UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 23 APRIL 2020

Title:	**CARE QUALITY REPORT**
Responsible Director:	**Lisa Stalley-Green, Chief Nurse**
Contact:	**Hayley Flavell, Deputy Chief Nurse, 12416**

Purpose:	To present an update to the BOARD OF DIRECTORS
Confidentiality Level & Reason:	NoneBoard
Board Assurance Framework Ref: / Strategy Implementation Plan Ref:	BAF - SR1/19 - Prolonged and/or substantial failure to deliver standards of nursing care SIP - #3 Provide the highest quality of care to patients through a comprehensive quality improvement programme
Key Issues Summary:	• 3 Trust apportioned MRSA bacteraemia • 2,418 cases of COVID-19, 489 deaths and 1,085 patients have been discharged from UHB. • Decrease in number of falls, but an increase in falls rate per 1000 bed days to 5.75. • Complaints response rate increased in month to 84.2% • Further work in Maternity is required to meet the aim of the national ambition. A suite of initiatives are in place to work towards achieving this, however organisational support is required.
Recommendations:	The BOARD OF DIRECTORS is asked to receive and discuss the content of the report.

Signed: Lisa Stalley-Green	**Date:** 14 APRIL 2020

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 23 APRIL 2020

CARE QUALITY REPORT

PRESENTED BY CHIEF NURSE

1. Introduction and Executive Summary

To provide the Board of Directors with a report regarding Infection Control, Tissue Viability, Falls, and Patient Experience. This report has been discussed at the April 2020 Care Quality Group and includes February and March 2020 data.

2. Patient Safety Update

2.1 Infection Control

Over the past few months the Trust has focused on the worldwide coronavirus pandemic. Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses.
On 31st December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

On 12 January 2020 it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

As of 13 April 2020, more than 1.80 million cases have been diagnosed globally, with over 113,000 fatalities. In the 15 days to 13 April, over 1.09 million cases were reported.

In the UK as of the 13th April there have been 88,621 cases with 11,329 deaths reported. At UHB there have been 2,418 cases with 489 deaths. Currently there are 664 inpatients with 157 patients across our critical care units. To date there have been 1,085 patients who have been discharged.
The Trust has daily strategic and operational meetings to manage the coronavirus pandemic.

The Trust has adapted to the pandemic with novel ways of working and repurposing of staff groups and so far has coped well with the challenges faced. There are multiple initiatives the Trust has undertaken in response to coronavirus from increased laboratory testing, staff screening, multi-disciplinary COVID outreach teams, specialist expert groups, dedicated Trust micro-site, robust informatics dashboard, automated processes for alerting of results on PICS and the NEC Nightingale project ensuring appropriate IPC procedures are in place.

There were three MRSA bacteraemia identified during March at UHB. Two were community acquired, one presenting to the QEHB and the other at Heartlands. There was one hospital associated MRSA bacteraemia at QEHB, a repeat MRSA bacteraemia in a patient with severe dermatological problems. For the financial year 2019-20 UHB have had eleven Trust apportioned bacteraemia which is an increase to the previous year. The increase could be due to a large number of community associated MRSA bacteraemia being identified.

The annual objective for *Clostridioides difficile* infection (CDI) for 2019-20 at UHB is 250 Trust Apportioned cases. In March, UHB have had 13 Trust Apportioned cases. This was lower compared to February.

For the financial year 2019-20, UHB have had 256 Trust apportioned cases of *C. difficile*. Antimicrobial stewardship remains the biggest challenge in *C. difficile* prevention. The Trust wide Antimicrobial Stewardship Group is developing its strategic intentions to deliver effective antimicrobial stewardship across UHB.

