NHS

University Hospitals Birmingham

NHS Foundation Trust

Quality Account 2022/23

This report covers the period 1 April 2022 to 31 March 2023

2022/23 Quality Account

Contents

1 Chief Executive's Statement

2022/23 has been a very difficult year for UHB due to significant operational performance pressures in the wake of the COVID-19 pandemic and serious concerns raised through the media and other stakeholders regarding patient safety, leadership and culture.

There has also been a change in leadership since January 2023, when I became Interim Chief Executive and Dame Yve Buckland joined as Interim Chair. Dame Yve and I are fully committed to investigating and understanding all the issues raised and working tirelessly with staff and external experts to address them. Furthermore, we are working with an external consultancy to design and implement a new operating model for the Trust which will ensure leadership is strengthened at all levels, particularly at individual hospital level.

Providing safe and excellent care to our patients is what is most important to us at University Hospitals Birmingham (UHB). We all would like patients to be confident and assured that the care and treatment provided at our hospitals is safe and we want our colleagues to all feel proud of the quality of care that they are giving.

We are currently engaged in three independent reviews into patient safety, culture and leadership, which will help us to create positive, inclusive work environment where people want to come to work, in a place that they are proud to work in, to do their very best for our patients. The focus for 2023/24 must therefore be on moving forward, continuing to provide safe and effective care, focusing on our local hospitals and services, building a values-led culture and supporting our workforce.

I would like to formally offer my personal thanks to everyone for their contributions and immense efforts - in a multitude of ways - to manage the delivery of safe services during the recent industrial action. This has involved thousands of our people including those involved in the reorganisation of patient appointments. It has been a real team effort and I am very grateful for colleagues' ongoing support.

The Trust continues to make good progress against recovering our services, following the devastating impact of the COVID-19 pandemic; feedback from recent regulatory meetings has shown that we are performing very well in delivering our recovery and reducing waiting times.

During 2022/23 the Trust focussed on three main operational priorities:

- Reducing delays in the handover of patients from emergency ambulances to the Trust's Emergency Departments.
- Eliminating patients waiting longer than 78 weeks for treatment.
- Reducing the number of patients waiting longer than 62 days for cancer treatment or to have confirmation that they do not have cancer.

Over the year, the Trust saw a significant overall improvement in the total time ambulances were delayed at its sites. For example, in the week commencing 18 July 2022 when delays were particularly severe, there were 1,428 hours of delays. By the week commencing 27 March 2023 this had reduced by 71% to 410 hours, following the implementation of a comprehensive improvement plan.

During 2022/23, the Trust has worked with its partners across Birmingham and Solihull and beyond to ensure that the longest waiting patients are prioritised for treatment. This has resulted in the virtual elimination of patients waiting longer than 104 weeks and a very significant reduction in the number of patients waiting longer than 78 weeks. Unfortunately, the cancellation of procedures and outpatient appointments due to industrial action by junior doctors in March 2023 meant that it was not possible to treat all patients waiting longer than 78 weeks by 31 March 2023 as planned. On 31 March 2022 there were 9,035 patients waiting longer than 78 weeks which had reduced to 197 a year later (and indeed 32,000 patients who would have waited longer than 78 weeks required treatment over the year). Work is continuing to ensure all remaining patients are treated by the end of June 2023 and to deliver the 2023/24 national ambition to eliminate waits over 65 weeks by the end of March 2024.

The Trust also delivered a very significant reduction in its cancer backlog in 2022/23, in line with the requirement set by NHS England. On 31 March 2022 the Trust had 827 patients who had waited longer than 62 days for a cancer diagnosis or confirmation that they did not have cancer. By 31 March 2023 this had reduced to 460 patients, below the target of 500 agreed with NHS England and a lower number than the Trust had waiting before the start of the Covid-19 pandemic.

There is a new national key milestone for the 2023/24 financial year that no patients should be

waiting more than 65 weeks by March 2024. Plans are in place to address this new standard, support teams and ensure that patients are seen and treated in a timely way.

There has been a continued programme of capacity expansion during 2022/23, with two additional modular wards opening at Good Hope Hospital in August 2022 and Heartlands Hospital in March 2023 as well as the Heartlands Treatment Centre, which provides much-needed diagnostic and day case capacity. 2023/24 will see the opening of the Harborne Hospital on the Queen Elizabeth Hospital Birmingham site and six new elective theatres, which are expected to open at Solihull Hospital in spring 2024.

We have continued to focus on standardising high quality patient care across our four main hospital sites, alongside digital and technological transformation. Key electronic systems such as the Oceano patient administration system (PAS) and the Prescribing Information and Communication System (PICS) have now been implemented across the majority of our wards and clinical areas. These systems have enabled the quality of care to be measured, monitored and improved in the same way across the Trust. PICS is due to be implemented across paediatrics in late 2023 and obstetrics in 2024.

Performance for the six quality improvement priorities set out for 2022/23 in the 2021/22 Quality Report has been mixed. The six priorities were:

Priority 1: Freedom to Speak Up
Priority 2: Improving VTE prevention
Priority 3: Improving ward rounds
Priority 4: Improving nutrition and hydration
Priority 5: Improving the safety of invasive devices
Priority 6: Using real-time information to improve patient care

The Board of Directors has chosen to continue with these priorities for improvement for 2023/24.

Our focused approach to quality, based on driving out errors and making incremental but significant improvements, is driven by innovative and bespoke information systems which allow us to capture and use real-time data in ways which few other UK trusts are able to do. The Clinical Dashboard Review Group was set up in August 2019 and continues to meet monthly. The group is chaired by the Deputy Chief Nurse and the Chief Strategy and Projects Officer. The purpose of the group is to review performance at ward level in a supportive, learning environment with the clinical staff involved to drive continuous improvement.

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

The Trust's external auditor usually provides an additional level of scrutiny over key parts of the Quality Account. NHS England issued guidance to trusts at the start of the COVID-19 pandemic advising trusts they were not required to seek external assurance on the Quality Accounts. For the 2022/23 Quality Accounts, there is again no national requirement for NHS foundation trusts to obtain external auditor assurance on the quality account.

We will continue working with health and social partner, regulators and other organisations to implement improved models of care delivery and further improvements to quality during 2023/24.

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

Jonathan Brotherton, Interim Chief Executive
22 June 2023

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

2.1 Priorities for Improvement

The Trust's 2021/22 Quality Account set out six priorities for improvement during 2022/23 (see table below).

Performance has been mixed for the priorities and across the different Trust sites during 2022/23.

Further details for each priority are provided in the main body of the report.

The Board of Directors has chosen to continue with the same six priorities for improvement in 2023/24:

2022/23	Title of Priority	Plans for 2023/24
1	Freedom to Speak Up	To continue
2	Improving VTE prevention	
3	Improving ward rounds	
4	Improving nutrition and hydration	
5	Improving the safety of invasive procedures	
6	Using real-time information to improve patient care	

The improvement priorities for 2023/24 were discussed and confirmed by the Trust's Clinical Quality Monitoring Group chaired by the Chief Medical Officer and by the Care Quality Group, chaired by the Chief Nurse, following consideration of performance in relation to patient safety, patient experience and effectiveness of care. A full review of the quality priorities will be undertaken during the coming year.

The performance for 2022/23 and the rationale for any changes to the priorities are provided in detail below. It might be useful to read this report alongside the Trust's Quality Account for 2021/22.

Priority 1: Freedom to Speak Up

This quality improvement priority was first proposed by the Chief Executive and approved by the Board of Directors for inclusion within the 2019/20 Quality Account.

Background - Encouraging Staff to Speak Up
The appointment of Freedom to Speak Up Guardians was a recommendation of The Francis Report (Report of the Mid-Staffordshire NHS Foundation Trust public inquiry) published in February 2013. There are now more than 800 Guardians in secondary, primary and community care in England, coordinated by the National Guardian's Office; more than 20,000 contacts are received by Guardians each year. Freedom to Speak Up Guardians have a key role in helping to raise the profile of concerns within the Trust. They provide confidential advice and support to staff in relation to any concerns they may have which directly or indirectly impact on patient safety or the capacity of staff to deliver quality care, if they feel unable to raise those concerns with their line managers. Freedom to Speak Up Guardians do not get involved with investigations or complaints but help to facilitate the process of raising a concern where needed and ensure policies are followed correctly. They also have an important role in assisting the Trust in protecting staff from detriment as a consequence of raising concerns.

Speaking Up at UHB
UHB's Freedom to Speak Up Guardian is Professor Julian Bion, who has been in post since October 2018, and is now supported by two deputies and up to 30 Confidential Contacts and Champions across the Trust who provide additional points of contact for raising concerns. The service is supported by Prof. Glasby, Non-Executive Director and Senior Independent Director, and by the Chief Strategy and Projects Officer.

Staff can contact the Freedom to Speak Up Guardian and the Confidential Contacts using a 24/7 telephone line (staffed by the Freedom to Speak Up team 9am - 5pm, Monday to Friday), a dedicated email address, and an internal webpage with further contact information for the Guardian and confidential contacts.

The Freedom to Speak Up Guardian, Deputies and the Confidential Contacts meet quarterly, alternating between hospital sites or by videoconference, communicating regularly in between. The list of Confidential Contacts is available on the Trust intranet.

The Freedom to Speak Up Guardian meets quarterly with the Chief Executive, Chief Medical Officer, Chief Nurse, Chief Legal Officer, and the Chief Strategy and Projects Officer, to present a summary of contacts (anonymised where required) and to discuss specific issues requiring the attention of the Trust leadership. The Freedom to Speak Up Guardian also meets regularly with the Chief People Officer and the Head of Occupational Health to exchange insights. The Guardian reports twice a year to the Board of Directors, and meets four-monthly with the Chair of the Trust Board. Professor Glasby also attends the quarterly meetings with the Guardian and Confidential Contacts to gain an overview of current themes and issues being raised.

Concerns raised via the Freedom to Speak Up process are also reported quarterly to the National Guardian's Office housed at the Care Quality Commission, which allows national data to be collated on the sources and types of concerns being raised.

Performance

The Trust monitors its Freedom to Speak Up culture through the following means:

- Number of contacts per quarter
- Typology of concerns
- Feedback from contacts
- The percentage of respondents to the NHS staff survey giving an affirmative response to the statement: "I feel safe to speak up about anything that concerns me in this organisation"
- Other elements within the NHS Staff Survey

Number of contacts

In the 12 months April 2022 – March 2023, the service has been contacted by 118 members of staff, a substantial increase on previous years, as shown in Table 1 below. Doctors are the predominant professional group (36.1%), consultants more than juniors; we do not have benchmarking data from comparable Trusts, and the national benchmark (6.3%) will include community and ambulance Trusts with few doctors. Nurses account for 17.6% of contacts (21% if specialist practitioners are included). Managers, administrators and clerical staff represent 21.4%.

From November 2022, the number of contacts more than doubled compared with preceding years, and has remained at this rate since (Table 1). We attribute this initially to our Trust-wide promotional work in November 2022, and then to the BBC Newsnight programmes which aired in December 2022 and January 2023 and raised concerns about a bullying culture at UHB. This increase appears to represent a previously unmet need for the Speaking Up service as well as an increase in awareness. The typology of concerns has not changed but it is clear that many staff felt that the adverse publicity had 'given them permission' to raise concerns.

Typology of concerns

The most common concerns relate to **behaviours**: allegations of incivility, microaggressions, harassment or bullying (34%) by colleagues or line managers. These include disrespectful, non-empathic or controlling behaviours, exclusion from social groups and decision-making processes, and non-negotiated changes in work practices. Aspects of **discrimination** related to protected characteristics or health issues account for 8.8% of issues raised. Concerns about the **workplace** constitute 30% of issues: these are diverse, and include excessive workload, inadequate staffing, employment, patterns of working, access to leave, employment disputes and HR processes. **Patient safety** accounts for 8.2% of issues, but this underestimates the potential indirect impact that adverse behaviours have on patient care. **Leadership** issues include allegations of poor management skills, suboptimal service dispositions, and disagreements about longer-term strategy.

Table 1: SUMMARY OF UHB SPEAKING UP CONTACTS OCTOBER 2018 – MARCH 2023

Financial years	2018	2019-2020		2020-2021		2021-2022		2022-2023		Totals	National data[5]
No Contacts[1] by professional group:	Oct 2018 – Mar 2019	Apr-Sept 2019	Oct 2019-Mar 2020	Apr-Sept 2020	Oct 2020-Mar 2021	Apr-Sept 2021	Oct 2021-Mar 2022	Apr-Sept 2022	Oct 2022-Mar 2023	N(%)	
	Q3&4	Q1&2	Q3&4	Q1&2	Q3&4	Q1&2	Q3&4	Q1&2	Q3&4		
Totals	31	13	35	63	47	47	33	50	118	**437**	20,362
Consultants[2]	8	3	14	19	7	7	6	3	30	**97 (22.1)**	
Junior doctors	9	2	5	16	7	9	-	2	11	**61 (14)**	
Doctors overall	**17**	**5**	**19**	**35**	**14**	**16**	**6**	**5**	**41**	**158 (36.1)**	
Nurses Band 5-8	5	3	6	2	10	11	6	14	20	**77 (17.6)**	28.9%
CNS/ANPs/PAs	1	1	3		1	1		5	3	**15 (3.4)**	
HCAs/TNA	1	1		2	3		1	1	3	**12 (2.7)**	9.5%
AHPs incl Pharm		1		5	5	2	5	-	12	**30 (6.8)**	11.7%
Support staff					1			-	8	**9 (2)**	
Tech/Sci/ Labs/IT	2				3	1	1	2	3	**12 (2.7)**	
Education						1	1	1	5	**8 (1.8)**	
Domestic/ Porters			1	1	1	2		1	2	**8 (1.8)**	
Managers/Corp	2		3	3	1	7	8	18	12	**54 (12.3)**	
A&C	3	2	3	4	5	6	5	3	9	**40 (9.1)**	20.8%
Unknown				10	2				-	**12 (2.7)**	
Anonymous				1	1				-	**2 (0.4)**	10.4%
Patient/relative[3]			1				4			**5**	
TYPOLOGY of issues, allegations or concerns[4]											
Bullying, Harrass[t]	10	5	11	6	27	17	11	32	34	153 (34)	30.1%
Racism	1	1	1	2	4	1	2	6	9	27 (6)	
Gender/other	0	1	1	1	0	2	2	1	5	13 (2.8)	
Patient safety	6	2	3	2	4	4	3	1	12	37 (8.2)	19.1%
Staff safety	1	1	3	3	5	0	1	1	2	17 (3.7)	13.7%
Probity/fraud	0	0	2	4	3	1	4	2	4	20 (4.4)	
Leadership	4	5	7	4	4	3	3	7	11	48 (10.6)	
Workplace/HR	12	6	9	20	16	17	10	15	30	135 (30)	
Totals	**34**	**21**	**37**	**42**	**63**	**45**	**36**	**65**	**107**	**450**	

Notes:
1. A contact is a person. If six members of staff come with one issue, this = 6 contacts.
2. Doctors & dentists
3. Patient or relative contacts not included in analyses or totals
4. Staff may come with more than one issue or concern.
5. National data are for FY 2020-2021, or 2021-22, % of 20,388 contacts all Trusts including community Trusts.

NHS Staff Survey results

The Speaking Up 'climate'

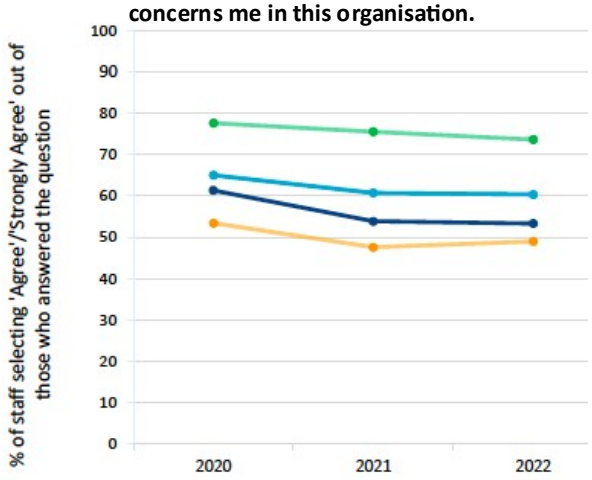
During the pandemic period 2020 – 2021, there was a 6.6% national reduction from 65% to 60.7% in the proportion of staff responding positively to the statement in the NHS staff survey relating to speaking up: *'I feel safe to speak up about anything that concerns me in this organisation'*. At UHB, the reduction was more marked at 12.1%, and from a lower starting point of 61.2% to 53.8%. Figure 1 below shows that the proportion of staff who responded positively to this question was 53.3% for UHB in 2022 (national median 60.3%). The best in class was for a Trust scoring 73.6%. Figure 2 shows the Trust's performance for the past three years and how this compares to the worst, average and best nationally for this question and another related question: *'If I spoke up about something that concerned me I am confident my organisation would address my concern'*.

Figure 1: Table showing breakdown of responses to questions Q23e and Q23f in the 2022 NHS Staff Survey

Q	Number responding	Strongly agree %	Agree %	Neutral %	Disagree %	Strongly disagree %
Q23e I feel safe to speak up about anything that concerns me in this organisation.	5,599	11%	42%	28%	13%	6%
		Total agree 2990 (53%)		Total 1548	Total agree 1061 (19%)	
Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.	5,589	9%	33%	36%	14%	8%
		Total agree 2341 (42%)		Total 1992	Total disagree 1256 (22%)	

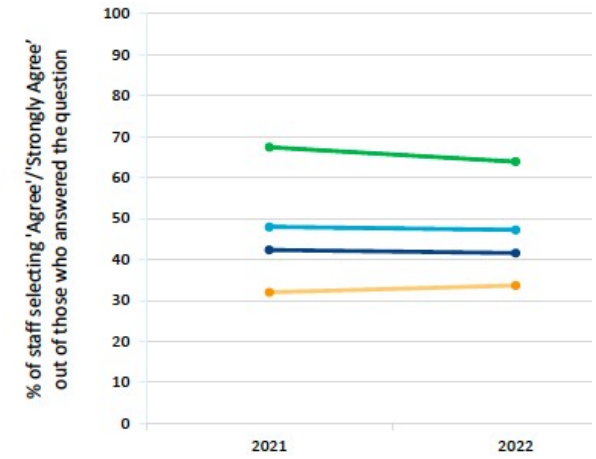
Figure 2: 2022 NHS Staff Survey responses to statements about raising concerns (2020-2022)

Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022
Your org	61.3%	53.8%	53.3%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	7288	7093	5599

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	42.3%	41.6%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	7088	5589

Responding to concerns:

A proportion of concerns raised with the Freedom to Speak Up service can be managed with advice and signposting to sources of support. However, more complex and long-standing issues need to be referred to managers or executives and these can be difficult and time-consuming to investigate and some prove resistant to resolution. Some issues raised several years ago are still active. In these circumstances, those who have raised concerns lose confidence in the Trust and find it less challenging to resign and move to another organisation.

Divisions vary in their capacity to find pathways to resolution. Some are models of excellence, others have more difficulty in dealing with complex behavioural issues. In the majority of instances action could have been taken earlier to try to modify behaviours and prevent friction from developing into chronic antipathy. The Freedom to Speak Up Guardian has previously drawn attention to instances where attempts to raise concerns have been disregarded or appear to have been suppressed. This may be because adverse behaviours are tolerated because the individual concerned is valued for being a strong manager or a high-throughput clinician. The error in that approach is to assume that dysfunctional behaviours are a necessary price for the perceived strengths; this results in missed opportunities for conversations which focus on promoting 'average to good' or 'good to great'. The bystander phenomenon is also common – ignoring adverse behaviours because these are perceived as being a management responsibility rather than shared with peers.

Investigating concerns is often laborious and time-consuming for HR staff as well as the participants. It is essential that the process is fair, and can be shown to be fair, particularly to those who are the subject of the investigation. It may therefore feel unempathic, which participants may interpret as threatening. Where concerns touch on groups or whole services ('unhappy families') culture surveys are a useful adjunct. However, the Guardian is aware of at least five such surveys the results of which have not been shared with the participants, or the degree of sharing has been so redacted that the staff do not feel that their voices have been heard. This closed approach may be interpreted by staff as biased, and limits reflective learning. The Guardian recommends that the Trust reconsiders its approach in this respect.

Activities to optimise the Speaking Up climate

We have expanded the Speaking Up service with the appointment of two deputy Guardians. The Trust now funds six working days for the service. The Guardian and deputies are supported by the Confidential Contacts and Champions, more of whom will be appointed this Summer, the Non-Executive Director for Speaking Up, Prof. Jon

Glasby, the Chief Strategy and Projects Officer and the Trust leadership. A link to the Freedom to Speak Up web pages is now on the Trust's home page. Options for a confidential communications and data management system are now being evaluated. This will also facilitate evaluating the Freedom to Speak Up service more effectively.

The Guardian and deputies give induction training seminars to new consultants and trainees, and new overseas nurses. Other staff receive a briefing note. The national training programme has three levels: 'Core Training' for all staff; 'Listen Up' training for managers and 'Follow Up' for senior leaders. Board members are invited to undertake all three levels of training, completion of which will become mandatory by 2024.

