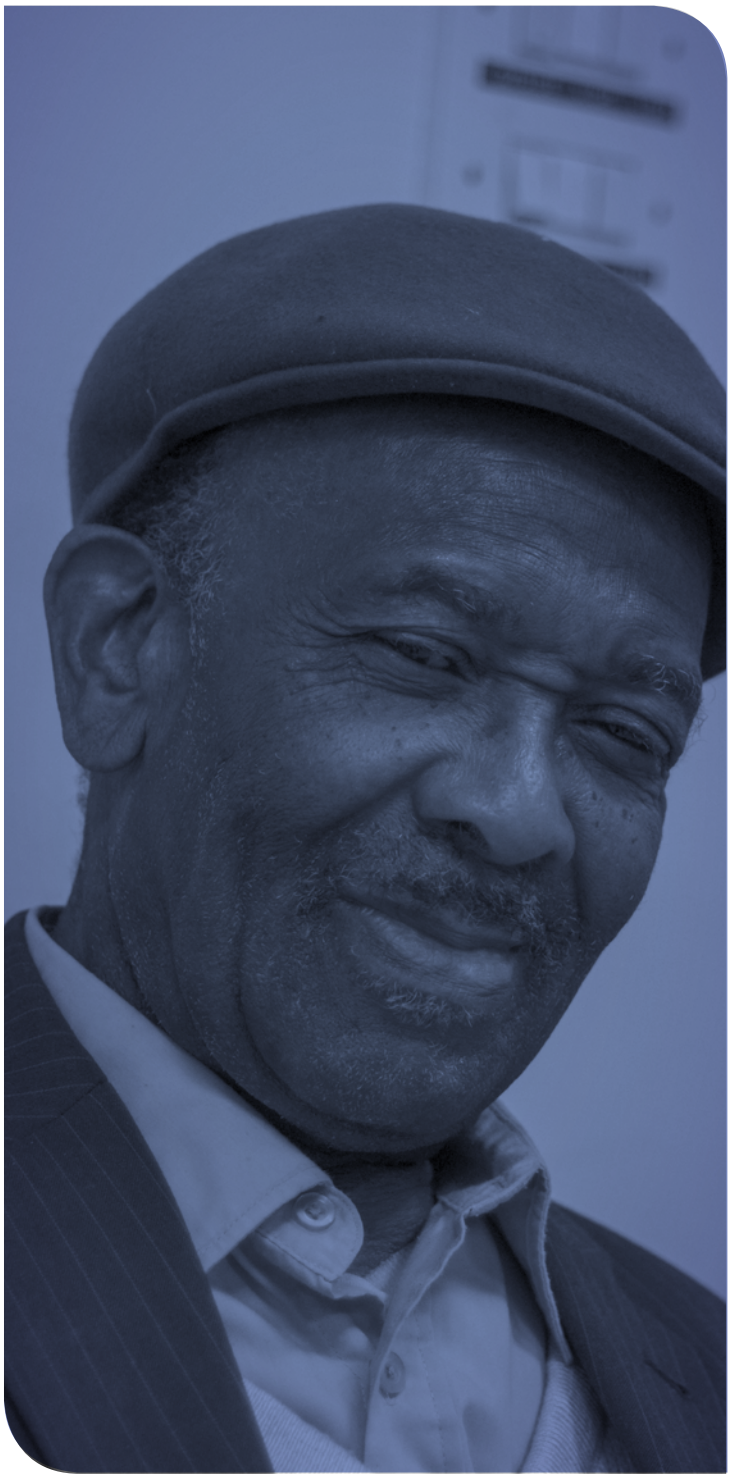
Sandwell and West Birmingham Hospitals NHS
NHS Trust



QUALITY ACCOUNT 2014/15

STICKING TO OUR LONG TERM PLAN

Where EVERYONE Matters

5. Our care and quality of services

Staff Nurse Ian Hartland observing good hand hygiene practice

Improving Quality and Safety: Our Quality Account 2014/15

Introduction

This chapter forms our Quality Account for 2014/15.

Quality Accounts are annual reports to the public from NHS healthcare providers about the quality of the services they deliver. Their purpose is to encourage the organisations to assess the quality of the services they provide and to continuously improve the quality of care provided to patients and their families. This Quality Account is a report which covers:

- How we performed against our priorities for 2014/15
- How well we performed against targets set by our Clinical Commissioning Group (CCG)
- How well we performed against targets we have been set by the Department of Health
- How well we performed when compared to other Trusts
- Our priorities for 2015/16

Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2012 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

- The Quality Account presents a balanced picture of the 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 and conforms to specified data quality standards and prescribed definitions, and is subject to scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

Peer Group

National Trust Development Authority guidance requires data to be reported against an agreed peer group, so that stakeholders can assess relative performance. For this Quality Account we have kept the same group of peers identified for last year. The peer group is a mix of Foundation Trusts, non-Foundation Trusts, Local and Inner City Trusts with a geographical spread and similar levels of activity to Sandwell and West Birmingham NHS Trust. It was also vital that there was access to data with which comparisons could be made.

The Trusts are:

- Bradford Teaching Hospitals NHS Foundation Trust (BTH)
- Kings College Hospital NHS Foundation Trust (KCH)
- Royal Liverpool and Broadgreen University NHS Trust (RLBUH)
- Royal Wolverhampton NHS Trust (RWH)
- University Hospital Bristol NHS Foundation Trust (UHB)
- Worcester Acute Hospitals NHS Trust (WA)
- Northumbria Healthcare NHS Foundation Trust (NH)

Toby Lewis, Chief Executive
26/06/2015

Richard Samuda, Chairman
26/06/2015

This Quality Account was published as part of the Trust's Annual Report 2014/15.

How we performed against our local priorities for 2014/15

In our quality account for 2013-14 we set out five priorities for the year ahead, now the year just completed. These were reflected in our annual plan agreed by our own Board, and with our regulator the Trust Development Authority.

In summary, we made really encouraging progress on mortality and on public health. Re-admissions saw considerable work, but as yet our overall outcomes have not changed by as such as we wish. This remains a priority for 2015-2016, as outlined in chapter 9 of this report. The same sense of more to do applies to outpatient change and to Ten Out Of Ten. Implementation has happened in part, albeit outpatient change has been slowed by some technology dependencies. We will keep going until we deliver the results we promised our patients.

Further details on our annual priorities for 2014/15 and 2015/16 can be found in our Annual Report at http://www.swbh.nhs.uk/

Aims	Latest Assessment	Did we achieve our goals?
Focus Area 1: Readmissions		
Embedding the use of the LACE tool.	We have used the LACE tool with patients with complex needs and involved community staff working closely with colleagues on two wards. This offered better support to patients on discharge and use a multi-disciplinary approach to ensure the patient's complex needs were met.	✓
Improving the quality and timeliness of information provided to GPs on discharge.	A new discharge summary is shortly to be rolled out that will include identification of patients at high risk of readmission with plans to support them in the community.	X
Implementation of evidenced based discharge bundles for patients with Respiratory disease and Heart Failure.	COPD, Brochiectasis, Community Acquired Pneumonia are all complete and published on our intranet.	✓
Improving specialist advice at the front door through initiatives such as a Cardiologist in AMU and the front door Geriatrician.	Cardiology have introduced 'Hot Clinics' and there is now a front door Geriatrician as part of the Fail Safe project.	✓
Improving integration of hospital, ambulance, primary care and community teams – with a system of alerts for patients at risk of readmission.	This is partially done. The Respiratory Team have set up an alert system internally and with community teams, but as yet we have not linked this to primary care or ambulance services.	X
Conduct an audit into the 'last year of life' – looking into reasons for multiple readmissions.	The End of life audit is complete. In May 2015 we are holding a workshop to look at Advance Care Planning. End of Life care planning and choice remains a priority for 2015/16.	✓

Aims	Latest Assessment	Did we achieve our goals?
Focus Area 2 – Reducing preventable deaths (mortality)		
Improving our mortality review system with the aim of reviewing 100% of deaths within 42 days by the end of the year.	Since our last report we have set up a mortality database to better manage the allocation of our mortality review process. There has been an improvement on last year's figures, but not yet to our stretch standard.	✗
Investigating differences in mortality between the weekend and week days and improving seven day services.	We have seen a reduction in the difference between mortality rates in the week and at weekends.	✓
Improving the process of death certification and referral to the Coroner. An electronic system for referral and recording of death will be used.	Notes of deceased patients are now scanned. An electronic system for referral to the Coroner has been implemented across the Trust.	✓
Introduction of Vital Pac – the electronic recording and monitoring of patients' vital signs. All adult acute wards will have Vital Pac by September 2014.	Vital Pac was successfully rolled out to all acute adult wards by September 2014. This year we are going to extend this to paediatrics and A&E and with other modules to promote safe care.	✓
Continuing with the work to improve the recognition and response to patients' sepsis. Increasing the percentage of patients who screen positive for sepsis and receive the sepsis six care bundle.	The role out of Vital Pac has helped with the identification of patients with sepsis. We have seen a comparative increase in the number of patients receiving the sepsis six bundle and a reduction in the number of patients with severe sepsis.	✓
Improving the prevention of hospital acquired venous thromboembolism (HAVTE) – improving risk assessment, prophylaxis and conducting root cause analysis on all HAVTE cases. More than 98% of inpatients to be risk assessed.	We met the national standard of 95%. We fell short of our own goal of 98%. We continue to address this, with a particular focus on ensuring improvement in obstetrics and gynaecology.	✗
Focus area 3 – Year of Outpatients		
Letters to patients and their GPs following appointments will be sent within five days.	We are now ensuring that letters are copied to patients and their GPs. In March 2015 we increased the numbers of letters sent within five days from 19% to 29%. This remains far short of our standard. Weekly monitoring is now being in place to address backlogs in either dictating, typing or signing off correspondence.	✗
Hospital led cancellation of appointments will be a rarity.	This has not yet been achieved because we have not yet implemented partial booking. We now expect to do so from autumn 2015. This change, combined with implementing a changed capacity plan during 2015-2016 will help to both reduce waits and cut hospital initiated cancellations.	✗
Patients will be informed that we have received their referral.	Since February 2015 an acknowledgment letter is sent to all patients when the Trust receives their referral, reducing uncertainty about care.	✓

Aims	Latest Assessment	Did we achieve our goals?
Focus Area 4 – Public Health Implementation		
Formally launch the strategy 'Our Public Health Plan' by June 2014.	We launched our plan in June 2014 as planned.	✓
Promote Health Improvement training in the Trust including the Making Every Contact Count (MECC) programme, focusing on giving staff the skills in very brief interventions for stopping smoking, reducing alcohol consumption and making lifestyle preventions for patients and employees.	Our goals and actions are not yet fully achieved. We are improving how we capture and evaluate health promotion interventions.	✓
Promote Health Improvement training in the Trust including the Making Every Contact Count (MECC) programme, focusing on giving staff the skills in very brief interventions for stopping smoking, reducing alcohol consumption and making lifestyle preventions for patients and employees.	During 2015 we will engage our staff in health promotion training to ensure the workforce are confident in advising colleagues, patients and relatives about prevention and be able to signpost for further advice if required. We have improved the range of healthy food in the cafeteria and other food outlets, and reduced its cost, to encourage better diet in staff, patients and visitors.	✓
With our partners in Public Health Departments, implement an integrated information technology support system across the Trust's computers to assist staff training in health promotion and referral of patients for formal smoking, alcohol and lifestyle counselling.	We are improving how we capture and evaluate our health promotion interventions. Data collection on employee lifestyle choices is progressing.	✓
We will offer lifestyle support services to our patients, staff and the wider local community in partnership with other agencies and organisations.	We have obtained a significant grant from the Trust Charity to improve how we deal with people who need particular help to reduce their drinking, increasing use of alcohol screening and referral to our alcohol treatment partners.	✓
Formally adopt the principles of the Health Promoting Hospitals Network into our Trust's mission statement, policies and procedures by December 2014.	Achieved.	✓
Make contact with other organisations locally, nationally and internationally to further develop our reputation and capability in Public Health.	We have engaged with our local authority Public Health Departments, local and national organisations and charities to establish links.	✓
Focus Area 5 – 10/10 Patient Safety Standards		
Implement a programme aimed at ensuring that we do everything possible to prevent harm being experienced by any patient	The 10/10 safety standards were implemented last year to improve safety by initiating checks and taking action to prevent harm. Although we have launched our 10/10 programme we have set ourselves achievement targets that are higher than national standards such as 100% compliance for VTE assessment and MRSA screening. We have not yet achieved these targets.	X
We want patients to know about our 10/10 Patient Safety standards and will be placing a copy beside every bed in our hospitals.	We have a wide range of information including posters, banners, leaflets and checklists that describe the standards.	X

