Heart of England NHS Foundation Trust

# Quality Account & Report 2013/14

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# Contents

# Introduction

The purpose of this Quality Account & Report is to provide patients, staff, members of the local communities and commissioners, with a report on the quality of services that the Trust provides. It provides an update on activities in the Heart of England NHS Foundation Trust (hereafter referred to as 'the Trust') over the last 12 months.

The Quality Account & Report represents one aspect of the continued drive to improve the quality and safety of the services which are provided.

In **Part 1**, there is a statement of the quality of services from Chief Executive, Mark Newbold.

In **Part 2** an update is provided on the priorities that were set by the Trust for 2013/2014. Details are also included regarding the priorities set for the coming year, how these priorities have been developed with stakeholders and what this will mean for the quality of services that patients receive.

In addition, there are a number of 'Statements of Assurance' regarding specific aspects of service provision. The Trust is required to provide these statements to meet the requirements of NHS England and Monitor (the regulator for NHS Foundation Trusts). All providers are required to provide these statements allowing for comparison between different organisations.

**Part 3** contains further information which will provide a picture of some of the other initiatives that have been implemented in the Trust to improve quality.

The final section of this document provides commentaries which express the views of some of the Trust's key stakeholders.

Thank you for taking the time to read the Heart of England NHS Foundation Trust Quality Account & Report 2013/2014. If you would like to comment on any aspect of this document, details are provided at the end of the document.

# Part 1:
# Chief Executive's Statement

Providing safe, quality care is our top priority at Heart of England NHS Foundation Trust. We are one of the busiest NHS Trusts in the country, serving a population of over 1 million, seeing over 250,000 adults and children in our emergency departments every year, and providing a huge range of both general and specialist services from our three hospitals sites and a range of community settings.

This Quality Account & Report provides you with a true and accurate reflection of our performance over the past year and is accurate to the best of my knowledge. We are always open about the challenges we face and we will continue to work hard at raising standards whilst maintaining our core values of 'safe and caring'.

By embracing a patient-centred approach, we have diligently focused on our emergency care challenges this year and successfully undertook the 'Breaking the Cycle' initiative in December 2013. This resulted in significant improvements for our emergency patients, but we are not complacent and we know the actions detailed in our Monitor undertaking will enable us to continue to improve our emergency pathways and discharge arrangements.

Under the CQC's new regime of the Chief Inspector of Hospitals, we were rated overall as 'Requires Improvement' although we were pleased that many areas were rated 'Good'. Following a re-inspection, Good Hope Hospital emergency areas showed substantial improvements and our 'inadequate' rating was amended accordingly. We were pleased to be commended by the inspection team for the caring and compassionate approach of our staff and for the open and transparent way in which this Trust operates.

We planned to fail the 18 weeks admitted target in Quarter 4 in order to reduce the number of patients waiting for the longest times. Work is ongoing to complete this and achieve the target performance in 2014/15.

This year we have invested in developing our clinical research base – this is an essential part of improving patient care, through recruitment to clinical trials. We are excited to have appointed a professor of public health to guide our work in improving population health within the communities we serve. We continue to invest in services across the Trust, with a new emergency department and two operating theatres for Good Hope opening last year, along with the new laboratory medicine building at Heartlands.

We are proud of our nursing initiatives which have directly contributed to a steady reduction in the incidents of hospital acquired pressure ulcers. We have also piloted a falls bundle which has resulted in a reduction in falls in those areas and are now rapidly sharing this practice across our hospital sites.

In the coming year, we are keen to establish some of the principles described in the recent Future Hospitals Commission Report and to build on our innovative work to create care options for our patients that are outside of the acute ward environment. These are successfully reducing the length of time patients spend in our wards and as a consequence, supporting shorter recovery times. We will continue to work together with other organisations to ensure our patients are cared for and treated in the right way appropriate for their individual needs, which may not necessarily mean being hospitalised. We will continue to focus on maintaining and improving quality of care and demonstrating strong clinical performance as we move forward.

Following the Kennedy Review in December 2013, we are implementing ten improvement programmes that pick up the learning from the Review. These are forward looking and will result in many inpatient improvements across the Trust.

I would like to thank our staff, volunteers and partners across the health community for all of their outstanding work and support through what has been a demanding yet rewarding year.

**Dr Mark Newbold**
**Chief Executive**

# Part 2:
# Priorities for Quality Improvement 2013/14

Quality Accounts are annual reports to the public regarding the quality of healthcare services that the Trust provides. They are both retrospective and forward looking.

As part of the Quality Account process, the Trust is required to set priorities for improvement. These are issues which are considered to be important to patients, local communities and stakeholders.

The Trust had chosen to continue focussing on the four priorities from the Quality Account & Report of 2012/13 (priorities 1 to 4) along with a further three priorities for the year **2013/14** (priorities 5 to 7).

The priorities are:

**Priority 1: Fundamentals of Care**

This priority is based on the National Care Campaign and specifically looks at: pain management; communications; privacy and dignity; and nutrition. Performance is being measured through Trust-wide developed scorecards and monitored at the Nursing Performance Committee.

**Priority 2: Falls**

Performance is measured through a Trust-wide developed scorecard which includes nursing metrics regarding assessments, falls per occupied bed days, which wards have the highest number of falls amongst other indicators. The scorecard is monitored at the Nursing Performance Committee.

**Priority 3: Pressure Ulcers**

Performance is also measured through a Trust-wide developed scorecard which includes nursing metrics regarding assessments, tissue viability audits, as well as incident numbers. The scorecard is monitored at the Nursing Performance Committee.

**Priority 4: Fractured Neck of Femur**

The Trust currently submits data to the National Hip Fracture Database (NHFD). The NHFD is a joint venture of the British Geriatrics Society and the British Orthopaedic Association, and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. It allows care to be audited against the six evidence-based standards and enables local health economies to benchmark their performance in hip fracture care against national data. This data will be used to assess the Trust's own clinical outcomes with regard to fractured neck of femur and to subsequently continue to improve its performance.

This priority is measured through the NHFD and is discussed at the Clinical Quality Performance Group. The performance is also monitored using Key Performance Indicators reported to the Trust Finance Performance Committee.

**Priority 5: Improving Clinical Outcomes for Stroke**

This priority aims to improve clinical outcomes for patients suffering a stroke. The four priorities specifically identified from the stroke pathway include:

- Number of acute stroke patients thrombolysed;
- Direct admission to stroke unit within 4 hours with a swallow assessment;
- The percentage of acute stroke patients who have received a swallow screen within 4 hours of arrival; and
- 90% of stay spent in a stroke unit.

This priority is measured through a combination of stroke key performance indicators including contract targets and best practice tariff (see page 20 for explanation) and monitored through the Clinical Quality Performance Group.

**Priority 6: Improving Dementia Care**

This priority aims to standardise the approach for dementia patients and hence lead to improvements in the care given.

This priority is measured by the collection of figures through Trust systems and is discussed at the Clinical Quality Performance Group. The performance is also monitored using Key Performance Indicators reported to the Trust Finance Performance Committee.

**Priority 7: Improving Discharge Arrangements**

This priority aims to improve the discharge process for patients and is measured through a Commissioning for Quality and Innovation payment framework (CQUIN). The CQUIN is discussed at Finance Performance Committee.

# Part 2:
# Looking back – Progress against 2013/14 priorities for quality improvement

## Priority 1: Fundamentals of Care

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

**How is this priority measured:** This priority and its core four areas are measured via the nursing metrics and monitored via a Trust-wide developed scorecard (figure 2).

This is an important part of the nursing metrics which are measured by peer review (please see attached card as an example). The information gathered from the nursing metrics is presented at the Nursing Performance Committee on a monthly basis and is monitored via exception reports.

This data forms part of the nursing report which is presented and discussed at Trust Board.

**What have we done to improve:**

**Communication**

Effective communication is an essential part of patient and carer involvement within the Trust. Knowing who is caring for you and who to speak to for information and care planning is key to building trust and understanding.

- All Trust staff wear a Trust identification badge with their name and job role displayed.
- All hospital based nursing uniforms are colour coded (light blue / navy blue / purple) and embroidered with the Trust's logo and associated nursing role, e.g. Head Nurse/ Senior Sister/ Sister/ Staff Nurse/ Healthcare Assistant.
- The Trust is supporting the "Hello My Name is" campaign. This campaign reminds staff to introduce themselves to patients properly as a confident introduction is the first step to providing compassionate care and is often all it takes to put patients at ease and make them feel relaxed whilst using our services.
- Good Hope hospital site is publicising the Chief Nursing Officer for England 6c's campaign. The national campaign focuses on 6 c's: Compassion, Care, Courage, Competence, Commitment and Communication. The current focus at Good Hope is on communication.
- Feedback from patients and carers through the nursing metrics and friend and family test is displayed on each ward.
- The Trust has invested in friends and family feedback stations for all wards to encourage real time feedback about the care being delivered.
- The Trust is working in collaboration with the National Council for Palliative Care and the Dying Matters Coalition on a 3 year compassionate care project. The compassionate carer's project focuses on difficult conversations that nurses may have with patients and carers around life changing conditions and end of life care and preparation. A bespoke training package has been created to train and support nurses to provide compassionate and effective communication with patients and carers.

- The Trust, in collaboration with the National Council for Palliative Care, has created a staff and carer information DVD entitled 'I didn't Know That' about end of life requirements from the Muslim perspective. It highlights cultural requirements at end of life and also medical and legal requirements.
- The introduction of Jonah[1] boards has provided individualised care plans for all patients at the Trust. Discharge planning commences on admission to the Trust and this is routinely discussed with patients, their relatives and the multi disciplinary team.

**Privacy and Dignity**

Dignity care rounds have been introduced where Head Nurses undertake visits to wards to observe care provided and ensure that a patient's privacy and dignity is being observed. Any issues identified are immediately addressed with the Ward Manager and good practice is fed back to staff.

- Dignity pyjamas which have a covered flap to maintain dignity for patients with indwelling catheters allow gentlemen to maintain their dignity.
- The use of t-shirts (rather than gowns) for patients who have impaired movement (e.g. stroke patients) provide comfortable and modest attire.
- Compassionate care packs are being trialled on wards at all 3 hospitals. The packs contain wet wipes, comb, tooth brush and tooth paste, a drink, mints and small snack. The packs are given to relatives who may have been called in to be with a critically unwell relative – or for relatives who are staying by a dying relative's bedside. Although a small gesture these packs have been welcomed by relatives and have allowed them to maintain dignity at a highly emotive time.

**Pain Management**

Effective pain management is an essential part of the care we provide.

- As part of the nursing metrics 10 patients per ward per month are audited for pain and appropriate pain control.
- The Anaesthetic Department also runs a Trust-wide pain clinic providing treatment plans and support for patients with acute and chronic pain.
- A carer and users forum has been set up around medication to gain feedback from patients and carers re medication issues.

**Nutrition**

- The Trust undertakes an annual Essence of Care Trust-wide mealtime audit.
- Quality rounds are undertaken annually with catering, dietetics and nursing involvement.
- Patient feedback monitored is monitored monthly through the nursing metrics to ensure that a nutritional assessment is undertaken on patient admission.
- Patient feedback is also captured through the friends and family test feedback where comments on food are captured and fed back to wards and departments.
- A new patient menu was launched in January 2014 and the Trust holds 'Come Dine with me' events to showcase to the public meals that are served to patients.

[1] The Jonah programme is a national initiative which has been developed using the several principles which support effective operational management and safe care. A key feature has been visual management to ensure the planned patient journey is visible, along with their progress. There is a heavy emphasis on coaching to develop leadership, improvement and problem solving skills at ward level. Jonah Boards are patient status at a glance interactive boards.

The aim of 'Jonah' is to provide safe and timely care as planned by the multidisciplinary team. Experience has shown this will reduce length of stay and increase the number of patients who are discharged as planned each day.

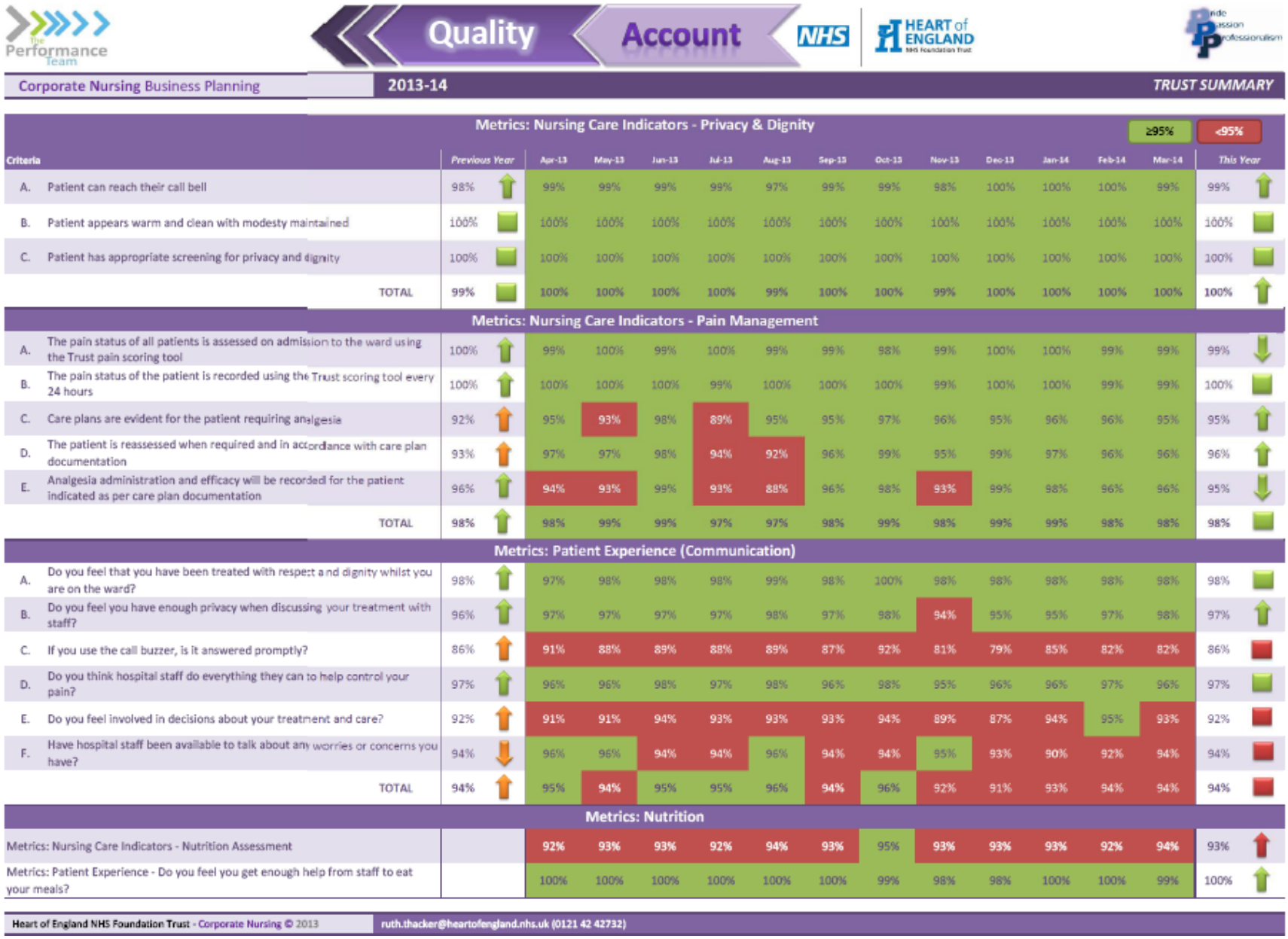
- There is catering for patients with all dietary requirements and acknowledgment of faith requirements including availability of halal and kosher food.
- Protected meal times are in place to ensure patients are not disturbed during meal times and red trays are continuing to be used to identify patients who require assistance with eating.
- Eating well, staying well hydrated and staying active while in hospital has a big impact on our patients' health, outcome and wellbeing. The launch of 'Eat... Drink... Move...' added a 'mobility bundle', a set of simple measures that ward staff can use to encourage patients to also 'STAY ACTIVE' in hospital**.**

**Future plans to improve compliance against the Trust targets include:**

The following actions, as well as embedding the initiatives detailed above, will hopefully improve the areas detailed on the scorecard (Figure 2):

- Compliance with the National Friends and Family Test and local CQUIN requirements.
- Ongoing initiatives to embed the 6C's in the delivery of patient care.
- Ongoing monthly monitoring of pain management through nursing metrics.
- Therapy teams will continue to raise awareness of the mobility bundle and related resources and promote their use.
- Call buzzers are being monitored via monthly metrics and patient experience metric with performance notices for continuing non compliance.

**Figure 2**



The Performance Team

Quality Account

NHS

HEART of ENGLAND NHS Foundation Trust

Pride Passion Professionalism

**Corporate Nursing Business Planning** | **2013-14** | ***TRUST SUMMARY***

**Metrics: Nursing Care Indicators - Privacy & Dignity** — ≥95% — <95%

| Criteria | Previous Year | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 | This Year |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A. Patient can reach their call bell | 98% ↑ | 99% | 99% | 99% | 99% | 97% | 99% | 99% | 98% | 100% | 100% | 100% | 99% | 99% ↑ |
| B. Patient appears warm and clean with modesty maintained | 100% ■ | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% ■ |
| C. Patient has appropriate screening for privacy and dignity | 100% ■ | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% ■ |
| TOTAL | 99% ■ | 100% | 100% | 100% | 100% | 99% | 100% | 100% | 99% | 100% | 100% | 100% | 100% | 100% ↑ |

**Metrics: Nursing Care Indicators - Pain Management**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A. The pain status of all patients is assessed on admission to the ward using the Trust pain scoring tool | 100% ↑ | 99% | 100% | 99% | 100% | 99% | 99% | 98% | 99% | 100% | 100% | 99% | 99% | 99% ↓ |
| B. The pain status of the patient is recorded using the Trust scoring tool every 24 hours | 100% ↑ | 100% | 100% | 100% | 99% | 100% | 100% | 100% | 99% | 100% | 100% | 99% | 99% | 100% ■ |
| C. Care plans are evident for the patient requiring analgesia | 92% ↑ | 95% | 93% | 98% | 89% | 95% | 95% | 97% | 96% | 95% | 96% | 96% | 95% | 95% ↑ |
| D. The patient is reassessed when required and in accordance with care plan documentation | 93% ↑ | 97% | 97% | 98% | 94% | 92% | 96% | 99% | 95% | 99% | 97% | 96% | 96% | 96% ↑ |
| E. Analgesia administration and efficacy will be recorded for the patient indicated as per care plan documentation | 96% ↑ | 94% | 93% | 99% | 93% | 88% | 96% | 98% | 93% | 99% | 98% | 96% | 96% | 95% ↓ |
| TOTAL | 98% ↑ | 98% | 99% | 99% | 97% | 97% | 98% | 99% | 98% | 99% | 99% | 98% | 98% | 98% ■ |

**Metrics: Patient Experience (Communication)**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A. Do you feel that you have been treated with respect and dignity whilst you are on the ward? | 98% ↑ | 97% | 98% | 98% | 98% | 99% | 98% | 100% | 98% | 98% | 98% | 98% | 98% | 98% ■ |
| B. Do you feel you have enough privacy when discussing your treatment with staff? | 96% ↑ | 97% | 97% | 97% | 97% | 98% | 97% | 98% | 94% | 95% | 95% | 97% | 98% | 97% ↑ |
| C. If you use the call buzzer, is it answered promptly? | 86% ↑ | 91% | 88% | 89% | 88% | 89% | 87% | 92% | 81% | 79% | 85% | 82% | 82% | 86% ■ |
| D. Do you think hospital staff do everything they can to help control your pain? | 97% ↑ | 96% | 96% | 98% | 97% | 98% | 96% | 98% | 95% | 96% | 96% | 97% | 96% | 97% ■ |
| E. Do you feel involved in decisions about your treatment and care? | 92% ↑ | 91% | 91% | 94% | 93% | 93% | 93% | 94% | 89% | 87% | 94% | 95% | 93% | 92% ■ |
| F. Have hospital staff been available to talk about any worries or concerns you have? | 94% ↓ | 96% | 96% | 94% | 94% | 96% | 94% | 94% | 95% | 93% | 90% | 92% | 94% | 94% ■ |
| TOTAL | 94% ↑ | 95% | 94% | 95% | 95% | 96% | 94% | 96% | 92% | 91% | 93% | 94% | 94% | 94% ■ |

**Metrics: Nutrition**

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metrics: Nursing Care Indicators - Nutrition Assessment | | 92% | 93% | 93% | 92% | 94% | 93% | 95% | 93% | 93% | 93% | 92% | 94% | 93% ↑ |
| Metrics: Patient Experience - Do you feel you get enough help from staff to eat your meals? | | 100% | 100% | 100% | 100% | 100% | 100% | 99% | 98% | 98% | 100% | 100% | 99% | 100% ↑ |

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# Priority 2: Falls

'Patient falls' account for the largest number of adverse events reported within the Trust and therefore a priority for all healthcare professionals in preventing harm to patients.

**What is the measure:** A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Age is one of the key risk factors for falls. Older people have the highest risk of serious injury arising from a fall and the risk increases with age.

Falls prevention is a Trust-wide priority and has Executive Board support in its challenge to achieve 'harm free care' by eliminating harm to our patients. The Trust recognises that a robust and coordinated approach is required to standardise clinical practices, focusing on preventative strategies and clinical interventions to reduce the incidence of harm to those patients at risk of falling in hospital.

**How is this priority measured:**

To provide assurance to the organisation the Trust also monitors the numbers of patient falls that are reported via the incident reporting system to ensure all incidents are reported robustly and accurately creating a culture of openness and transparency. The implementation of clinical forums has been established across all three hospital sites to review adverse incidents and lessons learned.

The injurious falls rate (falls with harm) demonstrate an improved position for the year end (Table 1) with all incidents now subject to a senior review by the deputy chief nurse, falls clinical specialist and Director of Medical Safety. Theses arising from these reviews are shared with the clinical teams

In support of our 'harm free' care ambition the NHS Safety Thermometer tool provides a quick and simple method for surveying patient harms and analysing results to measure and monitor local improvement and over time. An improved Trust position, using the point prevalence tool is demonstrated in Table 1.

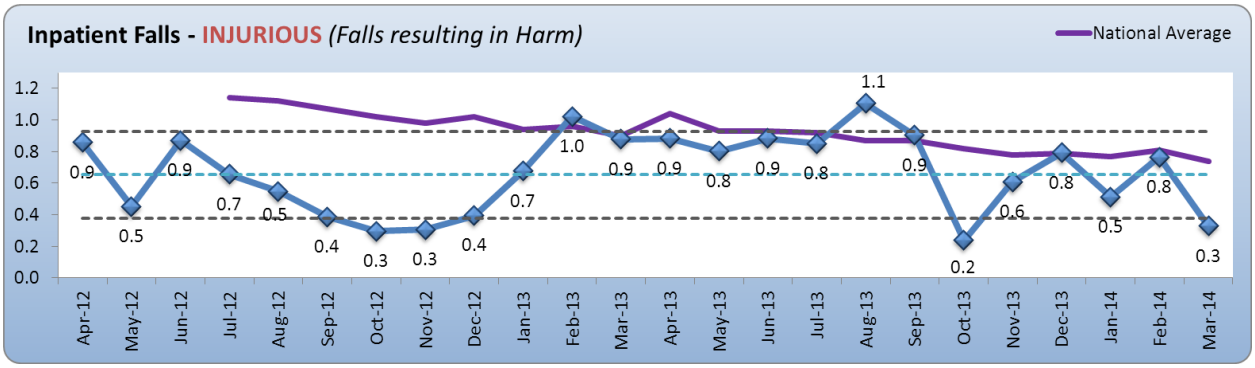


**Figure 1a: National Safety Thermometer Tool**

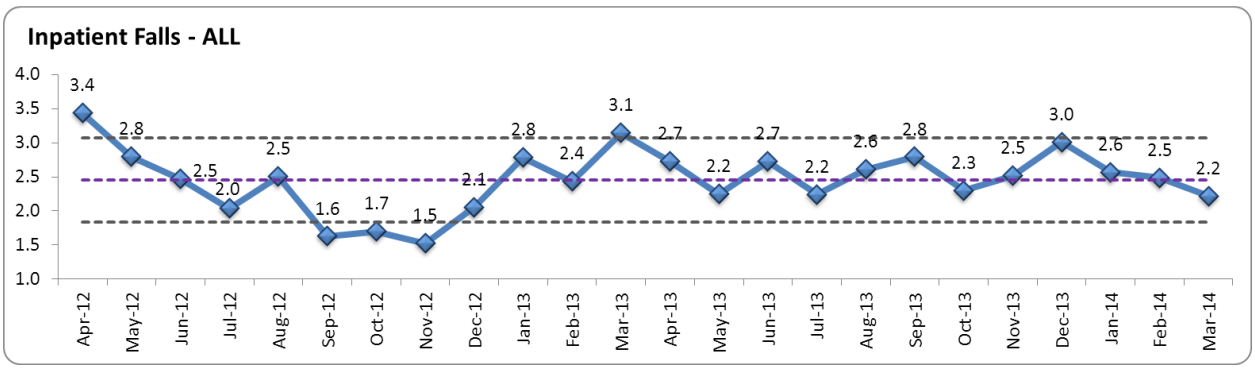


**Figure 1b: National Safety Thermometer Tool**

The development of a **'Staying Safe' Scorecard**, a National High Impact Action concerned with reduction of patient falls, enables local clinical teams to develop local action plans in response to performance data (See Figure 2). Clinical outcomes are measured through Trust-wide developed scorecards which include nursing metrics regarding assessments; falls per occupied bed days; and the clinical areas demonstrating a high number of patient falls.

The yearend position (2013/14) for inpatient falls rate is 8.1 (per 1000 occupied beds). This figure represents a small improvement on previous months but demonstrates the need for a greater clinical focus on preventative strategies to be used for high risk patients. The use of the STRATIFY tool currently measures the patients falls risk and is monitored using the nursing metrics. This measurement has been reported at between 98% and 100% since June of last year. This is a significant improvement on previous years however the percentage score achieved within the falls metric has been affected by reduced compliance with effective care plans.

**What have we done to improve:**

In response, the Trust wide falls steering committee has been established to coordinate fall prevention strategies and monitoring processes. Initial work focussed on recent NICE guidance which led to a revised falls prevention policy and associated falls care bundles. Implementation of the new policy commences in June 2014.

In support of the fall care bundles financial resources have been allocated to purchase additional equipment such as beds/ chair arms and hi-lo beds. The recruitment of an additional 2 falls coordinators will also provide enhanced clinical expertise and advice to clinical teams.

A range of educational programmes are also in place to support new starters / nurse / medical staff and allied health professionals. In addition there is bespoke training for clinical areas demonstrating a high incidence of patient falls.

Awareness is raised for all staff group through a range of mediums such as 'safety lesson of the month', newsletters, clinical forums and learning lessons events.

Patient / carer support is provided by the development of patient literature and patient falls notification forms which have enhanced communication in a joint approach to falls prevention.

**Future plans to improve compliance with Trust targets include:**

- Updating the nursing fall metrics to capture the implementation of the care bundles;
- A review of corporate induction and VITAL training to reflect the revised policy;
- Appointment of 2 falls coordinators
- A dedicated falls web page will provide further information to support referral options, advice, links to external agencies and guidelines.

**Figure 2**


Performance Team
Staying Safe
NHS
HEART of ENGLAND
Corporate Nursing Business Planning
Quarter 4 (January to March 2014)
ACUTE TRUST
Metrics: Nursing Care Indicators - Falls Assessment
95-100%
0-94%
Criteria
Previous Qtr
Jan-14
Feb-14
Mar-14
This Qtr
A. The patient received a falls risk assessment on admission to the Trust if over the age of 65 or if the patient has a history of falls
B. The assessment is dated and signed by the assessing staff member
C. Trust care plan to minimise the risk of falls is evident for the patient if assessed as being at risk
D. A further assessment is undertaken at least weekly for the patient if identified as being at risk
E. A bedrail assessment is undertaken on the patient if identified at risk and / or using bed rails
F. A manual handling risk assessment has been completed
TOTAL
Trust position
Trust minimum indicator (C.)
NHS Safety Thermometer: ALL Falls (Prevalence)
NHS Safety Thermometer: Injurious Falls (Prevalence)
National Average
Datix / IR1: Falls Rate per 1,000 Occupied Bed Days (Incidence)
Wards with the Highest Falls Rate
(Falls per 1,000 OBD) Q4 2013-14
Wards with the Highest Repeat Fallers
Q4 2013-14
Datix / IR1: Falls Incidents Breakdown of Type of Fall
ACUTE TRUST - Q4 2013-14
Unobserved fall
Fall from bed (including h/lo bed)
Fall from chair / wheelchair
Fall whilst transferring
Fall from bed onto crash mattress
Fall whilst mobilising
Bathroom / toilet associated fall
Fall from bed with bedrails
Fall from commode
Datix / IR1 : Falls Incidents Breakdown of Harm
ACUTE TRUST
No Harm
Low
Moderate
Severe
Catastrophic
Falls Resulting in Fracture or Head Injury
ACUTE TRUST
Jan-13
Feb-13
Mar-13
TOTAL
12
9
4
25
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# Priority 3: Pressure Ulcers

**What is a Pressure Ulcer:** Pressure ulcers are damage caused to the skin and underlying tissue; they cause pain and distress to patients and ultimately extend a patient's length of stay. Pressure ulcers are classified as a grade, 2, 3, 4 with 4 being the most severe, an extended length of stay and increased care pressure ulcers cost the NHS £3.8 million a day.

**What is the measure:** The Trust is committed to reducing harm caused to patients and strives to achieve zero hospital acquired pressure ulcers.

**What have we done to improve:**

The Trust has robust processes in place to monitor the reporting and improvement of any hospital acquired pressure ulcers:

- All pressure ulcers are reported via the Trust incident reporting system.
- The Corporate Nursing Team issue a daily harm alert listing the ward and grade of any hospital reported pressure ulcer in the previous twenty four hour period.
- All hospital acquired pressure ulcers are investigated using a Root Cause Analysis Tool (RCA) this is completed by Senior Sister /Senior Charge Nurse and the site Head Nurse or their nominated deputy to determine if the pressure ulcer was avoidable or not.
- Any pressure ulcer, which is reported as grade 3 or above are categorised as severe harm to patients and are required to be reported to the Trust Clinical Commissioning Group (CCG). The Commissioners will monitor the incident to ensure the timeline is adhered too and a robust action plan is implemented when it is confirmed the pressure ulcer was avoidable. Some patients can develop pressure ulcers despite all the preventative care and treatment implemented due to their underlying health conditions. These are classified as unavoidable.
- Preventative measures are always the best care and the Trust has robust timelines to be adhered too. Within the Emergency Department, all patients identified as being at risk are assessed against the frailty tool so appropriate interventions can be implemented.
- At ward level, all patients are assessed within 2 hours to determine their individual risk of developing pressure ulcers; once risks have been identified a preventative plan of care is implemented. This can include the use of specialist beds, cushions restrictions placed on the patient being able to sit out of bed and the use of care plans daily skin inspection tool for patients considered at risk. In May 2013, the Trust implemented the SSKIN[2] Bundle, which was part of the Strategic Health Authority (SHA) Midlands and East "Stop the Pressure" campaign. The tool has been revised twice since implementation to support both compliance and user feedback.