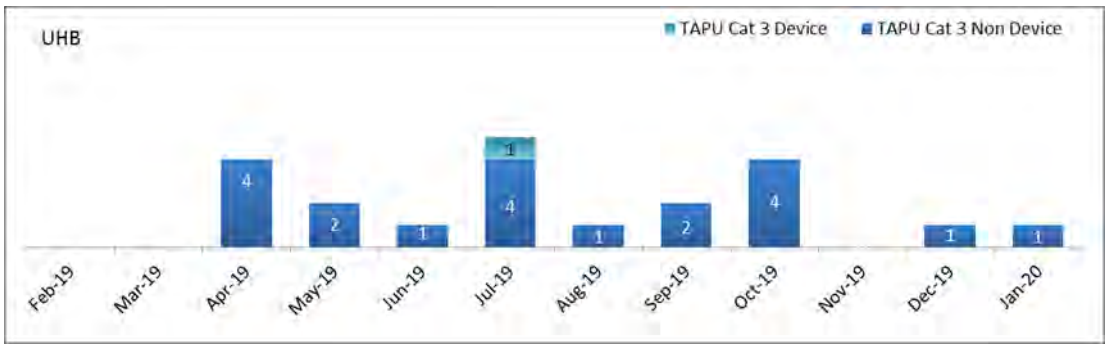
2.2 Tissue Viability

2.2.1 Trust Acquired Category 4 Pressure Ulcers

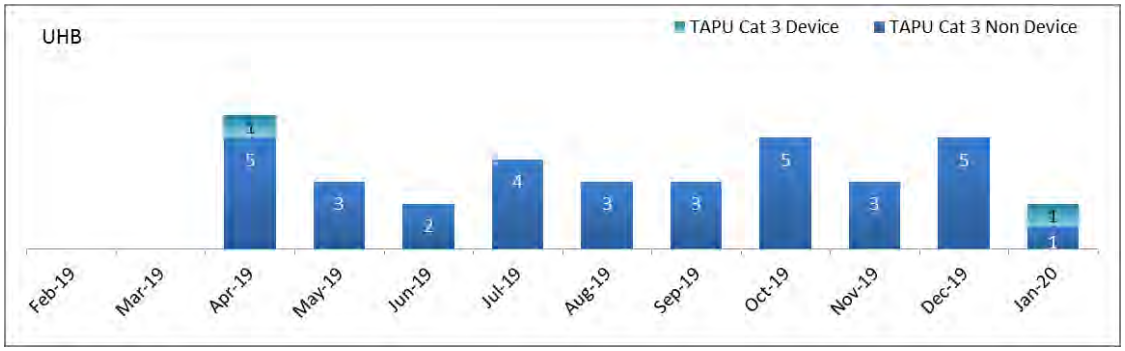
There was one Trust acquired category 4 pressure ulcer reported in January 2020 for a Community Services patient.

2.2.2 Trust Acquired Category 3 Pressure Ulcers

There were three Trust acquired category 3 pressure ulcers reported in January 2020, one on Ward 22 AMU 2 at Heartlands Hospital, and two for Solihull Community Services patients.



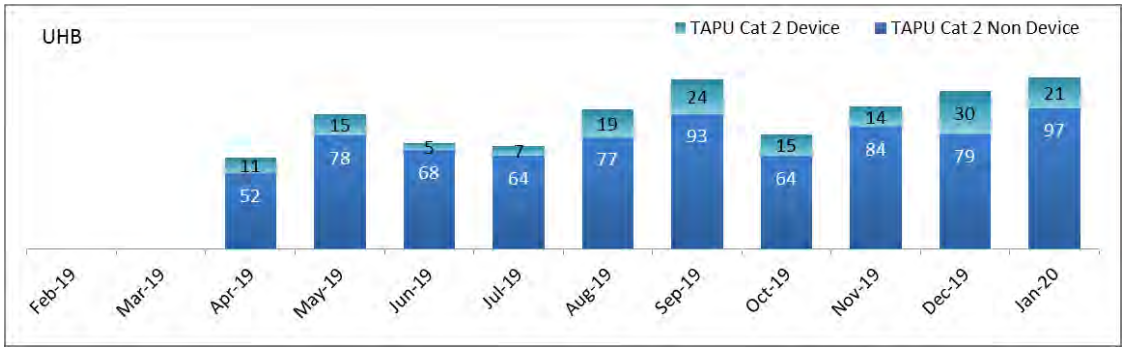
Number of Trust Acquired Category 3 Pressure Ulcers for acute hospital sites