The Guardian has held meetings during April and May 2023 with all Divisions to explore common themes and opportunities for improving confidence amongst staff that raising concerns will be used to promote excellence. The Guardian, deputies and confidential contacts will be staffing Speaking Up stands around the Trust during the last week of May 2023. All members of the FTSU team will participate in walk-arounds to clinical and non-clinical areas to distribute FTSU briefing leaflets.

The Chief People Officer is leading the development of a new approach to managing staff disputes called the Resolution Framework. The Freedom to Speak Up team has been involved in Phase 1 as one of several focus groups exploring current issues in dispute resolution. In Phase 2, the results from these focus groups will be synthesised to form an organisation-specific framework to provide a platform for interventions to be offered by a network of 'resoluters' – staff trained in early intervention, promoting good working relationships and conflict resolution. The aim is to encourage informal approaches, reserving the formal HR processes for disputes which prove resistant to mitigation. It is hoped that this will reduce the need for mediation and grievances.

The Trust has a substantial number of initiatives aimed at promoting good working relationships. These include:

- The Fairness Taskforce, with workstreams to promote equality, diversity and inclusion.
- Regular webinars for all staff with the CEO and other members of the Trust leadership.
- Board visits to departments
- 'Effective conversation' masterclasses for leaders
- Building Healthier Teams portal – effective conversations - film and workbook
- Monthly programme of virtual lectures on the theme of leadership.
- Seven leadership networks: Clinical Service Leads, General Managers, Matrons, Directors of Operations, Operational Managers, Operational Support Managers and First Line Leaders
- NHS Elect on-site masterclasses and virtual webinar programme
- 1-2-1 leadership coaching
- Reciprocal Mentoring platform

External Reviews

Following the BBC Newsnight programmes, three independent reviews of the Trust were announced by the NHS Birmingham and Solihull Integrated Care Board:

- a patient safety and governance review commissioned by NHS Birmingham and Solihull ICB and led by Dr Mike Bewick (first report published 28 March 2023)
- a Well-Led review of leadership and governance led by NHS England and NHS Birmingham and Solihull ICB (report due to be published shortly)
- a wider review of culture by thevaluecircle commissioned by Dame Yve Buckland, Interim Chair of UHB, and overseen by Roger Kline (due to report by July 2023)

Evaluation of impact of the Speaking Up service:

The Speaking Up service lacks an effective method for independent evaluation by those who have contacted us of the totality of their experiences of raising concerns. The point of initial contact is relatively easy to assess, and the service has only received one critical comment about this aspect (lack of responsiveness). It is the subsequent pathway which presents challenges, in terms of the need to preserve confidentiality, the length of time it takes to reach a conclusion, and the complexity of the process by which that conclusion is reached. We hope that a new data collection tool will allow contacts to provide an assessment of their experience without having to go through an intermediary.

The Bewick report referred to the need for the relationship between the Freedom to Speak Up service and the Trust's Board of Directors to be 'refreshed'. This means the Board of Directors needs to actively review how concerns are being managed by the Trust, ensure that raising concerns are framed as opportunities for organisational reflective learning and examine methods for preventing problems arising in the first place.

Update on the Trust Fairness Work Programme

In 2020, the Trust set up a dedicated Fairness Taskforce which is now chaired by the Chief Strategy and Projects Officer. The aim was to ensure a determined focus at all levels of the organisation, to tackle the well-known issues surrounding the fairness agenda. The taskforce is

inclusive of the protected characteristics defined by the Equality Act 2010:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

From the outset the Taskforce also included socio-economic disadvantage.

The Fairness Taskforce is made up of stakeholders from a wide range of key departments including Facilities, Pharmacy, Divisional teams, Human Resources, Communications, Procurement / Finance, Inclusion, Health and Wellbeing and Strategic Projects. Workforce groups are also represented: Nursing, Therapies, Doctors, Managers, UHB Staff Networks and the Freedom to Speak Up service. The Taskforce has also sought external expert assistance from Roger Kline who has supported the Fairness work since 2021.

Based on conversations with staff via webinars on the subject of Fairness and advice from members of the Fairness Taskforce, the initial focus of the Fairness programme was on the following three areas:

1. Reciprocal Mentoring
2. Fairness in Recruitment
3. Fairness Root Cause Analysis

A further priority set by the Core Group was to empower and increase the voice of UHB staff by strengthening the role of the Staff Network Chairs.

Reciprocal Mentoring

The Reciprocal Mentoring programme began in September 2020 and initially targeted 100 staff. Due to the overall success and popularity of the programme the Taskforce agreed that this should continue. In April 2023, Cohort 9 began, with 424 people involved from the outset.

An evaluation of cohorts 1 - 4 has taken place. The overall feedback for the participants who completed their sessions as a pair has been positive. Cohorts 10 and 11 are scheduled for the end of 2023.

Fairness Recruitment

The Fair Recruitment Experts programme was piloted in July 2022. Staff volunteered and were trained, then deployed to be part of recruitment selection processes. The evaluation of the pilot showed it was successful in assisting the debiasing of the recruitment process, and has been well received by recruiting managers, the Fair Recruitment Experts and the applicants. April 2023 saw a drive to recruit more Fair Recruitment Experts which will provide more capacity to deploy experts to panels.

A UHB Talent Management Framework has been developed and continues to be promoted and developed. Training videos for managers are available on the HR Website. Engagement with the Communications Team has taken place to further promote the Framework.

Fairness Root Cause Analysis

The Fairness Root Cause Analysis (RCA) group meets fortnightly. It is chaired by the Chief Strategy and Projects Officer and its purpose is to identify, review and analyse themes, trends and instances, where staff may have experienced discrimination, prejudice, inequity or any other unjust treatment (outside of HR investigations) to provide recommendations for improvement. Systems and processes are evaluated in order to prevent similar events occurring.

The Fairness RCA group worked with the Governance Team to ensure that a separate category of discrimination was included within the Datix system. From December 2022 to April 2023, 150 incidents have been reported by staff under this category. The Fairness RCA group receives a weekly report of these incidents and reviews them. The alarming nature and number of these incidents highlighted that staff are experiencing discrimination from patients, including refusal to be treated by them based on one or more protected characteristic, and required the following response:

- The group put steps in place to support staff who have reported an incident; and
- Set up a subgroup to look at the legal position in relation to these incidents.

A document to support staff who have experienced patient-on-staff violence and abuse, including discrimination, has been drafted. Discussions are ongoing with the Governance and Security teams to finalise the support offer available to staff and their line managers who are faced with these situations. There will be a clear communications plan outlining the support available within the Trust. Work is also underway to ensure that UHB involves the Police in instances of hate crimes.

Staff Networks

The Fairness Taskforce allowed the Staff Networks to be strengthened, by formalising the structure of the Networks and allowing the Network Chairs to be given official time during work hours to focus

on their work with their members and to influence policy, processes and decisions on the Fairness Taskforce.

Next Steps
These will include the development of a Fairness, Equity, Diversity and Inclusion Strategy, following the publication of the Culture Review report. To support this, partnership working has already begun with the ICB and other key stakeholders such as community groups, the Shelford group of hospitals and other sector employers.

Improvement priority for 2023/24

The Trust will continue to monitor the Trust's Freedom to Speak Up culture using the number and type of contacts per quarter and the four questions on raising concerns in the annual NHS Staff Survey. It is difficult to set a target for the number of contacts as the Trust is continuing to promote the Freedom to Speak Up process and would view an increase in the number of contacts as positive evidence of an open culture. Over time the Trust may want to see a decrease in contacts as the culture matures and staff feel more able to use existing channels to raise issues.

How progress will be monitored, measured and reported

- Regular reports provided by the Freedom to Speak Up Guardian to the Board of Directors.
- Regular discussions with the Freedom to Speak Up Guardian and senior leaders.
- Quarterly UHB internal staff survey feedback on questions relating to values, fairness and wellbeing.
- Annual NHS Staff Survey results for key questions relating to speaking up.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 2: Improving VTE prevention

This quality improvement priority was agreed at the Clinical Quality Monitoring Group chaired by the Chief Medical Officer and approved by the Board of Directors.

Background

Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs). VTE is associated with periods of immobility such as when a patient is in hospital. VTE can either develop during a patient's hospital stay or after they have left hospital.

The Trust has chosen to focus on reducing the number of hospital-associated thromboses (blood clots) because they cause considerable harm to patients and can often be avoided if appropriate preventative measures are taken. Preventative measures usually include compression stockings and/or prophylactic medication to reduce the risk of blood clots forming. It is important to note that these preventative measures do not reduce the risk to zero; a few patients will still go on to develop VTE even when all appropriate measures have been taken.

The Trust has been using an electronic VTE risk assessment tool within its Prescribing Information and Communication System (PICS) for inpatients for over a decade on the Queen Elizabeth Hospital site. The tool provides tailored advice regarding preventative treatment based on the assessed risk. The roll-out of PICS to the Solihull, Heartlands and Good Hope hospital sites is now almost complete. Maternity and Paediatrics do not currently have PICS but it is due to be implemented to these areas during 2023/24.

Improvement priority for 2022/23

The Trust set up a quality improvement project in 2020/21 to improve VTE prevention and reduce the number of hospital-associated thromboses. The focus of this work is both on inpatients and patients who may not be admitted to hospital but are at risk of developing VTE such as those with lower limb fractures. This work continued during 2022/23.

Performance

VTE risk assessment
The graph below shows the Trust's performance for VTE risk assessment by month for the period March 2022 to March 2023. The Trust has met or exceeded the 95% target each month. National reporting requirements have been suspended due to the Covid-19 pandemic. The Trust is currently reviewing and updating the VTE risk assessment methodology to ensure it meets the latest national definition. The Trust plans to re-start monthly reporting of VTE risk assessment performance externally from July 2023.

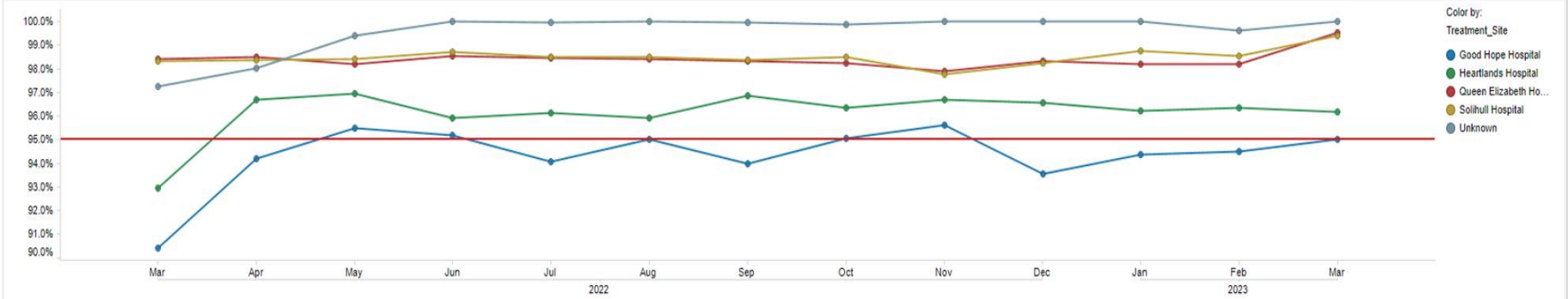
VTE risk assessment completion March 2022-March 2023

National Indicator - Performance by Site

Overview of the NHSE/I National Indicator "VTE assessment on admission".

	2022										2023		
Treatment_Site	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Good Hope Hospital	90.4%	94.2%	95.5%	95.2%	94.1%	95.0%	94.0%	95.1%	95.6%	93.5%	94.4%	94.5%	95.0%
Heartlands Hospital	93.0%	96.7%	97.0%	95.9%	96.1%	95.9%	96.9%	96.3%	96.7%	96.6%	96.2%	96.4%	96.2%
Queen Elizabeth Hospital	98.4%	98.5%	98.2%	98.5%	98.4%	98.4%	98.3%	98.2%	97.9%	98.3%	98.2%	98.2%	99.5%
Solihull Hospital	98.3%	98.4%	98.4%	98.7%	98.5%	98.5%	98.4%	98.5%	97.8%	98.2%	98.8%	98.5%	99.4%
Unknown	97.2%	98.0%	99.4%	100.0%	99.9%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	99.6%	100.0%
Grand total	95.1%	97.0%	97.4%	97.2%	97.0%	97.1%	97.1%	97.2%	97.2%	96.9%	97.0%	97.0%	97.6%

Latest_Admission	Report_Updated
22/03/2023 00:51:00	22/03/2023 08:37:28



Potentially preventable hospital-associated thromboses (blood clots)

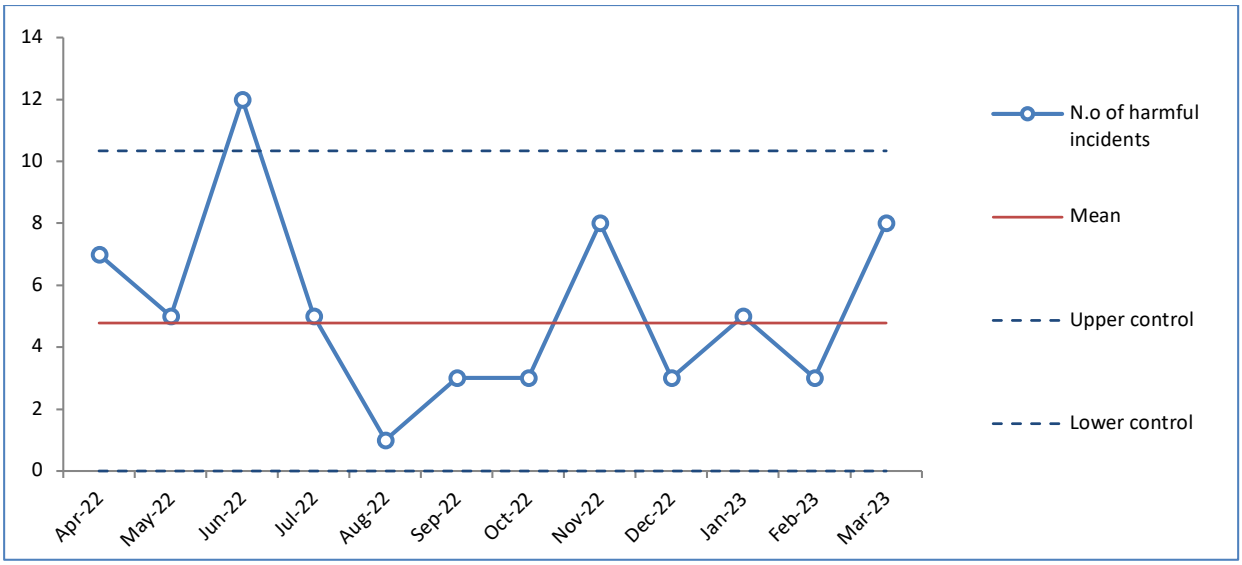
Unfortunately, the anticoagulant medical and nursing teams have not been able to reliably complete the root cause analysis (RCA) process for hospital-associated thromboses since August 2021 due to staffing shortages and the need to prioritise immediate clinical management of patients. A project is underway to develop a word mining algorithm to pull out 'positive' imaging (scans which show a blood clot or pulmonary embolism) from our electronic records. This will make it easier to identify patients with hospital-associated thromboses which can occur up to three months after admission to hospital to assess avoidability and identify any lessons to be learnt.

Number of incidents relating to VTE

There were no serious incidents relating to VTE reported during 2022/23.

The Trust has continued to monitor all levels of incidents reported. The graph below shows the number of less serious incidents relating to the topic of VTE which were reported during 2022/23.

VTE incident data 1st April 2022 - 31st March 2023
Number of incidents



Progress during 2022/23

To develop inpatient VTE pathway indicators within Power BI

In addition to the VTE risk assessment indicator, a number of automated indicators have been developed to track performance along the rest of the pathway:

- % of initial VTE risk assessments which are postponed
- % of anti-embolism prescriptions completed within 6 hours of VTE risk assessment recommendation
- % of anti-embolism prescriptions which are paused
- % of prophylactic enoxaparin prescriptions which are paused
- % of enoxaparin prescriptions completed within 14 hours of VTE risk assessment recommendation
- % of prophylactic enoxaparin administered within 14 hours of admission

The indicators are designed to measure whether clinicians are adhering to the outcomes of VTE risk assessments by prescribing and administering anti-embolism stockings and/or prophylactic medication e.g., enoxaparin in a timely manner when required. The indicators are currently being validated by clinicians before they go live in the new Health Observatory which presents performance data for a range of specialty indicators using Power BI software.

To develop lower limb VTE pathway indicators

An electronic VTE assessment form has been developed and will go live in the Prescribing Communication and Information System by Summer 2023. Manual audit tools remain in place in the interim.

Progress with lower limb pathways

- Until the new electronic risk assessment form goes lives in PICS, paper risk assessment forms are being used in the fracture clinics. These are

scanned and added into the patient's electronic medical record by the Trauma and Orthopaedics Secretaries.
- Generic email accounts have been created for Birmingham Heartlands and Good Hope Hospitals' fracture clinics so that plaster request forms can be completed and referrals made electronically via PICS.
- Manual audits of compliance with the use of VTE Risk Assessment in the Emergency Departments are currently being undertaken.
- The VTE Lower Limb guidelines are in place on the guidelines page of the intranet.
- The VTE Lower Limb guidelines are included in education and training sessions for staff in the Emergency Departments and Trauma and Orthopaedics.
- Patient information leaflets have been delivered to the relevant areas for issue to patients/carers at Queen Elizabeth Hospital and are available via an electronic system on the Heartlands, Good Hope and Solihull hospital sites.

Reviewing ward level performance for the VTE indicators at the Clinical Dashboard Review Group (CDRG) to identify where improvements can be made and providing support to deliver these improvements

Missed doses of enoxaparin for any reason continue to be measured at ward level within the Clinical Dashboard. Wards which are performing below or above expectation are asked to attend the monthly Clinical Dashboard Review Group to discuss their performance and share ideas for improvement.

Improvement priority for 2023/24

The VTE Quality Improvement Group has agreed to focus on the following three aspects in 2023/24:
- Improving patient information about VTE on admission.
- Reducing VTE in patients with lower limb fracture:
  - the new electronic VTE risk assessment is due to go live in PICS by Summer 2023.
  - timely completion of VTE risk assessments for patients with fractures will be monitored along with compliance with the outcomes of the risk assessments.
- Reducing missed doses of enoxaparin.

How progress will be monitored, measured and reported
- Missed enoxaparin data will continue to be made available to staff at ward level via the Clinical Dashboard and wards will be called to attend the CDRG meetings to discuss their performance.
- The VTE indicators will be made available to staff via the Health Observatory webpages and will include monthly performance data.
- Update reports will be provided to the monthly VTE Quality Improvement Project (QIP) Group and the Corporate QI Steering Group, both chaired by the Deputy Chief Medical Officer.
- Progress will also be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 3: Improving ward rounds

This quality improvement priority was agreed at the Clinical Quality Monitoring Group chaired by the Chief Medical Officer and approved by the Board of Directors.

Background

The Trust set up a quality improvement project in 2020/21 to improve the consistency and effectiveness of ward rounds following a number of incidents and patient complaints relating to ward-based care. In January 2021, the Royal College of Physicians and the Royal College of Nursing published a report which sets out best practice for ward rounds: *Modern ward rounds: Good practice for multidisciplinary inpatient review* (Modern ward rounds | RCP London). Ward rounds are defined as 'the focal point for a hospital's multidisciplinary teams to undertake assessments and care planning with their patients'.

A number of standards for ward rounds and an implementation tool including the mnemonic 'REMIND' were developed and tested to support clinicians during ward rounds:

Standards for a ward round
The following key elements of a ward round were agreed during 2021/22:
1. The ward round will occur every day.
2. The ward round will be multi-disciplinary.
3. The round will be undertaken with a board round, bedside ward round and a debrief.
4. The round will include prompts for each of the elements of the REMIND mnemonic.
5. The ward round will be clearly documented with actions recorded and handed over to relevant staff.
6. The ward rounds will be audited and improvements will be made based on audit findings.

'REMIND' mnemonic

The 'REMIND' mnemonic was expanded during 2022/23 to incorporate additional prompts for clinicians undertaking ward rounds and customised to different departmental needs:

R = Respect form and ceiling of treatment correctly completed.

E = Electronic prescribing up to date (antibiotics have end date, duration, IV/Po switch)
Examination: abdominal, internal

M = Mental capacity, Dementia, mobility status (physiotherapy, occupational therapy)
MEWS/NEWS fluid balance
Management of cannula and catheter

I = Investigations and tests (post/pre-op X-rays and blood tests)

N = Nutrition and hydration (IV nutrition and hydration/fluid chart), nil by mouth status

D = DVT risk assessment and thromboprophylaxis
Discharge planning (date of discharge)
Discussion with patient regarding options and plans
Extensive work had been incorporated from the Discharge project from winter 2022 using the "Ten Ts" methodology to ensure early and safe discharge and effective patient flow. Each ward was asked to do a discharge-focused PDSA cycle.

The Trust was also selected as a trial site for the national improving ward rounds project being led by the Emergency Care Improvement Support Team (ECIST) which is part of NHS Improvement and NHS England.