## How is the priority measured:

### **Monitoring** (Internal)

Tissue Viability compliance is monitored monthly via the nursing care indicators (Figure 1) where 10 patients on every ward have their nursing records and care reviewed against an agreed

[2]SSKIN is a five step model for pressure ulcer prevention:

**Surface**: make sure your patients have the right support.
**Skin inspection**: early inspection means early detection. Show patients and carers what to look for.
**Keep** your patients moving.
**Incontinence**/moisture: your patients need to be clean and dry.
**Nutrition**/hydration: help patients have the right diet.

standard. Compliance is set at 95%. A score below this would be non-compliant with the standard. Further scrutiny is applied through the Nursing and Midwifery Performance Committee, where each Head Nurse submits an exception report for any indicators that fall below the agreed 95% threshold. The exception reports are then escalated through the nursing reports to Trust Board.

| Section Name | Question Short | May 2013 | Jun 2013 | Jul 2013 | Aug 2013 | Sep 2013 | Oct 2013 | Nov 2013 | Dec 2013 | Jan 2014 | Feb 2014 | Mar 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tissue Viability | Documentation | 100% | 100% | 100% | | | | | | | | |
| | Risk assessment | 99% | 96% | 97% | 99% | 98% | 97% | 99% | 99% | 98% | 99% | 99% |
| | Care plan | 91% | 88% | 89% | 92% | 91% | 91% | 92% | 92% | 90% | 88% | 91% |
| | Reassessment | 96% | 94% | 94% | 97% | 96% | 95% | 96% | 97% | 92% | 90% | 93% |
| | Skin inspection | 95% | 93% | 100% | | | | | | | | |
| | Daily skin inspection | 84% | 84% | 85% | 88% | 84% | 86% | 87% | 87% | 86% | 87% | 89% |
| | Total | 95% | 93% | 92% | 94% | 92% | 92% | 94% | 94% | 92% | 91% | 93% |

Figure 1: Trust overview of nursing care indicators for Tissue Viability from May 2013 to March 2014

**Monitoring (External)**

The Trust supports and participates in the NHS Safety Thermometer national audit, which is a point prevalence audit undertaken every month to look at how organisations are delivering harm free care (Figure 2). Every month the Trust submits data on the number of new pressure ulcers and number of old pressure ulcers that are captured on the day of the audit.

New pressure ulcers are defined as any pressure ulcer that develops seventy two hours post admission.

The prevalence data within figure two demonstrates a decline in the number of new pressure ulcers and the Trust is below the national average for new pressure ulcers. The Trust has implemented a number of new initiatives over the preceding year, which will have contributed to the reduction.

- The SSKIN Bundle across all in-patient areas
- The use of the daily harm alert e-mail, which informs nursing staff every day which wards have had a hospital, acquired pressure ulcer.
- The monthly tissue viability forum where the Senior Sister as to attend a forum with either the Matron or Head to discuss any pressure ulcers that have occurred and whether these were avoidable.
- The monthly monitoring of the DATIX reporting system to ensure all pressure ulcers are reported accurately, thus creating a culture of openness and transparency
- The increase in tissue viability education including bespoke ward based training.

Old pressure ulcers are those in which the patient had present on admission. The patient may be receiving care for the pressure ulcer from a community care team and in these incidents, the primary and secondary care teams would work together. There are occasions, when the patients come into hospital with a pressure ulcer but are not known to any care agency. The Trust has a duty of care to escalate to the Clinical Commissioning Group any patients admitted with a community acquired grade three or above pressure ulcer. The Trust will raise a safeguarding concern for patients with a grade four pressure ulcer.

The attached scorecard (figure 3) shows an increase in old pressure ulcers - the Trust can attribute some of this to a more robust reporting and recognition of pressure ulcers on admission to the Trust.

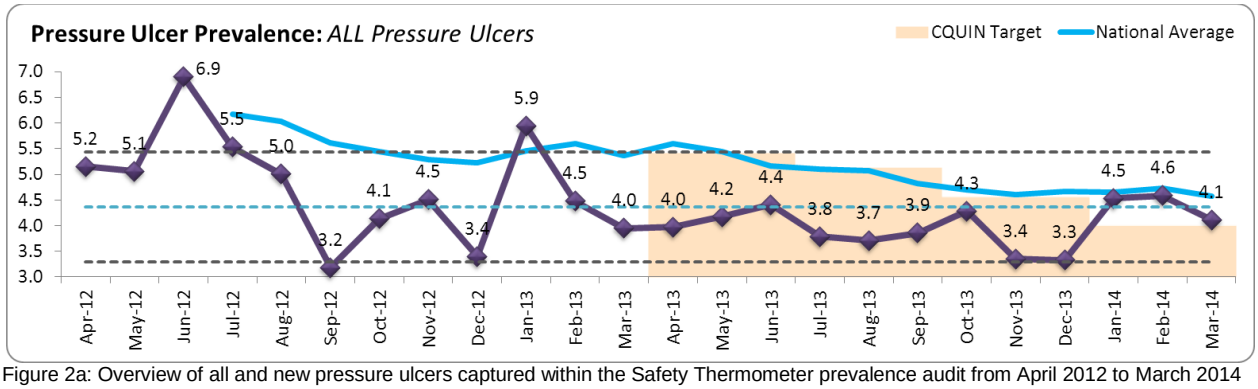


Figure 2a: Overview of all and new pressure ulcers captured within the Safety Thermometer prevalence audit from April 2012 to March 2014

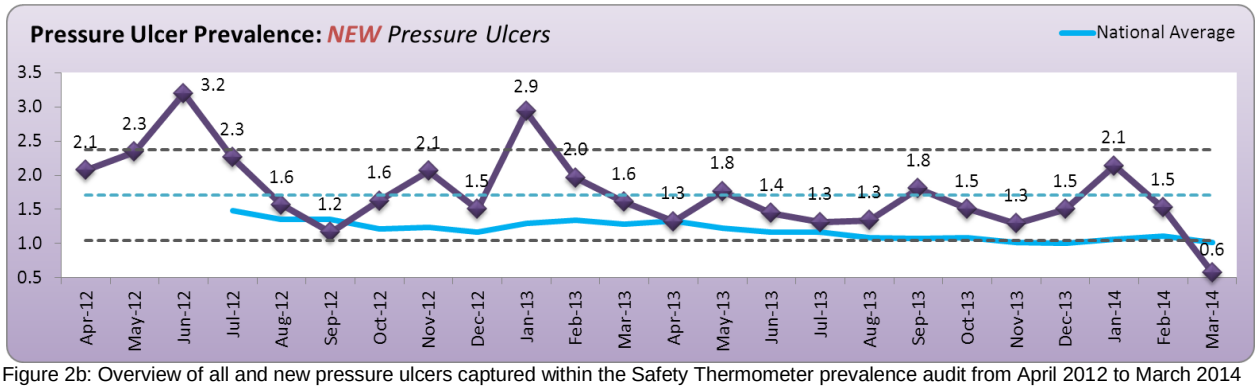


Figure 2b: Overview of all and new pressure ulcers captured within the Safety Thermometer prevalence audit from April 2012 to March 2014

The Trust also produces Your Skin Matters scorecard (See Figure 3 overleaf**)** which triangulates the evidence obtained from the nursing care indicators the avoidability outcomes from any pressure ulcers. The scorecard displays three areas within the Nursing Care Indicators which have not achieved the agreed Trust standard of 95% or above for this quarter. To improve performance the following actions have been taken:

- A revised Performance Framework has been developed with clear actions and levels of responsibility, and the process for issuing performance notices when standards are not met.
- The care plan has been revised and will now be incorporated into the Nursing Risk Assessment Booklet

**Resources and Education**

The Trust recognises having a well-educated workforce improves patient outcomes. Education on the prevention and management of pressure ulcers is delivered in a variety of ways:

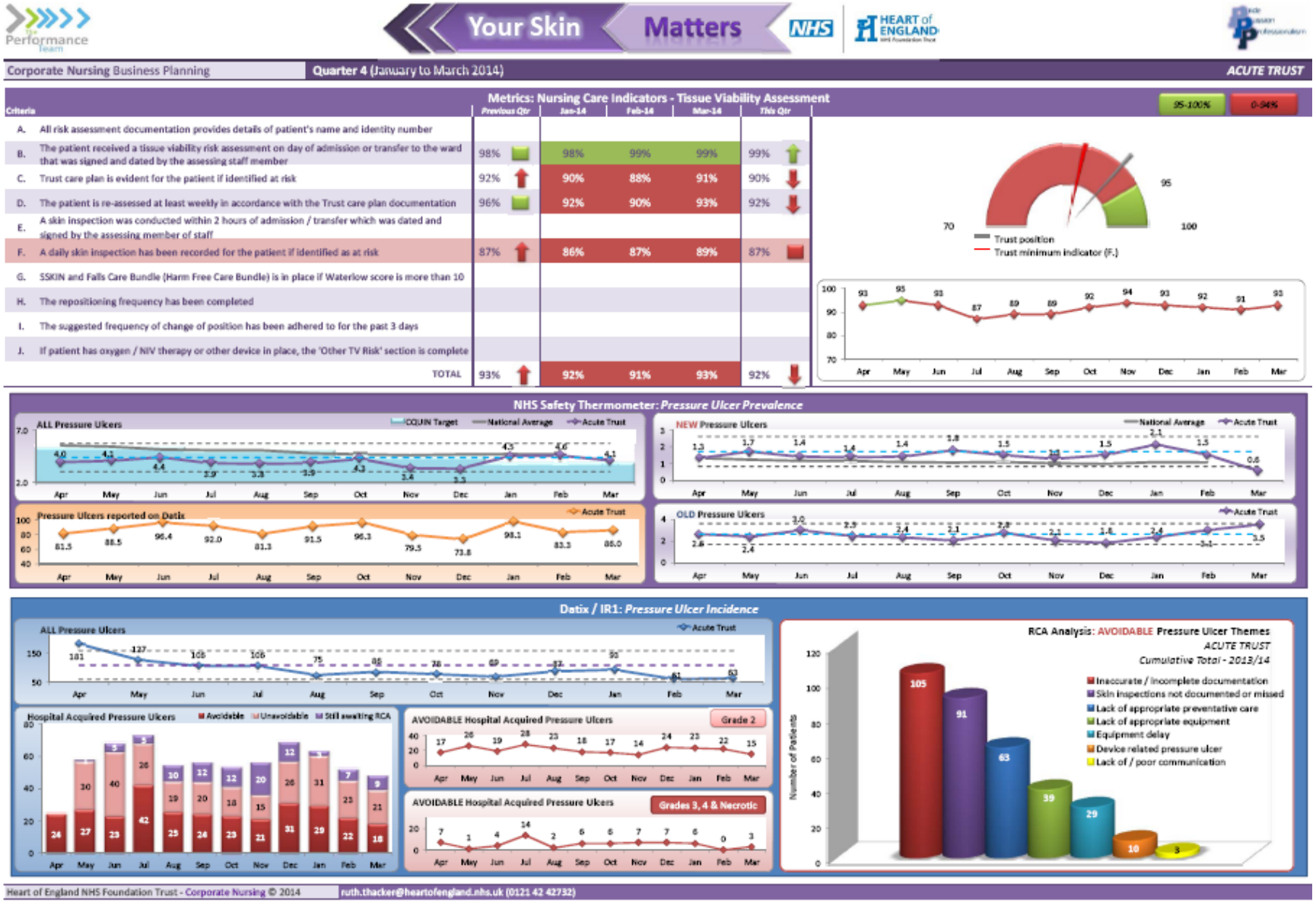
- Access to Tissue Viability Clinical Nurse Specialist Team;
- Monthly study days for both Registered Nurses and Healthcare Practitioners;
- October 2013 saw the introduction of Trust Skill Drills Days where registered nurses receive a 20 minute update on one aspect of tissue viability;
- Link nurses, are nurses who have a special interest in tissue viability and act as champions within their own clinical area for Tissue Viability. To support their role the link nurse has a bespoke training day to enhance their knowledge and skills; and
- Educational material is also accessible via the Intranet site to all practitioners.

**Future plans to improve compliance against the Trust targets:**

The Trust's future plans include:

- To reduce all avoidable pressure ulcers and ultimately reduce harm to patients;
- To continue to develop a well-educated proactive workforce in the management of pressure ulcers;
- To continue to apply new evidence based research in the management and care of pressure ulcers;
- To pilot a modified Midwifery Tissue Viability Assessment Tool; and
- ITU/HDU daily patient records to be amended to have a bespoke SSKIN Care bundle incorporated into them.

**Figure 3**


Your Skin Matters
NHS
HEART of ENGLAND
Corporate Nursing Business Planning
Quarter 4 (January to March 2014)
ACUTE TRUST
Metrics: Nursing Care Indicators - Tissue Viability Assessment
95-100%
0-94%
Criteria
Previous Qtr
Jan-14
Feb-14
Mar-14
This Qtr
A. All risk assessment documentation provides details of patient's name and identity number
B. The patient received a tissue viability risk assessment on day of admission or transfer to the ward that was signed and dated by the assessing staff member
C. Trust care plan is evident for the patient if identified at risk
D. The patient is re-assessed at least weekly in accordance with the Trust care plan documentation
E. A skin inspection was conducted within 2 hours of admission / transfer which was dated and signed by the assessing member of staff
F. A daily skin inspection has been recorded for the patient if identified as at risk
G. SSKIN and Falls Care Bundle (Harm Free Care Bundle) is in place if Waterlow score is more than 10
H. The repositioning frequency has been completed
I. The suggested frequency of change of position has been adhered to for the past 3 days
J. If patient has oxygen / NIV therapy or other device in place, the 'Other TV Risk' section is complete
TOTAL
98% 98% 99% 99% 99%
92% 90% 88% 91% 90%
96% 92% 90% 93% 92%
87% 86% 87% 89% 87%
93% 92% 91% 93% 92%
95
70
100
Trust position
Trust minimum indicator (F.)
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
NHS Safety Thermometer: Pressure Ulcer Prevalence
ALL Pressure Ulcers
COQUIN Target
National Average
Acute Trust
NEW Pressure Ulcers
Pressure Ulcers reported on Datix
OLD Pressure Ulcers
Datix / IR1: Pressure Ulcer Incidence
Hospital Acquired Pressure Ulcers
Avoidable
Unavoidable
Still awaiting RCA
AVOIDABLE Hospital Acquired Pressure Ulcers
Grade 2
Grades 3, 4 & Necrotic
RCA Analysis: AVOIDABLE Pressure Ulcer Themes
ACUTE TRUST
Cumulative Total - 2013/14
Number of Patients
105
91
63
39
29
10
3
Inaccurate / Incomplete documentation
Skin inspections not documented or missed
Lack of appropriate preventative care
Lack of appropriate equipment
Equipment delay
Device related pressure ulcer
Lack of / poor communication
Heart of England NHS Foundation Trust - Corporate Nursing © 2014
ruth.thacker@heartofengland.nhs.uk (0121 42 42732)

# Priority 4: Fractured Neck of Femur

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

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

The national target to meet all elements of best practice pathway is 76.4%.

The Trust continues to make progress in achieving all the 9 indicators and therefore improving the outcomes for patients with hip fracture during 2013/14.

**What is the measure:** The Trust has chosen 4 indicators (highlighted in bold above) to monitor in more detail for this priority. Time to theatre is set at a target of 90% being operated on within 36 hours with a 10% tolerance for medically unfit patients. All other elements of the pathway are targeted at 100%.

**The current end of year overall situation:**

**Trust Wide:**
In 2013/14 756 NOF patients were seen by the Trust compared to 836 patients in 2012/13; a reduction of 9.6%.

There has also been a fall in the number of patients meeting best practice down from 43.4% in 2012/13 to 39.7% in 2013/14.

There have been slight improvements in 2013/14 for the following best practice criteria compared to 12/13; Joint Care (100% v 97.7%), Assessment Protocol (88.5% v 86.1%), MDT Assessment (96.2% v 88.3%), Falls Assessment (95.2% v 91.2%) and Bone Protection Medicine (94.6% v 93.8%).

The biggest deterioration was for Dementia Test 2; 72.8% in 2013/14 v 86.5% in 2012/13. In addition, there was a fall in performance in 2013/14 for the following criteria; Time to Surgery (60.3% v 64.5%), Time to Ortho-Geriatric Assessment (87.4% v 88.2%) and Dementia Test 1 (86.4% v 89.7%).

**Birmingham Heartlands Hospital:**
In 2013/14 413 NOF patients were seen on the Heartlands and Solihull sites compared to 471 patients in 2012/13; a reduction of 12.3%.

There has also been a fall in the number of patients meeting best practice down from 46.9% in 2012/13 to 38.7% in 13/14.

There have been slight improvements in 2013/14 for the following best practice criteria compared to 2012/13; Joint Care (100% v 97.5%), Assessment Protocol (86.7% v 86.6%), Time to Geri

Assessment (94.0% v 93.2%), MDT Assessment (96.9% v 93.0%) and Falls Assessment (94.4% v 89.8%).

There have been deteriorations in 13/14 for the following best practice criteria; Time to Surgery (51.8% v 63.1%), Dementia Test 1 (86.4% v 91.6%), Dementia Test 2 (73.4% v 88.9%) and Bone Protection Medication (93.2% v 96.0%).

**Good Hope Hospital:**
In 13/14 343 NOF patients were seen on the Good Hope site compared to 365 patients in 2012/13; a reduction of 6.0%.

The site has improved the number of patients meeting best practice to 40.8% in 2013/14 compared to 38.9% in 2012/13.

There have been slight improvements in 2013/14 for the following best practice criteria compared to 12/13; Time to Surgery (70.6% v 66.3%), Joint Care (100% v 98.1%), Assessment Protocol (90.7% v 85.5%), MDT Assessment (95.3% v 82.2%), Falls Assessment (96.2% v 92.9%) and Bone Protection Medicine (96.2% v 91.0%)

There have been deteriorations in 2013/14 for the following best practice criteria; Time to Ortho-Geriatric Assessment (79.6% v 81.6%), Dementia Test 1 (86.3% v 87.3%) and Dementia Test 2 (72.0% v 83.5%).

The following information compares performance on 4 identified indicators for 12/13 vs 13/14.

## Time to Theatre Target 36 Hours

The tables below show the performance by site of the key indicators "**surgery within 36 hours**" which the Trauma and Orthopaedic directorate has focused on during the past 12 months. The local target is for 90% of patients should be operated on within 36 hours of admission.

**Birmingham Heartlands 2012 to 2013**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 Patients (number) | 52 | 47 | 45 | 32 | 44 | 43 | 29 | 45 | 47 | 67 | 46 | 41 |
| Patients to Surgery <36 hours | 38 | 23 | 28 | 24 | 25 | 24 | 24 | 33 | 29 | 52 | 25 | 24 |
| Patients to Surgery 36> hours | 14 | 24 | 17 | 8 | 19 | 19 | 5 | 12 | 18 | 15 | 21 | 17 |
| Percentage Passed | 73.1 | 48.9 | 62.2 | 75.0 | 56.8 | 55.8 | 82.8 | 73.3 | 61.7 | 77.6 | 54.3 | 58.5 |

**Birmingham Heartlands 2013 to 2014**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013 Patients (number) | 39 | 41 | 47 | 36 | 46 | 30 | 37 | 36 | 36 | 31 | 27 | 12 |
| Patients to Surgery <36 hours | 27 | 28 | 25 | 19 | 33 | 22 | 23 | 28 | 21 | 22 | 21 | 7 |
| Patients to Surgery 36> hours | 12 | 13 | 22 | 17 | 13 | 8 | 14 | 8 | 15 | 9 | 6 | 5 |
| Percentage Passed | 69.2 | 68.3 | 53.2 | 52.8 | 71.7 | 73.3 | 62.2 | 77.8 | 58.3 | 71.0 | 77.8 | 58.3 |

**Good Hope 2012 to 2013**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 Patients (number) | 34 | 31 | 26 | 30 | 39 | 30 | 25 | 30 | 48 | 31 | 33 | 24 |
| Patients to Surgery <36 hours | 26 | 19 | 15 | 18 | 23 | 17 | 22 | 22 | 27 | 26 | 26 | 19 |
| Patients to Surgery 36> hours | 8 | 12 | 11 | 12 | 16 | 13 | 3 | 8 | 21 | 5 | 7 | 5 |
| Percentage Passed | 76.5 | 61.3 | 57.7 | 60.0 | 59.0 | 56.7 | 88.0 | 73.3 | 56.3 | 83.9 | 78.8 | 79.2 |

**Good Hope 2013 to 2014**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013 Patients (number) | 25 | 30 | 29 | 35 | 27 | 35 | 30 | 31 | 33 | 24 | 31 | 13 |
| Patients to Surgery <36 hours | 23 | 25 | 13 | 24 | 16 | 26 | 15 | 23 | 26 | 17 | 22 | 10 |
| Patients to Surgery 36> hours | 2 | 5 | 16 | 11 | 11 | 9 | 15 | 8 | 7 | 7 | 9 | 3 |
| Percentage Passed | 92.0 | 83.3 | 44.8 | 68.6 | 59.3 | 74.3 | 50.0 | 74.2 | 78.8 | 70.8 | 71.0 | 76.9 |

The service has been able to utilise additional theatre space at Good Hope Hospital to be able to complete minor trauma patients, which has given some capacity in the main operating theatre for the fractured neck of femur patients to be treated.

There has been limited access to additional theatre capacity when demand has been high through admissions. This has had an impact on the Time to Theatre Target for 2013/14 due to vacancies in Trauma Theatres and skill mix across both Good Hope and Birmingham Heartlands Site.

The appointment of 3 new Consultants and implementation of a new trauma rota will assist in the improvement of list planning and assist in the full utilisation of all theatre time in 2014/15.

**Review at Multi-Disciplinary Team (MDT) meeting**

The trust has achieved the 100% local target set for MDT Assessment for three continuous months.

MDT Assessment has remained at 100% at Birmingham Heartlands site with an increase to 100% at Good Hope site. This has been achievable with the introduction of the electronic Jonah and MDT teams meeting each morning and discussing each patient.

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

We failed to meet the local target of 100% of patients having Dementia screen both pre-operative and post-operativly.

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

place. With the introduction of the Ortho-Geriatric input at weekends patients are being reviewed and assessed in a timelier manner. Additional Ortho-Geriatric input at Good Hope is still in its infancy and the Trust are looking that these figures will increase in 2014/15.

**Birmingham Heartlands 2012 to 2013**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 Patients (number) | 52 | 47 | 45 | 32 | 44 | 43 | 29 | 45 | 47 | 67 | 46 | 41 |
| Pre Op AMT Done - Yes | 44 | 44 | 44 | 32 | 43 | 39 | 29 | 44 | 45 | 63 | 38 | 36 |
| Pre Op AMT Done - No | 8 | 3 | 1 | 0 | 1 | 4 | 0 | 1 | 2 | 4 | 8 | 5 |
| Percentage Passed | 84.6 | 93.6 | 97.8 | 100.0 | 97.7 | 90.7 | 100.0 | 97.8 | 95.7 | 94.0 | 82.6 | 87.8 |
| | | | | | | | | | | | | |
| Post Op AMT done - Yes | 46 | 44 | 45 | 32 | 43 | 39 | 28 | 42 | 36 | 56 | 35 | 29 |
| Post Op AMT done - No | 6 | 3 | 0 | 0 | 1 | 4 | 1 | 3 | 11 | 11 | 11 | 12 |
| Percentage Passed | 88.5 | 93.6 | 100.0 | 100.0 | 97.7 | 90.7 | 96.6 | 93.3 | 76.6 | 83.6 | 76.1 | 70.7 |

**Birmingham Heartlands 2013 to 2014**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013 Patients (number) | 39 | 41 | 47 | 36 | 46 | 30 | 37 | 36 | 36 | 31 | 27 | 12 |
| Pre Op AMT Done - Yes | 36 | 40 | 43 | 35 | 42 | 28 | 29 | 26 | 25 | 26 | 20 | 11 |
| Pre Op AMT Done - no | 3 | 1 | 4 | 1 | 4 | 2 | 8 | 10 | 11 | 5 | 7 | 1 |
| Percentage Passed | 92.3 | 97.6 | 91.5 | 97.2 | 91.3 | 93.3 | 78.4 | 72.2 | 69.4 | 83.9 | 74.1 | 91.7 |
| | | | | | | | | | | | | |
| Post Op AMT done - Yes | 35 | 34 | 33 | 26 | 28 | 23 | 20 | 24 | 23 | 26 | 19 | 10 |
| Post Op AMT done - No | 4 | 7 | 14 | 10 | 18 | 7 | 17 | 12 | 13 | 5 | 8 | 2 |
| Percentage Passed | 89.7 | 82.9 | 70.2 | 72.2 | 60.9 | 76.7 | 54.1 | 66.7 | 63.9 | 83.9 | 70.4 | 83.3 |

**Good Hope 2012 to 2013**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 Patients (number) | 34 | 31 | 26 | 30 | 39 | 30 | 25 | 30 | 48 | 31 | 33 | 24 |
| Pre Op AMT Done - Yes | 26 | 25 | 19 | 25 | 35 | 29 | 24 | 27 | 41 | 31 | 32 | 23 |
| Pre Op AMT Done - no | 8 | 6 | 7 | 5 | 4 | 1 | 1 | 3 | 7 | 0 | 1 | 1 |
| Percentage Passed | 76.5 | 80.6 | 73.1 | 83.3 | 89.7 | 96.7 | 96.0 | 90.0 | 85.4 | 100.0 | 97.0 | 95.8 |
| | | | | | | | | | | | | |
| Post Op AMT done - Yes | 16 | 21 | 22 | 25 | 37 | 29 | 24 | 25 | 46 | 30 | 30 | 13 |
| Post Op AMT done - No | 18 | 10 | 4 | 5 | 2 | 1 | 1 | 5 | 2 | 1 | 3 | 11 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage Passed | 47.1 | 67.7 | 84.6 | 83.3 | 94.9 | 96.7 | 96.0 | 83.3 | 95.8 | 96.8 | 90.9 | 54.2 |

**Good Hope 2013 to 2014**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013 Patients (number) | 25 | 30 | 29 | 35 | 27 | 35 | 30 | 31 | 33 | 24 | 31 | 13 |
| Pre Op AMT Done - Yes | 25 | 29 | 26 | 34 | 21 | 31 | 27 | 27 | 21 | 19 | 24 | 10 |
| Pre Op AMT Done - no | 0 | 1 | 3 | 1 | 6 | 4 | 3 | 4 | 12 | 5 | 7 | 3 |
| Percentage Passed | 100.0 | 96.7 | 89.7 | 97.1 | 77.8 | 88.6 | 90.0 | 87.1 | 63.6 | 79.2 | 77.4 | 76.9 |
| | | | | | | | | | | | | |
| Post Op AMT done - Yes | 24 | 27 | 27 | 31 | 14 | 23 | 19 | 21 | 24 | 18 | 20 | 6 |
| Post Op AMT done - No | 1 | 3 | 2 | 4 | 13 | 12 | 11 | 10 | 9 | 6 | 11 | 7 |
| Percentage Passed | 96.0 | 90.0 | 93.1 | 88.6 | 51.9 | 65.7 | 63.3 | 67.7 | 72.7 | 75.0 | 64.5 | 46.2 |

**Combined 2012 to 2013**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 Patients (number) | 86 | 78 | 71 | 62 | 83 | 73 | 54 | 75 | 95 | 98 | 79 | 65 |
| Pre Op AMT Done - Yes | 70 | 69 | 63 | 57 | 78 | 68 | 53 | 71 | 86 | 94 | 70 | 59 |
| Pre Op AMT Done - No | 16 | 9 | 8 | 5 | 5 | 5 | 1 | 4 | 9 | 4 | 9 | 6 |
| Percentage Passed | 81.4 | 88.5 | 88.7 | 91.9 | 94.0 | 93.2 | 98.1 | 94.7 | 90.5 | 95.9 | 88.6 | 90.8 |
| | | | | | | | | | | | | |
| Post Op AMT done - Yes | 62 | 65 | 67 | 57 | 80 | 68 | 52 | 67 | 82 | 86 | 65 | 42 |
| Post Op AMT done - No | 24 | 13 | 4 | 5 | 3 | 5 | 2 | 8 | 13 | 12 | 14 | 23 |
| Percentage Passed | 72.1 | 83.3 | 94.4 | 91.9 | 96.4 | 93.2 | 96.3 | 89.3 | 86.3 | 87.8 | 82.3 | 64.6 |

**Combined 2013 to 2014**

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013 Patients (number) | 64 | 71 | 76 | 71 | 73 | 65 | 67 | 67 | 69 | 55 | 58 | 25 |
| Pre Op AMT Done - Yes | 61 | 69 | 69 | 69 | 63 | 59 | 56 | 53 | 46 | 45 | 44 | 21 |
| Pre Op AMT Done - No | 3 | 2 | 7 | 2 | 10 | 6 | 11 | 14 | 23 | 10 | 14 | 4 |
| Percentage passed | 95.3 | 97.2 | 90.8 | 97.2 | 86.3 | 90.8 | 83.6 | 79.1 | 66.7 | 81.8 | 75.9 | 84.0 |
| | | | | | | | | | | | | |
| Post Op AMT done - Yes | 59 | 61 | 60 | 57 | 42 | 46 | 39 | 45 | 47 | 44 | 39 | 16 |
| Post Op AMT done - No | 5 | 10 | 16 | 14 | 31 | 19 | 28 | 22 | 22 | 11 | 19 | 9 |
| Percentage passed | 92.2 | 85.9 | 78.9 | 80.3 | 57.5 | 70.8 | 58.2 | 67.2 | 68.1 | 80.0 | 67.2 | 64.0 |

**How is this priority measured:**

The figures for fractured neck of femur are discussed at the Clinical Quality Performance Group and the performance of the above is reported on the Key Performance Indicators to the Trust Finance Performance Committee.

Best Practice Tariff for all elements are discussed at fortnightly Trauma Action Group Meeting with all parties of the multidisciplinary team present and actions agreed in areas that require

improvement. The figures are also reported to the Clinical Director at weekly Management Meetings.

**What have we done to improve:**

Birmingham Heartlands Hospital has undertaken bed modelling around trauma beds and as a result it has been identified that further capacity is required to prevent the admission of fracture neck of femur patients to none trauma wards.

