NHS

University Hospitals Birmingham

NHS Foundation Trust

Quality Account 2023/24

This report covers the period 1 April 2023 to 31 March 2024

2023/24 Quality Account

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1 Chief Executive's Statement

2023/24 has been a challenging year for University Hospitals Birmingham NHS Foundation Trust (UHB) due to the continuing 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.

Providing safe and excellent care to our patients is what is most important to us at 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.

Three independent reviews into patient safety, culture and leadership have now reported their findings. These reviews are helping us to focus on areas for improvement so that we create a positive, inclusive work environment where people want to come to work, in a place that they are proud to work in, and to do their very best for our patients.

In recent months, workshops have been held for staff to contribute their thoughts on what the new values for UHB should be, and the outcomes from these workshops are feeding into the new Behavioural Framework. A 'Wise Council' has also been set up– this is an Advisory Group which will support the work of the Culture and Inclusion Board, and all staff can apply to join. An improvement programme for our maternity services has also been set up.

The focus for 2024/25 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.

Despite the challenges faced by UHB and external pressures through ongoing industrial action, a tremendous effort was made by staff to ensure the safe delivery of services.

New Operating Model

In October, UHB moved to a new operating model with site-based leadership. The new model has been designed with input from colleagues across the organisation, and sees UHB move from a centralised management approach to a model that gives individual hospitals more autonomy to make decisions that will benefit the services they offer, the colleagues they work with and the communities they serve.

Under the new model, the Group Executive, which is more commonly known as the 'Executive Team' has been refreshed. The Group Executive, who are part of the Group Board of Directors support the leadership teams across all sites and continue to maximise the benefits of being a large trust, for both patients and staff.

Details of the Group Board are available on the UHB website: Board of Directors

New hospital leadership teams have been established at each of our four hospital sites. These are made up of a Hospital Executive Director, a Hospital Operations Director, a Hospital Medical Director, and a Hospital Nursing Director. The Hospital Executive Directors sit on the Group Executive and are non-voting members of the Group Board.

Hospital-managed services are organised into eleven 'Clinical Delivery Groups' (CDGs). The CDGs bring together specialties that have clinical synergies. Services are managed and delivered at a hospital-level, with some cross-cutting services in order to maximise efficiency.

Building works

A new hospital building, The Harborne Hospital, has opened at the Queen Elizabeth site and is a joint private and public initiative. The building has two NHS wards and is directly connected to the Queen Elizabeth Hospital and Heritage Building via the existing link bridge. The first NHS patients moved into their new ward in January 2024.

In the Princess of Wales Women's Unit at Heartlands Hospital, a new Maternity Emergency Assessment Unit and staff base have been established, and there is a new Cardiology Day Case Unit at Good Hope Hospital. After securing £45m to construction Elective Hub at Solihull Hospital, the biggest investment in the hospital for decades, work is underway to build the new facility which will provide six new theatres in a two storey state-of-the-art building at the hospital. The hub is due to open in July 2024.

Trust Safety Priorities

The NHS England Patient Safety Incident Response Framework (PSIRF) advocates a co-ordinated and data-driven response to patient safety incidents. The associated UHB Policy also addresses inclusion of, and communication with, patients and relatives.

UHB is committed to a restorative Just Culture within the organisation. Involving staff in the investigation of safety incidents is a key priority for UHB to ensure that a culture of fairness, openness and learning is promoted and supported, empowering all staff to speak up and be part of learning and recommendations. Through the new approaches in how we will respond to safety incidents, wider systemic issues will be considered when learning for improvement, ensuring all staff working with and in our systems can be open and honest in the knowledge investigations are not about individuals, thus removing the fear of blame or retribution.

As part of the development of the Patient Safety Incident Response Plan (PSIRP) at UHB, a review was carried out, which looked at incidents, complaints, claims and inquests, mortality reviews, patient feedback, Learning from Excellence, enquiries and inspections, risk registers and associated actions. From this review a number of Trust Patient Safety Incident Priorities were identified – please see Part 2.1 for further details.

Quality Account

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 Prescribing Information and Communication System (PICS) have now been implemented across the majority of 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 the summer of 2024, and planning for rollout to Maternity in 2025.

This Quality Account provides an update on the following six priorities:

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

UHB has chosen to continue four of these priorities (#2 to #5) for 2024/25. The other two priorities have been discontinued in the Quality Account but remain vital workstreams at UHB. Both the Freedom to Speak Up arrangements and patient safety information dashboards are governed elsewhere by mechanisms other than the Quality Account.

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. 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 purpose of the group is to review performance at ward level in a supportive environment where clinical staff can learn from each other and 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 Clinical Dashboard and reports in PowerBI.

The Trust's external auditor previously provided an additional level of scrutiny over key parts of the Quality Account. In 2020 at the start of the COVID-19 pandemic, NHS England issued guidance advising that trusts were not required to seek external assurance on their Quality Account. For the 2023/24 Quality Account, 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 partners, regulators and other organisations to implement improved models of care delivery and further improvements to quality during 2024/25.

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, Chief Executive
22 June 2024

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

2.1 Priorities for Improvement

The Trust's 2022/23 Quality Account set out six priorities for improvement during 2023/24 (see table below).

UHB has chosen to continue with the four of the six priorities for improvement in 2023/24, with two to finish. It has been decided to not continue reporting on #1 and #6 in 2024/25 as they are not directly related to patient safety initiatives, but they remain importance workstreams for UHB.

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

The improvement priorities for 2024/25 were agreed with the interim Chief Medical Officer and Chief Nurse, and then confirmed at the Group Clinical Quality Meeting.

The performance for 2023/24 and the rationale for any changes to the priorities are provided in detail below.

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.

It has been agreed that this Priority will not continue into the 2024/25 Quality Account as UHB has chosen to focus on the existing QI Projects. However it remains a vital piece of work across the Trust.

The Trust has multiple ways that staff can raise concerns beyond their immediate line manager:

- Wellbeing hubs
- Occupational Health
- Staff Networks
- Fairness Taskforce
- Reciprocal Mentoring
- Chief Executive's Team Brief
- Incident Reporting
- Human Resources
- Staff Survey
- NHS Staff Survey
- Freedom to Speak Up

NHS Staff Survey results

The Speaking Up 'climate'

Results for two statements from the NHS Staff Survey are shown in Table 1 and Figure 1

- Q25e: I feel safe to speak up about anything that concerns me in this organisation.
- Q25f: If I spoke up about something that concerned me, I am confident my organisation would address my concern.

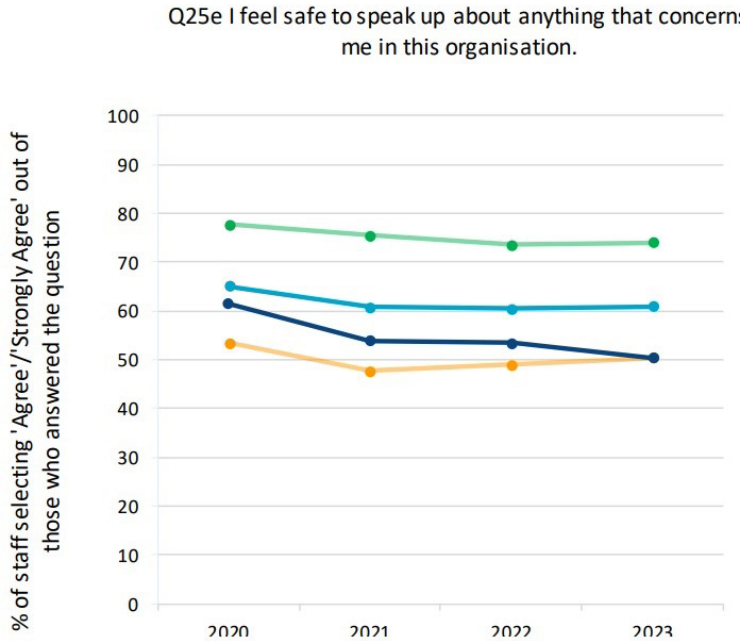
Figure 1 shows that the proportion of responding staff at UHB who agree with these propositions has declined over the last year, in contrast to an improvement in the mean for the NHS as a whole.

Table 1 shows that at UHB around a quarter of respondents actively disagree, and a further quarter to one third are undecided.

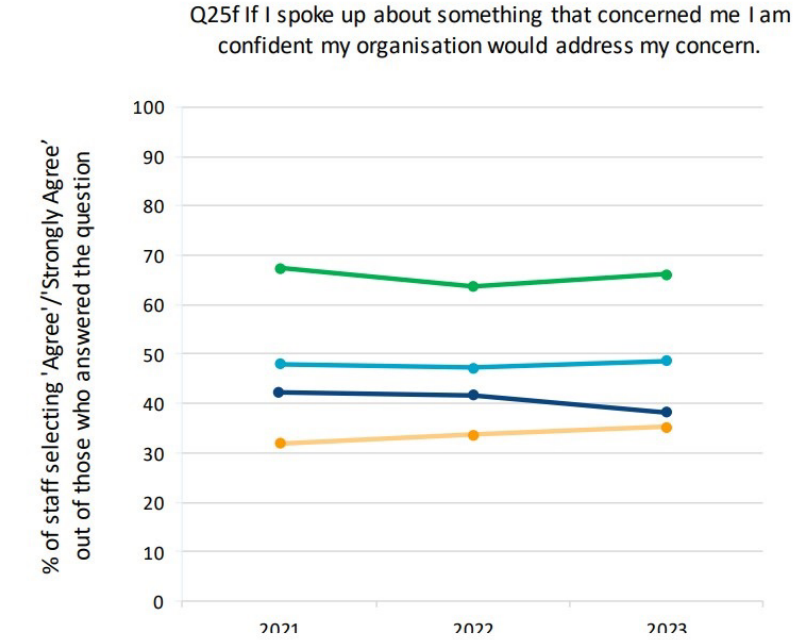
Table 1: Responses to questions Q25e and Q25f in the 2023 NHS Staff Survey

Question	Number responding	Strongly agree %	Agree %	Neutral %	Disagree %	Strongly disagree %
Q25e I feel safe to speak up about anything that concerns me in this organisation.	6825	11%	39%	27%	15%	8%
		Total agree 3436 (50%)		Total 1833	Total agree 1556 (23%)	
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	6822	8%	30%	36%	17%	9%
		Total agree 2619 (38%)		Total 2435	Total disagree 1768 (26%)	

Figure 1: 2023 NHS Staff Survey responses to statements about raising concerns (2020-2023)



	2020	2021	2022	2023
Your org	61.34%	53.87%	53.37%	50.32%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	7288	7093	5599	6825



	2021	2022	2023
Your org	42.39%	41.65%	38.24%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	7088	5589	6822

This continued deterioration in positivity about speaking up likely reflects the impact of the Newsnight programmes and subsequent publicity, the reorganisation of the Trust to a federated model, and the extensive changes in senior and middle-grade leadership. The views of staff specifically about the Freedom To Speak Up service have been captured in the ValueCircle Culture Review published in September 2023, and the CQC Well-Led inspection undertaken in October 2023 and published in March 2024. Both reports describe staff concerns about detriment, loss of confidentiality, delays, and lack of confidence in achieving desired outcomes. Lack of awareness of the service remains a factor. Positive experiences were offered by those respondents who had used the service. Unsolicited feedback to the FTSUG from staff who have consulted the service has been uniformly positive in relation to the initial phase of consultation and raising concerns.

Given the complexity of the speaking up pathway, improvements are required in responsiveness once concerns have been escalated, and in protecting contacts from detriment. The Trust has just completed a stakeholder review of the FTSU service and the results will be presented in April. A devolved model is a possible outcome with further investment in the service to allow the FTSU team expand its current contributions to staff training and promotion.

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 1000 Guardians in secondary, primary and community care in England, coordinated by the National Guardian's Office; more than 23,000 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 Prof. Julian Bion, who has been in post since October 2018, and is now supported by two deputies and 37 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 for Speaking Up, and by Ms Cathi Shovlin, the Chief People 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 direct 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, 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 and Chief People 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, the Director or HR and the Head of Occupational Health to exchange insights. The Guardian reports formally twice a year to the Trust Board and to the Governors, attends and reports to the People and Culture Committee, and meets four-monthly with the Chair of the Trust Board. Prof. Glasby also attends the quarterly meetings with the Guardian and Confidential Contacts to gain an overview of current themes and issues being raised.

A summary of concerns raised via the Freedom to Speak Up process are also reported quarterly to the National Guardian's Office based 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

Table 2: Summary of Speaking Up Data, April 2020 to September 2023

Financial years:	2020/21		2021/22		2022/23		2023/24	
	Q1&2	Q3&4	Q1&2	Q3&4	Q1&2	Q3&4	Q1&2	Q3&4
No. contacts[1] by professional group	Apr-Sept 2020	Oct 2020 - Mar 2021	Apr-Sept 2021	Oct 2021 - Mar 2022	Apr-Sept 2022	Oct 2022 - Mar 2023	Apr-Sept 2023	Oct 2023 - Mar 2024
TOTALS	63	47	47	33	49	113	141	141
Consultants[2]	19	7	7	6	3	30	14	18
Junior Doctors	16	7	9	-	2	11	8	13
Doctors Overall	**35**	**14**	**16**	**6**	**5**	**41**	**22**	**31**
Nurses Band 5-8	2	10	11	6	14	20	28	35
CNS/ANPs/PAs	-	1	1	-	5	3	3	3
HCAs/TNAs	2	3	-	1	1	3	11	20
AHPs incl Pharm	5	5	2	5	-	12	29	9
Support staff	-	1	-	-	-	8	10	1
Tech/Sci/Labs/IT	-	3	1	1	2	3	4	6
Domestic/Porters	1	1	2	-	1	2	6	3
Managers/Corp/Ed	3	1	8	9	18	12	8	14
A&C	4	5	6	5	3	9	15	15
Unknown	10	2	-	-	-	-	3	3
Anonymous	1	1	-	-	-	-	2	1
Patient/relative[3]	-	-	-	**4**	-	-	**1**	

Financial years:	2020/21		2021/22		2022/23		2023/24	
	Q1&2	Q3&4	Q1&2	Q3&4	Q1&2	Q3&4	Q1&2	Q3&4
Typology of issues, allegations or concerns[4]	Apr-Sept 2020	Oct 2020 - Mar 2021	Apr-Sept 2021	Oct 2021 - Mar 2022	Apr-Sept 2022	Oct 2022 - Mar 2023	Apr-Sept 2023	Oct 2023 - Mar 2024
Bullying, Harassment	6	27	17	11	32	34	51	54
Racism	2	4	1	2	6	9	6	24
Gender/other	1	0	2	2	1	5	7	5
Patient safety	2	4	4	3	1	12	10	10
Staff safety	3	5	0	1	1	2	-	2
Probity/fraud	4	3	1	4	2	4	15	10
Leadership	4	4	3	3	7	11	30	9
Work, wellbeing	12	10	6	2	4	2	27	14
Employment/HR	8	6	11	8	11	8	24	57
TOTALS	42	63	45	36	65	87	170	185

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, but are referred to PALS.

4. Staff may come with more than one issue or concern.

Number of contacts

There is a distinct inflection point in the 6-monthly number of contacts in Table 2, starting in October 2022, when the number of contacts increased markedly. This is attributable in part to our promotional efforts in October that year, but also to the BBC Newsnight programme broadcasts about UHB in December 2022. Our average number of contacts rose from 6.6 to 21.5 per month, and have remained around that level. This is a substantial increase in workload for the team. The increase is mostly attributable to contacts from non-physician members of staff, while the number of doctors contacting the FTSU service remained unchanged. This suggests a substantial prior un-met need revealed by the publicity. Several contacts said that the Newsnight programmes had assured them that their experiences were not unique, and that this had given them 'permission' to express their views to us.

As of February 2024, the FTSU service has now supported 679 members of staff since October 2018, and the current rate of contacts shows no signs of slowing.