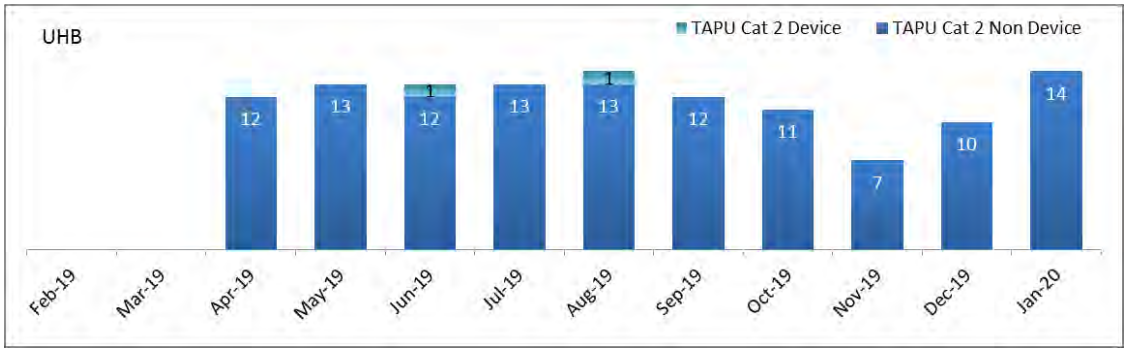
Number of Trust acquired category 3 pressure ulcers for Solihull Community Services

2.2.3 Trust Acquired Category 2 Pressure Ulcers

There have been 118 Trust acquired category 2 pressure ulcers reported in January 2020 across the four acute hospital sites (97 non-device and 21 device related), and 14 reported for Solihull Community Services patients (all non-device related).



Number of Trust acquired category 2 pressure ulcers for acute hospital sites



Number of Trust acquired category 2 pressure ulcers for Solihull Community Services

The top themes emerging from the RCAs are:

- Frequency of repositioning / documentation of repositioning;
- Missed / inaccurate skin inspections;
- Inaccurate risk assessment leading to preventative strategies not being implemented;
- Lack of timely intervention with pressure reducing/relieving equipment.

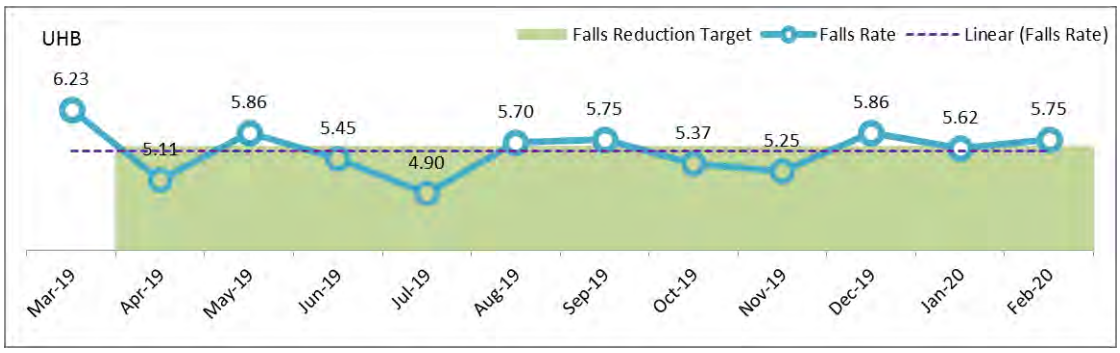
Actions:

- In response to COVID-19 in line with guidance from Public Health England and on advice from Infection Prevention and Control, staff are using personal protective equipment (PPE) to assist them in delivering safe and effective care for patients. There have been reported cases of staff developing pressure damage from wearing the FFP3 masks. In conjunction with NHSi, the Tissue Viability Nurses within the Shelford group of hospitals and the West Midlands Tissue Viability Association, a poster has been developed to provide advice and information for staff wearing this equipment.
- Patients who are in intensive care and who have severe breathing difficulties may need to be nursed in a prone position (on their fronts) to maximise the benefits of ventilation for up to 16 hours per day. When placing a patient into the prone position the risk of developing pressure ulcers to the front of the body, where risk is normally low, is significantly increased. To reduce the risk to the vulnerable areas the Tissue Viability Team are currently updating the information around pressure ulcer prevention in the guidelines for "Turning and Care of the Patient Being Ventilated in the Prone Position" and producing a poster as a quick reference guide.