Work to improve these indicators across the Trust include:

- The introduction of the electronic Jonah system which has aided in the progression and monitoring of the 36 hour operating target with this deadline being displayed visually;
- Re-introduction of the 19.00pm wards round to establish list planning. This is beginning to aid in the time to theatre target being met with better communication between all teams and better planning of theatre utilisation;
- Fracture neck of femur patients being prioritised first on the operating list to ensure time to theatre is met;
- TAG (Trauma Action Group) meet fortnightly at Birmingham Heartlands site where fractured neck of femur performance is reviewed to insure implementation of previous actions and discussion and documentation / plans made on improving and achieving standards;

**Future plans to improve compliance against the Trust targets:**

- A Trauma Lead surgeon with clear accountability for delivery has been appointed for patients attending theatre.
- A business case has been approved and is being developed to implement a new trauma rota at Birmingham Heartlands Hospital to strengthen the service and improve outcomes even further for patients.
- Appointment of 3 Locum Consultants to assist in making the Trauma service at Birmingham Heartlands Hospital a viable trauma unit.
- Review and introduction of a universal pathway data form is to be introduced across both sites from June 2014 to capture and increase performance;
- A live data base is being piloted with the Data Manager reviewing current records of patients on the wards and raising any areas where assessments have not taken place. Working closely with the Trauma Lead nurse to aid in the improve dementia testing.
- Review of underutilised day case theatre space on Birmingham Heartlands site to accommodate some minor trauma and create additional theatre time in main theatres.
- Proforma to be completed by Consultants for all patients failing to achieve time to theatre within 36hours.
- Information from live data to be shared with Directorate and Consultant body to identify areas of improvement.
- Surgical Reconfiguration includes the proposal to have Trauma on one site with the increase in theatre/bed capacity.

# Priority 5: Stroke

The Trust is responsible for providing a stroke service to 3 sites.

Solihull Hospital provides an 'office hours' hyper acute stroke service with a permanent stroke unit. Good Hope Hospital has the same. Birmingham Heartlands Hospital receives all out of office hours hyper acute stroke patients and provides a 24/7 service. It has a permanent hyper acute stroke unit (HASU) and a permanent acute stroke unit.

Early assessment by stroke specialist teams with care being delivered within defined specialist units is nationally accepted as achieving the best outcomes for stroke patients.

**What is the measure:** Four priorities have been chosen to be prioritised from the acute stroke pathway (listed below) in order to manage patients correctly to achieve the best outcomes.

**How is the priority measured:** These are chosen from a combination of stroke key performance indicators including contract targets and best practice tariff (BPT)[3].

**1. Acute Stroke Patients Thrombolysed – Target 10%.**

This measure is collected a part of hyper acute stroke service measured nationally and reported through SSNAP[4].

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

**2. Direct Admission to Stroke Unit within 4 hours – Target 50%.**

This measure is reported through BPT.

- Focuses on the hyper-acute to acute phase.
- Emergency Department performance in rapid stroke assessment and referral.
- Stroke unit capacity.
- Bed management and protection.

**3. Swallow Assessment for Stroke patients within 4 hours – Target Q1 70% / Q2 77% / Q3 82% / Q4 85%.**

This measure is part of our contracts and is reported as a Key Performance Indicator (KPI) to the commissioners.

- Focuses on the hyper-acute to acute phase.

[3]Best Practice Tariffs (BPTs) aim to reduce unexplained variation in clinical quality and ensure that best practice is widespread. The Department of Health (DH) seeks to structure and price BPTs so that they adequately reimburse and incentivise high quality and cost-effective care. The DH introduced BPTs in 2010/11 and has gradually expanded their range. The DH's policy intention is to continue to increase the number of BPTs.

[4]Sentinel Stroke National Audit Programme – hosted by the Royal College of Physicians. It produces quarterly reports on performance that are made available to the NHS domain and to commissioners. This is a very thorough and intensive ongoing audit of the whole pathway for stroke and transient ischaemic attack (TIA) or 'mini stroke'

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

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

This measure is part of our contracts and is reported as a KPI as above.

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

**What have we done to improve:**

**1. % of Acute Stroke Patients Thrombolysed – Target 10%.**

Currently the performance is below expected national figures but regional variations are accepted. The Trust needs to ensure that its data capture on SSNAP is consistent to include all stroke patients.

| | Q1 12/13 | Q2 12/13 | Q3 12/13 | Q4 12/13 | Q1 13/14 | Q2 13/14 | Q3 13/14 | Q4 13/14 |
|---|---|---|---|---|---|---|---|---|
| % of acute stroke patients thrombolysed | 4.1% | 6.0% | 2.2% | 2.8% | 3.9% | 4.3% | 6.2% | 7.1% |

6.2% equates to the figure nationally and a fair figure for the population the Trust serves. There is no evidence that the Trust misses opportunities to thrombolyse patients.

The figures show a progressive increase in numbers thrombloysed over 13/14. 10% is a target for the Trust, however local variations to this figure are expected. There is a scrutiny process to ensure that opportunities to thrombolyse patients are minimised in the current circumstances.

**What have we done to improve:**

The out of hours service moving to Birmingham Heartlands Hospital has shown improvements in the numbers of patients thrombolysed. This has coincided with an increase in stroke volume meaning the percentage rise has been less obvious.

**Future plans to improve compliance against the Trust targets include:**

All hyperacute stroke services moving to BHH from SH and GHH with the increased specialist workforce across medicine and nursing is expected to improve the pathway through economy of scale, availability of newer imaging techniques and more complex thrombolysis treatments.

This is one of the purposes of the Trust and Regional reconfiguration.

**2. % of Direct Admission to Stroke Unit within 4 hours – Target 50%.**

Capacity throughout the 3 sites remains a challenge. Recent changes to operating procedures with regards to the protection of stroke beds, as well as the relocation of HASU at Birmingham Heartlands Hospital, have facilitated an improvement in performance. Each site needs to continue to focus on keeping specialist bed capacity free to enable further improvements in performance.

| Percentage of Patients Directly Admitted to Stroke Unit within 4 hours | | | | |
|---|---|---|---|---|
| | **Q1 13/14** | **Q2 13/14** | **Q3 13/14** | **Q4 13/14** |
| Heartlands | 44% | 68% | 64% | 73% |
| Good Hope | 41% | 58% | 38% | 47% |
| Solihull | 19% | 30% | 38% | 44% |
| HEFT | **25.3%** | **36.4%** | **45.1%** | **51.4%** |

The Trust figure overall is improving but is not at the level the Trust strives for going forward. This is possibly the single most evidence based intervention for stroke patients. An early admission to a stroke unit generally means early assessment by specialists and less variation in treatment and care. The stroke services are affected by capacity issues during peak times of the year.

Birmingham Heartlands Hospital has managed bed protection and flow to gain access to HASU beds progressively throughout 2013/14. This has been through collaboration with the Emergency Department, the Acute Medicine Department and through changing HASU locations and priorities. Birmingham Heartlands Hospital has also been able to extend specialist nursing cover to allow early assessment and facilitation of admissions.

Good Hope Hospital figures have remained reasonably static in performance and this is affected by overall site capacity.

Solihull Hospital has improved performance steadily but remains below target.

**What have we done to improve:**

The out of hours service moving to Birmingham Heartlands Hospital has improved Trust figures as more patients are meeting the targets at Birmingham Heartlands Hospital and out of hour missed targets on the pathway are reduced at Good Hope Hospital and Solihull Hospital.

**Future plans to improve compliance against the Trust targets include:**

All hyperacute stroke services moving to Birmingham Heartlands Hospital from Solihull Hospital and Good Hope Hospital with the increased specialist workforce across medicine and nursing is expected to improve the pathway.

Specialist nursing cover will be extended to 24/7 from June 2014 at Birmingham Heartlands Hospital.

The out of hours service move will alter capacity needs at Birmingham Heartlands Hospital and work is in progress to build a new HASU at the Heartlands site with additional capacity to cope with the increased flow.

This is one of the purposes of the Trust and Regional reconfiguration.

**3. % of Stroke Patients with a Swallow Assessment Completed within 4 hours – Target Q1 70% / Q2 77% / Q3 82% / Q4 85%.**

This performance is directly related to specialist nursing cover which has been acknowledged in the reconfiguration and recruitment new posts which is currently underway. 24/7 cover from a specialist nurse team is essential in order to gain improvement with this measure.

| Percentage of Stroke Patients with a Swallow Assessment Completed | | | | |
|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 |
| Birmingham Heartlands | 47.8% | 61.4% | 72.7% | 84.6% |
| Good Hope | 73.9% | 84.9% | 75.0% | 59.3% |
| Solihull | 65.1% | 64.4% | 78.2% | 81.0% |
| Trust | 63.18% | 74.2% | 75.6% | 75.9% |

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

This was not being provided 24/7. In December 2013 the Trust invested in 2 secondments for 6 months to try address this at Birmingham Heartlands Hospital, where the out of hours stroke service is based. This is expected to improve the metric for Birmingham Heartlands Hospital and the Trust as a whole, but there are still gaps at Solihull Hospital and Good Hope Hospital sites that require further discussion and potential investment.

Nationally again the Trust sits just above the average.

**What have we done to improve:**

Out of hours service moving to Birmingham Heartlands Hospital has shown improvements in the numbers of patients seen at the site where performance is best managed out of hours. This has in turn improved the percentage performance at Solihull Hospital as the failure to hit the targets were mainly out of hours.

Good Hope Hospital have had a transition in specialist nursing and this has caused a drop in performance. Two new posts are now in place and will be covering 7 days. This will secure an improvement in performance at Good Hope Hospital.

**Future plans to improve compliance against the Trust targets include:**

All hyperacute stroke services moving to Birmingham Heartlands Hospital from Solihull Hospital and Good Hope Hospital with the increased specialist workforce across medicine and nursing is expected to improve the pathway.

Specialist nursing cover will extend to 24/7 from June 2014 at Birmingham Heartlands Hospital and this is the main marker for swallow performance. As all hyperacute services move to Birmingham Heartlands Hospital where immediate 24/7 assessment is available, the performance for the Trust as a whole will improve.

Prior to this the teams on all sites have been informed that rapid assessment of stroke patients in the Emergency Department, which will include swallow screens, is a priority.

This is one of the purposes of the Trust and Regional reconfiguration.

### 4. % of Patients Spending 90% of Hospital Stay in a Stroke Unit – Target 80%.

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

| Percentage of Patients Spending 90% of stay in a Stroke Unit | | | | |
|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 |
| Birmingham Heartlands | 89.7% | 90.0% | 91.7% | 86.0% |
| Good Hope | 86.2% | 89.6% | 85.0% | 78.4% |
| Solihull | 68.8% | 83.9% | 76.2% | 79.6% |
| Trust | 82.3% | 88.3% | 83.7% | 82.2% |

These are consistently stable figures that are reasonable but the Trust is aiming for 90% compliance. This is associated to the direct admission metric as anyone who has a short length of stay who is not initially admitted to a stroke unit is likely to fail this metric. Nationally the Trust sits just within the upper quartile (best performing organisations).

**What have we done to improve:**

The Trust better manages the flow from HASU to ASU and looks after all stroke patients at all stages of the pathway in stroke units wherever possible.

**Future plans to improve compliance against the Trust targets include:**

This is very closely linked to the 4 hour admission standard as direct admission to a stroke unit will ensure this standard. Thus capacity needs to be sufficient to not only allow front door access, but also to allow stroke patients to be looked after by stroke specialist teams for the entirety of their hospital stay. Thus the proposed changes in staffing and centralisation of hyperacute care as well as bed protection will improve compliance with this important indicator.

# Priority 6: Dementia Care

Dementia and delirium are two of the commonest problems encountered by older people, resulting in increased rates of death and harm in hospital. Evidence shows that identification of patients with dementia, and, implementation of simple tools, such as 'about me' lead to a large improvement in this position. Management of acute confusional states requires a standardised approach, which is not covered by current training standards for work in an acute hospital.

This priority measures four standards, in an attempt to identify how the Trust, as an organisation, is responding to the challenge of caring for dementia. As an acute trust, at any one time and in any clinical area 20-40% of patients will have a dementing illness. These four standards were selected by the dementia strategy and steering group as valuable in monitoring Trust progress in addressing the needs of our patients.

| Standards | Previous Position | Current Position | Future Aims |
|---|---|---|---|
| **S1:** Every unplanned admission for a patient aged over 75 to result in querying dementia as a known diagnosis. **Target 90%**<br><br>**[Note: The target was changed midyear to querying dementia within 72 hours following admission]** | This was requested with central collection of the data. A computerised tool was developed to make this easier. | This is now a Trust requirement. Access is at the same time as prescribing medication.<br><br>At March 2014 the % of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening question was 69.5% | • Implementation of new care pathway making collection of this data central to patient care.<br>• Continuing education so that staff are clear why this is important for their patients;<br>• Creation of a clear care bundle / pathway<br>• Creation of metrics for ward managers to manage the implementation. |
| **S2:** Every patient with potential dementia to have communication with primary care teams. | There was no standardised way for this to happen. It was not possible to communicate with the community mental health team (CMHT) other than on an ad-hoc basis. | Now standardised advice given on how to communicate. Previous figures represented a sample of discharge letters to primary care. Further work is needed to develop robust data to measure compliance with this target. | • Integrate local IT system so information collected for patients with dementia or where dementia is suspected is automatically passed to primary care<br>• Urgent need to improve cover at Solihull site. 0.5 consultant required initially<br>• Integrate Trust system with the Mental Health Trust IT system |
| **S3:** Joint elderly care medicine and old age psychiatry expertise to be routinely available | Old age psychiatry was provided as an external service, with presence only at the | RAID plus liaison model implemented across the Trust. Old age psychiatry | Permanent Old age Psychiatry presence at Solihull site, supporting |

| | | | |
|---|---|---|---|
| on all three sites for older people in need. | Solihull site (sporadically). No appointed lead for dementia. No elderly care dementia specialist. | available at Heartlands site, with joint liaison at Good Hope and no current Consultant at Solihull site though one member of the team does have training in older adult mental health. | experienced Elderly Care Team. |
| **S4:** Care of delirium will be standardised and improved. | A Clinical guideline was available which offered advice only. There was no standardised diagnostic tool or approach. | A new guideline approved by the Trust across all 3 sites. Agree initial assessment method in Emergency Department, rapid assessment / triage point. Agreed method of assessment of confusion in AMU assessment (Solihull) Trust Medical Director is now the Executive lead for dementia | • Increasing education, including involvement of acute medicine.<br>• Changes to clerking documentation planned.<br>• 12 month educational rollout programme beginning.<br>• Embed 'About me' |

The Trust will be using NICE guidance on delirium and dementia to assist with this as well as the Prime Minister's Challenge[5].

[5] The Prime Minister's challenge on dementia builds on the achievements of the existing National Dementia Strategy.
The Prime Minister has set out his dementia challenge to society, the medical profession, business and Government, alongside the Alzheimer's Society publishing their report 'Dementia 2012: A national challenge'.

The government will focus on improving the areas that matter most for dementia:

- awareness
- quality care
- research

# Priority 7: Discharge Arrangements

**What is the measure:** To improve communication relating to discharge arrangements for patients and relatives

**What have we done to improve:** The Trust has developed an electronic system, called e-Jonah to help staff manage and improve the patient discharge process. This electronic system identifies key teams involved in the discharge process for any particular patient and highlights delays or issues leading to unnecessary delays to discharge. The benefits expected from the system are:

- Improve patient safety and patient experience;
- Timely clinically appropriate discharge;
- Reduced length of stay and readmissions;
- Systematic approach to reducing causes of delay;
- Improved cross boundary communication;
- Improved internal communication;
- Visual management of the pathway;
- Clear escalation process; and
- Bedside to board information identifying constraints.

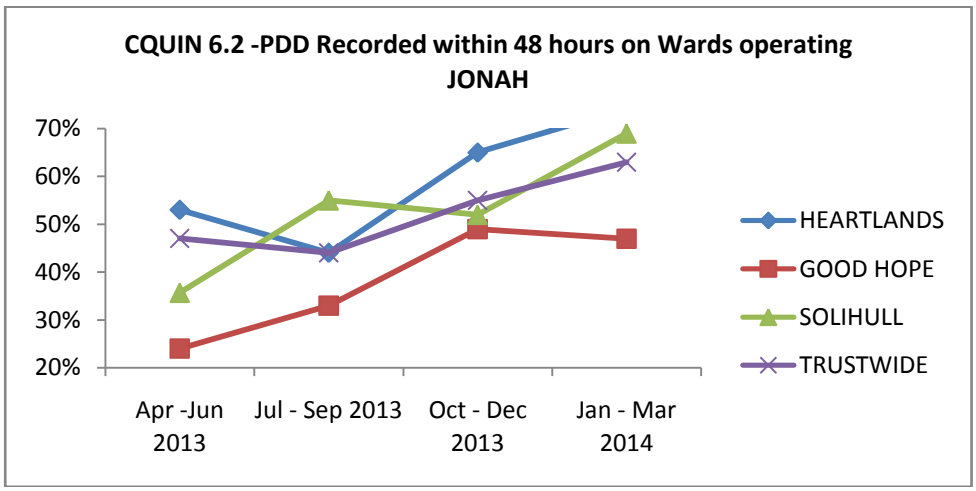
The system is now established across the inpatient areas (excluding paediatrics, maternity and gynaecology) at Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. Maternity is also currently looking to implement the system at Good Hope Hospital.

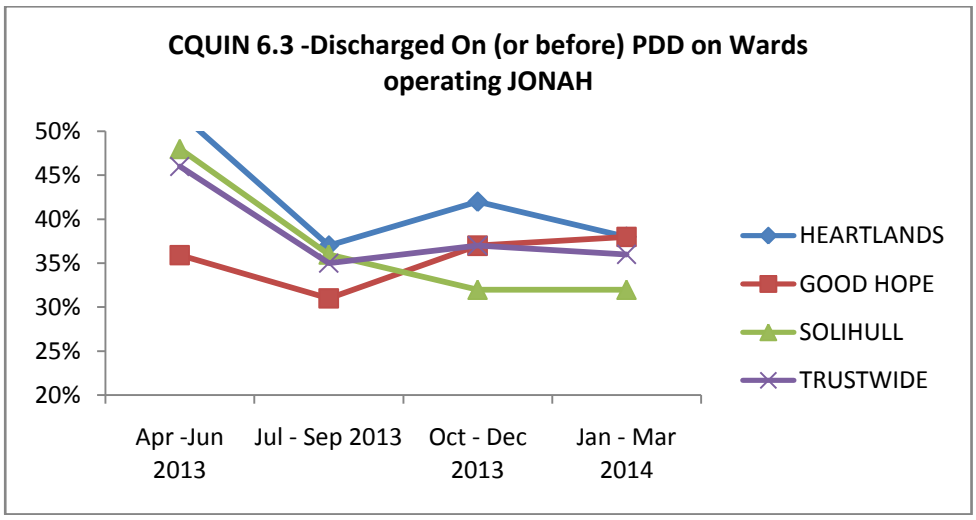
**How is the priority being measured:** This initiative is being monitored by our commissioners through a related CQUIN (explained on page 33).

**What improvements have been put in place:**

- 100% of identified wards across the Trust are utilising the electronic monitoring system;
- % of patients across the Trust who received a PDD (predicted date of discharge) within 48 hours of admission was 47% at the start of the project – current Trust performance is 55%; and
- % of patients who went home before or on their D4D (date for discharge) was 19% - current Trust performance is 38%.

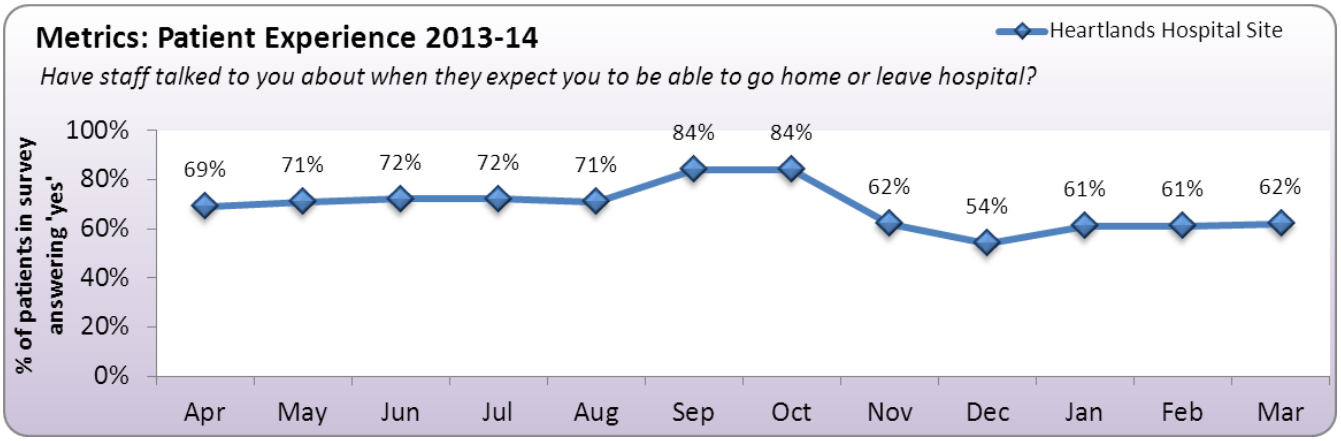
The Trust monitors progress against the numbers of patients given a predicted date of discharge within 48 hours of admission and the numbers of patients who go home on or before their date for discharge.





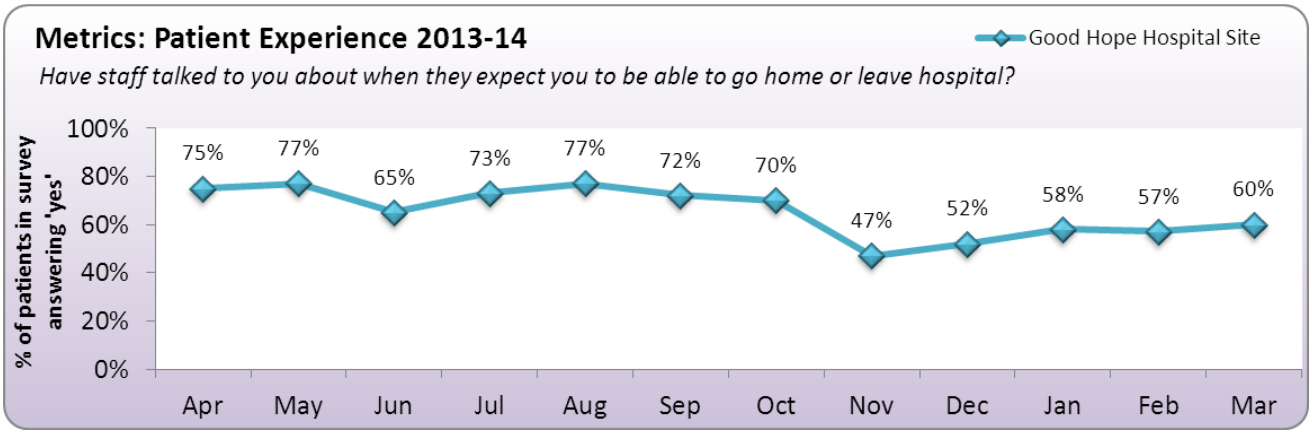

Performance against these indicators reflect that the Trust rolled the system out in a methodical way by site and that the sites were at different stages of embedding the process.

**Future plans for improvement:** The Trust is aiming to increase the patient experience metrics relating to patients knowing when they are going home and although the Trust had seen an increase in performance, this deteriorated over the latter part of the year. The rationale for the Trust wide dip in performance is currently unclear however it is likely that this is due to data collection issues. The Trust is currently embedding a care bundle approach called SAFER[6] which comprises of a number of key actions to minimise delays, proactively plan discharge and create hospital flow. This is still a very new initiative and therefore performance indicators are not yet available. However, these will be developed in year to track progress with performance.




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

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


Metrics: Patient Experience 2013-14
Good Hope Hospital Site
Have staff talked to you about when they expect you to be able to go home or leave hospital?
% of patients in survey answering 'yes'
100%
80%
60%
40%
20%
0%
75%
77%
65%
73%
77%
72%
70%
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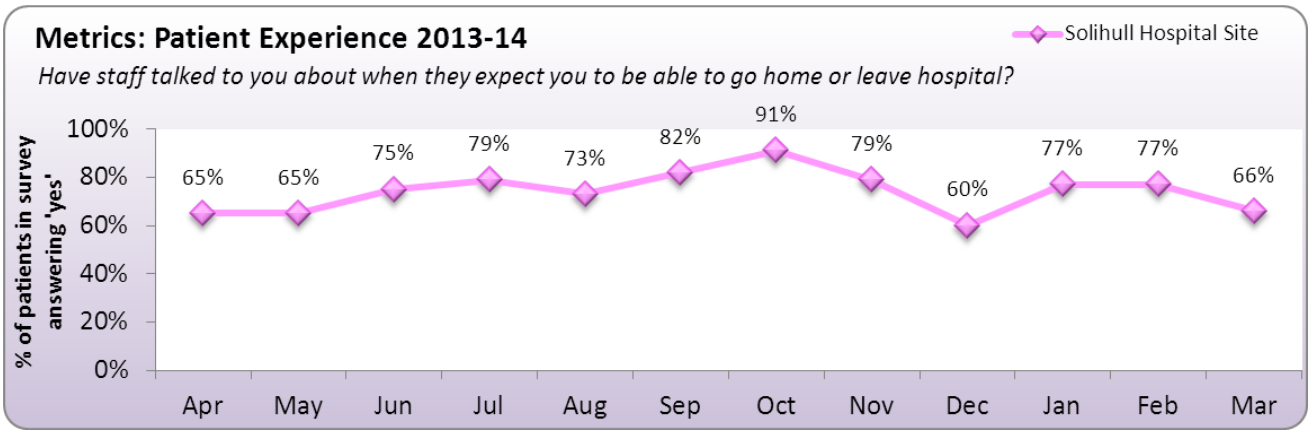
Metrics: Patient Experience 2013-14
Solihull Hospital Site
Have staff talked to you about when they expect you to be able to go home or leave hospital?
% of patients in survey answering 'yes'
100%
80%
60%
40%
20%
0%
65%
65%
75%
79%
73%
82%
91%
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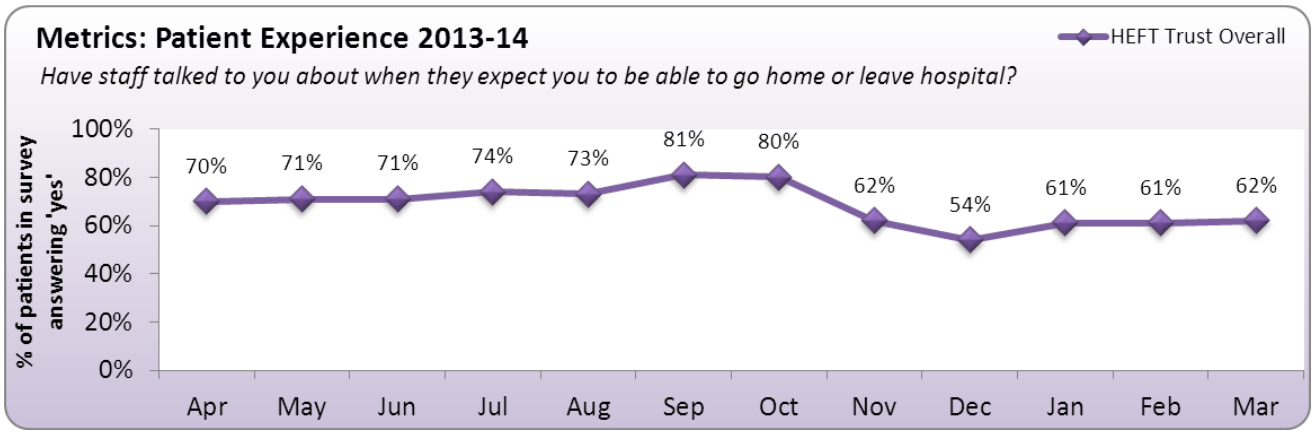
Metrics: Patient Experience 2013-14
HEFT Trust Overall
Have staff talked to you about when they expect you to be able to go home or leave hospital?
% of patients in survey answering 'yes'
100%
80%
60%
40%
20%
0%
70%
71%
71%
74%
73%
81%
80%
62%
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**The official launch of the new first of its kind Cedarwood Rehabilitation service**

As part of the Collaborating Care Programme (CCP), the Hospital has been working with local provider, Midland Heart, to provide this exciting new service, which is unique to Good Hope Hospital, to act as a stepping stone for patients **who are ready to be discharged but not ready to return home**.

Based on ward 26 of the Sheldon Unit, the service consists of 29 private, modern and comfortable bedrooms, a garden, communal area and restaurant bringing together independent living with support services.

Focusing on a person-led care plan, it enables older patients to re-familiarise themselves with essential personal skills required to help them live independently, reducing the chances of readmission to hospital once discharged.

Trust chief executive, Mark Newbold and experienced TV presenter, Esther Rantzen CBE, were present to open the fantastic new facility. There were over 100 attendees at the event who were given the opportunity to take a tour of the facility and meet some of the patients and see the changes it has helped to instigate in their lives.

Esther Rantzen CBE, said: “Older people can sometimes feel that it’s not safe to go back home, not feel able to go home or not want to be home alone. Here, we have a rehabilitation facility which has worked due to collaboration by practical people who know how to make an idea become reality.”

Liz Hamilton, capacity site lead, said: “The CCP programme and Cedarwood service offer a great example as to how hospitals are looking at alternative solutions with financial budgets available to them.

“The CCP will work alongside a community follow-up service aimed at preventing patients from representing at A&E within seven days of discharge.

“We need to use our budgets to the best effect and continuing to provide life-saving services is essential. Lack of beds is a major problem but Cedarwood will enable continuation of care in line with a patient’s requirements without compromising welfare.”

Referrals to the short-term accommodation facility will be delivered through a dedicated assessment team working with Healthcare at Home’s Care Bureau.

# Part 2:
# Looking forward: Priorities for Quality Improvement 2014/15

Looking forward, the Executive Management Team has decided to continue looking at all seven priorities during **2014/15** with the agreement of the Governors' Patient Experience Committee (a subcommittee of the Council of Governors which includes public, patient and staff governors), following consideration of performance in relation to patient safety, patient experience and effectiveness of care. This will ensure that quality will continue to be measured, maintained and developed in all of these priorities and enable comparison against progress.

# Part 2:
# Looking Back: Review of Services/ Statements of Assurance from the Board

The Quality Account & Report has the dual function of looking backwards and forwards. This section includes statements which are mandated by the Department of Health. The aim of this nationally requested content is to give information to the public that is common to Quality Accounts across all trusts.

These statements demonstrate that the organisation is:

- Performing to essential standards;
- Measuring our clinical processes and performance; and
- Involved in national projects and initiatives aimed at improving quality.

The data reviewed covers the three dimensions of quality which are patient safety, clinical effectiveness and patient experience and this objective has not been impeded due to availability of data.

# Service Income

During 2013-14 the Heart of England NHS Foundation Trust provided and / or sub-contracted 81 relevant health services.

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

The income generated by the relevant health services reviewed in 2013-14 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 2013-14.

# Clinical Audit

During 2013/14, 32 national clinical audits and 4 national confidential enquiries covered relevant health services that Heart of England NHS Foundation Trust provides.