KPI (Key Performance Indicators) 2014/15

Access Metrics	2014/15	Target
Cancer – 2 week GP referral to first outpatient appointment	93.5%	=>93%
Cancer – 2 week GP referral to first outpatient (breast symptoms) appointment	94.7%	=>93%
Cancer – 31 day diagnosis to treatment for all cancers	98.6%	=>96%
Emergency Care – 4 hour waits	92.52%	=>95%
Referral to treatment time < 18 weeks non admitted	95.09%	=>95%
Referral to treatment time < 18 weeks admitted	90.41%	=>90%
Referral to treatment time – incomplete pathway < 18 weeks	93.15%	=>92%
Acute diagnostic waits > 6 weeks	1.03%	<1%
Cancelled operations	0.78%	=<0.8
Cancelled operations (breach of 28 day guarantee)	0.71%	0%
Delayed transfers of care	3.76%	=<3.5%
Outcome Metrics		
MRSA Bacteraemia	5 cases	0
Clostridium Difficile	29 cases	<37
Mortality reviews	84%	=>80%
Risk adjusted mortality index (RAMI)	88 RAMI	<100
Summary hospital level mortality index (SHMI)	95.7 SHMI	<100
Caesarean Section rate	23.9%	=<25%
Patient safety thermometer – harm free care	93.5%	=>95%
Never Events	0 cases	0
VTE risk assessment (adult inpatient)	97.8%	=>95%
WHO Safer Surgery Checklist	99.9%	=>98%
Quality Governance Metrics		
Mixed sex accommodation breaches	105 cases	0
Patient Satisfaction Friends and Family response rate (inpatient wards and Emergency Care)	43.2/21.9%	>28/>20%
Patient Satisfaction Friends and Family score (inpatient wards and Emergency Care)	72/52%	>68/ >40%
Staff sickness absence	4.69%	=<3.15%
Staff appraisal (as at 31 March 2015)	90.5%	=>95%
Medical staff appraisal and revalidation	92.8%	=>95%
Mandatory training compliance (as at 31 March 2015)	87.6%	=>95%

Clinical Quality and Outcomes	2014/15	Target
Stroke Care – patients who spend more than 90% stay on Stroke Unit	91.77%	=>83%
Stroke Care – Patients admitted to an Acute Stroke Unit within 4 hours	79.42%	=>90%
Stroke Care – patients receiving a CT scan within 1 hour of presentation	71.48%	=>50%
Stroke Care – Admission to Thrombolysis Time (% within 60 minutes)	80.28%	=>85%
TIA (High Risk) Treatment within 24 hours of presentation	98.10%	=>70%
TIA (Low Risk) Treatment within 7 days of presentation	97.11%	=75%
MRSA screening for elective patients	96.90%	=>80%
MRSA screening for non elective patients	82.52%	=>80%
Inpatient falls – Acute	811 cases	<660
Inpatient falls – Community	184 cases	<144
Hip fractures – Operation within 24 hours	69.5%	=>85%
Patient Experience		
Complaints received – Formal	837	
Patient average length of stay	3.7 days	=<4.3
Coronary Heart Disease - Primary Angioplasty (<150 mins)	90.95%	=>80%
Coronary Heart Disease – Rapid Access Chest Pain (<2weeks)	92.7%	=>98%
GU Medicine – patients offered appointment <48 hours	100%	N/A

Disabled car parking Sandwell Hospital

How well we performed against targets set by our Clinical Commissioning Group (CCG)

CQUINs (Commissioning for Quality and Innovation)

The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals. The regime operates on a fines basis.

The Trust works closely with the commissioners to develop the quality schemes. The contract value for 2014/15 was £8.328 million. The table below details the CQUINs for 2014/15 and the outcome at the end of the year. As there were two areas that were only partially achieved (Dementia – Find, Assess, Investigate and Refer and Community Dietetics) the actual income received was £7.956 million.

CQUIN Target	Compliance
Family and Friends Test	✓
Dementia - Find, Assess, Investigate and Refer	X
Learning from safeguarding concerns	✓
Reducing mortality due to Sepsis - Implementation of Sepsis Six	✓
Eliminate the pain review process that leads to variation in patient's experience of pain relief.	✓
Medication and falls	✓
Serious Untoward Incidents / Never Events	✓
Community Dietetics	X
Maternity	✓

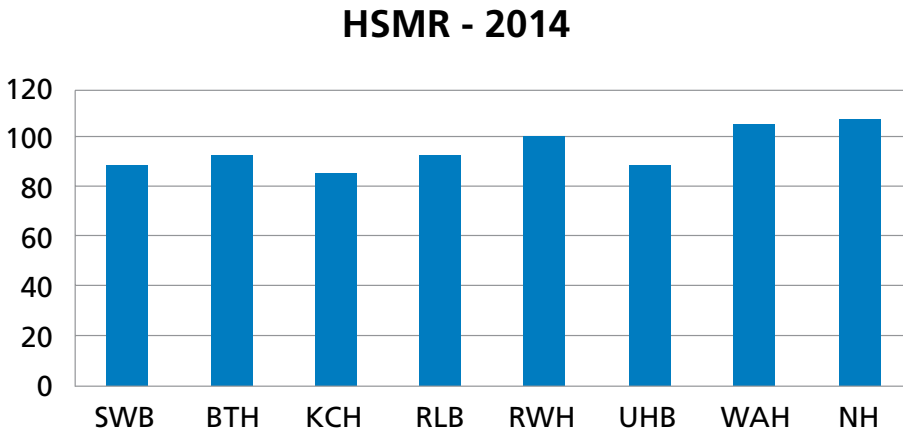
City Hospital on the Dudley Road

How well we performed against our targets set nationally

Mortality

Our current performance

Mortality data is now extracted from CHKS system which reports the Risk Adjusted Mortality Index (RAMI) as the principle measure of an organisation's mortality. We also have HSMR as a comparator with our peers. (Last year we used Dr Foster).



HSMR (Hospital Standardised Mortality Ratio) data for the Trust and peers (lower is better)

The Trust's RAMI for the most recent 12 month cumulative period (December 2014) is 88, which is equal to the National HES peer RAMI of 88.

The aggregate RAMI for both sites of the Trust are within statistical confidence limits with RAMI of 108, beneath that of the National HES peer that has a RAMI of 113.

Mortality rates for the weekday and weekend low risk diagnosis groups are within or beneath the statistical confidence limits. This data is derived from HED for the Summary Hospital Level Mortality Indicator (SHMI). The SHMI includes all deaths up to 30 days after hospital discharge and is currently 95.7 for the Trust.

Mortality Comparisons against National results

	Lowest	Highest	SWBH
Observed	396	4316	2046
Expected	663.7	4121.2	2128.2
Score (SHMI)	.88	.95	.93*

The data above compares our mortality figures against all other Trusts nationally.

A Trust would only get a SHMI value of one if the number of patients who died following treatment was exactly the same as the expected number using the SHMI methodology.

* The values for the Trust must be taken from 2 different periods as reported by HSCIC, and include the lowest and highest value for other Trusts from the reporting period, by way of comparison.

The Trust also monitors its SHMI value taken from a national benchmark data provider (HED) site and includes this within its various mortality and performance monitoring reports. This data is available for a more recent period than is available from the HSCIC website.

Mortality rates are an important indicator of quality of care and last year (2014/15) we set ourselves a target of reviewing 100% of all hospital deaths within 42 days. By reviewing the care given we can identify areas where learning can take place to improve outcomes for our patients. Although there has been an improvement in the numbers reviewed within 42 days we have not achieved our target and will keep this as a priority for 15/16.

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
Deaths total	107	102	109	318	99	118	128	345	138	109	181	428	183	136	141	460
Reviewed	96	87	96	279	72	91	100	263	114	90	168	372	165	117	114	396
% Reviewed within 42 days	89	85	88	87	72	77	78	76	82	82	92	86	90	86	80	86

Deaths with Palliative Care

The table below provides information relating to the number of deaths at the Trust where there was a diagnosis of palliative care made.

Total number of deaths	Palliative Care	%
1586	304	19.16
Score (SHMI)	.88	.957

Palliative Care : Any diagnosis code = Z515

Sepsis

A success for 2014/15 was the implementation of Vital Pac, an electronic recording and monitoring system for patient's vital signs (temperature, pulse, blood pressure and respirations). The system identifies those patients whose vital signs trigger an 'early warning score' and alerts the need for intervention. This system is now on all acute wards in the Trust. The implementation of Vital Pac has also helped us to improve the identification of patients with sepsis. This was another area where we said we would improve. Our aim was to increase the percentage of patients being screened positive for sepsis receiving the Sepsis Six bundle of care to 50%. This was also a CQUIN for 2014/15 and the CCG set an exit trajectory of 65%. The trajectory was achieved but there remains work to be done and the CQUIN for 2015/16 focuses on the Emergency Department as well as the Acute Medical Units.

Data for Quarter 4 sepsis audit

Audit forms completed	Patients that trigger screening tool	% of patients that trigger screening tool	Patients where screening tool was used	% patients where screening tool was used	Patients requiring Sepsis Pathway	Patients with Sepsis Pathway commenced	% patients with Sepsis Pathway commenced	Patients that received bundle within Golden Hour	% patients that received bundle within Golden Hour
277	219	79%	87	40%	140	68	49%	59	87%

Infection Control

Target	Agreed target/rate [Year end]	Trust target/rate [Year end]	Compliant	Comments	
MRSA Bacteraemia	0	5	No	**Pre 48hrs** 2 = City Site 1 = Sandwell Site	**Post 48hrs** 2 = Sandwell Site
				All Pre and Post 48 hrs bacteraemias have a post infection review to identify issues and lessons learnt.	
C.difficile acquisition toxin positive	37	29	Yes	22 = Sandwell Site 7 = City site	
MRSA Screening - Elective	80% (locally agreed)	96.90%	Yes		
MRSA Screening - Non Elective	80% (locally agreed)	82.52%	Yes		
Post 48hrs MRSA Bacteraemia (rate per 100,000 bed days)	N/A	0.05		All Post 48 hrs bacteraemias have a post infection review to identify issues and lessons learnt.	
Post 48hr E Coli Bacteraemia (rate per 100,000 bed days)	N/A	0.18		All Post 48 hrs bacteraemias – urinary catheter related have a post infection review to identify issues and lessons learnt.	

Blood culture contamination rates (Target = 3% by Ward, dept. and site.)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	City	2.3%	3.6%	2.6%	3.2%	2.0%	2.9%	2.5%	3.0%	3.3%	2.3%	4.1%	2.9%
	S'well	3.7%	2.8%	2.8%	2.9%	5.7%	4.2%	5.1%	2.7%	3.7%	3.5%	5.1%	3.1%
	It needs to be recognised that due to the clinical condition of some patients there is a risk of obtaining an unavoidable blood contaminant. However, any Clinician identified as taking a contaminated blood culture is required to attend for further training to reiterate practices. In addition to this, since August 2014 the team has introduced a training programme for all new doctors to the Trust.												

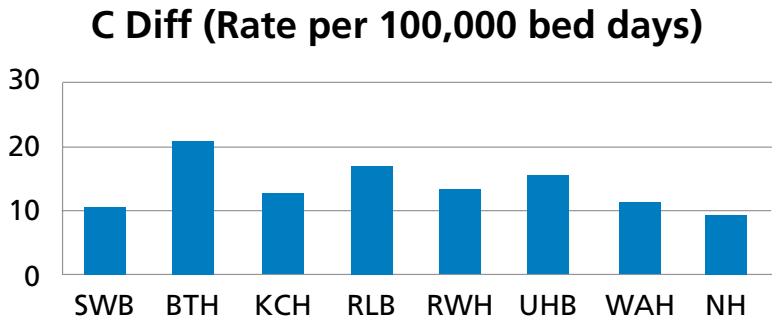
During 2014/15 there were a total of three ward closures that were attributed to diarrhoea and/or vomiting. Closures by site equated to one at City, two at Sandwell. The outbreaks involved a total of 39 patients and one member of staff. Wards were closed for a total period of 32 days with a range of between nine and 13 days dependent upon severity of the outbreak.

Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by clinical and non-clinical Groups and healthcare personnel. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

C difficile comparisons against national results

	Lowest	Highest	Average	SWBH
C Diff - number of reported infections	1	144	31.4	29
C Diff infection rate per 100,000 bed days	25.6	1.2	13.9	11.4

The data above compares our C Diff rates against all other Trusts who report C Diff infections. This includes specialist units.



Never Events

Last year we reported one Never Event which occurred in the previous financial year. A Never Event is a serious untoward incident that has either caused or has the potential to cause serious harm that should never happen if the proper procedures are carried out to prevent them from happening.