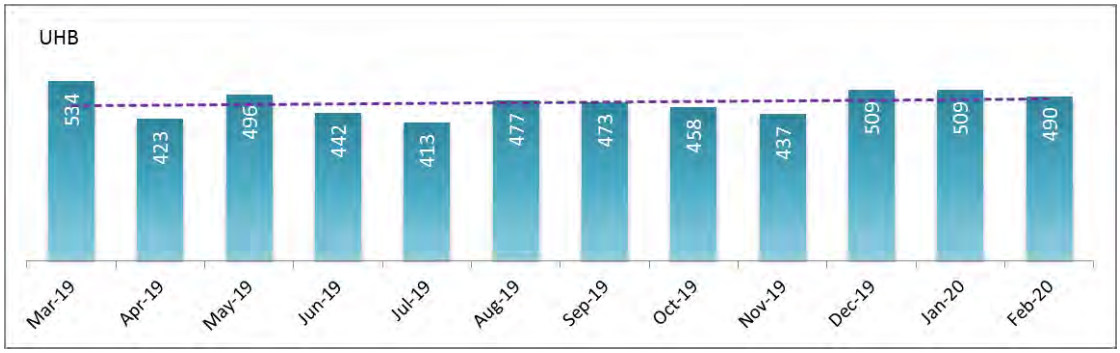
2.3 Inpatient Falls

The Trust inpatient falls rate increased in February 2020 to 5.75 falls per 1,000 occupied bed days. The Trust is achieving target of 5.65 year to date (5.51). The trend line for the previous 12 months shows that performance is static.

The number of inpatient falls decreased in February 2020 to 490 falls, however the falls rate shows an increase due to their being a reduction in occupied bed days as a result of the COVID-19 pandemic. The trend line for the previous 12 months shows that the number of inpatient falls is static.

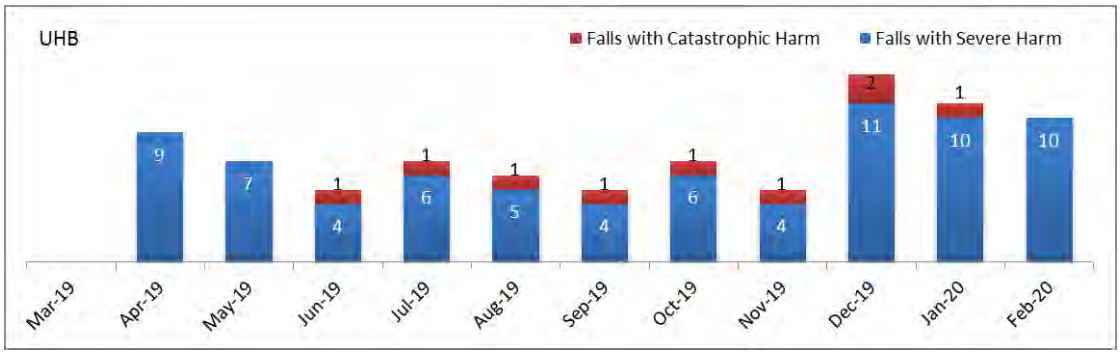


Inpatient falls rate per 1,000 occupied bed days



Number of inpatient falls

There were ten falls resulting in severe harm reported in February 2020, none of these were catastrophic (eight neck of femur fractures, and two subdural haematoma).