Improvement priority for 2022/23

The Trust was aiming to develop a framework of local ward round standards and to set out an implementation plan during 2022/23. The Trust also planned to start measuring indicators linked to ward rounds to gauge their effectiveness as follows:

- All emergency admissions should be reviewed with 14 hours of admission by a Consultant
- All emergency admissions should be reviewed daily by a Consultant
- Timely VTE risk assessment completion
- Timely administration of preventative VTE medication if required
- ReSPECT form completion
- Dementia risk assessment completion for patients over 75
- Mental capacity assessment completion

Broader measures:

- Reduction in the number of serious incidents where ward rounds is a theme
- Reduction in complaints around ward based care
- Reduction in incidents related to nutrition and hydration
- Positive staff and patient survey responses
- Length of stay (LOS)
- Increased patient discharges before 11am

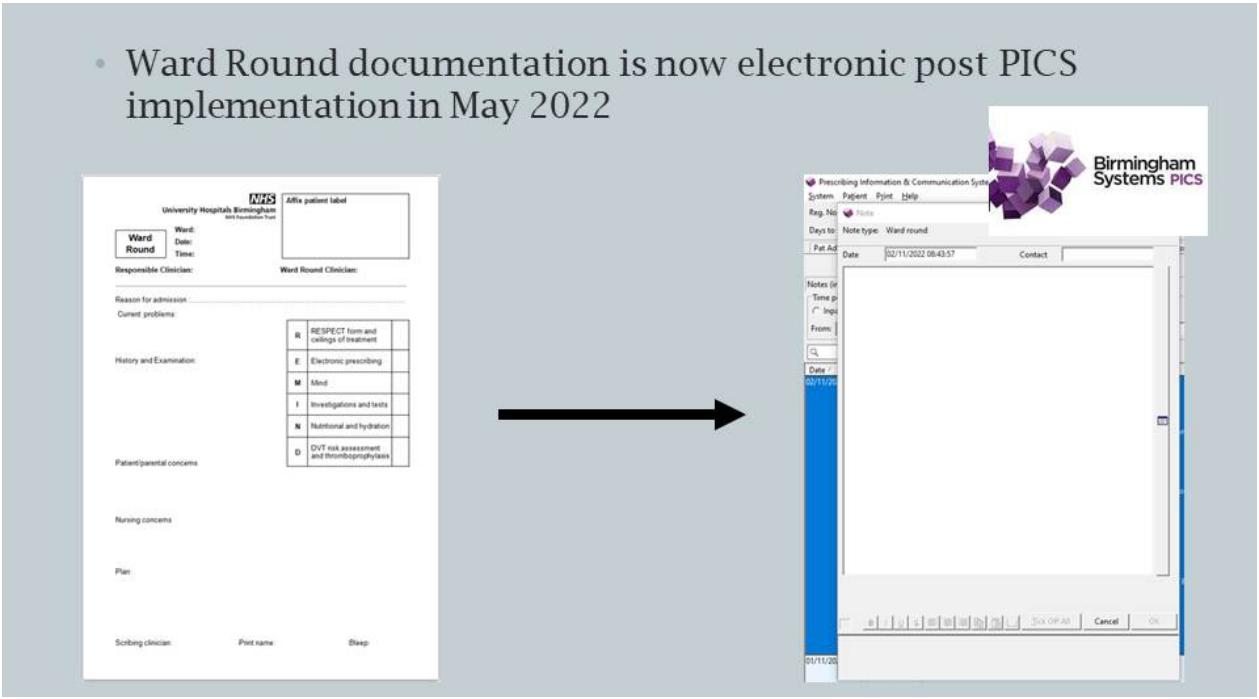
Progress during 2022/23

- Over 30 wards across different sites and a wide range of clinical specialties have been involved at various stages of the ward round quality improvement project during 2022/23.
- Longitudinal improvement data have been obtained from 3 respiratory wards, 2 infectious disease wards, 2 GIM wards, 1 stroke ward and more. More metrics developed from PowerBI are now able to show live patient level data.
- Widespread adoption of ward round champions are selected to represent each area and attend monthly ward round meeting to provide update
- Establishment of a data dashboard to allow wards to benchmark against peers have been developed
- Peer review work was done for ward round and discharge to promote learning from each other
- Alignment of the ward round quality improvement project to sub-projects emerging from the NHS England & NHS Improvement review were achieved / commenced:
  - Estimated discharge date: to improve documentation and use of estimated discharge date by wards
  - Nurse led and therapy led discharge: to develop a standard operating procedure for nurse/therapy led discharge
  - Discharge bundle completion: to improve timely discharge via introduction of a discharge bundle comprising tick boxes for key aspects of the discharge process
  - Multi-disciplinary team (MDT) board round: to improve documentation of the board round by wards
- Implementation of a quality improvement intranet site for staff education and sharing of best practice.
- Development of a standard operating procedure, board round and discharge bundle paperwork
- Quality improvement prize developed and awarded via grand rounds, in order to raise the profile of quality improvement across the Trust.
- Ongoing work is underway with Health Informatics and the Quality Development Team to develop measures, some of which are already in place. For example, Infectious Disease has used the metrics developed in PowerBI to monitor length of stay and early discharge before 11

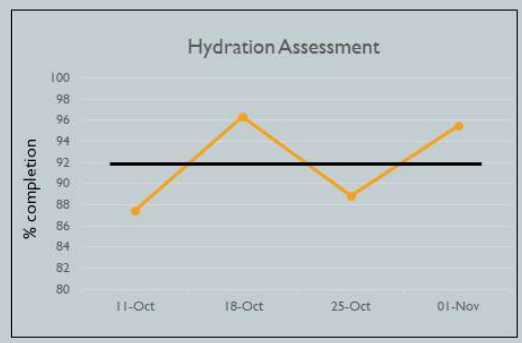
am. Additionally, a new ward round metric has been developed for UHB to measure ward round happens daily for each patient.
- A CMO Fellow supports the project.
- Two Infectious Diseases wards at Heartlands Hospital have completed in the ECIST improving ward rounds project.
- General good feedback from the ECIST project was received from infectious disease. We are providing support for ongoing improvement work at Good Hope HCOP wards.
- Key elements of a ward round training module using the Moodle platform is being developed and agreed. However, most training are still delivered in person, as this is the preferred method from staff.
- Quarterly QI Prize and roadshows have been introduced to celebrate success and promote engagement.
- There is regular senior nursing presence at the monthly ward round QI meeting. We have implemented a number of nursing-led projects, such as patient VTE compliance and effective handover.
- Respiratory, Stroke, Infectious disease and General internal medicine are leading the way in this project with sample data shown below.

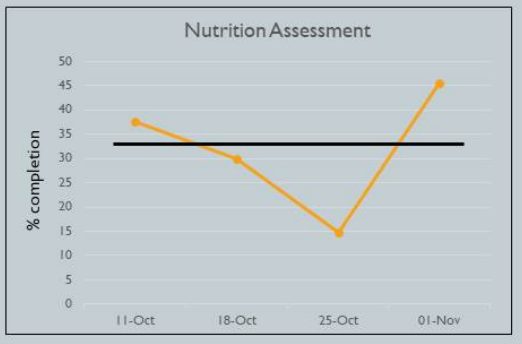
Performance

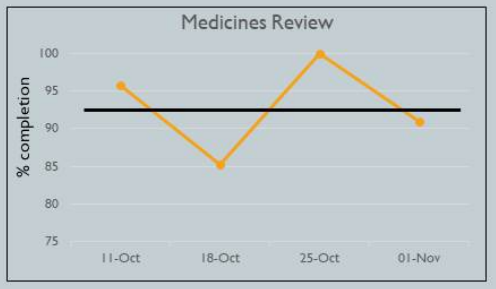
Implementation of the ward round project and PICS on respiratory wards at Good Hope has achieved good results for improvement.



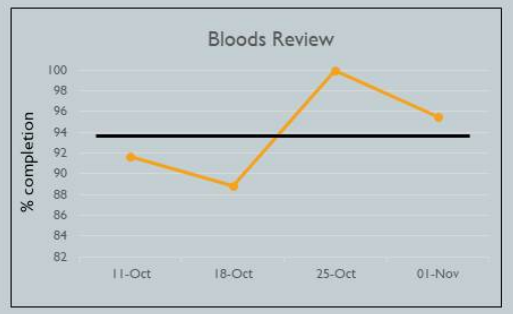
- Nutrition Assessment had a low rate of completion (mean completion rate = 31.95%)

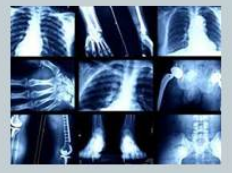




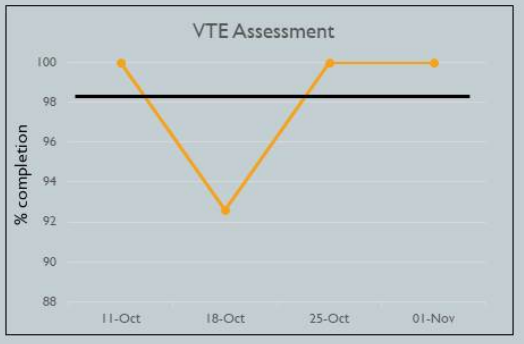


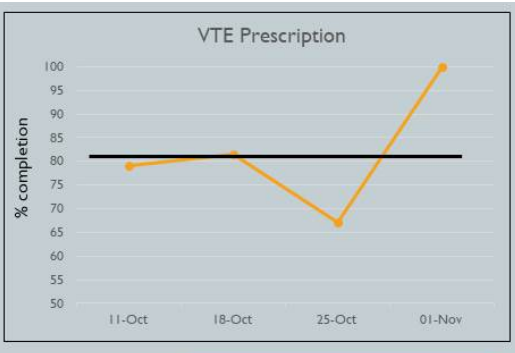
- No WR entry data on PD medication review

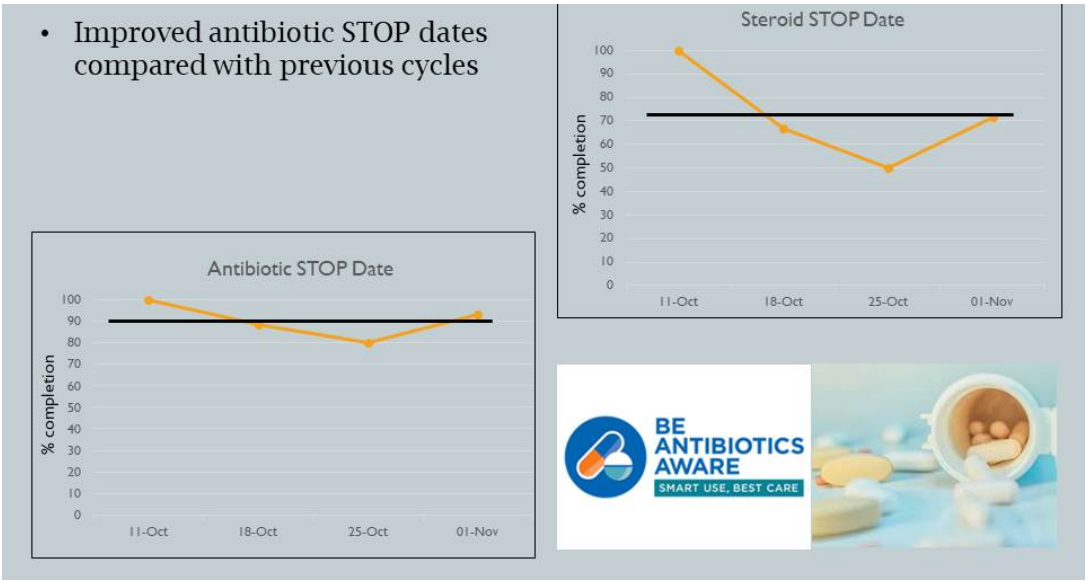




- High rates of VTE assessment due to PICS requirements







Run charts for other wards and specialties will be developed and monitored once the project has been running for long enough in each area.

Improvement priority for 2023/24

- Increased engagement of clinicians with the project via better communication.
- All participating sites/areas to deliver a discharged focussed PDSA cycle.
- All participating sites/areas to have a PDSA cycle led by AHPs/nurses.
- One area on each hospital site to demonstrate meaningful improvement in at least one patient level or process level indicator.

How progress will be monitored, measured and reported

- Progress will be monitored through the Trust's ward rounds quality improvement project.
- Some indicators will be included within existing performance dashboards such as the Clinical Dashboard. New performance dashboards may be developed as required.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 4: Improving nutrition and hydration

This quality improvement priority was agreed at the Clinical Quality Monitoring Group chaired by the Chief Medical Officer and approved by the Board of Directors.

Background

The Trust has had a safer swallow quality improvement project in place following previous serious incidents relating to this topic. The Trust chose to make improving nutrition and hydration a Trust-wide improvement priority during 2021/22 based on the number and types of incidents and complaints related to this topic. There have also been more serious cases that have been discussed at the Trust's Clinical Ethics Committee which reinforces the need to raise the profile of nutrition and hydration and clinical accountability for it across the Trust.

Building on the existing safer swallow quality improvement project, the Trust decided to set up a new, multi-disciplinary Nutrition and Hydration Steering Group in 2021/22 with senior clinical input.

Two areas of focus for this priority were:

1. Improving the management of patients who are nil by mouth (NBM):

There are two distinct groups of nil by mouth patients:

- Pre-operative patients who need to fast before their procedure
- Patients with dysphagia (difficulty in swallowing)

2. Ensuring patients' baseline and on-going weight and Malnutrition Universal Screening Tool (MUST) risk assessments are accurately completed.

The Trust aimed to standardise the approach to managing the two groups of nil by mouth patients, decision-making and nil by mouth signage across all hospital sites. The Trust also chose to focusing on ensuring patients received the right type of food (from a consistency perspective) at the right time.

Improvement priority for 2022/23

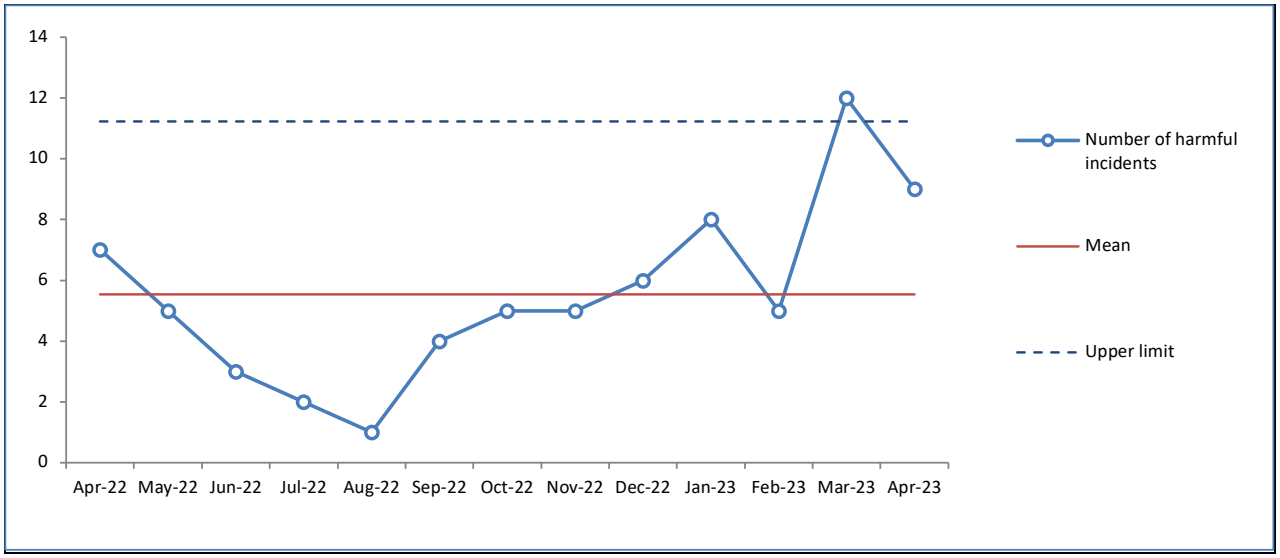
The focus of this priority for 2022/23 was improving the management of nil by mouth patients and delivering the priorities of the five sub-groups:

- Safer Swallow
- Enteral Nutrition
- Nutrition and Weight Assessment
- Parenteral Nutrition
- Eating Disorders and Disordered Eating

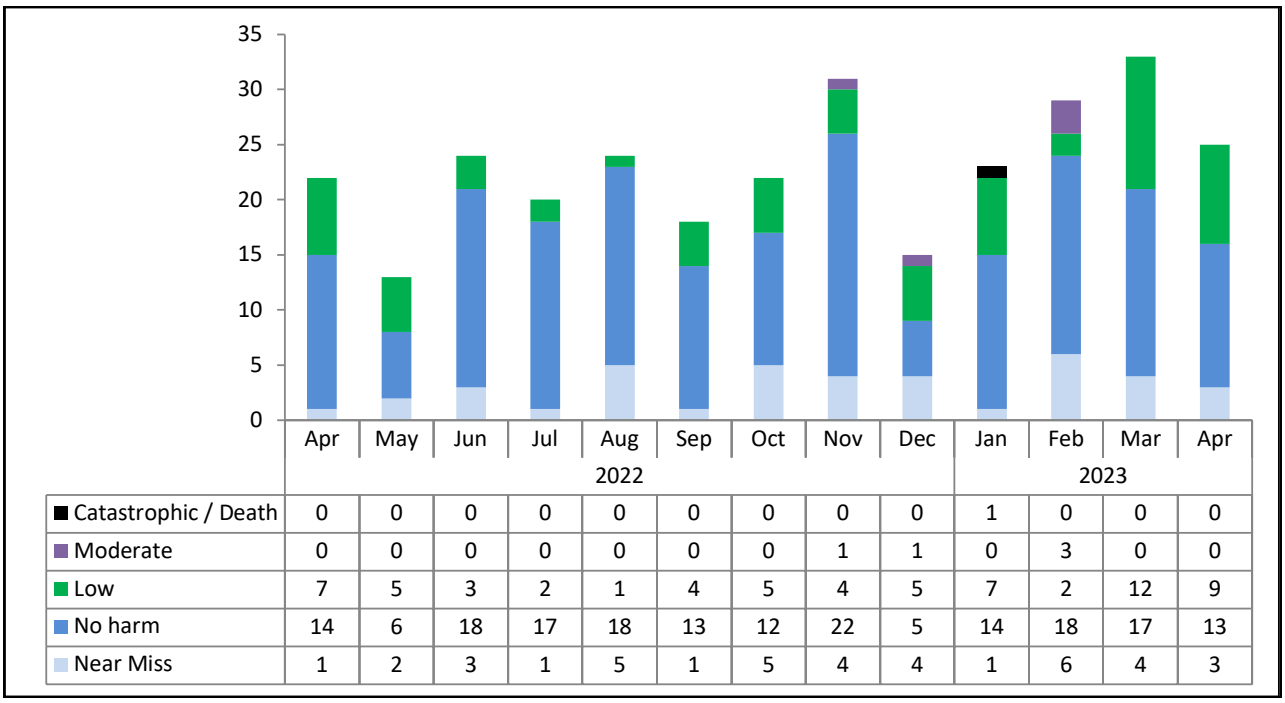
Performance and progress during 2022/23

Nutrition and Hydration Incident Data 1st April 2022 – 31st March 2023

Number of harmful incidents



Number of harmful incidents by level of harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
	2022									2023			
Catastrophic / Death	0	0	0	0	0	0	0	0	0	1	0	0	0
Moderate	0	0	0	0	0	0	0	1	1	0	3	0	0
Low	7	5	3	2	1	4	5	4	5	7	2	12	9
No harm	14	6	18	17	18	13	12	22	5	14	18	17	13
Near Miss	1	2	3	1	5	1	5	4	4	1	6	4	3

Progress

Nil by mouth

The Trust has made significant improvements over the past year. For patients who are nil by mouth, a robust service evaluation has been undertaken. This began with a Trust-wide audit of 1,000 patients who were nil by mouth. The Trust has then analysed when and why patients are made nil by mouth and for what duration they remain nil by mouth for. This data has led to changes to clinical practice including the creation of a new Trust-wide Standard Operating Procedure for Fasting to ensure patients do not remain nil by mouth for long durations. This is being disseminated via Trust Communications teams online, Trust 'myth busters', the library, junior doctor fora, in monthly Consultant inductions and via all matrons and volunteers on the wards. The team are creating updates to PICS noting and use of icons to facilitate greater visibility and recognition of patients who are nil by mouth. There are also plans for each sub-specialty which requires patients to be nil by mouth to lead on the implementation of education updates to ensure the Trust enacts best practice. Staff plan to re-audit once the education, practice and infrastructure changes have been made and report back to the Board of Directors. The Trust will collate this significant system-wide work to share with other acute Trusts facing similar challenges, and a publication for the BMJ Safety publication is in draft. Where clinical incidents relating to nutrition and hydration happen on wards, rapid, multi-professional plans are enacted quickly with clear oversight. The Trust aims to further reduce the severity and frequency of clinical incidents relating to patients who are nil by mouth.

Safer Swallow

Multi-professional safer swallow meetings continue to happen every 6 weeks and involve nursing, speech and language therapy, patient safety, facilities staff, dietetics, catering staff and the education team. Incidents involving harm relating to swallowing issues have continued to decrease as has the frequency of reports. Teams continue to report near miss and no harm incidents, which we encourage as this provides opportunities for learning and supports a healthy safety culture.

