix).

During 2013 the Trust conducted in-depth case note reviews and data analysis. No obvious patterns of concern for in-patient care were identified; however as a Trust that is focussed on reducing both avoidable harms and avoidable mortality we identified further opportunities for improvement and further analysis.

In the autumn of 2014 the Board commissioned an external review of mortality by Mr Silverman, Deputy Medical Director of the Trust Development Authority. This report produced a number of recommendations and these have been combined with other mortality reduction initiatives into an overarching plan to reduce mortality.

The Heart of England NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by the actions identified below. This list is not exhaustive.

Development of a combined quality improvement plan to include:

- improving mortality governance,
- service transformation to address congestion,
- staff engagement,
- improving coding and data quality within the clinical record and mortality quality improvement projects
- quality improvement projects :
- Improving time of STAT dose antibiotics,
    - Reinstatement of the deteriorating patient recognition group to focus on sepsis, MEWS escalation, electronic observation systems, cardiac arrest and DNAR.
    - CQUIN for deteriorating patient
    - NHS Quest breakthrough series collaborative for deteriorating patient
    - Sepsis quality improvement work
- continue to monitor, review and explore our mortality data to help focus any improvement activities including the trial of the CRAB data analysis tool

Palliative Care

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

- An internal process flaw which resulted in a significantly lower number of Trust palliative care episodes being recorded. This was discovered in April 2013 and addressed as below.

The Heart of England NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by:

- Validating the coding of patients who have received palliative care against those recorded on the system. Since this practice was introduced there has been an increase in the number and accuracy of palliative care episodes to levels seen prior to April 2012 and for time period Jul 13 – Jun 14. Although this has shown a marked increase it is below the national average
- Towards the latter part of 2014 we also noted that we were not including patients for whom palliative care advice had been provided by telephone call as allowed following changes in coding rules. This has been addressed
- There have been appointments to the palliative care team over the last year with an increase of 1 whole time equivalent (WTE) consultant and 3 WTE Clinical Nurse Specialists (CNS) which has allowed us to see more patients and increase the provision of advice to staff caring for patients.

patient reported outcome measures scores	Trust performance Latest Apr 12 – Mar 13	Trust performance Latest Apr 13 – Mar 14	Trust performance Latest Apr 14 – Sep 14	National Average	Lowest reported Trust	Highest Reported Trust
(i) groin hernia surgery	0.095	0.115	0.104	0.081	0.009	0.125
(ii) varicose vein surgery	0.115	0.110	0.115	0.100	0.054	0.142
(iii) hip replacement surgery	0.397	0.412	0.361	0.442	0.350	0.501
(iv) knee replacement surgery	0.311	0.315	0.306	0.328	0.249	0.394

Data correct up to Feb 2015

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

- The trust has focused on Trauma & Orthopaedic (T&O) PROMS due to being an outlier in the CQC Intelligent Monitoring Report.
- Age and socioeconomic differences; data submitted as part of a Benchmarking exercise "Civil Eyes Research" substantiate this view.
- Over the last four months the fit healthy joints have been sent to have their procedure in the private sector leaving the tougher, more complex longer length of stay patients at the trust.

The Heart of England NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- re-launching the enhanced recovery work at Solihull Hospital; and
- improving the understanding of the data, this will be included on future agendas for the T&O directorate.

Percentage of patients 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 during the reporting period.	2009/10	2010/11	Trust performance Latest 2011/12	National Average	Lowest reported Trust	Highest Reported Trust
(i) 0 to 15	10.87%	11.39%	10.85%	10.26%	0.00%	14.94%
(ii) 16 or over	13.18%	14.06%	12.81%	11.45%	0.00%	17.15%

Data correct up to Feb 2015

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is produced by the health and social care information centre but it should be noted that it is 3 years old.

The Heart of England NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- improving data quality particularly in the light of the Trust clinical system change.
- Developing intelligence in relation to readmission rates, variance and causative factors.
- Further improving discharge practice including the quality of support to patients regarding discharge practice.
- Working in partnership with commissioners and community providers to improve pathways between primary and secondary care.
- reviewing specialties that appear to be outliers to address any clinical concerns or process factors.

