Heart of England NHS
NHS Foundation Trust

Heart of England NHS Foundation Trust

Quality Account

2015-16

Building **healthier** lives

Section 3 **Quality Account**

This Annual Report covers the period 1 April 20015 to 31 March 2016

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Section 2

Quality Account

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.

Part 1: Chief Executive's Statement on Quality

Heart of England NHS Foundation Trust (HEFT) has undergone a particularly difficult year, both in terms of finances and performance. In line with national trends, the Trust has seen unprecedented demand for its services with large increases in Emergency Department attendances and admissions which has put significant pressure on our ability to deliver planned treatments.

In October 2015, Monitor found that the Trust was in breach of its licence to provide NHS services and agreed to direct the Trust Board of Directors and Council of Governors to appoint a new interim leadership team.

I was appointed as Interim Chief Executive and Rt Hon Jacqui Smith took up the role of Chair in December. This is a dual role across HEFT and University Hospitals Birmingham NHS Foundation Trust.

In the six months since we have joined the organisation our priorities have been to bring financial and operational stability to the organisation to ensure we are delivering the best quality care to patients as possible.

We have implemented a new operational structure to ensure clear roles, responsibilities and accountabilities across the organisation. Monthly CEO-led Root Cause Analysis meetings have also been established to clearly focus the organisation on clinical quality.

An independent estates review has been undertaken and draft strategy produced identifying £160m for investment needed in the first phase, and a preliminary review of ICT has been undertaken in a bid to understand how the use of intelligent informatics can help drive improvements in clinical outcomes.

The most important task of all faced by the new executive team is to reinvigorate the clinical and support staff to engage with addressing the challenges, to move from passive to active in resolving performance issues. This is a significant cultural change and will take time to deliver.

Prior to Monitor's intervention, HEFT has been concentrating on improving the basics. Work focused on improving:

- Governance
- Urgent care
- Scheduled care
- Information management and technology
- Mortality
- Culture and engagement
- Financial stability

With regard to quality, there have been many improvements against the priorities detailed in the 2014/15 quality account. The Trust has made excellent progress with the stroke pathway since the reconfiguration in quarter 3 of 2014/15 and is now performing above the national average in all of the indicators measured in this report.

There has also been a reduction in the number of hospital acquired grade 2 pressure ulcers, with the Trust narrowly missing the 10% reduction trajectory set by the Clinical Commissioning Group (190 grade 2 pressure ulcers against a trajectory of 187).

A key safety priority is to reduce the number of falls in the Trust, and several work streams have enabled this to happen.

The final priority was to improve the response rate and overall score in the Friends and Family Test in the Emergency Department. Unfortunately, despite a number of initiatives, the Trust has not improved as much as planned, and therefore this

priority will be continued into 2016/17 Quality Account.

The national Sign up to Safety campaign was launched in 2014 and aims to make the NHS the safest healthcare system in the world. The ambition is to halve avoidable harm in the NHS over the next three years. Organisations across the NHS have been invited to join the Sign up to Safety campaign and make five key pledges to improve safety and reduce avoidable harm. HEFT joined the Sign up to Safety campaign in 2015 and made the following four Sign up to Safety pledges:

- Reducing harm from deterioration including sepsis
- Reducing medication related harm
- Reducing harm from pressure ulcers
- Reducing harm in maternity services.

2016/17 will be particularly challenging for HEFT as we focus on building healthier lives for our patients and achieving outcome/access targets alongside rising demand for our services and bringing financial stability and sustainability to the Trust.

The Trust will continue working with commissioners, healthcare providers and other organisations to influence future models of care delivery and to deliver further improvements to quality during 2016/17.

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

Dame Julie Moore,
Interim Chief Executive Officer

Part 2: Priorities for Improvement Statements of Assurance from the Board of Directors

Priorities for improvement:

This part of the report sets out progress made against the four priorities identified for improvement during 2015/16, which were:

Priority 1:
Reduce avoidable grade 2 hospital acquired pressure ulcers;

Priority 2:
Reduce the number of patients experiencing multiple falls whilst in hospital;

Priority 3:
Improve the Friends and Family Test response rate and overall score within the Emergency Department; and

Priority 4:
Improve the response time/rate to manage the acute stroke patient.

The Trust has made significant progress against three of the four priorities:

No	Priorities for improvement	2015/16	2016/17	Comments
1	Reduce avoidable grade 2 pressure ulcers	Yes	No	Consistent reduction and established monitoring systems
2	Reduce multiple falls whilst in hospital	Yes	No	Consistent reduction and established monitoring systems
3	Improve Friends and Family Test responses within the Emergency Department	Yes	Yes	To remain for 2016/17 in response to the poor response rate
4	Improve the response time / rate to manage the acute stroke patient	Yes	No	Consistent reduction

Based on these improvements the Trust has chosen to continue with only 1 of the 4 priorities from 2015/16 (Improve Friends and family Test responses within the Emergency Department) for 2016/17.

A further three local priorities, aligned to the Sign up to Safety initiative, have been agreed for 2016/17:

Priority 1:
Reduce avoidable harm to patients from omission and delay in receiving Parkinson's disease medication.

Priority 2:
Improve early recognition and management of sepsis and reduce hospital acquired sepsis.

Priority 3:
Reduce maternal harm through the category Caesarean section 1 Quality Improvement Programme (QIP) pathway.

These three priorities will be measured via quarterly reports to the Clinical Quality Monitoring Group, using Trust established systems and processes.

Progress against 2015/16 priorities:

Priority 1: Reduce avoidable grade 2 hospital acquired pressure ulcers

Aim and Rationale:

All patients within the care of the Trust are potentially at risk of developing a pressure ulcer. However, people with impaired mobility and nutrition are more at risk of developing pressure ulcers. The Trust has been committed to reducing the incidence of avoidable grade 2 pressure ulcers throughout 2015/16. Detailed work has been carried out to review the assessments and interventions to reduce the incidence of avoidable hospital acquired grade 2 pressure ulcers by 10%.

Process for monitoring progress:

The incidence of pressure ulcers is monitored daily by a 'harm alert', which provides all clinical areas with an overview of all pressure ulcers reported within the preceding 24 hour period. Monthly pressure ulcer compliance is recorded within nursing care indicators for all adult inpatient areas and monitored using a performance scorecard.

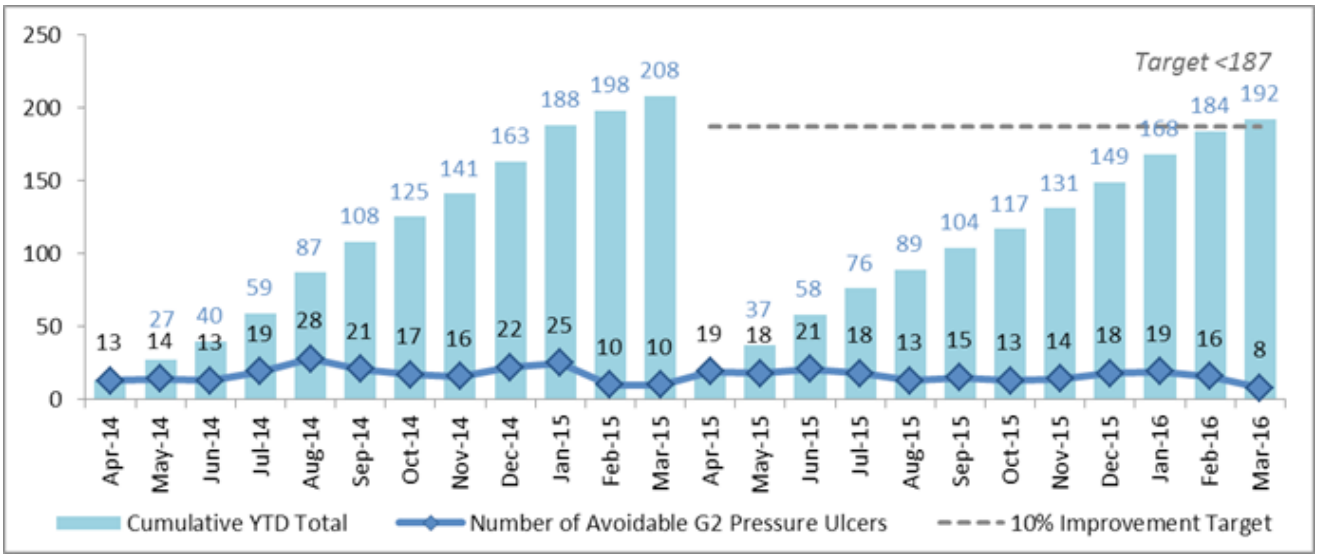
Improvement is measured against three indicators:

- Compliance with documentation for the frequency of repositioning. At the end of Quarter 4 the Trust has achieved 95%
- Compliance with the frequency of actual repositioning. At the end of quarter 4 the Trust has achieved 83%
- Compliance with daily skin inspections. At the end of quarter 4 the Trust has achieved 92%.

The monthly Divisional Tissue Viability Steering Groups are responsible for monitoring and identifying areas of non-compliance and facilitate the sharing of good practice, providing updates to all clinical areas. The Divisional Tissue Viability leads report to the monthly Trust Tissue Viability Steering Group which is chaired and led by the Deputy Chief Nurse. At this forum each division is responsible for the submission of divisional performance against the overall trajectory.

Current performance:

Table 1: Number of avoidable hospital acquired grade 2 pressure ulcers set against the 10% trajectory



At the end of quarter 4, the Trust performance against avoidable hospital acquired grade 2 pressure ulcers equates to 192 against a target of 187, narrowly missing the trajectory. This number is however likely to increase as there are 14 pressure ulcers with their RCAs still being completed which determines the avoidability of each pressure ulcer.

What has the Trust done to improve/ progress against 2015/16 initiatives:

- A 12-month tissue viability re-energising communications campaign commenced in September 2015 with a different focus of pressure ulcer prevention each month;
- Changes to the performance framework commenced in November 2015. All clinical areas that have areas of concern formally present avoidable pressure ulcer incidents to share the learning and undergo peer confirm and challenge;
- Introduced a programme of bespoke ward and speciality based training focussing on the learning from trends and themes and the management of complex patient devices;
- Mandated daily skin checks undertaken before midday to aid contemporaneous documentation.
- Introduction of repositioning clocks above each patient's bed to support wards in achieving a structured approach to patient repositioning;
- 'Safety huddles' undertaken on wards where compliance falls below 90%.

Initiatives to be implemented in 2016/17:

- The Tissue Viability campaign will continue throughout 2016/17, particularly focussing on areas identified for improvement. The campaign will expand to include non-ward based areas such as the emergency departments, adult theatres and out patients;
- There will be a focus on developing the Tissue Viability steering groups within each division. This approach will strengthen the delivery of patient centred care, encourage innovation and enhance the role of the Tissue Viability link nurses;
- The Trust will target grade 2 pressure ulcers which have a potential to deteriorate to grade 3 pressure ulcers within high risk areas and where devices have the ability to cause harm e.g. naso-gastric tubes;
- The Trust will implement a series of high level actions in response to the themed review undertaken in December 2015 in partnership with the CCG.

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

Aim and Rationale:

Whilst patients of all ages fall, the occurrence is greater in older people: one in three people over the age of 65, and half of those over 80 will fall each year. For hospital inpatients the risk is compounded by factors such as delirium and cognitive impairment; medical diagnosis/condition which can be multi-factorial; disabilities for example, poor eyesight, hearing and mobility; and other problems associated with continence. Slips, trips and falls are collectively the most reported patient safety related incident, which is consistent across England.

Process for monitoring progress:

All falls are reported via the Trust's incident reporting system. The data is disseminated to all clinical areas via the Daily Harm Alert. The Daily Harm Alert indicates if a fall has been reported causing any potential injury.

- All significant falls resulting in harm are investigated by the supervisory ward sister/ matron. Each fall is evaluated and reviewed by the clinical nurse specialist for falls and a site head nurse. Lessons learned are agreed and feedback is given to staff.
- A weekly retrospective look back at all falls where patient safety has been compromised with resulting harm is undertaken.
- All three hospital sites have an appointed falls lead responsible for facilitating the monthly local falls group. This group reports into the Trust Steering Group. Trends and themes, areas for improvement and agreement against improvement plans are discussed.
- The Trust continues to complete the National Safety Thermometer Audit; this is a monthly point prevalence audit aimed at capturing any fall that has taken place within the preceding 72-hour period.
- The falls nursing care indicator has, since October 2015, presented a compliance score of 95% and above.

Current performance:

A key Trust safety priority is to reduce significant harm arising from such falls for example, fractured neck of femur. The local trajectory is to achieve a 10% reduction against 2014/15 out turn and a trajectory of 6.36/1000 bed days.

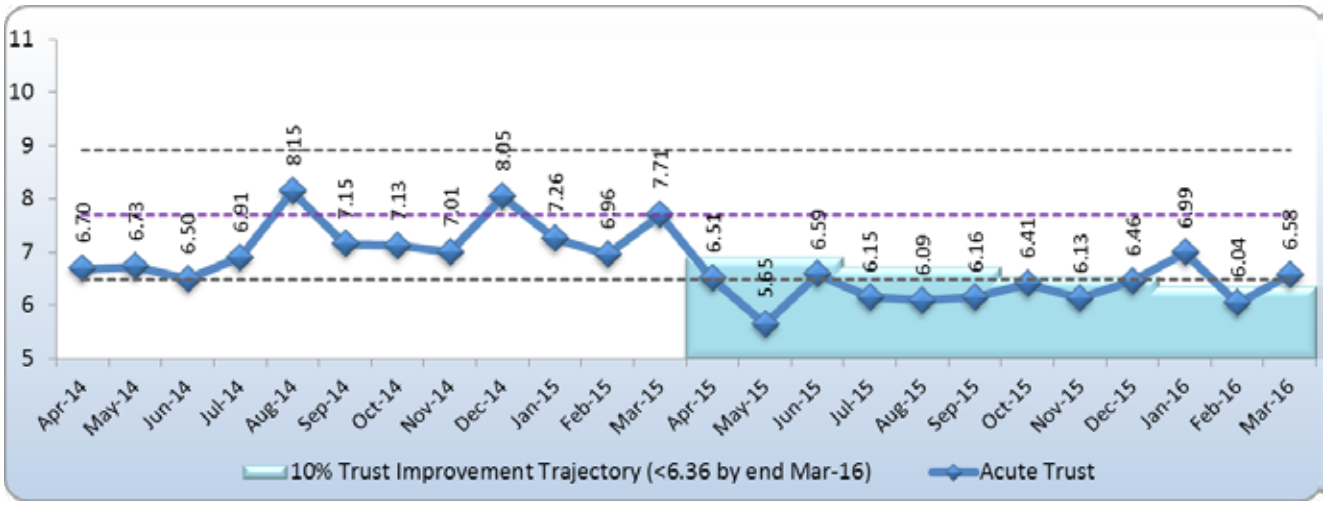
Quarter 3 data demonstrates a reduction of 75 recorded falls (788 in Quarter 3 2015/16) from the same period in 2014/15 (863 falls) meaning a reduction in falls rate from 7.40 falls per 1,000 occupied bed days in Quarter 3 2014/15 to 6.34 in Quarter 3 2015/16.

Quarter 4 data shows a reduction in the number of

recorded falls from 851 reported during Quarter 4 2014/15 compared to 849 falls reported during the same period of 2015/16. This means a reduction in falls rate from 7.32 falls per 1,000 occupied bed days in Quarter 4 2014/15 to 6.55 in Quarter 4 2015/16.

Overall, 2015/16 data demonstrates a reduction of 234 recorded falls (3,094), compared to 2014/15 (3,328), meaning a reduction in falls rate from 7.19 falls per 1,000 occupied bed days to 6.32 for 2015/16.

Table 2: Trust falls rate per 1,000 occupied bed days



What has the Trust done to improve/ progress against 2015/16 initiatives:

- Each ward uses a visual safety cross which clearly identifies to staff those patients at risk and indicates when and where they have fallen;
- In March 2015 the Trust introduced open visiting across all in-patient areas and whilst there is no clear explanation, this appears to have positively impacted on falls reduction;
- Two falls practitioners were appointed for a 12-month period to support the clinical lead nurse to embed practice;
- Birmingham Cross City Commissioners undertook a themed review in November 2015; all three hospital sites were reviewed, receiving positive feedback. All recommendations have been adopted by the Trust Falls Steering group;
- Implementation of the Enhanced Observation Tool to assess patients requirement for '1 to 1' observation;
- All wards that report an increase in falls are reviewed by the clinical nurse specialist with an agreed action plan;
- The falls VITAL module remains in use as part of falls prevention education for both registered nurses and healthcare assistants;
- The falls web page is now operational.

Initiatives to be implemented in 2016/17:

The Trust's commitment to reduce the overall falls rate will focus on existing work and include the following going forward:

- Inclusion of operational managers at steering group meetings – this is a recommendation of the National Audit of Inpatient Falls 2015.
- Working with site capacity teams to stop at risk patients from being transferred between wards.
- Fully implement an electronic root cause analysis (RCA) tool to investigate multiple falls and those falls resulting in significant harm.
- Review of the falls risk assessment to ensure it remains fit for purpose.

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

Aim and Rationale:

The Friends and Family Test (FFT) is seen as an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

The national average for positive recommender score in Emergency Services is 88%. The Trust uses this figure to assess the response rate.