We have audited over 6,000 patients in 2022/23 and collected feedback on the quality of oral care as well as adherence to nil by mouth and swallow recommendation signage. Analysis of the feedback data will inform our priorities for safer swallow and nutrition and hydration. We have provided feeding support and training cross site, interviewed staff and patients about their experiences of optimal nutrition and hydration and are collating findings to target future education, training and clinical support requirements. These findings will also be reported to the Nutrition and Hydration Steering Group and Clinical Quality Monitoring Group. Over 3,000 members of staff have accessed safer swallow training via online packages and around 200 members of staff a year attend face-to-face training on providing safe swallowing delivered by the Speech and Language Therapy team.

The team has submitted a research funding bid to the National Institute of Health Research to explore how we can improve eating and drinking in acute trusts from a research perspective, to enhance our practice and further improve outcomes for patients. We have reviewed and updated standard operating procedures where required for managing dysphagia, patients who are nil by mouth, patients who have complex feeding issues and supporting mealtimes.

Enteral Nutrition

The enteral nutrition sub-group had its first meeting on 20th September 2022. Membership includes Directors of Nursing or a delegate from all divisions, cross site dietetic representatives, nutrition nurses, a consultant gastroenterologist a representative from the governance, quality and clinical assurance team. The sub-group identified naso-gastric feeding tubes as a key area of concern and the main workstream for the group.

Key activities currently:

The survey of staff showed that a lack of time and confidence were key barriers to practice in the correct insertion of naso-gastric feeding tubes.

Face-to-face naso-gastric feeding tube training has been instigated across sites by the Nutrition Nurses and is available to book via the Trust's Easy Learning portal. There has been collaboration with the Clinical Education teams who will encourage and support staff in their areas to undertake training.

Divisions have provided the Enteral Group with updated structures and contacts to allow audit reports to be directed to appropriate senior staff. This will allow divisional leads to have management and oversight of standards in their areas

The NG feeding tube audit was repeated in March – April across BHH, GHH and QEHB. The report is now in draft but shows several important areas for improvement. This report will be directed to divisional leads and fed back to the Nutrition and Hydration Steering Group.

There had been a number of issues with the brand of NG feeding tube we had been using across the Trust. This has now been changed and an alternative brand (GBUK Nutricare long term tube) is now coming in to clinical areas.

Clinical incidents related to enteral nutrition are reviewed at each group meeting. As a result of several incidents involving the incorrect use of enteral feeds, the dietetic members of the group are developing a cross site dietetic SOP to standardise feed use and prescribing practice.

Due to previous incidents related to delayed insertion of NG feeding tubes, and delayed feeding, an escalation procedure was developed by the Enteral sub group. This is now being amalgamated in to the review and update of the NG procedure.

A patient safety notice has been developed by the Patient Safety Team related to interpretation of chest x-rays to confirm NG feeding tube position. This is in relation to a recent never event at GHH, and the NG audit showing that many chest x-rays are not reported according to Trust standards.

The enteral feeding guideline has been reviewed and updated by the group. A new standardised emergency enteral feeding regimen is included within the guideline. This will be sent to the NHSG for wider review and then to controlled documents.

Intestinal Failure

Last year QEHB become an NHSE Commissioned and funded Tertiary/Regional Severe Intestinal Failure Unit. A business case is being developed, this is vital in delivery of several work streams and its approval will enable Intestinal Failure team dietetic team expansion, additional pharmacy time, Band 7 nurse appointment to decrease wait times for PEG placements and improve central venous access device, new sessional time for an additional gastroenterology consultant, psychology and surgical time, including theatre and colorectal stoma specialist nurse appointment. Three new specialist nurses have already been appointed at QEHB and will enable refresher training for safe PN connections/disconnection, and thus reduce central venous access device for PN infection rates.

Intestinal Failure referrals have now been streamlined to attend QEHB.

Referrals for Parenteral Nutrition (PN) will go live on PICS at the Heartlands Hospital and Good Hope Hospital sites with the next PICS update.

The PN SOP is in correction phase following review from the Chair of the SOP Group. This will unify PN management across the Trust

Consultant led nutrition ward-rounds have recommenced at Good Hope Hospital using QEHB consultants visiting once a week, providing consultant led PN and enteral nutrition care.

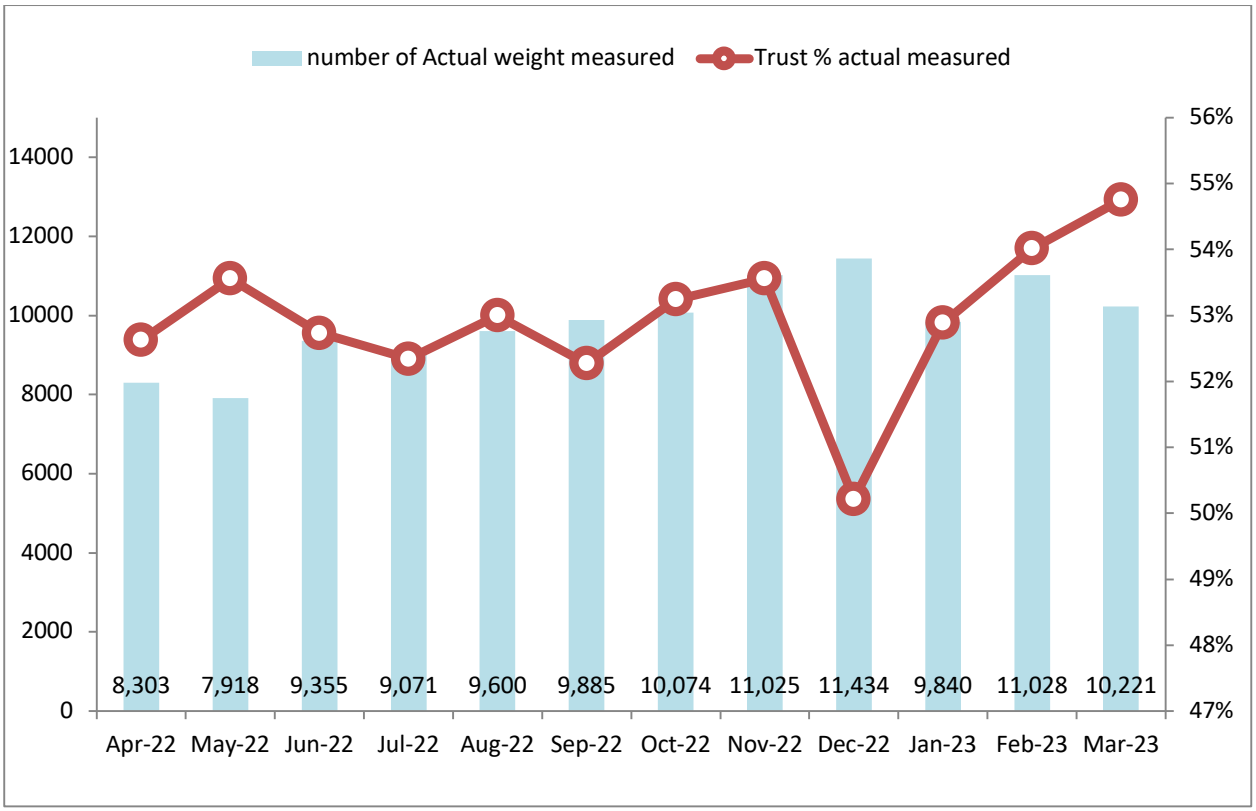
Central venous access device for PN infection rates are a focus of the PN working stream and we are seeing a reduction at QEHB using the new official definitions but at 1.2/1000 catheter days, we still need to get below 1/1000 catheter days. Rates are higher at other sites and plans are outlined as above.

Nutrition and Weight Assessment

A Nutrition and Weight Assessment sub-group has been established. This multi-professional group meets bi-monthly it includes representation from dietetics, SLT, Education, manual handling and nursing.

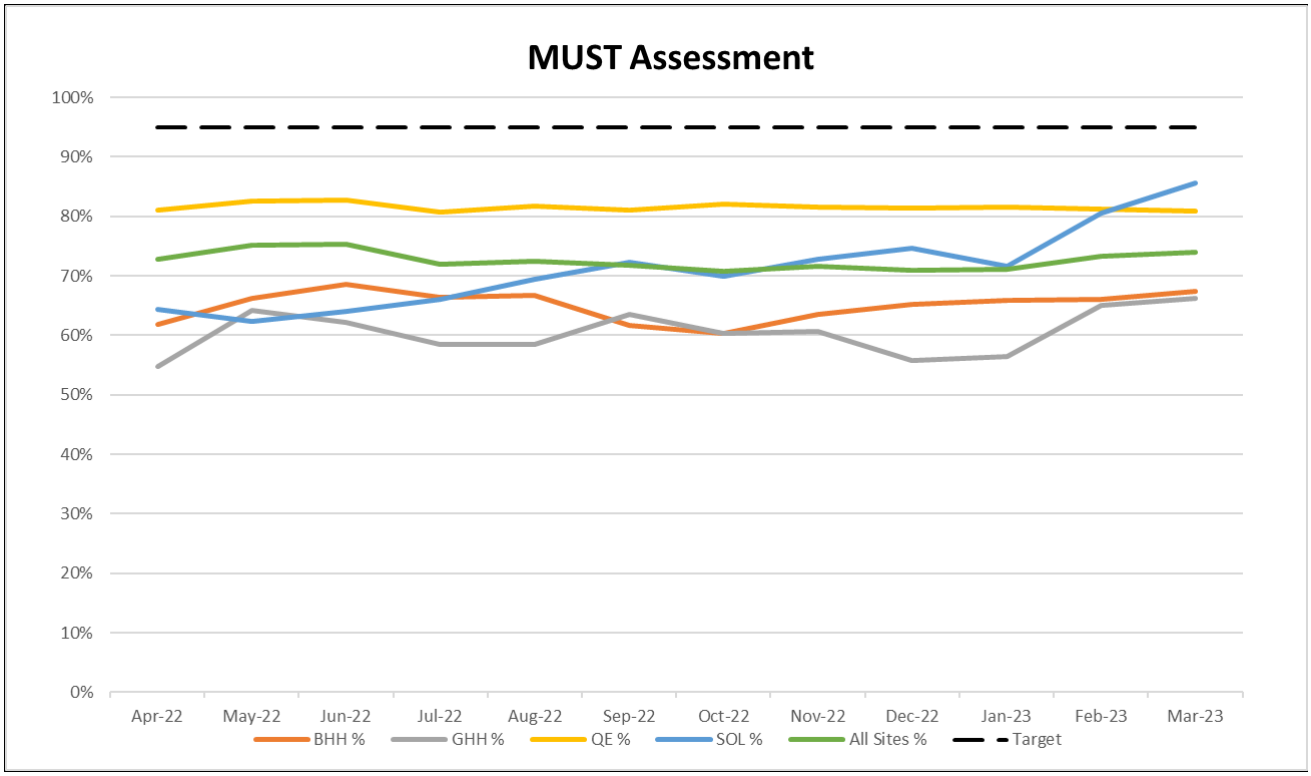
The group has reviewed ward data for actual versus estimated weights. Data for April 2023 shows that 55% of patients have actual weights recorded. There is still too great a reliance on using estimated weights when actual weights should be measured. The group also monitors performance for the completion of MUST risk assessments within 6 hours of admission or transfer to a ward.

Percentage of patients who have an actual weight recorded in PICS (April 2022 - March 2023)



MUST assessment completed within 6 hours of admission or transfer to a ward

Target 95% or higher



A data pull has also been requested to monitor completion of regular nutritional screening during a hospital admission

- The timing of MUST screening as part of the admission process is being reviewed to consider if 6 hour target is appropriate.
- Standards have been set for weight and height measuring equipment to ensure all areas have appropriate weighing scales and other assessment equipment in place to weigh patients and complete nutritional screening
- An audit of wards and outpatient areas was completed on all sites in summer 2022 against these standards. Wards have ordered scales and other equipment where it was not in place so all areas now have the necessary equipment in place
- The Environmental Audit Group has agreed to incorporate checking of correct weight and height assessment equipment into the regular Environmental Audit. This will ensure to ensure a regular check is made going forward and any missing equipment is replaced.
- A Patient Safety Notice was issued in August 2022 to raise awareness of on the importance of weighing patients and recording actual not estimated weight within 6 hours of admission and weekly during an admission
- National 'Malnutrition Awareness Week' was used as an opportunity to share key messages on social media and hospital radio about the importance of nutritional screening and nutritional support
- Training of ward staff on accurate nutritional screening and first line nutritional support is being delivered at ward level by the Therapy team (Dietetics and SLT) to raise awareness and improve practice This is initially targeting wards at GHH and QEH

Improvement priority for 2023/24

- See sub-group sections above

How progress will be monitored, measured and reported

- Progress will be monitored and reviewed by the Nutrition and Hydration Steering Group.
- Progress will be reported to the Care Quality Group chaired by the Chief Nurse.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors and the Council of Governors.

Priority 5: Improving the safety of invasive procedures

This quality improvement priority was agreed at the Clinical Quality Monitoring Group chaired by the Chief Medical Officer and approved by the Board of Directors.

Background

NHS England* published a set of National Standards for Invasive Procedures (NatSSIPs) in September 2015 which were endorsed by all relevant professional bodies. The aim of the NatSSIPs is to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. Never Events are defined as "Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers", (NHS England, January 2018). The NatSSIPs set out the minimum standards considered necessary for the delivery of safe care during invasive procedures as well as underpinning aspects of education and training.

NHS England then issued a Patient Safety Alert requiring trusts to review clinical practice and develop their own Local Safety Standards for Invasive Procedures (LocSSIPs) to improve patient safety. Since that time, the Trust has implemented a large number of LocSSIPs within a wide range of specialties.

The Trust has now incorporated this work within the Local Safety Standards for Invasive Procedures (LocSSIPs) / World Health Organization (WHO) Safety Checklist quality improvement project.

In January 2023, revised National Standards for Invasive Procedures 2 (NatSSIPs 2) were published by the Centre for Perioperative Care (CPOC). CPOC was commissioned to update NatSSIPs ensuring that it is multi-profession and applicable to all four nations. The new standards have been designed to reduce misunderstandings or errors and to improve team cohesion.

* NHS Improvement and NHS England have worked together as a single organisation since 1 April 2019.

Improvement priority for 2022/23

The Trust planned to introduce new Local Safety Standards for Invasive Procedures into Acute Medicine, Critical Care and Gastroenterology and implement cross-departmental LocSSIPs for procedures such as ascitic drain insertions and lumbar punctures

Progress during 2022/23

- New cross-departmental LocSSIPs were implemented in Acute Medicine, Critical Care and Gastroenterology as planned.
- New Safety Standards for Invasive Procedures have also been implemented in Ear, Nose and Throat, Neonates, Ophthalmology, Vascular and Breast.

Specialty	LocSSIPs Implemented
Neonates	1.Chest drain 2.Umbilical Vein and Artery Catheter Insertion
Vascular Surgery	Varicose veins Out Patient Department
Ear, Nose and Throat	1. Grommets insertion 2. Out Patient Department Procedures
Maxillofacial	Out Patient Department Procedures
Breast	Freehand biopsy
Gastroenterology Liver Medicine Acute Medicine Oncology	Abdominal Paracentesis (Ascitic Tap & Drain)
Ophthalmology	Adult Squint – BoTox Procedure
Critical Care	Tracheostomy/ percutaneous tracheostomy

- Specialties are auditing their Local Safety Standards for Invasive Procedures. These are presented to the LocSSIPs steering group and shared with Specialities and Divisions via the Quarterly Quality and Safety Report.
- The table below shows recent audit performance. The compliance column shows the percentage of required LocSSIPs that were completed. The 'correctly completed' column shows the percentage of completed LocSSIPs which were completed properly. Where there is poor compliance or LocSSIPs which are not being completed properly, discussions are held with departments to ensure remedial actions are put in place such as presentations at departmental governance meetings and teaching sessions for junior doctors.

Specialty	Compliance	Correctly Completed
Renal Surgery (QE)	100%	100%
Endoscopy (SH)	100%	100%
Ultrasound (GHH)	50%	100%
Sexual Health (Whittall Street Clinic)	100%	40%
Ultrasound Radiology (QE)	100%	100%
Cardiology (QE)	100%	100%
Ultrasound Radiology (BHH)	100%	65%
ITU (BHH)	5%	100%

- A Trust wide staff education module is now available on Moodle. The training includes videos based on real incidents and Never Events, with a focus on human factors.
- There continues to be regular communication with staff following the development and implementation stages to ensure each LocSSIP is fit for purpose.

Improvement priority for 2023/24

- The aim for 2022/23 is to continue to develop and implement LocSSIPs throughout the Trust. Work is in progress with Obstetrics, Gynaecology, General Surgery (haemorrhoid banding) and Cardiology (impella device).
- Over the next 12 months we will work towards embedding the revised NatSSIPs 2 standards.

How progress will be monitored, measured and reported

- Quarterly audits of compliance following the introduction of each Safety Standard.
- Quarterly progress updates to the Clinical Quality Monitoring Group (CQMG) chaired by the Chief Medical Officer.
- Regular progress reports will be provided to the quarterly Joint Clinical Quality Assurance Group (JCQAG) jointly chaired by the Chief Medical Officer and Chief Nurse.
- Never Event data will continue to be regularly reported to the Board of Directors and Clinical Quality Group.
- Progress will be included in the mid-year Quality Account Update to the Board of Directors.

Priority 6: Using real-time information to improve patient care

Background

The Trust's Clinical Dashboard was first implemented at the Queen Elizabeth Hospital site in 2009. The dashboard provides clinical staff with up to date information about the care they are providing to patients for a range of clinical indicators. The dashboard covers most inpatient beds, medical and surgical assessment units, ambulatory care areas and critical care units. A wide range of clinical indicators are presented at ward and Trust level automatically without the need for staff to undertake manual audits. Staff are able to see how their own and other wards/areas are performing at a glance as well as being able to drill down to view which patients did not receive their medication, assessments or observations for example. Data is regularly refreshed and is drawn from various clinical IT systems, predominantly the Trust's Prescribing Information and Communication System (PICS).

The design and content of the Clinical Dashboard are regularly reviewed and updated together with clinical and technical staff. The most recent review took place in 2021 before the roll-out of the Clinical Dashboard to the Solihull, Heartlands and Good Hope hospital sites. The roll-out to inpatient areas is predominantly complete with just Paediatrics and Obstetrics outstanding at this point.

Improvement priority for 2022/23 & 2023/24

To improve performance and reduce variation across the four hospital sites for six of the indicators on the Clinical Dashboard, as selected by Matrons.

In 2022/23, this Priority covered five indicators, and a sixth has been added for 2023/24:

"Full set of observations and pain assessment within 12 hours of admission or transfer to a ward".

No.	Indicator Title	Notes	Target	Higher or lower is better
1	Full set of observations and pain assessment within 6 hours of admission or transfer to a ward	A full set of observations includes: › Alertness (using ACVPU scale) › Temperature › Heart rate › Blood pressure › Respiratory rate › Oxygen saturation Plus pain assessment	95%	Higher
2	Full set of observations within 12 hours of admission or transfer to a ward	A full set of observations includes: › Alertness (using ACVPU scale) › Temperature › Heart rate › Blood pressure › Respiratory rate › Oxygen saturation The 12 hour time slots are defined as: › From 00:00hrs to 12:00hrs › From 12:00hrs to 00:00hrs	99%	Higher

No.	Indicator Title	Notes	Target	Higher or lower is better
3	MUST assessment completed within 6 hours of admission or transfer to a ward	The Malnutrition Universal Screening Tool (MUST) is used to assess individual patients' risk of malnutrition.	95%	Higher
4	Missed doses of antimicrobials	Missed antimicrobials include antibiotics, antivirals and antifungals	2%	Lower
5	Electronic wristband identity check before administration of medication	Staff are expected to check each patient's identity by scanning their electronic wristband before giving medication.	95%	Higher
6	PICS document archive print	Each ward/area must have an archive printer which can be used if the electronic Prescribing Information and Communication System (PICS) ever goes down. Staff are expected to print out one document such as a drug chart each day to ensure they know what to do if PICS goes down.	96%	Higher

Performance

The following graphs show performance for six selected Clinical Dashboard indicators for 2022/23. The black dashed line on the graphs shows the target.