The published list has been revised by NHS England but incidents which have occurred at the Trust, such as 'Wrong Site Surgery', 'Retained Instruments or Swabs' and 'Wrong Implant' will remain. The following table gives an overview of the Never Event that we reported:

Incident	What Happened	Where it happened	What we learned
Retained guide wire (January 2014; reported June 2014)	Retained guide wire is thought to be from a PICC line insertion undertaken at the end of January 2014.	This incident occurred at City Hospital under the care of ENT.	The root cause was a failure to follow the Trust policy on the introduction of a new device or procedure. There were inadequate safety controls to ensure appropriate governance process around the use of and introduction of a new device. The Insertion, Management and Removal of Midline Catheters policy has been updated, including the development of a Standard Operating Procedure (SOP) re device storage/distribution/access/ logging/who can insert/where the procedure takes place. Specific competency based training is now in place.

During the year a review of never event controls was carried out for those which have not happened at the Trust. This review examined controls in place which are intended to reduce the likelihood of these never events happening.

Incident Reporting

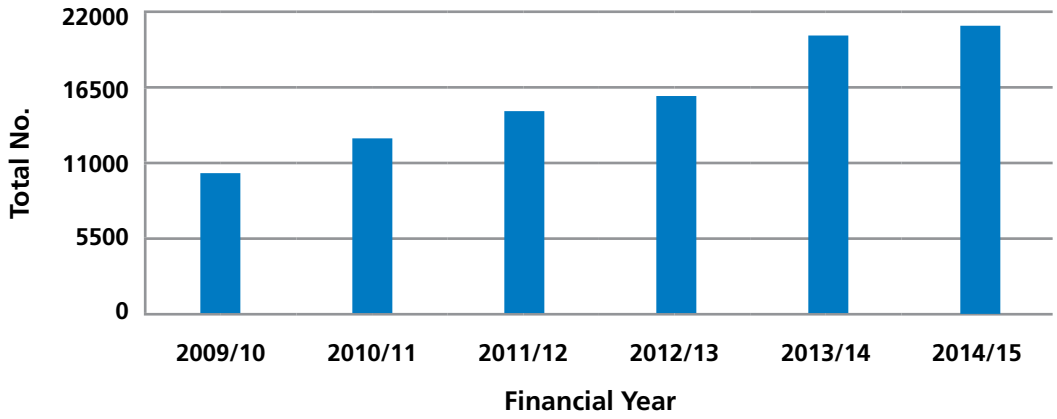
Safety culture or climate remains essential for the delivery of high quality care. We continue to submit incident data to the National Reporting & Learning System (NRLS) which is publically available and provides comparative data with like sized Trusts. For this reporting period (April-September 14) the NRLS has grouped acute non-specialist Trusts together meaning that we are benchmarked against 139 Trusts, where previously it was 38-40. The comparative data shows that as at the September 2014 report we remain in the highest 25% of Trusts with a reporting rate of 51.65 per 1000 bed days. This is a change from previous reports which showed us measured per 100 admissions.

Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82	2.34	86	1.15	14	0.2
2012/13	9.58	12.65	2.49	32	0.32	19	0.15
2013/14	11.13	12.46	1.72	24	0.2	16	0.1
2014/15*	51.65	74.96	0.24	14	0.2	3	0.0

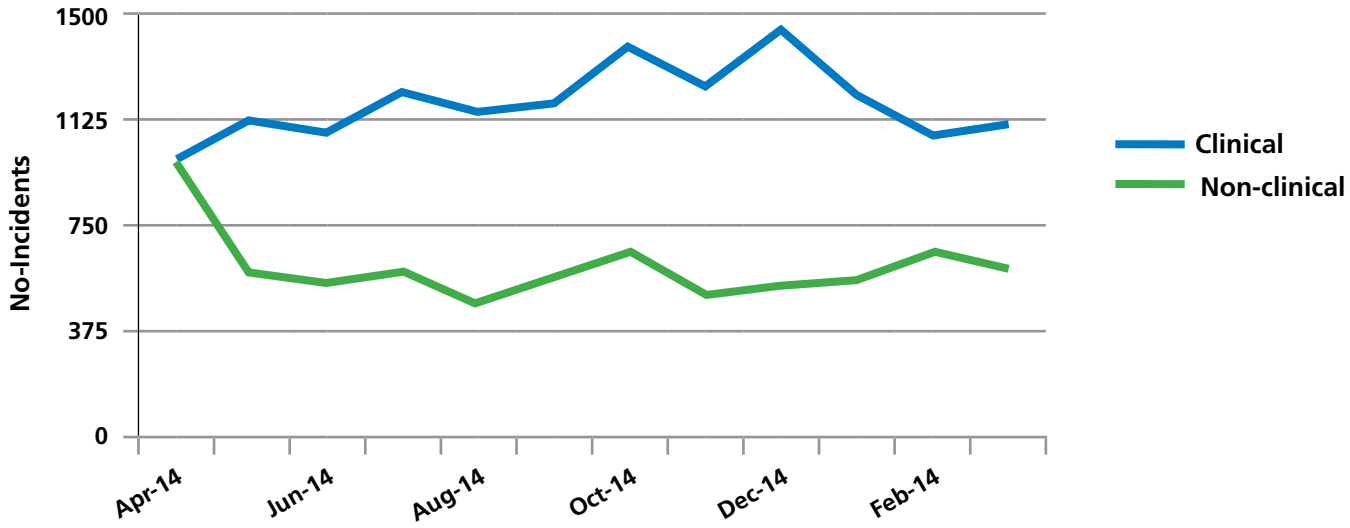
2014/15* this data has changed to be average rate of reporting per 1000 bed days.

The latest data (April - September 2014) shows we have improved our position in the rate of reporting remaining within the top 25% of large acute Trusts. The data shows an improving position for incidents which result in severe harm and which result in death. The table shows our position per 100 bed days as compared against the best and worst reporters and the previous financial year's position on reporting of degree of harm.

Total Incidents reported by financial year 2009/10 to 2014/15



Types of Incidents 2014/15



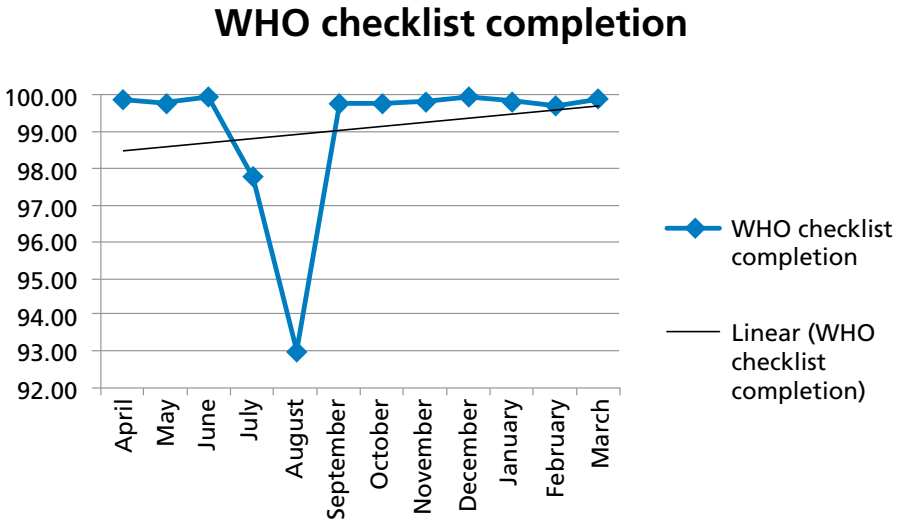
Incidents are generally categorised into clinical (patient safety) and non-clinical and then further categorised dependant upon their causative factor.

The chart above shows the data for the main types of incidents throughout the year, month on month.

Serious incidents continue to be reported to the CCG and investigations for these are facilitated by the corporate risk team. Those incidents designated as 'amber' are investigated at clinical group or corporate directorate level.

The number of serious incidents reported in 2014/15 is shown in the following table. This does not include pressure sores, fractures or serious injuries resulting from falls, ward closures, some infection control issues or health and safety incidents.

Month 2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of serious incidents reported	2	7	3	2	2	1	1	0	5	4	1	2



We have also strengthened the investigation review process around near miss never events, and share these with all clinical groups to strengthen existing processes and practices. We have done this by:

- Strengthening of our WHO Checklist steering group to look at all potential never events and gain assurance on control measures to prevent them.
- A program of safety culture assessment using the Manchester Patient Safety Framework tool.
- A review and update of policies and procedures in theatres.
- Incorporation of Never Events assurance audit as a CQUIN.

VTE

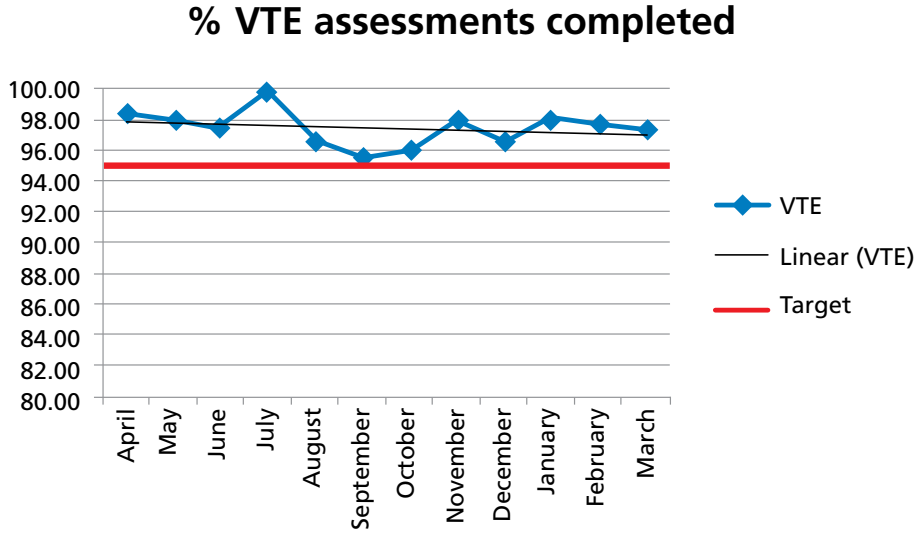
A venous thromboembolism (VTE) is a blood clot (thrombus) that forms within a vein. Commonly they are found in deep veins (deep vein thrombosis). If the thrombus breaks off and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs.

Since 2010, the Department of Health (DH) requires that VTE risk assessments take place for every patient, and that results are closely monitored in order to reduce the 25,000 preventable deaths that occur in UK hospitals every year.

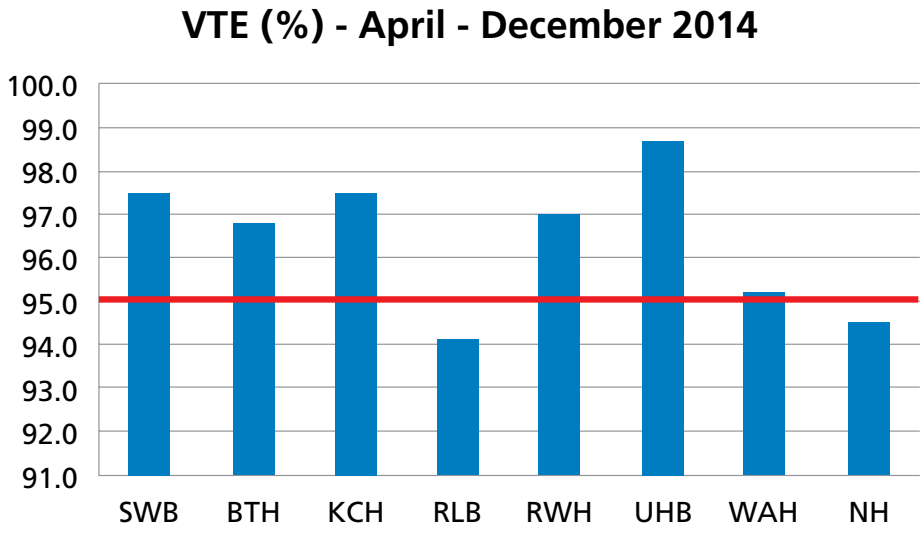
We are reporting our achievements against the national indicator. This gives us a percentage of 97.82%. We have calculated the percentage of patients risk assessed for venous thromboembolism (VTE) based on the number of adults admitted to hospital as inpatients in the reporting period who have been risk assessed for VTE. This gives us a percentage of 97.82%. Following an audit of our data we have identified a cohort of patients who received their initial VTE assessment after admission. This falls outside of our Trust policy definition of VTE assessment at the point of admission and which is based on the criteria set out in the national VTE risk assessment tool. Applying this definition gives us a percentage of 93.4% which is below the national target of 95%.

Lowest	Highest	Average	SWBH
91%	100%	96%	97.82%

The data above compares our VTE assessment compliance against all other Trusts and was sourced from data provided by NHS England.