Process for monitoring:

Progress is monitored via the patient experience dashboard and is accessible at ward, division and Trust level. The results are monitored by the patient experience team, ward managers, matrons and site leads. The data is discussed at the divisional quality and performance meetings and is presented to the Trust Board of Directors. The newly formed Patient Community Panels also review and monitor patient experience.

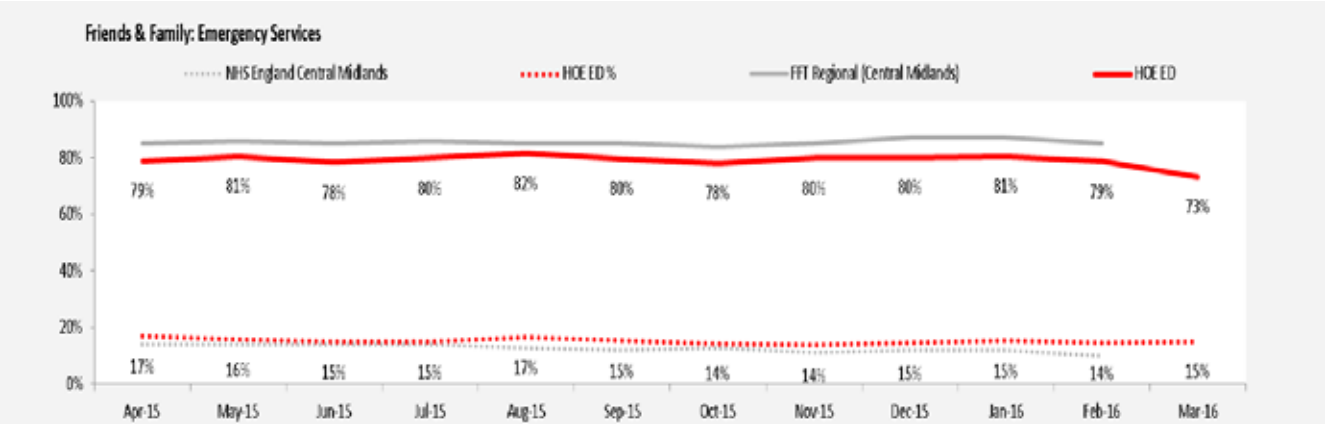
Current performance:

The average positive recommendation for the period April 2015 – April 2016 was 79%. This compares to the previous 12 months, April 2014 to March 2015 of 74%, an increase of 6%.

Table 3: ED FFT Positive Responder Rate April 2015 – March 2016

Emergency FFT Metric	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS England	88%	88%	88%	88%	88%	88%	87%	87%	87%	86%	85%	
FFT Regional (Central Midlands)	85%	86%	85%	86%	85%	85%	84%	85%	87%	87%	85%	
Good Hope	79%	82%	81%	81%	83%	81%	80%	79%	82%	83%	80%	79%
Heartlands	76%	76%	72%	76%	76%	77%	71%	78%	75%	74%	72%	63%
Solihull	83%	85%	82%	84%	88%	83%	86%	86%	85%	89%	87%	85%
HOE ED	**79%**	**81%**	**78%**	**80%**	**82%**	**80%**	**78%**	**80%**	**80%**	**81%**	**79%**	**73%**

Table 4: Trust FFT Emergency Department (ED) response rate and positive recommender score compared with the region



The Trust's FFT captures approximately 30,000 comments a year for ED and received 6,881 comments for ED for Quarter 4. This data is predominantly captured via text message.

Table 5: ED FFT %response rate April 2015 – March 2016

Emergency FFT %	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS England %	15%	14%	15%	15%	14%	14%	14%	13%	13%	13%	13%	
NHS England Central Midlands	14%	14%	14%	14%	13%	12%	13%	11%	12%	12%	10%	
Good Hope %	20%	19%	19%	18%	20%	18%	17%	17%	18%	18%	17%	18%
Heartlands %	12%	12%	11%	12%	13%	12%	11%	10%	11%	12%	12%	13%
Solihull %	19%	20%	17%	17%	19%	18%	18%	16%	19%	19%	18%	17%
HOE ED %	17%	16%	15%	15%	17%	15%	14%	14%	15%	15%	14%	15%
Target	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
HOE Completed Surveys	2172	2058	2426	2346	2536	2361	2323	2203	2292	2443	2277	2692

What has the Trust done to improve/ progress against 2015/16 initiatives:

- Refurbishment of the Acute Medical Unit (AMU) at Good Hope Hospital (GHH) operational from 5th November 2015.
- Redesign of the ED at Birmingham Heartlands Hospital (BHH) - doubled the size of the major injury area and introduced a new minor injuries area.
- A quality dashboard has been devised which provides information per area / department relating to patient care and includes patient experience results.
- Access to dementia boxes within ED at GHH.
- Development of a learning disability toolkit in association with Keele University. This includes picture cards to facilitate communication and has been successfully used with other patient groups, for example patients whose first language is not English and patients with a hearing disability.
- Employed housekeepers within the ED at GHH and BHH.
- GHH has initiated a system to ensure that all patients are seen, spoken to and cared for wherever they are in the department.
- There is a quarterly thematic analysis of complaints undertaken to evaluate what people are saying and what areas need to be improved upon.
- BHH and GHH ED departments have a designated quiet room for patients requiring a calming environment.
- GHH has recently appointed a senior sister for patient experience in ED. They have created a display board for patients and carers which displays waiting times and an explanation of why there are delays, for example speciality related or procedure related.
- GHH has also created a display board specifically for staff which presents patient and carer feedback.

Initiatives to be implemented in 2016/17:

- Explore the possibility of volunteers in ED and AMU to provide compassionate care for vulnerable patients, for example elderly patients on their own, patients with dementia, delirium and patients with learning disabilities.
- Key ED staff from BHH and GHH will be undertaking a site visit to one of the top ten performing EDs for FFT in the country to look and their good practice and what can be done differently.
- A leaflet has been developed for GP's to give to people referred to AMU which explains the process for people attending AMU. This will be rolled out in the coming year.
- Patient Community Panels have been asked to assist with surveys and observational visits in ED to gain specific information and offer solutions from a patient/carer perspective.
- NHS Elect is working with the Trust and will be providing workshops on customer care training for staff.

Priority 4: Improving stroke care

Aim and Rationale:

Evidence from large-scale clinical trials have shown that certain interventions are associated with improved stroke outcomes. HEFT is a major provider of stroke care treating over 1,000 patients annually with suspected acute stroke. Four high-impact quality improvement interventions reported here are making a difference to clinical outcomes.

Process for monitoring progress:

Intervention #1: Increasing the percentage of patients receiving thrombolytic therapy within 1 hour of arrival in the BHH Emergency Department (ED)

The evidence is straightforward, namely "time is brain" and in general the earlier a thrombolytic drug is administered the better the clinical outcome and the lower the risk of intracranial haemorrhage.

At BHH, thrombolysis is administered to all patients that meet the criteria; however this new measure is extremely important for the reasons outlined above.

Current performance:

All key stroke indicators are collected locally by the hyper acute stroke service and reported nationally in the Sentinel Stroke National Audit Programme (SSNAP). This indicator is monitored monthly through internal performance reports and discussed at the Trust Stroke Governance meeting.

Table 6: Percentage of patients thrombolysed within 1 hour of arrival at ED, BHH

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
BHH	20.0%	16.7%	63.2%	86.4%	83.3%	68.8%	73.9%	Not available
GHH	0.0%	0.0%	50.0%	N/A	N/A	N/A	N/A	N/A
SH	0.0%	0.0%	N/A	N/A	N/A	N/A	N/A	N/A
National	55.2%	56.4%	57.0%	56.4%	57.7%	59.8%	57.9%	Not available

As part of the Trust reconfiguration of stroke services, the thrombolysis service transferred to BHH from SH in Quarter 3 2014/2015 and from GHH in Quarter 4 2014/2015. BHH is currently performing at level A for this indicator which means that it achieves the target of >= to 55%.

The reconfiguration has led to a significant increase in the number and concentration of specialist staff at BHH. As the new pathway has been embedded, individual parts of the process have rapidly become more effective and efficient:

- A Stroke Nurse Practitioner (SNP) and medical bleep holder will attend within 5 minutes of a fast +ve patient being identified 24/7. Work has also been done to analyse any door to needle (DTN) time greater than 1 hour to clarify and resolve the delays in the thrombolysis pathway.
- Earlier call to expert decision makers (the stroke consultant) with clear separation of ED and SNP roles.
- Telemedicine is now available which allows the SNP and consultant on-call to interact with each other more efficiently and effectively. This has proved valuable out of hours aiding a reduction in call to needle time.
- The stroke service engages in collaborative meetings with ED and WMAS to improve the clinical interfaces including review of pre-hospital communication: WMAS now has open access to the stroke mobile phone held by the SNP for pre-alert discussions; this has made the alert pathway more efficient and reduced inappropriate patients travelling to BHH. This new process facilitates CT scans to be requested and agreed prior to registration in ED. This has the potential to save approximately 5-10 minutes for each patient which can make a material difference to the patient.

Initiatives to be implemented in 2016/17:

The Trust is planning to extend the data analysis to review instances where DTN time is greater than 45 minutes which will highlight areas for further improvement.

There are plans to further develop the current stroke telemedicine service at BHH to improve the management of patients out of hours when the specialist consultant is not on site. The use of this facility will support the decision making process and can further reduce the time taken to reach a decision regarding administering thrombolysis which in turn will improve patient outcomes.

Intervention #2: Percentage of patients directly admitted to stroke unit within 4 hours of arrival in ED

Early admission to a stroke unit generally means early assessment by specialists and less variation in treatment and care.

Table 7: Percentage of patients directly admitted to a stroke unit within 4 hours of arrival in ED

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
BHH	37.8%	38.3%	53.9%	66.0%	77.7%	80.9%	75.9%	Not available
GHH	40.5%	37.9%	34.9%	15.8%*	11.8%*	4.3%*	4.3%*	N/A
SH	8.1%	14.6%	N/A	N/A	N/A	N/A	N/A	N/A
National	58.0%	59.8%	56.9%	53.6%	58.7%	61.8%	59.8%	Not available

The Trust is currently performing at level B for this indicator which means it is achieving the standard between 75-89%.

What has the Trust done to improve / progress against 2015/16 initiatives:

Work to analyse times greater than 4 hours to clarify and resolve the delays in the admission pathway. Many delays have been resolved by collaborative working between the stroke service, the site capacity management team and ED.

In the early phase of the reconfigured service, the stroke repatriation process of patients back to SHH and GHH proved challenging to implement consistently; however the process is now working much more effectively. This has helped to maintain bed capacity and flow in the BHH HASU and therefore prompt admission from ED.

Initiatives to be implemented in 2016/17:

The Trust plans to extend the data analysis to review times greater than 2 hours and ultimately 1 hour with the aim of an average time from arrival in ED to admission into HASU of 1 hour.

Intervention #3: The proportion of applicable patients given a swallow screen within 4 hours of arrival in ED

This intervention is a marker for the level and speed of initial specialist assessment. Swallow screens are a taught competency.

Table 8: Proportion of applicable patients who were given a swallow screen within 4 hours of arrival In ED

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
BHH	80.8%	81.6%	90.9%	90.3%	91.9%	92.5%	91.8%	Not available
GHH	68.9%	77.9%	67.9%	43.1%*	18.2%*	13.6%	4.3%*	N/A
SH	44.1%	14.6%	N/A	N/A	N/A	N/A	N/A	N/A
National	67.3%	69.2%	68.7%	68.0%	71.1%	72.8%	72.0%	Not available

What has the Trust done to improve / progress against 2015/16 initiatives:

Following service reconfiguration, virtually all acute swallowing screens are required at BHH where the 24/7 SNP is appropriately trained. BHH is currently performing well consistently achieving above 90% for this indicator which is well above the national average.

Over the last year, the care of patients suffering a stroke whilst an inpatient has improved: with more timely access to specialist care, which includes a swallow screen.

Initiatives to be implemented in 2016/17:

Plans are in place to further engagement with ED on all three sites and staff education.

Intervention #4: The percentage of patients who spent at least 90% of their stay on a stroke unit

This relates to the direct admission measure (2) above and site capacity issues. Any patient who spends a prolonged amount of time in ED and has a short length of stay, or any patient who is not initially admitted to a stroke unit, is likely to be denied access to stroke unit care.

Table 9: Percentage of patients who spent at least 90% of their stay on a stroke unit

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
BHH	80.7%	75.4%	78.2%	87.7%	92.3%	93.4%	89.8%	Not available
GHH	74.7%	75.0%	72.7%	75.6%	72.3%	66.1%	76.6%	Not available
SH	68.8%	62.9%	75.6%	100.0%	95.8%	81.0%	78%	Not available
Nationally	83.5%	84.3%	83.4%	82.1%	84.0%	86.1%	85.6%	Not available

BHH and SHH have both improved since the reconfiguration.

GHH is underperforming. The reasons for this include: patients presenting to ED with non-typical stroke symptoms, admitted to a non-stroke bed, only to be diagnosed with stroke later. Many of these patients will also have 'milder' symptoms and tend to have a shorter Length of Stay and therefore less opportunity to access a stroke specialist bed 90% of the time.

This cohort of patients is likely to fail many of the performance indicators and the team at SSNAP recognise this issue. SSNAP will reclassify hospitals that directly admit fewer patients than get transferred into non-routine admitting hospitals and only publish the relevant indicators. GHH was not reclassified by SSNAP as a non-routine admitting hospital until Q2 15/16 because they were still directly admitting slightly more patients than were repatriated from BHH. Therefore the figures for Q4 and Q1 are particularly low due to the small numbers and the specific cohort of patients directly admitted to GHH in this time period. It is expected that GHH will be reclassified like SH to non-routine admitting in the near future.

What has the Trust done to improve/ progress against 2015/16 initiatives:

The reconfiguration of stroke services at the Trust has improved the performance in admitting patients directly to a stroke bed within 4 hours. The stroke repatriation policy is working well to ensure patients are consistently repatriated to stroke beds at SH and GHH in a timely fashion and HASU maintain patient flow through the unit.

New initiatives continue within the Trust to improve patient flow and facilitate the discharge process for all patients. Engagement with both social services and community health services in addition to a strengthened enhanced supportive discharge team continues to reduce the length of stay across the Trust for stroke patients.

Initiatives to be implemented in 2016/17:

To improve performance at GHH it is necessary to reduce the number of patients with non-typical stroke symptoms. As described earlier, this will be done through engagement with ED and staff education.

For BHH and SH, the challenge is to maintain the level of performance. This is regularly monitored via the monthly internal performance reports so the stroke team can react to any deterioration in the quality of care.

* Since the reconfiguration GHH and SH still directly admit a small number of patients who are not initially thought to have a stroke diagnosis and then the diagnosis of stroke is confirmed later.

SSNAP data caveats

i) SSNAP data is collected by admission date. There is a deadline for submitting the data that is approximately one month after the quarter ends. SSNAP analyse the data and release their report approximately two months after the quarter ends. The data for Q4 2015/2016 is not officially validated and released by SSNAP until the beginning of June 2016. Unfortunately the Trust is unable to obtain this data sooner.

ii) In the last year, HEFT reported figures from the data submitted for both Sentinel Stroke National Audit Programme (SSNAP) and Best Practice Tariff (BPT). These figures vary slightly as SSNAP data is clinically validated to confirm the diagnosis of stroke and BPT data is from clinical coding on a stroke diagnosis. Patients can only be coded to one diagnosis; whereas HEFT can submit patients to SSNAP where the patient has more than one

diagnosis and the diagnosis of stroke is significant.

iii) This year, the Trust has reported data from SSNAP which is a nationally recognised, validated and comprehensive measure based on clinical data collection and clinical validation. SSNAP is currently the single recognised source of national stroke data and has 100% participation of acute hospitals in England and Wales. SSNAP is considered reliable and is directly comparable with other acute hospitals.

Part 2:

Review of Services/Statements of Assurance from the Board

The Trust is required to include statements of assurances from the Trust Board. These statements are common across all NHS Quality Accounts.

Service Income

During 2015-16, Heart of England NHS Foundation Trust provided and/or sub-contracted 101 relevant health services.

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 2015-16 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 the financial year 2015-16.

Clinical Audit

During 2015/16, 34 national clinical audits and 2 national confidential enquiries covered relevant services that Heart of England NHS Foundation Trust provides.

During that period, 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 2015/16 can be found at Appendix 1.

The national clinical audits and national confidential enquiries that Heart of England NHS Foundation Trust participated in during 2015/16 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 2015/16, 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.