Typology of concerns

This has not changed much until the last quarter, where we see accentuation of the predominantly bimodal distribution, with concerns clustering either around harassment and bullying, or workplace concerns including disputed HR processes or outcomes (and these two typologies are of course closely related).

Concerns relating to protected characteristics discrimination are comparatively infrequent at 8.5%. We suspect that this is an underestimate (a view espoused by the recent BRAP 2024 report 'Too Hot to Handle'), probably attributable to normalisation of discriminatory behaviours, or attribution to other classes of dysfunctional behaviour. As an example, a nurse described numerous bullying behaviours by a more senior member of staff; one of these involved interrupting her at prayer in a room set aside from the workplace. This was not described as discrimination, but the circumstances would suggest that this is an underlying factor.

Patient safety issues represent a relatively small proportion of concerns (7.5%), but the true magnitude will be greater given the known detrimental impact on reliability of care of adverse behaviours.

Around 10% of concerns involve Human Resources specifically, usually in connection with perceived delays, detriment, or dissatisfaction with outcomes. The FTSU service makes it clear to contacts with such concerns that we will not run parallel processes, but we will ensure that their concerns have been adequately heard and their well-being is prioritised.

Improvement priority for 2024/25

The Trust's Freedom to Speak Up process will no longer be reported in the Quality Account, as it has an existing reporting and governance process as a statutory function.

How progress will be monitored, measured and reported

- Regular reports are provided by the Freedom to Speak Up Guardian to the Trust Board.
- Regular discussions are held 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.

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 2024 and 2025.

Improvement priority for 2023/24

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 2023/24.

Performance

In May 2023, UHB was revalidated as a VTE Exemplar centre and received a commendation for Excellence in VTE Prevention Practice and Leadership.

VTE risk assessment

The Trust is currently reviewing and updating the VTE risk assessment indicator to ensure it meets the latest national definition. As at writing, the indicators are still in development and sign off will occur once data validation testing is complete.

Potentially preventable hospital-associated thromboses (blood clots)

Under the new national PSIRF (Patient Safety Incident Response Framework), potentially preventable hospital associated thrombosis incidents will be identified for review by staff / trust groups. Reviews of hospital associated thromboses are ongoing and are undertaken by a specialist nurse and thrombosis Consultant using a Trust agreed template and SOP. The SOP is currently under review with the Trust clinical governance lead in order to update it according to PSIRF requirement. A pilot has been undertaken to use word mining software to streamline this process.

Number of incidents relating to thrombosis

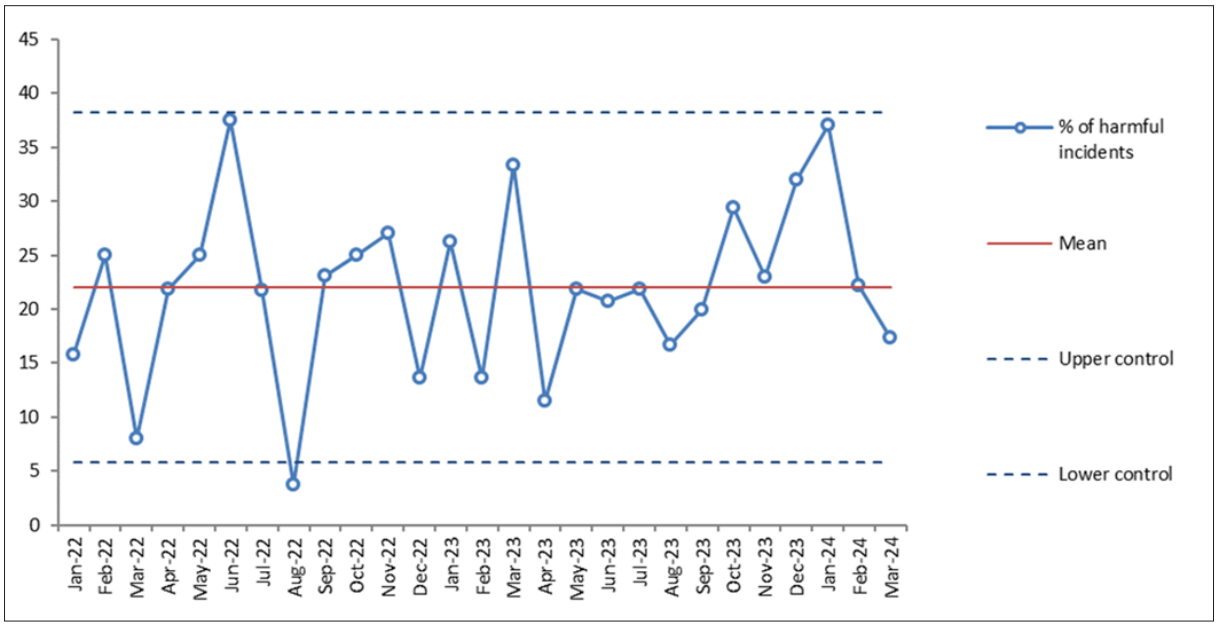
Where a patient experiences a Hospital Acquired Thrombosis resulting in severe harm or death, a higher level incident response is undertaken. These were investigated as a Serious Incident investigation up to October 2023, and following the introduction of the PSIRF since November 2023, are now subject to a Patient Safety Incident Investigation (PSII). The purpose of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident, and these responses are led by a senior lead investigator who is trained to conduct investigations for learning.

In the year April 2023 to March 2024, one such case was identified. This is currently under investigation as a PSII and is expected to be completed in June 2024. Examples of actions taken from past investigations include:

- Implementation of lower limb pathways (described below).
- Review and update the rules and alerts in the electronic prescribing system.
- Auditing of VTE risk assessments and prophylaxis prescribing.
- Communicating learning from the incidents to staff via Q+S newsletter, M&M meetings, department meetings.

The graph below shows the number of harmful incidents relating to the topic of thrombosis which were reported during 2023/24. Thrombosis and VTE related incidents are responded to using the Patient Safety Incident Response Plan.

Total Number of incidents Jan 2022 to March 2024



Progress during 2023/24

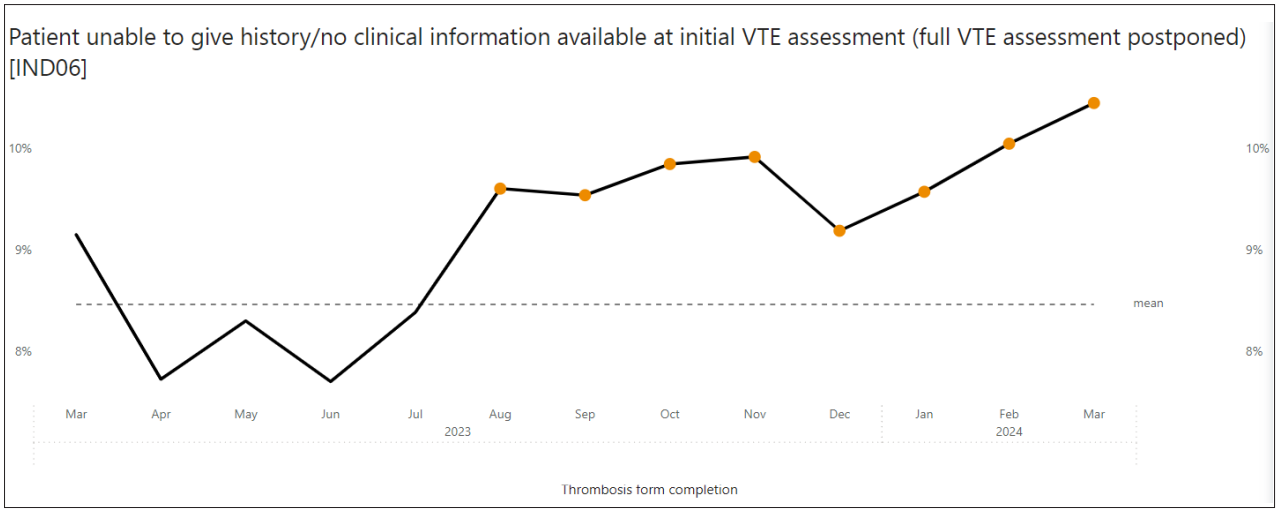
To Use Indicators within Power BI to Monitor VTE Pathways

A number of automated indicators have been developed to track performance along the rest of the pathway.

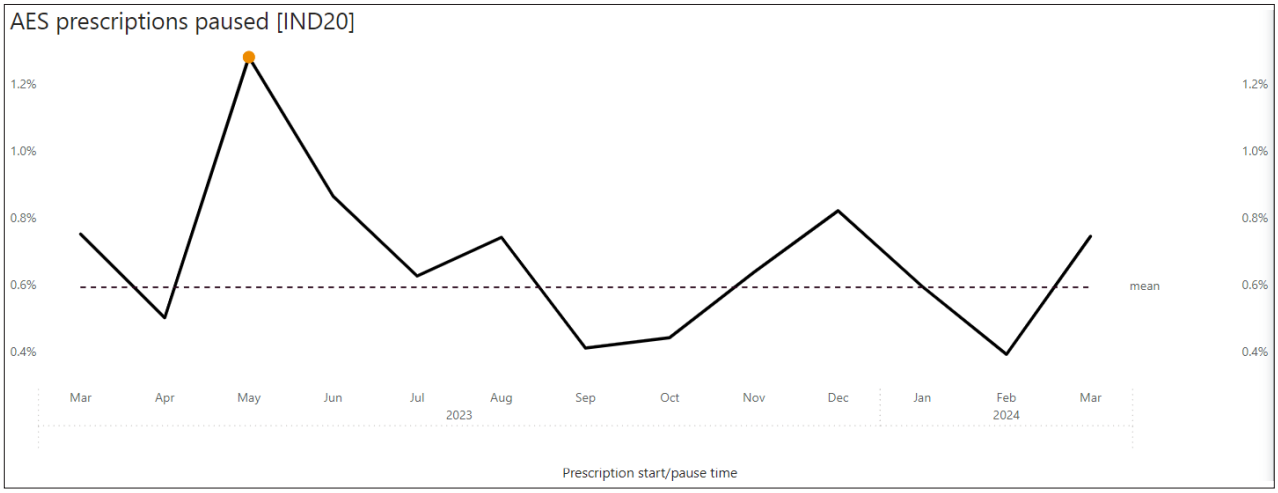
The indicators were designed to measure whether clinicians are adhering to the outcomes of VTE risk assessments by prescribing and administering anti-embolism stockings and/or prophylactic medication, e.g., enoxaparin in a timely manner when required. The indicators are live in the new Health Observatory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

VTE Indicators

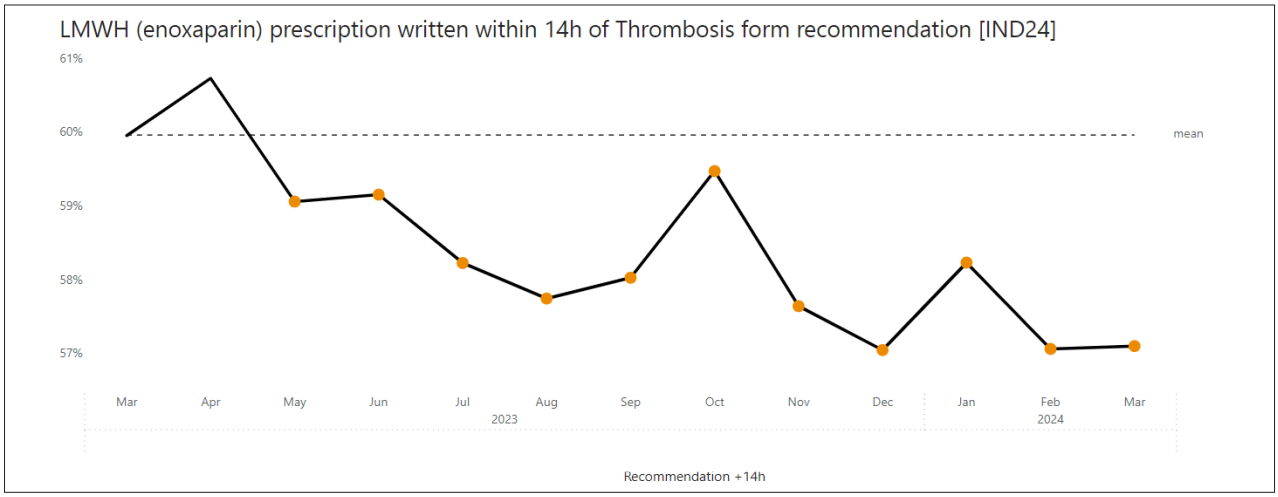
The graph below shows the number of patients whose VTE risk assessment was postponed. This has increased from 9.15% (1,434 of 15,678 patients) in March 2023 to 10.44% (1,743 of 16,690 patients) in March 2024.



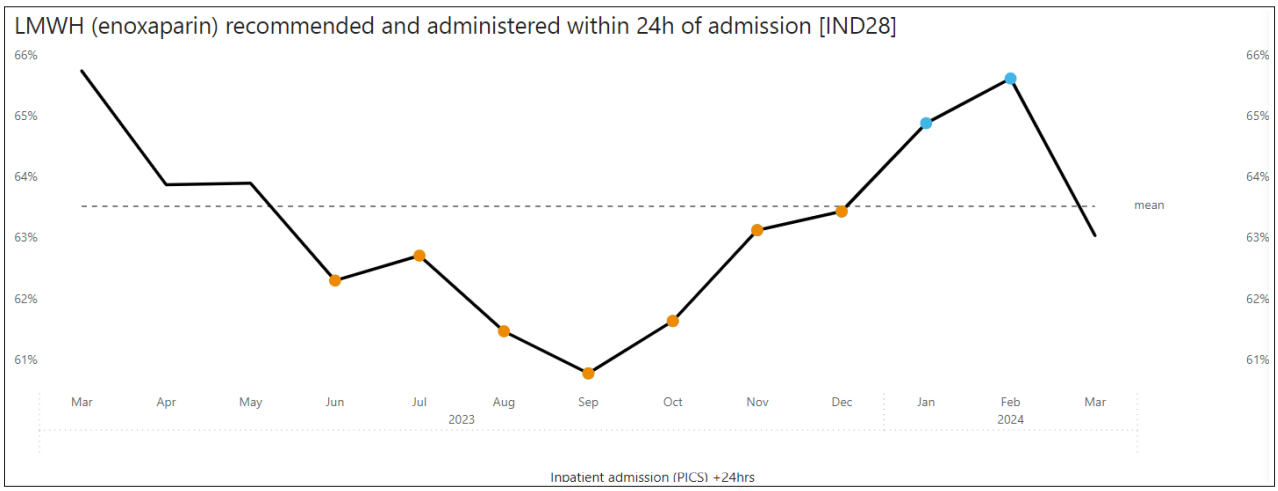
The graph below shows the number of anti-embolism stocking prescriptions that were paused from March 2023 to March 2024. This has decreased from 0.75% (29 of 3680 patients) in March 2023, to 0.74% (31 of 4163 patients) in March 2024.



