15th May, 2018

Statement from Healthwatch Birmingham on Heart of England NHS Foundation Trust (HEFT) Quality Account 2017/18

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Heart of England NHS Foundation Trust. We are pleased to see that the Trust has taken on board some of our comments regarding the previous Quality Account. For example, the Trust has:

- Given some examples of changes in practice or improvement to services that have been made as a result of patient feedback and experiences.
- Given some examples of learning from safety incidents and actions taken as a result.

Patient and Public Involvement

It is positive to see that the Trust continues to use varied methods to measure patient feedback in order to improve services. This includes local and national patient surveys, the NHS Friends and Family Test, complaints and compliments. In addition the use of online sources, including not only NHS choices but feedback received by Patient Opinion and local Healthwatch. We note that the Trust has added a new priority for 2018/19 – improve patient experience and satisfaction.

Healthwatch Birmingham welcomes the inclusion of this priority, as it will help the Trust develop a better focus on the use of patient experiences and feedback to improve services. In our response to the 2016/17 Quality Accounts, we asked the Trust to consider developing a strategy for involving patients, carers and the public in decision-making. We argued that such a strategy would outline how and why patients, the public and carers are engaged, to improve health outcomes and reduce health inequality. In particular, a strategy would make clear arrangements for collating feedback and experience. It would also ensure that there is commitment across the Trust to using patient and public insight, experience and involvement.

We note that patient feedback from local surveys and the Friends and Family Test show positive feedback about the care received. It is positive that the Trust received 77,808 pieces of inpatient feedback through local surveys. Ninety percent of this feedback indicated that patients were happy with the care received. Regarding the Friends and Family Test, we note that for inpatients, 93.9% positive recommendations were received and for the Emergency Departments, 82% positive recommendations were received. This is an increase on the 2016/17 score of 79%. For maternity, outpatients and community, the positive recommendations scores are above 90% (91%, 91.2% and 98.7% respectively). Whilst we commend the Trust on these scores, we see that these are still below the regional score. We would like to see a further improvement towards this goal in the 2018/19 Quality Accounts.

Healthwatch Birmingham recognises that the Trust received 129,946 comments from patients, carers and relatives about their experiences of care during 2017/18. It is positive that 89.3% of these comments were positive reflections of care and treatment. We welcome that the Trust receives more positive comments than it does improvement/negative comments across its services. We note the use of these to either change or improve services and practice; or use of compliments to build staff morale and motivation. The Trust should consider demonstrating how it uses compliments to share good practice across the Trust and the impact of this on services.

Regarding the National Survey, we note that the Trust participated in the national inpatient experience survey on behalf of the CQC. The survey highlighted the following areas for improvement:

- Planned admission – not offered choice of hospitals
- Admission – waiting a long time to get a bed on a ward
- Discharge – not feeling involved about decisions about discharge from hospital

These issues are among those that Healthwatch Birmingham receives through its feedback system. We note following these findings the Trust consulted with clinical staff to understand these scores and develop action plans. We believe that the Trust should also be involving patients, carers and the public in not only identifying, but in understanding the issue, and developing actions. We would like to read in the 2018/19 Quality Accounts how the Trust has involved patients, carers and the public to understand issues around discharge, waiting times, and lack of choice.

We welcome the work that the Trust has carried out through 'patient community panels' and the work streams members of the panel have contributed to. For instance, assistance with PLACE (patient led assessments of the care environment), assistance with maternity surveys, mystery shopper audits, discussions of the new ambulatory care and diagnostics building at Heartlands. These panels can be a useful platform where the Trust can discuss findings from the national survey with patients.

In relation to patient and public involvement, Healthwatch Birmingham would like to read in the 2018/19 Quality Accounts more examples of how the Trust uses feedback and experiences, across the Trust, to make changes to services and practice. Second, we would like to read more about how the Trust uses service user and carer's insight and experience to identify barriers to improved health outcomes and to identify, understand and address health inequality. Ensuring that health and social care organisations are addressing health inequality is a key priority for Healthwatch Birmingham. We look forward to reading in the 2018/19 Quality Account how the Trust is meeting the needs of patients with differing needs.