Participation in Clinical Audits and National Confidential Enquiries 2015/16

Reviewing Reports of National and Local Clinical Audits

The reports of 15 national clinical audits were reviewed by the provider in 2015/16 and Heart of England NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- **Epilepsy 12 National Audit: Round 2** – The Trust has continued to fulfil best practice tariff requirements to deliver high quality care by developing dedicated epilepsy clinics across sites with a consultant expert in paediatric epilepsy. Also the Trust is holding a joint epilepsy clinic with a visiting tertiary neurologist every month and holding transition clinics on alternating sites quarterly. In addition, the team has appointed a 0.7 whole time equivalent epilepsy specialist nurse at Good Hope Hospital to improve ECG results.
- **Trauma Audit and Research Network (TARN): Orthopaedic Injuries** – The service continues to meet NICE guidelines ensuring that head injury positive patients receive a CT head scan within 60 minutes and have successfully reduced this time to 30 minutes. We have established a Trauma Quality Improvement Forum to promote wider engagement of other specialities and to find multidisciplinary solutions to trauma care.
- **National Audit of Cardiac Rhythm Management Devices** – Following data input and coding concerns within the previous audit, the team has improved its infrastructure to support real time data analysis by acquiring a bespoke database. This enables data to be collected at the time of the implant or directly after and then uploaded to the National Institute for Cardiovascular Outcomes Research (NICOR) database.

- **National Comparative Audit of the Use of Anti-D** – The service has restructured its clinics to include weekends to facilitate post natal prophylaxis. Anti-D can now be requested electronically thereby minimising errors. The Trust has arranged for a designated team to ensure the pathway process is recorded, completed and audited. Any errors in requesting and administration will continue to be reported via SHOT, the haemovigilance scheme.
- **Emergency Use of Oxygen Audit** – The team is working towards ensuring that the ward pharmacy teams provide prompts to staff regarding appropriate oxygen prescription and validating these in the same way as other medications. Educational programmes emphasizing the importance of oxygen prescription and charting is being delivered to junior doctors and nursing staff as part of their induction training.
- **National Diabetes Inpatient Audit** – A Trust wide educational campaign was launched in June 2015 to improve clinical knowledge and awareness around errors in medication, prescription and appropriate management of patients. A Delivering Excellent Care in Diabetes and Education (DECIDE) group has been set-up to meet bimonthly to identify risks and develop strategies to improve patient safety.
- **National Neonatal Audit Programme (NNAP)** – The Trust is working towards improving the documentation of consultations with parents within 24 hours and recording health outcomes at 2 years by developing an improvement plan and reviewing progress.
- **Sentinel Stroke National Audit Programme (SSNAP)** – Following stroke reconfiguration, The Trust has its improved our performance significantly with whole scale improvements being seen throughout the stroke pathway, particularly at Birmingham Heartlands Hospital which is now managing all emergency stroke admissions and performing at the highest standard.
- **National Oesophago-Gastric Cancer (NOGCA)** – The team will work to improve the service so that all patients considered for palliative chemotherapy are discussed at regular multidisciplinary team meetings with surgeons, oncologists and clinical nurse specialists present to generate key learning points and actions. Also, an improved data recording system has been adopted to enhance data submission for palliative endoscopic treatments, providing a key information link between the Endoscopy service and the wider multidisciplinary team.
- **National Comparative Audit of Blood Transfusion Programme: Blood sample collection and labelling** – A phlebotomist in ED has been appointed and the team is working towards using addressograph labels on all samples (except those tested in blood bank) to minimise the risk of error and to improve efficiency.

The reports of 86 local clinical audits were reviewed by the provider in 2015/16 and Heart of England NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Acute Medicine team at Good Hope Hospital has highlighted the need to improve the overall uptake of the sepsis screening tool and sepsis 6 at the point of triage within the acute medical unit and emergency department. To raise awareness, the sepsis pathway and its management has been included in the junior doctor induction training programme.
- The Acute Medicine team is developing a new process to ensure that patients' regular medications are documented correctly in the clerking sheet when admitted to the acute medical unit by inserting a universal coloured form with tick boxes in all patients' notes.
- The Birmingham Heartlands Hospital Elderly Care team has streamlined its process for admitting fractured neck of femur patients to an orthopaedic ward within four hours of admission, by ensuring that senior clinicians within trauma and orthopaedics are contacted directly by the on-call doctor regarding confirmation of a hip fracture x-ray in A&E rather than waiting for the ward round or review by a registrar.
- Following a partnership audit undertaken between the Trust's gastroenterology team and Rapid Assessment Interface and Discharge (RAID) team at Birmingham & Solihull Mental Health NHS Foundation Trust, the electronic prescribing system has been amended to reduce variation and establish just one standardised IV vitamin B and C regime for alcohol.
- The trauma and orthopaedic service at Good Hope Hospital will continue to use collagenase injection and manipulation treatment for Dupuytrens contracture following a successful pilot which has demonstrated that the procedure is minimally less invasive resulting in fewer complications, with early recovery by 1-2 weeks and overall increased patient satisfaction.
- The radiology team are working towards developing a new pathway for shoulder pain imaging with the orthopaedic team and General Practice (GP's) to reduce patients' exposure to unnecessary imaging and to reach diagnosis using the most efficient pathway and provide a better service.
- The Neonatal Unit is working towards

establishing a formal neurodevelopmental service consisting of neonatal consultants, physiotherapists and speech and language therapist to ensure that high risk preterm infants at two years are appropriately followed up.

- The obstetrics and gynaecology team at Good Hope Hospital has introduced copies of the massive obstetric haemorrhage proforma to the major haemorrhage trolley to reinforce its use and have educated staff around the proforma and pathway so that consultants are informed of all cases.
- The community dental services have amended the new dental therapist proforma to ensure it meets 100% documentation standards for date and signature of dentist, along with fluoride dose and justification of x-ray. This has been made available to all clinics and mobile areas.
- The community paediatrics service has revised its process around documenting advanced care plans so that scanned copies are uploaded to TPP, a shared IT system.

Research

There are over 500 research projects being undertaken across the Trust in various stages of activity, from actively recruiting patients into new studies to long-term follow-up. In 2015/16, over 100 new studies have been given Trust approval to commence. There are 28 departments across the Trust currently taking part in research with between one and six research active consultants in each of these areas.
The number of patients receiving relevant health services provided or sub-contracted by Heart of England NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 6,086. Clinical trials remain the largest research activity performed at the Trust, in terms of project numbers. The Trust has a mixed portfolio of commercial 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.

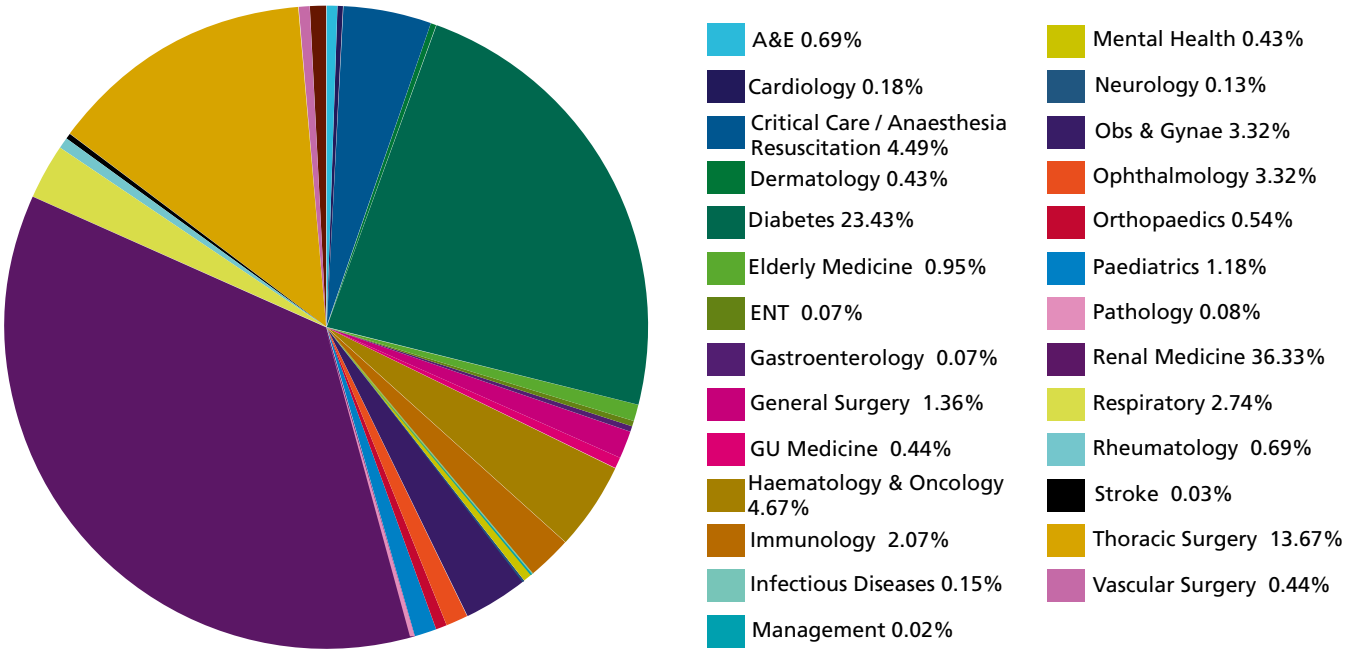
During 2015/16, patient recruitment was highest in renal medicine, diabetes and thoracic surgery. Renal medicine has been particularly successful this year due to a Trust investigator led study; which has been supported by the critical care, anaesthetic and resuscitation research team. This is an on-going study looking at the identification and management of acute kidney injury, the results of which may have national impact.

Areas to highlight research growth in 2015/16 are:

- Mental Health: 0.43% in 2015/16 compared to 0.08% in the previous year
- General surgery: 1.36% in 2015/16 compared to 0.06% in the previous year
- Vascular surgery: 0.44% in 2015/16 compared to 0.16% in the previous year.

The Guardian Research table published annually, ranks Trusts based on patient recruitment into trials. For an acute trust, the Trust ranked 20th out of 161 in 2014/15, being the current table published.

Table 10: The Trust's Research Portfolio by Directorate



2015/16 has seen the continuation of new research lead grant applications and research collaborations both within the Trust and with external partners. Academic appointments have also strengthened these partnerships, particularly in new research areas for example public health and patient safety. 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 2015/16 totalled in excess of £13 million. To date much of this still awaits an outcome against the application; with many NIHR funding streams taking in excess of 8 months to conclude. There has been a continued increase in support and advice particularly relating to local projects as part of further degrees, for example junior doctors, nurses, midwives and allied health professionals.

Professor Debbie Carrick-Sen, Florence Nightingale Chair of Nursing, has started the Clinical Research Internship Programme and has eight nurses and midwives undertaking a Research for Masters at the University of Birmingham. Professor Carrick-Sen is helping develop these students into future researchers, all of whom have expressed a desire to continue to a PhD. In addition to this, the Research and Development Department has developed a Research Fellows Forum, led by Professor Fang Gao, which aims to provide an introduction to research in the NHS. This forum provides an opportunity for the research fellows to be informed of the practicalities of research from experienced researchers within the Trust as well as an opportunity to discuss their own research with their peers. The continued commitment to the support and nurturing of the junior doctors, nurses, midwives and allied health professional in developing their research skills and knowledge. This is essential to encourage and develop the researchers of the future, for changing practice and also in the potential of findings being used for further, larger research projects.

- Dr Mark Thomas (Renal Medicine) has successfully led his Acute Kidney Outreach to Reduce Deterioration and Death (AKORDD) study, recruiting over 1,700 patients. This aims to improve patient care and patient outcomes in the management of acute kidney injury patients.

- Dr Indy Dasgupta (Renal Medicine) has led as principal investigator on several new studies within renal medicine, including being the first UK site to use an American device in the treatment of persistent hypertension.

- Dr Ed Nash (Respiratory Medicine) has introduced home monitoring for cystic fibrosis patients.

- Professor George Tadros (Mental Health) as well as expanding the mental health research portfolio within the Trust, this has expanded to include further research in the area of dementia. Professor Tadros has been working with Dr Dasgupta on several joint research projects in the areas of cognitive function in dialysis patients and helping patients manage their hypertension.

This year has also seen the publication of a research newsletter focusing specifically on 'our patients', and highlights the impact of being involved in clinical research.

Commissioning for Quality and Improvement (CQUINs)

A proportion of the Heart of England NHS Foundation Trust income in 2015/16 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 2015/16 and for the following 12 month period are available by contacting the Deputy Director of Finance at the Trust. The CQUIN value within the contract was £12,664,928 of the Trust's income in 2015/16. CQUINs encompass the Acute, Specialised services, Community Services and Public Health contracts and include the following CQUINs detailed below.

Table 11: QUARTER 3 (October to December) 2015-16

Provider	Ref	Title	Achievements as at end Quarter 3 2015-16
Acute	1	**Acute Kidney Injury (AKI)**	Achieved
Acute	2a	**Sepsis:** Screening	Achieved
Acute	2b	**Sepsis:** Antibiotic Administration	Not Achieved The Trust did not achieve the Q3 target of 70% - current performance is at 59% (BHH 45%, GHH 87%, SH 41%), however the Commissioners awarded the Trust half of the funding agreed for Q3 in light of the improvements that were made.
Acute	3a	**Dementia:** Find, Assess and Refer	Not Achieved The Trust did not achieve the Q3 target of 90%. The lowest score (FIND) being 87.4%. Therefore a partial achievement of 70% of the Q3 value has been achieved.
Acute	3b	**Dementia:** Staff Training	Achieved
Acute	3c	**Dementia:** Supporting Carers	Achieved
Acute	4a	**COPD:** Implementation of the COPD Discharge Bundle	Achieved
Acute	4b	**COPD:** Compliance with Specialist Respiratory Review	Achieved
Acute	4c	**COPD:** Staff Education and Training	Achieved
Acute	5	**Maternity Safety Thermometer**	Achieved
Acute	6	Cancer Survivorship Framework: Well-Being Clinics (Gynaecological Speciality)	Achieved
Acute	7a	**Reducing the Proportion of Avoidable Emergency Admissions to Hospital (AEC)**	Milestone not due until end Q4
Acute	7c	**Safer Care Bundle:** Improving Patient Experience by Reducing Number who are in Hospital for Over 14 Days	Milestone not due until end Q4

Provider	Ref	Title	Achievements as at end Quarter 3 2015-16
Community	3a	**Dementia**: Find, Assess and Refer	Achieved
Community	3b	**Dementia**: Staff Training	Achieved

Community	3c	Dementia: Supporting Carers	Achieved
Specialised	B2	**HIV:** Reducing Unnecessary CD4 Monitoring	Milestone not due until end Q4
Specialised	C6	N**ICE DG10:** Eligible Patients Receiving a Compliant Test with Provision of Monitoring Data (Cancer)	Milestone not due until end Q4
Specialised	TBC	**Right Care, Right Place:** HIV Medicine	Achieved
Specialised	CUR1	**Clinical Utilisation Review:** Installation and Implementation	Milestone not due until end Q4
Public Health	(3)	**Integrated Working:** Maternity and Child Health	Achieved

CQUIN Update: Quarter 4 Delivery

Table 12: Acute Contract

CQUIN Name		Quarter 4 Risks
1	**Acute Kidney Injury (AKI)**	Issues with the IT system that has been developed in order to populate the discharge summaries with required key information in relation to AKI. This issue has been escalated to IT Services for investigation and rectification.
2a	**Sepsis:** Screening	Trust is not on track to achieve the Q4 target of 90%. Good Hope is currently lowest performing site (53% for Q3). Current performance indicates that the Trust is only likely to achieve 5% of the total CQUIN value for Q4.
2b	**Sepsis:** Antibiotic Administration	Trust is not on track to achieve the Q4 target of 90%. Solihull is currently lowest performing site (41% for Q3). Current performance indicates that the Trust is only likely to achieve 5% of the total CQUIN value for Q4.
3a	**Dementia:** Find, Assess & Refer	Based on current performance, the Trust is only likely to achieve 70% of the Q4 CQUIN value. Concerns have been escalated continually and a list of Patient Identification Numbers (PIDs) for patients requiring screening is emailed daily to all relevant consultants.
4a	**COPD:** Discharge Bundle	Heartlands and Good Hope sites not on track to achieve the Q4 target of 80%. Current performance indicates a partial achievement of 90% of the Q4 value for BHH site and 0% for GHH. Solihull site is on track to achieve their Q4 target.
4b	**COPD:** Specialist Respiratory Review	Heartlands and Good Hope sites not on track to achieve the Q4 target of 90%. Current performance indicates a partial achievement of 70% of the Q4 value for both BHH and GHH sites. Solihull site is on track to achieve their Q4 target.

Table 13: Community Contract

CQUIN Name		Quarter 4 Risks
3c	**Dementia:** Supporting Carers	Figures have yet to be received from Community Services to demonstrate the number of completed 'About Me' booklets, therefore this CQUIN remains at risk as there is a 90% target associated with Quarter 4 performance.

Table 14: Specialised Services Contract

CQUIN Name		Quarter 4 Risks
B2	**HIV:** Reducing unnecessary CD4 monitoring	The Trust is unlikely to achieve the target of 90% by year end. The Trust wrote to commissioners on 28th January 2016 proposing an interim target of 65% of clinically appropriate caseload having annual CD4 counts by the end March 2016.

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 requirement notices (see table below). Heart of England NHS Foundation Trust does not have any 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.

These actions were identified during the December 2014 inspection (table of ratings is shown below). Following the inspection, a comprehensive action plan was developed which has been monitored and reviewed by the executive team on a regular basis. The majority of actions identified have been completed and the Trust awaits confirmation from the CQC that compliance has been achieved.

The Care Quality Commission has not taken enforcement action against Heart of England NHS Foundation Trust during 2015/16.

Heart of England NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during 2015/16.