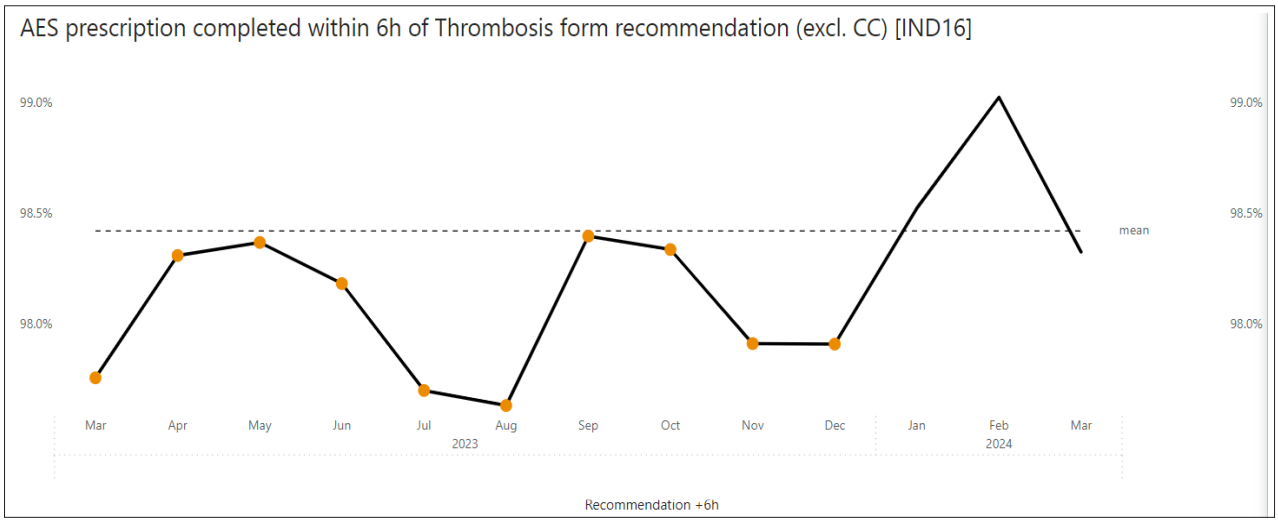
The graph below shows the enoxaparin prescriptions written for patients within 14 hours of their thrombosis form recommending prescription. This has decreased from 59.95 (4,348 of 7,253 prescriptions) in March 2023 to 57.1% (4427 of 7753 prescriptions) in March 2024.



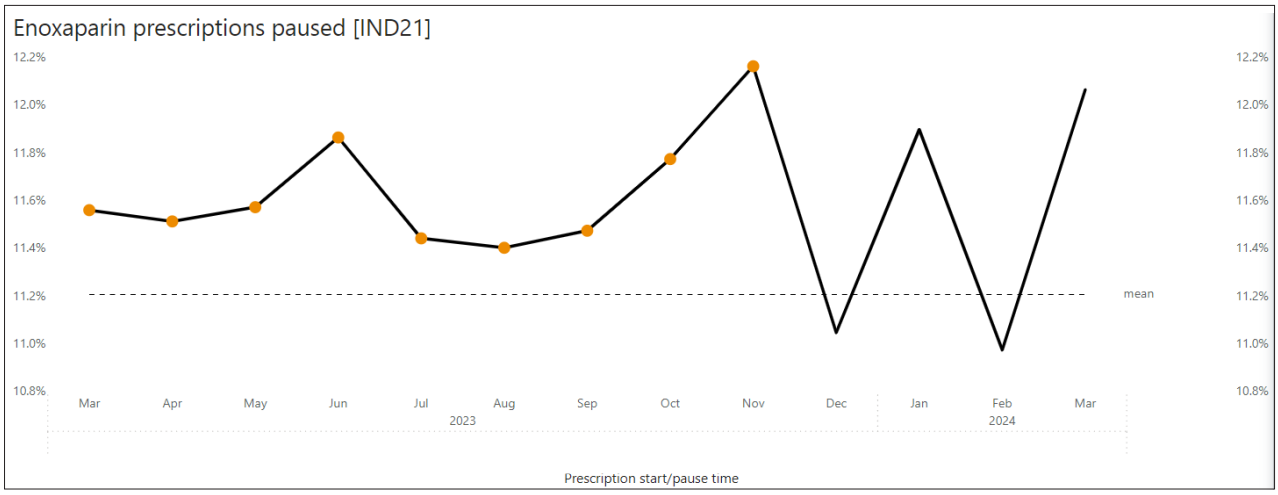
The graph below shows the enoxaparin recommendation and administered to the patient within 24 hours of the patient being admitted. This has decreased from 65.73% (2,983 of 4,538 patients) in March 2023 to 63.11% (2,913 of 4,616 patients) in March 2024.



The graph below shows the number of AES prescriptions completed within 6 hours of the thrombosis form recommending prescription. This has increased from 97.76% (2,570 of 2,629 prescriptions) in March 2023 to 98.32% (2,758 of 2,805 prescriptions) in March 2024.



The graph below shows the number of enoxaparin prescriptions paused across the period of March 2023 to March 2024. This has increased from 11.56% (1,079 of 9,336 prescriptions) in March 2023 to 12.06% (1,150 of 9,533 prescriptions) in March 2024.



To Develop Lower Limb VTE Pathway Indicators.

An electronic VTE assessment form is live in PICS, however use of the form is yet to be rolled out.

Progress with Lower Limb Pathways.

- The electronic VTE risk assessment form is live in PICS and a Trauma and Orthopaedics consultant is leading on implementation.
- The VTE Lower Limb guidelines are being updated to reflect organisational changes and interventions and are in place on the guidelines page of the intranet.
- Patient information leaflets continue to be distributed to the relevant areas.
- There has been a pilot of word mining software for Hospital Acquired Thrombosis reviews.

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 can be asked to attend the monthly Clinical Dashboard Review Group to discuss their performance and share ideas for improvement. The CDRG is attended by members of the VTE Quality Improvement Project (QIP) group to allow areas for potential improvement to be discussed, and to facilitate discussion.

Improvement priority for 2024/25

Performance in VTE prevention is reviewed at the Electronic Health Record Executive Authority, as well as focused QI meetings. A key QI priority for VTE during 2024/25 will be to reduce missed and paused doses of thromboprophylaxis. This will involve patient and public involvement and education.

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 can be called to attend the CDRG meetings to discuss their performance.
- VTE indicators will continue to be made available to staff via the Health Observatory webpages and will include monthly performance data.
- Update reports will be provided to the VTE QIP Group and the Corporate QI Steering Group, both chaired by the Deputy Chief Medical Officer. Updates are also included in the Integrated Quality Report to the Group Clinical Quality Meeting.
- VTE prevention is being assessed within the Electronic Health Records QIP.

Priority 3: Improving ward rounds

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

This was originally a standalone QIP, but has now been joined up with the Discharge Project and associated work.

Background

The Trust set up a QIP 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 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.
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.

The focus is now on the "Eight Ts" to ensure early and safe discharge and effective patient flow.

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 2023/24

The Trust was aiming to develop a framework of local ward round standards and to set out an implementation plan during 2023/24. 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.
- 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 2023/24

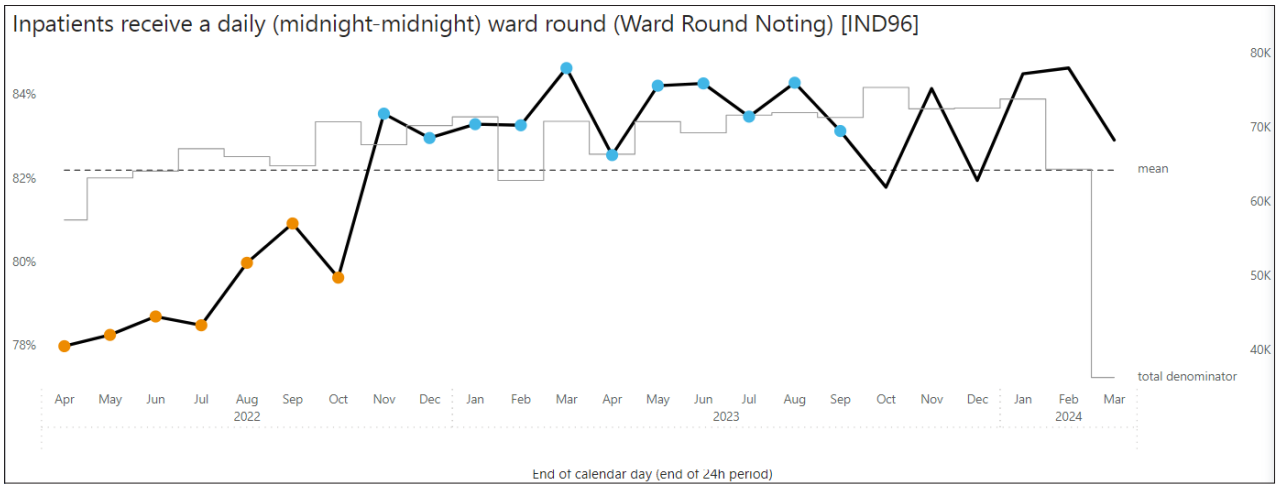
- Approximately 10 wards across different sites and clinical specialties have been involved at various stages of the ward round QIP during 2023/24.
- Longitudinal improvement data have been obtained from wards covering Respiratory, Infectious Diseases, GIM, Stroke and Acute Medicine.
- Development of reports in PowerBI such as the Board Round report which will become a single location for identifying patient treatment pathways and therefore precipitating safe and effective discharge – see Performance below.
- Meetings held for Ward Champions, who are nominated by Executive Teams.
- Implementation of a quality improvement intranet site for staff education and sharing of best practice. A SharePoint website has also been developed.
- Ongoing updates to the standard operating procedure, board round and discharge bundle paperwork.
- A CMO Fellow supports the project.
- Quarterly QI Prize and roadshows took place to celebrate success and promote engagement.
- The monthly ward round QI meeting continued for part of the year before the work was joined with the Discharge Project.

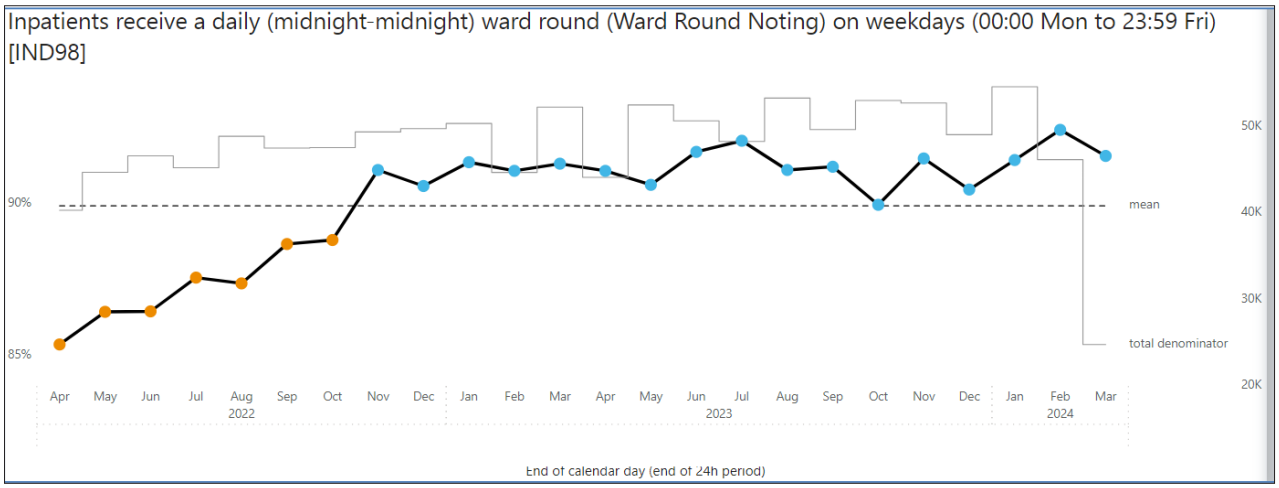
Performance

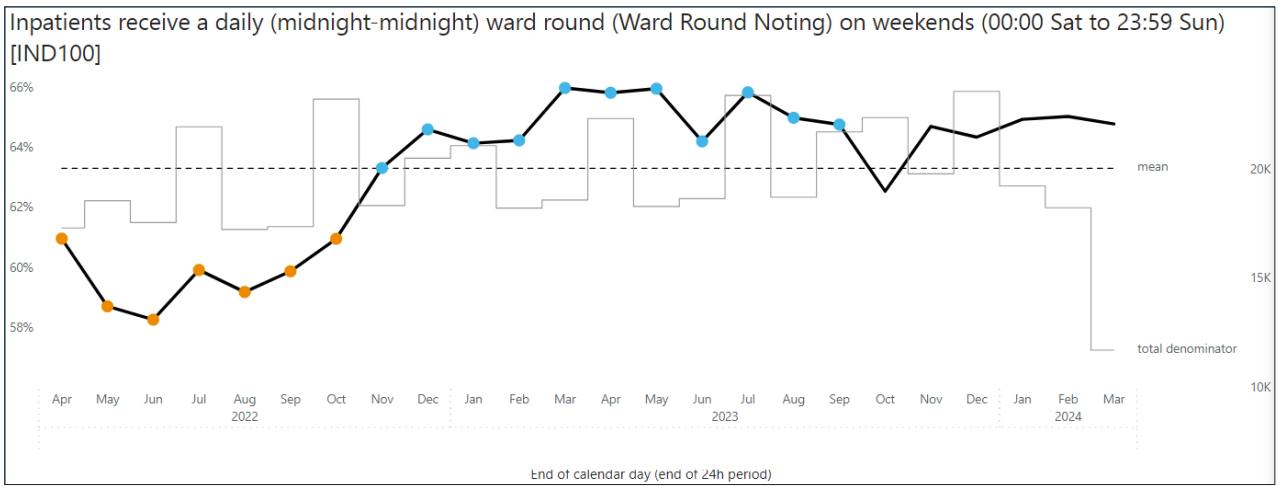
Indicators available in PowerBI / Health Observatory and show percentage of patients who have a daily ward round – the charts show overall performance, and also broken down into weekday and weekend.

The data is shown as SPC (Statistical Process Change) charts.

The blue dots show where there appears to have been a sustained improvement.







Improvement priority for 2024/25

- Under the new site-based leadership model - to work with the four sites to set their own priorities around ward round and discharge QI.
- Continue to develop a single location for the "Home of Discharge" which will contain information for staff on discharge processes as well as standards for board rounds and ward rounds.
- Continue to work on the suite of reports in PowerBI to allow ward staff to locate relevant information from multiple Trust IT systems and review performance metrics at ward and site level.
- Increased project engagement of clinicians and leaders via better communication and provision of data to ensure ward level compliance against the multiple metrics that influence, positively or negatively, a patient's length of stay.
- To continue to emphasise the importance of the quality of ward rounds as this impacts on discharge planning and other aspects of patient care.
- All participating sites/areas to deliver a discharged focussed PDSA cycle.
- All participating sites/areas to have a PDSA cycle led by AHPs/nurses.
- To review "Your Day", a system that gives information to patients on what they can expect during their day on the ward.
- Metrics built in PowerBI for the following aspects:
  - Estimated discharge date (EDD): to improve documentation and use of estimated discharge date by wards.
  - Criteria-led discharge (CLD): to improve documentation and use of clinical parameters to precipitate discharge – this gives ownership to nurses and junior doctors to discharge patients without requiring consultant review.
  - Discharge bundle completion: to improve timely discharge via introduction of a discharge bundle comprising tick boxes for key aspects of the discharge process within PICS.
  - Multi-disciplinary team (MDT) board round: to improve documentation of the board round by wards.

How progress will be monitored, measured and reported

- Progress will be monitored through the Trust's ward rounds QIP, which has been joined with the Discharge Project.
- Further indicators to be built, monitored and reported via PowerBI.
- Expectation that senior / executive level leadership ensure that regular progress reports are being reviewed and acted on in order to improve safer more efficient discharges at individual ward level.

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 Group 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.