Number of falls resulting in severe and catastrophic harm

Key areas of focus have subsequently now changed in response to the Pandemic, including:

- Ongoing daily review of falls Datix to identify any falls resulting in harm;
- Completion of all falls RCA investigations on behalf of clinical teams;
- Working closely with Bereavement teams on all sites to identify and record true catastrophic falls, and separating these from COVID-19 related catastrophic 'collapses' to the floor.
- Additional non-falls related work to support clinical and corporate teams, such as recruitment of bank and substantive nursing staff, and providing pastoral support for student nurses entering paid band 4 roles.

3. Patient Experience

3.1 Complaints

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Complaints	156	173	155	145	148	137	184	155	132	143	162	105	**1795**
Follow ups	25	15	28	20	26	21	27	23	16	13	18	14	**246**
Trust Response rate %	74.5	61.6	55.4	71.6	87.4	84.8	73.8	74.6	82.8	84.2	*	*	

*not yet available

CCG response KPI	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
Commissioner-led	100%	0%*	n/a	100%	100%	100%	100%	100%	n/a	n/a
Non-commissioner	96.1%	80%	81.6%	95.8%	100%	99.3%	97.3%	100%	99.2%	100%

*relates to just one complaint

The Trust received a total of 105 new complaints in March compared to 162 in February, a reduction of 35%, reflecting the impact of the Covid-19 pandemic. For context, in March 2019, 158 complaints were received.

Division 3 continues to receive the most complaints, with the greatest number received for Emergency Medicine and Acute and Short Stay Medicine. The total number of complaints received in the full year 2019/20 is 1795, which represents a reduction of 155 cases compared to 2018/19 (1950). In March the main issues raised through complaints related to clinical treatment, communication, staff attitude and patient care. The total number of follow ups received in the year (246) also represents a welcome reduction of 24.3% compared to 2018/19.

There was sustained improvement in the Trust's complaints response performance for January 2020 to 84.2%, just below the 85% target. New KPIs for complaint responses were agreed at the Patient Experience Group in March 2020 to start in April 2020. A tiered approach, that brings the Trust more in line with Shelford and regional peers, permits a more realistic turnaround time for complex cases, while reducing the timeframe for simpler complaints. The target remains at 85% response rate, with 25 working days for simple complaints, 40 working days for regular complaints and 65 working days for complex complaints.

The CCG contractual response performance KPI of 90% of cases responded to within the timeline agreed with the complainant (in place since July 2019) continues to be exceeded.

During the Covid-19 pandemic the PHSO have suspended activity around complaints. From 26 March 2020 until further notice they will not accept new complaints nor progress existing ones where this would require contact with health services.

NHS England and NHS Improvement have also agreed a system-wide 'pause' of the NHS complaints process to support responsiveness to the pandemic. Trusts should still enable the public to raise concerns or make complaints, but to manage the expectation of an investigation and response in the near future. Trusts should continue to acknowledge, log and triage complaints and take any immediate action necessary. All complaints would then remain open until further notice unless an informal resolution could be achieved, or the complainant choses to withdraw their complaint.

PALS continue to provide support by email and telephone from a single call centre set up on the Heartlands site.

3.2 Compliments

Month/Site	BHH	GHH	SOL	QEHB	Total
Q1 2019-20	**87**	**43**	**71**	**348**	**549**
Q2 2019-20	**108**	**54**	**89**	**519**	**770**
Q3 2019-20	**82**	**43**	**91**	**426**	**642**
January 2020	21	26	11	160	**218**
February 2020	41	18	38*	158	**255**
March 2020	20	26	25	97	**168**
Q4 2019-20	**82**	**70**	**74**	**415**	**641**
2019-20 Total	**359**	**210**	**325**	**1708**	**2602**

*

*corrected figure now includes Community compliments

Examples of some compliments are provided below:

Birmingham Heartlands Hospital

"…to all staff on Ward 10. This is just a small token of thanks for the care, dedication and kindness to [patient name removed] who sadly passed away. To us, he was a husband, uncle and brother and brother in law. To you, he was a patient but you gave him so much in the short time you cared for him. Thank you from the bottom of our hearts…"

Good Hope Hospital

"…very autism aware staff in children's AE department this afternoon. They were so good with my autistic son, duty of care fantastic and they handled him perfectly. Settled him in a sensory area with mirrors, dimmed overhead lights. Supplied sensory items and a teddy bear for my daughter's anxiety, and a coffee for mum! They were amazing. Thank you!!!"