During 2013/14 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 2013/14 are as follows (**Table 1**):

Table 1: National Clinical Audits and National Confidential Enquiries

| Audit Title | Participation in 2013-2014 | Submission % |
|---|---|---|
| 1.Acute coronary syndrome or Acute myocardial infarction (MINAP National Institute for Cardiovascular Outcomes Research) | Yes | 100% |
| 2.Adult Cardiac Surgery (National Institute for Cardiovascular Outcomes Research) | Not applicable to the Trust | |
| 3.Ad<br>ult Critical Care (Intensive Care National Audit and Research Centre) | Yes | 100% |
| 4.Bowel Cancer (National Bowel Cancer Audit Programme) (NHS Information Centre) | Yes | 100% |
| 5.Cardiac Arrhythmia (HRM National Institute for Cardiovascular Outcomes Research) | Yes | 100% |
| 6.Chronic Obstructive Pulmonary Disease (COPD(Royal College of Physicians) | Yes | 100% |
| 7.Congenital heart disease (Paediatric cardiac surgery) (National Institute for Cardiovascular Outcomes Research) | Not applicable to the Trust | |
| 8.Coronary Angioplasty (National Institute for Cardiovascular Outcomes Research) | Yes | 100% |
| 9.Diabetes (Adult) (NHS Information Centre) | Yes | 100% |
| 10.Diabetes (Paediatric) (Royal College of Child Health and Paediatrics) | Yes | 100% |
| 11.Elective surgery (National PROMS Programme) | Yes | 100% |
| 12.Emergency use of oxygen (British Thoracic Society) | Yes | 100% |
| 13.Epilepsy 12 (Childhood Epilepsy) (Royal College of Child Health and Paediatrics) | Yes | 100% |
| 14.Falls and Fragility Fractures Audit Programme (FFFAP Royal College of Physicians) | Yes | 100% |
| 15.Head and neck oncology (DAHNO NHS Information Centre) | Yes | 100% |
| 16.Heart failure (National Institute for Cardiovascular Outcomes Research) | Yes | 100% |
| 17.Inflammatory bowel disease (Royal College of Physicians) | Yes | 100% |
| 18.Lung cancer (NLCA NHS Information Centre) | Yes | 100% |
| 19.Moderate or severe asthma in children (care provided in Emergency Departments - College of Emergency Medicine) | Yes | 100% |
| 20.National Audit of schizophrenia (Royal College of Psychiatrists) | Not applicable to the Trust | |
| 21.National audit of Seizure Management (NASH University of Liverpool) | Yes | 100% |
| 22.National Cardiac Arrest Audit (Intensive Care National Audit and Research Centre ICNARC) | Yes | 100% |
| 23.National comparative audit of blood transfusion (NHS Blood and Transport) | Yes | 100% |
| 24. National emergency laparotomy audit (NELA Royal College of Anaesthetists) | Yes | 100% |
| 25.National joint registry (National Joint Registry Centre) | Yes | 100% |
| 26.National Vascular Registry (Royal College of Surgeons) | Yes | 100% |
| 27.Neonatal intensive and special care (NNAP Royal College of Child Health and Paediatrics) | Yes | 100% |
| 28.Oesophago-gastric cancer (NAOGC Royal College of Surgeons) | Yes | 100% |
| 29.Paediatric asthma (British Thoracic Society) | Yes | 100% |
| 30.Paediatric Intensive Care (PICANet) | Not applicable to the Trust | |
| 31.Paracetamol overdose (care provided in emergency in emergency departments)(College of Emergency Medicine) | Yes | 100% |
| 32.Prescribing Observatory (Royal College of Psychiatrists) | Not applicable to the Trust | |
| 33.Renal replacement therapy (Renal Registry) (NHS Blood and Transplant, Organ Donation and Transplantation Directorate) | Yes | 100% |
| 34.Rheumatoid and early inflammatory arthritis | Yes | ongoing |
| 35.Sentinel Stroke National Audit Programme (SSNAP Royal College of Physicians) | Yes | ~50% |
| 36. Severe sepsis &septic shock (College of Emergency Medicine) | Yes | 100% |
| 37. Severe Trauma (Trauma Audit and Research Network TARN) | Yes | 100% |
| 38. Paediatric Bronchiectasis (British Thoracic Society) | No - audited locally | |
| 39. Child health programme | Not applicable to the Trust | |
| 40. Maternal infant and newborn clinical outcome review programme MBRRACE-UK | Yes | 100% |
| 41. Medical and surgical programme NCEPOD<br>• NCEPOD – Tracheostomy Care Study<br>• NCEPOD – Lower Limb Amputation Study<br>• NCEPOD – Gastrointestinal Haemorrhage Study | <br>Yes<br>Yes<br>Yes | <br>100%<br>100%<br>100% |
| 42.Mental Health programme NCISH | Not applicable to the Trust | |

The national clinical audits and national confidential enquiries that Heart of England NHS Foundation Trust participated in during 2013/14 are shown in the second column in Table 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 2013/14, are listed in the third column in Table 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Reviewing reports of national and local clinical audits

The reports of 21 national clinical audits were reviewed by the provider in 2013/14 and Heart of England NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- Following participation in the Acute Coronary Syndrome audit, the organisation has undertaken a process mapping session to increase efficiency around the process.
- The Coronary Angioplasty audit has resulted in the Trust continuously liaising with ambulance staff to improve its processes as well as build a Day Case Unit to treat and transfer patients.
- The Heart Failure audit has highlighted the need to improve data submitted from Good Hope Hospital, thus a dedicated Specialist Registrar will have time built in on a weekly basis to capture all relevant cases.
- Following participation in the Oesophago-gastric Cancer audit, the Trust continues to conduct internal audits targeting mortality surrogate markers as well as review outcome data regularly.
- The Epilepsy 12 audit has resulted in the Trust updating its guidelines to increase the number of children receiving an ECG and MRI for convulsive episodes, as well as introducing targeted discussions at junior doctor teaching sessions.
- To ensure that regular data is fed into the National Joint Registry, a dedicated clerk has been put in place to input forms collected from the wards and the process is being assessed monthly.
- The Hip Fracture Database performance figures continue to be discussed at monthly directorate meetings. Following a job planning exercise, the Trauma and Orthopaedic trainees have been reconfigured to support the orthogeriatrician so that more sessions can be provided which has resulted in a weekday 9am-5pm service.
- As a result of the Trauma audit, the Trust has issued training and posters for staff around the risk of under-triaged patients and when to activate the trauma team.
- The Fractured Neck of Femur audit has seen improvements to the assessment system in order to facilitate rapid administration of analgesia. Also, a receptionist has been secured for 6 months to address winter pressures from 10am to midnight during Monday to Friday, to ensure Ambulance Staff presenting patients with suspected fractured neck of femur are seen as a priority.
- Following participation in the Fever in Children audit, a traffic light system has been implemented successfully. Also, learning from the audit has been disseminated throughout the organisation through posters and risky business forums for staff.
- The Renal Colic audit has highlighted the importance of pain scores, repeat pain scores and appropriate analgesia which have all been included in the regular Emergency Department staff education programme.

The reports of 94 local clinical audits were reviewed by the provider in 2013/14 and Heart of England NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- An audit into the use of Propess versus Prostin has resulted in the Trusts Induction of Labour guideline being updated.

- Following an audit of consent for elective caesarean section, the need for a standardised consent form was highlighted. This is currently being developed by the organisations Stepps Programme.
- A case review of patients admitted with a stent thrombosis, revealed that improvements could be made with regards to stents. The April lesson of the month initiative was used to publicise the key issues. The anti-platelet card has been reintroduced and each operator's case is analysed through regular mortality and morbidity meetings.
- An audit into the management of sepsis in acute medical admissions has resulted in targeted training on sepsis for junior doctors as well as issuing quick reference sepsis 6 guidance cards and key chains.
- Following an audit into preventing wrong site surgery in Radiology, useful learning has been presented at the directorate audit meeting.
- An audit into the initial management of vulval cancer has ensured that the guidelines are available to staff in various formats to ensure referral practices and processes for documenting locations of biopsy sites is followed.
- A case review of patient with negative laparoscopies for ectopic pregnancy has resulted in the Ectopic Pregnancy Guideline being revised.
- The joint British HIV Association (BHIVA)/British Association of Sexual Health and HIV (BASHH) national clinical audit of HIV partner notification has identified the need to develop a brief protocol for partner notification in HIV which is under development.
- The findings from inpatient amputation mortality audit have been disseminated amongst vascular anaesthetists and surgeons to further reduce mortality.
- Two audits against care quality in rheumatoid arthritis have identified the need to complete annual health assessment questionnaires for all suitable patients, and to improve documentation of Disease Activity Score 28 score in patients at each clinic visit.

# Research

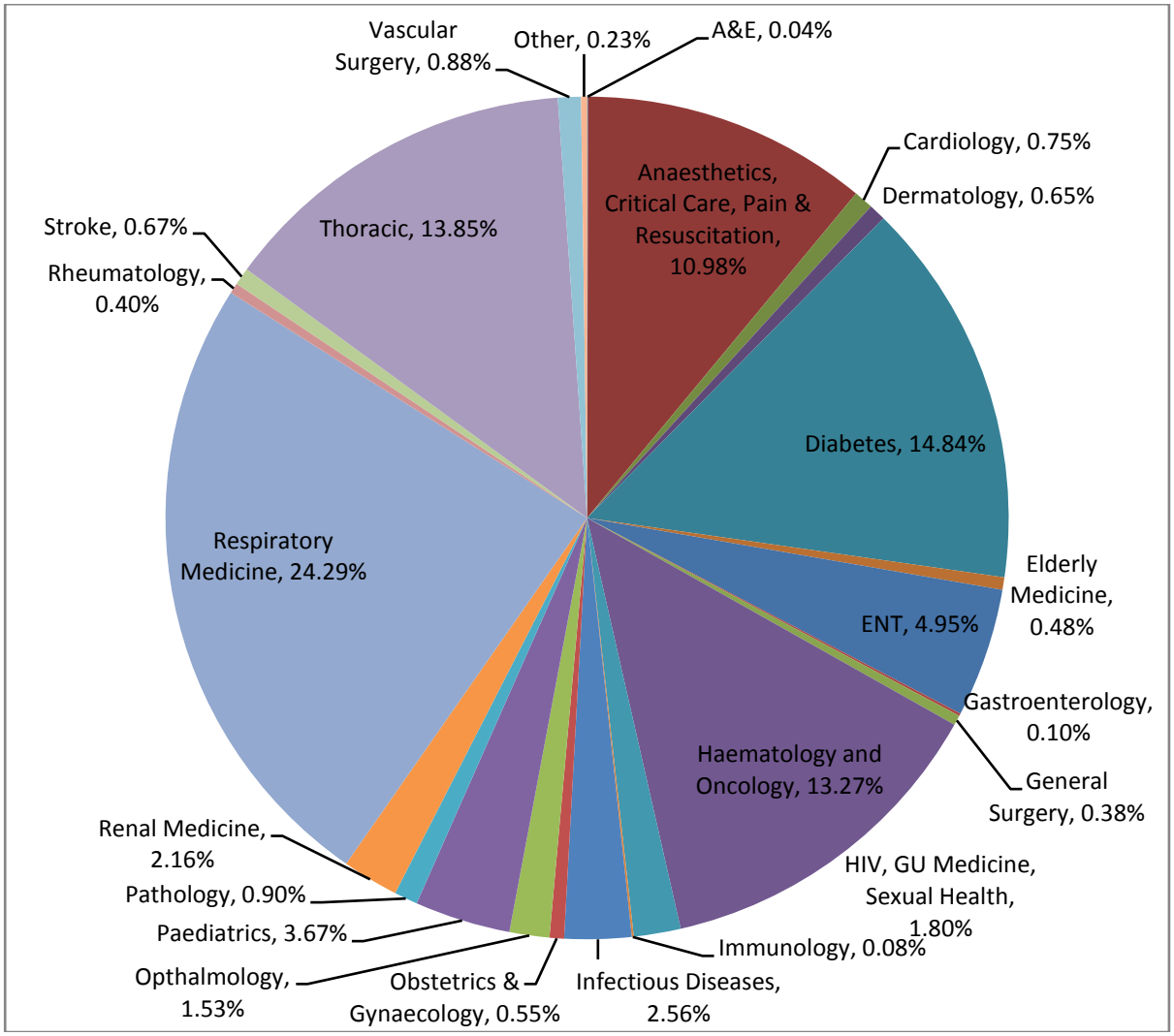
Over 400 research projects are being undertaken across the Trust in various stages of activity from actively recruiting patients into new studies to long-term follow-up. There are 23 departments across the Trust currently taking part in research with between one and six research active consultants in each of these areas. The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2013/14 that were recruited during that period to participate in research approved by the Research Ethics Committee was 5,626 patients in 2013/14. This was compared with 4,013 in 2012/13, an increase of 28%.

Clinical trials are the largest research activity performed at the Trust, in terms of project numbers. We have a mixed portfolio of commercial studies and academic studies, the majority of which are adopted on to the National Institute for Health Research (NIHR) portfolio.

Non-portfolio work is also undertaken and this comprises commercial clinical trials, student based research or pilot studies for future grant proposals. Patient recruitment is highest in anaesthetics, pain, critical care and resuscitation, diabetes, haematology and oncology, respiratory medicine and thoracic surgery.

Over the last 12 months the Trust has doubled its recruitments into NIHR portfolio adopted trials, with significant increase in research undertaken in ENT (Ear Nose and Throat), Infectious Diseases and Paediatrics. Taking total research activity as the indicator, in England in 2012/13 the Trust was ranked 5/42 for large acute hospitals in the Guardian Research Table (an improvement of 3 places from 2011/12) and 24/69 for all large acute hospitals and teaching hospitals in (an increase of 7 places). The Trust also has considerable activity in non-NIHR commercial trials that is not reported by the Guardian table.

**The Trust's Research Portfolio by Directorate**




In 2013/2014 research grants totalling nearly £14 million were applied for, with the Trust being the lead applicant. From this funding of £1.5 million was awarded, with decisions still awaited on £8m worth of funding applications. Funding is predominantly from NIHR funding streams, although some funding has been secured from charities. Funding success has been seen in a variety of directorates and also in the awarding of fellowships for Trust clinical staff to develop their own research careers.

In addition, numerous local projects are undertaken by junior doctors, nurses, midwives and allied health professionals, under the supervision of experienced research staff. These projects are vital for the professional development of staff and encouraging and developing the researchers of the future, for changing practice and also in the potential of findings being used for further, larger research projects.

In addition to clinical trials, the Trust hosts academic appointments in partnership with three local Universities; Universities of Birmingham, Warwick and Aston University. The Trust continues to be ambitious to increase research activity, recognising that improved care and better outcomes are strongly associated with research active institutions.

In July 2013, the Trust invested £3 million over 3 years in research. This investment shows the commitment and importance the Trust places on research and development in shaping the treatments, services and choices available to its patients.

# Commissioning for Quality and Innovation (CQUINs)

A proportion of the Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between the 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 (CQUIN) payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available by contacting the Head of Performance at the Trust. The CQUINs value within the contract was £12.6 million of the Trust's income in 2013/14 (based on 2.5% of the contract value of £550 million). For 2012/13 the figures were 12.2 million (based on a contract value of £536 million). The CQUIN goals were agreed jointly by the Trust and its commissioners. The Acute, Specialised Services, Community Services and Public Health Contract included the following CQUINs:

### Acute Contract

| Goal Number | Performance Indicator | Agreed Target | HEFT Achievements |
|---|---|---|---|
| **1.1 Friends and Family Test – Phased Expansion** | Delivery of friends and family roll out for Maternity Services by end of October 2013. | Not applicable | **CQUIN Achieved** |
| **1.2 Friends and Family Test – Increased Response Rates** | Provider to achieve an increase in response rate that improves on Q1 and is 20% or over for A&E and Inpatients combined. | **20% by year end** | **17.42%** |
| **1.3 Friends and Family Test – Improved Performance** | Improved performance or remaining in the top quartile on the Staff Friends and Family Test. | | **CQUIN Achieved** |
| **2 NHS Safety Thermometer Pressure Ulcer Reduction** | Demonstrable reduction in the number of grade 2, 3 and 4 avoidable ulcers using NHS Midlands and East definition of avoidable pressure ulcers. | Trajectory set for no more than 4% grade 3,4 avoidable pressure ulcers at end Q4 2013/14 | **4.40%** |
| **3.1a - Dementia Screening** | % of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening question. | **90%** | **69.50%** |
| **3.1b - Dementia Assessment** | % of all patients aged 75 and over who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital, using the hospital dementia risk assessment tool. | **90%** | **92.30%** |
| **3.1c - Dementia** | % of all patients aged 75 and over identified as at risk of having | **90%** | **68.80%** |

| | | | |
|---|---|---|---|
| **Referral** | dementia referred for specialist diagnosis. | | |
| **3.2 Dementia – Clinical Leadership** | Completion of planned training programme and confirmation of named clinician by end of the year. | Not applicable | **CQUIN achieved** |
| **3.3 Dementia – Supporting Carers of People with Dementia** | Completion of monthly audit of carers of people with dementia to test whether they feel supported and report the results to the Board. | Not applicable | Due to poor response rates to the two surveys undertaken this was not taken forward |
| **4.1 VTE – Risk Assessment** | % of all adult patients who have had VTE risk assessment on admission to hospital using the clinical criteria of the national tool, | **95%** | **92.45%** |
| **4.2 VTE – Root Cause Analysis** | The number of root cause analysis carried out on hospital associated thrombosis. | Not applicable | **All RCA Cases recorded on VTE database** |
| **5 Falls Inpatients and A&E** | Patients are identified as fallers and referred appropriately to reduce risk of future fall to prevent harm. | Not applicable | **Out of 7 potential indicators for the Falls CQUIN, 3 have been fully met.** |
| **6 – Facilitated Discharge** | Improved discharge planning for patients from hospital to home or community care. | Not applicable | **CQUIN Achieved** |
| **7 - End of Life (EOL)** | Appropriate use of EOL pathways and improving the patient and carer experience of EOL and bereavement pathways | Not applicable | **CQUIN Achieved** |
| **8 – Surgical Site Infection Surveillance** | The number of patients identified with a post operative surgical site infection | Not applicable | **CQUIN Achieved** |

### Community Services Contract

| Goal Number | Performance Indicator | Agreed Target | HEFT Achievements |
|---|---|---|---|
| **1 - NHS Safety Thermometer Pressure Ulcer Reduction** | Demonstrable reduction in the number of grade 2, 3 and 4 avoidable ulcers using NHS Midlands and East definition of avoidable pressure ulcers. | Trajectory set for no more than 4% grade 3,4 avoidable pressure ulcers at end Q4 2013/14 | **5.90%** |
| **2 – End of Life/Bereavement** | Improving the patient and carer experience of end of life care | | |

| | | | |
|---|---|---|---|
| | through community supportive care pathway, having named district nurse, advanced care planning (ACP) and improving the data quality to help commissioners understand why patients are not referred onto supportive pathways. | **Q3 80%<br>Q4 95%** | **Q3 Target met. Q4 target not achieved** |
| **3 – Stay Healthy at Home** | Assessment of risk factors in patients home which may affect their health. | 95% | **83%** |
| **4 – Patient Engagement** | Developing opportunities for frail, elderly patients to provide feedback on Community Nursing services they have received and influence. | Not applicable | **CQUIN on track for yearend milestones** |

## Specialised Services Contract

| Goal Number | Performance Indicator | Agreed Target | HEFT Achievements |
|---|---|---|---|
| **1 Friends and Family Test – Increased Response Rates** | Provider to achieve an increase in response rate that improves on Q1 and is 20% or over for A&E and Inpatients combined. | **20% by year end** | **17.42%** |
| **2 - NHS Safety Thermometer** | To reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally. | **Not applicable** | **All submissions made on time as required.** |
| **3.1a - Dementia Screening** | % of all patients aged 75 and over who have been screened following admission to hospital, using the dementia screening question. | **90%** | **69.50%** |
| **3.1b - Dementia Assessment** | % of all patients aged 75 and over who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital, using the hospital dementia risk assessment tool. | **90%** | **92.35%** |
| **3.1c - Dementia** | % of all patients aged 75 | | |

| | | | |
|---|---|---|---|
| **Referral** | and over identified as at risk of having dementia referred for specialist diagnosis. | **90%** | **68.80%** |
| **4 -VTE Risk Assessment** | % of all adult patients who have had VTE risk assessment on admission to hospital using the clinical criteria of the national tool. | **95%** | **92.30%** |
| **5 - Specialised Services Quality Dashboards** | Quarterly submission of Clinical Dashboards for Specialised Services. | Not applicable | **All dashboards submitted on time** |
| **6 – Renal Dialysis RPV** | This CQUIN measures the number of patients under the care of a renal unit who are registered with Renal Patient View.<br><br>It also measures the rate of use of Renal Patient View as a proportion of the number of patients under the care of a renal unit. | | **CQUIN achieved** |
| **7 - Neonatal Intensive Care (NIC)** | Percentage of preterm babies who are fed on mother's breast milk at discharge from neonatal unit.<br><br>Neonatal Intensive Care (NIC) – Timely administration of total parenteral nutrition in preterm infants (TPN) Neonatal intensive care (NIC) – Retinopathy of prematurity (ROP) screening. | | **CQUIN achieved** |
| **8 –BMT Donor Acquisition** | This is a single CQUIN made up of 4 elements aimed at gaining a better understanding and improvement of a number of processes used to identify unrelated donors. | | **CQUIN achieved** |
| **9 – HIV Registration and Communication with GPs** | To increase the role of primary care in the care of HIV patients. | | **CQUIN achieved** |

The CQUIN for the dementia case finding question is part of a national CQUIN scheme, and was rated red for 2013/14 as the target was not achieved by the Trust.

Following the roll out of mandating the case finding question on the relevant electronic system in Autumn 2013, incremental improvements were made month on month, but these were not enough to meet the target.

Dementia case finding will be highlighted to all Operational Managers, Associate Medical Directors and Clinical Directors. This will emphasise the clinical needs driving the CQUIN. A standardised clerking document is being agreed with acute medicine and Emergency Department to improve performance. For 3.1c there is a historical problem in collecting data held by Birmingham and Solihull Mental Health Trust (BSMHT). This is part of a local work stream with the Rapid Assessment, Interface and Discharge (RAID) team. Efforts continue to connect the RIO IT system (Mental Health Electronic Patient Record System) used by BSMHT and Icare (the Trust patient information management system).

The dementia CQUIN has been carried over nationally for 2014/15, and as such, progress will be reported on in the 2014/15 Quality Account & Report.

Please see the national quality indicators for information on VTE and the Falls Priority for further information as to plans to improve the VTE and Falls CQUIN.

# Care Quality Commission

Heart of England NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered with some compliance actions. The Trust has compliance conditions relating to Regulations 9, 22 and 23.

The CQC has not taken enforcement action against Heart of England during 2013/14.

The Trust was subject to two unannounced inspections during 2013/14:

May 2013
This inspection took place at Good Hope Hospital and was a follow up from the visit in February 2013 when the Trust was found to be non compliant with Regulation 17 (respecting and involving services users) and Regulation 19 (Complaints). Following the visit in May, the Trust was found to be compliant with both of these regulations. The final report is available on the CQC website www.cqc.org.uk.

November 2013
In November 2013, the Trust received a new CQC style inspection. The announced inspection took place over a week long period on the 3 main acute sites (Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital). This was followed by a series of unannounced inspections to the above sites. A quality summit took place with the CQC and various stakeholders prior to the publication of the final report.

The outcomes, included in the final reports, are summarised as follows:

Warning Notice (Regulation 10) - Good Hope Hospital:
Concerns were raised regarding triage in A&E, checking of resuscitation equipment in A&E, patient pathways in the Clinical Decisions Unit and medicines storage in the assessment unit.

Compliance actions - (Regulation 9) - Heartlands and Good Hope Hospitals:
People who use services were not protected against the risks of receiving treatment that is inappropriate or unsafe as there was no timely assessment of the needs of the person using the service. The planning and delivery of care did not always occur in the A&E department to ensure that the patient's basic needs were attended to.

Compliance actions – (Outcome 23) - Heartlands, Solihull and Good Hope Hospitals:
Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time

Compliance actions – (Outcome 22) – Heartlands Hospital:
Patients did not always have their health, safety or welfare needs met due to the lack of sufficient numbers of staff on duty

The Trust provided four action plans to the CQC and to Monitor in response each of the sets of compliance actions raised in the reports. These action plans are monitored by the Executive Management Team.

The Trust was one of three first wave Trusts to receive a CQC rating for its services. The ratings identified for A&E services at Good Hope hospital as a result of the Warning Notice was 'Inadequate' for safe, caring and responsive. As a result of the CQC follow up visit this was revised to 'Requires Improvement'.

In February 2014, the CQC completed a follow up visit to Good Hope hospital relating to the concerns raised in the Warning Notice. The CQC report has been received by the Trust and it confirmed that significant improvements have been made. The CQC report stated that:

- Significant improvements had been made in A&E to the process of streaming patients. Effective action had been taken to ensure that patients were assessed by a healthcare professional within 15 minutes of arrival.
- The process of risk assessment had been changed. This meant that all patients had a nursing risk assessment completed within two hours of arrival. When risk was identified 'intentional rounding' was commenced.
- At this inspection we found that the hospital had good systems in place to ensure that medications were stored in line with national guidance. We found that a regular team of staff were allocated to the ward area ensuring greater continuity of care. We found that the resuscitation trolley was appropriately stocked and that patients had sufficient furniture to meet their needs. Audits were undertaken and effective systems were in place to identify risks.

The CQC have confirmed that no further action will be taken in relation to the Warning Notice.

The Trust participated in a special review by the CQC relating to a 'review of services for looked after children and safeguarding in Solihull'. The Trust is contributing to the health economy action plan to address the issues raised by the CQC.

The CQC has replaced its Quality and Risk profiles for Trusts with 'Intelligent Monitoring Reports'. In March 2014, the Trust had 7 'risks' and 6 'elevated risks' which are outlined in the table below.

| | |
|---|---|
| Elevated Risk | Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators |
| Elevated Risk | Composite indicator: In-hospital mortality - Genito-urinary conditions |
| Elevated Risk | PROMs EQ-5D score: Hip Replacement (PRIMARY) |
| Elevated Risk | Monitor - Governance risk rating |
| Elevated Risk | NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months |
| Elevated risk | Whistle blowing alerts |
| Risk | Never Event incidence |
| Risk | Proportion of patients risk assessed for Venous Thromboembolism (VTE |
| Risk | Composite indicator: In-hospital mortality - Cardiological conditions and procedures |
| Risk | Composite indicator: In-hospital mortality - Haematological conditions |
| Risk | Maternity Survey 2013 C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10) |
| Risk | Composite indicator: A&E waiting times more than 4 hours |
| Risk | GMC - Enhanced monitoring |

Progress against these risks will be monitored by the Quality and Risk Committee.

# Data Quality

The Trust submitted records during 2013/2014 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:

Admitted patient care: 99.90%;
Outpatient care: 99.49%;
Accident & Emergency care: 96.69%.

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

Admitted Patient Care: 99.96%;
Outpatient Care: 99.97%;
Accident & Emergency care: 99.29%.

# Information Governance Toolkit

Heart of England NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 70% and was graded Green.

The following table includes details of Information governance Level 2 incidents reported in year:

| **SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2013-14** | | | | |
|---|---|---|---|---|
| **Date of incident (month)** | **Nature of incident** | **Nature of data involved** | **Number of data subjects potentially affected** | **Notification steps** |
| November 2013 | Unauthorised access/disclosure | Clinical information | <10 | Individuals were aware of breach |
| **Further action on information risk** | | The Trust is reviewing its access to patient systems and is continuing to ensure that all members of staff are aware that they must not access records without a legitimate reason.<br>The member of staff responsible for this incident received a final written warning. | | |
| December 2013 | Unauthorised access/disclosure | Clinical information | <10 | Individuals were aware of breach |
| **Further action on information risk** | | The Trust is reviewing its access to patient systems and is continuing to ensure that all members of staff are aware that they must not access records without a legitimate reason.<br>HR Investigation is in progress. | | |

| SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2013-14 | | | | |
|---|---|---|---|---|
| **Date of incident (month)** | **Nature of incident** | **Nature of data involved** | **Number of data subjects potentially affected** | **Notification steps** |
| December 2013 | Disclosed in error | Name, address, date of birth, NHS number, GP practice code. | 50 | Individuals were notified by post |
| **Further action on information risk** | | Changes to systems for contacting patients were introduced. An audit will be undertaken of the Information Governance arrangements in place. | | |
| February 2014 | Unauthorised access/disclosure | Clinical information | <10 | Individuals were aware of breach |
| **Further action on information risk** | | The Trust is reviewing its access to patient systems and is continuing to ensure that all members of staff are aware that they must not access records without a legitimate reason.<br>HR Investigation is in progress. | | |
| February 2014 | Unauthorised access/disclosure | Clinical information | <10 | Investigation still ongoing |
| **Further action on information risk** | | The Trust is reviewing its access to patient systems and is continuing to ensure that all members of staff are aware that they must not access records without a legitimate reason.<br>HR Investigation is in progress. | | |

# Clinical Coding Error Rate

Heart of England NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by Capita under the current Audit Commission framework and the error rates reported in the 2012/13 published audit for diagnoses and treatment coding (clinical coding) was:

| | % procedures coded incorrectly | | % diagnoses coded incorrectly | | % spells changing HRG |
|---|---|---|---|---|---|
| | Primary | Secondary | Primary | Secondary | |
| **Overall** | 19.3 | 18.6 | 13.9 | 18 | 8.8% |

The specialties audited were 100 Finished Consultant Episodes (FCE) related to zero length of stay, 55 FCEs in HB non trauma orthopaedic procedures, 20 FCEs in HB61C Major Shoulder and

Upper Arm procedures, 30 FCEs in EA36A Cardiac Catheters, 20 FCEs in BZ23Z vitreous retinal procedures selected from our quarter 1 data submissions.

The results should not be extrapolated further than the actual sample audited.

1. In 2012/13 the Trust's average HRG error rate is 8.8 per cent. This is a continuing improvement, from an episode HRG error rate of 19 per cent in 2009/10, to 13.3 per cent in 2010/11, to 11% in 2011/12.
2. The report made two recommendations relating to an internal audit programme and training of coders in extraction of information from systems.
3. An action plan has been developed to address the recommendations. Quarterly updates will be provided to the Trust Finance and Performance Committee and to the Primary Care Cluster.

In 2012/13, as well as auditing inpatients, the Audit Commission also looked at coding in Accident & Emergency and Outpatient Attendances. Coding for these areas do not sit under Clinical Coding and are owned by each area.