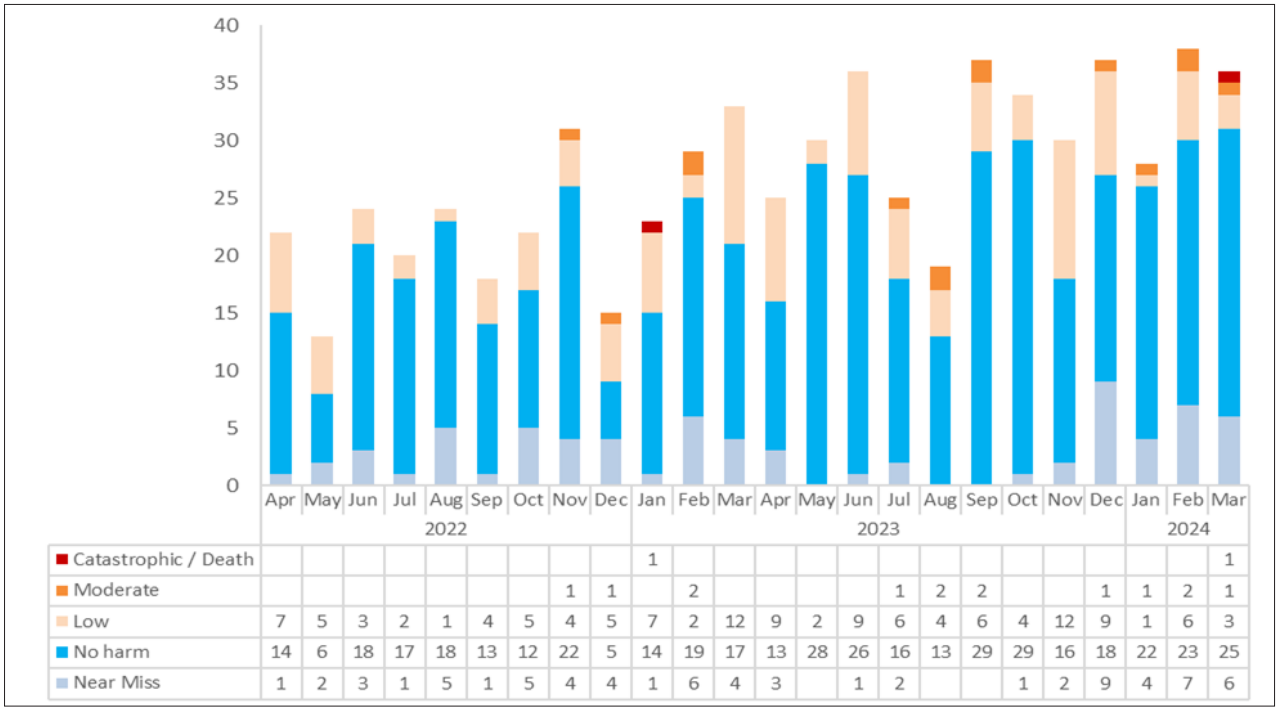
The Trust aimed to standardise the approach to managing the two groups of nil by mouth patients, decision-making and nil by mouth signage across all hospital sites. The Trust also chose to focus on ensuring patients received the right type of food (from a consistency perspective) at the right time.

Improvement priority for 2023/24

The focus of this priority for 2023/24 was improving the management of nil by mouth patients, although the work covered other aspects of care too – see "Progress" section below.

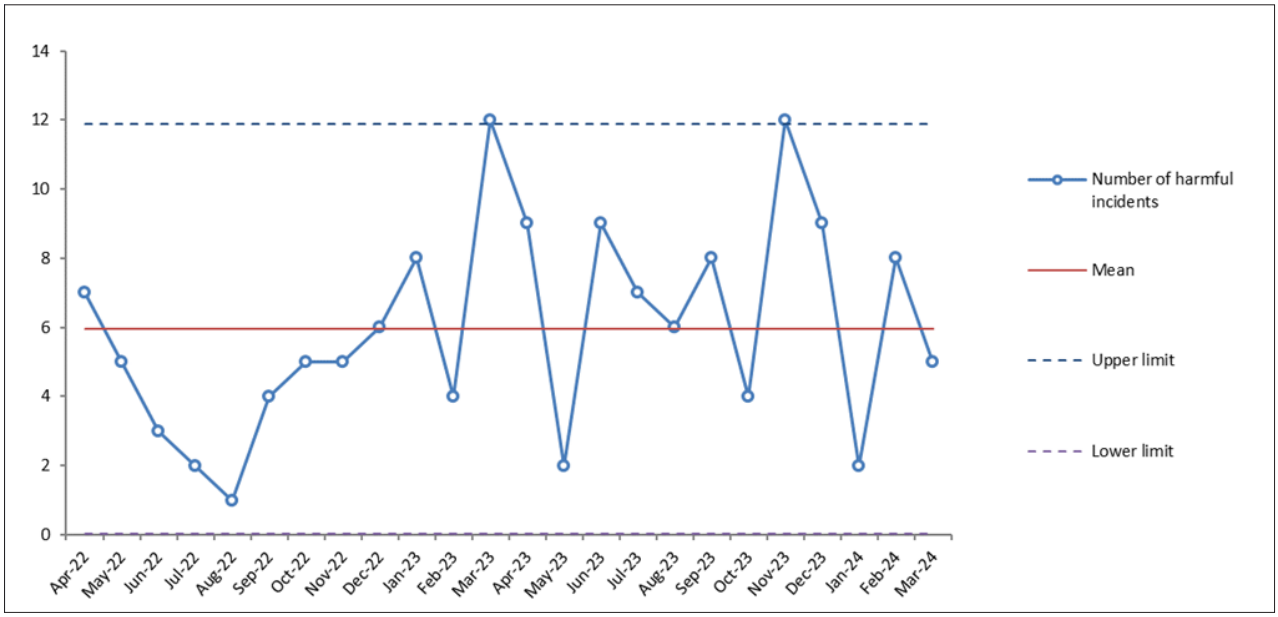
Performance and progress during 2023/24

Incidents by level of harm 01/03/2022 – 31/03/2024



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2022									2023												2024		
Catastrophic / Death										1														1
Moderate								1	1		2				1	2	2			1	1	1	2	1
Low	7	5	3	2	1	4	5	4	5	7	2	12	9	2	9	6	4	6	4	12	9	1	6	3
No harm	14	6	18	17	18	13	12	22	5	14	19	17	13	28	26	16	13	29	29	16	18	22	23	25
Near Miss	1	2	3	1	5	1	5	4	4	1	6	4	3		1	2			1	2	9	4	7	6

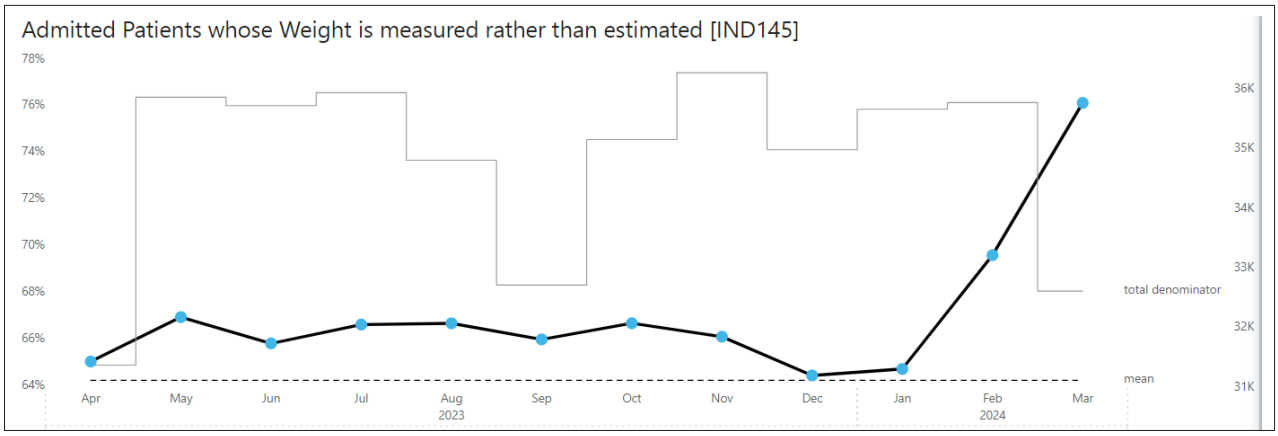
Number of incidents (low – death)



Progress in 2023/24

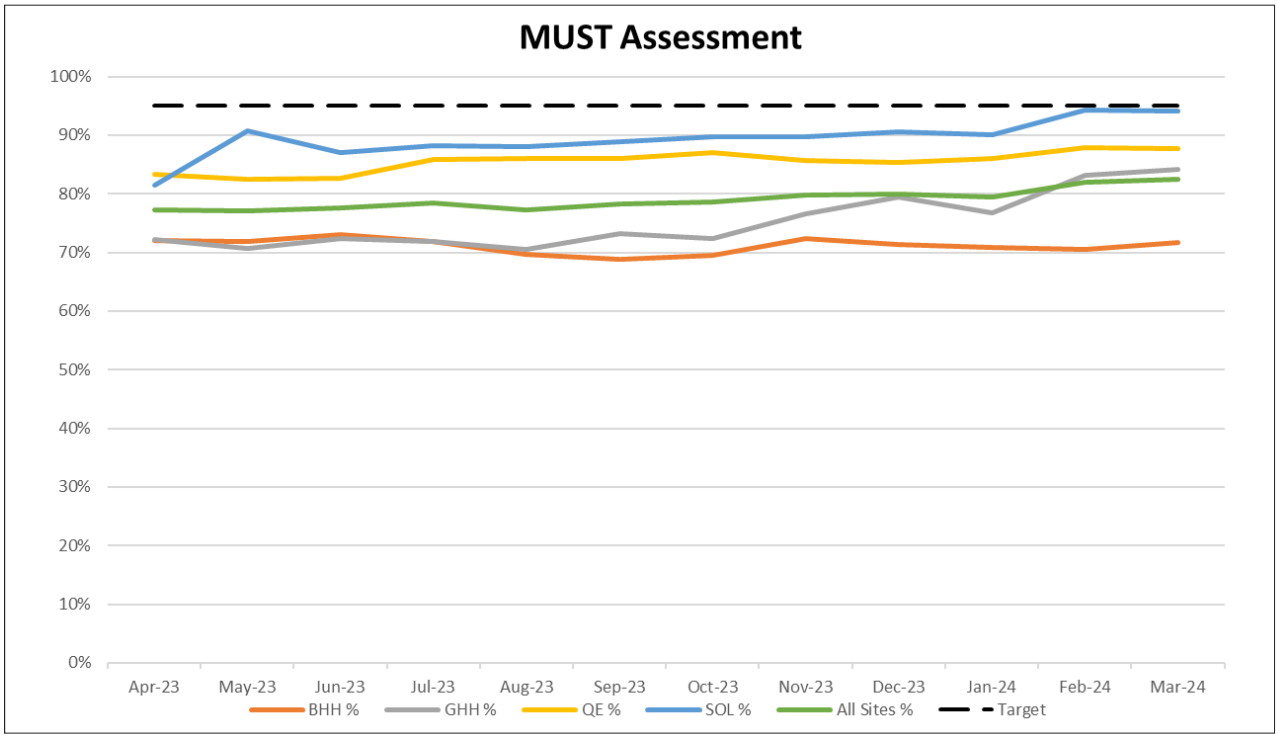
- An updated NG feeding tube Moodle package has been launched and the NG Procedure has been updated this year with an escalation flowchart for staff to prevent delays in NG feeding tube insertion.
- There is now a link on the HI dashboard so wards can see their estimated weights and matrons in each area are now auditing wards regularly with regards to estimated weights.
- The group continued to do mealtime audits across the trust to ensure provision of meals meets a high standard.
- The group are reviewing PICS with regards to the section on MUST.
- A new subgroup of the trust Nutrition and Hydration Steering group is a catering group that will feed in to the trust group.
- SOPs developed, updated and in use across the Trust for fasting, nil by mouth, complex swallow problems and dysphagia, to support all members of staff across medicine, surgery, Therapies, Nursing and facilities.
- A yellow NBM sign is in use, this is put above a patient's bed when they are NBM, to increase awareness and to support all staff.
- Over 6800 people have completed the online Moodle training for safer swallowing, and hundreds more staff have received face to face training from the speech and language therapy team.
- Safer swallow meetings happen every six weeks, with good representation from all disciplines across the trust.
- We are applying for NIHR research funding to explore how we can further improve provision of safer mealtimes for patients.
- There has been a reduction in incidents about patients who are nil by mouth or have swallowing problems since we provided our training, signage and SOPs. We continue to monitor this carefully and respond promptly to any issues identified across site.
- Data is available on the number of actual weights recorded vs the number of estimated weights, this is important to allow accurate calculations and risk of malnutrition.
- A LocSSIP (Local Safety Standard for Invasive Procedures) has been developed for NG tube insertions, this covers use of a line flag, appropriate dressings, use of x-ray to confirm correct positioning, and standards for interpreting the x-ray.
- A Patient Safety Notice has been issued for learning regarding x-ray reporting.
- An audit into approximately 100 NG tubes has been completed. Placements and dressings were found to be correct. The audit is to be repeated in 2024/25.
- Monthly review of incidents highlighted as being related to Nutrition & Hydration, including identification of any themes arising.
- Monitoring of relevant course completion / staff competencies e.g. for NG tubes.
- Food and drink strategy is being developed, the group is looking to improve sustainability in this area as well as meeting the needs of patients and staff.

Percentage of patients who have an actual weight recorded in PICS



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

Target 95% or higher



Improvement priority for 2024/25

- To continue with the work detailed under 'Progress'.
- Further ratification of SOPs.
- Continue to work on metrics and audits.

How progress will be monitored, measured and reported

- Progress will be monitored and reviewed by the Nutrition and Hydration Steering Group.
- Update reports will also be provided to the Corporate QI Steering Group, and included in the Integrated Quality Report to the Group Clinical Quality Meeting.

Priority 5: Improving the Safety of Invasive Procedures

This QIP 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 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 LocSSIPs / World Health Organization (WHO) Safety Checklist quality improvement project.

In January 2023, revised 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 2023/24

Engagement with specialities to support development and implementation of LocSSIPs.

The Trust continued to support specialities to develop and implement LocSSIPs.

Worked with Obstetrics, Gynaecology, General Surgery and Cardiology on their LocSSIPs.

Working towards embedding the revised NatSSIPs 2 standards.

Progress during 2023/24

- New departmental LocSSIPs were implemented in:

Specialty	LocSSIPs Implemented
Ophthalmology	Laser Procedures Outpatient procedures
Trauma and Orthopaedics	Joint injection Minor Procedures
Ear, Nose and Throat	Grommet insertion Outpatient procedures
Radiology	MRI GA
General Surgery	Haemorrhoid banding
Maxillofacial	Tooth extraction Facial lesions
Urology	Flexible Cystoscopy for Stent Removal Post-Renal Transplantation

Assurance

- 62 LocSSIPs checklists representing 24 departments across Birmingham Heartlands, Good Hope, Solihull, and Queen Elizabeth Hospitals. Audits are completed by local departmental staff and reports discussed in LocSSIPs steering group meetings.
- Recommendations and outcome feedback are provided to local teams.
- Departments are sub-categorised into Red, Amber, and Green (RAG) according to engagement and compliance.

Assurance		
<60%	**60-80%**	**80-100%**
Critical Care	Ophthalmology	Radiology
Dermatology		Pain Management
		Gynaecology
		Maxillofacial

- The standardised audit methodology and improved audit standards have been reinforced to ensure more accurate results.
- Specialities where a Never Event has occurred have implemented regular observation audits. Compliance with the LocSSIPs checklists have significantly improved and recommendations have been developed to support safer practice.
- A Trust wide LocSSIPs Patient Safety Notice has been issued with links to the staff education module via Moodle.

- Site specific incident data related to incidents and Never Events is now included in the LocSSIPs outcomes report.
- Specialities have been RAG rated for engagement and audit assurance which is being shared with the Sites and included in their quarterly quality and safety reports

Improvement priority for 2024/25

- The aim for 2024/25 is to continue to develop and implement LocSSIPs throughout the Trust.
- Identify invasive procedures that may require a LocSSIP from incidents reported.
- Monitor assurance for Local Safety Standards via audit for Invasive Procedures that have been implemented.
- Share the specialities RAG rating for engagement and audit assurance with sites via their Quality and Safety Reports.
- Share good practice with specialities who are achieving and improving their LocSSIPs with sites via their Quality and Safety Reports.
- Continue to embed NatSSIPs 2 standards.
- Improve organisation of the LocSSIPs page on the intranet.
- Work with hybrid clinical areas where a wide range of procedures are undertaken, to facilitate WHO and LocSSIPs checklists where appropriate.