Birmingham Heartlands

	Safe	Responsive	Well-led
Emergency Care	Requires Improvement	Inadequate	Inadequate
Medicine	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Not rated	Not rated	Not rated
Maternity	Requires Improvement	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement

Good Hope

	Safe	Responsive	Well-led
Emergency Care	Requires Improvement	Requires Improvement	Requires Improvement
Medicine	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Not rated	Not rated	Not rated
Maternity	Requires Improvement	Good	Requires Improvement
Outpatients	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement

Solihull

	Safe	Responsive	Well-led
Emergency Care	Requires Improvement	Requires Improvement	Requires Improvement
Medicine	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Not rated	Not rated	Not rated
Maternity	Requires Improvement	Good	Requires Improvement
Outpatients	Good	Good	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement

Data Quality

Heart of England NHS Foundation Trust submitted records during 2015/2016 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	99.69
Outpatient Care	99.85
A&E	98.43

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

Valid GP Practice	%
Admitted Patient Care	100%
Outpatient Care	100%
A&E	99.95

Information Governance Toolkit

Heart of England NHS Foundation Trust's Information Governance Assessment Report score overall score for 2015/16 was 71% and was graded Green.

Clinical Coding Error Rate

Heart of England NHS Foundation Trust will not be subject to the Payment by Results clinical coding audit for the reporting period. This is due to there no longer being a national PbR assurance framework.

Improvement of Data Quality

The Trust is taking the following actions to improve data quality:

- A suite of data quality indicators form part of monthly directorate reports and are a standing agenda item on the Data Quality Steering Group Committee with action plans in place to improve on performance.
- Reports monitoring the timeliness against the new target of within 2 hours for admissions, discharges and transfers (ADT) have been set up with links on the data quality SharePoint site for use by all operational inpatient areas. A monthly Data Quality ADT matrix report detailing the top 3 areas of concern across all divisions is reported monthly to Matrons and Lead Nurses.
- A Data Quality Strategy and Data Quality Steering Committee are in place, this committee focuses 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 2015/16 for some of the indicators. The Trust's performance for the applicable quality indicators is shown in Appendix 3 for the latest time periods available.

Further information about these indicators can be found on the HSCIC website: www.hscic.gov.uk

Part 3: Further Information

The selected indicators below relate to patient safety, clinical effectiveness and patient experience and present the Trust's latest performance for 2015/16. Where applicable, these are governed by standard national definitions.

Two of the patient safety initiatives for medication safety and deteriorating patients are now part of the Sign up to Safety campaign. There is further information regarding this national programme further on in this report.

Patient safety:
Medication safety
Deteriorating patients (sepsis)
Infection control

Clinical effectiveness:
Incident reporting
Serious incidents and never events
Morbidity and mortality

Patient experience:
Inpatient satisfaction
Friends and family test
Complaints

Patient Safety

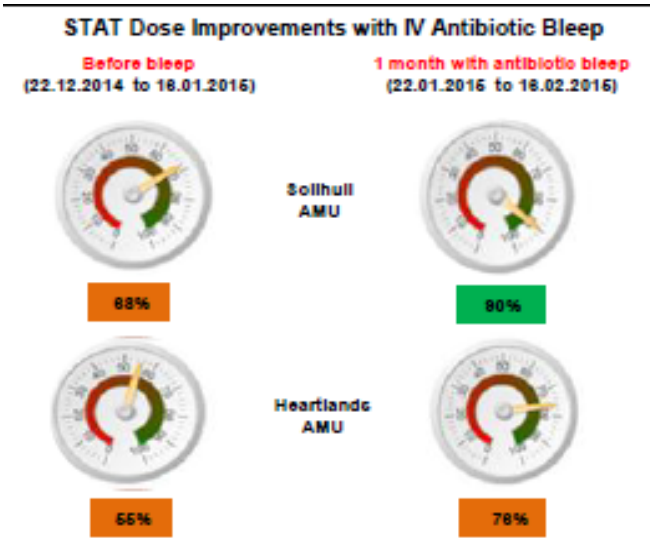
Medication Safety

Medication safety is a long-standing priority for Heart of England NHS Foundation Trust. The Trust started its improvement work in 2013 to reduce omissions and delays with antibiotic STAT doses. This development was progressed by a multi-disciplinary team through the development of a 'live' antibiotic dashboard, available to wards to support the reduction in delays of STAT antibiotic dose administration.

Following the dashboards, a bleep system has been implemented to alert staff when a STAT dose has been prescribed. The introduction of the bleep has driven further improvements and is proving to be an effective IT based solution. As a result, the following improvements have been seen:

- Antibiotic stat doses – from 2013-2015 - from 58% to 73% given within the hour. This has had a major impact on the management of patients with sepsis
- Stop-dates have improved year-on-year by 17%
- Compliance to antibiotics against guidelines within ward audits improved to 90%
- Improved documentation of indications for antibiotics are over 80% in clinical notes.

Plans are underway to roll out the medication bleep model across all wards on all three hospital sites. Antibiotic STAT doses are now part of the Quality Dashboard metrics. The project has received local and national recognition and is well on its way to achieving the 80% target for STAT doses administered.



The next patient safety initiative will be to focus on reducing omitted and delayed medication in Parkinson's Disease (PD). This is one of the projects in the Medication Safety work stream aligned to Sign up to Safety.

If PD medication is missed or delayed, patients can deteriorate quickly in terms of their ability to move, speak and swallow. In some cases, this can occur within minutes of delayed medication. The problem is recognised nationally; and is the reason why Parkinson's UK promotes their 'GET IT ON TIME' campaign.

The Trust has developed the following resources for staff:

- Parkinson's educational video: sharing patient experiences of living with Parkinson's Disease
- A lesson of the month has been launched reminding staff of the importance of timely administration of PD medication. The lesson outlines responsibilities for doctors, nurses, therapists and pharmacists
- Parkinson's Intranet Webpage: An intranet page has been developed which provides supportive information and resources for clinicians caring for Parkinson's patients in hospital.

Deteriorating patients (Sepsis)

One of the key drivers for patient care has always been early recognition of the deteriorating patient. Once identified the focus is to appropriately monitor and manage those patients at risk via the MEWS scoring system (Modified Early Warning Score).

The Trust's aim for 2015/16 was to improve the early recognition and management of patients with sepsis in all assessment areas on all sites. These included:

- Emergency Department
- Acute Medical Unit
- Surgical Assessment Unit.

Improvement targets were set to improve:

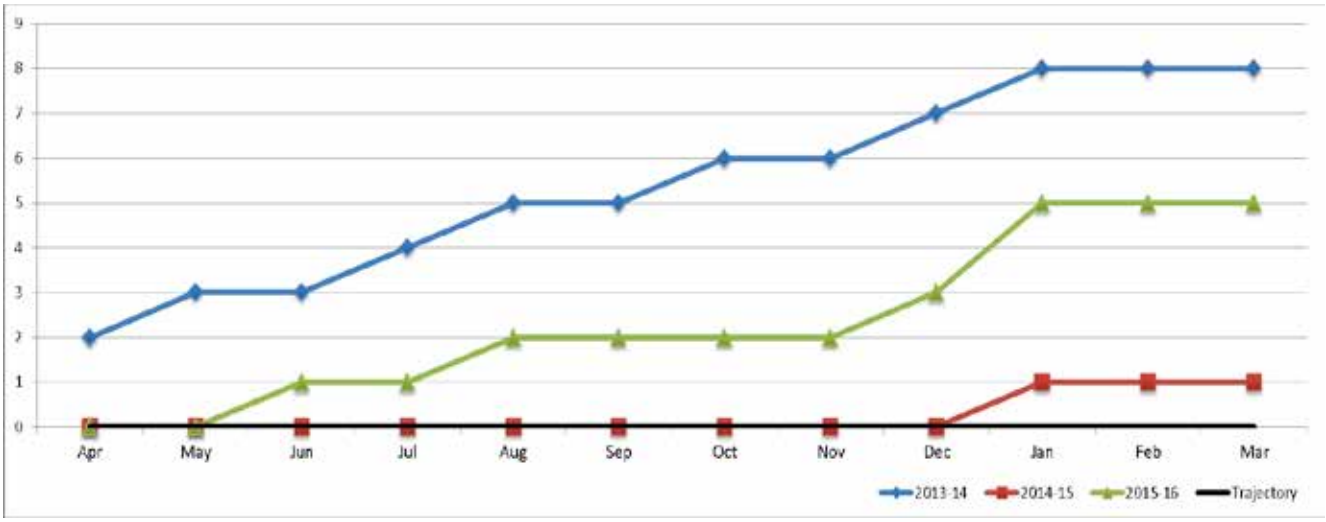
- Sepsis screening
- One-hour antibiotic administration in acute admission areas
- Paediatric sepsis screening and treatment
- Antibiotic stewardship programme to reduce antibiotic resistance.

The Trust has now evaluated the improvements set against the key indicators, which indicate a positive impact on staff engagement and improved recognition in the management of sepsis.

Infection control

This year a trajectory of zero post 48-hour MRSA bacteraemias was set. Four (YTD) post 48-hour MRSA bacteraemia have been reported for 2015/16 and with one community acquired MRSA bacteraemia. This was deemed to be attributable to the Trust. This leaves the Trust with a total of five MRSA bacteraemia for 2015/16. There have been nil reported MRSA bacteraemias for the past four years at Solihull Hospital and nil at Good Hope Hospital for over two years. The Trust acknowledges that improvements can still be made.

Table 15: MRSA bacteraemia cases for April 2015 to March 2016, with the annual threshold shown



A very challenging trajectory of 64 post 48 hour Clostridium difficile cases was set this year. The Trust has remained within this with a total of 61 cases. It is likely that an irreducible minimum has now been achieved and the trajectory for 2016-17 remains at 64 cases.

Table 16: C. difficile toxin-positive post-48 hour cases from April 2015 to March 2016 with the annual threshold shown

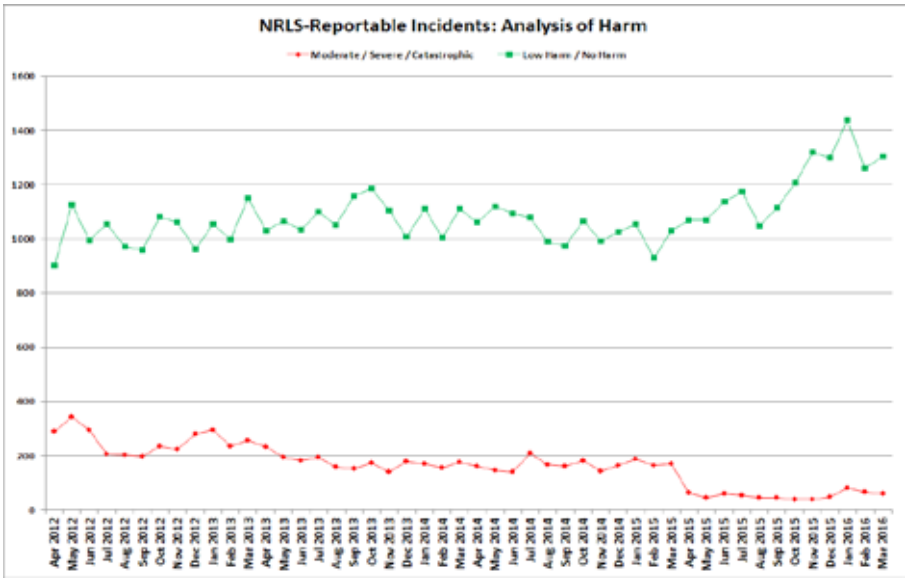
Clinical Effectiveness

Incident Reporting

The Trust actively encourages the reporting of all types of incidents[1] to ensure that lessons can be learnt from such occurrences. A high level of incident reporting is considered, by the Trust, as an indication of a good safety culture.

Patient Safety Incidents (PSI's) are broadly defined as any incident causing or having the potential to cause harm to a patient in receipt of care or accessing Trust services. These incidents are reported to the National Reporting and Learning System (NRLS) in support of national data analysis, comparison and learning.

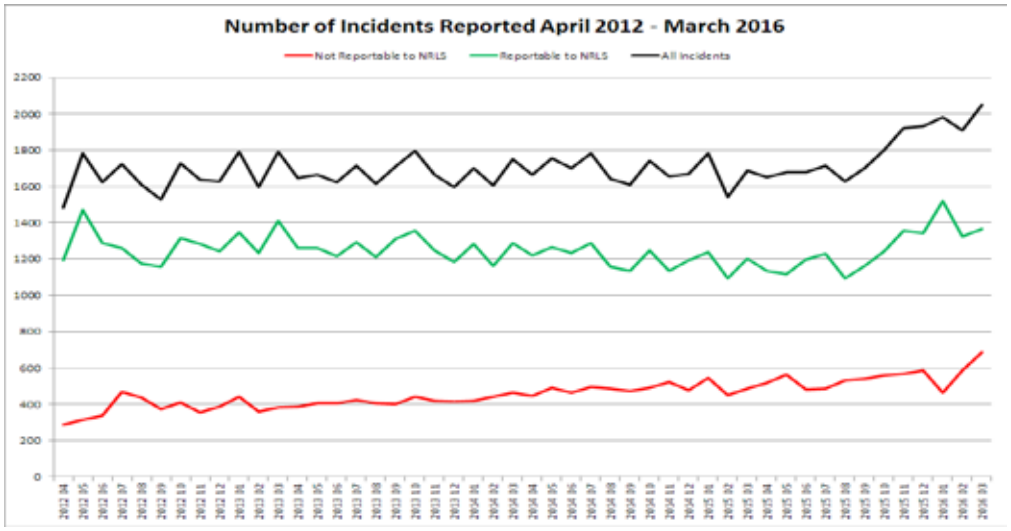
Table 17: Number of incidents reported April 2012-March 2016



[1]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.

Table 18: Number of NRLS reportable incidents



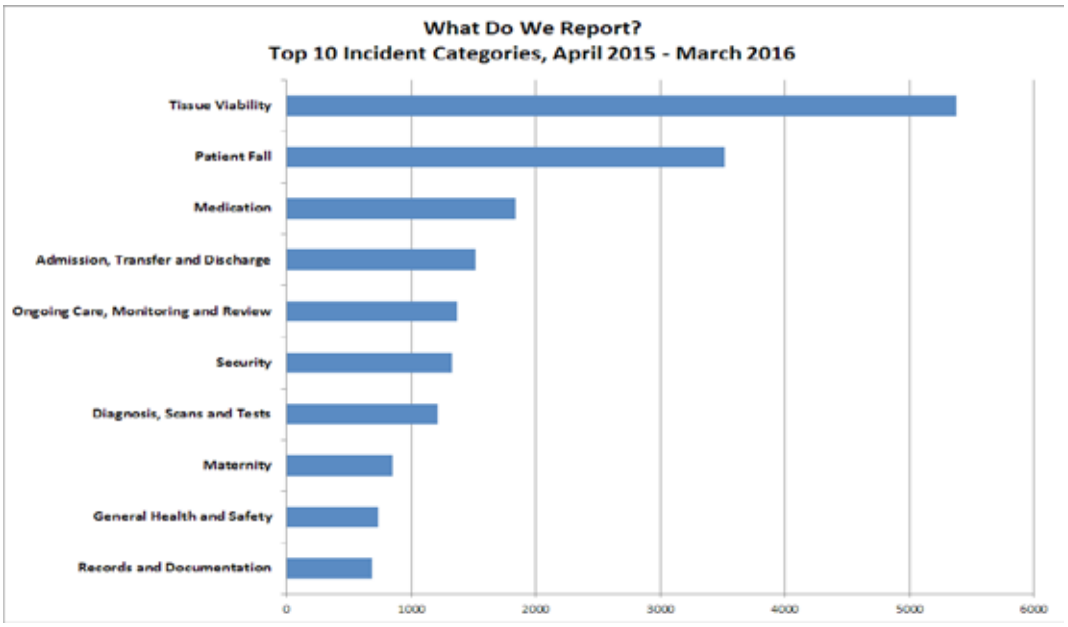
The incident reporting profile indicates that for 2015/16 there has been an overall increase in the number of incidents reported particularly no harm and low harm with a reduction in moderate/severe or catastrophic. This is an indication of a mature safety culture within an organisation.

To date the Trust has reported 21,645 incidents for this financial year. Of those over 15,000 are PSIs reportable to the NRLS.

Incidents are reported from all the locations where Trust services are provided including primary care settings and from the patient's 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, which is a reflection of where the Trust provides the majority of its services.

The top 10 categories of reported incidents present little change in reporting patterns over this fiscal year.