A&E results were:

| Attendances tested | % attendances changing payment | % investigation codes incorrect | % treatment codes incorrect |
|---|---|---|---|
| **150** | 18.0 | 11.2 | 21.8 |

Outpatient results were:

| Attend-ances tested | % attend-ances changing payment | Procedure coding | | | Other data items | | | |
|---|---|---|---|---|---|---|---|---|
| | | Attend-ances with tariffed HRGs | % HRGs changing | % procedure codes incorrect | % attended flag incorrect | % first / follow incorrect | % TFCs incorrect | % age incorrect |
| **150** | 8.7 | 30 | 15.3 | 38.3 | 0.0 | 3.3 | 0.0 | 0.0 |
| **30** | 3.3 | 30 | 3.3 | 42.3 | 0.0 | 0.0 | 0.0 | 0.0 |

In 2013/2014 the specialties audited were 100 Finished Consultant episodes (FCEs) relating to Vascular Surgery and 100 FCEs from the Healthcare Resource Group (HRG) LB Urological and Male Reproductive System Procedures and Disorders from the August – October data submissions.

The 2013/14 audit was performed 17th – 19th February 2014. The final results for this audit will be available in June 2014.

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

- A suite of measures known as the Data Quality Health Check which identifies areas of poor performance are reported on a weekly basis to a range of operational and managerial staff throughout the Trust. Data Quality also forms part of monthly Directorate reports and has been a standing agenda item on performance meetings with action plans in place to improve on performance.

- Reports monitoring the timeliness against the new target of within 2 hours for Admissions, Discharges 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 three areas of concern across all divisions is reported monthly to Matrons and Lead Nurses and is monitored via the Nursing and Midwifery Performance Committee.

- The Trust has introduced electronic discharge letters to GP practices for Outpatient attendances, ensuring that patient correspondence is sent to the correct GP practice. This helps with timeliness and reduces the misdirected mail returned to the Trust.

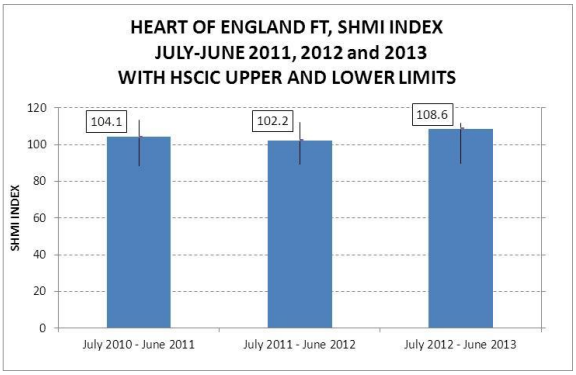
- The Data Quality Strategy is currently in draft and the terms of reference and membership of the Data Quality Project Board are currently being reviewed; this Board focuses on areas of concern requiring improvement in data quality.

- The Trust employs a team of Data Quality staff within the Performance department 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

| Indicator | Jan 2012 - Dec 2012 | Apr 2012 - Mar 2013 | Trust performance Latest Jul 2012 - Jun 2013 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| **The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period** | 1.0296 (Band 2) | 1.0787 (Band 2) | 1.0855 (Band 2) | 1.0007 | 0.6259 (Band 3) | 1.1563 (Band 1) |
| **The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period** | 16.7% | 11.8% | 10.6% | 20.5% | 0.0% | 44.1% |

**The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:**
The SHMI is provided by the Health and Social Care Information Centre. During the period February to May 2013 the Trust experienced a spike in hospital mortality which is reflected by the rise in SHMI. However despite this rise the SHMI remains within the 'expected band' (band 2). Prior to this rise the SHMI was also within the expected band 2 in the previous two years as below.



The SHMI is a complex measure and can be influenced by many factors. During the period in question there was:

- a marked increase in 'winter pressures' on the Trust as reflected in a deterioration in the 4 hour ED performance standard
- a rise in influenza cases across the health economy.
- an increase in the number of elderly patients admitted- who are generally the sickest of our patients - with often with complex comorbidities.
- during late 2012, and into 2013, a significant reduction in patients coded as palliative care
- admission avoidance schemes introduced, so only the sicker patients were admitted(with an attendant impact on case mix).

However in spite of these factors the Trust is not complacent and to further understand the root causes of this rise at a patient level, the Trust conducted in-depth case note reviews and data analysis. No obvious patterns of concern for in-patient care were identified; however as a Trust that is focussed on reducing both avoidable harms and avoidable mortality we identified further opportunities for improvement and further analysis.

The Heart of England NHS Foundation Trust is taking the following actions to improve the SHMI figure and so the quality of its services by the actions identified below. This list is not exhaustive.

- In-depth case note review of a number of diagnostic groups such as pneumonia and acute myocardial infarction has been undertaken and action plans developed to address any areas or opportunities identified for improvement, continue to monitor, review and explore our mortality data to help focus any improvement activities including the trial of the CRAB data analysis tool.
- Recommencement of the deteriorating patient recognition group to review the care being provided to this group of patients along with compliance with the various care bundles including the sepsis bundle and MEWS escalation. This group has strong clinical representation.
- Enhanced access to non-invasive ventilation.
- Multiple initiatives aimed at improving the flow in the hospital and waiting times in the emergency department

We are continuing to develop and strengthen our approaches to avoidable mortality over the forthcoming year.

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

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

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

- Validating the coding of patients who have received palliative care against those recorded on the system. Since this practice was introduced there has been an increase in the number and accuracy of palliative care episodes to levels seen prior to April 2012.

| Patient reported outcome measures scores | Apr 11 - Mar12 | Trust performance Latest Apr 12 - Mar 13 | Trust performance Latest Apr 13 - Sept 13 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| (i) groin hernia surgery | 0.089 | 0.093 | 0.128 | 0.085 | 0.019 | 0.138 |
| (ii) varicose vein surgery | 0.145 | 0.121 | 0.000 | 0.076 | 0.058 | 0.094 |
| (iii) hip replacement surgery | 0.374 | 0.396 | 0.439 | 0.447 | 0.373 | 0.545 |
| (iv) knee replacement surgery | 0.286 | 0.314 | 0.280 | 0.339 | 0.264 | 0.429 |

**The Heart of England NHS Foundation Trust considers that this data is as described for the following reasons:** It is published national data by HES online.

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

- Developing a PROMS reporting dashboard
- Undertaking individual patient level analysis of the data to map back to specific consultants
- To improve compliance with rates with PROMs, performance particularly for varicose veins has dipped in the past few months by reinstating the operational delivery group

| 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% | 10.01% | 0.00% | 13.65% |
| (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**:

It is produced by the Health and Social Care Information Centre. The Trust notes that the data is 2 years old and although performance remains above the national average for both measures there was an improvement on the previous 12 months.

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

- Continue its work in relation to the improving discharge practice with a focus on providing the patient with a predicted date of discharge at the point of admission, to ensure patients are better prepared for discharge
- To further explore the reason why the Trust remains a significant outlier for readmissions within 0 and 1 day
- To continue review of counting and coding of activity to ensure that there are no errors in the collection of data and to ensure that there is clear understanding of how the admission

of patients directly to an Acute Medical Unit at Solihull, rather than an A&E department impacts on our reported figures
Undertake a focussed review of specialties that are recognised outliers to address any clinical concerns

| Indicator | 2009/10 | 2011/12 | Trust performance Latest 2012/13 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| **Trust's responsiveness to the personal needs of its patients during the reporting period** | 65.90 | 66.50 | 65.20 | 68.10 | 57.40 | 84.40 |

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

- The static nature of the scores demonstrates that the organisation has delivered to consistent levels. We are one of the largest acute providers in the country and with this comes an incredibly diverse population, at our largest site in particular.

- The data is reflective of the challenges of providing services in a large complex acute healthcare organisation with some very diverse needs amongst patient groups.

**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:**

- Review of current methods of patient experience data collection and simplification of the amount the Trust collects. Also in how this information is presented to local leads in a way that is meaningful. This will allow them the opportunity to truly understand what can be improved for patients and their carers.

- The Trust will develop our systems of reporting back to patients about actions implemented as a result of feedback they have provided. Bespoke action planning will therefore be developed in each area.

- More specifically ward Sisters/Charge Nurses are becoming supervisory, which means they will no longer be included in the establishment for each shift. Patient Experience measurement will also be installed as a key performance indicator for all ward leaders.

- Sisters/Charge Nurses are being provided protected time between 8am – 10am to allow them to have more face to face time with patients, their carers and relatives if needed. This will allow them to better understand and proactively ask about what is important to individual patients during their stay with the Trust.

- To help the Trust better understand our local communities, a short film has been created, using contacts from our local communities which helps staff to understand issues they may not have understood about end of life and bereavement within the Islamic faith.

In addition the Trust has implemented the Safer Care Bundle which includes patient care and responsiveness to feedback.

| Indicator | 2011 | 2012 | Trust performance Latest 2013 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| **Friends and Family Test - Question Number 12d – Staff – The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' for each acute & acute specialist trust who took part in the staff survey.** | 54.57% | 54.67% | 55.81% | 67.11% | 39.57% | 88.51% |

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

- The current climate and challenges within the Trust and the NHS as a whole are having an impact on staff morale, and on their views and perceptions of the care delivered.
- The Trust has seen no significant change in its score on this data point from 2012. A number of initiatives were successfully launched, and continue to be embedded for sustainable change. However, in retrospect, the Trust believes the 2012/13 engagement approach may have focused too heavily on improving a small number of 'hotspots,' leading to minimal impact across the wider staff groups.
- Having worked with staff during 2013 to understand the how their climate and challenges impact their engagement, the Trust believes it has a consistent picture of the key issues for staff in their delivery of consistent quality and safe care. The Trust's Organisational Development (OD) plan for 2014 will focus around these themes, incorporating staff feedback on 'how to do this better'.

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

- Development of a Trust-wide OD strategic plan, which for 2014/15 focuses on supporting the Trust's 'Safe & Caring' priority. The plan brings together the priority operational activities across the Trust which are fundamental to a Safe & Caring environment, and looks at ways of delivering these in a more engaging, involving and patient-centred way.
- Introduction of a Staff Engagement Steering Group – an active staff led group, looking at staff feedback via various survey routes, prioritising action areas and commissioning solutions.
- Support and thought-leadership from Professor Sir Muir Gray on creating a patient-centred culture.

- A focus on sustainable change around key pressure / conflict areas – Emergency pathways and flow. Introduction of the SAFER bundle, and focus on involvement and engagement.
- Raising Concerns: a programme to equip line managers with the skills and techniques to create and maintain safe environments, so that staff feel safe to speak out about any concerns they may have.
- Introduction of improved recruitment process and 'behavioural compact' for Consultants, to ensure personal characteristics linked to positive patient experience are a key part of selection and development decisions, in addition to technical skills.
- Continued regular safety walkabouts that focus on patient and staff safety.
- The Trust's dedicated patient safety team continue to lead on innovative approaches to improve patient safety and support staff in the delivery of care, with growing recognition for their "Lesson of the Month."
- Continued development of the excellent education provision and curriculum to grow and develop staff.
- Increase the Trust responsiveness – introduction of the new quarterly Staff Friends & Family survey, and use of its more regular feedback to update and adapt engagement planning.

| Indicator | Nov-13 | Dec-13 | Trust performance Latest Jan 14 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| **Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period** | 93.90% | 93.40% | 92.28% | 96.13% | 74.65% | 100.00% |

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

The majority of failures of completion of the venous thromboembolism risk assessment (VTE RA) are due to patients with hospital attendances of less than 12 hours (64% in March 2014). These patients are often seen solely in areas where the Trust's electronic prescribing system (EP) is not instigated in the time the patient is in hospital. Most of this group of patients would automatically be assigned to a risk assessment not being required under current Trust policy but have not been identified as such. If this group of patients are identified prospectively as being excluded from the RA as per protocol, then our more recent percentage Risk Assessment completed would be greater than 95%.

Of the patients whose admission is greater than 12 hours, a proportion where admitted to wards which were also not using the trusts EP system which automatically prompts users to perform the VTE RA.

**The Heart of England NHS Foundation Trust has taken the following actions to improve this percentage, 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.
- 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.

| Indicator | 2010/11 | 2011/12 | Trust performance Latest 2012/13 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| **Number of positive Clostridium difficile (CDiff) infections identified post 48 hours from admission for patients aged two or over on the date the specimen was taken** | 33.10 | 24.40 | 17.10 | 17.30 | 0.00 | 30.76 |

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

- A deep cleaning program across 2 of the hospital sites.
- RCA of all post-48 hour cases, based on infection control criteria, and antibiotic audits, with feed-back to clinical and ward teams.
- Detailed Period of Increased Incidence reviews, with feedback, for affected wards.
- Reduction in the number of C.Difficile outbreaks across the Trust.

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

- Introduction of the new agent fidaxomycin into the treatment algorithm for C.Difficile.
- A project with Solihull Primary Care, mapping the medical and antibiotic history of the community and hospital C.Difficile patients for the period September-December 2012. This is being done to obtain a more detailed understanding of the overall "antibiotic pressures" that could influence development of disease.
- The development of a service providing faecal transplants to patients with protracted/relapsing C.Difficile infection. This is new initiative in the West Midlands.

| Indicator | Oct 11 - Mar 12 | Apr 12 - Sep 12 | Trust performance Latest Oct 12 - Mar 13 | National Average | Lowest reported Trust | Highest Reported Trust |
|---|---|---|---|---|---|---|
| **number of patient safety incidents reported within the trust during the reporting period** | 5,660 | 6,440 | 7,835 | 3,285 | 174 | 11,495 |
| **rate of patient safety incidents reported within the trust during the reporting period** | 5.12 | 5.80 | 7.76 | 6.28 | 1.70 | 30.95 |
| **the number of such patient safety incidents that resulted in severe** | 67 | 98 | 114 | 20 | 0 | 114 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **harm or death.** | | | | | | |
| **percentage of such patient safety incidents that resulted in severe harm or death.** | 1.20% | 1.50% | 0.10% | 0.05% | 0.00% | 0.44% |

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

Whilst there are some discrepancies, due to the way that the information is collected and updated, analysis of our local incident reporting database provides broadly similar data, with the number of patient safety incidents reported within the trust during the reporting period as 7800 and the number of such patient safety incidents that resulted in severe harm or death as 91

The Trust considers a high level of incident reporting as a sign of a good safety culture and actively encourages staff to report both clinical and non clinical incidents. We have had a relatively stable incident reporting profile for the last few years with approximately 20,000 incidents reported from April 2013 to March 2014. These incidents include both patient safety incidents (which are subsequently uploaded to the National Reporting and Learning System (NRLS)) and other categories of incidents (for example those that affect staff or property and have no actual or potential clinical impact on patients).

As part of our incident reporting process we identify patient clinical incidents which need to be uploaded to the NRLS and provide regular uploads to this system. The NRLS publish some of this data as national statistics as well as providing bi-annual reports for individual organisations.

This year we have continued to work with users to make incident reporting as streamlined as possible, in particular using Datix to capture the duty of candour information required by our commissioners. We also continue to review the training we provide to keep it responsive and accessible to those users.

We have continued development of our framework for investigating and learning from incidents, increasing the support for clinical investigation leads through the appointment of two clinical investigations and legal managers.

**The Heart of England NHS Foundation Trust intends to take the following actions to improve the total rate of patient safety incidents reported within the Trust, and so the quality of its services, by:**

- Introducing bespoke root-cause analysis tools to aid the investigation of and learning from medication incidents that result in severe or catastrophic harm.

- Roll out the incident reporting, management and learning framework working with key staff groups to support wider learning from incidents and strengthening local feedback on reported incidents.

- Revise the training and resources available to support incident investigation and management, introducing “root cause analysis master-classes” for clinical investigation leads.

# Part 3:
# Other Information

Part 3 includes an overview of the quality of care initiatives offered by the Trust against indicators chosen by the Executive Management Board because of their importance regarding patient care. There are three measureable indicators for patient safety, clinical effectiveness and patient experience along with details of other quality initiatives. Where applicable, these are governed by standard national definitions. These are:

| | |
|---|---|
| Patient Safety Indicators: | Cumulative Balance<br>Medication Safety<br>Infection Control |
| Clinical Effectiveness Indicators: | Incident reporting<br>Never Events<br>Morbidity and Mortality |
| Patient Experience Indicators: | Friends and Family Test (Net Recommender Index)<br>Inpatient Survey<br>Complaints |

Harm free care, which was included under Patient Safety in 2012/13, forms part of the two priorities of pressure ulcer and falls. Nursing metrics form part of several of the Trust's priorities, as well as medication safety and fluid balance detailed below.

# Patient Safety

During 2013-2014 the patient safety team has continued to work with clinical teams on several patient safety improvement programmes. These include:

**Trust Safety Manual**

The nursing pocket safety manuals are designed to help practitioners to deliver safe, reliable evidence based care at the bedside.

The manual for nurses working with adult patient was launched in July 2011. The safety manual was reviewed and some of the information cards were updated in May 2013 to ensure that the content reflected current policy or guidance.


The following cards were updated:

- Confirmation of nasogastric tube position;
- Tissue viability care bundle/Dressing selection guide;
- Sepsis; and
- Blood Transfusion.


The paediatric safety manual was launched in August 2012. This manual was also reviewed in February 2013. The confirmation of nasogastric tube position was updated to reflect current practice.

Replacement cards were issued to all ward and department managers for their teams.

**Doctors' Safety App – eMapp**

A safety manual for junior doctors has been developed in the form of an app for smart phones. E-Mapp is an Emergency Medicine app designed by lead clinicians in Emergency Care.


E-Mapp, launched in September 2013, provides up to date HEFT and national guidelines, scoring systems and algorithms to guide clinicians working in acute areas such as Emergency Department, Intensive Therapy Unit, Acute Medical Unit and Paediatric Assessment Unit.

Work is underway to evaluate the impact and usefulness of the app with front line clinicians.


In November 2013 the Neonatal Safety app was launched. The app has been designed by lead clinicians in Neonatal Care.

It provides up to date algorithms, flash cards, care pathways, neonatal formularies and Network Guidelines to guide nurses and clinical teams working in neonatal areas.

**Promotion of HEFT apps**


The apps are available to download onto smart phones/ devices directly from the app stores.

Posters with Quick Response codes allow clinicians to scan the code direct from the poster and download the apps

The patient safety team have worked in collaboration with the communications team and faculty of education to promote awareness of these safety apps to relevant clinicians.

With advancing smart phone technology being used at the Trust a campaign to raise awareness with visitors about staff using mobile devices has also been promoted using "new technology" posters.

**Patient Safety Walkabouts**

In this financial year April 2013 to March 2014 a total number of 14 patient safety walkabouts were conducted by the executive team. The walkabouts give front line staff the opportunity to discuss safety issues with the executive team.

Four of the walkabouts were on the Birmingham Heartlands site, six on the Good Hope site, two on the Solihull site, one at Birmingham Chest Clinic and one at Solihull Community Services.

Several safety improvements have been initiated as a consequence of the patient safety walkabouts conducted this year. These include:

- Agreement from West Midlands Ambulance Service that emergency transfers for seriously ill children from Minor Injuries Unit, Solihull Hospital, will be treated as 999 calls if the person calling makes it clear it is a "life threatening" problem.
- Purchase of a new blood fridge for Obstetrics at Good Hope Hospital to avoid delays in administration of blood.
- Purchase of a trolley for Radiology at Solihull Hospital to reduce the delay in patient's radiological investigations due to no trolley being available.
- Repair to the ceiling in the staff locker room at Birmingham Chest Clinic.

**Fluid Balance Toolkit**

Work has continued with a number of wards across the Trust in relation to improving the quality of fluid balance monitoring. Real time data from monthly nursing metrics audits undertaken by the Corporate Nursing Team were used to identify where to target the improvement programme. A pareto chart was developed from the nursing metrics data to show which wards should be targeted for inclusion in the fluid balance improvement programme. Wards were selected based on poorest compliance on completing cumulative fluid balance scores and also a highest usage of fluid balance charts. This allowed resources to be targeted on wards where improvement would have the most impact. The progress is shown in Figure 1 below.

A fluid balance toolkit was created to provide ward leaders with tools to help diagnose areas for improvement with both fluid balance documentation and communication. The tool kit also provided a range of educational materials including an iSkills video and other information to help ward leaders drive improvement in their areas.

In addition to this, an accountability framework through Nursing Performance Board provided additional leverage to drive improvement as ward leaders were held to account for fluid balance performance in their areas. Incremental improvements have been achieved and sustained across all sites over a four year period. The performance is detailed in the chart below:

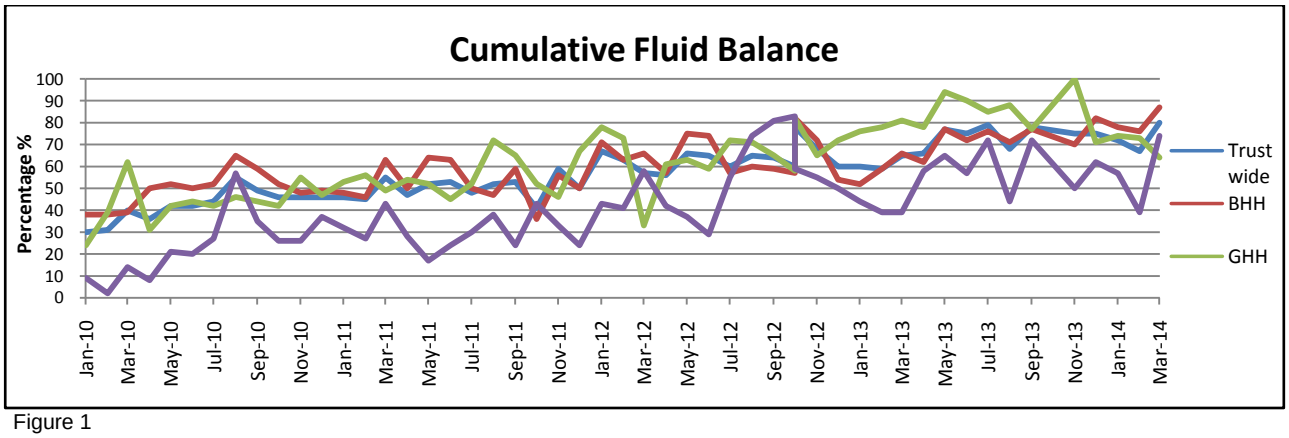



Figure 1

## Medication Safety

Following a scoping exercise in January 2013 involving an extensive review of a wide range of internal and external data sources, medication safety was identified as a top safety priority for the Trust.

A project group comprising the patient safety team, the microbiology team and pharmacy have led the first medication safety improvement programme. The overall aim of the programme is to reduce the numbers of missed and delayed doses of medicine in the Trust. This is important as patient harm from missed and delayed doses is a nationally recognised problem. The initial focus for the improvement programme is antibiotics. Two clear aims have been identified both of which directly link to patient safety and outcome:

1. To promote prompt administration of stat dose antibiotics within a time frame of 1 hour; and
2. To ensure that all antibiotic prescriptions have a clear stop date.

The improvement programme was initially piloted on four surgical wards in the Trust and a medication dashboard linked to the Trust electronic prescribing (EP) system was developed as a result of feedback from these areas. The medication dashboard allows front line clinicians to view their own and Trust-wide performance in relation to antibiotic performance. Significant improvements were seen with the pilot wards and in January 2014 the dashboard was launched on the Solihull site.

The project team is currently working closely with clinical leads on the Solihull site. The site has seen significant improvements in timely stat dose antibiotic administration and antibiotic stop date performance. Progress is detailed in Figure 2 below.

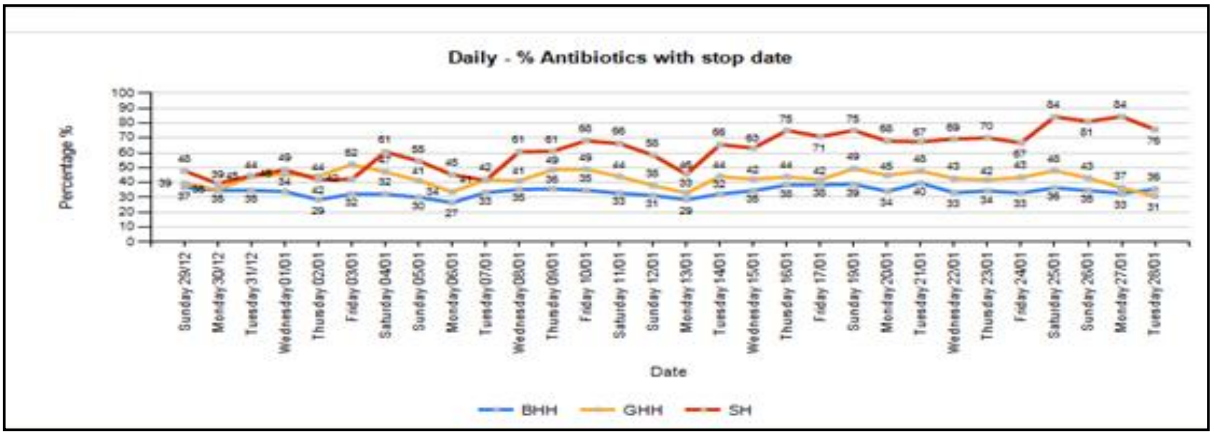



Figure 2

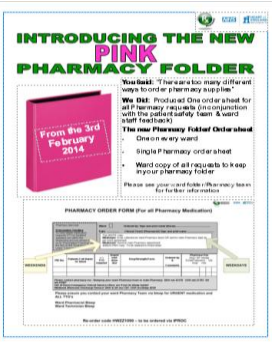
Plans are underway to roll out the improvement programme and launch the dashboard on the other hospital sites.

### Electronic Prescribing (EP) code changes


To assess the impact of any improvement work relating to minimising omitted/delayed doses, it was essential to determine the current amount of avoidable omitted medication doses. This required changes to the current EP non-administration codes to allow nursing staff to accurately and efficiently record the reasons for non-administrations. Extensive consultation relating to refining and reducing the codes was undertaken and the new codes were launched in July 2013.

The patient safety team have facilitated a process mapping exercise of pharmacy ordering processes. From this exercise it became apparent that there were a variety of different order forms for ordering drugs from pharmacy, such as different forms for stock and non stock items, for ordering drugs during routine pharmacy times and out of hours.

The information was fed back to the pharmacy team; a new single order sheet has been created for all requests alongside a new pink single order sheet has been launched with a pink folder to alert staff to the new system.




**Safety communications strategy, learning lessons and engagement: The story so far...**

In 2012/13 a new safety learning and engagement manager post was established. This role was developed to facilitate and improve organisational learning from incidents and error across the Trust.

In 2012 a scoping survey was undertaken to gather baseline measurement to determine the current awareness of the incident reporting process, and lessons learnt from incidents within the organisation. The aim of this survey was to create a focus on where to start improvements and to assess the current position.

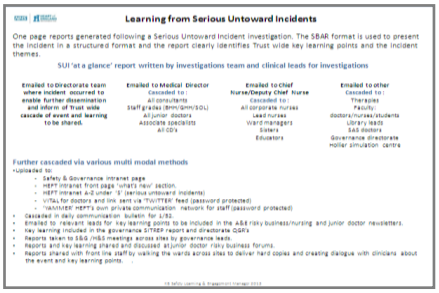
The survey identified that **54%** of staff who completed the survey were not aware of any Serious Untoward Incidents (SUI) that had occurred within the Trust. Some face to face responders did not actually understand what a SUI was.

The survey also identified that although staff were completing incident forms; **63%** of those completing the survey had not received any form of feedback from incidents that they had reported.

Following review of the survey, innovative multimodal communication systems were developed and implemented to ensure that essential learning from incidents and error are cascaded across the organisation as detailed below.

**<u>Learning from Serious untoward incidents (SUI)</u>**

A communication strategy to share learning from Serious Untoward Incidents (SUI's) has been developed. A short SUI 'at a glance' report is produced from all SUI's that occur in the organisation. The reports share the incident that occurred and key learning for the organisation. The reports are cascaded widely using multimodal methods to ensure that lessons from adverse events are shared.




The reports are also uploaded to the Safety and Governance intranet page and easily accessible to all Trust employees and are identified by both themes and years.

To ensure that learning from serious events which have occurred prior to 2009 are also shared and disseminated, previous SUI's are being formulated into the 'at a glance' formats. These will be readily available for all staff and circulated using the same cascade process. These reports will also include implemented changes to practice following the SUI. The aim of this is to create organisational memory for learning from incidents and error.

## Lesson of the month

The ‘Lesson of the month’ initiative was launched in September 2012.The objective of the ‘lesson’ is to increase organisational learning and widely communicate lessons to be learned. The lessons are all based on incidents and errors that have occurred in the organisation, and are patient focused, and written by clinicians, for clinicians. The aim is to increase the profile of specific incidents and relay key guidance


Lesson of the month cascade

Objective of ‘lesson’ is to increase organisational learning. To communicate and ensure wide dissemination of lessons to be learned across the organisation, thus increasing the profile in relation to specific incidents/safety topics and key messages, with the aim to improve patient safety.

The lessons are all based on incidents that have occurred in the organisation, are patient focused, and written by clinicians, for clinicians.

Lessons added to the compilation slide

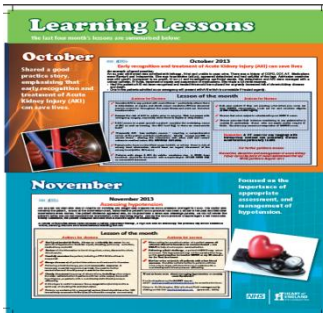
| Emailed to Medical Director | Emailed to Chief Nurse/Deputy Chief Nurse | Emailed to other |
|---|---|---|
| Cascaded to: | Cascaded to: | Cascaded to: |
| All consultants | All corporate nurses | Therapies |
| Staff grades (SHO/SPR/SCU) | Lead nurses | Faculty, doctors/nurses/students |
| All junior doctors | Ward managers | Library leads |
| Associate specialists | Sisters | SAS doctors |
| All CD’s | Educators | Governance directorate |
| | | Holler simulation centre |
| | | Solihull CCG |

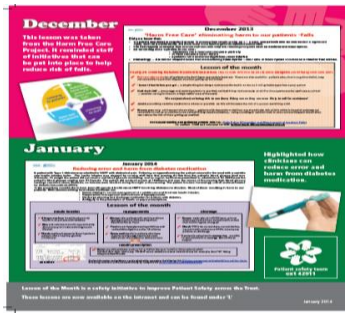
Lesson further cascaded via various multi modal methods

- Uploaded to:
  - Safety & Governance Intranet page
  - HEFT Intranet front page ‘what’s new’ section.
  - HEFT Intranet A-Z under ‘L’ (lesson of the month)
  - ‘VITAL’ for doctors and link sent via TWITTER feed (password protected).
  - ‘YAMMER’ HEFT’s own private communication network for staff (password protected).
- Cascaded in daily comms for 1/52.
- Emailed to relevant leads for inclusion to A&E risky business /nursing and junior doctor newsletters.
- Included in the governance SITREP report and directorate QSR’s
- Lesson taken to S&S/H&S meetings across sites by leads.
- Shared and discussed at junior doctor risky business forums.
- Lessons shared with front line staff by walking the wards across sites to deliver hard copies and have dialogue with clinicians about the lesson.
- Compilation of last four months lessons disseminated across the whole organisation via thrice yearly payslip flyers.

These lessons of the month are disseminated widely, posted on the front page of the Trust’s Intranet and uploaded to the safety and governance intranet page, accessible to all Trust employees.