How progress will be monitored, measured, and reported

- Quarterly audits of compliance following the introduction of each Safety Standard. Increased frequency of audits where concern with compliance or a Never Event has occurred.
- Regular reports on progress will be provided to the current Corporate QI Steering Group, Group Clinical Quality Meeting (GCQM) and are included in the Integrated Quality Report to the GCQM.

Priority 6: Using Real-Time Information To Improve Patient Care

Background

The 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 refreshes daily and is drawn from the Trust's PICS.

The most recent review of the design/content of the Clinical Dashboard 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 Maternity outstanding at this point.

Plan for 2024/25

This Priority is not being carried forward to 2024/25 as it is not a direct patient safety initiative. However, the work around the Clinical Dashboard and associated meetings (CDRG: Clinical Dashboard Review Group – Trust and site/CDG level) continues.

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.

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 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 The 12 hour time slots are defined as: › From 00:00hrs to 12:00hrs › From 12:00hrs to 00:00hrs	99%	Higher
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 check that the equipment is working, and to ensure they know what to do if PICS goes down.	100%	Higher

Performance

The following graphs show performance for the six selected Clinical Dashboard indicators for 2023/24. 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

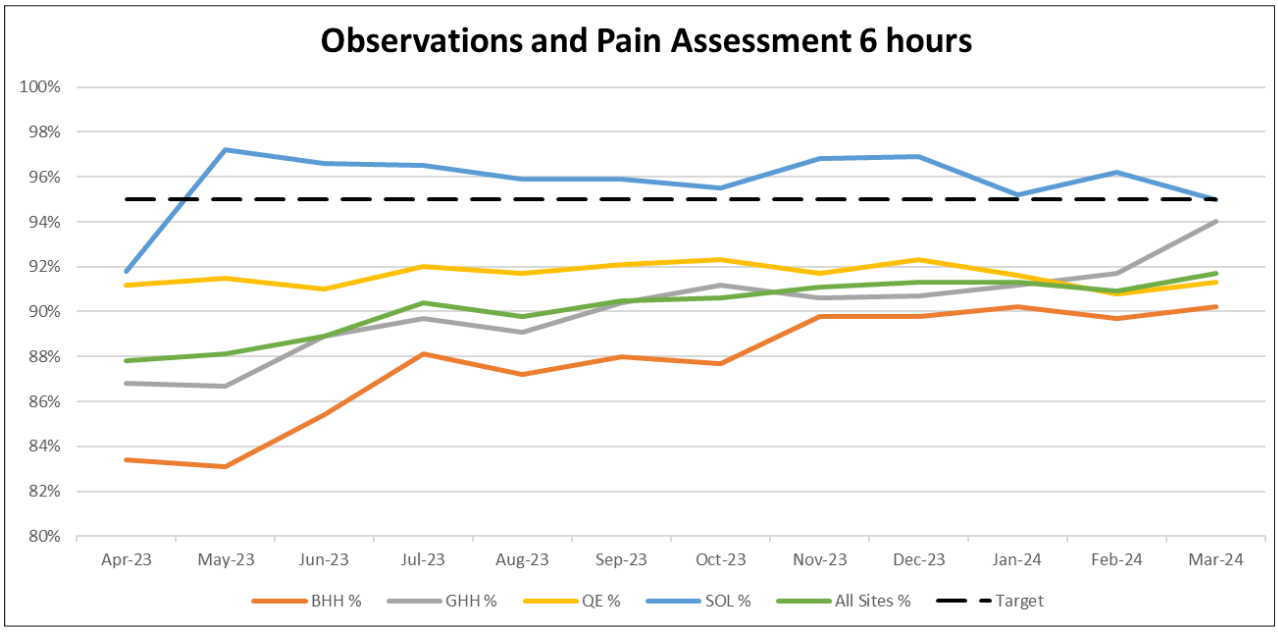
GHH – Good Hope Hospital

QE – Queen Elizabeth Hospital

SOL – Solihull Hospital

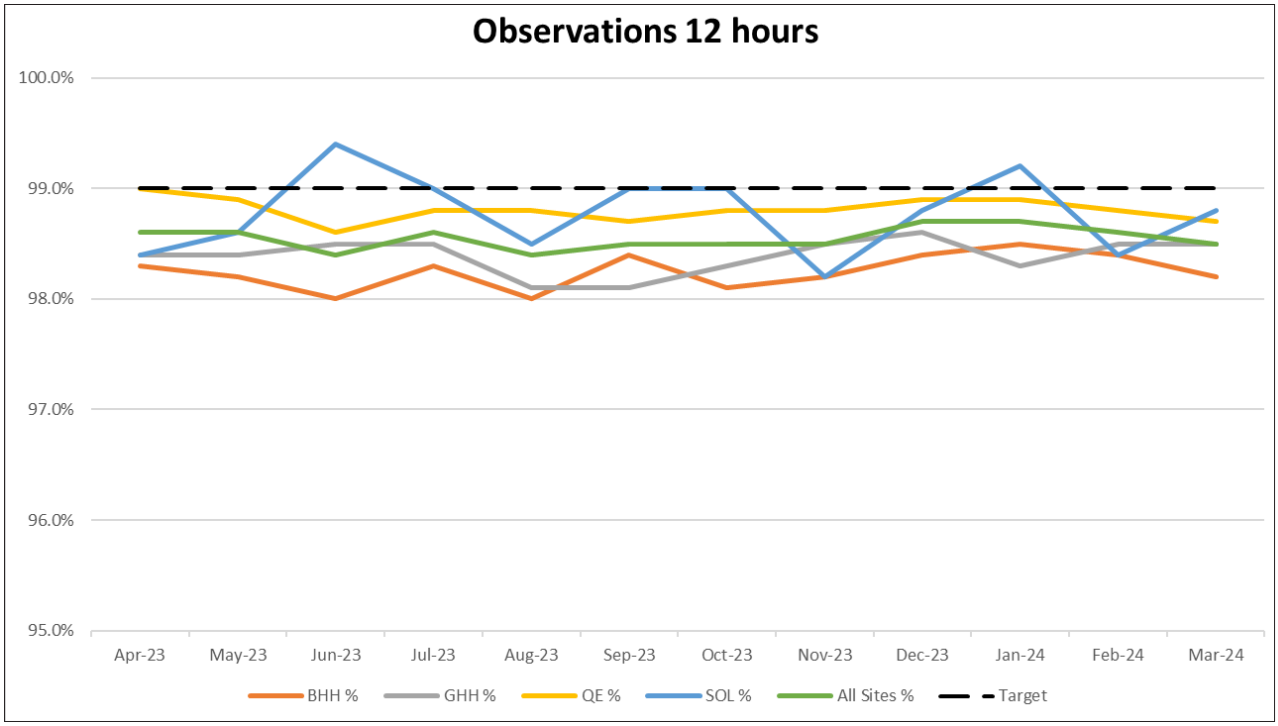
Full set of observation and pain assessment within 6 hours of admission or transfer to a ward

Target 95% or higher



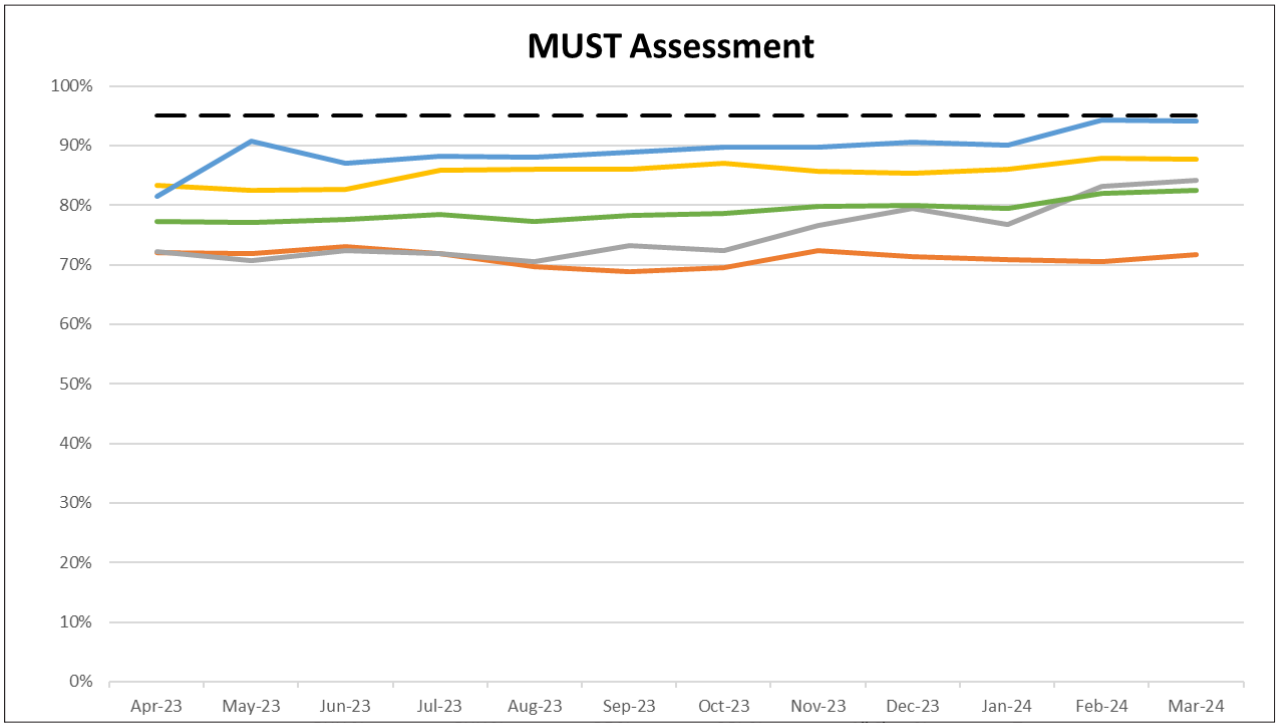
Full set of observations within 12 hours of admission or transfer to a ward

Target 99% or higher



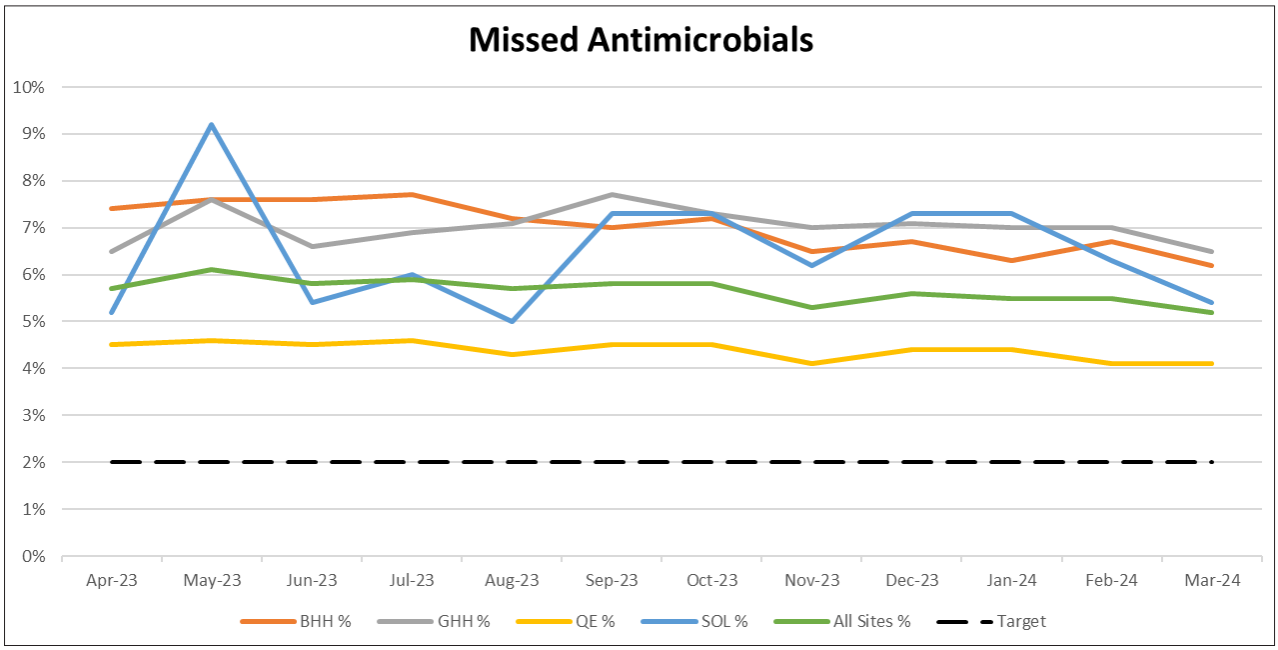
MUST assessment completed within 6 hours of admission or transfer to a ward