We would also like to read more about the impact of feedback, and how the Trust communicates with patients about how they are using their feedback to make changes. At Healthwatch Birmingham, we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback

Learning from death, complaints and patient safety incidents

We commend the Trust for implementing the 'Reviewing Inpatient Deaths Policy and associated procedures'. We note the process the Trust takes when a death occurs. Especially, the identification of key points where care did not meet the required standard through case reviews and investigations. Consequently, using findings from case reviews and investigations, to review practice and improve quality of care. We commend the Trust for the actions it has taken in response to lessons from Deaths. We look forward to reading in the 2018/19 Quality Accounts the impact of these actions.

We note that the role of Medical Examiners includes liaising with bereaved relatives to assess whether the care provided was appropriate and whether the death was potentially avoidable. However, it is not clear how and when the Trust involves families and carers in the review or investigation process. We ask that the Trust follows the NHS National Guidance on Learning from Deaths regarding family and friends. The guidance states: "*Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken*"

Involving families and carers in case reviews and investigations offers a more rounded view and understanding of patient experience. We would like to read in the 2018/19 Quality Accounts, how families and patients have been involved in various stages of case reviews and investigations. In addition, how the Trust weights families and patient's views, compared with how they weight the views of clinical staff.

We are concerned that the number of complaints the Trust receives has continued to increase over the last three periods from 1075 in 2016/17; 1120 in 2016/17 to 1136 in 2017/18. We welcome the initiatives that the Trust has taken to address complaints:

- Divisional leads are working with the complaints team to compile details of all actions pledged as a result of complaint investigation, to allow them to monitor and ensure lessons are learnt from complaints, and provide assurance that improvement to enhance patient experience is taking place
- Providing divisions with quarterly logs of all actions pledged through complaints investigations. Divisions then have to provide assurance of the implementation of these actions.

We would like to read more about the impact of these actions in the 2018/19 Quality Account. We acknowledge the examples of improvements made as a result of patient complaints that the Trust has provided in the Quality Account. For example, purchase of a fusion prostate biopsy machine to increase early detection and treatment of prostate cancer; tissue viability training; information notice boards in place; changes in practice to improve patient hygiene; auditing buzzer proximity to patients and various training for staff.

We welcome the Trust's plans for the fourth annual Recognising Carer conference in June 2018, whose focus will be on the carer experience in an acute hospital setting. We would like to read in the 2018/19 Quality Accounts how feedback from the conference has led to changes in how the Trust supports and involves carers. We also recognize the Trust's plans to map the correlation between re-opened complaints and those referred to the PHSO. This will provide a more in-depth understanding of why complainants may remain dissatisfied with the initial responses to their complaints. We believe that the Trust would benefit from collecting feedback from complainants about the complaints process in order to understand why patients are dissatisfied with the outcome. A recent investigation by Healthwatch Birmingham into 'patient involvement and the complaints system'

looked at the barriers to and benefits of using complainant's feedback to improve the quality of complaints systems.

Regarding patient safety incidents, the 2017/18 Quality Account has stated that the Trust has had eight never events[1]. In addition, the percentage of patient safety incidents reported to the National Reporting and Learning System (NRLS) has increased from 0.6% in 2016/17 to 0.91% in 2017/18. We note the duty of candour the Trust follows when an incident occurs. However, we would like to know how the Trust learns from never events and other safety incidents, and examples of actions taken in response to lessons learnt. The Trust should also consider reporting on how it involves patients, carers and families in the review or investigation process.