Indicator	2011/12	2012/13	Trust performance Latest 2013/14	National Average	Lowest reported Trust	Highest Reported Trust
trust's responsiveness to the personal needs of its patients during the reporting period	66.5	65.2	63.6	68.7	54.4	84.2

Data correct up to Feb 2015

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

The data reflects that the organisation has dealt with increasing demand and the challenges associated with being one of the largest and most diverse providers of acute healthcare in the country.

The Heart of England NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

Focusing on staff engagement locally as a means to understanding what improvements need to be made and to empower staff to initiate these.

Additionally Schwartz rounds have been implemented and will be developed to allow staff time for reflection and for sharing of experience across staff groups.

The patient experience standards measured locally have been altered over the previous year and we have increased the amount of feedback we receive. We will continue to refine these methods and improve access to the information to help staff drive improvements in their areas, in tandem with the focus on staff engagement.

We will also look to make better use of the qualitative feedback provided by patients, carers and relatives and make this more meaningful to the staff in clinical areas.

We are also implementing a project focusing of the experiences of carers which is funded by Health Education West Midlands
We will develop how we provide care to patients who have dementia and our research we are currently doing with patients, carers and relatives on person centeredness will help us to develop this.

We are implementing a follow up service for carers and relatives who suffer bereavement. This is to offer any support that they may need to help them cope with the loss. It will also allow them the opportunity to ask any questions they may be unsure of whilst their loved one was a patient with us.

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

- the climate and challenges within Heart of England and the NHS as a whole have had an impact on staff morale, and on their views and perceptions of the care delivered.
- The Trust has seen no significant change in its positive recommender score on this metric point year on year, however the organisational development approach started by the trust in 2014 is starting to show results. From the Staff FFT Q1 measure (June 2014), to the NSS (Dec 2014), there has been a sizeable movement from "Extremely Unlikely / Unlikely" into "Neither/ Nor" which we believe is an indicator of change.
- The trust has increased the opportunities for staff to give feedback, spent an increased time listening, and is confident that its 2015 approach will continue to significantly build on the early positive change seen so far.

The Heart of England NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- CEO providing clear priorities to all staff, with staff engagement in the top three priorities.
- Development of a trust-wide culture & engagement plan based on staff feedback received, focused on staff engagement, values led culture and leadership development
- Commitment to funding for additional resource to drive the engagement agenda throughout the organisation, and partnership working with successful trusts
- Continued implementation of key initiatives from 2014 diagnostics and staff feedback, across 4 key enablers (strong strategic narrative, engaging managers, employee voice and organisational integrity)
- Introducing and embedding structured engagement approach, based on Wrightington, Wigan & Leigh model. Includes trust wide listening and celebration events, team engagement programme, improved diagnostics, focussed toolkit
- Increased responsiveness – use of quarterly Staff Friends & Family survey, and full census NSS to more regularly update and adapt engagement planning
- Development of trust values underway, with involvement of 900 members of staff to date via 'drop-in' sessions, with opportunity for all staff to take part via Staff FFT
- Continuation of Staff Engagement Steering Group (staff led group) to analyse staff FFT, and to develop ideas and solutions to key engagement issues

Indicator	2012	2013	Trust performance Latest 2014	National Average	Lowest reported Trust	Highest Reported Trust
percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	52.97%	52.97%	47.66%	64.71%	38.17 (REF)	89.27% (RDU)

Data correct up to Feb 2015

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

The majority of failures of completion of the venous thromboembolism risk assessment (VTE RA) are due to patients attending for day surgical procedures, assessment areas (both medical and surgical), short stay surgical wards with patients mobilising soon after their elective procedures, intensive care unit where patients are commenced on prophylaxis immediately on admission. In areas such as day procedures unit and critical care unit we currently do not use trust electronic prescribing systems which automatically prompt users to perform VTE RA. In post-operative surgical patients who are at high risk of DVTs patients are commenced on prophylaxis. If these patients are excluded from these assessments, the performance on this screening procedure would enable higher screening rates.

The Heart of England NHS Foundation Trust intends to take the following actions to improve this percentage of patients undergoing the VTE Risk assessment, and so the quality of its services, by:

- Identify patients who are admitted for less than 12 hours, usually to the various assessments units and day case units within the trust and exclude them from requiring a VTE risk assessment as per our policy. Intensive Care unit and Post-operative surgical patients on elective thromboprophylaxis will also be excluded from this assessment.
- Raise awareness of the need to perform a VTE RA in those areas who admit patients for greater than 12 hours but do not routinely use the trusts electronic prescribing system.
- Feedback to poorly performing areas on a more frequent (monthly) basis.
- Request to the Trust Board for the extension of use of the trust's electronic prescribing system to all clinical inpatient areas.