Solihull Hospital

"I've just met with the son of the late [Patient name removed], he stated that the care his mother received was 'world class' and he couldn't thank everyone enough. He said he was so grateful for everything that was done for his mother on the ward and was also grateful for the care and help provided to him from the Bereavement Office. Please can you pass on his thanks to the nursing team."

Queen Elizabeth Hospital

"I feel it is time to write to you to express my sincere thanks for all that you and your team have done for me over that past couple of years since the tumour diagnosis. During a very difficult time for me, and of course my wife, I have at all times felt to be in the most capable hands and I was very happy to receive the news that the small residuary tumour has not increased in size and I can now manage my condition to the best of my ability with more confidence".

3.3 COVID-19

The patient experience team are supporting the COVID-19 efforts via a number of initiatives including; letters for loved ones, activity packs and a family liaison service set up for when the wards feel they can no longer support this themselves due to numbers.

3.4 2019 PLACE Results

The results of the 2019 Patient Led Assessment of the Care Environment, published earlier this year, showed increases in the majority of scores from 2018, with the exception of cleanliness at Heartlands, Solihull and Queen Elizabeth sites, and privacy and dignity and maintenance at the Queen Elizabeth site (though these latter two remain above the national average).

Actions underway have included reformatting of cleaning schedules and additional resource being put into the emergency departments. The fall in privacy and wellbeing on the QE site related to the televisions not working, and to outside space. An operational review group has been established with Engie to plan equipment lifecycle replacements which will tackle the maintenance issues raised.

3.5 Volunteering

The onset of the COVID-19 pandemic has seen the volunteer numbers drop from a high of 1195 on 11 February 2020, on the back of the funding from NHSi to support more volunteering into emergency departments, to less than 60 in early April.

A recruitment campaign is underway under an STP-wide memorandum of understanding which will permit system movement of volunteers to where they are most needed.

4. Maternity Update

4.1 Continuity of Care

"Better Births: improving outcomes of maternity services in England – A five year view of Maternity Services" was published on 22 February 2016. This was followed by a Cochrane review both recommending that providing a continuity of carer model to pregnant women improves clinical outcomes ensuring care is safe, clinically effective and affords a good experience for women and their families as well as midwives. Findings include that women who receive continuity of carer are:

- 16% less likely to lose their baby at any stage of pregnancy
- 19% less likely to lose their baby before 24 weeks
- 24% less likely to experience pre-term birth
- 15% less likely to have regional anaesthesia
- 16% less likely to have an episiotomy
- 10% less likely to have an instrumental delivery

This makes a compelling case for change to the current model of care as continuity of carer will improve physical and psycho-social well-being in both short and long term trajectories for women and families. The aspiration is that this model of care is available to most women; care cannot be given in a piecemeal fashion, but needs to be a total service approach in order to be successful. Our action plan aims to provide assurance of how at UHB intends to progress from limited continuity of carer throughout all three elements of pregnancy to providing over 51% continuity of carer by March 2021, however as outlined below progress is slow.

4.1.1 Update since the last report

In our initial plans for continuity of carer we projected four teams would go live in April 2020, however we have been unable to achieve this and have 2 teams ready to go live. The main reason for this is reluctance in the workforce to accept and adapt to change and embrace the opportunity to self-select and pioneer the new service. Our engagement strategy is constantly evolving to find new ways to communicate the benefits of working in this way, with a new continuity of carer closed facebook group, roadshows for community midwives and involving Royal College of Midwives representatives.

In line with our LMS partners all teams are planned to be named after inspirational women. The teams are planned to target geographical areas and groups where our intelligence suggests are the highest areas of our perinatal mortality.