Performance is shown for the four hospital sites and the Trust overall ("all sites")

BHH – Heartlands Hospital

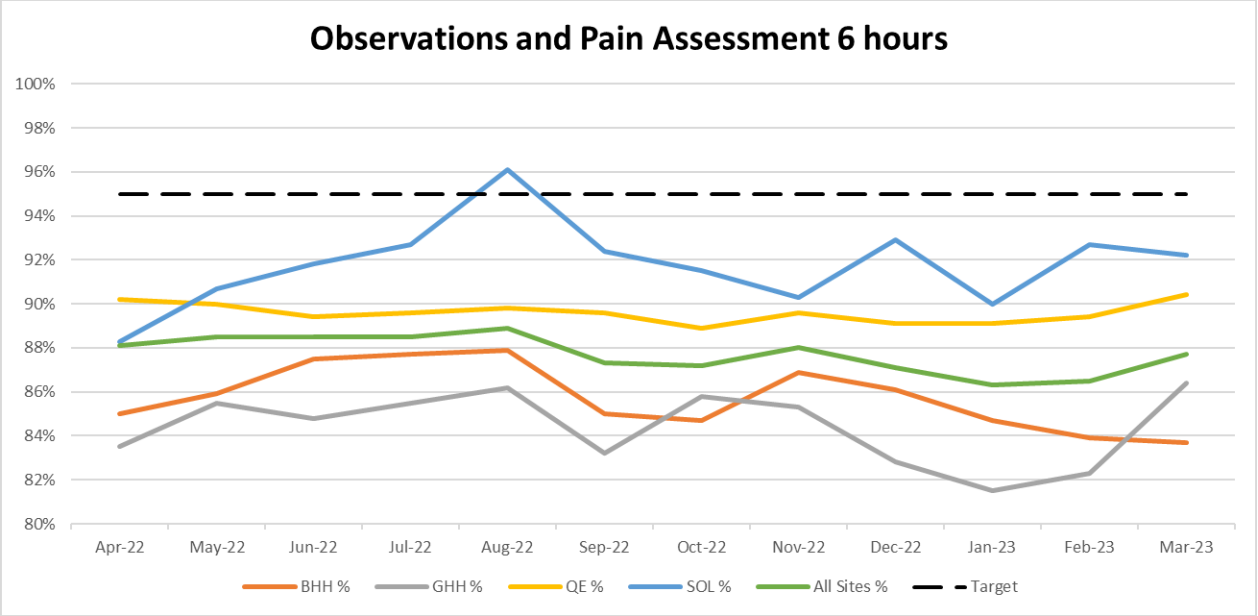
GHH – Good Hope Hospital

QE – Queen Elizabeth Hospital

SOL – Solihull Hospital

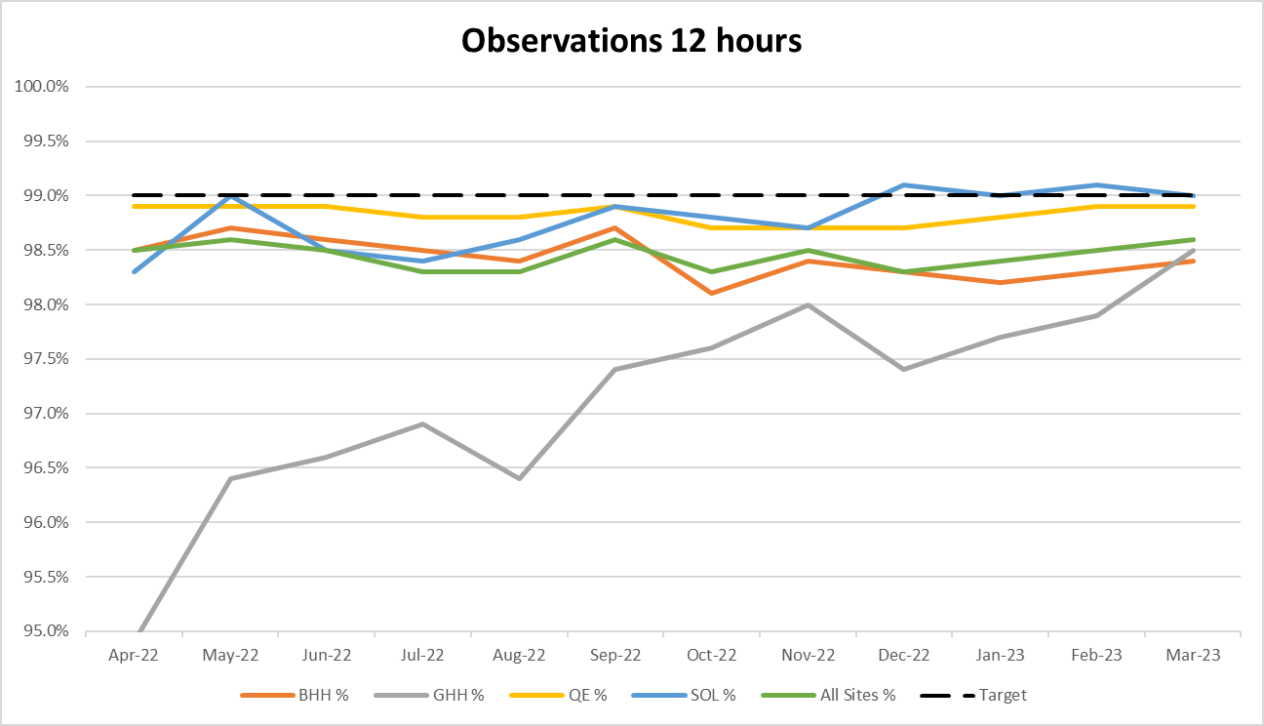
Full set of observation and pain assessment within 6 hours of admission or transfer to a ward

Target 95% or higher



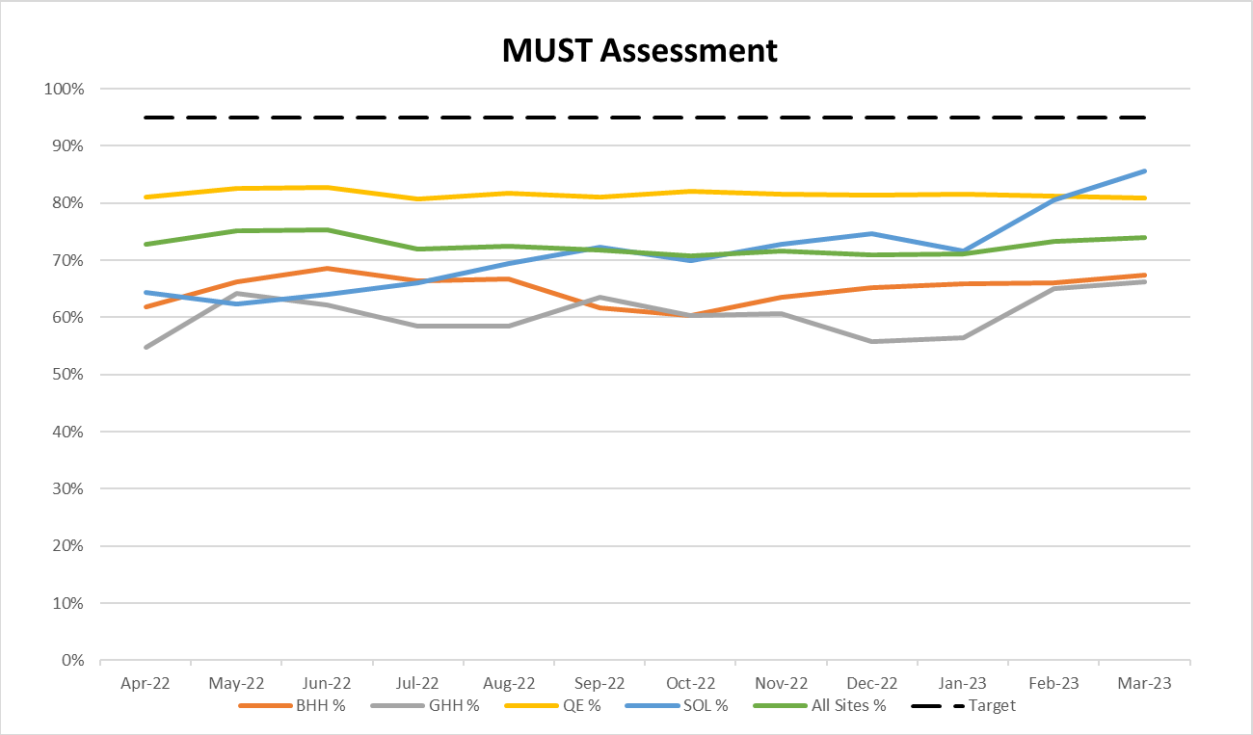
Full set of observations within 12 hours of admission or transfer to a ward

Target 99% or higher



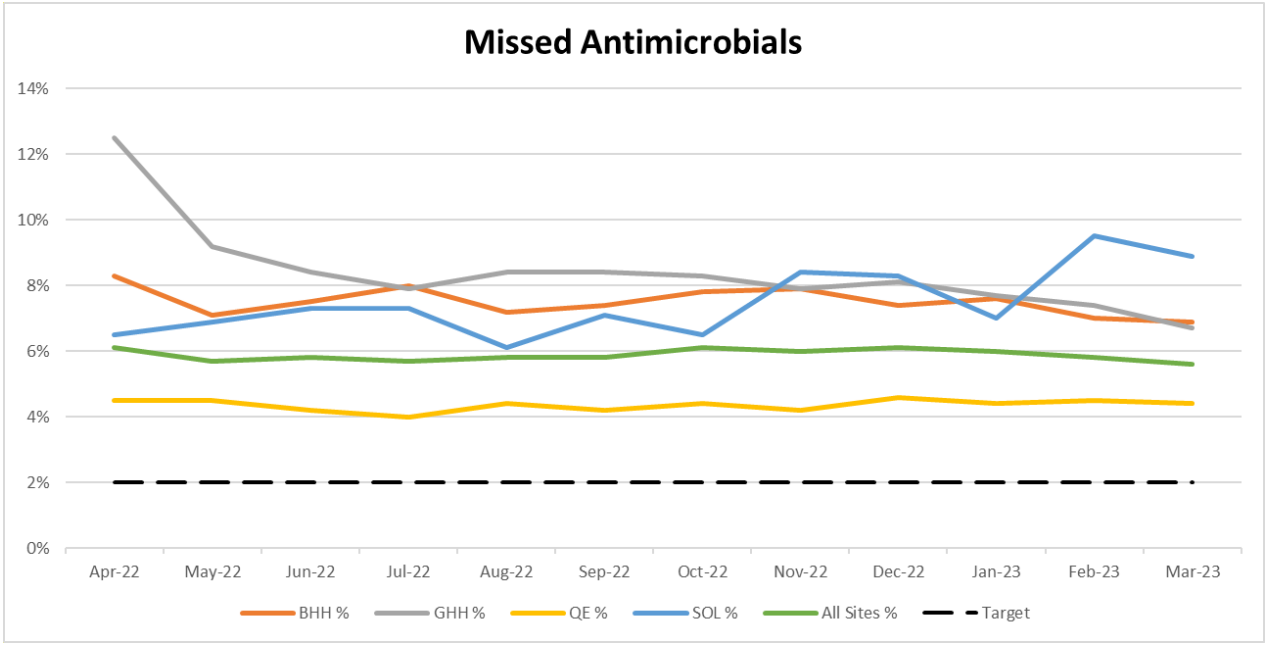
MUST assessment completed within 6 hours of admission or transfer to a ward

Target 95% or higher



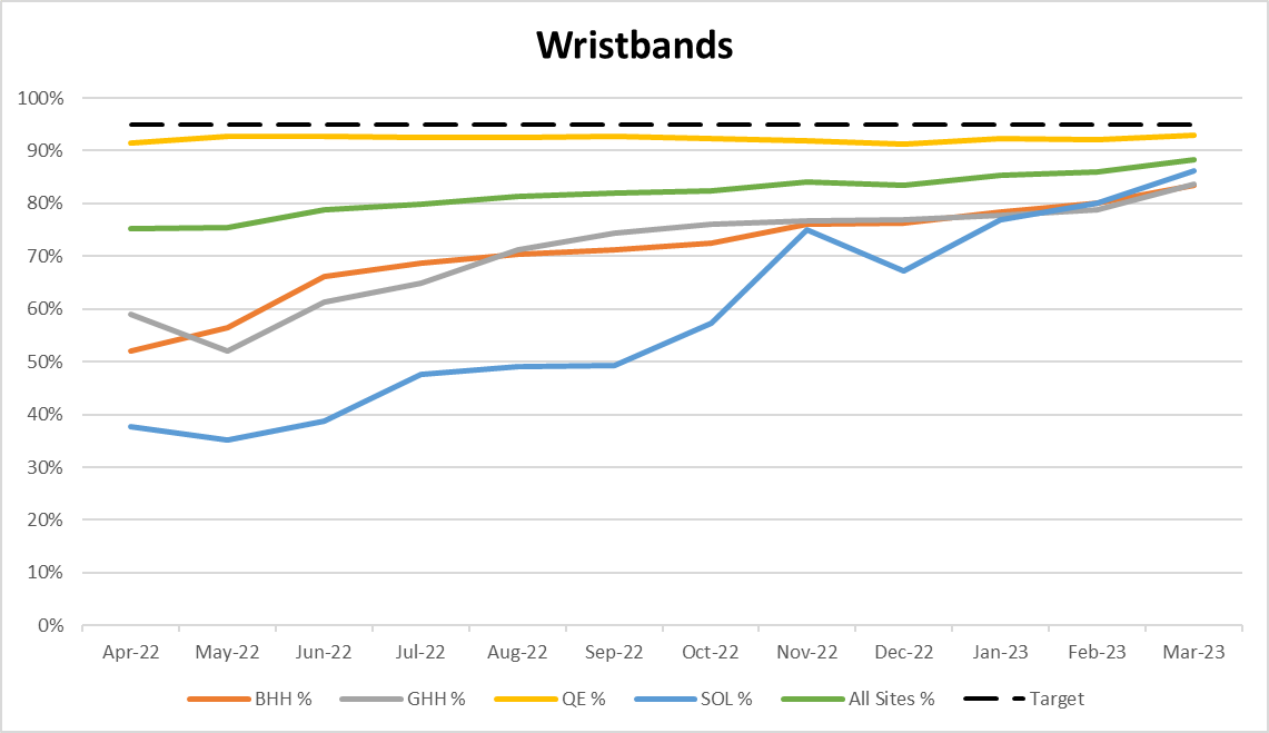
Missed doses of antimicrobials

Target 2% or lower



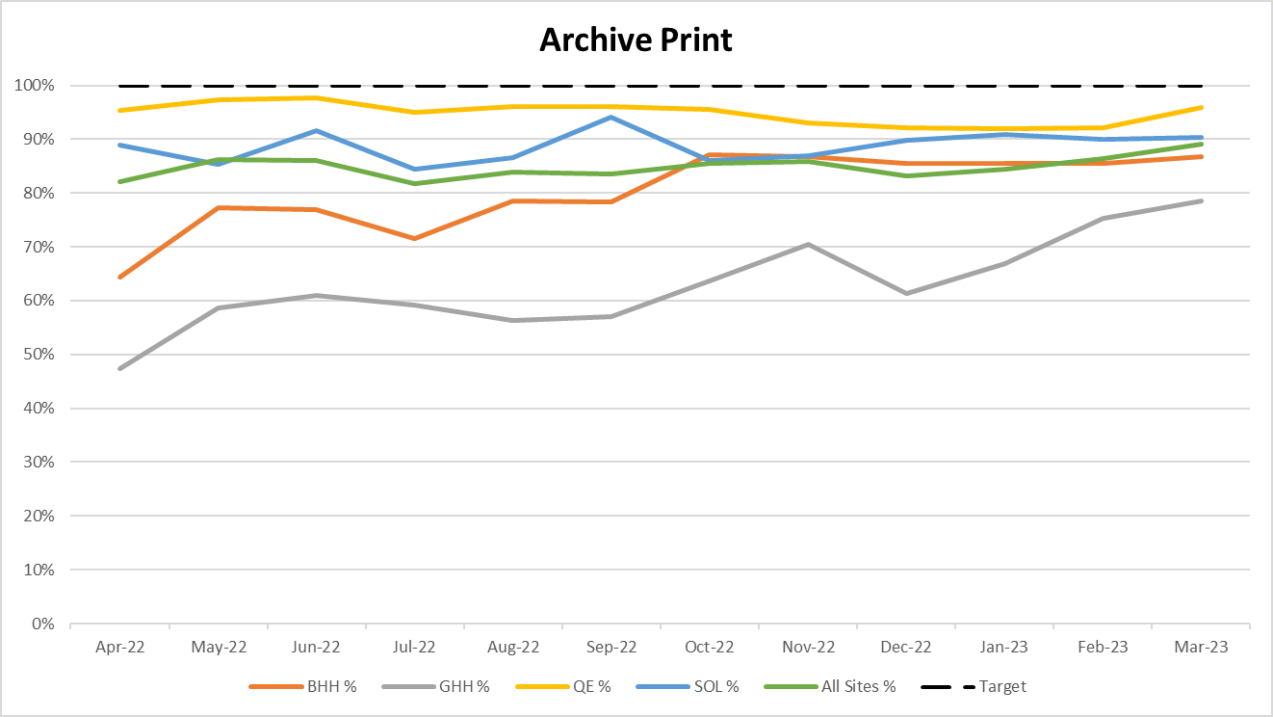
Electronic wristband identity check before administration of medication

Target 95% or higher



PICS document archive print

Target 96% or higher



Progress during 2022/23

Clinical Dashboard Review Group (CDRG)

The Clinical Dashboard Review Group was set up in August 2019 and is jointly chaired by the Chief Strategy & Projects Officer, and the Deputy Chief Nurse. The group meets monthly with an average of 20 staff attending from different disciplines over the past 13 months. Ward Managers and Matrons for the selected wards are expected to attend along with representatives from Pharmacy, IT, Corporate Nursing and the Quality Development team. Specialist staff (e.g. from Diabetes, Haematology) also attend when relevant indicators are being reviewed to provide guidance and support.

The purpose of CDRG is to provide a supportive learning environment for reviewing and improving ward level performance for a range of quality indicators.

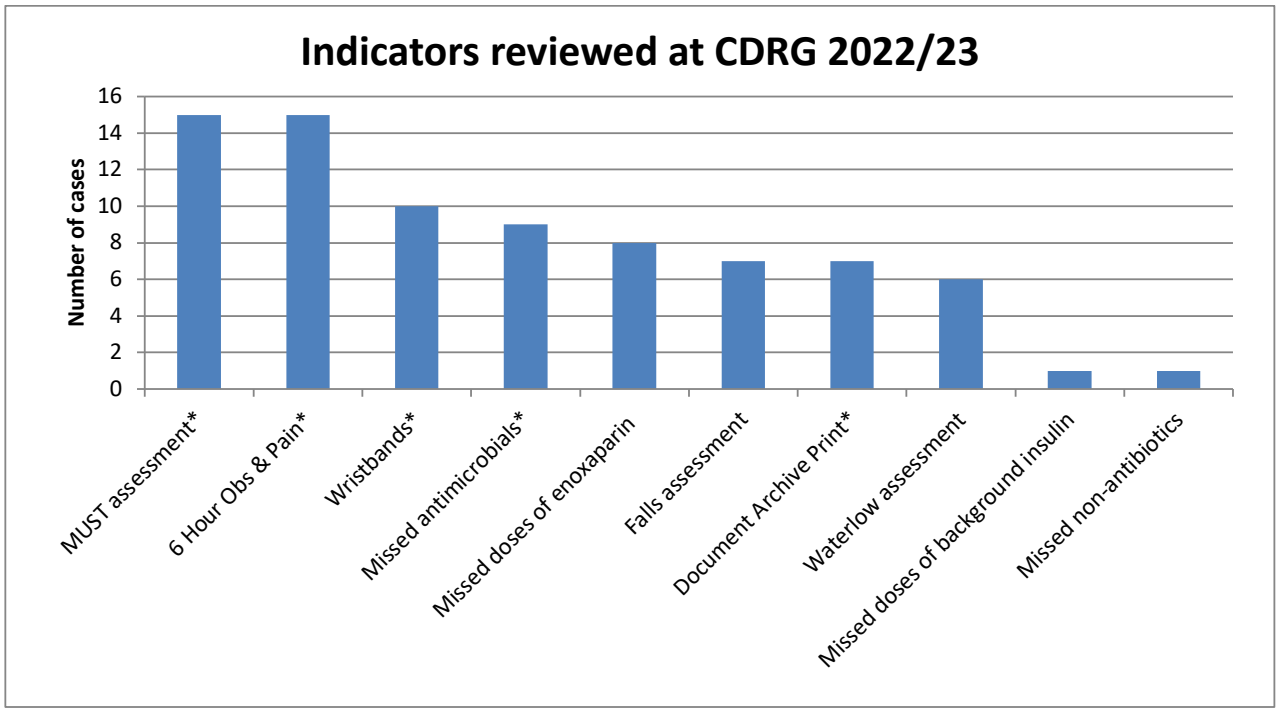
Ward staff have had to get used to an entirely new way of doing things – PICS – at a time of considerable pressure due to the Covid-19 pandemic, staffing shortages and significant patient demand. The content of the Clinical Dashboard was reviewed before being rolled out to Solihull, Heartlands and Good Hope hospitals. The challenging targets already in place at the Queen Elizabeth Hospital were rolled out to the other sites to ensure they are all being measured to the same high standards. It will therefore take some time for ward level performance to gradually improve over time as staff become more familiar with PICS, the Clinical Dashboard indicators and the standards required.

The Chief Strategy & Projects Officer and the Deputy Chief Nurse, supported by the Quality Development team, have chosen to take a supportive approach to reviewing performance and sharing learning to drive improvement. Wards which have either been performing highly or have significantly improved as well as those which are performing poorly have been invited to present to the group. This approach allows wards which are not performing so well to learn from those which are performing better as well as showing that is possible to achieve the targets which have been set.

The group has reviewed 79 cases of ward-level performance for Clinical Dashboard indicators during 2022/23:

- 13 cases were selected based on good performance
- 66 cases for poor performance.

Cases were split between "new" wards (those which have recently gone live with PICS and the Clinical Dashboard), and "regular" wards (which have had PICS and the Clinical Dashboard for longer).



* Indicators with an asterisk denote the five indicators chosen for the Quality Account Priority for 2022/23

Divisional Clinical Dashboard Review Groups

Divisions are also encouraged to run Divisional level Clinical Dashboard Review Groups which the Quality Development team attend to provide support when required.