Work with IT department to automated e-mail reminders that VTE RA's have not been performed on specific inpatients. Specific consultant based performance are now being released on a monthly basis to improve compliance with this screening programme.

Indicator	Sep-14	Oct-14	Trust performance Latest Nov-14	National Average	Lowest reported Trust	Highest Reported Trust
percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.08%	94.54%	95.09%	95.99%	4.86% (RGT)	00.00% (Several trusts)

Data correct up to Feb 2015

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons, reflecting as it does, a drop from a rate of 32.6 in the 2010-2011 year, which is due to a comprehensive C. Diff. control program which includes:

- A deep cleaning program across all three of the hospital sites.
- Root cause analysis of all post-48 hour cases of C. Difficile; carried out jointly with CCG and feed-back given to clinical and ward teams.
- Detailed Period of Increased Incidence (PII) reviews with feedback for wards with two or more cases of post 48 hours C. Difficile in any 28 day period.
- Typing of individual strains of C. Difficile to identify transmission incidents and outbreaks thus facilitating timely and effective management.
- Twice weekly review of all post 48 hour cases of C. Difficile by the infection prevention and control team.

The Heart of England Foundation NHS Trust has taken the following actions to improve this rate, and so the quality of its services by:

- The use of the new agent Fidaxomycin into the treatment algorithm for C. Difficile
- The development of a service providing faecal transplants to patients with protracted/relapsing C. Difficile infection. This is new initiative in the West Midlands

Indicator	2011/12	2012/13	Trust performance Latest 2013/14	National Average	Lowest reported Trust	Highest Reported Trust
rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period	24.4	17.1	16.7	14.7	0.0	37.1

Data correct up to February 2015

The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:

Whilst there are some discrepancies, due to the way that the information is collected and updated, analysis of our local incident reporting database provides broadly similar data, with the number of patient safety incidents reported within the trust during the reporting period as 7,570 and the number of such patient safety incidents that resulted in severe harm or death as 82.

The percentage of severe harm/death incidents quoted above is also noted to be inaccurate and should be 1.14%. This has arisen as a result of adding the rounded percentages of 1.0% and 0.2% for severe and death respectively from the NRLS feedback report, rather than using (87/7,610)*100.

The Trust considers a high level of incident reporting as a sign of a good safety culture and actively encourages staff to report both clinical and non clinical incidents. We have had a relatively stable incident reporting profile for the last few years with approximately 20,000 incidents reported in 2014. These incidents include patient safety incidents, which are subsequently uploaded to the National Reporting and Learning System (NRLS), data for which are shown above. The remaining incidents are those that affect staff or property, or where the patients involved were not in the care of the Trust at the time of the incident occurring, for example non-hospital acquired pressure ulcers.

As part of our incident reporting process we identify patient safety incidents which need to be uploaded to the NRLS and provide regular uploads to this system. The NRLS publish some of this data as national statistics as well as providing bi-annual reports for individual organisations.
This year we have continued to capture the duty of candour information required by our commissioners. We also continue to review the training we provide to keep it responsive and accessible to those users.

The Heart of England NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by:

- Implementation of a revised incident reporting, management and learning policy to support staff in learning from incidents and strengthening local feedback on reported incidents
- Revise the training and resources available to support incident investigation and management, providing "root cause analysis master-classes" for clinical investigation leads

Indicator	Apr 13 – Sep 13	Oct 13 – Mar 14	Trust performance Latest Apr 14 – Sep 14	National Average	Lowest reported Trust	Highest Reported Trust
number of patient safety incidents reported within the trust during the reporting period	7,757	7,610	7,383	4,196	35 (RP5)	12020 (RW3)
rate of patient safety incidents reported within the trust during the reporting period	7.04	6.91	33.97	-	0.24 (RP5)	74.96 (RBZ)
the number of such patient safety incidents that resulted in severe harm or death.	68	87	95	2851	0 (several trusts)	97 (RWJ)
percentage of such patient safety incidents that resulted in severe harm or death.	0.90%	1.20%	1.30%	1.11%	(several trusts)	3.05% (RF1)