Team Nightingale is made up of 7 midwives (6.1WTE) who are set to leave their current establishment on April 13th to commence a 2 week settling in period before going live on April 27th. Our intention is that this team will look after a geographical area within Erdington that serves our highest concentration of vulnerability facing our Good Hope site.

Team McCall is made up of 8 midwives (6.3WTE). Due to staffing in the BHH unit, it has been agreed that this team will leave their current establishment on May 31st to commence a 2 week settling in period before going live on 14th June. This team will look after all teenagers booked at UHB that are eligible for full continuity of carer.

Plans are in place for a second team in Erdington and we are actively encouraging interest from community midwives, particularly at Heartlands site, so that we can mobilise a team within the Highfield area as soon as possible. This area has been identified as our highest concentration of BAME women with evidence of high levels of perinatal mortality.

As soon as each team reaches full capacity, a date will be set for live launch so that we are constantly working to meet our set trajectory towards 51% by March 2021.

Plans are also in place to link a named obstetrician to each of the teams to enable all midwives in the team to communicate directly with their named obstetrician by phone or email which has been shown to reduce the number of consultant antenatal appointments needed in the hospital.

4.2 Strategic Maternity and Neonatal Safety Improvement Group

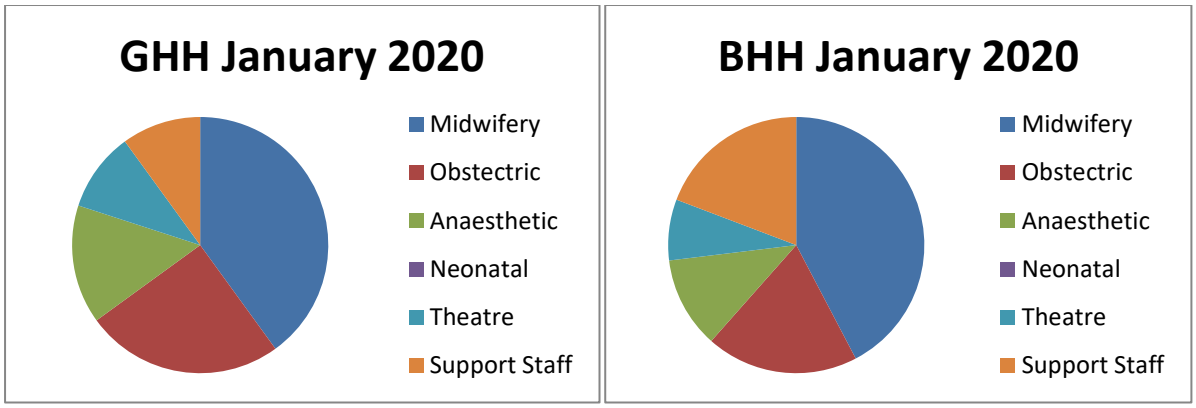
This new group has been set up for the multidisciplinary teams from maternity and neonates which includes safety champions at all levels to discuss maternity and neonatal safety and met for the first time in February 2020 to agree the agenda moving forwards which will include safety intelligence, progress against the bespoke safety improvement plan, metrics and actions from the production board meetings, Quality improvement activities as part of the maternal and neonatal safety collaborative and feedback from local learning system events and the national clinical leaders group at which the Trust is represented.

4.3 Board Level Safety Champions Production Board meetings

These stand up meetings take place monthly on each site (GHH and BHH) led by Alison Talbot, Head of Midwifery and Lead Midwife safety champion, Amit Chauduri, Lead Obstetrician safety champion and Lisa Stalley Green, Executive Chief Nurse and Board level Maternity Safety Champion.

Production board methodology is used to track key safety metrics including stillbirths and neonatal deaths, any learning shared and actions taken immediately and all levels of the multidisciplinary team who attend are given the opportunity to raise any concerns about maternity safety. Each meeting starts with a 'you said, we did' section ensuring timely feedback is given to staff. Staff feedback since these have been commenced has been overwhelmingly positive.

Multidisciplinary attendance at these meetings is excellent and is growing every month as outlined below.