Table 19: Top 10 Trust Incident categories

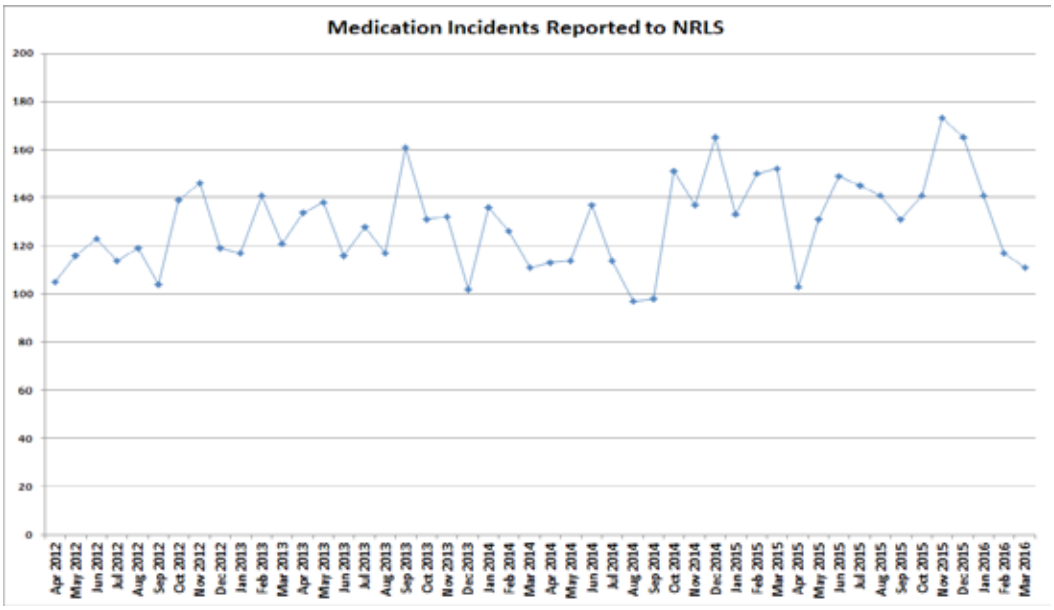


Much work, described elsewhere in this document continues to ensure reporting and learning from tissue viability and patient falls.

This year the Trust has developed a framework to support the reporting, investigation and learning from medication incidents, which included a bespoke root cause analysis tool.

- All medication incidents graded as severe or catastrophic harm are fully investigated. This financial year we have 'scoped'[2] 20 medication incidents and followed 6 of these with RCA investigations.
- Focus has been placed on the number of medication related incidents. The number of incidents reported to the NRLS has remained consistent. This will be a focus for improvement over the next reporting year.

Table 20: Medication incidents



Serious Incidents and Never Events[2]

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

In 2015/16 over 198 reported severe harm incidents have been 'scoped', leading to:

- 28 investigations in line with the Trust's Serious Incident Policy (SI). See table 21 below for details
- 52 local level RCAs with oversight / review from investigation team.

[2]'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
- Occurrence can be easily defined, identified and continually measured.

Table 21: Trust serious incidents scoped from 2010/11 – 2015/16

Site	10/11	11/12	12/13	13/14	14/15	15/16
BHH	8	11	7(2xN)	7 (1xN)	17 (1xPN)	19 (5xN)
GHH	5	1	3 (1xN)	4 (2xN, 1xPN)	6	5
SH	-	5	1	3 (2xN)	2 (1xN)	4 (1xN)
Other	-	-	-	1	-	-
Total	14	17	11	15	25	28

This year the Trust has had six Never Events:

- Retained foreign object (thoracic surgery)
- Wrong route medication (maternity)
- Wrong site anaesthetic block (anaesthetics)
- Wrong site hip aspiration (trauma and orthopaedics)
- Wrong site nerve block (anaesthetics)
- Retained foreign object (surgery).

The Trust has continued to actively share and disseminate learning from SIs with 'Safety Lessons of the Month', doctors' 'Risky Business Forum' and 'SI: At a glance' reports. It is also continuing to work with the commissioners to share learning from incidents and best practice in incident management across the local healthcare economy.

Duty of Candour

As of November 2014, NHS England required a contractual duty of openness to be included in all commissioning contracts, called 'duty of candour' (DOC). 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. The essence of 'being open 'is that patients, relatives and carers should receive the information required to understand what has happened, receive an apology, details of the investigation and assurance that lessons will be learned to help prevent the incident reoccurring.

These principles are not new, and are outlined in the Trust's 'Being Open' policy. This year the Trust has taken the opportunity to review the process, by which DOC is implemented,

Compliance within the Trust is monitored monthly. An audit of compliance was undertaken in March 2016, this showed the Trust to be fully compliant.

Morbidity and Mortality

The Trust monitors mortality rates weekly using crude number of deaths, monthly using the Hospital Standardised Mortality Rate (HSMR), and quarterly using the Summary Hospital Level Mortality Indicator (SHMI). It also monitors monthly surgical mortality and complications outcomes using the CRAB tool. (Copeland Risk Adjusted Barometer).

The outcomes of the National Audits and surgeon specific data are also reviewed. A regular report on mortality indicators and review of alerts is reported to Trust Board and Quality Committee.

Care Quality Commission Mortality Outlier Reports

Patients admitted with an initial diagnosis of upper gastrointestinal haemorrhage was identified as a mortality outlier by the CQC requiring further investigation last year. This related to a run of higher than expected mortality from December 2014 to April 2015.

The review reveals a cohort of elderly patients, most with extensive comorbidities. There were no clearly preventable deaths and management was done well in most cases. There are no recurrent themes of poor practice. It was not possible to determine why there had been a change in mortality.

However as with any case note review, opportunities to improve care were identified and are being actioned. A review of the Trust's position against the recent NCEPOD recommendations in relation to gastrointestinal haemorrhage has also been completed.

Dr Foster HSMR, April 2008 – December 2015

Table 22: HSMR

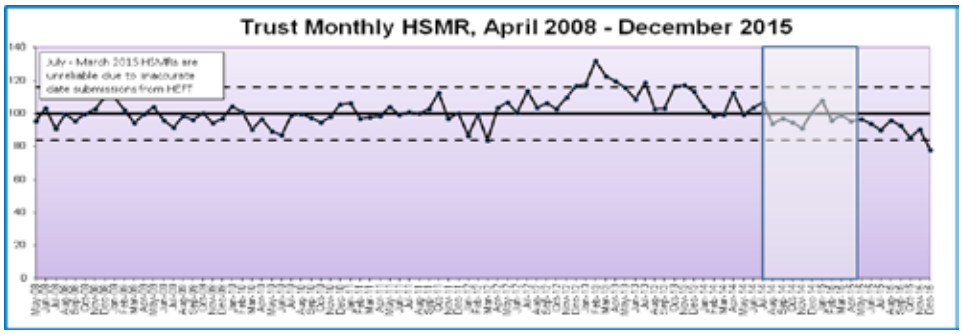


Table 23: Yearly Dr Foster HSMR by Hospital and Trust April 2010 – December 2015

					Unreliable HSMR	Partly rebased
Site	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Trust Wide	97.3	97.9	**108.4**	**108.6**	100.3	91.9
Heartlands Hospital	97.0	101.2	**110.3**	**114.2**	109.8	101.5
Good Hope Hospital	100.8	97.4	**108.2**	**106.6**	99.0	86.1
Solihull Hospital	92.2	92.6	104.9	100.4	82.9	79.7

As can be seen from the graph and table above, the Trust has seen a steady decline in its monthly HSMR over the last two years since a peak during 2013. 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 being coded as emergency rather than elective admissions. As a result the HSMR and SHMI may be affected for the periods covering data July 2014-end of March 2015 and was not reliable for mortality measurement.

Current figures are based on reliable figures and show the lowest sustained HSMR for a number of years.

SHMI

The latest published SHMI is 97 for Oct 2014 – Sept 2015 representing an HSCIC 'as expected' banding. This is slightly higher than the previous quarter's figure but below the national average of 1. The influence of data quality concerns lessens with each iteration of the SHMI as shown below.

Below is a summary of the impact of data quality (DQ) issues on SHMI:

Jan 14 – Dec 14 6 months DQ problems
Apr 14 – Mar 15 9 months DQ problems
Jul 14 – Jun 15 9 months DQ problems
Oct 14 – Sep 15 6 months DQ problems

Future:

Jan – Dec 15 3 months DQ problems
(due to be published Jul 2016)

Apr15 – Mar 16 Data Quality will be fine
(due to be published Oct 2016)

Table 24: Yearly SHMI

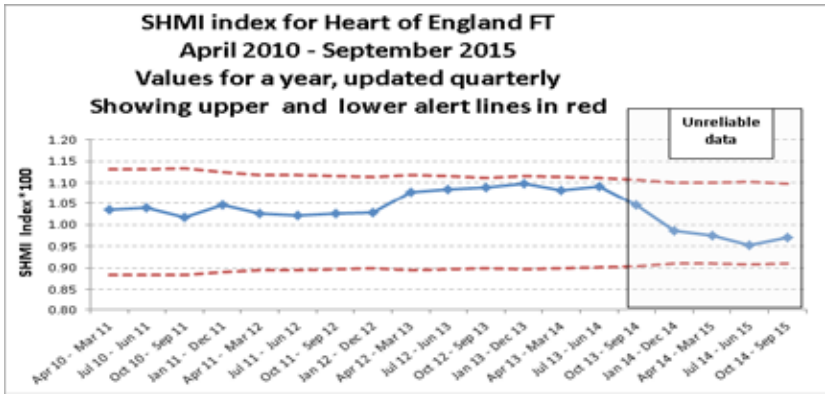
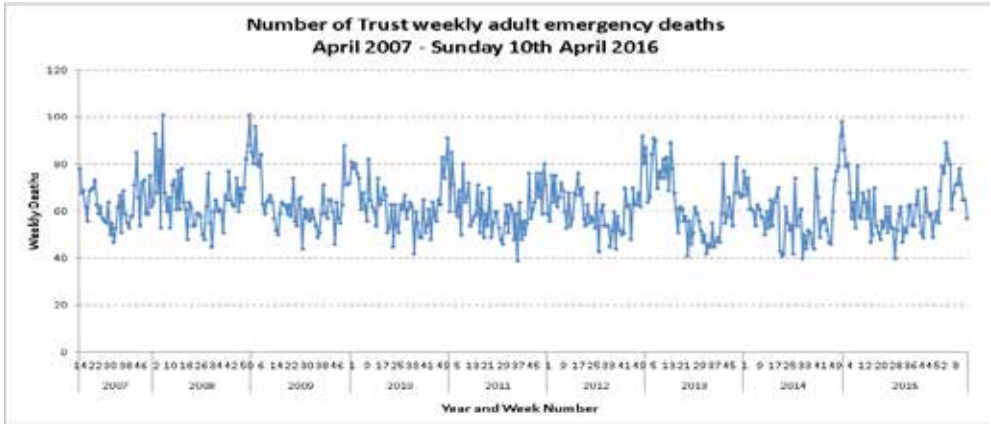


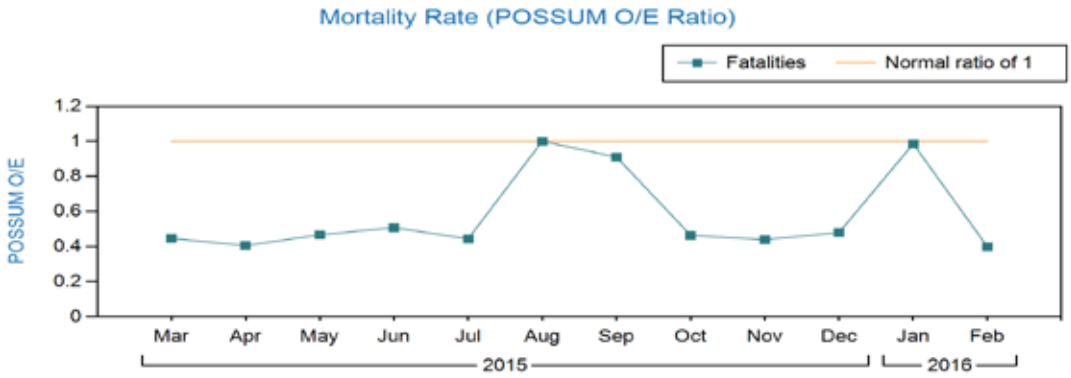
Table 25: Number of Trust weekly adult emergency deaths



CRAB Surgical Mortality

The CRAB 30 day surgical mortality observed/ expected (O/E) ratio continues to show a level at or significantly below the average of 1.

Table 26: 30 day surgical mortality



What is the Trust doing to reduce mortality and morbidity further?

The Trust has been reviewing and improving the mortality framework and processes over the last year.

The list below includes some of the initiatives that are currently being undertaken:

- Improving coding and data quality within the clinical record to help capture data along with local quality improvement projects
- Trust wide quality improvement projects
- Improving timeliness of administration 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 the screening for sepsis patients and administration of antibiotics for severe red flag sepsis within one hour of attendance. This is in addition to ongoing work from last year's sepsis quality improvement work
- Focus on diabetes management.

Patient Experience

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

Inpatient Satisfaction

Between April and November 2015 patients were asked to give their feedback in relation to Eight different aspects of their stay and this data is shown on the next page.

Following review, the Trust sought to understand how patients felt about the overall experience of care. Between December and March this score has remained constant each month for the Trust as a whole at 86% satisfaction with care overall.

This information is available Trust wide and disseminated down to divisional, and ward level. This ensures that all Trust staff are able to view and respond easily to individual patient comments and experience.

Information is also available about how patients felt about their care experience during the day, at night time and over a weekend.

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 if they were in need of similar treatment or care. The Trust undertakes this feedback work across inpatient care, emergency department, maternity services, outpatients, day case surgery and community services. Response to this measure has seen an increase in the number of patients who gave feedback from 64,616 in 2014/15 to 205,822 in 2015/16.

In line with national practice driven by NHS England, the Trust presents results as a percentage of respondents who would recommend the service to their friends and family, or our proportion of positive responders.

In tables 27 and 28 the solid lines represent the proportion of patients which responded positively about their care. The dotted lines represent the proportion of patients who participated. The grey lines represent the regional picture, the coloured lines represent the Trust.

Table 27: FFT Inpatients

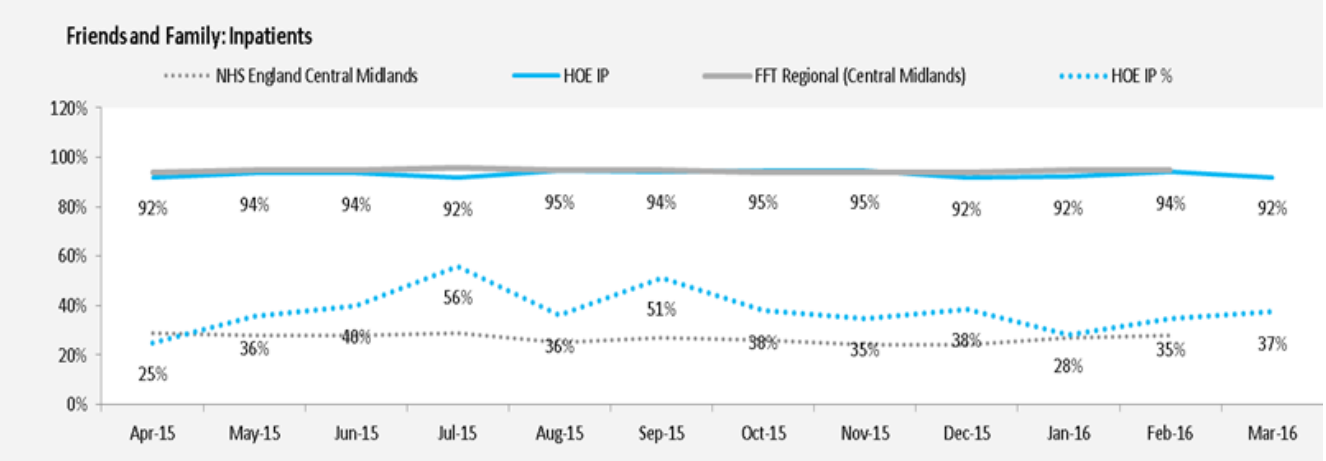
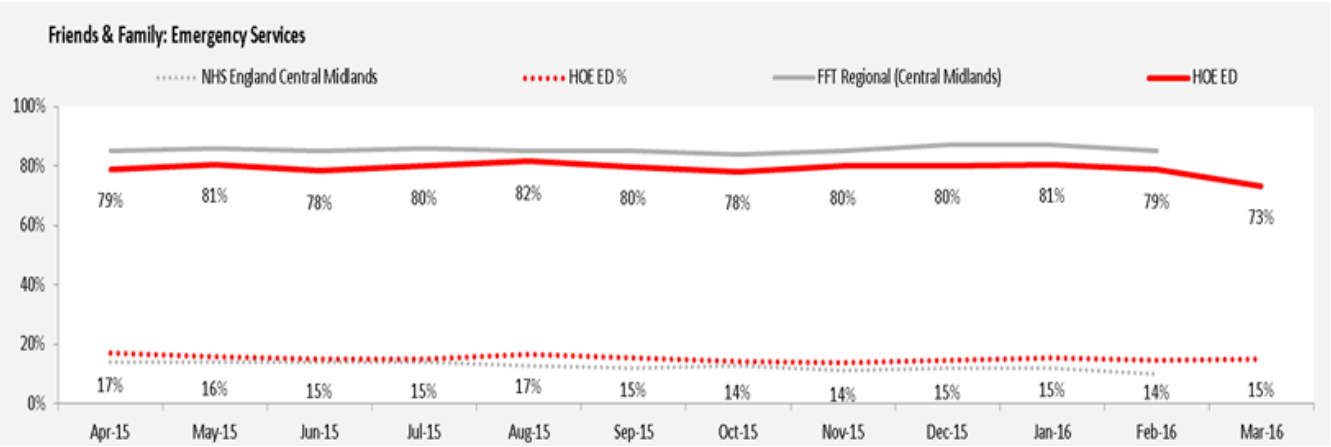


Table 28: FFT Emergency Services



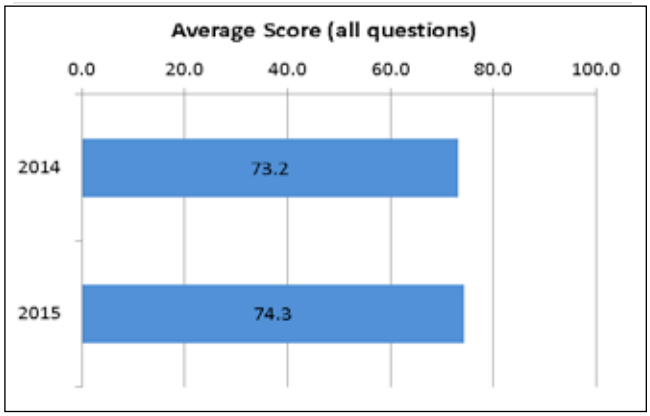
The average inpatient FFT score for 2014/15 was 90.7%. During 2015/16 this average score was 93.4%. The average emergency department FFT score for 2014/15 was 74.2%. During 2015/16 this average score was 79%.