VTE assessments completed (higher is better – Target 95%)



VTE assessments compared to peers (higher is better)

Safeguarding

Children's Safeguarding

Excellent partnership working in Sandwell's Multi-Agency Safeguarding Hub (MASH) saw an increase in the number of domestic abuse notifications requiring screening by the Domestic Abuse Lead Nurse leading to a recent support for extra funding to increase this team. SWBH has been successful in a joint charitable bid with Sandwell Women's Aid to provide specialist workers in the emergency department to support both clients and staff in the identification of domestic abuse.

Birmingham MASH commenced in July and although there is no SWBHT resource required, joint working has increased with the safeguarding children team, frontline practitioners and MASH staff to improve the quality of inter-agency referrals completed to ensure children and family's needs are better recognised and responded to in order to better safeguard children.

There have been two Safeguarding Children Care Quality Commission inspections during the summer which identified the need for the organisation to improve its provision of supervision for frontline staff in Emergency Department and midwifery so they are better equipped to safeguard vulnerable children and people. Other areas identified were mandatory safeguarding children training (an area the Trust had already recognised as requiring improvement), 72% of staff have received face to face training on how to recognise and refer issues of concern; 68% of key staff groups such as health visitors, paediatricians and community nurses have received more in-depth training.

The report praised the organisation's Paediatric Liaison Service which reviews all children's admission cards following attendance at the Emergency Department to ensure that all safeguarding concerns have been reported and will also refer on to health visitors and school health advisors for additional support a family or young person may need.

Our key challenges for 2015/16 are to work closely with external partners (local authority, police, school nurses etc) and internal departments such as the emergency department, maternity and paediatric wards to reduce child sexual exploitation, alert to cases of female genital mutilation by increasing awareness and training amongst staff.

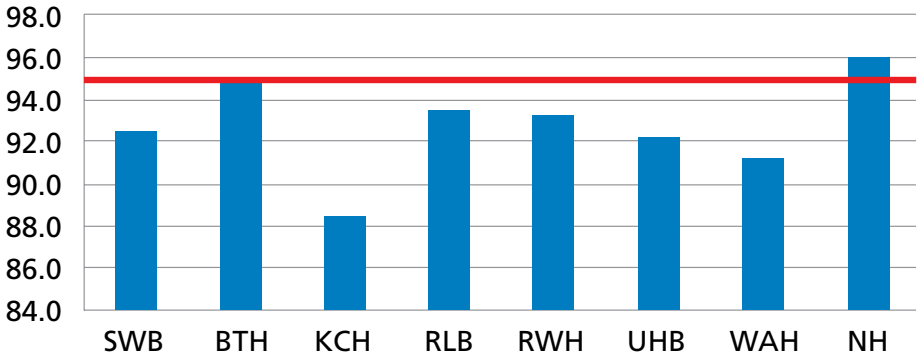
Safeguarding Adults

The Safeguarding Vulnerable Adults Team supports staff in the organisation to protect the most vulnerable and frail in our society. In 2014/15 the team received 780 referrals where staff needed advice/support or where harm needed to be investigated.

Safeguarding Vulnerable Adults Training continues as planned throughout 2014/15. All of our 7,500 staff received leaflets describing different forms of harm/abuse, how to recognise abuse and who to contact for support. 77.8% of senior staff (nurses, doctors etc) received classroom training on actions to take to protect patients. We have undertaken audits to review how we support adults at risk by reviewing five cases each quarter to identify any learning. We continue to raise the importance of patients and families being more involved in their care and in difficult /complex decisions where appropriate.

The Learning Disability Liaison Nurse continues to work across the Trust with patients from Sandwell, and the Chief Executive has made pledges to the Peoples' Parliament in Sandwell which includes: a system for identifying patients with learning disabilities on admission and provision of reasonable adjustments for patients with a learning disability. This has improved care for patients in both inpatient and outpatient areas.

Emergency Care 4-hour waits (%) - 2014 / 2015



Percentage of patients waiting 4 hours or less in the emergency department compared to peers (Higher is better – target 95%)

The national target for A&E waits is four hours. This means that we aim to ensure that 95% of patients will wait for no more than four hours within the Emergency Department. Although the majority of patients were seen within four hours on average we achieved 92.5%. This is less than year's figure of 94.4%. Nationally we saw how the additional pressures of the cold weather; norovirus and flu impacted on all A&E departments across the UK. We remain committed to improving our targets and we are working closely with the community teams to improve our integrated care pathways (see priorities for 2015/16). The only way we can know if we are getting it right is to ask, listen and involve patients, carers, relatives and the general public.

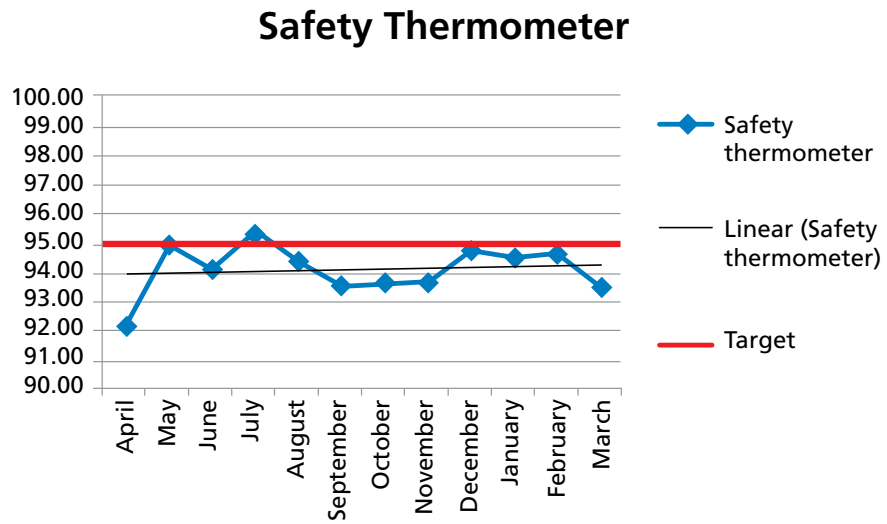
Accident and Emergency department at Sandwell Hospital

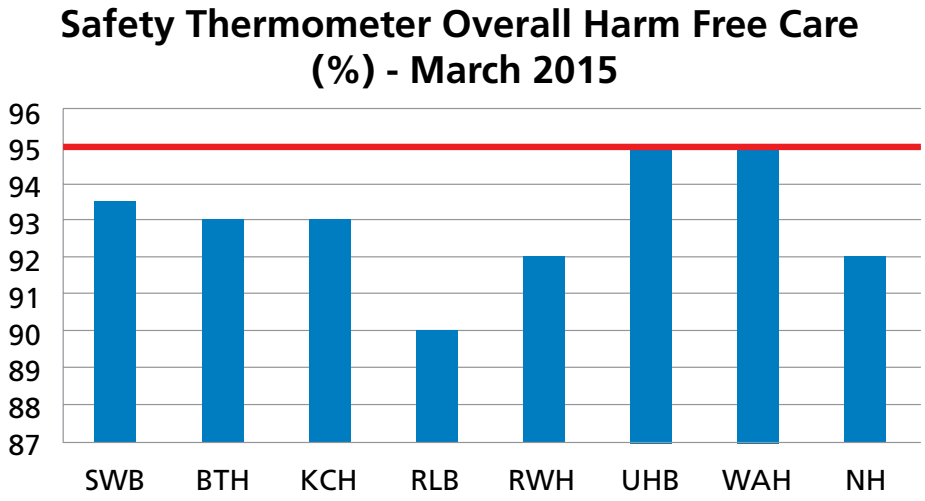
Safety thermometer

The Safety Thermometer audit is completed trust wide including community services on a pre-prescribed day, once a month. The data is then submitted to the NHS Information Centre.

This tool which was introduced by the Department of Health enhances the understanding of harm free care experience by our patients in four specific areas:

1. Pressure Ulcers
2. Falls
3. Catheter-associated Urinary Tract Infections
4. VTE





Safety thermometer performance compared to peers (Target 95% Harm free care)

We intend to continue to improve the safety and enhance patient experience through specific attention to the reduction of harm events and through efforts to measurably improve care delivered.

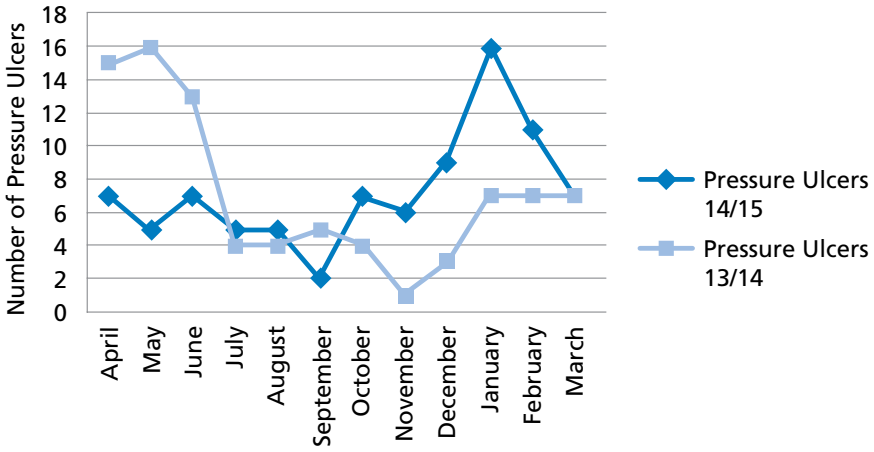
The monthly whole Trust audit of patients for three harm free events has been accepted very positively with good engagement of nursing staff.

The Trust harm-free percentage for 2014/15 dipped mid-year, but it has improved to 93.5% which is just below the target with few patients sustaining more than one harm.

Pressure ulcer prevention is one of the key safety standards within the Trust 10/10 safety standards with a clear focus on assessment of all patients to identify if someone is at risk of developing pressure damage and implementing preventative strategies to prevent pressure ulcers developing. Following the implementation of a focussed pressure ulcer reduction campaign, the reduction in the incidence of avoidable hospital acquired pressure ulcer has been sustained with the exception of a small rise during December. This increase in incidence was investigated and it was identified that the increase was not related to a specific area in within the Trust. Many of our wards have achieved sustained elimination of pressure ulcers with the highest celebrating 800 days pressure ulcer free.

All severe pressure damage is reviewed to identify the cause and implement local actions reflecting the lessons learnt.

Monthly Avoidable Pressure Ulcers



Following the sustained success of reducing pressure ulcer incidences within the hospital setting, focus of the pressure ulcer reduction campaign has been placed on reducing incidences within Sandwell community and patients under the care of our District Nursing teams with the achievement of 10% reduction this year.

End of life (palliative) care

2014/15 has seen positive developments in palliative care, which we believe has improved access to services for both patients and staff. We now deliver a seven day service where a clinical nurse specialist is available across both hospital sites and also in the community 8am – 4pm. Outside of these hours we also have an on-call service where we can offer telephone advice to staff out of hours. Our referrals out of hours are increasing and in 2015/16 we will be evaluating the impact of this service on the patient experience.

Our other key focus will be on updating and developing our written patient information which should be available in 2016, including reviewing the existing End of Life Care Pathway (care plan) in accordance with national guidelines and standards.

Preferred Place of Care Data 2014/15

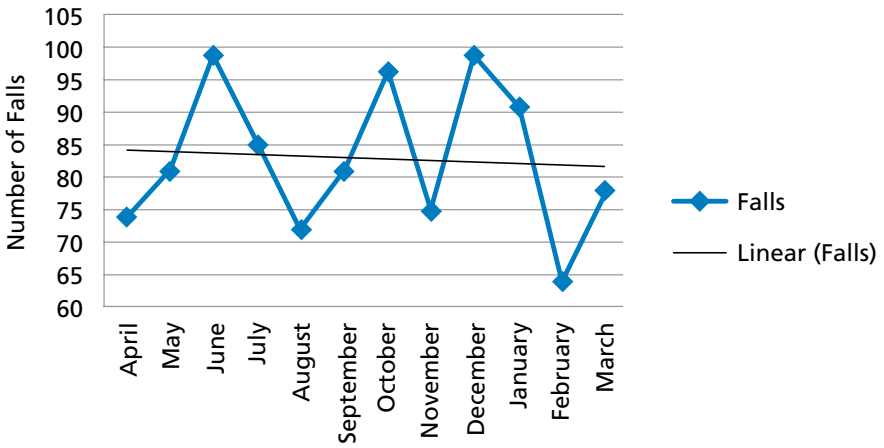
The hospital and community palliative care teams strive to ensure that patients achieve their preferred place of care and death and this year has been no exception.

The national target is 63 % and over the last financial year, the percentage of patients who achieved their preferred place of care and death has fluctuated between 67% and 87% with the mean average being 76% for the year.