An ongoing action plan to address concerns raised by staff is completed.
Concerns raised have been:

Concerns raised	Action and progress
Medical staffing gaps / consultants covering multiple areas	3 new consultants appointed – waiting to start. Sickness covered with locums
Lifts at Good Hope Hospital not working and being slow	External company working with the division
Maternity trigger list removed from datix	Discussions with the corporate governance team to address this
Some junior neonatal doctors not being newborn life support (NLS) trained	All junior neonatal doctors scheduled to attend NLS training
Capacity in the Princess of Wales building	Capacity being managed daily. Action plan in place to address this. Strategic group working with estates to design future plans

Positive actions discussed:

- Fetal surveillance midwife post has been appointed
- Ward 4 have started a 'hug in a mug' and this is now across the unit to support staff well being

- Staff working really hard in response to capacity and staffing challenges – Thank you to all staff

4.4 ATAIN (Avoiding Term Admissions into Neonatal units)

UHB ATAIN action plan was shared and agreed with our Board level Safety Champion, Lisa Stalley Green, Executive Chief Nurse in January 2020.

Monthly audits are completed which include a detailed case review of every admission using the national ATAIN proforma and any thematic actions identified and shared at the safety champions production board monthly. They are also included in the action plan.

4.5 Progress February 2020

The Term Care Bundle has now been written and ratified and is awaiting corporate sign off. This document will support thermoregulation of the new-born, and therefore will incorporate all elements of the warm bundle currently used at GHH. This is planned to be launched in March 2020.

An application has been made to Clevermed to incorporate all aspects of the Term Care Bundle into the BadgerNet maternity data system.

Monthly action plan update	**Green**	**Amber**	**Total no of actions**
February 2020	43	3	46

The amber actions include;
Saving Babies Lives care bundle (NHSE 2016) – Action plan in progress
Review the provision of transitional care at UHB – revised transitional care pathway at GHH written and implementation plan written
Ensure that staff are aware of factors contributing to admission of full-term babies and the availability of all local and national resources. There is a new monthly reporting mechanism of ATAIN related information at the monthly Safety champion's production board meetings and monthly updates to the O&G Quality and Safety group.

In order to progress the ATAIN objective of reducing term admissions to the neonatal unit to 5% or below, the multidisciplinary group have planned to meet in March 2020 to redefine the action plan.

4.6 Maternity Services Data Set (MSDS)

Safety action 2 of the CNST maternity incentive scheme is relating to the submission of maternity service data to a required standard. MSDSv2 post – implementation review questionnaire is required to be completed and returned to NHS Digital by March 31st 2020. This includes a question that asks Trust Boards to confirm that they have a plan in place to fully confirm with the MSDSv2 Information Standards Notice. UHB plan is dependent on Clevermed as all of this information comes from our maternity information system, Badgernet. Clevermed have written to the Trust to confirm that they are fully participating in the Digital Maternity Transformation Programme, including implementing the Digital Maternity Record Standard (DMRS).

They have also confirmed that they will continue to work with NHS Digital on behalf of all of our Trusts using BadgerNet Maternity to ensure compliance within the timeframes required.

4.7 Perinatal Mortality Review Tool

A collaboration led by MBBRACE UK was appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'. The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The tool is completed by a multidisciplinary team for every stillbirth and neonatal death and a quarterly report and action plan generated. This is presented at the Trusts Care Quality Medical Group.

4.8 Maternity and Neonatal safety Collaborative (MatNeoSIP)

The Trust have supported safety champions to attend the annual national learning event in March 2020 and the Trust presented at this event about a quality improvement project relating to reducing term admissions to the neonatal unit and also about their board level safety champions work.

4.9 CILG

CILG is a national group of Clinical Leaders who have been invited by the national team to share learning and support initiatives across the national learning system. The Trust was represented at the CILG group in March 2020

5. Recommendation

The Board of Directors is asked to receive and discuss this exception report on the progress with Care Quality.

LISA STALLEY-GREEN
CHIEF NURSE
14 APRIL 2020

None Board