Ward Visits / training

The Chief Strategy & Projects Officer, the Deputy Chief Nurse and the Quality Development Team perform ward visits to address performance and provide support.

Face-to-face and online training sessions delivered to clinical staff on how to use the Clinical Dashboard to improve patient care.

Health Observatory

Quality Development and Informatics are working with clinical staff to design a new Clinical Dashboard using the PowerBI software as part of the Health Observatory Project.

This project involves oversight into indicator selection, prioritisation, and development of a suite of clinical quality indicators that will form the UHB clinical quality indicator framework.

The indicators to be developed will provide a suite of metrics for each specialty across the different service levels within UHB:

a. Trust wide indicators e.g. corporate QI projects clinical dashboard, VTE
b. Common functional/professional indicators e.g. performance of full set of observations, consultant ward rounds, return to theatre
c. Specialty chosen indicators with possible national audit components

The UHB Clinical Quality Indicator Framework, named the Health Observatory, and its governance structure have now been agreed. Clinical Service Leads (CSLs) have been asked to review their current list of quality indicators that they have previously proposed in the last few years. CSLs have been asked to submit their top five chosen indicators in ranked order, noting that these will need to be fully automatable and available from current Trust electronic systems.

Initiatives to be implemented during 2023/24

- To continue to deliver face-to-face and online training sessions to clinical staff on how to use the Clinical Dashboard to improve patient care.
- To continue to review and monitor low and high performing wards at the Clinical Dashboard Review Group and share learning across the hospital sites.
- To work with the Health Informatics team to ensure clinical staff have the information they need to improve performance at ward level.
- To work with the IT and Procurement teams to ensure staff have the right equipment in place to deliver excellent care to their patients.
- To build, review and update the selection of indicators and targets with clinical lead input through the Health Observatory.
- To continue to support wards with divisional Clinical Dashboard Review Group meetings to improve performance.
- To set up a Clinical Dashboard working group with clinical staff to regularly review and update the selection of indicators and targets included within the dashboard.
- To continue work with clinical staff to design a new Clinical Dashboard using PowerBI software.

How progress will be monitored, measured and reported

- Performance for the Clinical Dashboard indicators will continue to be reviewed monthly at the Clinical Dashboard Review Group jointly chaired by the Deputy Chief Nurse and Chief Strategy & Projects Officer.
- Performance exceptions will be reported to the Joint Clinical Quality Assurance Group chaired by the Chief Medical Officer and Chief Nurse.
- Performance for the Health Observatory will continue to be reviewed monthly by the 'Health Observatory Indicator Development Group' which is chaired by a Senior Clinical Lead for Surgery/Medicine and involves lead nurses and specialty representation.

Other Quality Improvement (QI) Projects

In addition to the Trust's Quality Improvement Priorities listed above, the Patient Safety Team holds a register of Quality Improvement (QI) Projects. This table provides details on these.

Multi-Disciplinary Team (MDT) / Multi-Disciplinary Meeting (MDM) Review	
Project Aims	To reduce number of patients lost to follow-up following cancer MDM.
Project Measures	› Reduction in level of harm incidents › Reduction in incident themes and trends › Referral Metrics › Audits of MDM practice following implementation › Reduction in incidents related to patients who are referred to Cancer MDMs
Project Update	› The audit demonstrates improved usage of the PICs referral system since its introduction in January 22. › The controlled document was widely shared and created much discussion about the process of referral to Cancer MDM. › Clinical Nurse Specialists were added to the list of approved referrers on PICs. › Metrics have been agreed and reports created to pull the data from Trust systems. › Themes are now emerging as to differences in referral patterns across MDMs. This will feed further work and ongoing development for MDT Effectiveness within Cancer MDMs at UHB
End of Life Care/DNACPR	
Project Aims	To improve the standard of end-of-life advanced care planning and to reduce incidents/ complaints related to end-of-life care.
Project Measures	› % of deaths with a valid DNAR › % of all inpatients with a valid DNAR › Months since last SI › Number of complaints related to EOL care
Project Update	Several new indicators for EoL are being developed by the Health Observatory including: deaths on comfort observations, use of daily care plan in patients who die and investigations for patients on comfort obs. A staff position in informatics has been made for EoL to expand the number of indicators. New digitalised ReSPECT form launched last month, focused more on patients wishes . A key improvement with this form is that it can be printed at discharge and will be live and valid in the community. EoL ward audit: the QI team have audited an unselected series of deaths at QEHB, BHH and GHH. The results are now being fed back to the departments audited – so far this has been shared with Oncology at QEHB. Suggestions from this series discussed at Oncology M&M include earlier use of comfort observations, reducing burdensome treatments e.g. blood tests for dying patients, and steps to make nurses and junior doctors empowered to speak up about end of life.
Patient letters	
Project Aims	To increase the percentage of letters written directly to patients and improve letter readability
Project Measures	› Percentage of outpatient letters where patient is addressee › Percentage of outpatient letters where patient is addressee or CC › Percentage of letters that follow standard format/key elements › Percentage increase in diagnosis, management and actions for GP documented in letters to patients › Average reading age of letters/Flesch readability score
Project Update	› Initial contact made with pilot groups (breast, thoracics, ENT). › Patient and GP focus groups to ascertain important features of an outpatient letter for these stakeholders. › Contact with the Royal Literary Fund to provide a liaison to assist with training and support for staff wishing to improve their writing skills – in progress

Improving Diabetes management	
Project Aims	Reduce the number of DKA incidents and recurrent hypoglycaemic episodes suffered by inpatients on diabetic medication
Project Measures	› Reduction in number of hospital acquired DKA incidents and harm – Datix. Now available as NADIA harms, though work is underway to improve reliability of validation. • DKA criteria -patient diagnosed with new onset DKA >2 hours after admission. • Hypoglycaemia Rescue criteria - patient requiring injectable rescue treatment for an episode of hypoglycaemia starting > 6 hours after admission › Reduction in incident numbers, insulin incidents, themes and trends – Datix › Nursing Metrics – based on PICS data in the Clinical Dashboard › Previous QuORU metrics – based on PICS to be relocated to Clinical Quality Indicator Framework in PowerBI › Training records (Moodle/ward based)
Project Update	› Datix reported NADIA harm validation by a consultant and diabetes nurse has commenced. › Egg timer pilots as reminders for staff to retest after 15 minutes continue on 513/West 2 QEHB and ward 8 at GHH. › The first one indicator in relation to re testing blood glucose following hypo treatment (948b) has been developed and is currently being validated. › Other work is being undertaken to look at causative factors leading to hypos at UHB and also exploring the possibility of an Early Warning Score for patients at risk of hypoglycaemia Education: › Initial scoping undertaken of current diabetes education materials available to doctors and nurses. › Discussion with medical and nursing groups regarding current challenges in accessing existing materials. › Liaison with simulation team to assess diabetes-specific cases currently being used. › Scoping of use of QR codes for diabetes guideline dissemination
Sepsis	
Education and feedback	› Co-ordinated approach being developed with QI education lead › CCOT continue to recruit and educate local Sepsis Champions › CCOT piloting sepsis boxes › PICS acknowledgment of sepsis alerts now includes CCOT with NPS › Guidelines available on intranet › Sepsis dashboard › Review of blood culture data for Acute Medical Areas › Provide CSLs with quarterly performance data for inpatient areas, monthly to acute admission areas › Ongoing work with Informatics to automate reports and review indicators.
Improvement initiatives	› Blood culture QI projects in progress: ED, Renal (new junior doctors have been recruited), Gen Surgery & Paediatrics › Implement Sepsis Trays in the above specialties › To add a focus on lactate performance in the near future
RAD alert	
Project Aim	Eliminate clinical incidents where a failure in communication of a radiology report is a key contributing factor
Project Update	› A standard operating procedure has been published. › The RAD-Alert system is well embedded. › Individuals and teams need to work out how to make the best use of the emails and the RAD-Alert functionality. Leads for the project are intending to send some nuggets of helpful hints in the daily summary email on the RAD-Alert functionality.

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2022/23 University Hospitals Birmingham NHS Foundation Trust provided and/or sub-contracted 74 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in 74 of these relevant health services*.

The income generated by the relevant health services reviewed in 2022/23 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2022/23.

* The Trust has appropriately reviewed the data available on the quality of care for all its services. Due to the sheer volume of electronic data the Trust holds in various information systems, this means that UHB uses automated systems and processes to prioritise which data on the quality of care should be reviewed and reported on.

Data is reviewed and acted upon by clinical and managerial staff at specialty, divisional and Trust levels by various groups including the Clinical Quality Monitoring Group chaired by the Executive Chief Medical Officer.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2022/23, 63 national clinical audits and 6 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 56 (89%) national clinical audits and 6 (100%) national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that UHB was eligible to participate in during 2022/23 are as follows (see table below).

The national clinical audits and national confidential enquiries that UHB participated in during 2022/23 are as follows: (see table below).

The national clinical audits and national confidential enquiries that UHB participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2022/2023	Percentage of required cases submitted
Breast and Cosmetic Implant Registry	Yes	At the time of writing this report an audit is being completed to determine the number.
Case Mix Programme	Yes	100%
Emergency Medicine QIPS	Yes	Pain in Children – 100% Care Of Older People – Ongoing Data Collection Mental Health self harm – Ongoing Data Collection
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disabilities Mortality Review)	Yes	100%
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data) Perinatal confidential enquiries Perinatal mortality surveillance
National Adult Diabetes Audit	Yes	1. National Diabetes Foot care Audit data collection – 100% 2. National Core Diabetes Audit National Adult Diabetes Audit (NDA) – 100% 3. National Pregnancy in Diabetes Audit data collection – 100% 4. Integrated Specialist Survey – 100%
Falls and Fragility Audit Programme	Yes	1. Fracture Liaison Service - 100% 2. National Audit of Inpatient Falls – 100% 3. National Hip Fracture Database Jan to Dec 2020 National Standard – 85% QEH – 182% BHH – 27.5% GHH – not eligible (did not participate in full reporting period)

National Audit UHB eligible to participate in	UHB participation 2022/2023	Percentage of required cases submitted
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Yes	1. Paediatric Asthma Secondary Care data collection –0% 2. Adult Asthma Secondary Care – No case ascertainment data published due to COVID 3. Chronic Obstructive Pulmonary Disease Secondary Car - 100% 4. Pulmonary Rehabilitation- Organisational and Clinical Audit data collection – 194%
National Audit of Breast Cancer in Older People	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Cardiovascular Disease Prevention	Yes	99%
National Audit End of Life Care	Partial	25% - Organisational level participation only
National Audit of Dementia	Yes	100%
National Bariatric Surgery Register	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Participation recommenced Oct 2022.
National Cardiac Arrest Audit	Yes	100%
National Cardiac Audit Programme	Yes	1. National Audit of Cardiac Rhythm Management - Data collection 100% 2. Myocardial Ischaemia National Audit Project – 100% 3. National Audit Cardiac Surgery – 100% 4. National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) – 100% 5. National Heart Failure Audit: Apr 2019 – Mar 2020 – 71% (National Standard 70%) 6. National Congenital Heart Disease Data collection 100%
National Child Mortality Database	Yes	100%
National Early Inflammatory Arthritis Audit	Yes	No new data to report currently
National Emergency Laparotomy Audit (NELA)	Yes	QEH – 100% BHH – 100% GHH – 97.8%

National Audit UHB eligible to participate in	UHB participation 2022/2023	Percentage of required cases submitted
Gastro-Intestinal Cancer Audit Programme	Yes	National Oesophago-gastric Cancer (NOGCA) April 2017 to Mar 2019 UHB – 85-100% National Bowel Cancer Audit (NBOCA): Apr 2019 to Mar 2020 – Case ascertainment not reported nationally
National Joint Registry	Yes	April 2020 – March 2021 – case ascertainment = 19.8% (National Standard: 95%) – Impact of COVID. Assured that all required data were submitted.
National Lung Cancer Audit	Yes	100%
National Maternity and Perinatal Audit	Yes	Not Available - Data Quality Issues impacted many Trusts ability to participate.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%
National Ophthalmology Database Audit (NOD)	Yes	Adult Cataract Surgery Audit – 100%
National Paediatric Diabetes Audit	Yes	100%
National Perinatal Mortality Review Tool	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	Jan 2020 to Dec 2020 National Standard: 85% Case Ascertainment [Abdominal Aortic Aneurysm]: 85%
Neurosurgical National Audit Programme	Yes	No new report this year
Renal Audits	Yes	National Acute Kidney Injury Audit – 90-100%
Respiratory Audits	Yes	Adult Respiratory Support Audit-Data collection phase
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion Scheme (SHOT)	Yes	100%
Society for Acute Medicine Benchmarking Audit	Partial	GHH – 0% (planned non-participation) Other sites - 100%
Trauma Audit and Research Network	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
UK Parkinson's Audit	Yes	100%
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	Yes	100%

National Confidential Enquiries (NCEPOD)

National Confidential Enquiry (NCEPOD)	UHB participation 2022/2023	Percentage of required number of cases submitted
Epilepsy	Yes	100% (organisational questionnaire only in 2022/23 period)
Transition	Yes	63%(12/19 clinician questionnaires) 100% (13/13 case notes return)
Crohn's	Yes	100% organisational questionnaire 89%(17/19 clinician questionnaires) 68% (13/19 case notes return)
Community Acquired Pneumonia	Yes	100% organisational questionnaire 95% (18/19 Clinician Questionnaires 100% case notes)
Testicular Torsion	Yes	100% clinician questionnaires and notes (Note ongoing Organisational Questionnaire submission)

Percentages given are the latest available figures.

Local Audits

At UHB a wide range of local clinical audits are undertaken. This includes Trust-wide audits and specialty-specific audits which reflect local interests and priorities. A total of 1127 clinical audits were registered with UHB's clinical audit team during 2022/23. Of these audits, 678 were completed during the financial year. (See separate clinical audit appendix published on the Quality web pages: http://www.uhb.nhs.uk/quality.htm).

2.2.3 Information on participation in clinical research

The Trust's research portfolio continues to have a Covid-19 focus, although this is now a smaller portion of open to recruitment studies. All divisions have an active research portfolio.

The total number of UHB patients recruited into open studies at the Trust during 2022/23 was

NIHR Portfolio Recruitment	5773	Commercial 340 Non-commercial 5433
Non-NIHR Portfolio Recruitment	824	Commercial 62 Non-commercial 762
Total Patient Recruitment	**6597**	

The Trust overall research portfolio has also focussed on delivering commercial studies as per the national (NIHR) priority. At the end of the 2022/23 financial year:

- 940 research studies were open to recruitment with 21% of these studies being commercial studies
- 616 research studies which are closed to recruitment and continue as open to follow up patients, of which 33% are commercial studies.

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

A proportion of UHB income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between UHB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2022/23 and for the following 12-month period are available electronically at https://www.uhb.nhs.uk/about/reports/quality/quality-reports.htm .

The CQUIN policy was reintroduced to 2022/23 contracts following its suspension during the Covid pandemic.

The amount of UHB income in 2022/23 which was conditional upon achieving quality improvement and innovation goals was £19.1m.

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

UHB is required to register with the Care Quality Commission (CQC) and currently has no conditions on the registration status.

The Care Quality Commission has taken the following enforcement action against UHB during 2022/23:

Criminal Enforcement Action – August 2022
Two fixed penalty notices were issued to the Trust for failures in respect of ensuring care and treatment is only provided with consent of the relevant person. The Trust failed to ensure that where a person was aged 16 or over and unable to give consent because they lacked capacity to do so, they acted in accordance with the Mental Capacity Act (2005). These failings were in relation to documentation of capacity assessment, the completion of training, and the conducting of oversight audits and monitoring.
A number of actions were identified and implemented following the Trust SI investigation.
Section 29a Warning Notice issued for Medical Wards at Good Hope Hospital - December 2022
A Warning Notice was issued following a CQC inspection due to concerns that there were insufficient or suitably qualified staff to provide patients with the timely or appropriate care they required to meet their needs.
A response was submitted to the CQC outlining the Trusts recruitment and retention strategy including assurance around safe staffing.
Section 29a Warning Notice issued for Maternity and Midwifery services at Birmingham Heartlands Hospital - February 2023
A Warning Notice was issued following a CQC inspection due to concerns that there was insufficient medical staff to provide safe care and treatment to support the triage/Pregnancy Assessment Emergency Room (PAER) effectively.
A response is currently being written to address and provide the CQC with assurance regarding the concerns raised.

UHB has not participated in any special reviews or investigations by the CQC during 2022/23.

Two visits were conducted by Birmingham and Solihull Integrated Care Board during 2022/23:

- 03/11/2023 – contract monitoring visit to Selly Oak Health Centre.
- 23/02/2023 – assurance visit to look at the actions identified in response to a Serious Investigation in the Mortuary at Good Hope Hospital.

CQC Inspection Ratings Grids

Six CQC inspections took place across services at University Hospitals Birmingham during 2022/23. These inspections covered a variety of core services and across all hospital sites.

Final reports have been published for the inspections, which confirm the following ratings have been given to the Trust for the services inspected:

Year	Type of CQC Inspection	Site	Outcome
2023	Unannounced Inspection of Dialysis Unit	Assure Dialysis Unit Smethwick	See grids below
2023	Announced Inspection of Maternity and Midwifery Services	GHH & BHH	See grids below
2022	Unannounced Inspection of Children and Young People Services & MAU	BHH	See grids below
2022	Unannounced Inspection of Medical Wards (Medicine and healthcare for older persons)	GHH	See grids below
2022	Unannounced Inspection of Medical Assessment Unit (Medicine and healthcare for older persons)	BHH	See grids below
2022	CQC-IRMER/HSE joint inspection (Diagnostic Imaging)	QEH	No impact on ratings

Overall Trust Rating (unchanged since September 2021)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Trust Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Ratings for Core Services by Site, for inspections during 2022/23

Birmingham Heartlands Hospital (BHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care (inc. Older Peoples Care)	Requires improvement (April 2023)	Requires improvement (Feb 2019)	Good (Feb 2019)	Good (Feb 2019)	Requires improvement (April 2023)	Requires improvement (Feb 2019)
Children and Young People	Requires improvement (April 2023)	Not yet inspected	Not yet inspected	Not yet inspected	Good (April 2023)	Not rated
Maternity	Inadequate (June 2023)	Not yet inspected	Not yet inspected	Not yet inspected	Inadequate (June 2023)	Inadequate (June 2023)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Good Hope Hospital (GHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care (inc. Older Peoples Care)	Inadequate (April 2023)	Requires Improvement (April 2023)	Good (April 2023)	Requires Improvement (April 2023)	Requires Improvement (April 2023)	Requires Improvement (April 2023)
Maternity	Requires Improvement (April 2023)	Not yet inspected	Not yet inspected	Not yet inspected	Inadequate (June 2023)	Inadequate (June 2023)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Assure Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Service Overall	Requires Improvement (April 2023)	Good (June 2023)	Good (June 2023)	Good (June 2023)	Good (June 2023)	Good (June 2023)

2.2.6 Information on the quality of data

Secondary Uses Service data
UHB submitted records during 2022/23 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS Number was:
- 99.6% for admitted patient care
- 99.7% for outpatient care
- 98.7% for accident and emergency care

Which included the patient's valid General Medical Practice Code was:
- 100% for admitted patient care
- 99.7% for outpatient care
- 99.9% for accident and emergency care

Data Security & Protection Toolkit (formerly Information Governance Assessment Report)
The Trust has carried out a self-assessment against the assertions within the Data Security and Protection Toolkit 2022/23 (DSPT v5). The Trust is compliant with the majority of assertions, with only a few areas requiring additional work to ensure full compliance before the final deadline for DSPT submission on 30 June 2023.

The DSPT v5 self-assessment has also been audited by KPMG as part of the internal audit schedule and the report was presented at the Audit Committee meeting in April 2023.

The Trust had been working to an improvement plan comprising two outstanding actions from the last DSPT submission in 2021/22 (v4), both of which have now been fully implemented leading to the overall submission '21/22 Approaching Standards'. NHS Digital have been asked to revise this status to '21/22 Standards Met' but this is pending.

Payment by Results clinical coding audit

UHB was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

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

Actions to improve data quality (DQ)

1. A Data Quality Issues Group (DQIG) was established in November 2021. There are Terms of Reference for this group and the chair is the Head of Health Informatics. This group report to the IGG (Information Governance Group) quarterly.

   The DQIG are responsible for monitoring and recording data quality issues identified within the Organisation. The issues are prioritised via the DQIG. DQIG have established processes for DQ issues to be raised within the Organisation. Membership of this group more recently has been extended to include members of the Finance and Contracting teams and the Outpatients department. Currently work is in progress to identify ways of getting DQ risks recorded on the Trust's risk register. The Compliance team is working with the Head of Health Informatics, Chief Technology Officer (IT services) and Head of Operational Support (Corporate Affairs) to enable this.

   Action plans for prioritised areas are created, maintained and managed through the DQIG.

2. Quality monitoring checks are in place for inpatient records and ward clerk team leaders across the QEH and Solihull site. Compliance is checked against 13 indicators to assess the quality of the information on our PAS systems in relation to inpatients. Plans are in place to roll these checks out to the other hospital sites, however due to current staffing levels we have had to pause existing checks and have not been able to roll out to the other sites at this point.