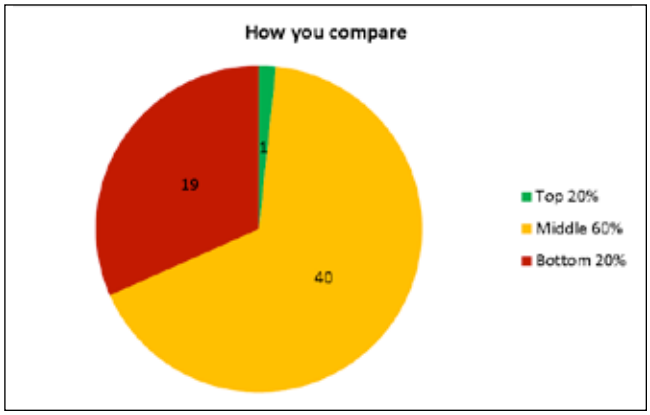
This indicates that patients are reporting improved experiences of care in these areas.

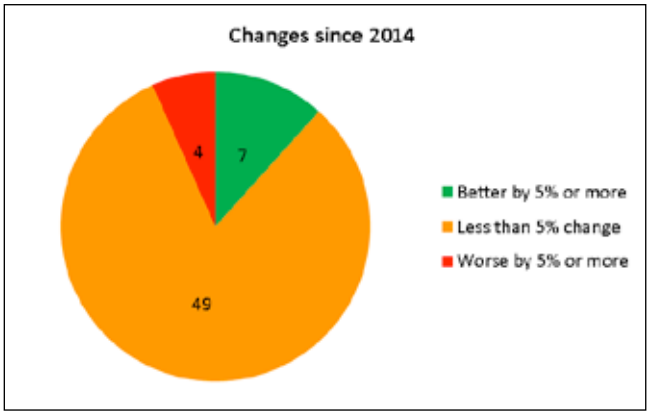
National Survey Programme

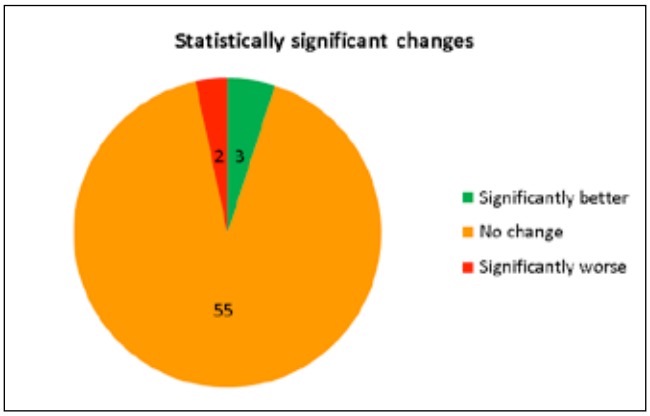
The Trust participated in the national inpatient patient experience survey during 2015-16 on behalf of the Care Quality Commission (CQC). Key findings from this survey are shown on the next page.

National Inpatient Survey

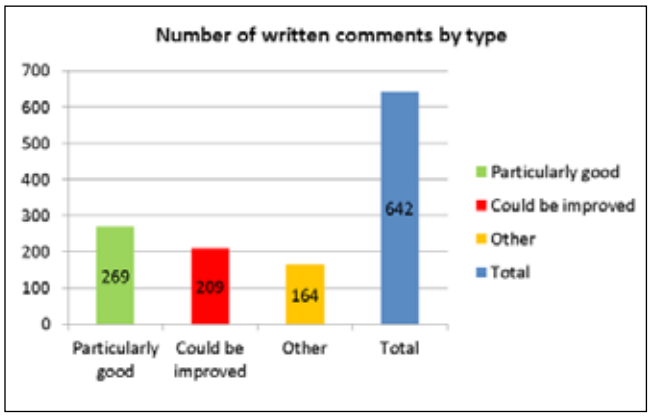








Patient Comments



The Trust improved significantly compared with 2014 regarding:
- Waiting to be provided with a bed on a ward
- Mixed-sex bathroom or shower areas
- Delayed discharge.

The Trust declined significantly compared with 2014 regarding provision of:
- Written or printed discharge information
- Information explaining how to complain about care received.

The Trust was in the top 20% of Trusts regarding one issue, mixed sex accommodation after moving ward and was in the bottom 20% of Trusts regarding 19 issues. These are grouped below into themes.

Staff behaviour
- Staff, noise at night
- Doctors speaking about patients as if they were not there
- Nurses speaking about patients as if they were not there.

Care/ward issues
- Feeling threatened by other patients/visitors
- Help with eating
- Emotional support provided by staff.

Explanations
- Information passed to the specialist by the person referring
- Explanations of risks and benefits before operations
- Before operations, the anaesthetist's explanations of how they will control pain.

Discharge
- Provision of written or printed discharge information
- Explanations of the side effects of medication to watch out for at home
- Danger signals to watch out for at home

- Staff taking account family/home situation when planning discharge
- Doctors and nurses providing all information needed to family/friends to help care
- Staff advising who to contact if worried about condition/treatment once home
- Staff discussing whether patients would need further health/social care services after leaving
- Staff discussing whether patients would need any equipment/adaptations in their home.

Feedback
- Patients being asked their views on the quality of care
- Availability of information explaining how to complain.

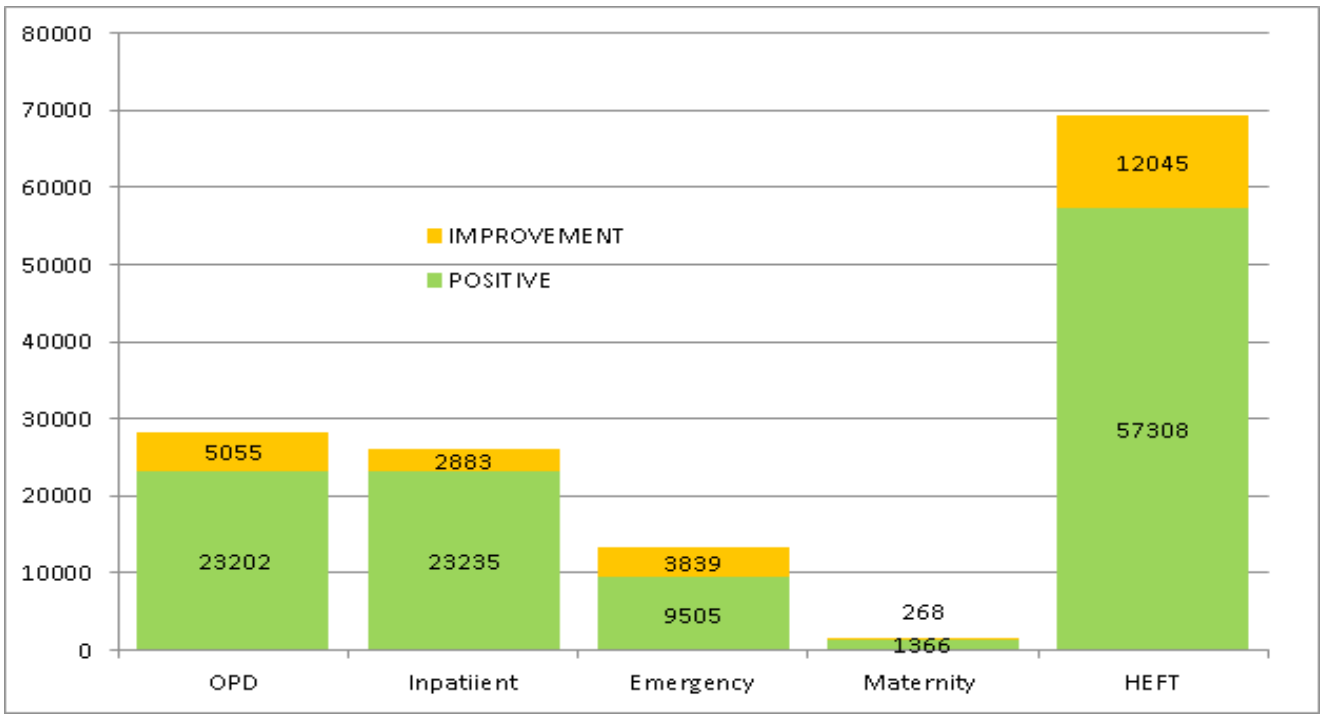
There are actions completed, in progress and to scope in order to address the issues highlighted by the findings of the HEFT 2015 National Inpatient Survey.

Through its FFT work, the Trust has received almost 70,000 written or text message comments from patients, carers and relatives about their experiences of care during 2015/16.

The vast majority of these comments, over 83%, were positive reflections of care and treatment and are used at service level to reinforce the positive messages when feeding back to staff. Further training is on-going with staff on how to access and use the feedback provided.

The following chart demonstrates the proportion of positive versus requires improvement comments received and by location.

Table 29: Proportion of positive versus requires improvement comments



The key themes for improvement identified through the less positive comments are shown below:

Table 30: Top improvement themes

Service	Top 3 Improvement Themes
Outpatient	Staff attitude
	Environment
	Waiting time
Emergency	Staff attitude
	Environment
	Waiting time
Inpatient	Staff attitude
	Implementation of care
	Environment
*Maternity	Staff attitude
	Environment
	Implementation of care

Positive Feedback

Whilst compliments are not consistently collated across the Trust (compliments come in a vast array of forms from a verbal thank you on the ward, a formal thank you card / letter, calls to the chief executive), the Trust is able gain a sound understanding of what patients appreciate from the FFT narratives. Specific examples include:

- BHH Ward 10 - 'kindness and friendliness of staff, conscientious and eager to help and make me comfortable'
- GHH Ward 17 – 'Staff were extremely personable, professional and caring. Always happy to help and whenever needed came with help and support'
- SHH Ward 14 – 'Everything was excellent, they understand my needs and provided high quality service to meet my needs and made me comfortable'
- BHH Maple (Maternity) – 'The staff are very helpful and caring. I observed them working as a team, very diligent and responded quickly to patients'
- GHH Ward 2 - 'Staff are friendly, helpful, kind hearted, supportive caring, and bubbly'
- SH Ward 8 - 'All staff were polite, helpful and kept us informed, answered questions we had and generally cared, making me comfortable'
- BHH ward 22 - 'The care and consideration given at all times was second to none. Thank you.'

The nursing quality dashboard now allows wards to look at their individual patient experience data per ward so the many patient comments can be viewed directly at service level.

How the Trust is responding

Feedback tells us that a large proportion of patient experience improvements centre around how well staff communicate with patients, relatives and carers and how systems are built with the patient in mind. Previously, user-led patient groups existed with varying levels of involvement and function. In response, the Trust now has three Community Patient Panels (CPPs) aligned to each main hospital site with a Youth Council and a Carers' Forum.

Since the CPP terms of reference were finalised in September 2015, members have contributed to the work streams described overleaf:

Date	Task	Details
October 2015	Website Task & Finish Group	Members were requested to assist with helping improve the section on the Trust website where patients can leave feedback (positive or negative). Feedback was given and the website has been updated to incorporate the comments made
On-going	Quality Review	The Compliance team has invited panel members to participate in Trust-wide quality reviews and inspections
October 2015	Oncology letter	Members were asked for their feedback on a letter that is sent to patients whose GP has referred them to hospital due to suspected cancer
October 2015	Delirium Leaflet	A leaflet has been produced at Solihull Hospital giving patients and visitors information on delirium. Panel members were asked to share their feedback about the leaflet
October 2015	Exercise Dark Star	One member from each site panel was requested to assist with Exercise Dark Star. This was a large Department of Health funded regional exercise. Members were asked to attend to observe and listen to some of the discussions being held about the complexities of major incidents both for planning and responding to
November 2015	Patient Pathways	The Planned Care Directorate requested members assistance who had previously been a patient in ENT, Cataract Surgery, T&O and Diabetes to assist with reviewing patient pathways in those areas
December 2015	Good Governance Institute (GGI) Focus Groups	Panel members were invited to attend one of two focus groups arranged by Good Governance Institute to share their views on the Trust's governance arrangements
January 2016	AMU Leaflet	Members were asked for their feedback on an information leaflet that will be given to GPs to share with patients who they are referring to AMU
January to June 2016	PLACE (Patient Led Assessments of the Care Environments)	Members, as in the previous two years were asked to assist with PLACE inspections on all three sites in the role as patient inspectors.

Complaints

A significant amount of work has been undertaken during 2015/16 to improve the Trust's complaint handling process. This work will continue into 2016/17.

An independent external peer review of complaints was undertaken and a number of recommendations have been implemented including a review of all associated policies and procedures. The key changes to Trust policy were:

- Replacement of the 25 working day standard with a 30 working day timescale for each complaint
- Provision for initial resolution meetings to be a default option to complaint resolution
- All complaint responses to be signed by the Chief Executive
- Guidance and assistance in the management of complainants that may be termed vexatious
- Incorporation of PHSO standards for good complaint handling
- Incorporation of consideration of Duty of Candour
- Confirmation of routes of assurance reporting (Quality Committee as a sub-committee of Trust Board).

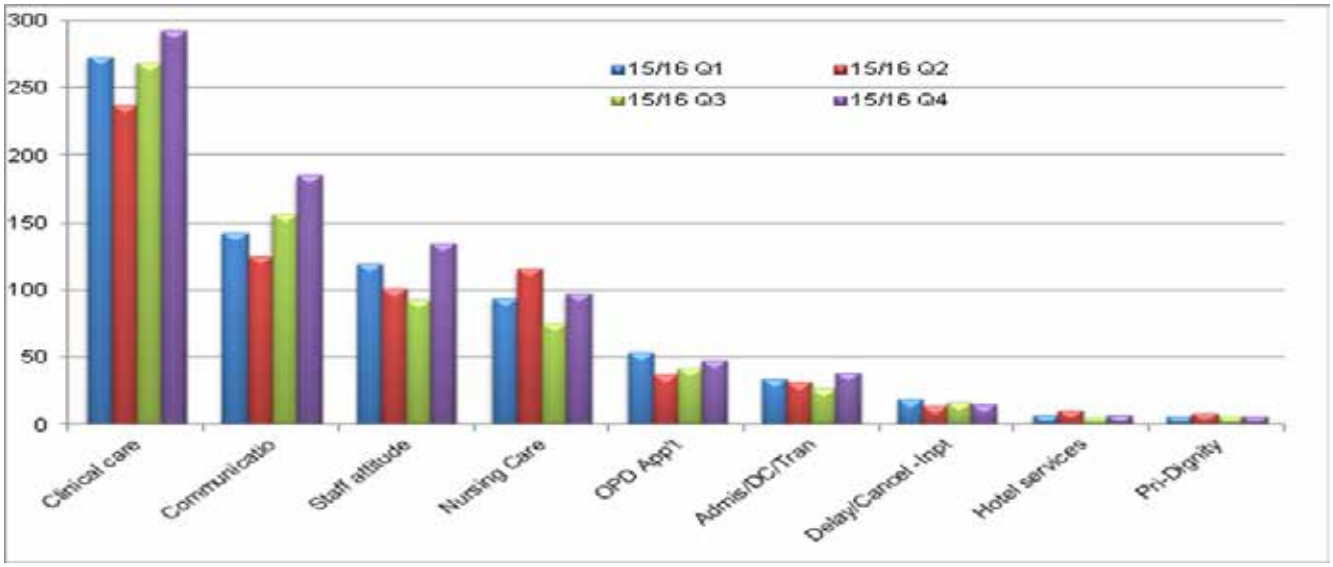
Ratio of complaints received

The table below shows the rate of formal complainants by quarter per 1,000 patients seen and treated by the Trust. Over the year this ratio was 0.84 formal complaints for every 1000 patients.