We note that the Trust will supplement Safety in Healthcare approach with Learning from Excellence to identify, capture, celebrate and learn from episodes of excellence. As per our comment in the 2016/17 Quality Account, the Trust should include examples of learning from excellence and the impact on service delivery, access and quality. We would like to see these examples in the 2018/19 Quality Account.

Quality of Care

Reduce Avoidable harm to patients from omission and delay in receiving Parkinson's disease medication

In our response to the 2016/17 Quality Accounts, we expressed concern that the Trust had not met its target of 90% of inpatients receiving their Parkinson's disease medication within thirty minutes. We note that for 2017/18, the percentage has further decreased to 73% from 75% in 2016/17 against a target of 90%. We acknowledge the various initiatives that were implemented over the last year and the actions taken as a result. For instance, the audit of delays and omissions at Heartlands Hospital and the development of a Parkinson's sticker to prompt staff to act.

We note the initiatives planned for 2018/19, such as the review of a patient self-administration policy and the establishment of a working group to look at how improvements can be made for patients to self-administer their own medication. The Trust should consider getting feedback from patients to identify factors that might hinder some patients from being able to self-administer. Therefore, ensuring that the policy addresses this and puts solutions in place to capture these groups. We also welcome the Parkinson' disease study in October 2018 that will include the patient voice. We look forward to reading more about the impact of this on services and practice in the 2018/19 Quality Accounts. We note that whilst this is no longer a standalone priority for 2018/19, it will be reported under the missed doses priority.

Timely Treatment of Sepsis

We are concerned that the 2017/18 Quality Account shows that the timely identification of sepsis in emergency departments and acute inpatient settings was 56.1% in quarter four; well below the target of 90%. The percentage for those diagnosed with sepsis who received IV antibiotics within one hour of diagnosis was

[1] Two misplaced nasogastric tubes, two wrong implant/prosthesis, one retained foreign object, one wrong site surgery, one overdose of methotrexate, one wrong use of medical air

below 50% for all quarters (Q1 – 38.3%; Q2 – 25%; Q3 – 39.1%; Q4 – 46.2%) in 2017/18. For the acute department, we note that identification was at 88.7% in quarter one and dropped to 50% by quarter four. The percentage for those diagnosed with sepsis who received IV antibiotics within one hour of diagnosis was above 50% (Q1 – 76.3%; Q2 – 81.8%; Q3 – 79.4%; and 68.8% for Q4).

We note that a CQUIN re-audit of the emergency department found issues with data quality and found that true screening performance was 70% rather than the 50% reported by auditors. We note that more robust reporting systems are being put in place and a new audit database will help identify precise points where delays occur. We also note that HEFT's sepsis team is working to develop electronic tools suitable for all its services. We would like to read more on the impact of these actions in the 2018/19 Quality Account.

Patient Experience

Healthwatch Birmingham is pleased that 'improving patient experience and satisfaction' is a priority for the Trust. Considering that HEFT and University Hospitals Birmingham NHS Trust (UHB) will be producing a single Quality Account in 2018/19, we would like to see the Trust incorporate into their plans some of the initiatives being planned by UHB. Such as:

- Increased identification and support for carers
- Develop feedback methods to give a voice to hard to reach groups
- Continued staff engagement in relation to patient experience
- Introduce Android tablets to wards for patients to feedback more easily
- Information screen in A&E to include pathways that will explain waiting times
- Engaging with staff on the effective use of patient feedback

Healthwatch Birmingham has been working in partnership with Trusts in Birmingham through our 'Patient and Public Involvement Quality Standard'. Through this project, Healthwatch Birmingham is supporting providers in Birmingham to meet their statutory role of consulting and engaging with patients and the public. Consequently, we are helping Trusts ensure they are using public and patient feedback to inform changes to services, improve the quality of services and understand inequality in access to services and health outcomes. We have worked with Trusts to review their patient and public involvement processes (PPI), identify areas of good PPI practice and recommended how they can make PPI practice more effective. We look forward to establishing how we could partner with the Trust on PPI and building best practice.

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