Glossary

Term	Definition
CCG	Clinical Commissioning Group
FFT	Friends and Family Test
6Cs	National nursing initiative
Root Cause Analysis (RCA)	A process for identifying the basic or causal factor(s) that underlie variation in performance
Executive Management Board	Hospital trust management
National Safety Thermometer	The NHS Safety Thermometer provides a quick and simple method for surveying patient harm and analysing results so that you can measure and monitor local improvement and harm free care over time
VITAL	Training package
KPI	Key performance indicator
SSKIN	5 step model for pressure ulcer prevention
MDT	Multi-disciplinary team meeting
Best Practice Tariff (BPT)	A national tariff that has been structured and priced to incentivise and adequately reimburse care that is high quality and cost effective
'About me' tool	A tool for people with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes
'Ticket home'	Informs the patient & carer/family about all aspects of their discharge, from the time of admission
MEWS	The modified early warning score (MEWS) is a simple guide used by hospital nursing & medical staff to quickly determine the degree of illness of a patient
CQUIN	The Commissioning for Quality and Innovation Payment Framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
SHMI	SHMI is a hospital-level indicator which reports mortality at trust level across the NHS in England using standard and transparent methodology. This indicator is being produced and published quarterly by the Health and Social Care Information Centre.
Daily Harm	The daily harm is a report that is ran every day from the corporate nursing team and highlights to the ward the number of hospital acquired pressure ulcers and falls that have been reported in the preceding 24hrs. The information is displayed on a monthly calendar by site so each ward can see at a glance the number of reported pressure ulcers and falls are noted for each ward. The information is raw data so does not determine if the pressure ulcers are avoidable or not

Auditors Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Heart of England NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Heart of England NHS Foundation Trust to perform an independent assurance engagement in respect of Heart of England NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance (the "specified indicators"), marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified indicators	Specified indicators' criteria (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Page 129 "18 week incomplete pathways."
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Page 130 "Patients receiving their first definitive treatment for cancer within 2 months (62 days) of GP or dentist urgent referral for suspected cancer."

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 specified indicators' criteria referred to on the pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2014/15" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- the Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014/15";
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2014/15 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT

ARM and the "Detailed requirements for quality reports 2014/15; 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 following documents:

- Board minutes for the period April 2014 and up to the date of signing this limited assurance report (the period);
- papers relating to the Quality Report reported to the Board over the period April 2014 to the date of signing this limited assurance report;
- feedback from the Commissioners Solihull Clinical Commissioning Group dated 22 April 2015;
- feedback from Local Healthwatch organisation, Healthwatch Birmingham, dated 1 April 2015;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – KO41A dated May 2015;
- feedback from other named stakeholders, Solihull Health and Wellbeing Scrutiny Board, dated 21 April 2015;
- the 'Care Quality Commission – Patient survey report 2014 - Survey of adult inpatients 2014 Heart of England NHS Foundation Trust' latest national and local patient survey dated 2014;
- the '2014 National NHS staff survey – Brief summary of results from Heart of England NHS Foundation Trust' latest national staff survey dated 2014;
- the Care Quality Commission Intelligent Monitoring Report – Draft Report on Heart of England NHS Foundation Trust dated May 2015; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 22 April 2015.

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

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

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

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 '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:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2014/15";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;

- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less 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 impact 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 thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM the "Detailed requirements for quality reports 2014/15 and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Heart of England NHS Foundation Trust.

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

The Trust reports monthly to Monitor on the Incomplete 18 Weeks indicator, based on the waiting time of each patient who has been referred to a consultant but whose treatment is yet to start. The Trust has been unable to report against this target since the implementation of a new Patient Administration System (PMS2) in July 2014 and is unable to access records from the previous Patient Administration System (HISS) for performance for April to July 2014. As a result, we have been unable to access data to verify the waiting period from referral to treatment.

Conclusions (including disclaimer of conclusion on the Incomplete Pathways indicator)

Because the data required to support the indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the Incomplete Pathways indicator.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2015:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality report 2014/15";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The Cancer Waits indicator has not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "Detailed guidance for external assurance on quality reports 2014/15."

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Date

The maintenance and integrity of the Heart of England NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.