Target 95% or higher



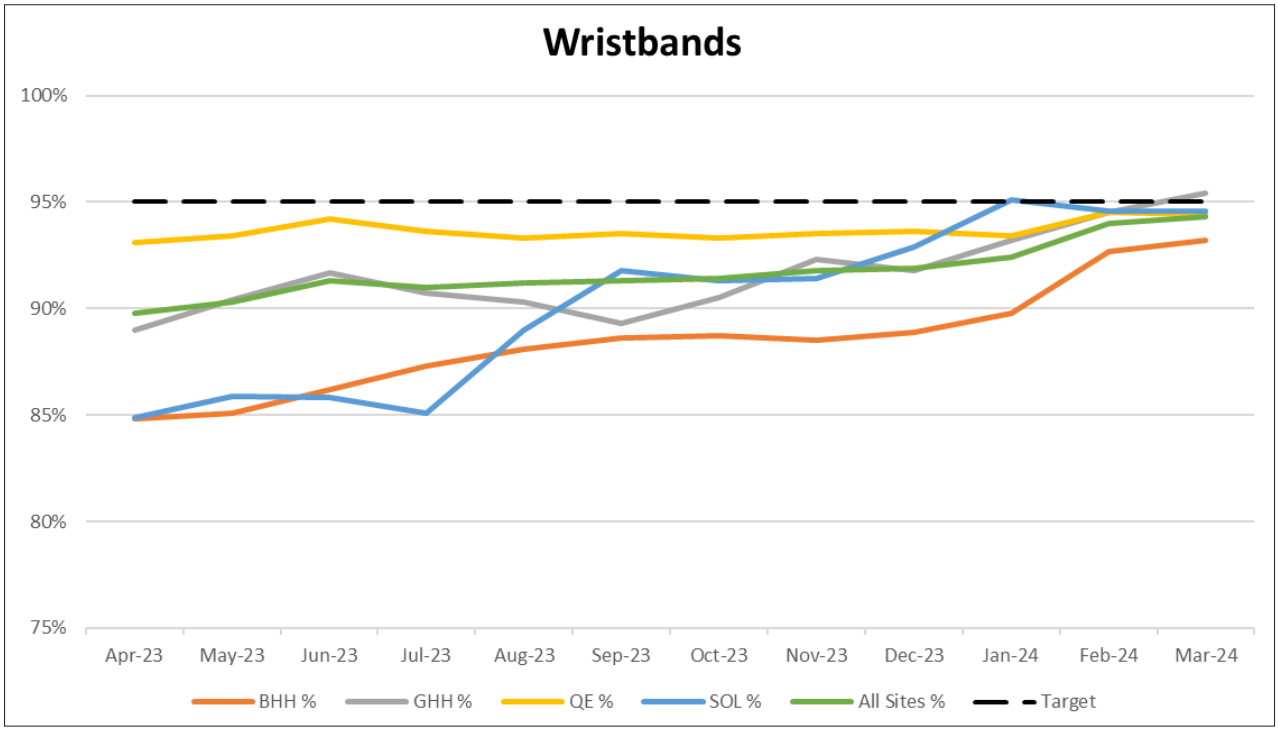
Missed doses of antimicrobials

Target 2% or lower



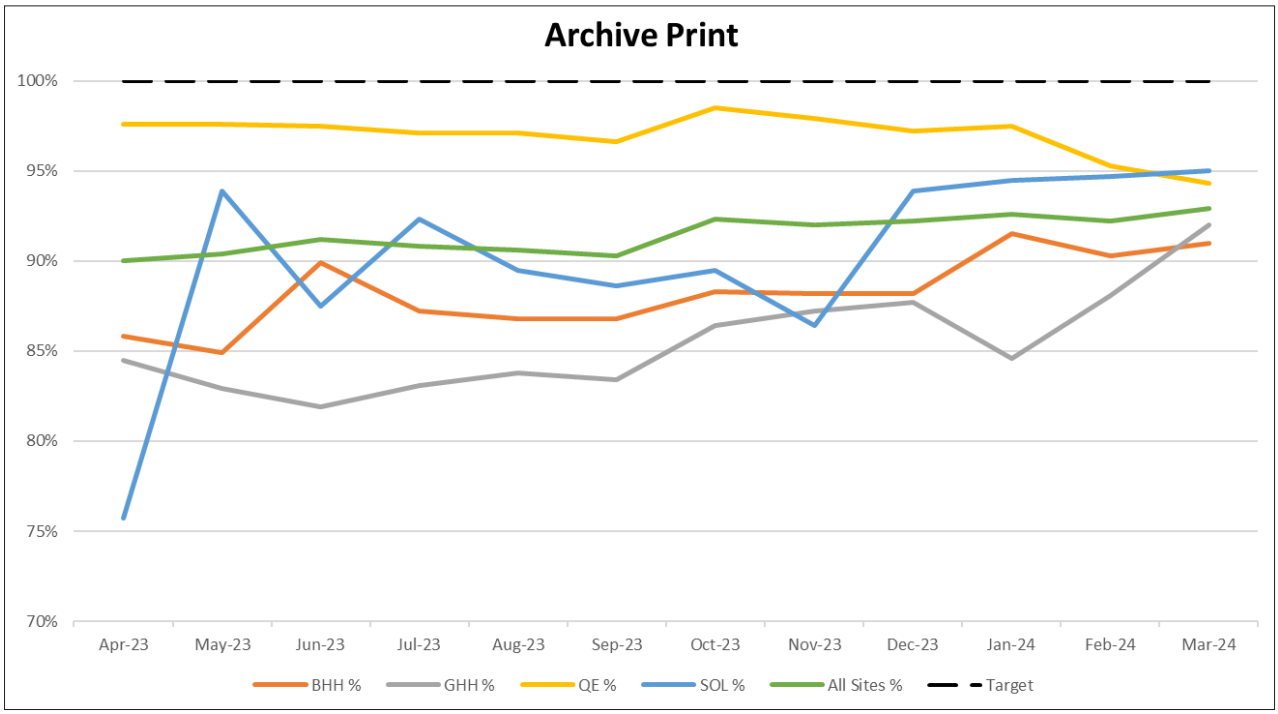
Electronic wristband identity check before administration of medication

Target 95% or higher



PICS document archive print

Target 100%



Progress during 2023/24

Clinical Dashboard Review Group (CDRG)

The monthly CDRG was set up in August 2019 and is chaired by the Deputy Chief Nurse. Ward Managers and/or Matrons for selected wards attend along with representatives from Pharmacy, IT, Corporate Nursing and the Quality Development team. Specialist staff (e.g. from Diabetes, Haematology, Dietitians) 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 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 implemented at the other sites to ensure they are all being measured to the same high standards. It will therefore take time for ward level performance to gradually improve as staff become more familiar with PICS, the Clinical Dashboard indicators and the standards required.

The Deputy Chief Nurse, supported by the Quality Development team, has 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 62 cases of ward-level performance for Clinical Dashboard indicators during 2023/24:

- 8 cases were selected based on good performance
- 60 cases for poor performance.

Indicator	No. wards presenting	
	Good performance	Poorer performance
Included in Quality Account		
6 hour Obs & Pain		4
Observations (12 hours)		1
MUST Assessment	2	12
Missed Antimicrobials	3	21
Wristbands	3	11
PICS Document Archive Print		1
Other indicators		
Falls Assessment		2
Waterlow Assessment		2
Total	**8**	**54**

Site / CDG Clinical Dashboard Review Groups

Clinical Delivery Groups (CDGs) and Sites are also setting up more local Clinical Dashboard Review Groups which the Quality Development team can attend to provide support when required.

Ward Visits / training

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

Initiatives to be implemented during 2024/25

- 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 continue to support wards with CDG / Site CDRG meetings to improve performance.

How progress will be monitored, measured and reported

- Performance for the Clinical Dashboard indicators will continue to be reviewed monthly at the CDRG, chaired by the Deputy Chief Nurse.

Other Patient Safety / Quality Improvement (QI) Programmes

In addition to the Trust's Quality Improvement Priorities listed above, the NHS England PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. As part of the development of the PSIRF at UHB, the following Trust Patient Safety Incident Priorities have been identified:

- Vulnerable patients.
- Nutrition & Hydration (see also Quality Account Priority 4 above).
- Management of the deteriorating patient.
- End of Life care.
- Management of Patient treatment pathway including associated Booking Processes.
- Urgent or critical radiology results not acted upon.
- Discharge planning and Communication.
- Preventable Falls.
- Preventable Pressure Ulcers.
- Preventable hospital acquired infections.
- Operative Management relating to Safety checks (see also Quality Account Priority 5 above).
- High Risk Medications.
- Maternity:
  - Diabetes Management in Pregnant Patients.
  - Fetal Monitoring.
  - Management of deteriorating patient.
  - Delays in maternity triage (MUAU, previously PAER).
  - Risk assessment in ANC.
  - Fetal Growth.
  - Consent / birth choices.
  - Interpreters and Translators.
  - Did Not Attend (DNA).

Quality Improvement at UHB

UHB is aiming to launch our new QI approach: UHB Improve in July 2024, supported by one QI Team and associated governance framework. In order to do this successfully, we may need short-term support from an improvement partner.

A self-assessment against NHS IMPACT identified some gaps and opportunities for improvement, namely:

- A vision for Quality Improvement which aligns to UHB's strategy, with a consistent and systematic methodology.
- Improved organisational culture to enable all staff to focus on continuous quality improvement.
- Improved staff morale and engagement, by giving staff more control over the system they work in, more autonomy to make changes, and equipping them with the tools and skills to tackle these.
- Sustained and lasting change, through providing consistency of purpose, momentum and infrastructure needed for complex improvement initiatives.
- Optimised efficiency and productivity through a sustained focus on reducing unwanted variation in services and practices, ensuring best use of resources.
- We have excellent teams and individuals across the Trust who are experts in Improvement, these need to be more coordinated.

2.2 Statements of assurance from the Board of Directors

2.2.1 Service income

During 2023/24 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 2023/24 represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2023/24.

* 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.

2.2.2 Information on participation in clinical audits and national confidential enquiries

During 2023/24, 62 national clinical audits and 4 national confidential enquiries covered relevant health services that UHB provides. During that period UHB participated in 57 (92%) national clinical audits and 4 (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 2023/24 are as follows (see table below).

The national clinical audits and national confidential enquiries that UHB participated in during 2023/24 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 2023/23, 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 audit outliers are captured within the integrated quality report to Trust board including improvement activities undertaken to address issues.

National Clinical Audits

National Audit UHB eligible to participate in	UHB participation 2023/24	Participation
Adult Respiratory Support Audit	Yes	All sites participated.
BAUS Urology Audits - Nephrostomy Audit	Yes	New for 23/24 – launched September 2023. All sites participating and data submitted.
Breast and Cosmetic Implant Registry	Yes	Participating; some issues relating to data entry in 2022/23
British Hernia Society Registry	No	National pilot stage – unable to participate
Case Mix Programme (Intensive Care National Audit & Research Centre)	Yes	Full participation
Elective Surgery (National PROMs Programme; T&O)	Yes	Participating but no data submitted 22-23
Emergency Medicine QIPS	Yes	Care Of Older People and Mental Health self harm – Ongoing participation
Epilepsy12: National Audit of Seizures and Epilepsies in Children and Young People	No	Did not participate 23-24 as insufficient resource to complete audit. Work underway to address this
Falls and Fragility Audit Programme	Yes	Fracture Liaison Service (QEH only) – continuous audit. 100% National Audit of Inpatient Falls – participating; awaiting Trust level report on 2022 data. National Hip Fracture Database – Participating and submitting, however May 2023 outlier for data capture, accuracy and completeness
Improving Quality in Crohn's and Colitis (previously known as Inflammatory Bowel Disease Audit)	No	The Trust has not participated in the Inflammatory Bowel Disease Registry since 2018. The Registry closed in March 2024.

National Audit UHB eligible to participate in	UHB participation 2023/24	Participation
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disabilities Mortality Review)	Yes	100% submission
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	Maternal mortality surveillance – full participation Perinatal mortality surveillance – full participation
National Adult Diabetes Audit	Yes	National Diabetes Foot care Audit data collection – 100% National Core Diabetes Audit National Adult Diabetes Audit – 100% National Pregnancy in Diabetes Audit data collection – 100% National Diabetes Inpatient Safety Audit (NDISA) - began participating January 2024 (approval to participate received October 2023). Now submitting all data.
National Respiratory Audit Programme (previously National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme)	Yes	Adult Asthma Secondary Care – BHH yes, QEH yes, GHH did not participate. Children and Young People's Asthma Secondary Care - participating Chronic Obstructive Pulmonary Disease Secondary Care - 100% Pulmonary Rehabilitation (not applicable to QEH) – participating
National Audit of Cardiac Rehabilitation	Yes	QEH collecting data but unable to submit data to website due to ongoing IT compatibility problems. 100% HGS sites.
National Audit End of Life Care	Yes - pilot	N/A. Was paused for 2023 due to audit redesign. UHB participated in national pilot during 2023.
National Audit of Dementia	Yes	May 2023 BHH an outlier for data submission, alarm status. Different sites across the Trust uploaded data differently leading to conflicting audit metric outcomes. Improvement plan in place – all data has been inputted within the NAD timeframe. Next audit results available July 2024.
National Bariatric Surgery Registry	Yes	100% submitted
National Cancer Audit Collaborating Centre	Yes	National Audit of Metastatic Breast Cancer – participating National Audit of Primary Breast Cancer - participating
National Cardiac Arrest Audit	Yes	100% submitted

National Audit UHB eligible to participate in	UHB participation 2023/24	Participation
National Cardiac Audit Programme	Yes	National Audit of Cardiac Rhythm Management (Not BHH as no access; aiming for year 24-25) Data collection 100% Myocardial Ischaemia National Audit Project)– 100% National Adult Cardiac Surgery Audit - participating National Audit of Mitral Valve Leaflet Repairs (QEH only). New for 2023. National Audit of Percutaneous Coronary Intervention – 100% National Heart Failure Audit – participating National Congenital Heart Disease (QEH only) Data collection 100% UK Transcatheter Aortic Valve Implantation (QEH only) - participating
National Child Mortality Database	Yes	100% submitted
National Comparative Audit of Blood Transfusion	Yes	New for 2023: Audit against NICE Quality Standard QS138 - participating 2023 Bedside Transfusion Audit - participating
National Early Inflammatory Arthritis Audit	Yes	No results yet. Current cycle data entry until 15 April 2024.
National Emergency Laparotomy Audit (NELA)	Yes	QEH – 100% BHH – 100% GHH – 97.8%
National Gastro-Intestinal Cancer Audit Programme	Yes	National Oesophago-Gastric Cancer Audit (NOGCA) case ascertainment 2020-2022 75-84% National Bowel Cancer Audit (NBOCA) – Case ascertainment 2021-2022 "Fair" 50-80%
National Joint Registry	Yes	100% submission
National Lung Cancer Audit	Yes	100% submission, some issues being addressed related to completeness of data (data quality).
National Maternity and Perinatal Audit	Yes	Participating
National Neonatal Audit Programme	Yes	100%
National Obesity Audit	No	IT data submissions which have since been resolved.
National Ophthalmology Database Audit (NOD)	Yes	National Cataract Surgery Audit – 100%

National Audit UHB eligible to participate in	UHB participation 2023/24	Participation
National Paediatric Diabetes Audit	Yes	Participating – plans in place to improve data collection.
National Perinatal Mortality Review Tool	Yes	100%
National Prostate Cancer Audit	Yes	Participating
National Vascular Registry	Yes	Participating
Perioperative Quality Improvement Programme	No	Participation did not go ahead in 2023 as it was non-mandatory and due lack of funding to participate
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit	Yes	GHH – 0% (planned non-participation) Other sites - 100%
Trauma Audit and Research Network	Yes	Participating
UK Cystic Fibrosis Registry	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	90-100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	

National Confidential Enquiries (NCEPOD)

Percentages given are the latest available figures.

National Confidential Enquiry (NCEPOD)	UHB participation 2023/2024	Participation
Community Acquired Pneumonia	Yes	Case notes 100% (submitted) Clinician questionnaire 95% (18/19) Organisational questionnaire 100% (submitted)
End of Life Care	Yes	Case notes 100% (submitted) Clinician questionnaire 30% (6/20) (organisational questionnaire not yet received)
Juvenile Idiopathic Arthritis	Yes	Case notes 100% (submitted) Clinician questionnaires study closed by NCEPOD as no patients relevant. Organisational questionnaire ongoing. N.B. UHB had advised NCEPOD that audit not relevant/UHB not able to provide required data as does not provide service per se.
ICU Rehabilitation	Yes	Data collection stage only at end of 2023-2024 - submitted to NCEPOD.

Percentages are given wherever available and relevant.

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 1279 clinical audits were registered with UHB's clinical audit team during 2023/24. Of these audits, 604 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 total number of UHB patients recruited into open studies at the Trust during 2023/24 was:

NIHR Portfolio Recruitment	7188	Commercial 375 Non-commercial 6813
Non-NIHR Portfolio Recruitment	1442	Commercial 10 Non-commercial 1358 Other 74
Total Patient Recruitment	**8630**	**Commercial 385 Non-commercial 8171 Other 74**

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

A proportion of UHB income in 2023/24 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 2023/24 are available electronically at http://www.uhb.nhs.uk/about/reports/quality/quality-reports.htm.

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

The amount of UHB income in 2023/24 which was conditional upon achieving quality improvement and innovation goals was £22.2m.

The total CQUIN value is £22.2m, broken down as follows:

- BSOL ICB - £13.0m
- Other ICB - £2.2m
- NHSE - £7.0m

CQUIN is being removed as a contractual requirement in 2024/25.

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 two conditions on the registration.

The Care Quality Commission has taken the following enforcement action against UHB during 2023/24:

Section 29a Warning Notice issued for the Urgent and Emergency Care service at the Queen Elizabeth Hospital (regulated activity: treatment of disease, disorder or injury) – April 2023.

A Warning Notice was issued following a CQC inspection due to concerns around the storage of oral medication and gaps in daily resuscitation trolley checks.

A response along with relevant evidence was submitted to the CQC on 16 and 31 May 2023 showing improvements in the areas that were highlighted as concerns.