3. The Health Informatics Compliance Team check NHS Digital DQMI (Data Quality Maturity Index) and SUS dashboards once per month to identify any areas of concern. Any issues identified are flagged to DQIG and action plans put in place to address.

4. The Clinical Coding team carry out the DSPT (Data Security and Protection Toolkit) required audit annually. This is an audit of 200 FCEs and is carried out by the Trusts internal clinical coding auditor. DSPT audit to be completed for 2022/23 by 15th June 2023 for internal reporting to IGG.

5. A programme of continuous improvement audits on Clinical Coding is in place and monthly audits take place.

6. The Trust's internal Clinical Coding trainer delivers the following training: Coding Standards, Refresher and Exam Revision using NHS Digital approved material, Classification Updates, Ad hoc issues that arise from validation and audit.

7. Clinical Coding reports are in place to ensure quality of coding is maintained and continually approved - examples include HED Report, MHA, SHMI, Palliative Care and the Sepsis Dashboard.

8. The Trust's Data Quality policy is in place and was reviewed in February 2022 to ensure the DQIG processes are reflected and that we continue to review the Data Quality Policy and develop associated procedures.

9. Continue to support improvement of the data quality programme for the operational teams by providing data in relation to 18 week referral to treatment time (RTT)

2.2.7 Learning from deaths

UHB currently has a team of Medical Examiners who are required to review the vast majority of inpatient deaths. The role includes reviewing medical records and liaising with bereaved relatives to assess whether the care provided was appropriate and whether the death was potentially avoidable.

Any death where a concern has been raised by the Medical Examiner is escalated for further review, either to a specialty mortality & morbidity meeting, to the Clinical Governance for review or directly to the Trust's Clinical and Professional Review of Incidents Group (CaPRI). The outcomes of reviews are reported to the Trust's Clinical Quality Monitoring Group (CQMG) where a decision will be made on whether further review or investigation is required.

1.	During 2022/23 5968 UHB patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: › 1360 in the first quarter; › 1373 in the second quarter; › 1667 in the third quarter; › 1568 in the fourth quarter.
2.	Up to 27th April 2023, 4957 case record reviews and 42 investigations have been carried out in relation to 5968 of the deaths included in item 1. In some cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review was carried out was: › 1156 in the first quarter; › 1141 in the second quarter; › 1207 in the third quarter; › 1453 in the fourth quarter.
3.	Twenty deaths, representing 0.3% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: › 8 representing 0.6% for the first quarter; › 4 representing 0.3% for the second quarter; › 3 representing 0.2% for the third quarter; › 5 representing 0.3% for the fourth quarter. These numbers have been obtained based on the findings of thorough, independent investigations of all deaths considered potentially avoidable after case record review, using recognised root cause analysis tools and a human factors perspective.
4.	As part of every investigation a detailed report that includes all learning points and an in-depth action plan is produced. Each investigation can produce a number of recommendations and changes, and each individual action is specifically designed on a case by case basis to ensure that the required changes occur. The implementation of these actions and recommendations is robustly monitored to ensure ongoing compliance. Actions are varied and may include changes to, or introductions of, policies and guidelines, changing systems or changing patient pathways. Similarly, the outcomes of every case record review are monitored and ongoing themes and trends are reported and escalated as required to ensure any and all required changes are made.
5.	As described in item 4, each investigation involves the creation of a detailed, thorough action plan which will involve numerous actions per investigation. These actions are specifically tailored to individual cases and monitored on an on-going basis to ensure the required changes have been made. Some examples of actions taken include: › Review and update of the information contained within ED discharge summaries › Rollout of decision support and prompt for stat dosing of antibiotics across all sites › Updates to Imaging guidelines and associated processes including transfer of patients and VTE prophylaxis › Numerous improvements to infection control processes related to Covid-19 › Multiple 'Lesson of the Month' publications throughout the year
6.	All actions are monitored to ensure they have had the desired impact. If this has not happened, actions will be reviewed and altered as necessary to ensure that sustainable and appropriate change has been implemented.
7.	No case record reviews and no investigations completed after 1st April 2022 related to deaths which took place before the start of the reporting period.
8.	None of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been obtained based on the findings of thorough, independent investigations of all deaths considered potentially avoidable after case record review, using recognised root cause analysis tools and a human factors perspective.
9.	No patient deaths during 2021/22 were subsequently reviewed and judged to be more likely than not to have been due to problems in the care provided to the patient.

3 Part 3: Other information

3.1 Overview of quality of care provided during 2022/23

The tables below show the Trust's latest performance for 2022/23 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience. The Board of Directors has chosen to include the same selection of indicators as reported in the Trust's 2022/23 Quality Account to enable patients and the public to understand performance over time.

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

The latest available data is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible.

Indicator	Data source	2020/21	2021/22	2022/23	Peer Group Average (where available)
Patient Safety Indicators					
1a. Patients with MRSA infection / 100,000 bed days Includes all bed days from all specialties › Lower rate indicates better performance	› Trust MRSA data reported to PHE, › HES data (bed days)	**0.28**	**0.93**	**0.60** (Apr-22 to Feb-23)	**0.44** Acute trusts in West Midlands
1b. Patients with MRSA infection / 100,000 bed days Aged >15, excluding elective orthopaedics › Lower rate indicates better performance	› Trust MRSA data reported to PHE, › HES data (bed days)	**0.29**	**0.98**	**0.61** (Apr-22 to Feb-23)	**0.47** Acute trusts in West Midlands
2a. Patients with C. difficile infection / 100,000 bed days Includes all bed days from all specialties › Lower rate indicates better performance	› Trust CDI data reported to PHE, › HES data (bed days)	**21.10**	**20.21**	**23.37** (Apr-22 to Feb-23)	**21.70** Acute trusts in West Midlands
2b. Patients with C. difficile infection / 100,000 bed days Aged >15, excluding elective orthopaedics › Lower rate indicates better performance	› Trust CDI data reported to PHE, › HES data (bed days)	**22.01**	**21.25**	**24.62** (Apr-22 to Feb-23)	**23.34** Acute trusts in West Midlands

Indicator	Data source	2020/21	2021/22	2022/23	Peer Group Average (where available)
Patient Safety Indicators					
3a. Patient safety incidents Reporting rate per 1000 bed days › Higher rate indicates better reporting	› Datix (incident data), › Bed days data	**70.2**	**72.1**	**59.0**	**57.5** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
3b. Never Events Number of Never Events that been reported on STEIS during the time period › Lower number indicates better performance	› Datix (incident data)	**12**	**4**	**10**	Not available
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	› Datix (incident data)	**80.94%**	**78.95%**	**74.70%**	**73.60%** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4b. Percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) resulting in severe harm or death › Lower % indicates better performance	› Datix (patient safety incidents reported to the NRLS)	**0.47%**	**0.41%**	**0.34%**	**0.40%** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
4c. Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)	› Datix (patient safety incidents reported to the NRLS)	**35,754**	**49,198**	**53,717**	**14,368** Apr-21 – Mar-22 Acute (non specialist) hospitals NRLS website (Organisational Patient Safety Incidents Workbook)
Clinical Effectiveness Indicators					
5a. Emergency readmissions within 28 days (%) Elective and emergency admissions aged >17 › Lower % indicates better performance	› HED data	**14.35%**	**15.12%**	**14.43%** (Apr-22 to Jan-23)	**13.13%** Apr-22 to Jan-23 University hospital
5b. Emergency readmissions within 28 days (%) All specialties › Lower % indicates better performance	› HED data	**14.04%**	**14.72%**	**14.25%** (Apr-22 to Jan-23)	**14.88%** Apr-22 to Jan-23 University hospitals

Notes on patient safety & clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that not all hospitals within the Trust undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection, for example, and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

1a, 1b:
- Peer group figures are not final.

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

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

3a & 4a:
The indicators 3a and 4a have decreased in 2022/23 compared to previous years. This is due to the process of automated incidents stopping in early 2022/23. Incidents used to be automatically generated into Datix based on data in PICS, for these indicators if the following occurred:
- No full set of observations in a 12-hour period
- A delayed discharge of a patient from PICS
- A daily check print of the PICS archive was not done

However during a software downtime, a discussion was held at CQMG and this process was placed under review. There are plans to implement the Learning from Patient Safety Events (LfPSE) process in 2023/24 and a review of the Local Risk Management Software, so any plans for automated incidents would need to take account of these changes, and plans will need to be reviewed again before doing so. The performance of these three indicators is monitored via the Clinical Dashboard Review Group (see Priority 6 for information on this group).

Reporting rates for non-automated incidents increased during 2022/23.

3b:
This is based on incident date between 01 April 2022 and 31 March 2023 and reported to STEIS as per the published NHS Never Events data.

UHB reported ten Never Events during 2022/23 in the following categories:
- Wrong site surgery (6)
  - wrong site Botulinum toxin (Botox) injection
  - wrong patient joint aspiration
  - wrong site eye injection
  - patient booked for biopsy of site B; but was biopsied from site B and A
  - wrong site femoral angiogram
  - wrong site block
- Retained foreign object post procedure (2)
  - Retained swab (2)
- Transfusion or transplantation of ABO-incompatible blood components or organs (1)
- Misplaced naso- or oro-gastric tubes (1)

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

Patient experience indicators

The National Inpatient Survey is run by the Picker Institute on behalf of the Care Quality Commission (CQC); UHB's results for selected questions are shown below. Data is presented as a score out of 10; the higher the score for each question, the better the Trust is performing.

In the 2020 report, the authors stated "Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month".

Therefore although results from 2019 are included for information, it is not possible to say if there was an improvement or decline.

Time period	2019		2020		2021	
Data source	Trust's Survey of Adult Inpatients 2019 Report, CQC		Trust's Survey of Adult Inpatients 2020 Report, CQC		Trust's Survey of Adult Inpatients 2021 Report, CQC	
Patient survey question	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England	Score	Comparison with other NHS trusts in England
Overall were you treated with respect and dignity	8.8	About the same	9.1	About the same	8.8	About the same
Involvement in decisions about care and treatment	7.1	About the same	7.1	About the same	6.7	About the same
Did staff do all they could to control pain	7.8	About the same	8.8	About the same	8.3	Worse than expected
Cleanliness of room or ward	8.6	About the same	9.1	About the same	8.7	About the same
Overall rating of care	7.8	About the same	8.1	About the same	7.7	Somewhat worse than expected
Response rate	38% (464 respondents) National: 45%		38% (450 respondents) National: 46%		34% (399 respondents) National: 39%	

3.2 Performance against indicators included in the NHS Improvement Single Oversight Framework

Indicator	Target	Performance		
		2020/21	2021/22	2022/23
A&E: maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	77.6%	57.0%	52.0%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	58.4%	42.8%	41.2%
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer1	85%	42.6%	40.9%	37.1%
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	69.6%	59.2%	54.1%
Maximum 6-week wait for diagnostic procedures	99%	60.6%	63.0%	52.9%

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

"*C. difficile*: variance from plan" is no longer part of the NHS Improvement Single Oversight Framework.

"Venous thromboembolism (VTE) risk assessment" - national reporting requirements have been suspended due to the Covid-19 pandemic.

3.3 Mortality

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

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

Measure	Value	Data period
SHMI, calculated by UHB Informatics	101.51 - within tolerance	2022/23 (Apr-22 – Jan-23)
SHMI, from NHS Digital website	99.00 - within tolerance	2022/23 (Apr-22 – Nov-22)
HSMR, calculated by UHB Informatics	103.47 - within tolerance	2022/23 (Apr-22 – Feb-23)

SHMI: Summary Hospital-level Mortality Indicator

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

The SHMI should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care[1].

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

HSMR: Hospital Standardised Mortality Ratio

UHB has concerns about the validity of the HSMR which was superseded by the SHMI but it is included here for completeness. The validity and appropriateness of the HSMR methodology used to calculate the expected range has been the subject of much national debate and is largely discredited[2][3]. UHB continues to robustly monitor mortality in a variety of ways as detailed above.

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

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

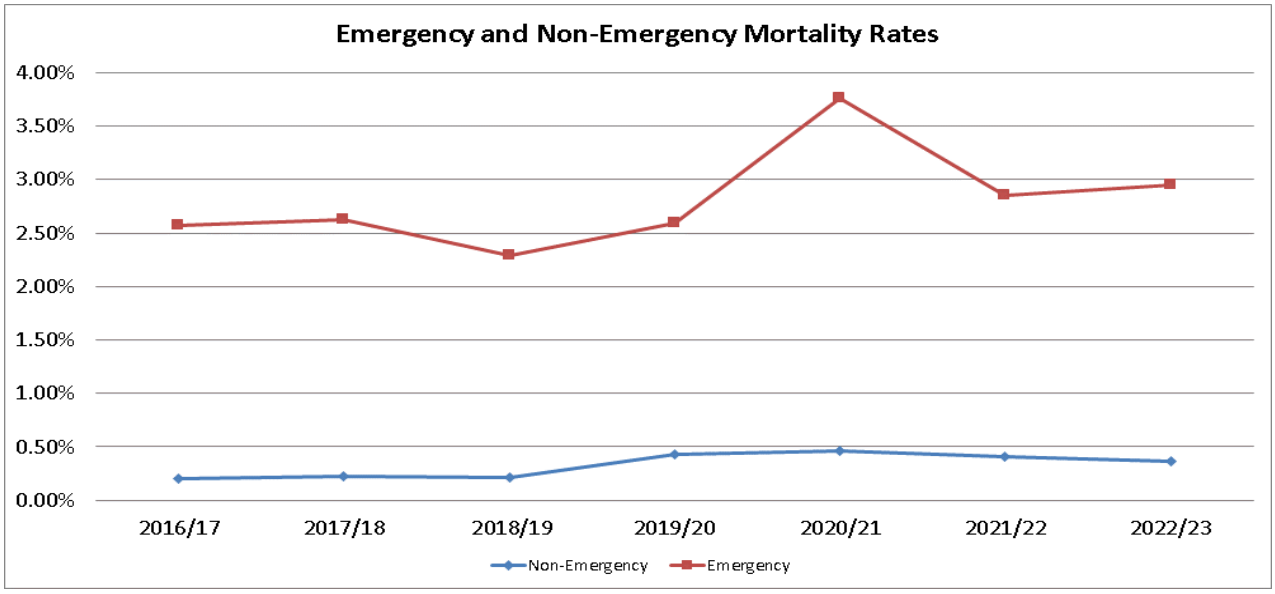
[3] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Crude Mortality

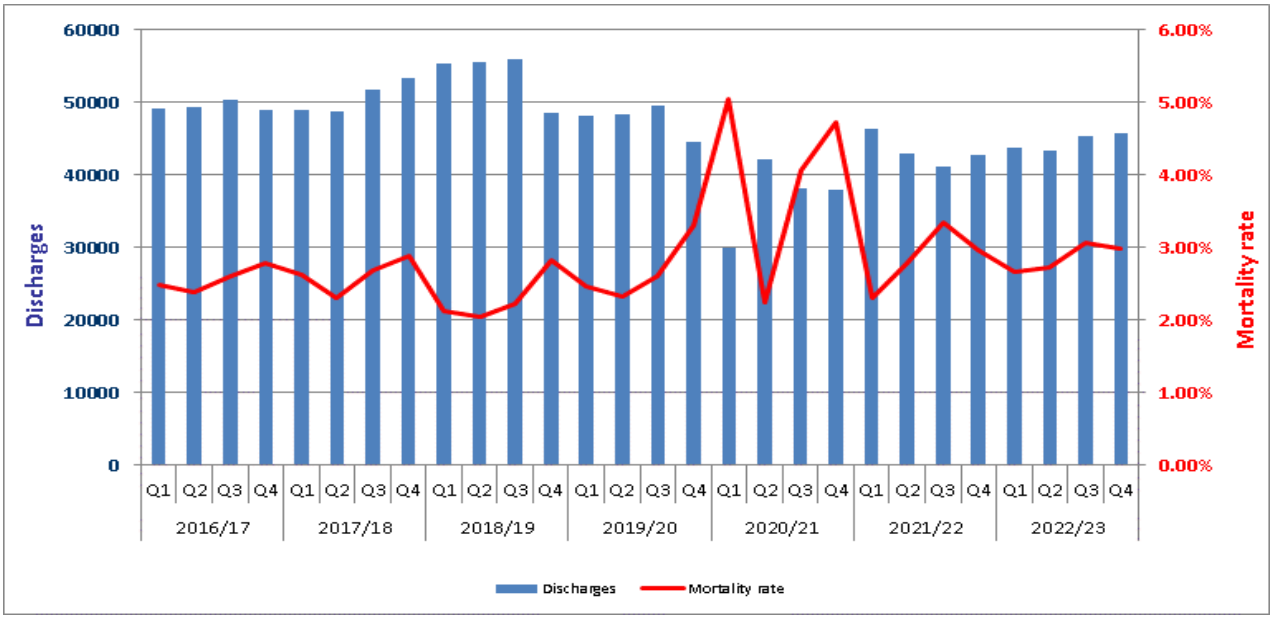
The first graph below shows crude mortality rates for emergency and non-emergency (planned) patients. The second graph shows the overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number of patients discharged from hospital in any given time period. The crude mortality rate does not take into account complexity, case mix (types of patients) or seasonal variation.

The emergency crude mortality rate for 2022/23 is 2.86%, which is a slight increase when compared to 2021/22 (2.78%), but remains lower than 2020/21 (3.76%).

Emergency and Non-emergency Mortality Graph



Emergency Crude Mortality Graph



3.4 Statement regarding junior doctor rota

Guardian of Safe Working: Quarter 2 Report (2022/23)

Date period 08/11/22 - 31/01/23

It remains a requirement of the 2016 Junior Doctor contract for the trust Guardian of Safe Working (GSW) to hold responsibility for ensuring that issues of compliance with safe working hours are addressed in accordance with the terms and conditions of the Junior Doctor contract - this includes overall responsibility for overseeing the Junior Doctors' Exception Reporting (ER) process. The GSW is required to submit a report at least quarterly, on the analysis of the ERs submitted by junior doctors with an extended Annual Report to the Trust Board. Quarterly reports are presented through the Performance Report structure. A final Annual Report at the end of each academic year will be produced to coincide with major house change.

Summary of junior doctor exception reports in period

Junior Doctor Exception Reports (ERs) for Q2 period:

TABLE 1: Exception Reports Q2 combined (2022/23)

	BHH / SOL	GHH	QEHB/ UHB	Total
Hours	5	2	25	32
Education	1	0	5	6
Pattern of work	0	0	3	3
Service Support	0	0	6	6
Total ERs for period Q2 21/22	**6**	**2**	**39**	**47**

Immediate Safety Concerns (ISCs)

BHH / SOL	GHH	QEHB/UHB	TOTAL
0	0	7	7

ISCs were addressed on site by the junior doctors at the time of incidence and escalated accordingly - junior doctors have also been instructed to submit safety concerns via the standard Datix mechanism.

GSW Penalty Fines

When a junior doctor exception report is found to breach contractual hours, a Guardian of Safe Working (GSW) penalty fine applies for the period of time that leads to the 'breach'. The junior doctors are paid for the additional hours at the penalty rate set out in Annex A (TCS) and the GSW will levy a fine on the department employing the doctor for those additional hours worked at the rates also set out in Annex A. The 'fine' monies are distributed in agreement with the Guardian Exception Reporting Group.

In Q2 there was 1 concluded occurrence of GSW divisional penalty fines as follows:

Rota code	Spec	Level	Breach	Penalty to Div £
QEHB047 ENT FY/CT/GPST 7 Doc v11	ENT	FY1	Rest	£54.44

Areas of significant trend/concern in period

Rota code	Key Concerns and work schedule reviews
QEHB048 ENT ST3+ 6 Doc v10	Rota gaps in various grades in Ear, Nose and Throat Surgery (ENT) from August 2022 had a significant impact on working hours and educational experience in ENT in this quarter.
QEHB047 ENT FY/CT/GPST 7 Doc v11	The rota gaps resulted in increased workload necessitating overtime work for the FY/CT level doctors. The overtime work was appropriately recompensed. ENT StRs were asked to step down to carry out overnight resident CT level on call duty (from their usual non-resident StR on call rota) as the CT gaps were not covered consistently by locum. In response, JSDs were successfully recruited but their start date was held back by Visa issues. We understand that the situation will only improve from February 2023 onwards which is when the gaps are expected to be fully filled. The ENT StRs were thanked formally for their efforts and paid appropriately for stepping down to do resident on call.
BHH-005 GIM & AIM FY1 15Doc v31	Five exception reports from this rota, spread over the period of interest. The ERs are sporadic with no particular signal detected

Guardian exception reporting review group (GERRG)

A virtual 'teams' meeting of the group took place on Tuesday 10th January 2023 to cover the reports generated in Q1 2022/2023.

High level data

Doctors/dentists in training	Ref: Med Resourcing
Doctors/dentists in training on 2016 TCS	Ref: Med Resourcing
Time available in job plan for GSWs	GSW/Dep 4 PAs
Admin support provided to the GSWs	Manager 0.3 WTE, B3 Admin 1.5 WTE
Job-planned time for Ed. Supervisors	0.25 PAs per trainee within agreed job plans

GSW analysis/comments

Over the winter period, UHB was not exempt from the impact of the 'twindemic' of influenza and Covid on junior doctor workload and staff sickness. This was further compounded by rota gaps and difficulty in obtaining locum cover. In response to the crisis, a 15% uplift in locum rates was approved for all locum and bank cover for a period. At the time of this report, the Trust was past the peak of the influenza epidemic.