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	123	133589	0.92	121	132972	0.91	133	133352	1.00	164	132506	1.24
GHH	84	107001	0.79	72	109503	0.66	83	56278	1.47	95	108337	0.88
SH	39	77976	0.50	53	77440	0.68	38	51282	0.74	43	78476	0.55
Community	2	17648	0.11	7	16522	0.42	4	22271	0.18	1	17913	0.06
Other areas	2	NA	NA	2	NA	NA	3	NA	NA	4	NA	NA
HEFT Total	250	336214	0.74	255	336437	0.76	261	263183	0.99	307	337232	0.91

The graph below illustrates the number of issues identified by category (top 10 themes) not the number of individuals contacting the service. For example, one complainant may raise several issues of concern within one complaint. It shows the most prevalent of the themes across all staff types and areas.

Table 31: Number of issues identified by complaint category



Parliamentary Health Service Ombudsman (PHSO)

The PHSO provides a service to the public by undertaking independent investigations into complaints that government department, other public bodies in the UK, and NHS in England that 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 2015/16 the PHSO requested information regarding 25 complaints, a year on year decrease of 10. The decrease is attributed to an increased focus on the quality of complaint responses and attempts to resolve concerns in person initially.

Three 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. The Trust either has action plans in place to address these issues or have acted in accordance with PHSO advice.

In Other News…

Sign up to Safety

The Sign up to Safety Campaign is a national campaign which was launched in 2014. It is a three year long Campaign that supports the NHS to reduce avoidable harm by 50% and save 6,000 lives.

Heart of England Foundation Trust joined the Sign up to Safety Campaign in 2015 and has the following four safety priorities:

- Reducing harm from deterioration including sepsis
- Reducing medication related harm
- Reducing harm from pressure ulcers
- Reducing harm in maternity services.

Solihull Approach

A modern version of a memory box for parents and a new online antenatal course are the latest innovations available from The Solihull Approach, a well-established parenting model that has been used all over the world to help support parent and child relationships.

The Solihull Approach team, part of Heart of England NHS Foundation Trust, has developed 'Ourplace', a new online service for every parent offering a secure online space for parents, grandparents, friends and relatives to connect, learn, record and share treasured information about their children as they grow and develop.

Dr Douglas explained: "Ourplace' is a modern version of a memory box – a special interactive archive that parent and child will treasure as they get older, and that you can share with family and close friends. It is a completely free, secure, advert and mailing list free place to record important milestones along a child's journey through childhood.

The latest online course to be developed by the Solihull Approach is an online antenatal course called 'Understanding Pregnancy, Birth and Your Baby'. It is the second online course to be developed by the team following the popular online course about 0-18 year olds 'Understanding Your Child', which can also be accessed on' Ourplace.'

The Solihull Approach was founded in 2000 by Dr Hazel Douglas, together with practitioners and parents. Since then it has been adopted by local authorities across the UK, as well being recommended by the government departments for health and education.

In recent years the Solihull Approach has also found its way into countries around the world, including the USA, Australia, Pakistan and even Ghana, Barbados and St Lucia.

Solihull Community Services, part of Heart of England NHS Foundation Trust, has earned international recognition for its efforts to make the borough a place where babies get the best start in life.

UNICEF has re-accredited the Solihull community health visiting and infant feeding services as "baby friendly" following a rigorous assessment. The UK Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent-infant relationships by working with public services to improve standards of care and is a proven way of increasing breastfeeding rates. Re-accreditation by UNICEF Baby Friendly is a prestigious award and confirmation that Solihull Health Visiting and Infant Feeding Teams are providing a high quality service to families, who can be assured they are receiving the best possible care.

Part 4: Statements from Stakeholders

Birmingham Cross City CCG

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

In the version of the Quality Account we viewed there were some gaps in data which we have not been able to validate. We assume, however, that the Trust will populate these gaps in the final published edition of this document.

The review of progress made against the 2015/16 is clearly presented providing information on the work undertaken to achieve targets, current performance and work being carried forward. The data suggests that additional time and focus is required to further embed and make sufficient progress on the targets of 'reduce avoidable grade 2 hospital acquired pressure ulcers' and 'reduction of incidence for patients who have multiple falls in hospital' and that these could remain an improvement priority for 2016/17.

The CCG is aware that the Trust has made improvements in documentation of pressure ulcers; however, we note that ensuring the accurate recording of the repositioning of patients to reduce risks still appears to be a problem.

Information is not included within the account of the poor performance, in terms of the planned trajectory, for reduction of grade 3 avoidable pressure ulcers, or how the Trust intends to tackle this in 2016/17. This is an omission and needs to be included within the account.

It is good to see a reduction in the overall number of falls; however, the specific outcome was to look at reducing patients having multiple falls and there is no data to support this level of detail. There is also significant variation during the year.

The Trust needs to provide further detail in respect to 2016/17 priorities for improvement. For example, it is unclear why the priority around Parkinson's disease medication was chosen, how it aligns to strategic priorities, what the current or target performance is.

It is pleasing to see that the Trust is focusing on improving emergency department (ED) Friends and Family Test (FFT) scores and considering supporting carers in ED, but there is a lack of detail about the other FFT areas such as Maternity, which we are aware, has been a focus due to the lack of information collected.

The CCG is aware that the Trust has agreed to focus on the theme of 'staff attitude' (in relation to complaints) and will be working on improving this over the coming year and yet this has not been included within the account. Narrative is missing on what action is being taken to address the top three complaint themes.

The Trust refers to a Duty of Candour compliance audit undertaken in March 2015, but it is unclear who completed this audit; the CCG undertook an audit in March 2016 which showed the Trust to be compliant against the sample reviewed.

It is pleasing to note that the Trust has identified the need to "reinvigorate the clinical and support staff to engage with addressing the challenges, to move from passive to active in resolving performance issues" and that it sees this as key to improving quality of care. The CCG looks forward to hearing about the Trust's plans to put this into action.

There is no reference to safeguarding in the account. Safeguarding arrangements are integral to the wider quality, patient safety and experience agendas and are a statutory responsibility for the Trust in relation to adults and children. We are aware that over the past year the Trust has expanded its safeguarding resource and has been active in developing its safeguarding arrangements.

Given that the Trust is the largest provider of maternity services in Europe the account lacks information on the quality and improvement activities related to the services provided.

As a commissioner we recognise the considerable challenge around infection, prevention and control and would like to see reference made to how the Trust is implementing national guidance and recommendations. The account does not contain information on the outbreaks of infections which have occurred (i.e. Carbapenamese-producing Enterobacteriaceae).

Whilst the Trust states that it has completed the 'majority of actions' relating to their action plan compiled in response to the Care Quality

Commission inspection in December 2014, it would have been helpful if more information had been provided on the actions, progress made and outstanding areas to address. Inclusion of such information would improve public confidence in the Trust.

There are CQUINS that the Trust has not achieved as at Quarter 3 (Sepsis and Dementia) and the report sets out a number of real risks on the delivery of Quarter 4, yet there is little assurance given on how the Trust intends to address these risks.

It is encouraging to see that the Trust has signed up to the national 'sign up to safety' campaign; the Trust's pledges show a keen focus on reduction of harm. It is noted, however, that the pledges do not address all five pledge areas of the campaign. The quality account would have been enhanced if brief information on the delivery plan had been included.

Readers of the quality account might find it useful to have a glossary explaining technical terms, abbreviations and any terms specific to the Trust such as the 'safety cross'.

The lack of quality information regarding Community Services was disappointing. There was a missed opportunity to celebrate the considerable work undertaken over the past year to provide a rapid response service to reduce hospital admissions.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group

Response: The Trust has taken into consideration all the points raised above. The section on community services, which includes UNICEF accreditation, has been expanded.

Healthwatch Birmingham

Thank you for sending us a draft copy of Heart of England NHS Foundation Trust Quality Account 2015/16.

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

Patient Experience

It is disappointing to see that the Trust has not attained its goal with regards to improving the response rate and overall score in the Friends and Family Test (FFT) in the Emergency Department (ED) (priority 3). The draft shared with us shows the overall ED response rate at the Trust decreased from 17 per cent in April 2015 to 15 per cent in March 2016. The ED FFT positive responder rate also remains below the national and regional average in February 2016 (the latest national and regional data given in the draft we have received). However, it is encouraging that the overall 2015/16 average positive recommendation for ED is higher than in 2014/15.

We note that the Trust has carried priority 3 over to 2016/17, and that it has identified several actions to help improve performance. However, there is currently little information provided in the Quality Account on what is causing the FFT positive recommender score to remain relatively low. We therefore support the decision to carry out surveys and observational studies in ED, as this should help ensure the Trust fully understands the patient perspective on this issue. We look forward to learning about the results of this work in next year's Quality Account.

Unfortunately much of the patient experience section of the draft we have been provided is not currently populated. Therefore, whilst we are happy to see the Trust is gathering data on inpatient satisfaction and participating in two national patient experience surveys (inpatient and emergency services), it is not possible for us to comment on the results. The draft also does not give final year figures for the FFT Trust wide scores, or comments from positive feedback. In the

future we would appreciate more information to be provided in the draft we are sent so that we can give feedback.

As mentioned previously, one of Healthwatch Birmingham's focuses is on promoting health equity in the City. With this in mind, it is good to see that the Trust has developed a learning disability toolkit over the last year to better facilitate communication. In next year's Quality Account we would value any similar examples of how the Trust has monitored and improved the experience of 'hard to reach groups' (e.g. people with learning disabilities, people with mental health problems, minority ethnic groups etc.).

Other 2015/16 quality priorities

It is positive that the Trust has made improvements with regards to the remaining three 2015/16 quality priorities. We note the Trust has reduced the number of avoidable grade two pressure ulcers (priority 1), reduced incidence for patients who have multiple falls in hospital (priority 2), and made improvements with regards to stroke care (priority 4). It is also good to see that, even though these will not be carried over as quality priorities, the Trust has identified a number of actions to continue to make improvements in these areas.

Patient and public Involvement

We would value more information on the process by which the 2016/17 priorities have been decided, particularly on whether engagement has been carried out with PPSuC to help shape these priorities. If patient feedback/ engagement has not been used to shape these priorities, we would advise the Trust introduce this next year.

It is excellent to see that the Trust has now established three Community Patient Panels (CPPs) aligned to each main hospital site. It is also useful to see examples of how CPPs have been involved with work around the Trust. We look forward to seeing more examples of how CPPs have been involved with service developments in next year's Quality Account.

Complaints and feedback

It is positive to see the Trust is thematically analysing its complaints, and we would be interested to see how the main themes identified this year compare with last year (if this data is available). We would advise the Trust gives examples of changes it has made as a result of complaints over 2015/16. We would also appreciate data on the Trust's performance with regards to collecting and responding to complaints.

It is good to see the Trust has undertaken an independent external peer review during 2015/16 to improve its complaint handling process. We would be interested to learn whether PPSuC have also been consulted as part of these changes. If not, we recommend the Trust explores doing this in the coming year. Complaints systems can be hard to navigate for some PPSuC, so engaging with patients when making changes to complaints systems can help ensure they are made more accessible. We look forward to seeing evidence of the impact of changes made to the complaints system in next year's Quality Account.

We note that one of the major themes from this year's 'requires improvement' comments and complaints is patients reporting issues with the attitude of staff. We see in the Priority 3 section (improvement in ED FFT) that NHS Elect will be working with the Trust and will be providing workshops on customer care training for staff in 2016/17. We would appreciate clarity on whether this will be for all staff, or just those working in ED. We would also value information on any other initiatives taking place to address this issue.

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

Jane Upton PhD
Head of Evidence

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.

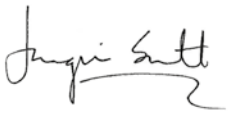
Monitor has issued guidance to NHS foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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 2015/16 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 2015 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 2015 to the date of signing this limited assurance report
  - Feedback from the Commissioners Birmingham Cross City Clinical Commissioning Group dated 17 May 2016;
  - Feedback from Local Healthwatch organisation, Healthwatch Birmingham, dated 17 May 2016
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – KO41A dated May 2016
  - The 'Care Quality Commission – Patient survey report 2015 - Survey of adult inpatients 2015 Heart of England NHS Foundation Trust' latest national and local patient survey dated 2015
  - The '2015 National NHS staff survey – Brief summary of results from Heart of England NHS Foundation Trust' latest national staff survey dated 2015
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 27 April 2016.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with 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



Rt Hon Jacqui Smith,
Interim Chair

Date: 25 May 2016

Dame Julie Moore,
Interim Chief Executive Officer

Date: 25 May 2016

CLINICAL AUDIT

Appendix 1

Table 1: Heart of England NHS Foundation Trust National Clinical Audit Participation:

Ref	Audit Title	Participation in 2015-2016	% of cases submitted
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	100%
2	Adult Asthma	Audit did not proceed	
3	Adult Cardiac Surgery	Not Applicable	
4	Bowel Cancer (NBOCAP)	✓	100%
5	Cardiac Rhythm Management (CRM)	✓	100%
6	Case Mix Programme (CMP)	✓	100%
7	Chronic Kidney Disease in primary care	Not Applicable	
8	Congenital Heart Disease (CHD) - Paediatric	Not Applicable	
9	Congenital Heart Disease (CHD) - Adult	Not Applicable	
10	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	✓	100%
11	Diabetes (Paediatric) (NPDA)	✓	100%
12	Elective Surgery (National PROMs Programme)	✓	100% patients receive surveys. Pre-operation survey return rate = 82% of patients Post operation survey return rate: Hip = 76.41% Knee = 71.96% Groin = 56.95% Varicose Veins = 18.72%
13	Emergency Use of Oxygen	✓	100%
14	Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database	Not Applicable	
15	Falls and Fragility Fractures Audit programme (FFFAP) -Inpatient Falls	✓	100%
16	Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	✓	100%
17	Inflammatory Bowel Disease (IBD) programme	✓	45%
18	Major Trauma Audit	✓	25.4% - 30.6%
19	National Audit of Intermediate Care	✓	50%

20	National Cardiac Arrest Audit (NCAA)	✓	100%
21	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme – Pulmonary Rehabilitation	✓	72%
22	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Secondary Care	Audit did not proceed	
23	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Primary Care (Data collection limited to Wales)	Not Applicable	
24	National Comparative Audit of Blood Transfusion programme - Use of blood in Haematology	✓	100%
25	National Comparative Audit of Blood Transfusion programme - Audit of Patient Blood Management in Scheduled Surgery	✓	100%
26	National Complicated Diverticulitis Audit (CAD) - Acute surgical services	Audit did not proceed	
27	National Diabetes Audit – Adults - National Footcare Audit	✓	12%
28	National Diabetes Audit – Adults - National Inpatient Audit	✓	BHH and SH – 100% patients included. 66% of these patients returned patient experience forms GHH – 100% patients included. 52% of these patients returned patient experience forms.
29	National Diabetes Audit – Adults - National Pregnancy in Diabetes Audit	✓	GHH - 100% BHH – 0%
30	National Diabetes Audit – Adults - National Diabetes Transition	Audit did not proceed	
31	National Diabetes Audit – Adults - National Core	X	Did not participate
32	National Emergency Laparotomy Audit (NELA)	✓	BHH - 67.4% GHH – 1.1%
33	National Heart Failure Audit	✓	52%
34	National Joint Registry (NJR) - Knee replacement	✓	83%
35	National Joint Registry (NJR) - Hip replacement	✓	73%
36	National Lung Cancer Audit (NLCA)	✓	100%
37	National Ophthalmology Audit - Adult Cataract surgery	X	Did not participate
38	National Prostate Cancer Audit	✓	100%
39	National Vascular Registry	✓	100% (Data not captured for Interventions for the treatment of peripheral arterial disease (PAD)
40	Neonatal Intensive and Special Care (NNAP)	✓	100%

41	Non-Invasive Ventilation - Adults	Audit did not proceed	
42	Oesophago-gastric Cancer (NAOGC)	✓	100%
43	Paediatric Asthma	✓	100%
44	Paediatric Intensive Care (PICANet)	Not Applicable	
45	Paediatric Pneumonia	Audit did not proceed	
46	Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for substance misuse - alcohol detoxification	Not Applicable	
47	Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for bipolar disorder (use of sodium valproate)	Not Applicable	
48	Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for ADHD in children, adults and adolescents	Not Applicable	
49	Procedural Sedation in Adults (care in emergency departments)	✓	100%
50	Pulmonary Hypertension Audit	Not Applicable	
51	Renal Replacement Therapy (Renal Registry)	✓	100%
52	Rheumatoid and Early Inflammatory Arthritis - Clinician/Patient Follow-up	✓	100%
53	Rheumatoid and Early Inflammatory Arthritis - Clinician/Patient Baseline	✓	100%
54	Sentinel Stroke National Audit programme (SSNAP)	✓	100%
55	UK Cystic Fibrosis Registry - Paediatric	✓	100%
56	UK Cystic Fibrosis Registry - Adult	✓	100%
57	UK Parkinson's Audit - Occupational Therapy	X	Did not participate
58	UK Parkinson's Audit - Speech and Language Therapy	X	Did not participate
59	UK Parkinson's Audit - Physiotherapy	X	Did not participate
60	UK Parkinson's Audit - Patient Management, elderly care and neurology	✓	100% (neurology data not captured)
61	Vital signs in children (care in emergency departments)	✓	100%
62	VTE risk in lower limb immobilisation (care in emergency departments)	✓	100%

Clarification for variation from 100 percent submission rate:

Ref 12: PROMs data relies on timely return of patient questionnaires by patients, completion of questionnaires is down to patient choice.
Ref 17, 18, 27, 29, 32, 33, 34, 35: Participation limited, under review by the organisation.
Reference 33, reported figures in the 2013/2014 Quality Account were incorrect, accurate participation figure was 39%.
Ref 19: Participation limited due to service transformation improvements.