Two conditions were formally imposed on the Trusts CQC registration on 10 July 2023 the for the regulated activity of Treatment of disease, disorder or injury:

- Condition 1: the provider must implement an effective system to ensure service users are safeguarded from the risk of abuse and improper treatment. This condition is in relation to UHBs 3 Emergency Departments.
- Condition 2: the registered provider must devise and implement an effective system to ensure that there are sufficient numbers of suitably qualified, skilled and experienced NMC (Nursing and Midwifery Council) and HCPC (Health and Care Professions Council) registered and non registered staff throughout the medical wards at Good Hope Hospital to support the safe care and treatment of patients.

In line with the requirements set out to meet the conditions outlined above, the Trust is required to submit assurance reports to the CQC each month until further notice.

Section 29a Warning Notice issued for all regulated activities at all UHB hospital sites following a Well-Led inspection of the Trust in October 2023.

A Warning Notice was issued due to concerns around board assurance and the culture of the Trust.

The Trust are required to:

1. make significant improvements to board assurance, accountability for actions and measurable improvements regarding the quality of healthcare by 30 June 2024
2. make significant improvements to culture, staff safety and wellbeing by 31 December 2024.

Birmingham and Solihull Integrated Care Board commissioned two reviews in 2023/24:

- 5th - 6th October 2023 - BSOL commissioned the Royal College of Physicians to undertake an external review of 7 never events highlighted within Prof. Mike Bewick' Patient Safety review.
- 22nd - 23rd February 2024 - BSOL commissioned Royal College of Physicians to undertake an external review of 13 cases that were highlighted within Prof. Mike Bewick Patient Safety review.

CQC Inspection Ratings Grids

Four CQC inspections took place across services at University Hospitals Birmingham during 2023/24. These inspections covered a variety of core services and across all hospital sites.

Final reports have been published for three of the inspections.

Year	Type of CQC Inspection	Site	Outcome
2023	Unannounced Inspection of Emergency Departments, QEH Cancer Services, QEH Neurosurgery, Medicine GHH (re-visit), Maternity Services (re-visit)	QEH, BHH & GHH	See grids below
2023	Unannounced Inspection of Critical Care Services	QEH	See grids below
2023	Announced Well-Led Inspection of the Trust	UHB	See grids below
2024	Unannounced Inspection of Medicine and Surgery	BHH	TBC

Overall Trust Rating (updated February 2024)

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

Ratings for Core Services by Site, for inspections during 2023/24

Queen Elizabeth Hospital (QEH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical Care	Requires Improvement (Feb 2024)	Outstanding (Feb 2024)	Outstanding (May 2015)	Good (May 2015)	Requires Improvement (Feb 2024)	Requires Improvement (Feb 2024)
Urgent and Emergency Services	Inadequate (Feb 2024)	Requires Improvement (Feb 2024)	Good (Feb 2024)	Requires Improvement (Feb 2024)	Requires Improvement (Feb 2024)	Requires Improvement (Feb 2024)
Cancer Services	Requires Improvement (Feb 2024)	Good (Oct 2021)	Good (Oct 2021)	Requires Improvement (Oct 2021)	Requires Improvement (Feb 2024)	Requires Improvement (Feb 2024)
Neurosurgery	Requires Improvement (Feb 2024)	Requires Improvement (Feb 2024)	Good (Feb 2024)	Requires Improvement (Feb 2024)	Inadequate (Feb 2024)	Requires Improvement (Feb 2024)
Overall	Requires Improvement (Feb 2024)	Good (Feb 2024)	Good (Feb 2024)	Requires Improvement (Feb 2024)	Requires Improvement (Feb 2024)	Requires Improvement (Feb 2024)

Birmingham Heartlands Hospital (BHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Inadequate (Feb 2024)	Good (Feb 2019)	Good (Feb 2024)	Good (Feb 2019)	Inadequate (Feb 2024)	Inadequate (Feb 2024)
Urgent and Emergency Services	Inadequate (Feb 2024)	Requires improvement (Feb 2024)	Good (Feb 2024)	Requires improvement (Feb 2024)	Requires improvement (Feb 2024)	Requires improvement (Feb 2024)
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 (Feb 2024)	Requires Improvement (April 2023)	Good (Feb 2024)	Requires Improvement (April 2023)	Inadequate (Feb 2024)	Inadequate (Feb 2024)
Maternity	Requires Improvement (June 2023)	Good (Feb 2019)	Good (Feb 2019)	Good (Feb 2019)	Inadequate (June 2023)	Requires Improvement (June 2023)
Urgent and Emergency Services	Inadequate (Feb 2024)	Requires improvement (Feb 2024)	Requires improvement (Feb 2024)	Requires improvement (Feb 2024)	Inadequate (Feb 2024)	Inadequate (Feb 2024)
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

2.2.6 Information on the quality of data

Secondary Uses Service data

UHB submitted records during 2023/24 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:

- 99.7% for admitted patient care (April 2023 – March 2024)
- 99.8% for outpatient care (April 2023 – March 2024)
- 98.8% for accident and emergency care (April 2023 – March 2024)

Which included the patient's **valid General Medical Practice Code** was:

- 100% for admitted patient care (April 2023 – March 2024)
- 99.8% for outpatient care (April 2023 – March 2024)
- 100% for accident and emergency care (April 2023 – March 2024)

Percentages are as at currently available National data.

Data Security & Protection Toolkit (formerly Information Governance Assessment Report)

The Trust is compliant with the majority of assertions and submitted its self-assessment on DSPT v5 on 30 June 2023. The Trust had been working to an improvement plan, where it has successfully completed four outstanding assertions, with three assertions expected to be closed before the next submission in June 2024; leading to the overall status of '22/23 Approaching Standards'.

Payment by Results clinical coding audit

UHB was not subject to the Payment by Results clinical coding audit during 2023/24 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 (TOR) for this group and the Chair is the Head of Health Informatics. The group meets monthly, and reports 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. Currently work is in progress to identify ways of getting DQ risks recorded on the Trust's risk register (currently held in Datix). 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. Datix is due to be replaced by RADAR. Once RADAR is implemented, plans will be developed to enable Trust's DQ issues to be recorded on the central organisational incident reporting system. This will provide a mechanism for users across the Trust to flag issues centrally.

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

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

   During 2023/24, Health Informatics have created PowerBI reports to enable a drill down into the DQMI indicators. These are reviewed by the Health Informatics compliance team and can be made available to users throughout the Trust as required:

   (1) Community Data Quality Report
   (2) Potential Lost to Follow-Up Report
   (3) Waiting List Data Quality Markers
   (4) RTT Data Quality Metrics
   (5) Inpatient Waiting List Data Quality Metrics

   Each report has a drill down facility to enable users to identify any areas of concern.

3. Quality monitoring checks are in place for inpatient records and ward clerk team leaders across the QE and Solihull sites. 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 out these checks 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. During 2023/24 the number of quality monitoring checks carried out were at a reduced level compared to previous years and in some months, it was not possible to carry out these checks. This was due to the reduced staffing levels within the ward clerk teams and operational demands have meant that the priority has been to ensure ward clerk roles have been covered wherever possible.

4. The Clinical Coding team carry out the DSPT (Data Security and Protection Toolkit) audit that is required annually. This is an audit of 200 FCEs (Finished Consultant Episodes) and is carried out by the Trust's internal clinical coding auditor. The 2023/24 DSPT audit is currently being written up (April 2024) and the results will be reported back to the Trust's DQIG and IGG as required.

5. A programme of continuous improvement audits on Clinical Coding is in place, and monthly audits take place. These audits are at individual coder level and by specialty / diagnosis / procedure as required.

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)

10. In high traffic medical areas such as MAU, spot check audits have been set up to ensure that paperwork relating to patients is scanned on to PICS.

11. The DQIG have also escalated to the IT department that the reinstatement of face-to-face training on the Trusts PAS system would be beneficial. This is being explored.

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 managed via the Trust's Patient Safety Incident Response Plan (PSIRP). The outcomes of reviews are reported to each of the four main Site Quality and Safety meetings for oversight. Assurance of the process is via the Trust's GCQM and the Clinical Quality and Patient Safety Committee of Trust Board.

1.	During 2023/24 5492 UHB inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: ▸ 1348 in the first quarter; ▸ 1290 in the second quarter; ▸ 1479 in the third quarter; ▸ 1375 in the fourth quarter.
2.	Up to 30th April 2024, 4538 case record reviews and 38 investigations have been carried out in relation to 5492 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: ▸ 1134 in the first quarter; ▸ 1039 in the second quarter; ▸ 1099 in the third quarter; ▸ 1266 in the fourth quarter.
3.	Twenty three deaths, representing 0.5% 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 0.7% for the first quarter; ▸ 3 representing 0.3% for the second quarter; ▸ 12 representing 1.1% for the third quarter; ▸ 3 representing 0.2% 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 incident investigation 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 of risks quoted for several surgical procedures, and establishment of high-risk clinics to support consenting process ▸ Extensive review of the processes for managing patient allergies in theatre and the labelling of chlorhexidine containing devices ▸ Enhancements to the echocardiogram reporting process ▸ Improved communication between medical teams and radiology team regarding urgent inpatient CT scans, and associated processes, including vetting of requests ▸ Clarify the system of responsibility for surgical patients transferred to critical care on another site ▸ Update the PUSH process to improve communication between the ED, medical navigator and ward ▸ 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 2024 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 2022/23 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 2023/24

The tables below show the Trust's latest performance for 2023/24 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience.

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	2021/22	2022/23	2023/24	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)	**0.93**	**0.55**	**0.75**	**0.68** 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)	**0.97**	**0.57**	**0.78**	**0.72** 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)	**20.21**	**22.92**	**23.63**	**20.03** Acute trusts in West Midlands

Indicator	Data source	2021/22	2022/23	2023/24	Peer Group Average (where available)
Patient Safety Indicators					
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)	**21.06**	**23.90**	**24.57**	**21.32** Acute trusts in West Midlands
3a. Patient safety incidents Reporting rate per 1000 bed days › Higher rate indicates better reporting	› Datix (incident data), › Bed days data	**72.1**	**59.0**	**65.2** (Apr-23 to Mar-24)	**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 › Figures for 2023/24 are based on nationally published data (as at time of writing)	› Datix › (incident data)	**4**	**10**	**12** (Apr-23 to Mar-24)	Not available
4a. Percentage of patient safety incidents which are no harm incidents › Higher % indicates better performance	› Datix › (incident data)	**78.95%**	**74.70%**	**79.79%** (Apr-23 to Mar-24)	**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)	**0.41%**	**0.34%**	**0.36%** (Apr-23 to Mar-24)	**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)	**49,198**	**53,717**	**48,989** (Apr-23 to Feb-24)	**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	**15.12%**	**14.32%**	**14.75%**	**13.69%** Apr-22 to Jan-23 Acute trusts in West Midlands
5b. Emergency readmissions within 28 days (%) All specialties › Lower % indicates better performanc	› HED data	**14.72%**	**14.22%**	**14.61%** (Apr-23 – Dec-23)	**13.42%** Apr-23 to Dec-23 Acute trusts in West Midlands

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.

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:
- These indicators decreased in 2022/23 compared to previous years. This was 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. Following the implementation of the Learning from Patient Safety Events (LfPSE) process in 2023/24 and a review of the Local Risk Management Software, there are no plans for automated incidents to be reinstated.

3a, 4a, 4b, 4c:
- NRLS data (peer group data) is no longer being published by NHS England. Their website states "we have paused the annual publishing of this data while we consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS". Therefore the data provided is the latest available.

3b:
- This is based on incident date between 01 April 2023 and 31 March 2024 and reported to STEIS as per the published NHS Never Events data.

UHB reported twelve Never Events during 2023/24 in the following categories:
- Retained foreign object post procedure (1)
- Misplaced naso- or oro-gastric tubes (1)
- Overdose of insulin due to abbreviations or incorrect device (1)
- Transfusion or transplantation of ABO-incompatible blood components or organs (2)
- Wrong site surgery (7)

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 readers are advised to take care if comparing recent results to those from 2019.

Time period	2020		2021		2022	
Data source	Trust's Survey of Adult Inpatients 2020 Report, CQC		Trust's Survey of Adult Inpatients 2021 Report, CQC		Trust's Survey of Adult Inpatients 2022 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	9.1	About the same	8.8	About the same	9.1	About the same
Involvement in decisions about care and treatment	7.1	About the same	6.7	About the same	6.8	About the same
Did staff do all they could to control pain	8.8	About the same	8.3	Worse than expected	8.6	About the same
Cleanliness of room or ward	9.1	About the same	8.7	About the same	8.8	About the same
Overall rating of care	8.1	About the same	7.7	Somewhat worse than expected	7.8	About the same
Response rate	38% (450 respondents) National: 46%		34% (399 respondents) National: 39%		35% (422 respondents) National: 40%	

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

Indicator	Target	Performance		
		2021/22	2022/23	2023/24
A&E: maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	57.0%	52.0%	54.6% (Apr-23 to Mar-24)
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	42.8%	41.2%	47.5% (Apr-23 to Mar-24)
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	40.9%	37.1%	40.3% (Apr-23 to Mar-24)
All cancers – maximum 62-day wait for first treatment from NHS cancer screening service referral	90%	59.2%	54.1%	50.9% (Apr-23 to Mar-24)
Maximum 6-week wait for diagnostic procedures	99%	63.0%	52.9%	62.0% (Apr-23 to Mar-24)

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 Integrated Quality Report to the Group Clinical Quality Meeting. 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	95.15 - within tolerance	2023/24 (Apr-23 – Dec-23)
SHMI, from NHS Digital website	94.70 - within tolerance	2023/24 (Apr-23 – Oct-23)

SHMI: Summary Hospital-level Mortality Indicator

The SHMI 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 . 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

NHS England / Improvement have decommissioned the HSMR, so UHB no longer includes it in the Quality Account.

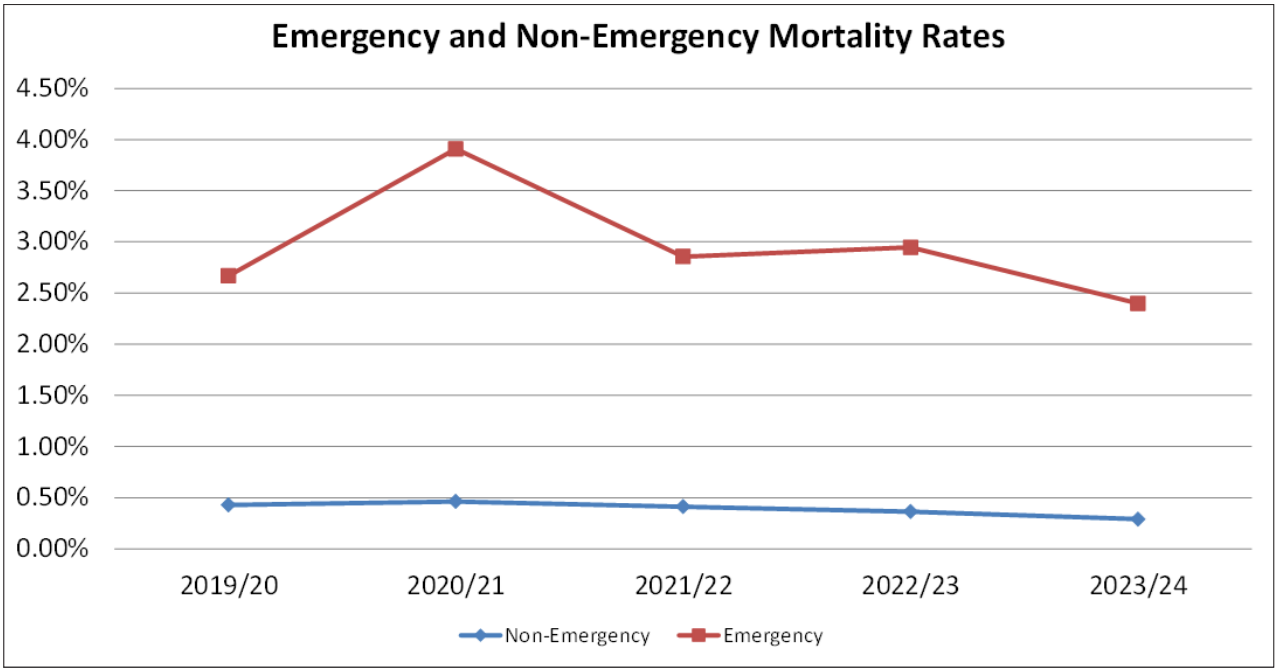
[1] Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Sun P, Pagano, D. Can we update the Summary Hospital Mortality Index (SHMI) to make a useful measure of the quality of hospital care? An observational study. BMJ Open. 31 January 2013.