Falls

The number of falls in 2014/15 is 995. The number of falls resulting in harm to our patients (for example a hip fracture/ head injury) has reduced from 30 in 2013/14 to 25 in 2014/15. We investigate and review each serious incident to ensure any learning points are shared with staff and that practice is reviewed to reduce the risk of repetition for that patient or others. All staff receive prevention of falls training on induction and annual mandatory training. The organisation is currently undertaking a project of reviewing medication of those patients that are of high risk of falling.

Number of Falls per Month 2014/15



Dementia

We have implemented a series of strategies to support an evidence based dementia care pathway:

- We continue to screen patients to determine risk of dementia which may lead the patient to undergo a further assessment. Our results have improved across the year and 90% of patients who need assessing are done so in a timely manner with the appropriate follow up.
- The environments of some of the wards across the inpatient areas have been improved to help those patients with dementia find their way and increase their independence.
- We have reviewed our guidance regarding patients who may require increased nursing supervision/support
- We continue to invest money in university training for staff and have employed activity co-ordinators to provide patients with dementia therapeutic activity to patients with dementia.
- We have hosted two dementia theatre events to raise awareness regarding the condition and role of carers which has received excellent reviews.

Our vision for the next twelve months is to encourage more activities for patients with dementia.

Measuring progress towards excellent patient and carer experience

We want to ensure our patients and their carers receive the very best experience possible. This is important for several reasons:

- It is everyone's constitutional right, as identified in the NHS Constitution 2010.
- Good patient experience is linked to better outcomes.
- It instils local and national confidence in the Trust, reinforcing our reputation as we move into new fields of care as an integrated provider.
- It will help to retain and recruit staff, as an organisation with a sense of wellbeing and is a place people want to work in.

We believe that delivering our promises 24/7 will deliver these recommendations.

We have captured our approach in our Staff and Patient Experience Strategy "Patient Knows Best" (PKB), a document that brings together these simple truths based on an important belief that our 'patients know best' as they have knowledge that we do not, because they know themselves better than we can.

Family and Friends Test (FFT)

The Trust participates in the national Family and Friends Test programme and has used the net promoter score generated by this to drive improvements in its services.

SWBH Inpatient score	National Average	National lowest	National Highest
72	72	33	93

SWBH ED score	National Average	National lowest	National Highest
52	54	-3	89

For staff, would you recommend this organisation to a friend or family member?

Strongly agree %	Strongly disagree %	Base number	National Strongly agree %	National strongly disagree %	National average score	National highest	National Lowest
68%	9%	1266	77%	8%	60%	98%	41%

NHS Choices

NHS Choices is a website that provides the Trust with valuable reflections from patients and their carers. These are used to provide feedback to clinical services whether positive or negative.

Urology at Sandwell District General Hospital ★★★★★

"I have been to Sandwell Hospital Accident and Emergency a few times over the past few years with kidney stones and always found the staff to be friendly, efficient and they always go that extra little bit to help. They treated me speedily and did their best to help. I would recommend Sandwell Hospital Accident and Emergency."

April 2015

Birmingham and Midland Eye Centre (BMEC) ★★★★★
Wonderful Service from Birmingham and Midland Eye Centre

"I wish to express how impressed I was at the care and service I was given by two doctors at the Birmingham and Midland Eye Centre on Friday, 6th March 2015. I have had a problem with watery eyes. The first doctor assessed my eyes in relation to her field of expertise, but then decided that they would like the drainage system of my eyes to be checked also. Instead of sending me home to wait for another appointment with a colleague, this doctor personally spoke to a second doctor, who saw me the same day. After consulting with each other, I am now booked in for a 3 snip punctoplasty. To witness true "joined up thinking" and collaboration in this way was fantastic. The doctor took extra time out of their day to initiate this, and the second doctor was kind enough to see me, even though I wasn't actually booked in to see them that day. I now have a diagnosis and a treatment forthcoming. I cannot thank these two doctors enough for their thoughtfulness and care."

D. Murphy. 11 March 2015

Patient Stories

Every month a real life patient story is shared with the Trust Board to accentuate good practice and learn from where we didn't meet expectations so we can put it right. The Board agreed that by October 2015 story-telling needed to become an evident feature of other layers of the management system.

Complaints

Patient Experience		
Complaints Received - Formal	No.	837

We remain committed to providing timely and proportionate responses to formal complaints which we receive about our services. Complaints provide us with information about how patients and their families have felt about their experience, giving us information which we can use to improve. Equally compliments let us know what people have found has been good.

The top themes of complaints received during 2014/15 were:

- All aspects of clinical treatment
- Attitude of staff
- Appointment delay/cancellation outpatient appointment
- Appointments delay/cancelled inpatient
- Communication/information to patient
- Admissions/discharges, transfers
- Transport services

The Patient Advice and Liaison Service (PALS) are dealing with more complex type of enquiries that were traditionally dealt with through the formal complaints route. We are also trying to support patients who may just need to sit down and talk through the issues with the doctor directly through PALS, as the patient may not necessarily want to register a formal complaint.

Category Type	2012/13	2013/14	2014/15
Appointments delay/cancelled/notification/time	269	337	423
All issues relating to clinical care/treatment	335	413	395
Formal complaint advice/referral	378	391	259

Complaints handling process

Throughout 2014 we have continued to develop the devolved model of complaints handling. Complaint co-ordinators support and assist staff within our services to address the complaints themselves and make any necessary amendments to services directly.

We have also set ourselves a target of 30 working days to resolve complaints. We have not consistently achieved this target but continue to work collectively to ensure that responses are timely and that complainants are kept informed. However, there is still further work to do.

As part of the renewed process for handling complaints, we are offering more meetings to try and resolve issues directly. These meetings are recorded so that no delays occur in transcribing and the complainant receives an accurate record of the conversation.

Information Governance

We are compliant across the Information Governance (IG) Toolkit requirements for 2014/15.

We successfully achieved 74%, which is a "Satisfactory" (GREEN) level, (Health and Social Care Information Centre) and a minimum Level 2 achieved for all requirements.

We will continue to build on this to strengthen our IG practices and processes and work towards attaining Level 3 compliance.

Review of Services

During 2014/15 we provided and/or subcontracted 46 NHS services.

We have reviewed all the data available on the quality of the care in these services.

Agreements between the Trust and the subcontracted providers require that the same high standards of care are given when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust.

The income generated by the NHS services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by Trust.

Providing data to Secondary Users

During 2014/14 we submitted data to Secondary Users for inclusion in Hospital Episode Statistics.

The information shared breakdown is below:

Admitted Care
Valid NHS Number 99.1%
Valid GP Practice 100%

Outpatient
Valid NHS Number 99.7%
Valid GP Practice 100%

A&E
Valid NHS Number 97.4%
Valid GP Practice 100%

Source: SUS DQ Dashboard 1415 M12.swf
Above percentages relate to April 2014 to March 2015

The reports of 19 national clinical audits were reviewed by the provider in 2014/15 and we to take the following actions to improve the quality of healthcare we provide:

Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently these cover four clinical procedures where the health gains following surgical treatment is measured using pre- and post-operative surveys. The Health & Social Care Information Centre publish PROMs national-level headline data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year.

The tables below shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England.

The CQC published Intelligent Monitoring data about Trusts. PROMs performance represents a key issue highlighted there for the Trust to improve upon.

Percentage reporting improvement

	Health Status Questionnaire Percentage improving			
	Finalised data for April 2012/March 2013 (Published August 14)		Provisional data for April 2012/March 2013 (Published February 15)	
	National	SWBH	National	SWBH
Hernia repairs	50.2%	49.3%	50.6%	42.9%
Hip replacement	89.7%	87.9%	89.3%	86.6%
Knee replacement	80.6%	73.7%	81.4%	74.3%

Average adjusted heath gain

	Health Status Questionnaire Average adjusted health gain			
	Finalised data for April 12 – March 13 (Published August 14)		Provisional data for April 13 – March 14 (Published February 15)	
	National	SWBH	National	SWBH
Hernia repairs	0.085	0.076	0.085	0.085
Hip replacement	0.438	0.420	0.436	0.45
Knee replacement	0.318	0.298	0.323	0.264
Varicose vein surgery	0.093	0.048	0.093	0.08

	SWBH below England average
	SWBH above England average

The finalised data for 2012/13 and the provisional data for 2013/14 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken the following action:

	Action taken
Hip & Knee replacement	Pre-operative questionnaires and an information leaflet explaining the importance of completing the pre-operative PROMs booklets are posted to patients at home with their admission letter for completion and return on the day of surgery. Patients attend a 'joint club' where advice and information is imparted. This includes discussion with patients so they are fully aware of the risk and benefits, as well as expected outcome. Audits of listing of patients are in place to ensure that they meet the criteria consistently for replacement and meet the current CCG guidance. A contact point after discharge is provided if there are any problems and there is direct access to clinic if needed. A six month follow up and review of performance after surgery is also in place.
Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation. Questionnaires are offered to patients at every opportunity. All patients have a discussion regarding risk and benefits and information leaflets are being updated to include more information on PROMS and on what symptoms to expect post operatively and in what time frame.

Clinical Research

In 14/15 we recruited 2067 patients receiving NHS service care from our Trust, to participate in research approved by a research ethics committee for National Institute for Health Research (NIHR) Portfolio studies. With a further 800 for non-NIHR Portfolio studies.

Participation in clinical research demonstrates our ongoing commitment to improving the quality of care offered and to making a contribution to wider health improvement. Engagement with clinical research also demonstrates our commitment to testing and offering the latest treatments and techniques. It further ensures that clinical staff stay abreast of the latest treatment possibilities and active participation in research leading to successful patient outcomes.

Research is undertaken across a wide range of disciplines including Cancer (Breast, Lung, Colorectal, Haematology, Gynae-oncology, Urology), Rheumatology, Ophthalmology, Stroke, Neurology, Cardiovascular, Diabetes, Gastroenterology, Surgery, Dermatology and Women and Children's Health. We use national systems to manage the studies in proportion to risk and implement the NIHR Research Support Service standard operating procedures.

Participation in clinical audits

During 2014/15, we participated in 29 national clinical audits and two national confidential enquiries covering NHS services which the Trust provides.

We have reviewed all the data available to us on the quality of care in all of these services.

During that period Sandwell and West Birmingham Hospiitals NHS Trust participated in 97% of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham Hospitals NHS Trust participated in and for which data collection was completed during 2014/15, 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 Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
Women's & Child Health		
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Fitting Child (Care in Emergency Departments)	Yes	100%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Epilepsy 12 Audit (Childhood Epilepsy)	Yes	98%
National Pregnancy in Diabetes Audit	Yes	100%
Acute care		
National pleural procedures audit (British Thoracic Society)	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	90%

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
Severe trauma (Trauma Audit & Research Network)	Yes	60%
Adult Critical Care (Case Mix Programme)	Yes	100%
National COPD Audit (Secondary Care)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	64%
Long term conditions		
Diabetes (National Diabetes Audit) Adult	Yes	100%
Inflammatory Bowel Disease (IBD)	Yes	93%
Rheumatoid and early inflammatory arthritis	Yes	Ongoing
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	98%
Heart Failure (Heart Failure Audit)	Yes	50%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SSSNAP)	Yes	90%+
Cardiac arrest (National Cardiac Arrest Audit)	Yes	96%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head & neck cancer (DAHNO)	Yes	100%
Oesophago- gastric cancer (National O-G Cancer Audit)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion (Audit of patient information and consent)	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Other		
Elective Surgery (National PROMs Programme)	Yes	73%
Older people (Care in Emergency Departments)	Yes	100%
Standards for ulnar neuropathy at elbow (UNE) testing	No	NA
Mental health		
Mental health (Care in Emergency Departments)	Yes	100%
National Confidential Enquiries (Clinical Outcome Review Programmes)		
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following study in 2014/15 - Gastrointestinal haemorrhage - Tracheostomy care - Sepsis - Acute pancreatitis	 Yes Yes Yes Yes	 100% 88% 86% Ongoing
Maternal, infant and newborn clinical outcome review programme	Yes	100%

External Visits

Care Quality Commission (CQC) – Chief Inspector of Hospitals Visit

We are registered with the Care Quality Commission and do not have any conditions attached. In October 2014 we had a large scale inspection from the CQC – this included both acute hospitals and our community services. The CQC inspected but did not report on community paediatric service. The CQC will complete that inspection in June 2015.

The inspection took place between 14th and 17th October 2014, and unannounced inspection visits took place between 25th and 30th October.

Overall, we "require improvement". We were rated "good" for caring for patients and effective care but "require improvement" in being responsive to patients' needs and being well-led. We were rated in the safe domain as "inadequate".