The GSW continues to highlight the importance of taking breaks. This has been communicated to junior doctors at the various education fora, and via emails to doctors' representatives and specialties, and to new consultants at their Induction. It is hoped that the culture change of building in breaks would be incorporated into the handover. The Junior doctors health and wellbeing officers are also proactively promoting this culture.

Dr Jason Goh
Guardian of Safe Working

Dr David Sandler
Deputy Guardian of Safe Working

February 2023

3.5 Glossary of Terms

Term	Definition
A&E	Accident & Emergency, also known as the Emergency Department (ED)
Acute Trust	An NHS hospital trust that provides secondary health services within the English National Health Service
BAUS	British Association of Urological Surgeons
Bed days	Unit used to calculate the availability and use of beds over time
Benchmark / -ing	A method for comparing (e.g.) different hospitals
BHH	Birmingham Heartlands Hospital
Cannula	A tube that can be inserted into the body, often for the delivery or removal of fluid or for the gathering of samples
CDI	*Clostridium difficile* infection
CEAG	Chief Executive's Advisory Group
Clinical Audit	*A process for assessing the quality of care against agreed standards*
Clinical Coding	A system for collecting information on patients' diagnoses and procedures
Clinical Dashboard	An internal website used by staff to measure aspects of clinical quality
CDRG	Clinical Dashboard Review Group – reviews ward performance against certain care indicators
Commissioners	See ICB
Concerto	Computer system showing patient details, hospital stays etc
COVID-19	A disease caused by a strain of Coronavirus, the cause of the current pandemic
CQC	Care Quality Commission: independent regulator of health and social care in England
CQMG	Clinical Quality Monitoring Group; a group chaired by the Executive Chief Medical Officer, which reviews the quality of care, mainly medical
CQUIN	Commissioning for Quality and Innovation payment framework
CSL	Clinical Service Lead – the lead doctor for a particular specialty
Datix	Database used to record incident reporting data
Division	Specialties are grouped into Divisions
DKA	Diabetic ketoacidosis: a serious condition that can lead to diabetic coma or even death. When cells don't get the glucose they need for energy, the body begins to burn fat for energy, producing ketones
DNAR	Do not Attempt Resuscitation
DSPT	Data Security and Protection Toolkit: an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards
Dysphagia	Swallowing difficulties - some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all
ED	Emergency Department (also known as A&E)
Elective	A planned admission, usually for a procedure or drug treatment
Enoxaparin	A drug that helps prevent the formation of blood clots
Enteral Nutrition	A form of nutrition that is delivered into the digestive system as a liquid
EOL	End of Life Care
Episode	The time period during which a patient is under a particular consultant and specialty. There can be several episodes in a spell
FCE	Finished Consultant Episode - a continuous period of admitted patient care under one consultant within one healthcare provider
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities.
FTSU INDEX	Freedom To Speak Up Index

Term	Definition
GHH	Good Hope Hospital
GP	General Practitioner
GSW	Guardian of Safe Working
HCA	Health Care Assistants
Healthwatch	An independent group who represent the interests of patients
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HSMR	National Hospital Mortality Indicator
Hyperglycaemia	An excess of glucose in the bloodstream
Hypoglycaemia	Deficiency of glucose in the bloodstream
Informatics	Team of information analysts
ICB	Integrated Care Board - a statutory NHS organisation, responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area
IT	Information Technology
ITU	Intensive Therapy Unit
JDMO	Junior Doctors Monitoring Office
KPI	Key performance indicator: a measurable value demonstrating how effectively targets are being met
KPMG	Trust Auditors
LOS	Length of Stay
MDT / MDM	Multi-disciplinary Team / Meeting – where patients are discussed and plans of care made
Medical Examiner	Senior doctors who review deaths that occur in hospital
MHA	Medical History Assurance – software used to capture information on patients' diagnoses and procedures
Missed Dose	A dose of prescribed medication not given to the patient
Moodle	A digital learning platform for obtaining training courses and information
Mortality	A measure of the number of deaths compared to the number of admissions
MRSA	Meticillin-resistant staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
NBM	Nil by mouth
NCEPOD	National Confidential Enquiry into Patient Outcome and Death - a national review of deaths usually concentrating on a particular condition or procedure
Neonatal	Newborn
Nephrectomy	Surgical removal of the kidney
NEWS2	National Early Warning Score – a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients.
Never Event	An incident that has the potential to cause serious harm/death
NHS	National Health Service
NHS Digital	A library of NHS data and reports (Formerly HSCIC - Health and Social Care Information Centre.)
NHS England	Now a merged organisation with NHS Improvement
NHS Improvement	The national body that provides the reporting requirements and guidance for the Quality Account. Now merged with NHS England
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research

Term	Definition
NRLS	National Reporting and Learning System
Observations	Measurements used to monitor a patient's condition e.g. pulse rate, blood pressure, temperature
Parenteral Nutrition	A form of nutrition that is delivered into the patient's bloodstream
PAS	Oceano - Patient Administration System
Percutaneous nephrolithotomy (PCNL)	Removal of a kidney stone via a cut in the back
PHE	Public Health England
PICS	Prescribing Information and Communication System
Prophylaxis / prophylactic	Treatment given or action taken to prevent disease
Pulmonary Embolism	Blocked blood vessel in your lungs.
QEHB / QE / QEH	Queen Elizabeth Hospital Birmingham
QIPs	Quality Improvement Priorities / Quality Improvement Projects
Radical	Surgery that is more extensive than 'conservative' surgery
RCA	Root Cause Analysis: a method of problem solving used for identifying the root causes of faults or problems
R&D	Research & Development
Readmissions	Patients who are readmitted after being discharged from hospital within a short period of time e.g., 28 days
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment: a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices
RTT	Referral to Treatment – the time elapsed between a patient being referred, and commencing treatment (or making the decision not to receive treatment)
Sepsis	A potentially life-threatening condition resulting from a bacterial infection of the blood
SH / SHH / SOL	Solihull Hospital
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SOP	Standard Operating Procedure
STEIS	Strategic Executive Information System - used to report and monitor the progress of Serious Incident investigations across the NHS
SUS	Secondary Use Services - the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
TEAL	Treatment Escalation and Limitation
Typology	A classification according to general type, especially in archaeology, psychology, or the social sciences
UHB	University Hospitals Birmingham NHS Foundation Trust
Vascular	Relates to blood vessels, or sometimes other tubes in the body
VTE	Venous thromboembolism, also known as a blood clot
Ward clerk	A member of staff who provides general administrative, clerical, and support services for a ward
WHO	World Health Organisation

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

The Trust has shared its 2022/23 Quality Account with:

- NHS Birmingham and Solihull Integrated Care Board (ICB)
- Birmingham Health & Social Care Overview and Scrutiny Committee
- Solihull Health and Adult Social Care Scrutiny Board
- Healthwatch Birmingham
- Healthwatch Solihull

These organisations have provided the statements below.

Statement provided by NHS Birmingham and Solihull Integrated Care Board (ICB)

1.1 Birmingham and Solihull Integrated Care Board (ICB), as coordinating commissioner for University Hospitals Birmingham (UHB), welcomes the opportunity to provide this statement for inclusion in the Trust's 2022/23 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on Tuesday 30th May 2023 and the review has been undertaken in accordance with the Department of Health and Social Care guidance. This statement of assurance has been developed from the information contained within the Quality Account and through our ongoing work together.

1.3 This statement provides the perspective of Birmingham and Solihull ICB as the statutory NHS organisation responsible for developing a plan for meeting the health needs of the Birmingham and Solihull population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area.

1.4 In reviewing this Quality Account, we acknowledge that the Trust has had a challenging year and that we are working, as an ICB, to support you to address concerns and put in place improvements for patients and staff. The Quality Account demonstrates that you have been working to deliver quality improvements throughout the year and that is against a backdrop of multiple disruptive periods of industrial action and work to continue to recover access to services following the impact of the Covid-19 pandemic.

1.5 In the Quality Account you reference serious concerns raised through the media and other stakeholders regarding patient safety, leadership and culture. It is good to see that Freedom to Speak Up remains one of your six key priorities for the year ahead. The ICB is committed to working with the Trust as the organisation works to address the recommendations of the patient safety, culture and well-led reviews.

1.6 The Quality Account also references a number of Care Quality Commission (CQC) inspections and two Section 29a Warning Notices issued in relation to Medical Wards at Good Hope Hospital and Maternity and Midwifery at Birmingham Heartlands Hospital. We will continue to support the Trust as it works to deliver improvements and provide the necessary assurance to the CQC.

1.7 The information provided within this account presents a report of the healthcare services that UHB provides. The report demonstrates the progress made by the Trust against last year's priorities and identifies a number of further improvements needed in 23/24.

1.8 We are committed to continuing to engage with the Trust, as one of our key system partners and to ensure that patients, staff and stakeholders are assured that they can continue to access services with confidence.

Lisa Stalley-Green
BSOL ICB Chief Nurse/Deputy Chief Executive

16th June 2023

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

The Birmingham Health and Adult Social Care O&S Committee (HASC) recognises the challenges faced by the Trust over the past 12 months to maintain services whilst coping with continuing operational pressures and demands resulting from the Covid-19 pandemic. They also recognise that the coming year will be equally challenging in restoring services and reducing patients waiting lists, in addition to restoring confidence and trust on patient safety, leadership and culture.

We fully support the continuing work and efforts being put into improving performance on the six quality improvement priorities. The Committee is committed to working with the Trust by way of its important scrutiny function and responsibility to the people of Birmingham, in ensuring that significant progress is made on the quality improvements, leading to improved public confidence in patient safety and in the quality of care. The next 12 months will be pivotal for the Trust, and we are committed to supporting it in ensuring improved performance across all the service areas.

We note the external reviews announced as a result of the BBC Newsnight programmes. The Bewick Report's recommendation that the relationship between the Speaking Up Service and the Board of Directors be 'refreshed' will be important in addressing staff concerns to ensure that their voice is valued. The Committee, through the Joint HOSC with Solihull, will be keen to ensure that work on this continues, ensuring an efficient Speaking Up service.

The Committee is assured to see the work done on the significant reduction of patient waiting lists during 2022/23; and is also pleased to see the reduction in cancer backlog. They are also aware that the junior doctors' strikes continue to impact on outpatient appointments and the cancellation of procedures.

The Committee is concerned about the Section 29a warning notices issued by the Care Quality Commission on key services such as the Maternity Services at Birmingham Heartlands and would be keen to work with the Trust on monitoring recommendations from the CQC being put in place to ensure improvements for patients. Likewise they are concerned about the performance on quality of care particularly on MRSA infections and would like to see this addressed as a priority. Overall, the CQC ratings across the Trust is disappointing, and the Committee would like to see further assurances from the Trust on performance and changes across the key areas identified by the CQC inspection process.

The Committee looks forward to working with the Trust, through the Joint Health Overview and Scrutiny Committee with Solihull, on the scrutiny of its work on the six quality improvements, ensuring there is continuing progress on these priorities; and in helping UHB in ensuring appropriate monitoring of performance mechanisms are in place.

Statement provided by Solihull Health and Adult Social Care Scrutiny Board

The Solihull Health and Adult Social Care Scrutiny Board welcomes the opportunity to comment on the Quality Account.

The Scrutiny Board recognises the points outlined as part of the Chief Executive's statement, that 2022/23 has been an extremely challenging year for UHB due to significant operational performance pressures following the COVID-19 pandemic and serious concerns raised through the media and other stakeholders regarding patient safety, leadership and culture. The Scrutiny Board appreciates the prompt reporting on this significant matter that has been undertaken to the Birmingham and Solihull Joint Health Overview and Scrutiny Committee (JHOSC).

The Scrutiny Board welcomes how University Hospitals Birmingham (UHB) are currently engaged in independent reviews into patient safety, culture and leadership. Members recognise how these reviews are essential to support a positive work environment for all employees, as well as ensure the best outcomes for patients – Members look forward to the future reporting on these reviews to the JHOSC at the earliest opportunity.

Operational priorities

The Scrutiny Board notes that, during 2022/23 the Trust has focussed on three main operational priorities:

- Reducing delays in the handover of patients from emergency ambulances to the Trust's Emergency Departments.
- Eliminating patients waiting longer than 78 weeks for treatment.
- Reducing the number of patients waiting longer than 62 days for cancer treatment or to have confirmation that they do not have cancer.

Members welcome that, whilst there are ongoing significant pressures, during the last 12 months, the Trust has overseen a notable overall improvement in the total time ambulances were delayed at its sites. The Scrutiny Board recognises how it is essential to ensure continual focus on this critical operational priority.

The Scrutiny Board recognises and appreciates that, over the last 12 months, the Trust and its partners across Birmingham and Solihull and beyond have worked together to ensure that the longest waiting patients are prioritised for treatment. It is noted this has resulted in the virtual elimination of patients waiting longer than 104 weeks and a very significant reduction in the number of patients waiting longer than 78 weeks. Again, Members agreed that continual focus on this essential operational priority is vital, in recognition of the major impact on residents' lives and wellbeing as they await treatment.

Members also welcome how the Trust also delivered a very significant reduction in its cancer backlog in 2022/23, in line with the requirement set by NHS England.

Quality Improvement Priorities

The Scrutiny Board notes with concern that performance for the six quality improvement priorities set out for 2022/23 in the 2021/22 Quality Report has been mixed.

The Scrutiny Board notes the following trends in regard to the Trust's Freedom to Speak Up work:

- From April 2022 – March 2023, the service has been contacted by 118 members of staff, a significant increase on previous years.
- From November 2022, the number of contacts more than doubled compared with preceding years and has remained at this rate since.

Members recognises the Quality Account report attributes this to the Trust-wide promotional work undertaken in November 2022 and then to the BBC Newsnight reporting from December 2022 onwards. The Scrutiny Board agrees this represents an increase in awareness, as well as a previously unmet need for the Speaking Up service. Going forward, Members stress it is vital the Speaking Up service has sufficient capacity to ensure staff can raise issues and be confident their concerns will be addressed – especially any concerns relating to bullying and behaviours.

The Scrutiny Board notes its concern that, as part of the Freedom to Speak Up Index, UHB is performing below the national average for the following questions posed in the NHS Staff Survey:

- I feel safe to speak up about anything that concerns me in this organisation – total 53%.
- If I spoke up about something that concerned me I am confident my organisation would address my concern – total agree 42%.

Members emphasise how important is for staff to have the confidence to raise any concerns and are also confident that any matters identified as addressed. The Board requests for the measures that UHB are undertaken to improve performance here are considered as part of the independent reviews UHB are currently engaged in and for all the findings to be reported to the JHOSC.

The Scrutiny Board emphasises its particular concern that, as part of the section 'Responding to concerns' the Quality Account highlights the following points:

- Some issues raised several years ago are still active – the Scrutiny Board agrees with the point that, in such circumstances, those who have raised concerns lose confidence in the Trust and may well move to another organisation.
- Divisions vary in their capacity to find pathways to resolution – Members agree upon the need for sufficient capacity across the whole Trust, to ensure a consistent, strong approach to finding resolutions.
- The Freedom to Speak Up Guardian has previously drawn attention to instances where attempts to raise concerns have been disregarded or appear to have been suppressed – the Scrutiny Board recognises UHB are looking to ensure good practise, whilst facing major operational demands. However, Members stressed it is vital the Trust ensures that adverse behaviours are never tolerated and all concerns raised are fully investigated.
- The Quality Account outlines how, where concerns touch on groups or whole services, culture surveys are a useful adjunct. However, the Guardian is aware of at least five such surveys the results of which have not been shared with the participants, or the degree of sharing has been so redacted that the staff do not feel that their voices have been heard. The Scrutiny Board supports the Guardian's recommendation for the Trust to reconsider its approach in this respect.

The Scrutiny Board notes the Bewick report referred to the need for the relationship between the Freedom to Speak Up service and the Trust's Board of Directors to be refreshed, with the Board of Directors actively reviewing how concerns are being managed by the Trust.

The Scrutiny Board agrees it is essential for the points raised by the Freedom to Speak Up Guardian, as outlined in the Quality Account, to be thoroughly investigated as part of the independent reviews UHB are engaging in, especially in regard to culture and leadership. Again, Members believe it is critical for all the findings from these reviews to be reported to the JHOSC at the earliest opportunity.

The Scrutiny Board has taken into account how the Fairness Root Cause Analysis (RCA) group have identified how an alarming number of staff are experiencing discrimination from patients, including refusal to be treated by them based on one or more protected characteristics. Members note how the

RCA group have put steps in place to support staff who have reported an incident, alongside a number further actions being taken forward by the Trust. The Scrutiny Board agrees it is vital to ensure continued focus on this extremely serious matter and supports the Trust in following a zero-tolerance approach to any form of discrimination, ensuring all staff are treated with respect in the workplace.

Never Events

The Scrutiny Board has taken into account Priority 5 – Improving the safety of invasive procedures – and notes how the report outlines progress during 2022/23. However, Members emphasise their concerns at the volume of Never Events - "Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers" – that have been recorded over the last 12 months. A total of 10 Never Events have been recorded for 2022/23, an increase from 4 for 2021/22. Members welcome the sharing of further information, outlining the actions being taken forward by the Trust to ensure these serious issues are being addressed.

Care Quality Commission (CQC) Enforcement Action

The Scrutiny Board notes, with significant concern, how the Care Quality Commission (CQC) has taken enforcement actions against UHB during 2022/23.

A Warning Notice was issued for Medical Wards at Good Hope Hospital in December 2022, following a CQC inspection due to concerns there were insufficient or suitably qualified staff to provide patients with the timely or appropriate care they require to meet their needs.

It is noted that a response was submitted to the CQC, outlining the Trust's recruitment and retention strategy, including assurance around safe staffing. Members request for assurances that the issues identified as part of the CQC inspection, and the response provided, are being investigated as part of the independent reviews UHB are participating in.

The Scrutiny Board also wishes to raise how the Quality Account identifies that a further Warning Notice was issued for Maternity and Midwifery services at Birmingham Heartlands Hospital in February 2023, following a CQC inspection, due to concerns that there was insufficient medical staff to provide safe care and treatment to support the triage/Pregnancy Assessment Emergency Room (PAER) effectively.

Members recognise that a response is currently being written to address and provide the CQC with assurance regarding the concerns raised. Again, the Scrutiny Board requests that the issues identified as part of the CQC inspection, and the actions being undertaken as a consequence, are thoroughly investigated as part of the independent reviews UHB are currently engaged in. Members reiterate their request for all the findings of these reviews to be reported to the JHOSC at the earliest opportunity.

CQC Inspection Ratings

The Scrutiny Board notes the Trust's overall CQC rating is requires improvement. Members raised their concerns, in particular, that Good Hope Hospital has received a rating of inadequate for the safety of its Medical Care (including Older People's Care). In addition, the Scrutiny Board has taken into account that, following the sharing of the draft Quality Account, the CQC has published it inspections into maternity services at University Hospitals Birmingham. Members note the service at Good Hope Hospital has been rated requires improvement. In addition, the Scrutiny Board raises its serious concerns that the service at Birmingham Heartlands Hospital has been rated inadequate and the CQC has issued a warning notice. Members request for information to be shared at the earliest opportunity, outlining the urgent actions being taken forward by the Trust, to ensure improved outcomes for patients.

Patient Experience

Members query whether there could be further reporting on patient experience, detailing how it does not highlight the number of complaints received, issues regarding outpatients, lost contacts or correspondence delays. Members question whether the Trust uses 'Experts by Experience' to help drive improvement.

Overall, Members query whether the Quality Account can provide further information on what the Trust does well, as well as what procedures have the longest waiting times.

Going forward, the Scrutiny Board welcomes how there has been a continued programme of capacity expansion during 2022/23 across the Trust's sites. Members are particularly pleased to see the six new elective theatres, which are expected to open at Solihull Hospital in spring 2024, alongside the opening of Solihull Urgent Treatment Centre for minor injuries and illnesses, scheduled for June 2023.

The Board wishes to place on record its thanks to employees at the Trust for their hard work and commitment over an extremely challenging 12 months.

Joint Statement provided by Healthwatch Birmingham and Healthwatch Solihull

Healthwatch Birmingham and Healthwatch Solihull have declined to provide a comment on the Quality Account 2022/23.

Annex 2: Statement of directors' responsibilities for the Quality Account

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts (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 Account.

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

- the content of the Quality Account meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for Quality Accounts 2019/20
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2022 to June 2023
  - papers relating to Quality Account to the board over the period April 2022 to June 2023
  - feedback from the commissioners dated 16/06/2023
  - feedback from governors dated 25/05/23
  - feedback from local Healthwatch organisations (feedback not provided for 2022/23)
  - feedback from Overview and Scrutiny Committee dated 19/06/23 (Solihull) and 20/06/23 (Birmingham)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 17/05/2023
  - the 2021 national patient survey (2022 expected late July 2023)
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 21/06/23
  - CQC inspection reports dated 08/10/2021 and 07/06/2023
- the Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

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

By order of the board.

Date: 22 June 2023 Signed  Interim Chair

Date: 22 June 2023 Signed  Interim Chief Executive

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

NHS England and NHS Improvement has advised that trusts' external auditors are not required to provide assurance on the 2022/23 Quality Accounts.