Crude Mortality

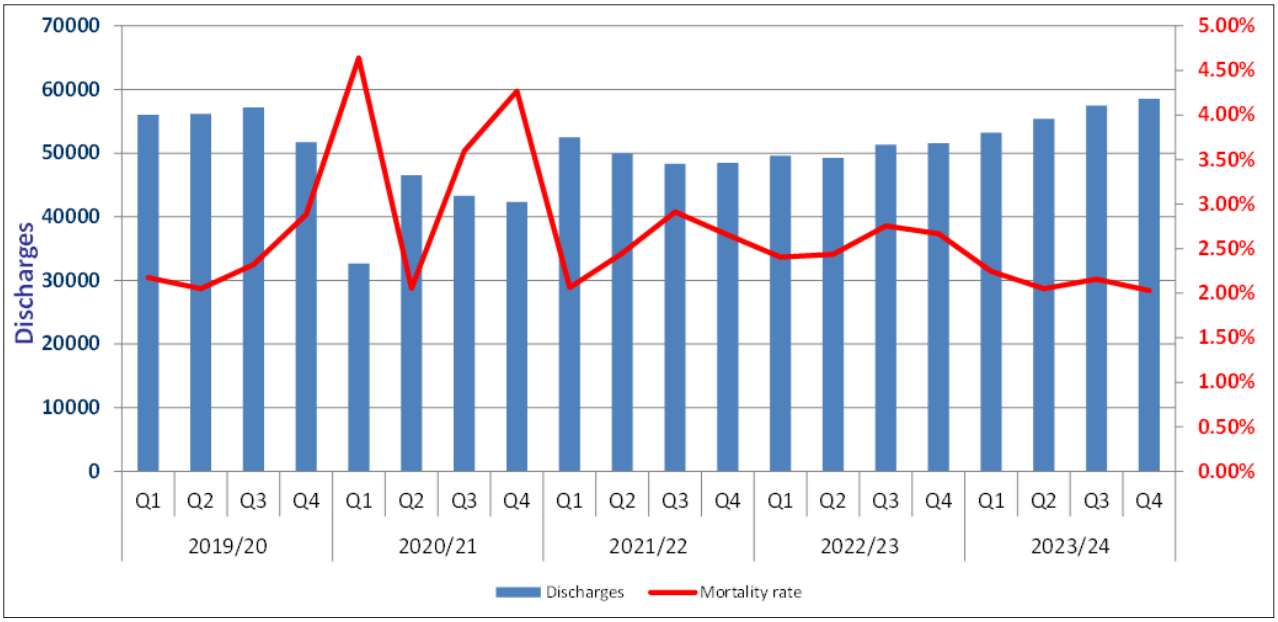
The first graph below shows crude mortality rates for emergency and non-emergency (planned) patients. The second graph shows the overall crude mortality rate against activity (patient discharges) by quarter. The crude mortality rate is calculated by dividing the total number of deaths by the total number 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 2023/24 is 2.40%, which has decreased when compared to 2022/23 (2.95%) and 2021/22 (2.86%).

Emergency and Non-emergency Mortality Graph



Emergency Crude Mortality Graph



3.4 Statement regarding junior doctor rota

Guardian of Safe Working (GSW): Quarter 2 Report (2023/24)

Date period 01/11/23 - 31/01/24

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 Doctors in Training (DiT) 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 Doctor in Training (DiT) exception reports in period

DiT Exception Reports (ERs) for Q2 period:

TABLE 1: Exception Reports Q2 combined (2023-2024)

	BHH	GHH	SOL	QEHB	Total:
Hours	13	0	0	6	19
Education	2	0	0	0	2
Pattern of work	0	0	0	1	1
Service Support	1	0	0	1	2
Total ERs for period	**16**	**0**	**0**	**8**	**24**

Immediate Safety Concerns (ISCs)

BHH	GHH	SOL	QEHB	TOTAL
2	0	0	1	3

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

GSW Penalty Fines

When an 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 DiT 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 were 2 concluded occurrences of GSW divisional penalty fines as follows:

Rota code	Spec	Level	Breach	Penalty to Div £
BHH-015 Gen Surg F1 20 Doc v12	Vascular	FY1	Yes	16.32
BHH-016 Gen Surgery FY2/ CT 23 Doc v29	Vascular	FY2	Yes	18.90

Areas of significant trend/concern in period

Rota code	Key Concerns and work schedule reviews
QEHB044 Neurosurgery ST3+ Tier 1 10 Doc v26	Recurrent exception reporting was triggered in Neurosurgery tier one StR rota following the GSW presentation at the Neurosurgery DiT Forum in September 2023. The firm structure requires the DiT to work in the operating theatre all morning and to do ward round in the afternoon within the shift. This has resulted in missed breaks and/or work over. The GSW has undertaken work schedule review with the Educational Lead and Clinical Service Lead (CSL) and have put an action plan in place: 1. Work hour monitoring exercise to be conducted for a period of 4 weeks. 2. DiT Forum to discuss alternative way of working including Ward Registrar of the week model to cover the wards, thus allowing other registrars to focus on operating or clinic experience.
BHH-015 Gen Surg F1 20 Doc v12	Recurrent exception reports have been noted from this rota. This has incurred a guardian penalty. Presently this is a rota in conjunction with Physician Associates and is part of a city wide service covering vascular surgery. A work schedule review is currently being undertaken

Rota Gaps / Vacancies

This information is held by Medical Workforce/Medical Resourcing.

Guardian exception reporting review group (GERRG)

A virtual 'Teams' meeting took place on 6th February to cover the reports generated in Q2.

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

The trend of low level of Exception Reporting continues in this quarter. It is believed to be a consequence of significantly improved staffing and low rota gaps. The proactive oversight and intervention by the Chief Medical officer via the Medical Academy Steering Group also ensure issues are solved or mitigated in a timely manner. The low rota gaps are a result of significant uplift in DiT staffing.

Name of Rota	Number of funded posts August 2022	Number of funded posts August 2023	Increase
BHH GIM	120	150	+30
GHH GIM	80	105	+25
QE GIM – 3rd Floor	36	45	+9
QE GIM – 5th Floor	96	120	+24
QE Oncology Haematology	14	30	+16

The GSW team continues to increase its effort at promoting Exception Reporting by attendance at DiT fora, bimonthly email newsletter communication, quarterly meeting with DiT and Local Negotiating Committee (LNC) representatives, and consultant induction. A new DiT Health and Well-being Group led by the Chief registrars has been tasked with undertaking a Quality Improvement project to improve awareness and use of Exception reporting.

Dr Jason Goh
Guardian of Safe Working

Dr David Sandler
Deputy Guardian of Safe Working

February 2024

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

The Trust has shared its 2023/24 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)

Birmingham and Solihull Integrated Care Board (ICB) as coordinating commissioner for University Hospitals Birmingham NHS Foundation Trust, welcomes the opportunity to provide this statement for inclusion in the Trusts 2023/24 Quality Account.

A draft copy of the Quality Account was received by the ICB on Wednesday 08 May 2024 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 provided to date.

The information provided within this account presents a balanced report of the healthcare services that University Hospitals Birmingham NHS Foundation Trust provides. The report demonstrates the progress made by the Trust against the 2023/24 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2024/25.

We have worked closely with University Hospitals Birmingham NHS Foundation Trust over the course of 2023/24, working collaboratively to review the organisations' progress in implementing its quality improvement initiatives. We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2024/25.

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

The Birmingham Health Adult and Social Care O&S Committee (HASC) recognises the challenges faced by the Trust over the past 12 months despite continuing operational pressures and demands. The Committee recognise the Trust's stated commitment over the next 12 months to ensure improvements and restore confidence and trust in leadership, organisational culture and patient safety.

The Committee notes that the Freedom to Speak Up priority project will not continue into 2024/25. Given that there has been an increase in number of concerns raised by staff on issues such as bullying/harassment, racism and Employment/HR related issues in year 23/24, the committee feels it would be important not to lose focus on how staff can feel confident that these issues will be dealt with when reported. So, it was reassuring to note that the Freedom to Speak Up initiative will continue to be a vital piece of work in the Trust in the coming year.

Birmingham Health and Adult Social Care (HASC) Overview & Scrutiny Committee as well as the Birmingham & Solihull (B/Sol) Joint Health Overview & Scrutiny Committee (JHOSC) look forward to working with the Trust on the scrutiny of its work on the six quality improvements, ensuring there is continuing progress on these. The latest CQC rating on Maternity Services (Heartlands Hospital Feb. 2024; 'Inadequate') is a major concern for the Committee. The HASC and the B/Sol JHOSC will work with UHB in ensuring appropriate monitoring of performance mechanisms across the Trust are properly scrutinised for improvement.

The Committee was concerned about the Section 29a warning notices issued by the Care Quality Commission for all regulated activities at all UHB hospital sites following a Well-Led inspection of the Trust in October 2023. The HASC and the JHOSC Committees look forward to seeing significant progress been made on planned improvements on culture and assurance.

Statement provided by Solihull Health and Adult Social Care Scrutiny Board

The Health and Adult Social Care Scrutiny Board is grateful for the opportunity to comment on the University Hospitals Birmingham (UHB) NHS Foundation Trust Quality Account for 2023/4.

The Scrutiny Board appreciates, as set out in the Chief Executives Statement, that 2023/24 has been a challenging year for UHB, due to the ongoing operational performance pressures, as well as serious concerns raised through the media and other stakeholders regarding patient safety, leadership and culture.

The Scrutiny Board notes the three independent reviews into patient safety, culture and leadership and recognises that the implementation of the recommendations arising from these reviews are being reported to the Joint Health Overview and Scrutiny Committee (JHOSC).

Building works

The Scrutiny Board welcomes the building work taking place across the UHB sites. Members are especially pleased that, after securing £45m to construct an Elective Hub at Solihull Hospital, the biggest investment in the hospital for decades, work is underway to build the new facility which will provide six new theatres in a two-storey state-of-the-art building at the hospital.

Priorities for Improvement

Members note, with concern, that UHB has chosen to discontinue the Freedom to Speak Up priority for 24/25. It is recognised the Quality Account states this priority remains a vital workstream at UHB and will be governed elsewhere by mechanisms other than the Quality Account; however, the Scrutiny Board queries this decision in light of the findings outlined in the report.

The Scrutiny Board understands the NHS Staff Survey includes the results for the following two statements:

- I feel safe to speak up about anything that concerns me in this organisation.
- If I spoke up about something that concerned me, I am confident my organisation would address my concern.

The Scrutiny Board has taken into account how the proportion of responding staff at UHB who agree with these propositions has declined over the last year, despite there being an improvement in the mean for the NHS as a whole. Also, that the responses have fallen over the last few years, from 2020. Members note it is particularly concerning that UHB is now recording the worst result nationally for the first statement.

The Quality Account states that 'given the complexity of the speaking up pathway, improvements are required in responsiveness once concerns have been escalated, and in protecting contacts from detriment.' The Scrutiny Board emphasises it is vital the FTSU service has sufficient capacity, so that staff can raise their concerns and are confident any issues identified will be addressed.

Members recognise the Trust has just completed a stakeholder review of the FTSU service and the results will be presented in April. It is requested for the results to be shared with Members at the earliest opportunity, reported to the JHOSC, alongside the reporting on the delivery of the recommendations arising from the three independent reviews into patient safety, culture and leadership.

The Scrutiny Board has also taken into account the significant increase in the number of contacts with the FTSU services, from 2022 onwards. It is recognised that Quality Account states this is attributable in part to promotional efforts in October that year, but also to the BBC Newsnight programme broadcasts about UHB in December 2022. Members appreciates this is a substantial increase in workload for the team and demonstrates a substantial prior un-met need revealed by the publicity. The Scrutiny Board reiterates the point raised above, that it is vital the FTSU service has sufficient capacity, to ensure need is met across the NHS Trust.

The Scrutiny Board notes, with particular concern, that in terms of the typology of issues, allegations or concerns raised, there has been a notable increase relating to bullying and harassment, as well as racism from 2022. Members believe this demonstrates it is critical for the recommendations arising from the three independent reviews into patient safety, culture and leadership to be delivered effectively. Also, the Scrutiny Board agrees it is essential for the Trust to ensure a zero-tolerance approach to any form of racism, ensuring all staff are treated with respect.

The Scrutiny Board has taken into consideration that, as part of Priority 2 – Improving VTE prevention - In May 2023, UHB was revalidated as a VTE Exemplar centre and received a commendation for Excellence in VTE Prevention Practice and Leadership. Members wish to put on record their thanks to all the staff concerned, for their hard work in achieving this.

Care Quality Commission (CQC) Enforcement Action

The Scrutiny Board notes, with significant concern, the enforcement action the Care Quality Commission (CQC) has taken against UHB during 2023-24. This included a Section 29a Warning Notice issued for all regulated activities at all UHB hospital sites following a Well-Led inspection of the Trust in October 2023. Also, a Warning Notice was issued due to concerns around board assurance and the culture of the Trust.

The Quality Account outlines how the Trust are required to:

- Make significant improvements to board assurance, accountability for actions and measurable improvements regarding the quality of healthcare by 30 June 2024.
- Make significant improvements to culture, staff safety and wellbeing by 31 December 2024.

Members agree it is critical the improvement actions outlined above are reported to the JHOSC at the earliest opportunity, as part of the reporting on the implementation of the three independent reviews into patient safety, culture and leadership.

CQC Inspection Ratings Grids

The Scrutiny Board has taken into account the Trust's overall rating is requires improvement.

Members note, with particular concern, the following areas have received an overall rating of inadequate:

- Birmingham Heartlands Hospital – Maternity.
- Good Hope Hospital – Medical Care (including Older Peoples Care).
- Good Hope Hospital – Urgent and Emergency Services.

It is recognised that the delivery of improvement actions being taken forward/implemented following the CQC rating of the Maternity Service at Birmingham and Heartlands Hospital has previously been reported to the JHOSC and Members agree it is essential this forms part of the Committee's future work programme.

The Scrutiny Board also requests that the delivery of Medical Care and Urgent and Emergency Services at Good Hope Hospital also forms part of the JHOSCs future work programme, linked to the existing arrangements for performance reporting.

Conclusion

The Quality Account states the focus for 2024/25 must 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 and Members are supportive of this approach.

Joint Statement provided by Healthwatch Birmingham and Healthwatch Solihull

Healthwatch Birmingham and Solihull have advised that they are unable to respond this year.

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.

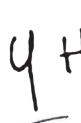
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- 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 2023 to June 2024
  - papers relating to Quality Account to the board over the period April 2023 to June 2024
  - feedback from the commissioners dated 14/05/2024
  - feedback from governors dated 02/05/2024
  - feedback from local Healthwatch organisations *Healthwatch have confirmed they will not be providing feedback*.
  - feedback from Overview and Scrutiny Committee dated 07/06/2024 (Solihull) and 14/05/2024 (Birmingham)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 17/05/24.
  - the 2023 national patient survey
  - the Head of Internal Audit's annual opinion of the trust's control environment dated (Date to be added once received)
  - CQC inspection reports dated 07/06/2023, 26/05/2023, 19/04/2023, 14/02/2023, and 07/03/2024.

- 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: 30 May 2024 Signed  Chair

Date: 30 May 2024 Signed  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 2023/24 Quality Accounts.