Ref 21: Participation figure is estimated by the audit providers based on anticipated patient referrals from the organisational audit. Only patients who consented could be submitted.
Ref 28: Participation dependant on patient choice to complete the questionnaire.
Ref 31: No participation due to insufficient resource, under review by the organisation.
Ref 37: No participation due to other departmental priorities.
Ref 57, 58, 59: No participation as therapies data was captured as part of the 2015 Parkinson's Patient Management audit.

Table 2: Heart of England NHS Foundation Trust Clinical Outcome Review Programme Participation:

Ref	Clinical Outcome Review Programme Participation Title	Participation in 2015-2016	% of cases submitted
1	Child Health Clinical Outcome Review Programme - Chronic Neurodisability	CORP did not proceed	
2	Child Health Clinical Outcome Review Programme - Young People's Mental Health	CORP did not proceed	
3	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	✓	100%
4	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	✓	100%
5	Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	✓	100%
6	Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance	✓	100%
7	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Pancreatitis	✓	100%
8	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Physical and mental health care of mental health patients in acute hospitals	✓	100%
9	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Non-invasive ventilation	CORP did not proceed	
10	Mental Health Clinical Outcome Review Programme (NCISH) - Suicide in children and young people (CYP)	Not Applicable	
11	Mental Health Clinical Outcome Review Programme (NCISH) - Suicide, Homicide & Sudden Unexplained Death	Not Applicable	
12	Mental Health Clinical Outcome Review Programme (NCISH) - The management and risk of patients with personality disorder prior to suicide and homicide	Not Applicable	

LOCAL AND NATIONAL PRIORITIES

Appendix 2

Description of Target	Target 2015/16	2012/13	2013/14	2014/15	2015/16	2015/16 Month Period
Reduction of incidence of Clostridium (post 48 hours)	≤64	86	82	75	61	April 2015 - March 2016
Reduction of incidence of MRSA bacteraemia (attributable cases)	0	7	8	1	5	
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat - Surgery modality	≥ 94%	97.42%	98.44%	98.79%	98.20%	April 2015 – March 2016
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat - Anti cancer drug modality	≥ 98%	99.72%	100.00%	100.00%	99.0%	
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat – Radiotherapy	≥ 94%	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%	86.35%	86.33%	85.12%	82.91%	April 2015 – March 2016
Patients receiving their first definitive treatment for cancer within 2 months (62 days) of urgent referral from the National Screening Service.	≥ 90%	99.13%	97.00%	90.65%	95.93%	
Admitted Patients Treated within 18 Weeks of Referral	≥ 90%	92.03%	89.39%	81.21%	81.47%	April 2015 - March 2016
Non-Admitted Patients Treated within 18 Weeks of Referral	≥ 95%	86.85%	96.29%	92.54%	90.53%	
18 week incomplete pathways (A)	≥ 92%	95.57%	94.21%	93.12%	90.28%	

Description of Target	Target 2015/16	2012/13	2013/14	2014/15	2015/16	2015/16 Month Period
Reduction of incidence of Clostridium (post 48 hours)	≤64	86	82	75	61	April 2015 - March 2016
Reduction of incidence of MRSA bacteraemia (attributable cases)	0	7	8	1	5	
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat - Surgery modality	≥ 94%	97.42%	98.44%	98.79%	98.20%	April 2015 – March 2016
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat - Anti cancer drug modality	≥ 98%	99.72%	100.00%	100.00%	99.0%	
Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat – Radiotherapy	≥ 94%	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%	86.35%	86.33%	85.12%	82.91%	April 2015 – March 2016
Patients receiving their first definitive treatment for cancer within 2 months (62 days) of urgent referral from the National Screening Service.	≥ 90%	99.13%	97.00%	90.65%	95.93%	
Admitted Patients Treated within 18 Weeks of Referral	≥ 90%	92.03%	89.39%	81.21%	81.47%	April 2015 - March 2016
Non-Admitted Patients Treated within 18 Weeks of Referral	≥ 95%	86.85%	96.29%	92.54%	90.53%	
18 week incomplete pathways (A)	≥ 92%	95.57%	94.21%	93.12%	90.28%	

Patients receiving their first definitive treatment within 1 month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer.	≥ 96%	96.92%	97.92%	97.99%	98.75%	
Patients first seen by a specialist within 2 weeks when urgently referred by their GP or dentist with suspected cancer.	≥ 93%	93.66%	92.86%	84.42%	91.44%	April 2015 – March 2016
Patients first seen by a specialist within 2 weeks when urgently referred by their GP with any breast symptom except suspected cancer.	≥ 93%	94.64%	93.20%	79.18%	91.28%	
Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge Ⓐ	≥ 95%	93.13%	93.02%	90.38%	88.13%	April 2015 - March 2016

Description of Target	Target 2015/16	2015/16				2015/16 Month Period
		Q1	Q2	Q3	Q4	
Community Services Data completeness: Referral to treatment	50%	100.00%	100.00%	100.00%	100%	
Community Services Data completeness: Referral information	50%	97.27%	98.12%	97.77%	97.25%	
Community Services Data completeness: Treatment Activity	50%	99.91%	99.81%	99.79%	99.73%	April 2015 – March 2016
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	out of 6 criteria	6	6	6	6	

18 week incomplete pathways Ⓐ

The reported indicator performance has been calculated based on all patients recorded as having been referred to the FT for consultant led services and who are on incomplete pathways at the end of the period. Completeness of this information is therefore dependent on the complete and accurate entry of data at source (referrals received for consultant led services) and the complete recording of all those on incomplete pathways at period end; it is not possible to check completeness to source because referrals may be received through different routes, for example, by letter, fax or via the live 'Choose and Book' system or may have been received in a prior period. Patients who have not been identified within the population will therefore not be included in the indictor calculation. To the best of the knowledge of the Trust, the information is complete.

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

The reported indicator performance has been calculated based on all patients recorded as having attended A&E. Completeness of this information is therefore dependent on the complete and accurate entry of data at source by the clinician who carries out initial assessment or by A&E reception. Patients who have not been correctly registered in A&E will therefore not be included in the indictor calculation. To the best of the knowledge of the Trust, it is complete.

Target	Definition	Criteria
Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge Ⓐ	Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	The indicator is defined within the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf
18 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 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 2015 to March 2016; 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.

SHMI & Palliative Care – data correct as of 18/04/2016

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:

Indicator	Apr 2014 - Mar 2015	Jul 2013 - Jun 2014	Trust performance Latest Oct 2014 - Sep 2015	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	0.975 (Band 2)	0.954 (Band 2)	0.970 (Band 2)	1.004	0.652 (RKE)	1.177 (RVW)
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	24.2%	24.3%	25.8%	26.6%	0.2% (RKE)	53.5% (RYJ)

The SHMI is provided by the Health and Social Care Information Centre. During July 2014 – April 2015, following the implementation of a new patient administration system PMS2, there were some issues with data quality. There were issues with the recording of the type of admission (emergency rather than elective) which will have had an effect on the risk adjustment for our indicator. This will potentially lower our SHMI level.

The latest SHMI is 95 for July 2014 – June 2015 representing an HSCIC 'as expected' banding. This is the lowest it has ever been. However, the trend is consistently downwards and the influence of the period of data quality concerns lessens with each iteration of the SHMI.

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.

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

This data is now reviewed and validated on a regular basis.

PROMs

Patient Reported Outcome Measures Scores (PROMS)	Trust Performance Latest			National Average	Lowest reported Trust	Highest Reported Trust
	Apr 13 - Mar 14	Apr 14 - Mar 15	Apr 15 - Dec 15			
(i) groin hernia surgery	0.113	0.094	0.084	0.087	0.024	0.156
(ii) varicose vein surgery	0.11	0.12	0.135	0.1	0.036	0.147
(iii) hip replacement surgery	0.406	0.397	0.425	0.425	0.27	0.543
(iv) knee replacement surgery	0.318	0.299	0.288	0.331	0.215	0.4

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 as they continue to be an outlier in the CQC Intelligent Monitoring Report.

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:

- All activity is now undertaken within the Trust and work is now focussed on the Solihull site to reduce length for elective hip surgery. The work within T&O also feeds into the Trust overall LOS programme which is one of the four key work streams 2016/17
- Continue work on the enhanced scheme piloted at Solihull Hospital
- The enhanced recovery scheme and the focus on the knee pathways are now starting to show improvement and this approach will now be applied to the hip pathway
- Improving the understanding of the data and undertake a detailed piece of work on capacity and demand across the T&O Directorate.
- Continuing our work on improving both Groin Hernia Surgery and Varicose Vein Surgery which have both shown consistent improvement month on month.

Readmissions

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%

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 4 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:

- Learning from recent multi-disciplinary audits across the health and social economy in relation to readmission rates, variance and causative factors. This will also incorporate any data quality improvement issues
- Further improving discharge practice via a locally agreed CQUIN in line with best practice guidance from NICE National Guidance 27

and the West Midlands Quality Review Service Quality Standards on Transfer of Care from Acute and Intermediate Care
- Evaluating results from the Solihull Discharge Surveillance Pilot aimed at reducing Readmissions and agreeing next steps through the Trust Workstream on reducing Occupied Bed Days
- Benchmarking specialties or care providers that appear to be outliers to address any clinical concerns or process factors and agreeing plans with partners where necessary i.e. GPs, care homes, community services, mental health and social care.

All these actions will be done in conjunction with the Trust's partners.

Patient Experience

Indicator	2012/13	2013/14	Trust performance Latest 2014/15	National Average	Lowest reported Trust	Highest Reported Trust
Trust's responsiveness to the personal needs of its patients during the reporting period	65.2	63.6	66.1	68.9	59.1	86.1

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 worked to make improvements to inpatient experience. Whilst the decrease in the ED FFT score is not a large one, this reflects that increasing demand and the challenges associated with being one of the largest and most diverse providers of acute healthcare in the country means that ED patient experience remains a priority for 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:

- Using the expertise and experience of Community Patient Panel members to support monthly ward quality reviews
- Dedicated action plan and work to support patient experience improvements in the ED, including volunteers to support vulnerable people receiving treatment in the department
- The increased use at ward level patient comments made via the FFT. A quality dashboard has been developed to facilitate the use of these comments by supervisory ward sisters
- Undertaking thematic analysis of patient comments in conjunction with complaints feedback
- Providing training for Trust staff in managing and prevention of complaints
- Patient experience monitoring to understand the differences in experience across weekdays, weekends and during the night.

Indicator	2013/14	2014/15	Trust performance Latest 2015/16	National Average	Lowest reported Trust	Highest Reported Trust
Friends and Family Test – Patient having a positive experience of care after being discharged from A&E	88.71%	85.96%	79.50%	84.39%%	46.33%	100.00%

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

- This is the same as detailed above under the Trust's responsiveness to the personal needs of its patients during the reporting period.

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

- This is the same as detailed above under the Trust's responsiveness to the personal needs of its patients during the reporting period.

Staff Experience

Indicator	2013	2014	Trust performance Latest 2015	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	56%	48%	55%	70%	46%	85%

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

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

- Current finance concerns, along with significant change in the management of the Trust may have an impact on the score in 2015. However, there has been a significant improvement from the previous year
- The Trust has held numerous Staff Listening Events, giving 2,000 staff the opportunity to give feedback on the way the Trust works, and the management team time to listen
- The Trust has implemented a steering committee for staff engagement, to review staff comments and to identify actions to take forward
- The Trust has used staff feedback to help the re-design of ED, majors and minors at BHH which has in turn improved patient flow
- There has been the development of Trust-wide Culture and Engagement Plan based on staff feedback focused on staff engagement and values led culture
- Recruitment initiatives continue to be delivered with short, medium and long term strategies being implemented.

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

- Continuation of the values led culture in 2016, with staff led values and behaviours to be launched in April 2016 and to be incorporated into: our appraisals; recruitment; induction; policies and procedures
- Continued approach to increasing responsiveness to Staff FFT and full census of NSS, thus allowing regular updates and adapt action planning
- The Trust's culture metric to be included within Staff FFT giving a bench mark of how staff "live our values"
- Continuation of the Staff Engagement Steering Group (staff led group) to analyse Staff FFT, and to develop ideas and solutions to key engagement issues
- Schwartz rounds will continue to be held, giving staff time to reflect and to share experience across staff groups.

Venous thromboembolism (VTE)

Indicator	Apr-15	May-15	Trust performance Latest Jun-15	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	95.00%	93.24%	93.30%	96.01%	74.08% (RWA)	100.00% (Several trusts)

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

Total 2015/16 VTE assessment was 94.75% against a target 95%. The current system is highly dependent on forced completion of Venous Thromboembolism Risk Assessment (VTE RA) via the Trusts electronic prescribing (EP) system.

Recurrent problem areas identified as follows:

- Areas where EP is not routinely used such as day surgical wards, acute medical and surgical assessment units areas and short stay surgical wards, usually coinciding with a short inpatient episode, have the lowest completion rates, in particular patients with a 4 to 12 hour stay
- Determining those patients mainly with short admissions undergoing low risk procedures, the 'cohort listed' patients, who do not have to undergo VTE RA is complex and requires accurate recording of the IP event. Errors in this step may explain some of the failures experienced
- Recent application of a revised 'Cohort' exclusion a pre-agreed procedures from VTE RA (mainly low risk day case surgery, endoscopy and chemotherapy) increased the Trusts performance from 94.75% to 98.24%.

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:

- 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 Trusts EP 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
- Remind all clinical staff to complete the VTE RA in those areas reliant on paper prescribing (ED, AMU, SAU, ITU, Ward 19).

Further actions planned:

- IT to close down workaround routes into Electronic Prescribing thereby bypassing the need to complete the VTE RA
- Revise the Trust's Cohort list, aligning it to those used by other trusts locally
- This appears to impact on many cases in short stay areas within the Trust
- Interconnect VTE RA algorithm to promote better thromboprophylactic decision making
- Extend use of EP for short stay units such as Surgical Assessment Unit and Day Case Surgery Unit.

All the actions should improve VTE RA completed numbers as well as quality of thromboprophylaxis prescribed. Theoretical improvement when using revised cohort list should also improve the Trust's performance comfortably greater than 95%.

C. Difficile

Indicator	2012/13	2013/14	Trust performance Latest 2014/15	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	17.1	16.7	16.9	15.1	0.0	62.2

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

This data represents a drop from a rate of 32.6 in the 2010-2011 year. This is due to a comprehensive Clostridium Difficile (C Difficile) control and management program which includes:

- Post infection review of all post-48-hour toxin positive cases of C. Difficile carried out jointly with CCG. Feed-back given to clinical and ward teams and an improvement action plan implemented
- 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. This includes an audit programme to monitor practice and the clinical environment to provide assurance of sustained improvement
- Typing of individual strains of C. Difficile to identify transmission incidents and outbreaks thus facilitating timely and effective management.

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

- Implementation of a RAG rated monitoring system for inpatients with C.Difficile to ensure timely and effective management. This includes twice weekly review of patients by the infection prevention and control and microbiology teams
- The use of Fidaxomycin in the treatment of C. Difficile
- Faecal transplants for patients with protracted/ relapsing C. Difficile infection
- Daily review of patients with diarrhoea in admissions departments at three hospital sites to ensure early detection of C.Difficile
- Identification and monitoring of inpatients previously positive for C.Difficile thus facilitating early detection of any C. Difficile relapse.

Patient Safety

Indicator	Oct 13 - Mar 14	Apr 14 – Sep 15	Trust performance Latest Oct 14 - Sep 15	National Average	Lowest reported Trust	Highest Reported Trust
Number of patient safety incidents reported within the trust during the reporting period	7,610	7,383	7,182	4,539	443	12,784
Rate of patient safety incidents reported within the trust during the reporting period	6.9	34.0	31.8	-	3.6	82.2
The number of such patient safety incidents that resulted in severe harm or death.	87	95	77	-	2	128
Percentage of such patient safety incidents that resulted in severe harm or death.	1.14%	1.29%	1.07%	0.51%	-	-

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 similar data, with the number of patient safety incidents reported within the Trust during the reporting period as 7,296 and the number of such patient safety incidents that resulted in severe harm or death as 77 (1.06%).

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. There has been a relatively stable incident reporting profile for the last two years with approximately 20,000 incidents reported in 2015. These incidents include patient safety incidents, which are subsequently uploaded to the National Reporting and Learning System (NRLS) as previously reported. 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 the Trust's incident reporting process patient safety incidents are identified and regularly uploaded on to the NRLS system. The NRLS publish some of this data as national statistics as well as providing bi-annual reports for individual organisations.

This year the Trust has continued to capture the duty of candour information required by our commissioners. The training that is provided is continually reviewed 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 score, and so the quality of its services, by

The Heart of England NHS Foundation Trust intends to take the following actions to increase the total rate of patient safety incidents reported within the Trust and so the quality of its services, by implementing a full review of the incident reporting and management systems and procedures including:

- Review of Datix incident reporting forms and codes
- Review of listed incident handlers and investigators and their roles and responsibilities
- Training needs analysis and production of full training program for staff
- Review and development of reporting and dashboard facilities in Datix
- Review of incident reporting and management policies.