The lessons of the month are also cascaded via a payslip flyer which is sent out thrice yearly and incorporates the previous four months lessons. They are also discussed at various forums, including junior doctor risky business forum.




Examples of lessons learnt shared to date have included:

Medication safety (insulin/anticoagulants/oxygen/antibiotics) deteriorating patients, falls, HIV, assessing hypotension, Do Not Attempt Resuscitation (DNAR) and acute kidney injury.

Animated presentations have also been used to disseminate widely key learning and important messages in response to incidents and trends.

All of these initiatives are disseminated in as many different ways as possible as previously described and have been supported by the Director for Medical Safety, Trust Medical Director and Chief Nurse all of whom assist in the wider cascade of these initiatives.

The initiatives have been recognised by the Trust Development Authority and Care Quality Commission as good practice initiatives. The Trust has recently been approached to share the learning lessons initiatives with other organisations.

The 2nd scoping survey results in 2013 indicate **68%** of staff who completed the survey know about “lesson of the month” and were able to name at least one lesson that had been disseminated. There has also been excellent engagement from clinicians to share learning via this method.

The SUI cascade initiative has also recently been evaluated using the scoping survey. Early results indicate there has been a **16%** increase in staff awareness of SUI’s that have occurred in the Trust. **52%** of staff had heard of the SUI reports and most of these knew how to access them.

## Infection Control

This year a trajectory of zero MRSA bacteraemias was set. 8 have been recorded and out of these 5 were considered unavoidable. There have been no MRSA bacteraemias at Solihull Hospital for over two years and none in Solihull community services for over four years. The Trust acknowledges that improvements are still required in comparison to other trusts.

A new innovation this year was the introduction of Octenisan universal antiseptic body for all adult patients' part of the 'washing away MRSA campaign'. This has been very successful resulting in a significant reduction of over 50% in the amount of MRSA detected in general screens and wounds swabs. A rationalisation to the screening programme was also made resulting in cost savings to the Trust.

**Figure 1. HEFT MRSA bacteraemia cases for April 2013 to March 2014, with the annual threshold shown.**

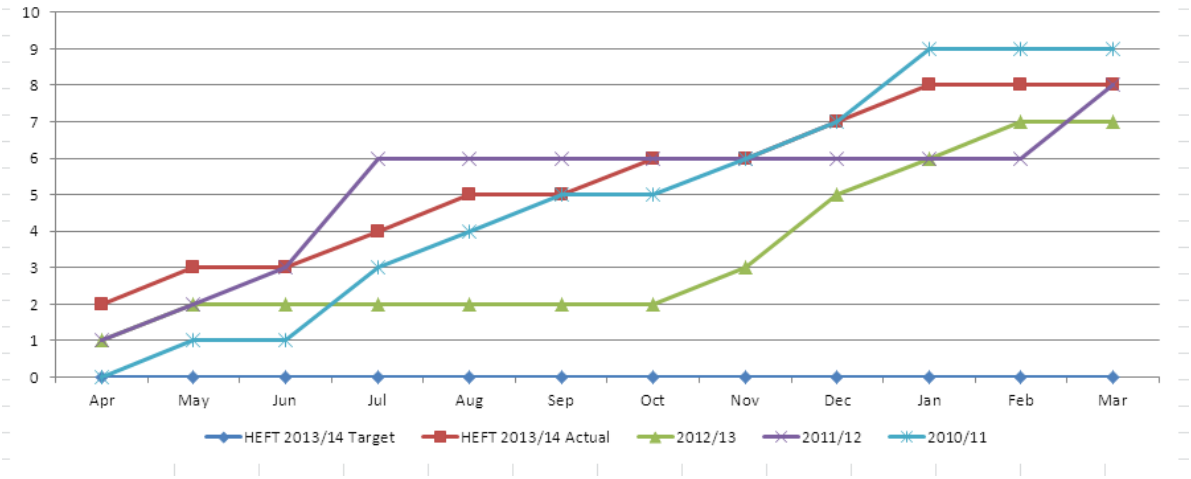
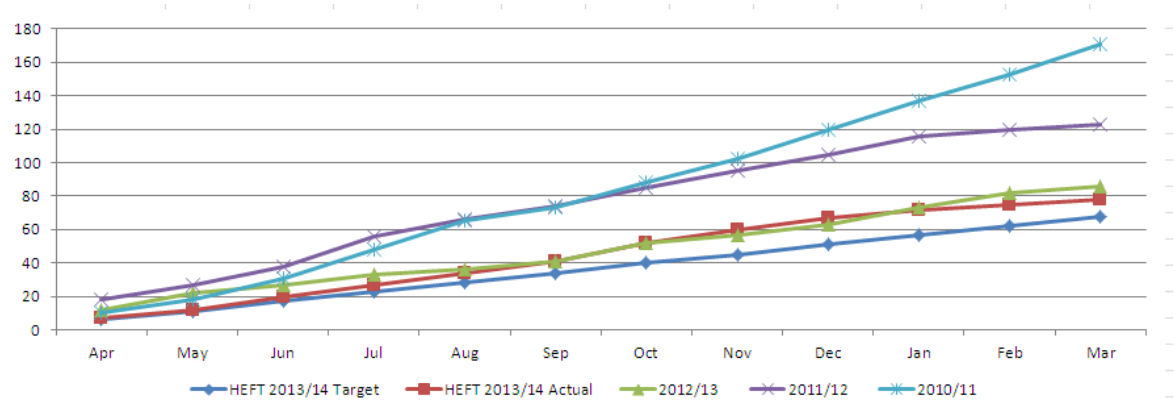



**Figure 2 HEFT *C. difficile* toxin-positive post-48 hour cases from April 2013 to March 2014, with the annual threshold shown.**




A very challenging trajectory of 67 C.difficile cases was set this year. Like the majority of trusts, Heart of England was unable to achieve its and the Trust has recorded 82 cases. A number of these cases were considered unavoidable and it is likely that an irreducible minimal has now been achieved.

The Human Probiotic Infusion Programme was further developed by Microbiology and Infectious Diseases this year, thereby providing treatment to patients with the most serious re occurring C.difficile infections. Heart of England is the only trust in the region providing such as service for its patients and those from other trusts.

The team training had a strong focus on improving urinary catheter care this year and the infection control nurses nurse were shortlisted for both the Nursing Times and Health Service Journal awards for this work.

# Clinical Effectiveness

**Incident Reporting**

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

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.

Figure 1 shows that most of the incidents that are reported are considered to be “Patient Safety Incidents (PSI’s)” broadly defined as any incident causing or having the potential to cause harm to a patient receiving services from the Trust. These incidents all have to be reported to the National Reporting and Learning System (NRLS) to support national data analysis, comparison and learning.

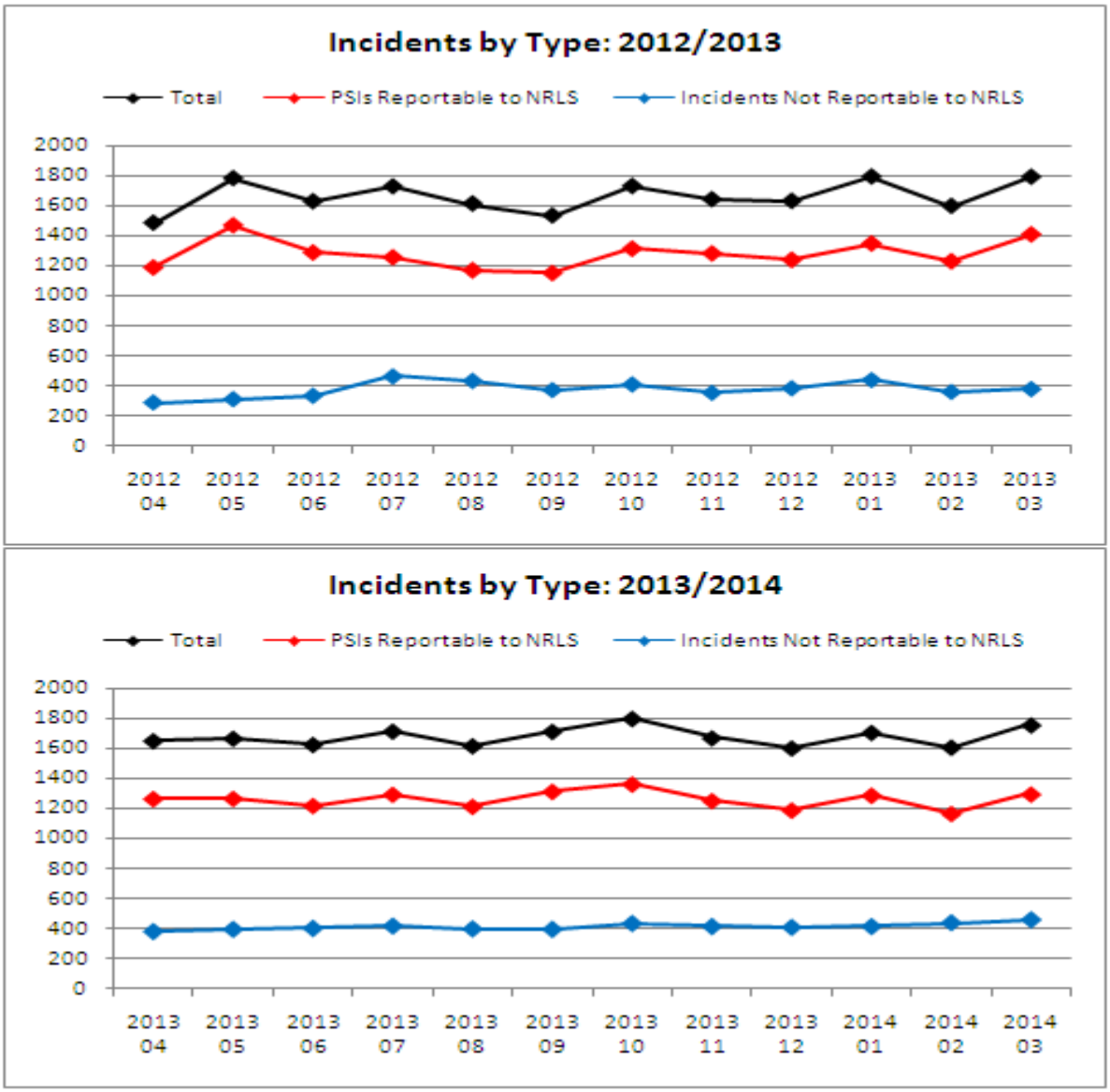



Fig.1 shows incidents occurring in 2012/2013 and 2013/2014. Incidents are split into patient safety incidents (PSIs), which the Trust is required to report to the NRLS and all other incidents.

Other high risk industries (such as the nuclear and airline industries) show that the Trust, in time, should aim to see an increase in the total number of incidents being reported, coupled with a reduction in the incidents resulting in the serious harm. Figure 2 shows that we have not yet achieved this profile with both the number of harm and no/low harm incidents reported being roughly the same over the last 2 years.

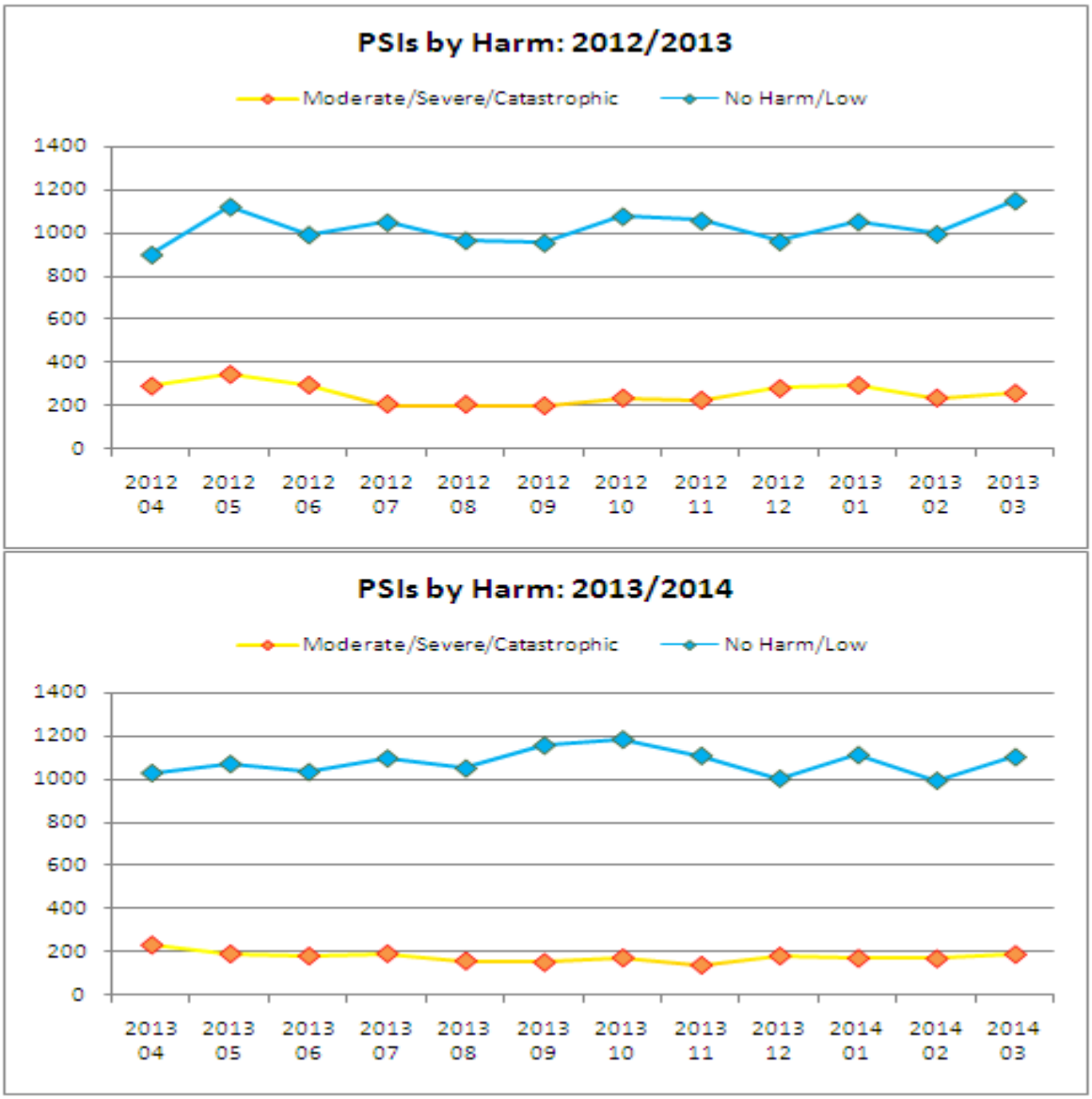


Fig. 2 shows patient safety incidents occurring in 2012/2013 and 2013/2014 split into those causing no harm or low harm and those causing moderate or severe harm or death.

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.

Approximately 20,000 incidents are reported by Trust staff each year. As illustrated in Figure 3, these are reported from all locations where Trust services are provided, this includes primary care settings and patients' own homes. The profile of where incidents are reported from remains broadly similar to last year, with the majority of incidents reported from Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospitals, reflecting where the Trust provides most of its services.

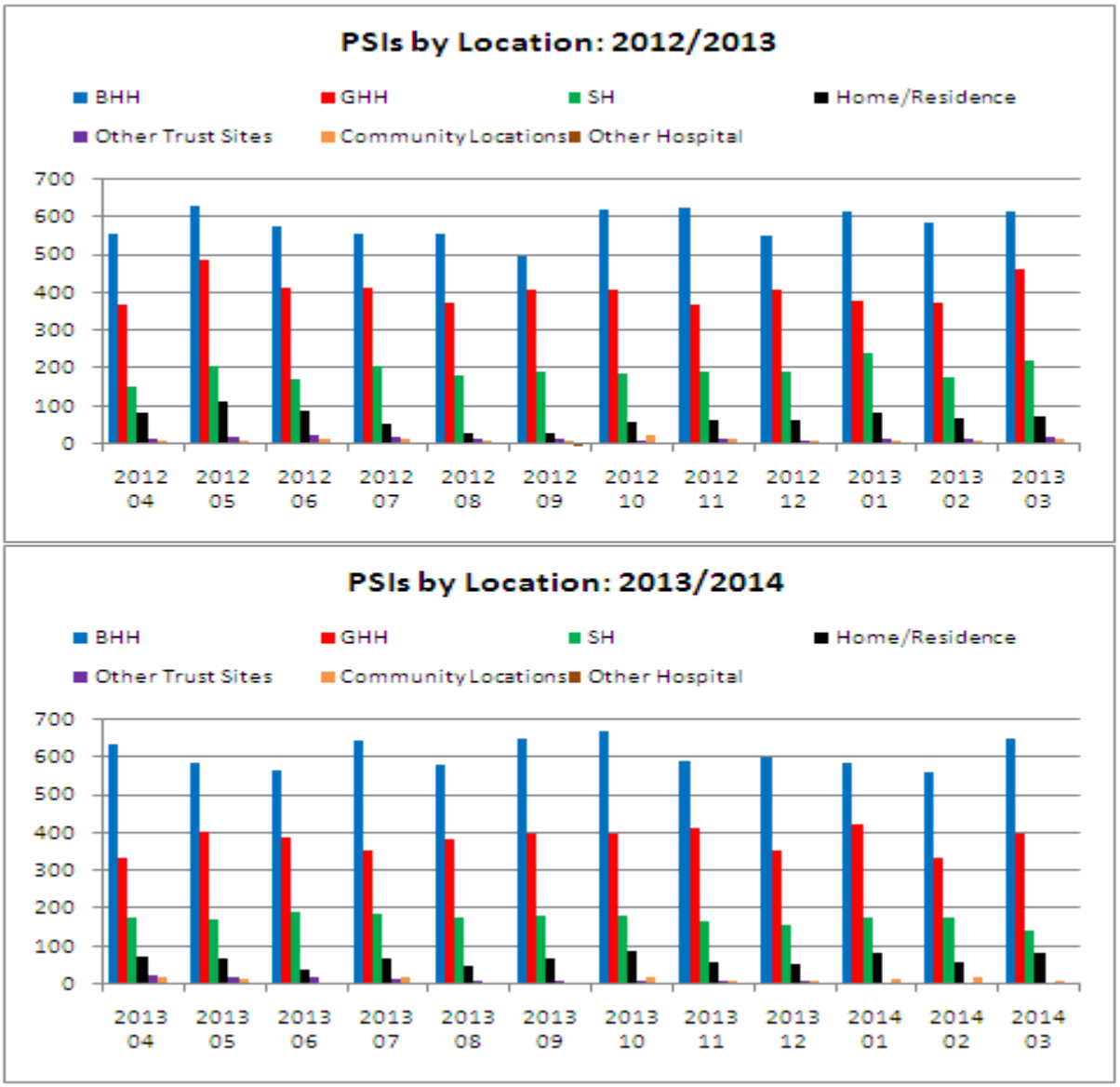


Fig. 3 shows patient safety incidents occurring in 2012/2013 and 2013/2014 and where they occurred.

The top 10 types of incidents reported are illustrated in Figure 4. The top three categories of incidents reported in 2013/14 are patient falls, tissue viability and medication, which, remain the same as last year and as expected. In line with national priorities, there continues to be much local work, described elsewhere in this document, to strengthen the reporting and learning from patient falls and tissue viability incidents which in turn is reflected by patient falls and tissue viability incidents being amongst the most frequently reported incidents.

A similar framework to support the reporting, investigation and learning from medication incidents is being developed for 2014/15.

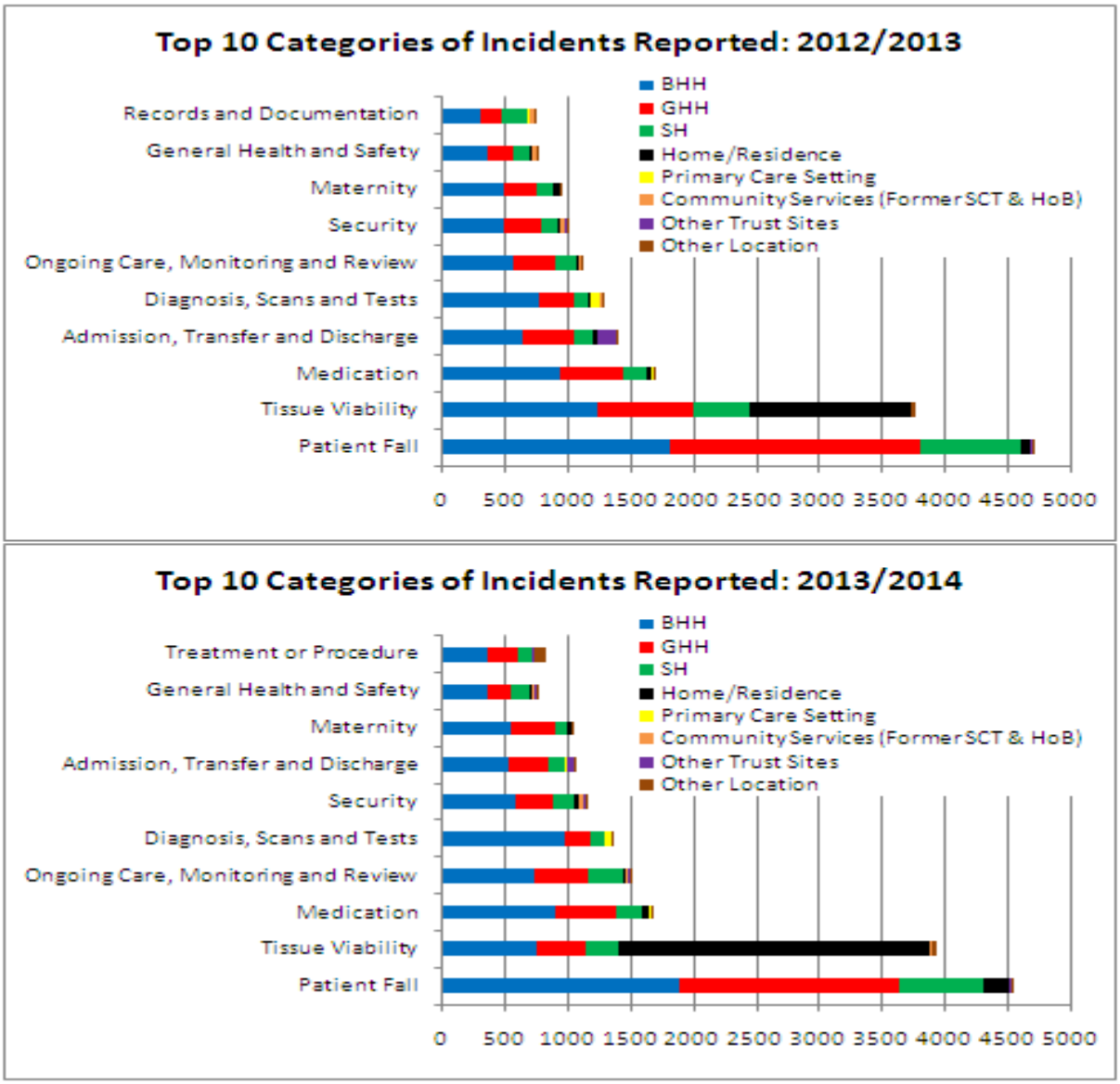


Fig. 4 shows the top 10 incident categories reported during 2012/2013 and 2013/2014 and where they occurred.

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

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

Whilst this can only be a very subjective assessment at the time of the incident, and may change as more is learned about the incident or outcome of the incident, this grading is used to identify the incidents that are to be investigated using root cause analysis (RCA) to identify learning.

## Duty of Candour

From April 2013, NHS England required a contractual duty of openness to be included in all commissioning contracts, called 'duty of candour'. This meant that NHS organisations were contractually required to tell patients about adverse events where moderate, severe or catastrophic harm has occurred, and ensure that lessons are learned to prevent them from being repeated.

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

This year the Trust has introduced a framework to record and monitor how this duty is being fulfilled and share this information with the Trust's CCG commissioners.

## Serious Incidents and Never Events

The Trust also uses incident severity as one way to identify the most serious of incidents which are investigated in line with the Trust's SUI Policy.

In 2013/14 the Trust identified and investigated 15 SUI's. The breakdown by site on which the SUI occurred as well as previous year's data for comparison is listed in the following Table 1.

**Table 1: Serious Incidents, Never Events (N) and Prevented Never Events (PN) data for last four years**
***incident was a service failure and not associated with a particular location**

| **SUI profile by location** | | | | |
|---|---|---|---|---|
| **Site/Division** | **10/11** | **11 / 12** | **12/ 13** | **13/14** |
| **Birmingham Heartlands Hospital** | 8 | 11 | 7 (2x N) | 7 (1xN) |
| **Good Hope Hospital** | 5 | 1 | 3 (1xN) | 4 (2xN; 1xPN) |
| **Solihull Hospital and Community Services** | 0 | 5 | 1 | 3 (2xN) |
| **Other / Not applicable** | | | | 1* |
| **Total** | 13 | 17 | 11 | 15 |

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

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

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

In 2013/14 there were 25 national Never Events listed, 23 of which are applicable to the acute and community services that the Trust provides.

Prevented Never Events were introduced in October 2012 and are defined as incidents that may have been never events had action not been taken to avoid an incident meeting the never events criteria and where such action is not part of the specified preventative action detailed in the relevant associated guidance or safety recommendations. For example, it is a prevented never event where an opioid naïve patient receives an opioid overdose, but the error is rescued and severe harm or death is prevented through rapid naloxone administration. This is also an actual patient safety incident and should be reported as such, but is not an actual never event.

During 2013/14 the Trust reported five Never Events and one prevented Never Event. Three of these (two of the Never Events and the one Prevented Never Event) occurred during 2013/14, the remaining having occurred in previous years.

- 2 wrong implant (Trauma & Orthopaedics/Theatres and Ophthalmology/Theatres)
- 2 retained foreign objects (General Surgery/Theatres and Trauma & Orthopaedics/Theatres)
- 1 wrong site surgery (General Surgery)
- Prevented : Opioid overdose of opioid naive patient (Elderly Care)

In 2013/14 through the course of incident investigations, the Trust identified that some of the actions following SUI's and Never Events in previous years had not had not resulted in the cross site sustained learning that would be expected. In response to this, the Trust has introduced executive led challenge meetings, starting with ophthalmology and T&O where there was evidence of repeated Never Events and weak implementation of actions from the previous incidents.

In addition to this, and working in close collaboration with our commissioners, the Trust has introduced 'Walk the Walks' where a team of Trust staff, including representatives from the non executive directors and executive directors, visit the area where the Never Event has occurred (e.g. theatres) to talk to staff and establish whether there is awareness of the incident and whether agreed actions have been put into place to mitigate the risk of recurrence.

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

**Mortality Statistics**

The Trust continues to monitor its mortality rate on a monthly basis using the Hospital Standardised Mortality Rate (HSMR) available from Dr Foster and on a quarterly basis using the Summary Hospital Level Mortality Indicator (SHMI) produced and published by the Health and Social Care Information Centre. Both of these indicators are a ratio of the observed number of deaths over expected deaths given the characteristics of the patients treated by the Trust.

The main differences between these two indicators are that:

- **They include different cohorts of diagnoses and deaths:** The SHMI monitors deaths from all diagnoses and includes both deaths in hospital and deaths 30 days after discharge. It includes death from all diagnoses as opposed to the HSMR which covers just 80% of diagnoses and only in hospital deaths. SHMI excludes palliative care codes and HSMR takes this into account.

- **They cover different time periods:** The SHMI covers a 12 month period and is published six months in arrears. HSMR is available three months in arrears as monthly, year to date accumulative and annual HSMR.

- **They are reported in different ways:** SHMI values are calculated using a ratio of 1 as the average and then categorised into one of the following three bandings for reporting:

- 1 - where a trust's mortality rate is 'higher than expected'
- 2 - where a trust's mortality rate is 'as expected'
- 3 - where a trust's mortality rate is 'lower than expected'

HSMR is calculated by Dr Foster using 100 as the average and Dr Foster have publically reported HSMR annually with similar commentaries groupings e.g. within expected range.

There is currently much debate about the usefulness of both the SHMI and HSMR and these figures require careful interpretation, and should not be taken in isolation as a headline figure of a trust's performance. They are best treated as a 'smoke alarm' and an indication of whether individual trusts are conforming to the national baseline of hospital-related mortality.

All trusts are encouraged to explore and understand the activity which underlies their SHMI and HSMR from their own data collection sources. The Trust's Mortality and Morbidity Performance Group meets monthly to review, analyse, interpret and request action upon Dr Foster data on behalf of the Trust. In 2013/14 this group consisted of clinicians from each hospital site, the Medical Director, the lead Medical Examiner, the Director of Safety and Organisational Development, the Director of Medical Safety, Head of Clinical Coding and a Technical Consultant (Analyst).

This data is also considered at the Clinical Quality Performance Group, one of the Trust's main quality, safety and risk committees, where mortality outcomes form part of a suite of indicators based on the outcomes framework. Exception reports are escalated to the Trust Board level Quality and Risk Committee and mortality data is also reported to Trust Board.

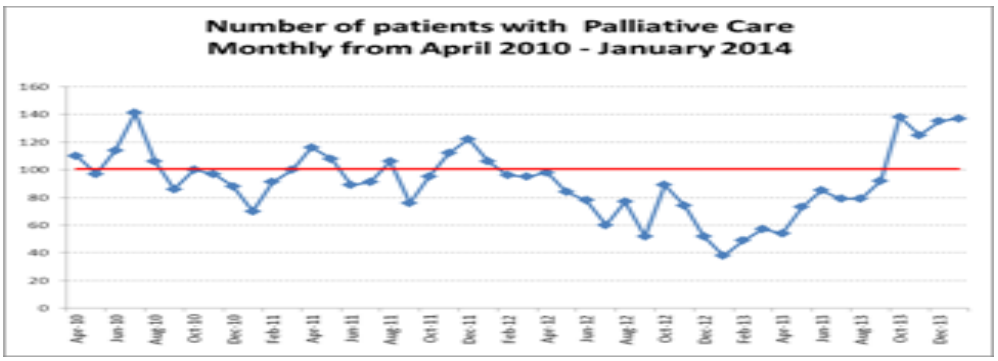
Over the last year the Trust observed a significant spike in mortality over the winter period with a resultant raised annual HSMR for April 2012/March 2013 of 107.5. The Trust's mortality rate 2012/13 was also identified as being an outlier in the annual Dr Foster report. An investigation using case note review and data analysis was undertaken to look at the main diagnoses that triggered this alert:

- Pneumonia;
- Acute myocardial infarction;
- Secondary malignancies; and
- Other upper respiratory diseases.

This review did not identify any obvious patterns of concern in relation to patient care. However, areas for improvement and further analysis were identified.

In November 2013 the Trust received a CQC mortality outlier alert in relation to mortality from Acute Myocardial Infarction (AMI). A comprehensive case note review and data analysis was undertaken and overall there were no significant patterns of concern identified in relation to AMI patient care. There were opportunities for improvement which had already been identified as part of our regular mortality and morbidity review. This information has been submitted to the CQC for review and the Trust is awaiting a response.