Overall rating for this trust	**Requires Improvement**
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Key Findings

- Staff were caring and compassionate, and treated patients with dignity and respect.
- Shared learning from incident reporting needed to be improved across the organisation.
- Infection control practices were generally good but there were pockets of poor practice that needed to be addressed.
- Medicines management was inconsistent. Pharmacy support was good and staff valued the input of the pharmacists. However, across the trust, the safe storage of medicines was not robust. This was an area in which the trust had failed to meet its targets for 2013/14.
- The trust had consistently failed to meet the national target for treating 95% of patients attending the accident and emergency (A&E) department within 4 hours.
- Generally community services were good, but required improvement for safety.
- We were concerned about wards D26 and D11 at City Hospital, which were not meeting the basic care needs for patients.
- The trust had recognised that end of life care was an area for development for the Bradbury House Day Hospice.
- The mortuary on both sites had long-standing environmental issues that needed to be addressed.

Outstanding practice

- The iCares service within the community and the diabetic service. These were outstanding and had received national recognition. Critical care services were good overall, with both staff and patients feeling well supported.
- The compassionate and caring dedication for end of life care with regard to a minor, which was rated as outstanding, especially how the service used the wider healthcare team to meet the needs of the individual. We were confident that this level of support would be repeated in a similar situation.

Improvements required

- Review the levels of nursing staff across all wards and departments to ensure that they are safe and meet the requirements of the service.
- Ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised so that service development and learning can take place.
- Ensure that all patient-identifiable information is handled and stored securely.
- Follow through from findings of safety audit data, and follow up absence of safety audit data.

- Address systemic gaps in patient assessment records.
- Take steps to improve staff understanding of isolation procedures.

We have taken the results of the CQC inspection very seriously and have published our improvement plan delivery of which is one of our key priorities for 2015/16. The full report from the CQC is available on our website www.swbh.nhs.uk. More information about it is set out in the first chapter of this report.

Health Education West Midlands visits

Health Education West Midlands (HEWM) visits are vitally important for the continued quality assurance of training we provide at Sandwell and West Birmingham Hospitals NHS Trust and ensure the development of good training practice for both undergraduate and postgraduate medical education.

Training undergraduate and post graduate staff plays a big part in ensuring safe, high quality care for our patients provided by caring and compassionate clinicians.

HEWM visited the trust five times within the last year, looking into areas such as the medical training provided in Radiology, Emergency Medicine, Paediatrics, Ophthalmology, and Trauma & Orthopaedics/Plastic Surgery. The University of Birmingham also visited the Trust for a routine quality assurance visit for undergraduate education during the past year.

Below is a selection of the positive feedback we received during these visits.

- The programme and department obtained excellent feedback from all trainees who unequivocally recommended their post. It was clear to the panel that the department prioritised training and adopted a holistic approach to the trainee experience.
- The college and clinical tutors are to be commended for their enthusiasm and involvement with training. The training opportunities and the environment were reported by the trainees to be generally very good. Local training was described as brilliant and supervision is very good.
- The Trust is commended for providing senior trainees with protected time to access specialist interest clinics. This is extremely well valued by trainees and is an area of best practice for paediatrics regionally.
- The panel noted that the change that has occurred within the department following the previous visit has been very positive with tremendous improvements and generally a very high standard of training.
- The panel recognised the progress the department had made since the previous QA visits. There was a noticeable refocus on education and training with a clearer clinical educational leadership and Trust engagement.
- The panel was confident that the Trust was delivering the undergraduate (UG) medical programme to all minimum standards, exceeding them in many areas and that there were no concerns about patient safety raised by students. The tone of the visit was very positive, with some impressive innovations displayed throughout. The panel was impressed with the enthusiasm from staff during the visit and several areas of good practice were demonstrated.

Cardiology external review

The Trust commissioned an Invited Service Review by the Royal College of Physicians. The review took place on 24th - 26th September 2014. There were specific areas that the Trust wanted to be the focus of the review. Therefore the terms of reference and scope of the review was set to include:

- Workforce
- Working Practices
- Team Working
- Clinic Utilisation
- Reconfiguration

The report highlighted that there are many hard-working, dedicated staff within the cardiology department of Sandwell & West Birmingham Hospitals NHS Trust and acknowledged the work done to date including improvements to the medical cardiology service relating to consultant appointments, leadership and job planning. There was also acknowledgement for heart failure and rehabilitation that were described as being examples of excellent practice within the wider service.

However there were equally areas where immediate improvement is needed and these were reported as being the essentials of a high quality service. These include shorter waiting times for outpatient appointments and meeting national clinical standards together with reconfiguration of invasive cardiology services on the City Hospital site should be the immediate priorities for the Trust. These aims are readily achievable with sufficient investment in time, capacity and capability of leadership and support of the specialty lead. An action plan has been developed highlighting the areas for improvement along with timescales for completion. This action plan includes the case for a whole service reconfiguration, which we expect to proceed during autumn 2015.

National Peer Review of Major Trauma Services: 2015

The national peer review of trauma services took place during the Spring of 2015. The two trauma units within the Trust, at City Hospital and Sandwell Hospital, were assessed independently.

The process and governance of major trauma care within the Trust is under the remit of a single major trauma group and the team responsible for presenting our services to the reviewers was the same for both visits. Accordingly, points raised by the team and identified by the reviewers have, in general, been common to both sites.

The visits occurred at a time when there continues to be ongoing reconfiguration of services between the acute sites within the Trust and the areas identified by the review were already known and contained within a work programme to attend to them.

The review focuses on three broad areas:

- Reception and resuscitation measures
- Definitive care measures
- Rehabilitation measures

Within these three areas are a number of benchmarks and all trauma units are assessed against these throughout the peer review process.

The SWBH team was identified for the clear and honest appraisal of our services and the open engagement with the peer reviewing teams at both sites. A number of points of good practice were identified in the way that care is organized and delivered.

The areas needing attention are graded as immediate risk, serious concern and concern.

Immediate risks

An immediate risk has been identified and included in our report although the required resolution spans the responsibilities of the major trauma centre services at University Hospital Birmingham NHS Foundation Trust (UHB NHS FT) and Sandwell and West Birmingham Hospitals NHS Trust (SWBH NHS).

Serious concerns

There are not any trauma team nurses who have been trained in the Advanced Trauma Nurse Course (ATNC) or equivalent, meaning that not all shifts have an appropriately trained trauma nurse on duty which could seriously compromise the quality of care for patients. (Both sites)

Response: There is agreement from the Emergency Department matron, supported by the Board, to train nurses through the accredited trauma course or to train to an equivalent standard via in-house training programme (or both) and to maintain the competency and training of nurses in trauma management.

Whilst only applicable to a small number of patients the administration of Tranexamic Acid (TXA) is a critical therapy in the trauma pathway for patients with significant haemorrhage. The reviewers were not assured that this is embedded in practice and this could seriously compromise the quality of care and affect clinical outcomes. (Both sites)

Response: In addition to targeted training of the multidisciplinary trauma team regarding early management of the bleeding patient, the trauma paperwork is being reformatted to provide distinct prompts to the team so that key interventions, some of which are uncommonly required, such as administration of TXA are highlighted. This change will also allow better data recording that will improve the quality of data submitted to Trauma Audit and Research Network (TARN).

There are delays in accessing CT scans for trauma patients beyond 30 minutes from request; there are also delays in reporting the scan results. These delays in undertaking and reporting of CT scans on major trauma patients may lead to significant adverse outcome for these patients. (Both sites)

Response: Imaging services need to implement more resilient processes for reporting (e.g. same model as stroke care) and be able to provide ongoing trauma specific data on process. The CT scanner at City Hospital needs replacing as the time taken to reconstruct the scans ready for reporting is excessively long. The capital investment for this to happen has not been confirmed to date but will form part of the tendered Managed Equipment Services (MES) provision over the next 12-18 months.

There are significant challenges in accessing referral pathways to the Major Trauma Centre (MTC) at UHB NHS FT for patients with neurological injuries. As a consequence patients do not get timely access to specialist care at the MTC. In the absence of timely transfer and provision of specialist support the reviewers were concerned that care is not delivered in the most appropriate care setting and this could seriously compromise the quality of care and affect clinical outcomes. As with the immediate risk, the required resolution is the responsibility of the major trauma centre services at UHB NHS FT and outside of the control of SWBH NHS Trust. (Both sites)

Response: This issue has been identified by many of the trauma units attempting to access services from UHB NHS FT for MTC patients and is expected to be identified by the peer review process as requiring resolution by UHB NHS FT and their commisioners.

Concerns

There is a lack of support services and resilience for Trauma Audit Research Network (TARN) staff and rehabilitation coordinators. (Both sites)

Overall response

The review is an important piece of work, which features on the organisation's risk register and is overseen by the Board. As trauma work is by its nature multi-specialty, we will govern our delivery of care through the new Theatres Management Board chaired by the Chief Operating Officer.

Emergency Department Consultant and Clinical Lead, Mr Prem John

Our priorities for 2015/16

Our approach

In this quality account, in our annual plan, and in submissions to the Trust Development Authority we identify the same 5 big priorities for action. These will be routinely reported to the Board, and feature in our Board assurance framework.

During 2015/16 we expect to agree a revised three year forward plan for safety, quality and patient experience. In that cycle will establish aims at a local level spanning every service.

1. Our Improvement Plan

The improvement plan sets out the Trust's response to the areas for action identified by the Care Quality Commission following their inspection of our services in October 2014. Every part of the organisation was found to be caring. Our adult community based services were rated 'good' by the inspection team and so were maternity services, critical care and end of life care. Other services at Sandwell and City Hospitals 'require improvement'. Through successful delivery of the improvement plan consistently good practice will be achieved across all services.

The key themes for our Improvement Plan are:

- We need to be better at learning across our organisation, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust.
- We need to ensure that we consistently deliver the eesentials of great care, with disciplined implementation of policies on hand-washing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time.
- We need to tackle our sickness and vacancy rates if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.
- We need to build on our best practice around local management and leadership, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way.
- We need to do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – we know where our issues are, and need to address them more quickly when they are identified.

2. Readmission

The reduction in the number of readmissions was one of our priorities last year. There is still a lot of work to be done and we will continue to work on identifying those who are at risk of readmission by using the LACE screening tool and providing supported care pathways for those that need them.

3. Year of the Outpatient (YOOP)

Our programme, notwithstanding its name, continues until we have delivered both the changes planned for 2014-2015, and the overall goal of improved patients satisfaction. We recognize that whilst tens of thousands of patients tell us about the quality of outpatient care, we both have high Do Not Attend rates and lower rates of satisfaction with our welcome and booking processes.

4. Community caseloads

This aim for improvement spans health visiting, district nursing and maternity services.

We will establish by the start of quarter 2 a trajectory for change. This is likely to combine:

- Additional recruitment
- Risk stratification of existing patients, along with GPs
- Setting discharge standards from services
- Looking again at our skillmix
- Improving productivity by use of tools used in other industries to tackle route-mapping

5. 10/10 Patient Safety Standards

We are exploring how to extend this concept into other parts of the Trust, such as theatres and outpatients, as well as community focused teams. However, we will not do so until we have convincingly delivered in all of our ward areas. During Quarter 2 of 2015/16 there will be a sustained multi-professional attempt to ensure that consistently we deliver not just the letter of these standards, but their spirit, which focuses on patients and their relatives being satisfied that the goal has been met.

Patient Afsana Akhtar, Chief Nurse, Colin Ovington, Surria Amin, Staff Nurse, Kim Kaur , Senior Nurse at the Ten out of Ten Safety Standard launch.