During last year the Trust was also aware that there was an under reporting of palliative care coding during 2012/13 which can have an adverse affect on HSMR (increasing it). This was investigated and addressed.




## Current position

The HSMR over the last year has gradually fallen since the marked winter spike and is now within the expected range. However currently the estimated rebased Trust HSMR for 2013/14 remains elevated (see below)

### Table 1a: Dr Foster HSMR, October 2012 – January 2014

| | | | | | | | NOT REBASED | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Site | Oct-12 | Nov-12 | Dec-12 | Jan-13 | Feb-13 | Mar-13 | Apr-13 | May-13 | Jun-13 | Jul-13 | Aug-13 | Sep-13 | Oct-13 | Nov-13 | Dec-13 | Jan-14 |
| Trust Wide | 96.8 | 101.1 | 113.6 | 110.2 | 130.2 | 122.0 | 110.2 | 111.1 | 94.0 | 103.5 | 93.1 | 95.9 | 99.4 | 103.0 | 98.7 | 87.9 |
| Heartlands | 98.9 | 105.9 | 112.6 | 112.5 | 130.6 | 122.4 | 122.8 | 107.2 | 95.5 | 111.1 | 92.0 | 102.6 | 108.8 | 109.7 | 104.9 | 78.3 |
| Good Hope | 99.1 | 102.7 | 113.0 | 110.0 | 127.3 | 115.7 | 95.0 | 111.5 | 94.8 | 96.3 | 98.0 | 95.0 | 99.2 | 96.2 | 104.1 | 93.8 |
| Solihull | 89.3 | 97.2 | 116.7 | 105.5 | 134.1 | 130.8 | 111.7 | 118.3 | 89.7 | 97.8 | 84.9 | 80.5 | 91.1 | 102.6 | 75.0 | 97.3 |

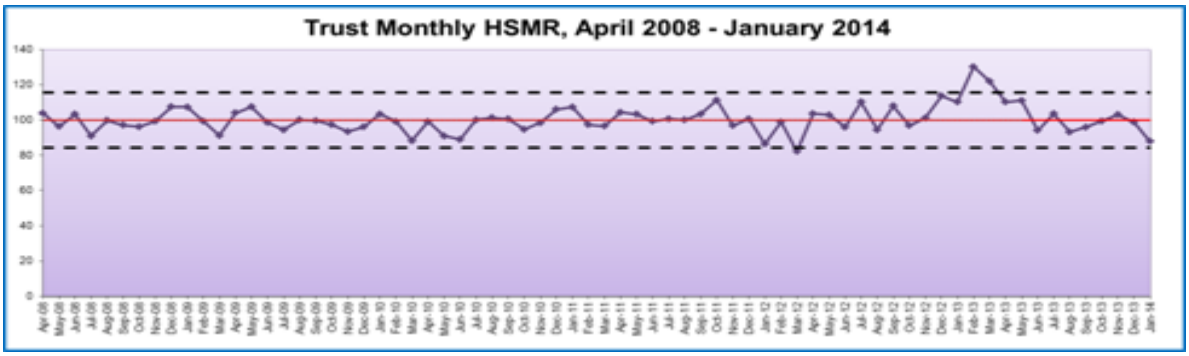
### Table 1b: Dr Foster HSMR, 2010/11 – 2013/14

| Site | 2010/11 (rebased) | 2011/12 (rebased) | 2012/13 (rebased) | 2013/14 YTD (not rebased) | YTD, estimated rebased Trust |
|---|---|---|---|---|---|
| Trust Wide | 98.5 | 98.2 | **107.6** | 99.6 | 111 |
| Heartlands Hospital | 97.5 | 100.7 | **108.7** | 103.0 | |
| Good Hope Hospital | 103.5 | 98.7 | **108.5** | 98.5 | |
| Solihull Hospital | 93.1 | 92.7 | 103.9 | 94.5 | |

*The HSMR YTD, estimated rebased Trust figure is a like-for-like calculation with previous year's figures.

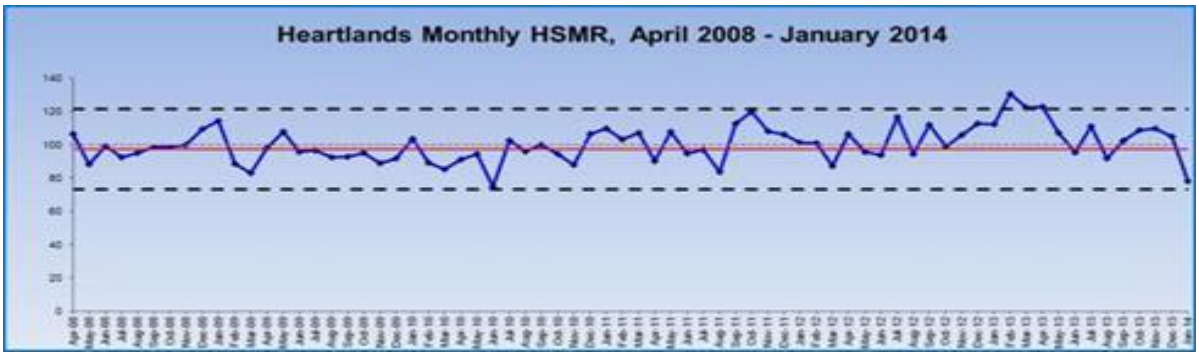
## 2. Monthly HSMR Charts

**Graph 1:** Trust Monthly HSMR - April 2008 to January 2014.



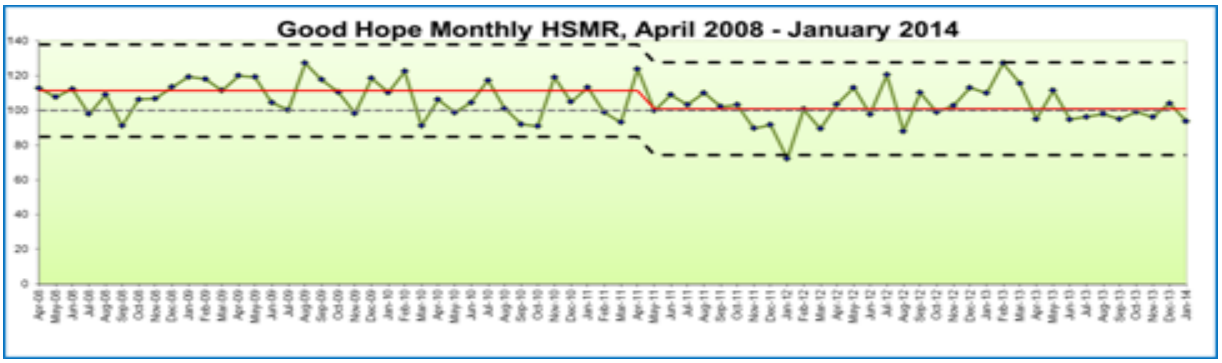

Notes: The red average line is calculated between March 2008 and October 2009.
April – October 2013 is not rebased, previous data is rebased.

**Graph 2:** Heartlands Monthly HSMR - April 2008 to January 2014



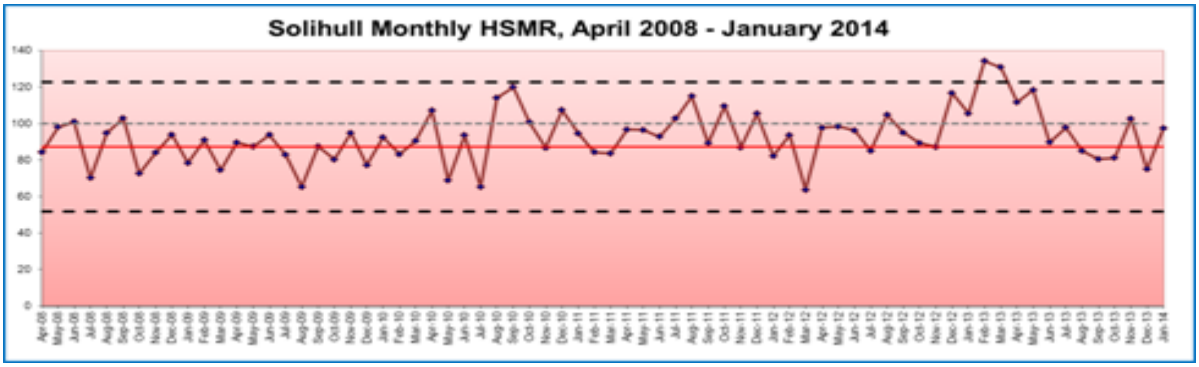

Notes: The red average line is calculated between March 2008 and October 2009.
April 2013 – January 2014 is not rebased, previous data is rebased.

**Graph 3:** Good Hope Monthly HSMR - April 2008 to January 2014




Notes: The red average line is calculated between March 2008 and October 2009 and May 2011- Dec 2012.
April 2013 – January 2014 is not rebased, previous data is rebased.

**Graph 4:** Solihull Monthly HSMR - April 2008 to January 2014




Notes: The red average line is calculated between March 2008 and October 2009.
April 2013- Jan 2014 is not rebased, previous data is rebased.

**SHMI:**

| Time period | Value | Banding |
|---|---|---|
| **January - December 2012** | 103.0 | as expected |
| **April 2012 - March 2013** | 107.9 | as expected |
| **July 2012 - June 2013** | 1.0855 | as expected |

**Rebasing**

Each year, Dr Foster and the Dr Foster Unit at Imperial College London recalculate the expected values and the risk estimates which are used to produce the risk adjusted outcomes found in the tools. The reasons for this include:

- Adding another year of data into the model;
- Improving the risk adjustment; and
- Refreshing historic data.

Implications for the HSMR are that due to the natural decline in mortality the annual update (rebasing) means a few trusts will change 'banding' and some may find their HSMR becomes higher or lower than expected when their pre banding provisional results have indicated that the HSMR will be 'within the expected range'.

# Patient Experience

## Complaints

Formal complaints continue to provide feedback to the Trust with regard to identified themes and trends which support training and service redesign across the Trust.

In 2012/2013 the Trust identified a need to improve the management of complaints and improved the process by responding to complainants on a more personal level. However, this still needed to be improved as complainants were still unhappy with the responses they received. A pilot study was prepared focussing on Solihull Hospital to introduce a centralised complaints function to bring the complainant at the heart of the complaint, allocating specific case managers whose responsibility it would be to communicate regularly at agreed times with complainants to update and provide support in relation to their complaint.

In order to demonstrate effective change across the complaints process, there are a number of key deliverables required to measure the benefits of this project:

- Effective and robust standard operating procedures to deliver complaints in line with the Parliamentary Health Service Ombudsman (PHSO) principles;
- Information and measurement, to ensure timelines are met, patients are kept informed and satisfied with the outcome;
- Workforce cost neutral;
- Physical environment to house the Patient Services team at each site;
- Reduction in the number of unsatisfied complaint outcomes seeking further resolution to their concerns after the final response is issued;
- Directorates demonstrating adoption of lessons learnt and providing evidence to that effect;
- Patient/ complaint experience measured.

**Including Key Performance Indicators:**

- Reduction of final responses that are returned by the complainant as the questions raised have not been answered.
- Working closely with the Divisional Management Teams identifying areas of concern as identified by number of complaints formal and concerns raised.
- Responses to complaints do not go over the agreed timescales – currently many complaints are renegotiated.
- Increase in the number of complaint responses passed as acceptable and appropriate quality.

- Ensure a smooth process that allows complainants to access the service easily.
- Survey of complainants 3 months following response letter to identify how the process worked for them.
- Monitoring of action plans and gathering evidence for Care Quality Commission CQC.

**What we have done well**

In line with the Clwyd Hart report the focus for complaints is a much more robust complaints handling which was highlighted as poor in the Clwyd Hart report. Therefore taking a step back to the 2009 'Making Experiences Count' policy which identified that communication is the key in good complaints management, our pilot site at Solihull ensures that all complaints are communicated with at initial contact, the aim is to:-

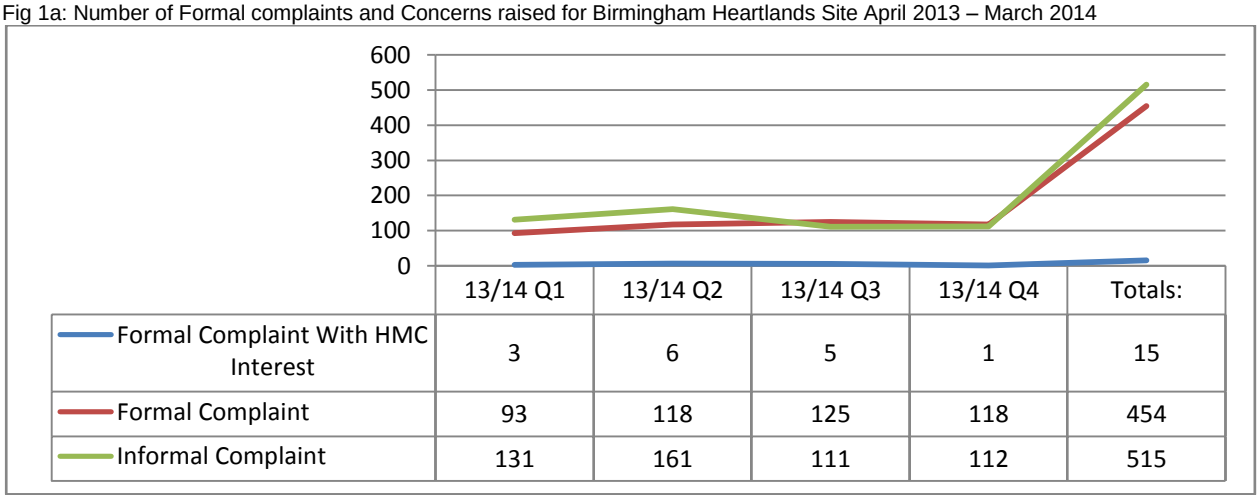
- Clearly identify what the complaint is about by direct communication with complainant, resulting in:-
    - More information with regard to specifics issues identified, names, times, places etc.
    - Clearer identification of questions raised.
- Communicating on a regularly agreed basis with the complainant which has resulted in:-
    - Fewer complaints regarding timescales.
    - Better quality final responses which answer the questions.

**Comparison Complaints Data**

Although complaints seem to remain fairly consistent, the number of concerns that are raised and dealt with and resolved at an early stage has increased, reducing the number of potential formal complaints to the Trust, as shown in Fig 1 below. The data for formal complaints and informal is used in conjunction with each other to identify themes and trends across the Trust.

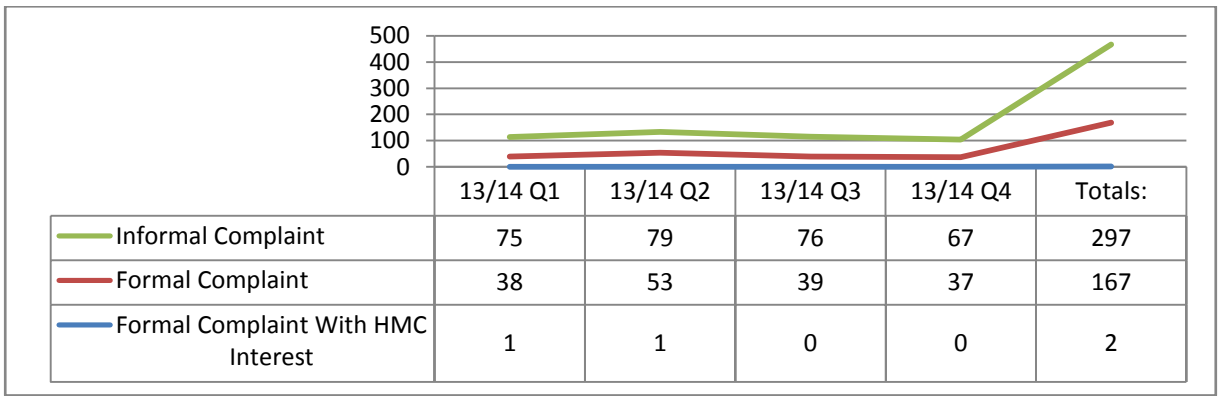
The Trust submits complaints data to the Health and Social Care Information centre via the Omnibus survey. The 2013/14 survey shows total written complaints received by the Trust of 958 (805 in 2012/13) with 574 of those upheld. Note that because of timing differences in the collection and submission of this data, scores reported internally for the period will differ.

Fig 1a: Number of Formal complaints and Concerns raised for Birmingham Heartlands Site April 2013 – March 2014



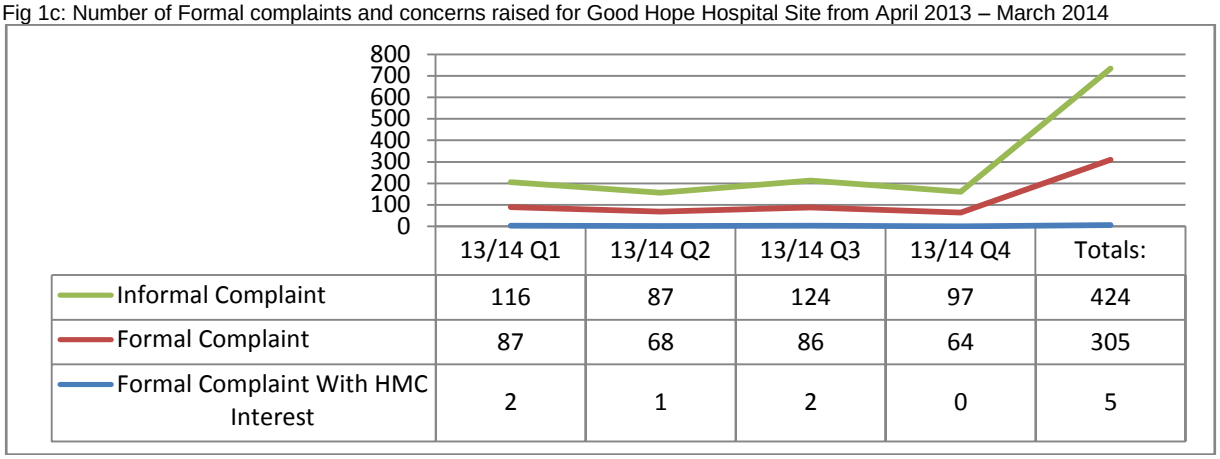

| | 13/14 Q1 | 13/14 Q2 | 13/14 Q3 | 13/14 Q4 | Totals: |
|---|---|---|---|---|---|
| Formal Complaint With HMC Interest | 3 | 6 | 5 | 1 | 15 |
| Formal Complaint | 93 | 118 | 125 | 118 | 454 |
| Informal Complaint | 131 | 161 | 111 | 112 | 515 |

Fig 1b: Number of Formal complaints and concerns raised for Solihull Hospital Site from April 2013 – March 2014



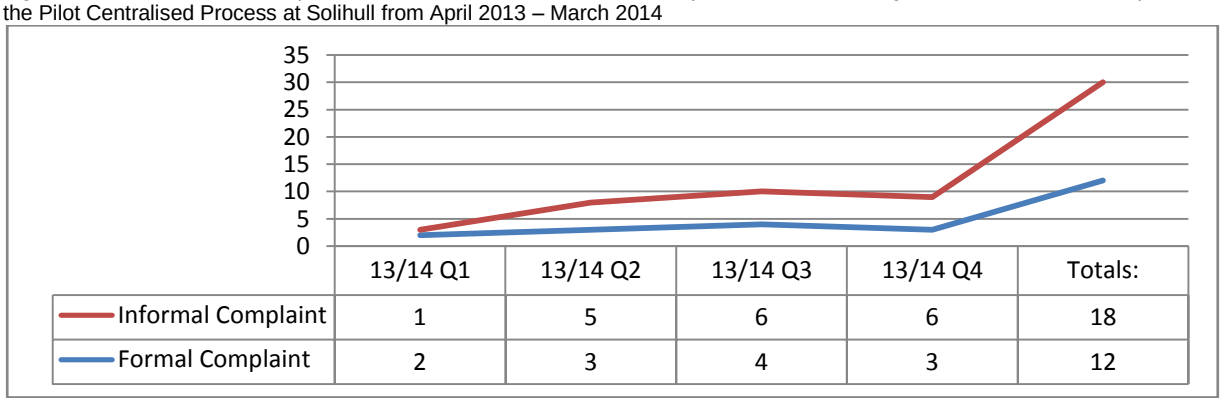

| | 13/14 Q1 | 13/14 Q2 | 13/14 Q3 | 13/14 Q4 | Totals: |
|---|---|---|---|---|---|
| Informal Complaint | 75 | 79 | 76 | 67 | 297 |
| Formal Complaint | 38 | 53 | 39 | 37 | 167 |
| Formal Complaint With HMC Interest | 1 | 1 | 0 | 0 | 2 |

Fig 1c: Number of Formal complaints and concerns raised for Good Hope Hospital Site from April 2013 – March 2014



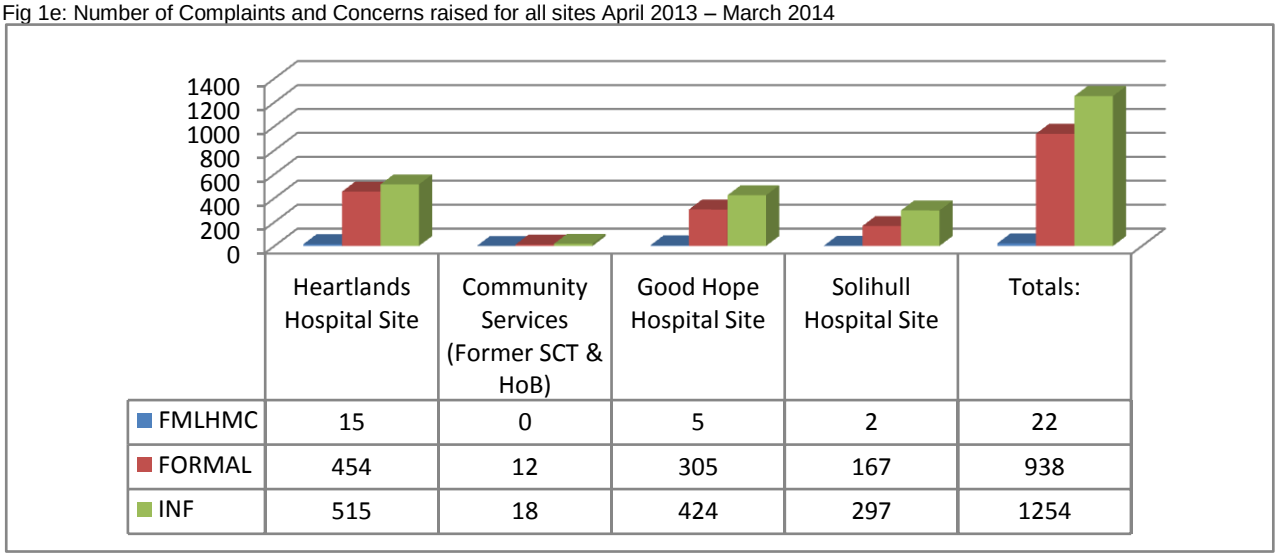

| | 13/14 Q1 | 13/14 Q2 | 13/14 Q3 | 13/14 Q4 | Totals: |
|---|---|---|---|---|---|
| Informal Complaint | 116 | 87 | 124 | 97 | 424 |
| Formal Complaint | 87 | 68 | 86 | 64 | 305 |
| Formal Complaint With HMC Interest | 2 | 1 | 2 | 0 | 5 |

Fig 1d: Number of Formal Complaints and concerns raised for Community Services – recording of these services has improved since the Pilot Centralised Process at Solihull from April 2013 – March 2014




| | 13/14 Q1 | 13/14 Q2 | 13/14 Q3 | 13/14 Q4 | Totals: |
|---|---|---|---|---|---|
| Informal Complaint | 1 | 5 | 6 | 6 | 18 |
| Formal Complaint | 2 | 3 | 4 | 3 | 12 |

Fig 1e: Number of Complaints and Concerns raised for all sites April 2013 – March 2014




| | Heartlands Hospital Site | Community Services (Former SCT & HoB) | Good Hope Hospital Site | Solihull Hospital Site | Totals: |
|---|---|---|---|---|---|
| FMLHMC | 15 | 0 | 5 | 2 | 22 |
| FORMAL | 454 | 12 | 305 | 167 | 938 |
| INF | 515 | 18 | 424 | 297 | 1254 |

Although there has been an improvement in the number of informal concerns raised, there is a need to develop this function further and the Trust is looking closely at how to utilise the Patient Services Staff to ensure that are available all day and every day at each site. An allocated Patient Services Officer will be in place at Solihull Hospital enabling a closer working relationship between the wards, departments and Patient Services to improve the patient pathway during their stays in hospital. Currently the Patient Services team is required to cover all three sites so having a dedicated Patient Services support working on one site will build knowledge and skills at Solihull and a bond between wards and Patient Services to resolve issues early on and still working closely with the Complaints Team to maintain improvements of the Centralised process.

On this basis there are plans to roll out 'centralised complaints' across the Trust to be completed by March 2015.

**Parliamentary Health Service Ombudsman**

Further improvement has been maintained with the number of complaints being forwarded to the Parliamentary Health Service Ombudsman (PHSO) reducing for the second year, continuing with the good work involving Directorates and Patient Services to achieve a satisfactory outcome with the complainants. Changes to the way PHSO investigate their current case load has changed and having a key person working within the organisation providing a link person to review cases such as those requiring investigation from the PHSO has improved considerably.

The table below shows the number of Ombudsman's contacts direct to the organisation relating to concerns raised for a specific patient reflective over a 4 year period

| PHSO profile by management team for Financial Year13/14 | | | | |
|---|---|---|---|---|
| Site/Division | 10/11 | 11/12 | 12/13 | 13/14(YTD up to January 2014) |
| BHH | 12 | 27 | 6 | 6 |
| GHH | 10 | 16 | 11 | 4 |
| SH | 6 | 5 | 1 | 3 |
| W&C | 6 | 3 | 1 | 0 |
| CSSD | 1 | 4 | 1 | 3 |
| Community | 0 | 0 | 1 | 0 |
| Corporate | 0 | 1 | 0 | 0 |
| Total | 35 | 56 | 21 | 16 |

| PHSO Profile by outcomes (Year To Date 31.3.14) | | | | |
|---|---|---|---|---|
| | 10/11 | 11/12 | 12/13 | 13/14 (YTD up to January 2014) |
| Upheld | 6 | 5 | 4 | 0 |
| Partially Upheld | 5 | 1 | 3 | 0 |
| Not Upheld | 1 | 2 | 2 | 2 |
| Not Investigated | 23 | 48 | 17 | 2 |
| Ongoing | 0 | 0 | 2 | 12 |
| Total | 35 | 56 | 28 | 16 |

| PHSO profile by Findings Financial Year 13/14 | | | | |
|---|---|---|---|---|
| Findings | 10/11 | 11/12 | 12/13 | 13/14 |
| Service failure | 10 | 5 | 0 | 0 |
| Maladministration | 4 | 2 | 1 | 0 |

| PHSO Profile by compensation paid Financial Year 13/14 | | | | |
|---|---|---|---|---|
| | 10/11 | 11/12 | 12/13 | 13/14 |
| Total | £24,779 | £10,000 | £250.00 | £0.00 |

| Complaints and Concerns raised to the PHSO (no data currently for year ending 2013/2014 from the PHSO) | | | | | | |
|---|---|---|---|---|---|---|
| Received | Total number of enquiries received by PHSO | Advice and Support given on where or how to complain | Number of complaints PHSO accepted | Number of complaints that they Upheld – agreed with | Number of complaints they partially upheld – agreed with elements of complaint | Number of complaints they were not upheld – did not agree with complaint |
| 2010/2011 | 171 | 0 | 12 | 6 | 5 | 1 |
| 2011/2012 | 124 | 7 | 8 | 5 | 1 | 2 |
| 2012/2013 | 111 | 28 | 9 | 4 | 3 | 2 |

# Patient Survey

The Trust is committed to ensuring patients have a positive experience of care, listening to their views is key to making improvements in the areas that matter most. The Trust uses a consortium of local and national measures which allow performance to be monitored and focus on areas which require attention. The most robust local programme was introduced four years ago to collect and report 'real time' feedback; which currently surveys 9,000 patients annually. The results are integral part of the Trust patient experience drive with monthly satisfaction reports presented to the Board of Directors. This work allows wards and departments to understand the key issues affecting patients. The table below shows the range of scores for the inpatient survey, it is organised into colour coded sections, the highest scores (green) are on the left and the lowest are on the right (red).

The findings of the 2013 CQC National Inpatient Survey show that the Trust performed about the same as the rest of England in all standards apart from the four detailed below in which we were found to be in the bottom 20% of Trusts.

- Availability of hand-wash gels
- Pain control
- Delays in discharge
- Taking family or home situations into account when planning discharge.

As a consequence plans to address these issues are under development and implementation.

Fig 1: Trust Inpatient Survey (April 2013 – March 2014)

| Help eating meals | Mixed sex bay | Hand hygiene | Respect & dignity | Cleanliness | Felt cared for | Regularly checks if comfortable | Pain control | Privacy discussing condition | Discuss worries or concerns | Recommend ward to family or friends | Involved in treatment decisions | Call buzzer response | Medication side effects | Informed about going home |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 100% | 100% | 99% | 98% | 98% | 97% | 97% | 97% | 97% | 94% | 93% | 92% | 86% | 84% | 68% |
| Top 20% of highest scores | | | Score in the intermediate 60% of scores | | | | | | | | | Bottom 20% of scores | | |

Fig 2: Trust Inpatient Yearly Comparison (April 2012 to March 2014)

| Trust Inpatient Survey: Overall Satisfaction Score | April | May | June | July | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012-13 | 91% | 92% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 92% | 92% | 93% | **93%** |
| 2013-14 | 94% | 94% | 94% | 94% | 94% | 94% | 96% | 91% | 89% | 93% | 93% | 93% | **93%** |

The Trust has dedicated resource and energy into ensuring the Friends and Family Test (FFT) is fully implemented for Inpatients, the Emergency Department and more recently Maternity Services. In real terms, for this measure alone, the Trust has increased the number of patients who gave feedback from 12,000 in 2012 to 27,000 respondents in 2013. Currently the Trust is achieving a 17% response rate; with the target for March 2014 is 20% (see table below for monthly trend).

Fig 3: Friends and Family Survey (April 2013 – March 2014)

| FFT Response Rate | April | May | June | July | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | 11% | 6% | 16% | 15% | 16% | 17% | 15% | 19% | 16% | 17% | 19% | 16% | 15% |
| Inpatient | 26% | 18% | 18% | 13% | 19% | 20% | 18% | 21% | 13% | 13% | 23% | 11% | 18% |
| Emergency | 4% | 1% | 15% | 16% | 15% | 16% | 14% | 18% | 18% | 19% | 18% | 18% | 14% |
| Maternity | | | | | | | 13% | 15% | 22% | 17% | 16% | 23% | 18% |

The Friends and Family Test is an important dimension of patient experience data. It is a simple headline metric which, when combined with follow-up questions, can be used in any patient pathway to measure the quality of care provided. Patients rate the Trust on the likelihood they would recommend services to relatives and friends. The score is calculated by subtracting the percentage of 'Promoters' from the percentage of 'Detractors' which gives a score from -100 to 100. To achieve a score of 100 all respondents must say they were 'extremely likely' to recommend the service. The responses are divided into the following categories:

- Promoters ('extremely likely' to recommend)
- Passives ('likely' to recommend)
- Detractors ('neither likely or unlikely, unlikely and extremely unlikely' to recommend)

The results from all of these sources are presented in conjunction with one another, which provides the Trust with a rich and comprehensive picture of patient experience. This information is shared every month with staff, the Trust Board and Governors Patient Groups. The table below shows the average scores for inpatient, emergency patients and maternity patients for 2013.

Fig 4: Friends & Family Test (April 2013 – March 2014)

| SOL : Labour/Birth | SOL : Inpatient | GHH : Inpatient | GHH : Labour/Birth | BHH : Inpatient | BHH : Labour/Birth | GHH : Postnatal Ward | GHH : Antenatal | Postnatal Community | BHH : Antenatal | SOL : ED | BHH : Postnatal Ward | Heart of England | GHH : ED | SOL : Antenatal | BHH : ED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 84 | 72 | 70 | 65 | 62 | 56 | 55 | 54 | 47 | 47 | 46 | 46 | 45 | 40 | 32 | 24 |
| Top 20% of highest scores | | | | Score in the intermediate 60% of scores | | | | | | | | Bottom 20% of scores | | | |

Fig 5: Trust Friends and Family Yearly Comparison (April 2012 to March 2014)

| Friends and Family Test | April | May | June | July | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2012-13** | 27% | 25% | 63% | 60% | 69% | 66% | 68% | 65% | 69% | 68% | 67% | 73% | **60%** |
| **2013-14** | 69% | 70% | 65% | 74% | 73% | 73% | 79% | 76% | 69% | 73% | 73% | 74% | **72%** |

The table above shows the percentage of inpatients who said they were 'extremely likely' to recommend the hospital to friends and family.

The Trust has increased the number of patients asked to give feedback by 64,000 during 2013, the table below shows year on year comparison:

| Comparison of patients surveyed and quality comments between 2013-2014 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Year** | **Patients sampled** | **Total Responses** | | **Compliments** | | **Improvement** | |
| | | **n** | **%** | **n** | **%** | **n** | **%** |
| **2013-14** | 213,464 | 41,813 | 20% | 14,503 | 35% | 6,435 | 15% |
| **2012-13** | 148,483 | 30,570 | 21% | 2,958 | 62% | 1,795 | 38% |
| **2011-12** | 38,795 | 14,650 | 38% | 1,598 | 52% | 1,500 | 48% |

The Survey Team is responsible for conducting patient experience surveys on behalf of the Trust, the main projects are summarised in the table below:

| **Title** | **Sample** | **Response** | **Compliments** | **Improvement** |
|---|---|---|---|---|
| National Inpatient Survey | 850 | 330 | 87 | 43 |
| National Maternity Survey | 776 | 288 | 81 | 53 |
| National Cancer Survey | 1,559 | 896 | 271 | 180 |
| Inpatient Metrics Programme | 21,160 | 9,786 | N/A | N/A |
| Inpatient Friends & Family Test (FFT) | 51,549 | 9,152 | 5,225 | 2,791 |
| Emergency Department FFT | 119,906 | 16,231 | 6,991 | 2,875 |
| Maternity Services FFT | 12,472 | 2,098 | 1,149 | 342 |
| Community Services | 5,192 | 3,032 | 699 | 151 |
| **Total** | **213,464** | **41,813** | **14,503** | **6,435** |

## Quality Improvement

Quality improvement is a very important aspect of patient experience, the table below highlights some of the main projects carried out in 2013:

| **2012 Concern** | **HEFT Action / Response** | **2013 Outcome** |
|---|---|---|
| 15% decline in the number of patients always given help to eat meals | **Keeping nourished scorecard and exception report** presented monthly at Nursing and Midwifery Performance Committee which were scrutinised to ensure, where necessary, patients are always given help to eat meals. Where appropriate trained volunteers and relatives now assist with feeding. | 12% increase in the number of patients always given help to eat meals (National Inpatient Survey 2013). Internal patient metrics programme has attained target satisfaction levels of 95% or higher for last 12 months. |
| 9 in 10 patients were not asked to give their views while in hospital | 600 patients surveyed each month on the wards asking them to rate the care they receive, results reported to Trust Board every two months. Successful launch of 'The Friends and Family Test' in April 2013 for Inpatients and Emergency patients, Maternity Services commenced in October 2013. The Trust is currently achieving CQUIN baseline target of a 15% response rate. | 6% increase in the number of patients who said they were asked to give views whilst in hospital (National Inpatient Survey 2012-13) |
| 1 in 2 patients not informed when they would be discharged | The Jonah Programme has been integrated across the Trust. A key feature has been visual management | Solihull Hospital patient metrics show a 9% increase in the number of patients |

| | | |
|---|---|---|
| from hospital (Inpatient Survey 2012-13). Patient Metrics show 60% of patients said staff did not talk about when they would go home | to ensure the planned patient journey is visible, along with their progress. There is a heavy emphasis on coaching to develop leadership, improvement and problem solving skills at ward level.<br>At ward level it focuses on individual patients and engages the multidisciplinary team in setting and delivering a Planned Date of Discharge (PDD). The focus is on defining clear plans for the patient's stay on the ward. | who were informed about their discharge date from 68% in the first quarter to 77% in quarter 3. Good Hope increased the number of patients by 15% between April and October, similarly, Heartlands increased by 10% in the same period. However, the results for November and December show a decline which is being monitored. |
| 12% decline in patients who knew how to complain about care received | Information campaign throughout the Trust, new leaflets and posters were designed that detailed the number of ways patients and relatives can escalate concerns and complaints. Posters are displayed in corridors, wards and outpatient clinics. The leaflets are in display boards and the information is also included in the Trust bedside folders. | 5% increase in the number of patients who said they were given information about how to complain about their care (Inpatient Survey 2013) |
| 2 in 3 patients not told about side effects of medication | The Chief Executive Safety Project focused on medication safety supported by a 'message of the month'. | The Trust set a target of 50% of patients completely told about the side effects of medication. It is monitored through the Key Performance Indicators (KPI). Results from quarter 3 show 47% of patients were told about side effects of medication, an increase of 15% since the previous quarter. |

# Staff Survey

The National Staff survey was carried out between September and December 2013 with a response rate of 32%. The overall indicator of staff engagement showed statistically no improvement from 2012.

The Trust has put in place a number of initiatives during the past year to try and improve this including specific action planning for certain specialities; listening events and new Apps to start dialogues on safety, the results of which have been mixed. Therefore the Trust has reviewed its approach again and has a number of planned changes for 2014 including the development of a Trust-wide Staff Engagement Strategy as well as introduction of a staff Friends and Family Survey. More information can be found in the Annual Report.

# Local and National Priorities

The National Priorities reflect the requirements for Monitor's Compliance Framework. This is one of the tools used by Monitor to assess the compliance of foundation trusts with their Terms of Authorisation and to determine where intervention may be necessary.

The Local Priorities are the main performance indicators, which are a combination of national and local measures, set out in the Trust's contract with the local commissioners. These are used to routinely review the Trust's performance and to hold the Trust accountable where performance is not meeting the required standard.

| **Description of Target** | **Target 2013/14** | **10/11** | **11/12** | **12/13** | ***13/14*** *(Apr13-Mar14)* |
|---|---|---|---|---|---|
| Reduction of incidence of Clostridium (post 48 hours)*. | 67 | 171 | 123 | 86 | *82* |
| Reduction of incidence of MRSA bacteraemia (post 48 hours). | 6 | 9 | 8 | 7 | *8* |
| Patients first seen by a specialist within 2 weeks when urgently referred by their GP or dentist with suspected cancer. | >=93% | 94.04% | 94.50% | 93.66% | *92.86%* |
| Patients first seen by a specialist within 2 weeks when urgently referred by their GP with any breast symptom except suspected cancer. | >=93% | 94.81% | 94.79% | 94.64% | *93.20%* |
| Patients receiving their first definitive treatment within 1 month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer. | >=96% | 98.62% | 97.42% | 96.92% | *97.92%* |
| Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat – **Anti cancer drug modality.** | >=98% | 100% | 100% | 99.72% | *100%* |
| Patients receiving subsequent treatment (surgery and drug treatment only) within 1 month (31 days) of a decision to treat – **Surgery modality.** | >=94% | 98.43% | 97.10% | 97.42% | *98.44%* |
| Patients receiving their first definitive treatment for cancer within 2 months (62 days) of GP or dentist urgent referral for suspected cancer. ** | >=85% | 85.62% | 85.44% | 86.35% | *86.33%* |
| Patients receiving their | >=90% | 99.44% | 98.16% | 99.13% | *97.00%* |

| | | | | | |
|---|---|---|---|---|---|
| first definitive treatment for cancer within 2 months (62 days) of urgent referral from the **National Screening Service.** | | | | | |
| Admitted Patients Treated within 18 Weeks of Referral | >=90% | NA | 90.00% | 92.03% | *89.39%* |
| Non-Admitted Patients Treated within 18 Weeks of Referral | >=95% | NA | 97.82% | 96.85% | *96.29%* |
| 18 week incomplete pathways | >=92% | NA | NA | 95.57% | *94.21%* |
| Maximum waiting time of 4 hours in A&E from arrival, to admission, transfer or discharge | >=95% target | 95.41% | 95.97% | 93.13% | *93.02%* |
| Self certification against compliance with requirements regarding access to healthcare for people with a learning disability | Meeting 6 out of 6 criteria | 6 out of 6 | 6 out of 6 | 6 out of 6 | *6 out of 6* |
| *2013/14* | | | | | |
| | *Target 2013/14* | *Qtr1* | *Qtr2* | *Qtr3* | *Qtr4* |
| *Community Services Data completeness: Referral to treatment* | 50.00% | 85.0% | 96.32% | 96.67% | 84.10% |
| *Community Services Data completeness: Referral information* | 50.00% | 89.10% | 97.71% | 99.98% | 97.01% |
| *Community Services Data completeness: Treatment activity* | 50.00% | 99.80% | 99.99% | 99.80% | 91.80% |

2013/14 has been a challenging year for the Trust in respect of its performance against a number of key targets.

The delivery of the A&E 4 hour target has proved to be particularly difficult and the Trust has been issued with Enforcement Undertakings by Monitor, our regulator in respect of this, further information on this is provided in the Annual Report and the Annual Governance Statement.

Performance against the cancer indicators has generally been good with occasional lapses in performance against the 2 week wait and 62 day cancers, the former due to a significant increase in referrals to the service and the latter in relation to the delivery of our urology cancer pathway. The Trust always works closely with our local CCGs when concerns around delivery of targets arise and develops action plans to improve performance.

Up until quarter 4 the Trust were delivering all of the 18 week referral treatment indicators, however for the admitted pathway, there had developed an increasing backlog of patients waiting to be treated and a decision was made that over Quarter 4 of 2012/13 and Quarter 4 of 2014/15 to treat some of the longest waiting patients, which means that the Trust will fail the indicator.

The Trust had 88 cases of C.difficile in the Trust this year, 6 less than last year and analysis up to the end of quarter 3 showed that only 24 of these were avoidable.

Away from the main national Monitor targets the Trust is measured against a number of other indicators including:

A range of indicators relating to patients that have had a stroke which is detailed earlier in this report;
A number of indicators relating to maternity services - these show that the Trust have improved breast feeding rates to 70% of women initiating breast feeding, up 3% on last year and that there are very good processes in place to ensure that babies that are at risk of developing TB are vaccinated before they leave hospital.

There is still some work to do to improve performance around ambulance handover times and are working with our partners across the Local Health Economy to address this.

The Trust is pleased that we have been able to reduce the average of length of stay in hospital for patients admitted as an emergency by nearly 2 days since the start of the year; this shows improvement in our processes for managing discharges.

In order to issue their opinion and long form report the external auditors tested the following indicators:

| | Definition |
|---|---|
| 62 day cancer targets | Maximum waiting time of 62 days from urgent GP referral to first treatment for all suspected cancers |
| Clostridium Difficile | Number of C.Difficile infections. |
| Stroke Swallow assessment | Number of confirmed strokes having a swallow screen within four hours of presentation |

The above table summarises the definitions used for each indicator.

# Part 4:
# Statements from Stakeholders

**Statement from Solihull Clinical Commissioning Group**

The statement is from Solihull CCG as host commissioners for the Heart of England Foundation Trust. The statement has been developed and informed and approved by a number of additional organisations including patient representatives across the local health economy as defined.[7]

2013/14 has been a challenging year for the Trust and Commissioners with a significant emphasis placed on improving quality and the patient experience of care. The year started with a follow-up 'risk' summit during May 2013 led by NHS England to review the implementation of the Trusts actions to improve both the patient experience of A&E services and the Trusts achievement of the A&E four hour wait target. The Trust has undertaken a number of internal reviews and initiatives to improve the experience of care in A&E however this remains a challenge. This has been more recently identified through the Care Quality Commissions (CQC) Trust wide inspection during November 2013. Commissioners were present at the CQC Quality Summit in January 2014 and the Trust has submitted an action plan to the CQC.

Commissioners are content that the information contained in the quality account represents a fair and balanced view of the acute services. We are however disappointed that the account does not reflect detailed information on community services as required stated in the MONITOR NHS Foundation Trust annual reporting manual 2013/14.[8] In addition there is very little information in relation to maternity or paediatric services. As commissioners we wish to comment on the particular areas;

- Reducing avoidable harm

As stated within the account HEFT reported 5 never events during the year 2013/14. This is an increase on last year. Commissioners issued a contract query to the Trust during December 2013 to understand the extent to which the Trust had put in place effective systems and processes to minimise recurrence. A remedial action plan was developed which involved the Trust reviewing all of the reported never events over a period of 3 years. We welcome the Trusts reflection that some previous actions did not result in the cross site sustained learning and acknowledge the introduction of executive led challenge meetings.

Commissioners led 2 themed reviews during the year 2013/14. The first was a falls themed review in collaboration with the Trust during June 2013. The Trust reports all falls resulting in serious injury to commissioners. Following the review an action plan was received (December 2013) which detailed a number of work-streams to reduce the number of falls. We note the Trust commitment to maintain a focus on falls and commissioners have placed a contractual requirement for reductions and improved outcomes during 2014/15.

Commissioners also undertook a themed review of pressure ulcers during February 2014. The report has been provided to the Trust with an action plan being developed. The Trust has a contractual requirement for pressure ulcer reduction during 2014/15.

[7] Birmingham Cross City CCG, South East Staffs and Seisdon CCG, NHS England, Birmingham South Central CCG

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

- Trust Priorities 2014/15

Commissioners welcome the continued focus on Falls and Pressure Ulcers as continuing priorities for 2014/15.

The Trust has provided a progress update against the priorities set during 2013/14. The Quality Account does not specifically reference the Chief Nurse (for England) national 6'Cs campaign as a Trust wide priority.[9] We do acknowledge the Trusts priority for 'fundamentals of care' and support the work the Trust is implementing and embedding as a result of this priority. We particularly commend the work in relation to the compassionate care packs, and the compassionate carers project together with the Trusts implementation of the 'hello my name is' campaign. We are unclear from the Quality Account how the 'fundamentals of care' is applied specifically within community services.

Although we welcome the continued clinical focus on stroke, dementia and fractured neck of femur and the focus for improved safety and experience of discharge arrangements, we note that the Trust has chosen to roll forward priority 1-4 for a 3rd consecutive year and priority 5-7 for a 2nd consecutive year rather than identify new priorities and focus on continual improvement of the previous priorities as a core business activity.

- Patient Safety

The Trusts safety manuals demonstrate one way the Trust seeks to improve patient safety. The Trust has developed some innovative methods for communicating and commissioners note the emergency medicine and the neonatal safety app in particular. Medication safety is a particular area of focus for commissioners during 2014/15 and we welcome the Trusts identification of this as a top priority. We feel that the Trusts patient safety section could be strengthened with further detail in relation to safety improvement programmes for community services.

It is positive that there has been an increase of staff awareness of SIS (significant incidents) however we would welcome a continued focus on this to increase staff awareness during 2014/15.

We commend the Trust in its approach to commissioning and reporting of the independent review of breast services in Solihull and it is the opinion of commissioners that the Quality Account should reflect some of the detailed work-streams arising from this review.

- Patient Experience

It is pleasing to note that the number of complaints referred to the parliamentary health services ombudsman has reduced as has the number of complaints upheld/partially upheld. We support the Trusts focus on its complaints management and in particular the deliverables and key performance indicators the Trust is measuring to demonstrate an improved service which places 'the complainant at the heart of the complaint.' Whilst the quality account highlights some of the main patient experience projects carried out during 2013, it would have been beneficial to demonstrate some quality improvement initiatives as a result of complaints. Similarly there is no detail included as to the actions taken to improve patient experience as a result of the Friends and Family test.

- Safeguarding

It is disappointing that the Trust has not outlined any key strategic challenges in relation to the safeguarding agenda and commissioners view this omission as surprising given the looked after children and safeguarding review of Solihull undertaken by the CQC during February 2014 and the serious case review published during 2013/4.

To summarise, commissioners welcomed the opportunity to comment on the account and to reflect on the year. We acknowledge the challenges that the Trust faced and acknowledge some of the key achievements of the Trust during 2013/14. We do however feel that the Quality Account could

[9] Compassion in practice – Care, compassion, competence, communication, courage and commitment

define more clearly the learning outcome and impact on patients and be more patient and public friendly in the language and terminology used. Commissioners look forward to continuing to work collaboratively with the Trust during 2014/15.

**Patrick Brooke**
**Chief Officer**
**Solihull CCG**

**Sue Nicholls**
**Chief Nurse**
**Solihull CCG**

**Statement from Solihull Healthwatch Organisation**

This report describes our judgment of the quality of care based on the submission of the Trust's Quality Account 2013/14. It is based on a combination of what we have observed from the statements in the report, information from the recent Care Quality Commission (CQC) inspection and members of the public.

Healthwatch Solihull (HWS) recognises the challenges the Trust has faced over the past twelve month since its last report with regards to Accident and Emergency (A and E) waiting times and that the Heart of England NHS Foundation Trust, across all the three sites, is below the national average in the Friends and Family Tests introduced in both A and E and inpatients. The trust scored 68, out of a possible score of 100 in the August inpatient Friends and Family Test, significantly below the national average of 72, with a response rate of 19%. The Trust scored 35 out of a possible score of 100 for the A and E department, again significantly below the national average of 64. The response rate was 15.1% for the department, which was above the national average of 11.3%.

It also acknowledges that in November 2013 the Trust received a new style of CQC inspection that generated candid reports across all three sites following announced and unannounced visits.
Healthwatch Solihull was present at the CQC Quality Summit in January 2014. The Heart of England NHS Foundation Trust has been inspected 17 times across its different locations since registration with the Care Quality Commission in 2010.

Healthwatch Solihull is keen to monitor progress as are the Trust's regulators MONITOR to see how the Trust is progressing against its four action plans and each of the sets of compliance actions raised in the CQC reports.

The outcomes from the Trust's involvement in the special review by the CQC relating to 'looked after children and safeguarding in Solihull' is of special interest to HWS as Children's services falls within the statutory framework of all local Healthwatch.

The Trust is to be praised for the very good work it does on a day to day basis caring for patients and being responsive to patient's needs. The E-JONAH system that highlights patients who are medically fit for discharge and promotes multidisciplinary working to discharge patients effectively whilst very new, is showing evidence of working well.

Despite some of its recognised difficulties facing all acute service providers, it is a credit to the Trust of how they respond to people with mental health conditions particularly at the Heartlands site. Once admitted to hospital the process from initial assessment to diagnosis and help and support (Rapid, Assessment, Interface and Discharge [RAID] team) is reportedly seen to be quick, with nursing staff demonstrating a genuine concern and empathy for the individual.
Where Healthwatch Solihull would like to see improvements:

- The efficient running of operating lists to reduce the number of cancelled operations. This is very distressing to patients when they mentally prepare for elective surgery to have an appointment last minute.

- Nutrition for frail elderly, that very sick patients are not just left to feed themselves and given food that is difficult for them to eat.

- Clarification with regards to the services provided by the A and E department at Solihull.

- To be proactive in the trust's commitment to meet its four action plans against each of the sets of compliance actions raised in the CQC reports.

These improvements are consistent with other external reports and HWS will continue to support the Trust by providing independent external challenge where appropriate.

**Samantha Mills**
**CEO – Healthwatch Solihull**

**Statement from Birmingham Healthwatch Organisation**

Healthwatch Birmingham recognise that Quality Accounts are a useful contribution to ensuring NHS providers are accountable to patients and the wider public about the quality of the services they provide. We welcome the opportunity to comment on the draft Quality Account and Report 2013/14 for Heart of England NHS Trust.

The Quality Account reflects a challenging year for the Trust, and Healthwatch Birmingham is pleased that the Trust has decided to continue to focus on all seven of the priority areas identified for improvement in the previous year.

We have the following observations with regard to performance against a number of the priority areas in 2013/14:

Fundamentals of care
There are a number of examples of good practice reported, such as the introduction of dignity pyjamas and the trialling of compassionate care packs for carers. Poor performance on the level of prompt response to call buzzers and on involving patients in decisions on their treatment and care both indicate areas for further improvement.

Falls
The Trust retains a clear commitment to reducing falls, whilst acknowledging they account for the largest number of adverse events reported. Trend data in the draft Quality Account & Report indicates areas for improvement including on putting care plans in place to minimise the risk of falls and carrying out bedrail assessments. These seem to be relatively easy improvements to implement.

Fractured neck of femur
Whilst there have been significant improvements across the nine indicators, which we welcome, there remain some areas of concern. Birmingham Heartlands Hospital indicates the reason for delays in 31% of incidents is "unknown", and 45% of delays at Good Hope Hospital are attributed to "awaiting space on theatre list". Given that each hospital performs much better in the other's area of concern, there may be lessons to learn from each site to improve performance.

Stroke
Healthwatch Birmingham shares the Trust's view that its 50.6% achievement in the target on direct admission to a Stroke unit within four hours needs to improve further. This is particularly the case for the Solihull data where the 50% target has been significantly missed through the reported trend data. Healthwatch Birmingham would like to see evidence in the year ahead of how the local and regional plans referred to are implemented.

Dementia care

Performance against the standards reported on indicates welcome improvements in dementia care, particularly relating to the querying of dementia diagnosis in unplanned admission. However, the Commissioning for Quality and Innovation (CQUIN) data highlights that targets on dementia screening and referral require further improvement.

Care Quality Commission (CQC)

We have reviewed the January 2014 CQC report alongside the draft Quality Account & Report. The CQC report rated the Trust as "requires improvement" in four of the five rating areas. In addition, performance against the Friends & Family Test was reported by the CQC as "significantly below the national average" in inpatient and Accident & Emergency scores. There were mixed patient experiences, from high scores in the Cancer Patients Experience Survey through to poor scores in the clarity of response from hospital doctors, pain management and patients' ratings of care. The CQC acknowledged that the experience of patients interviewed in its November 2013 inspection indicated more positive patient experience, which is reflected by positive patient ratings on Healthwatch Birmingham's Feedback Centre for Heartlands Hospital. We would like to see the Trust develop further plans to improve patient experience as a whole, and note that action plans have been put in place to deal with the compliance issues raised by the CQC.

Patient experience

Healthwatch Birmingham welcomes the increase in the rate of early complaint resolution, though we agree with the Trust that more needs to be done to improve this further. The patient survey indicates a lot of positive experience from patients though further work is needed to improve the lowest 20% of scores.

Overall the Trust has demonstrated progress across its priority areas, and acknowledges the further work that needs to be done to improve in the year ahead. Healthwatch Birmingham. Healthwatch Birmingham looks forward to seeing how the Trust carries forward learning into its future service planning and provision.

**Statement from Solihull Healthier Communities Board**

The Board considered the draft Quality Account at their formal Scrutiny Board meeting that took place on 9th April 2014.The Board were made aware that some of the content of the draft Quality Account was mandated and therefore was in a less accessible format. The Board placed on record their disappointment on not being able to see the Chief Executive's summary prior to their consideration of the draft Account as they felt this would have helped them to gain an understanding of Trust's perspective on their performance. An apology was made and this statement was circulated to the Scrutiny Board following the Scrutiny Board meeting.

We have read the Trust's Quality Account and similar to last year found that within the Account there was incomplete information/data which was disappointing and will inevitably impact on our comments. We again reiterate the need for the Trust to supply up-to-date and complete information to the Scrutiny Board and its other stakeholders to increase the Trust's transparency and accountability. We also feel that the Trust's Annual Report should be published at the same time as the Quality Account, contain similar information and readily be made available to the Scrutiny Board and its stakeholders. We also feel that the review by Sir Ian Kennedy into practices of Mr Ian Pattison should have been included in the Quality Account as this has been a significant issue which is likely to have affected the performance of the Trust.

Whilst we recognise that there has been some progress throughout the year and note the findings of the CQC inspection into Trust, we find that there is a need to make significant substantial improvements in the Trust's identified priorities, particularly in the area of fundamentals of care, hospital discharge and staffing capacity issues. One of our Members actually spent some time in Solihull and Heartlands Hospital receiving treatment and found through her own experiences and

by listening to the experience other patients, there appeared to be a number of concerns on which she intended to write to the Trust Board. The Scrutiny Board supported her in taking this action and asked that any response received from the Trust be shared with the Scrutiny Board.

Based on the information we have analysed within the Account and evidence we have received from members of the public, we are concerned about the following areas and would like the Trust to place extra emphasis on improving the following areas for patients in the following year.

- *Hospital Discharge* – Although we recognise that the Jonah system is in place, we still feel there is work for the Trust to do to discharge patients in a timely way and ensure that there is proactive working with the Trust's partners and with the community sector to improve discharge arrangements including communications with patients and their families.

- *Food and nutrition* – Although we recognise that the Trust had scored highly in terms of nutrition, it was felt that some nursing practitioners' needed to strengthen their professional support in helping the frail elderly to eat their meals and reducing food wastage through the provision of high quality meals.

- *Falls* – Although we recognise that the Trust has put initiatives in place to reduce falls, we note that that they are still occurring and therefore more work needs to be done to dramatically improve performance in this area and significantly reduce the number of falls occurring in hospital..

- *Pressure Ulcers* - We feel that the Trust needs to strengthen their use of national / international research in reducing the occurrences of pressure ulcers and also consider reinforcing the monitoring of patients who arrive in hospital with pre-existing pressure ulcers.

- *Fractured Neck of Femur* – we feel that there is a need to improve performance in this area and not just being able to reach a localised target.

- *Dementia* – we have noted the areas of under-performance and ask that the Trust ensures that their work is better aligned to the emerging localised dementia strategy.

Overall, we welcome the opportunity to comment on the Trust Quality Account and look forward to working with the Trust over the next 12 months. In particular, we are keen to follow-up in a number of areas and analyse complaints information from the Trust.

**Statement from Heart of England NHS Foundation Trust Consultative Healthcare Council**

Consultative Healthcare Council (CHC)

The Consultative Healthcare Council welcomes the opportunity to make comments on the Quality Account.

The Consultative Healthcare Council is a Patient/Carer organisation whose remit is patient care and the care environment, and we carry out ward inspections across the hospitals and clinics, which make up the Heart of England NHS Foundation Trust.

As our remit is patient care, it is encouraging that the main themes for the future are very much built around Illnesses and injuries which effect older people; and this is appropriate due to the increase in the elderly population. This is reflected in the number of patients in the over sixty five age group, and this forward planning is to be welcomed.

Continuing improvements in patient care, standards of cleanliness and infection control have been found in the ward inspections that the CHC have carried out over the past twelve months. However, CHC members are concerned over the effect of staff shortages on staff morale. However we also recognise the proactive efforts to recruit nurses.

The Consultative Healthcare Council broadly welcomes the findings of the Quality Accounts.

**Chairman Mick Corser**
**Vice Chairman Ann Horton**

# 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 2013/14;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2013 to the date of the signed quality report.
- Papers relating to Quality reported to the board over the period April 2013 to the date of the signed quality report
- Feedback from the commissioners dated 28/04/2014
- Feedback from governors dated 12/07/2013; 04/10/2013; 12/02/2014; 28/03/2014.
- Statement from the Consultative Health Council April 2014
- Feedback from Local Healthwatch organisations dated 18/04/2014 from Birmingham Healthwatch and 22/04/2014 from Solihull Healthwatch.
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 08/05/2014;
- The 2013 national patient survey
- The 2013 national staff survey
- The Head of Internal Audit's annual opinion over the trust's control environment dated 30th April 2014.
- CQC quality and risk profiles dated April 2014; July 2014 and the Intelligent Monitoring Report March 2014.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is

subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)).

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

By order of the board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

# Auditors Limited Assurance Report

**Independent Auditors' Report to the Board of Governors of Heart of England NHS Foundation Trust**

We have been engaged by the Board of Governors of Heart of England NHS Foundation Trust to perform an independent assurance engagement in respect of Heart of England NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

**Scope and subject matter**

The indicators for the year ended 31 March 2014 in the Quality Report have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

| ***Specified Indicators*** | ***Relevant criteria*** |
|---|---|
| Number of *Clostridium difficile* infections | As detailed on page 187 of the Quality Report |
| Maximum cancer waiting time of 62 days from urgent GP referral to first treatment for all cancers ('62 day cancer treatment') | As detailed on page 188 of the Quality Report |

We refer to these national priority indicators collectively as the "specified indicators".

**Respective responsibilities of the Directors and auditors**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with

the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "*Detailed requirement for quality reports 2013/14"* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14";*
- The Quality Report is not consistent in all material respects with the sources specified below;
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2013 to the date of signing this limited assurance report ("the period");
- Papers relating to Quality reported to the Board over the period;
- Feedback from the Commissioners (Solihull Clinical Commissioning Group) dated 28/04/14;
- Feedback from the Governors;
- Feedback from local Healthwatch organisations (Solihull Healthier Communities Board and Birmingham Healthwatch Organisations, dated 22/04/14 and 18/04/14 respectively);
- The trust's complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2013 national patient survey;
- The 2013 national staff survey;
- Care Quality Commission intelligent Monitoring Reports dated March 2014;
- Care Quality Commission inspection report dated January 2014; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 30 April 2014.

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

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

This report, including the conclusion, has been prepared solely for the Board of Governors of Heart of England NHS Foundation Trust as a body, to assist the Board of Governors in reporting Heart of England NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Board of Governors to demonstrate they have discharge their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Heart of England NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standards on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 300'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading documents.

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

**Limitations**

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information; as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

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

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

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014;

The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the *"Detailed requirements for quality reports 2013/14";*
The Quality Report is not consistent in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "*2013/14 Detailed guidance for external assurance on quality reports".*

**PricewaterhouseCoopers LLP**
Chartered Accountants
Birmingham
29 May 2014

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