CCG CQUINS 2015/16

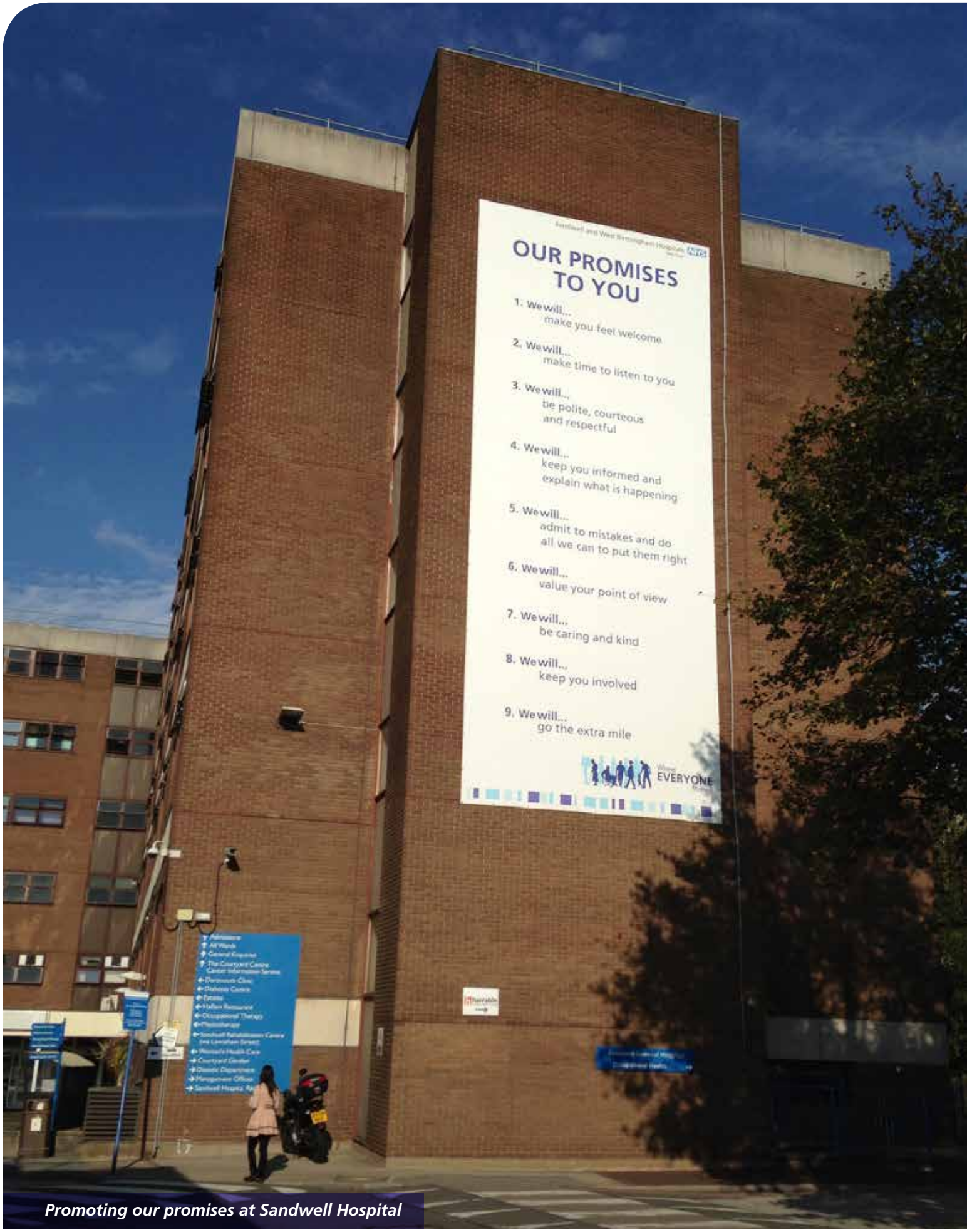
CQUIN	RATIONALE
National CQUIN – AKI (Acute Kidney Injury)	To improve the follow up and recovery for individuals who have sustained AKI, reducing the risks of readmission, re-establishing medication for other long term condition and improving follow up of episode of AKI, which is associated with increased cardiovascular risk in the long term.
National CQUIN - Sepsis	Providers are expected to screen for sepsis for all those patients for whom sepsis screening is appropriate, and to initiate intravenous antibiotics within 1 hour of presentation, for those patients who have suspected severe sepsis, red flag sepsis or septic shock.
National CQUIN - Dementia	i) Find, Assess & Refer; ii) Staff Training; iii) Supporting Carers; iv) Inform. The aim of this CQUIN is to ensure that people who are diagnosed as having dementia leave the hospital with a discharge letter that informs the GP and aimss to assist with care planning.
National CQUIN – Mental Health/A&E	To improve the diagnosis in A&E and reduce the rate of Mental Health re-attendances in A&E.
Local CQUIN – Dietetics - communication	Carry over from Q4 14/15.
Local CQUIN – Dietetics - RTT	Carry over from Q4 14/15.
Local CQUIN - Safeguarding	There is a need to ensure safeguarding practices support the needs of vulnerable children and adults. Therefore this indicator is aimed at ensuring that providers continue to embed safeguarding into practice, implement lessons learnt following a safeguarding event, reflect on practice and ensure that the voice of the child/adult is heard.
Local CQUIN – Dementia moves	The rationale for this CQUIN is an extension of the recommendations outlined in the Dementia Friendly Hospital Charter and the King's Fund programme, which looked at the environmental impact of hospital wards on patients diagnosed with Dementia. We want to limit the number of moves to ensure we minimise disorientation caused by repeated ward transfers.
Local CQUIN – Out of hours transfers	This CQUIN aims to offer an incentive to reduce avoidable transfers that occur during out of hours. This will increase patient experience of services. For this CQUIN we are classing 8pm – 6am as out of hours.

The last CQuin demonstrates our commitment to improving the patient experience. Involving our patients, relatives, carers and community to improve services is central to our success as an organisation. It is at the heart of all we do and we know that it is only by working together in this fashion that we can truly achieve the best for those in our care.

In addition the indicators above, we have agreed:

- Specialist services CQuins with NHS England
- Key performance indicators for quality with our CCG

Data on all of these indicators is published monthly in the Intergrated Performance Report of the Trust's Board held in public.



Promoting our promises at Sandwell Hospital

KPMG

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Sandwell and West Birmingham Hospitals NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

- the Quality Account presents a balanced picture of the 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, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated 22/06/2015;
- feedback from Local Healthwatch dated 18/052015;
- the latest national patient survey dated 14/04/2015;
- the latest national staff survey dated 24/02/2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 30/04/2015;
- the annual governance statement dated 04/06/2015; and
- the Care Quality Commission's Intelligent Monitoring dated June 2015.

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

This report, including the conclusion, is made solely to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and [Name of Trust] for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

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

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sandwell and West Birmingham Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP.

KPMG LLP
One Snowhill,
Snow Hill Queensway,
Birmingham
B4 6GH

29 June 2015

What others think of our Quality Account

We invited our Commissioners, the Overview and Scrutiny Committees (OSC) and the Healthwatch Groups from both Sandwell and Birmingham to tell us what they thought of our Quality Account.

Health Watch Birmingham made the following comments

Healthwatch Birmingham is pleased to read that the Trust has improved its position in the rate of Patient Safety and Incident Reporting, no doubt helped by 72% of the Trust's staff has received Safeguarding training with a further 68% of key staff receiving more in depth training. The number of falls has also reduced this year. Patient safety is paramount and we are pleased to see the Trust improve its figures in this area.

However, Healthwatch Birmingham is disappointed to read about a number of issues that have been flagged up in the quality account.

We are concerned that the number of deaths has increased throughout the year and spiked in December and January. Additionally, the Trust has failed to meet its target of reviewing 100% of deaths within 42 days with the figure dropping as low as 60% in quarter 4. We feel this places the Trust in a vulnerable position. The number of complaints has also increased this year and the Trust has failed to meet its target of resolving complaints within 30 days. Timely resolution of complaints is important to patients and Healthwatch Birmingham is keen to see the Trust keep this as a priority in 2015/16.

Healthwatch Birmingham is disappointed to read that CQC rated the hospital as needing improving, particularly in the Safe domain which was rated as inadequate. Patient Safety needs to be at the heart of any service. Similarly, CQC reported that the Trust was not meeting the basic needs of patients in two wards and has consistently failed to meet the 4 hour A&E waiting time target. CQC's concern about the effectiveness of the Cardiology department and not meeting national clinical standards is also alarming. Similarly, the lack of trauma trained nurses seriously compromises the quality of care. We urge the Trust to resolve these issues and improve standards in these areas.

Staff management is also an area of concern with only 90% of staff receiving an annual appraisal and sickness absence increasing to 4.69%.

Healthwatch Birmingham carried out one Enter and View visit this year at City Hospital Maternity Services and while we received positive feedback from patients about their experiences of using the service, we were concerned about basic Health and Safety issues such as hospital equipment being stored in walkways and corridors. This puts the Trust in a vulnerable position and risks the safety of patients. We raised this issue with staff on 5th December and reported our concerns.

Healthwatch Birmingham is keen to support Sandwell and West Birmingham NHS Trust to improve their performance in a number of the area's raised. If we can be a source of support then please do not hesitate to contact us.

Sandwell OSC notified the Trust that they were unable to provide comments on the Quality Account due to other commitments.

Sandwell and West Birmingham CCG provided an amalgamated feedback report with Birmingham Cross City CCG.

We asked them to report on the following national prompts:

- The accuracy of the data provided in the Quality Account against data they have been supplied with during the reporting period
- Whether the Quality Account is representative
- Is it comprehensive in its coverage of the provider's service?
- Are there any significant omissions?
- Are there any areas of concern that have been discussed with the Trust in relation to the Quality Account?

Comments

Overall a well put together report, clear, concise and easy to read, well structured.

Priorities for 2014/15

Area 1: Implementation of discharge bundles – they state that these are implemented and available on the intranet- have they checked/audited use and completion of? This would be a more robust method of gauging their effectiveness.

Area 5: patient safety standards – would be useful if they could expand on what the 10/10 standards are, the targets they have set and what they're achieving against.

Safety and incident reporting: – would be meaningful to include level of harm reporting as well as numbers.
Safeguarding Children and Adults: – noted good work being done and that they have published % of training figures. Would be beneficial to see some commitment to improve these in 2015/16
Details of 10/10 standards and Trust achievement in 14/15 – Could these be outlined?
Good reporting on audit outcome and actions

Priorities for 2015/16

What has happened to those they didn't achieve in 2014 -15. HAVTE, 10/10 standards, mortality reviews in 42 days and hospital cancellations of appointments? Should consider including them to ensure consistent improvement or at least reference where these will continue to be monitored and how by the Trust.

Focus Area 1: Embedding the LACE tool. GP and ANP colleagues in my surgery have not heard of this until this morning so I would say not universally embedded.

Focus Area 2: Reducing preventable deaths. I am glad the Trust acknowledge failure to reach the 42 day target for reviewing all deaths in hospital – of concern as this has been lagging behind target for a long time.

Focus Area 5: 10/10 Patient Safety Standards. High standard set mitigates failure to reach this target.
Access Metrics. 62 day RTT data is not included and though the overall averages have been at target on occasions some Groups have been significantly at variance with others. For example Surgery B achieved 40% GP referral to treatment within 62 days in March. Highlighting and tackling these variances could have featured.

Clinical and Quality Outcomes: KPI's in general are passed over quickly Some are detailed. I think there are a few which should have been picked out. One for example is Stroke Care – Admission to Thrombolysis Time (%within 60 minutes). Though the year end figure looks encouraging it does not tell the story of the variances and the improvements which are not sustained (44% in Sept 2014)

Peer Comparison: I do not recognise the acronyms used for other Trusts and I don't think a lay person would.

Complaint response rate: This is a fair and honest representation. It doesn't discuss that this has been an unfixed problem for several years.

Comprehensive account of external visits

CQC reports states 'Widespread learning from incidents outside staff's own wards or departments was limited'. I don't think that the Quality Account proposed improvements.

Surprised to see typo errors

Appendix1

Readmission rates

Information from the Health and Social Care Information Centre (HSCIC) provides data up to 2012. Current data is provided from the Trust's own data system.

We saw a higher than expected number of readmissions in 2012. This readmission rate put us in a significantly poorer position than the national average. Based on this information provided by HSCIC in 2012 our current % keeps us in the same significantly poorer banding A1.

2012 data from HSCIC	Lower percentile of 95%	Upper percentile of 95%
SWBH	12.3	12.8
National range	7.1 – 13.1	14.1 - 19.1

The table below details our readmission rates. The information is collected during a financial year period and we now measure readmission within 30 days (previously 28 days). Our readmission rates continue to rise and readmission reduction remains a priority for the Trust.

Age 0 – 15 years

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
14/15	15819	1360	8.6%
13/14	15331	1350	8.8%
12/13	15679	1463	9.3%
11/12	14533	1257	8.6%
10/11	15077	1219	8.1%

Age 16 and over

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
14/15	94349	7707	8.2%
13/14	96981	7530	7.8%
12/13	101647	7693	7.6%
11/12	102660	7235	7.0%
10/11	110729	7734	7.0%

All Ages

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
14/15	110168	9067	8.2%
13/14	112312	8880	7.9%
12/13	117326	9156	7.8%
11/12	117193	8492	7.2%
10/11	125806	8953	7.1%

Patient experience of hospital

It is now standard practice in healthcare to ask people to provide direct feedback on the quality of their experience, treatment and care. This indicator is intended to be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients' and service users' points of view and will ultimately play a role in driving improvements in the quality of service design and delivery.

Patient experience of hospital care is measured by scoring the results of a selection of questions from the National Inpatient Survey that looks at a range of elements of hospital care.

The domains	Score
Access and waiting	83%
Safe, high quality care	68%
Better information, more choice	68.9%
Building closer relationships	83.3%
Clean, friendly comfortable place	81.9%

Lowest	Highest	SWBH
69.9%	83.3%	77%

Weighted score average comparing the national lowest and highest score along with our own.

We are committed to improving the patient experience of our hospital and take seriously the feedback we receive.

National Audits conducted during 2014/15 and actions taken

Report	Our actions
Provisional Patient Reported Outcome Measures (PROMs) **Audit description** An audit of outcomes reported by patients undergoing hip replacement, knee replacement, varicose vein surgery and surgery for inguinal hernia repair The Health & Social Care Information Centre publishes data on a quarterly basis	**Action** A number of steps have been taken to ensure that patients undergoing these procedures receive appropriate information and support. The actions have included the updating of information on risks and benefits and the implementation of guidelines for the listing of patients for surgery.
Sentinel Stroke and Stroke Improvement National Audit Programme (SSNAP) **Audit description** The Sentinel Stroke National Audit Programme (SSNAP) is led by the RCP and commissioned by HQIP as part of the National Clinical Audit Programme. Updated reports are published every three months. This allows each hospital to be compared to other local hospitals and to the national average against a range of 10 categories of care.	**Action** The results had shown that there was a need to improve the quantity of Occupational Therapy (OT) provision. This issue was discussed by the Stroke Action Team discussed and an escalation process was agreed before the Stroke OT was used for other clinical areas. In addition, the need to improve the collection of post discharge data at 6 months was identified. The team to explore improving this further by recording this through SSNAP.
National Emergency Laparotomy Audit (NELA) **Audit description** The National Emergency Laparotomy Audit (NELA) is part of the National Clinical Audit and Patient Outcomes Programme, The audit was commissioned by HQIP following evidence of a high incidence of death, and a wide variation in the provision of care and mortality for patients undergoing emergency laparotomy in hospitals across England, Wales and Scotland.	**Action** Key aspects where the organisation of care could be improved in the Trust were identified. These included • To scope the introduction of routine daily input from elderly medicine into elderly surgical patients by building this into job plans. • To increasing the scope critical care Outreach provision. • To improve access to 24/7 Interventional Radiology though discussion of a rota with colleagues at a regional level. • To review emergency theatre flows to reduce elective cases overflowing into emergency theatres
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, 'Are we on the right trach?' **Audit description** The primary aim of this study was to explore factors surrounding the insertion and subsequent management of tracheostomies in both the critical care unit and ward environments.	**Action** Locally, an assessment against the key recommendations was conducted and the following actions were identified. • To review current documentation and to consider developing a specific tracheotomy care discharge document for adults and children. • To review current training and competencies and to consider introducing mandatory training for areas that 'routinely' care for patients with tracheostomies. • To introduce the National Tracheotomy Safety Project algorithm and associated notices. • To develop a local protocol and bedside data proforma with flowchart.
Head and Neck Cancer Audit (DAHNO) 2013 Report **Audit description** DAHNO aims to collect data about patients with primary squamous cell head and neck carcinoma involving the larynx and oral cavity.	**Action** The assessment against the key recommendations found that there was good compliance for the service that is run from the regional centre. The only area for improvement which was identified concerned improving the cover for the Speech and Language Therapist at the MDT meetings during leave periods. This to be raised with the regional centre.

Report	Our actions
National Cardiac Arrest Audit (NCAA) **Audit description** The NCAA is the only national, clinical, comparative audit of in-hospital cardiac arrest with the aim of improving resuscitation care and outcomes for the UK and Ireland. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre).	**Key findings/learning** The Trust's actual survival to discharge rate was reported as being 17.9%, which is in line with the national rate. The Trust has a predicted survival to discharge rate of 31.45%. This rate was considered to be at variance with locally collected data. As a result, a request has been made to the NCAA to provide further data on how the predicted value is calculated.
National Neonatal Audit Programme – Annual Report 2013 **Audit description** The key aims of the audit are: • To assess whether babies requiring neonatal care received consistent care across England; • To identify areas for improvement in neonatal units in relation to delivery and outcomes of care; • To provide a mechanism for ensuring consistent high quality care in neonatal services	**Action** For the neonatal unit to continue to work closely with the Infant Feeding Team on breast feeding initiation. In addition, to work with community paediatric team (consultant and Health Visitor) to improve data capture for 2 year survival rates.
The Trauma Audit and Research Network (TARN) **Audit description** The Trauma Audit and Research Network (TARN) is an established national clinical audit for trauma care and has been supporting trauma receiving trusts for over twenty years by providing each hospital with case mix adjusted outcome analysis, performance of key process measures and comparisons of trauma care.	**Action** A new proforma will be introduced to help improve data capture. In addition further work to be undertaken with the Network to review whether all relevant cases are being captured.
National Audit of Seizures in Hospital- Clinical Report 2014. **Audit description** The audit examined the care given to over 4,500 patients who attended the Emergency Department as a result of a seizure at 154 sites across the UK.	**Action** To include presentations on acute seizure management in junior doctors teaching sessions. In addition to develop a business case for the appointment of Specialist Epilepsy Nurse to help to address deficiencies, and also to create a Trust-wide guideline on Acute Seizure Management accessible via the Trust Intranet.
National Diabetes Inpatient Audit- 2013 Report **Audit description** The National Diabetes Inpatient Audit (NaDIA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) It is a snapshot audit of diabetes inpatient care in England and Wales. The aims of the audit include finding the answers to the following questions: • Did diabetes management minimise the risk of avoidable complications? • Did harm result from the inpatient stay? • Was patient experience of the inpatient stay favourable?	**Action** The need to improve education and training was identified, as the uptake on current training opportunities was reported to be variable. There is a need to target those areas where there is a poor uptake of training. In order to understand root causes of diabetes related errors including insulin errors, the Trust has participated in pilot study run through the National Diabetes Audit to understand the root causes of diabetes related incidents.

Report	Our actions
National Oesophago Gastric Cancer Audit Report 2013 **Audit description** The overall aim of the audit is to measure the quality of care received by patients with oesophago-gastric (O-G) cancer in England and Wales.	**Action** Although the surgery is not performed at the Trust, it is nonetheless an important contributor to the pathway of care. The key recommendations contained in the report were reviewed and overall good compliance with relevant key recommendations was reported. The main area identified for improvement was in ensuring the attendance of an oncologist to the multidisciplinary team (MDT) meetings. This would be addressed through a service level agreement. In addition, it was reported that the team were supporting a national awareness campaign to improve early detection of OG cancer.
Epilepsy 12 Audit, Round 2 Report 2014. **Audit description** Epilepsy12 is a national clinical audit was established in 2009, with the aim of helping epilepsy services and those who commission health services to measure and improve the quality of care for children and young people with seizures and epilepsies.	**Action** Locally, it was identified that Specialist Nurse input was required to improve practice and in particular in the provision of lifestyle advice. The need for CNS support would be raised promptly with Commissioners. In addition, an action to consider using 'Easy Read' for translation of leaflets to support more effective education was identified.
National Pregnancy in Diabetes Audit 2013 Report **Audit description** The National Pregnancy in Diabetes (NPID) Audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant. The audit measures the quality of pre-gestational diabetes care against NICE guideline based criteria and the outcomes of pre-gestational diabetic pregnancy. It aims to answer the following three key questions: • Were women with diabetes adequately prepared for pregnancy? • Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother? • Did any adverse outcomes occur?	**Action** The key recommendations contained in the report concerned pre-conception support and monitoring. Locally, this highlighted the need for a strategic approach to be taken with health partners and in taking opportunities for health promotion and enhancing staff training.
Prostate Cancer Audit –First Year Annual Report **Audit description** The NPCA is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer. It is designed to collect information about the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes. The findings from the audit will contribute to changes in clinical practice ensuring that patients receive the best care possible and experience an improved quality of life	**Action** Locally it was identified that there was a need to monitor the availability and uptake of high-dose rate brachytherapy, as this was recommended for men with intermediate and high-risk localised or locally advanced prostate cancer.
National Audit of Cardiac Rhythm Management Devices 2013-14 Report **Audit description** The National Audit of Cardiac Rhythm Management (CRM) collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK.	**Action** It was reported that there was a need to continue to ensure that referrals are appropriate so that a comprehensive service can be provided to all who need it.

Report	Our actions
National Audit of Intermediate Care. **Audit description** The core function of intermediate care is in providing alternatives to hospital care, either by preventing hospital admission or expediting discharge from hospital, using a rehabilitation-type intervention typically lasting less than six weeks. The audit enables the NHS to take stock; to pose and receive answers to two fundamental questions: can intermediate care deliver good outcomes at an affordable cost; and, is it making a difference?	**Action** The recommendations provide a focus for Commissioners. As a result locally there is need to work with Commissioners to ensure that there is a comprehensive geriatric assessment across all home based and bed based intermediate care, and to contribute to strategic planning for intermediate care that is undertaken jointly by health and local government.
National Paediatric Diabetes Audit 2012-13 Report **Audit description** The National Paediatric Diabetes Audit (NPDA) collects data on the quality of care for children and young people with diabetes mellitus in England and Wales	**Action** To monitor closely the collection and uploading of HbA1c data for City Hospital so that this accurately reflects clinical practice.
Adult Critical Care (Case Mix Programme) (ICNARC) – Summary Reports 2014 **Audit description** The audit aims to promote local audit of critical care through the provision of comparative data, and to promote the use of evidence in critical care practice and policy.	**Key findings/learning** The local summary reports indicated that data completeness was good overall and data submission deadline were met. The data also showed that there had been a decrease in the length of stay on the units, but also an increase in the discharges taking place 'out of hours'. In addition, data had shown an increase in acute hospital mortality ratios. **Action** Further work required to determine whether the units are always admitting appropriate patients and also whether patients are being followed up appropriately. It was also reported that there was an ongoing review of all in unit and late hospital deaths to determine if any lessons could be learnt.
Falls and Fragility Fracture Audit Programme (FFFAP). National Hip Fracture Database (NHFD) Annual Report 2014 **Audit description** The National Hip Fracture Database (NHFD) is a clinically led, web-based audit of hip fracture care and secondary prevention.	**Action** The audit found that the Trust was below the national average for patients meeting the best practice tariff. The main reason for this was that there were delays in getting patients to theatre within 36 hours. To address this it was reported that there was an ongoing review of 24hr breeches, but that further detailed multi-disciplinary audits were needed involving geriatricians; T&O and Anaesthetics to investigate further the reasons for any breaches in 24 hour door-to-theatre times.

The reports of 38 local clinical audits were reviewed by the Trust in 2014-15 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Audit topic	Actions
Audit of prevention and management of foot problems (Adult Community Services) **Audit description** The aim of the audit was to assess the compliance with NICEClinical Guideline 10 in relation to diabetic foot risk assessment and to ensure that these are being carried out annually. All diabetic patients registered with the foot health department should receive an annual diabetic foot risk assessment.	**Action** To take steps to ensure that clinicians record when a diabetic assessment is due after each treatment and for administration staff to highlight when the diabetic assessment has not been accommodated when this has been requested by the clinician and the reason why. In addition, to explore adding a flag to the electronic file, so that clinicians are alerted when the assessment should be requested.
Audit of community admissions avoidance response within 3 working hours. **Audit description** The specification for care management states that there is an avoidance response within 3 hours of referral. There was no baseline data available. The standard to be achieved was that 100% of urgent referrals will be managed within 3 working hours.	**Action** No specific further action was required as compliance with the standard was demonstrated.
Head injury Audit **Audit description** To evaluate compliance within the Emergency Departments (ED's) with Head Injury guidelines	**Action** To take steps to improve the capture of the GCS by ensuring that the head injury proforma is printed out from the Patient Administration System (Patient First) at time of triage. Also, to monitor compliance through the resumption of spot check audits. Further, to address CT scanning requirements through educational sessions and discussion of new novel anticoagulants.
Audit of new referrals to the Breast Service (RABC) **Audit description** An audit of new breast referrals to the Rapid Access Breast Clinic (RABC) to identify the quality and the quality of referrals.	**Action** To carry out targeted education and teaching to ensure appropriate referrals. In addition, to ensure that standardised information leaflets are available and to examine the 'Map of Medicine' referral pathways with GP's to see if these need to be adjusted.
An audit of the accuracy of recording of the hip replacement procedure information (THR and hemiarthroplasty) on the KMR form by surgeons. **Audit description** Several types of hip replacements are performed; cemented, uncemented, hybrid, total hip and hemiarthroplasties. Each procedure has a specific code and tariff. The audit was conducted to assess whether surgeons are entering the correct information on the KMR. This entry is important as it is the basis on which the coding is performed.	**Action** To take steps to ensure that the KMR form is filed in the notes before the patient is taken to theatre. Checks then to remain in place so that the patient does not leave the theatre recovery area unless the data is entered fully on the KMR, and then to check compliance through re-audit.

Audit topic	Actions
Lumbar Puncture Audit **Audit description** The purpose of the audit was to examine whether staff were documenting the required Information in the patient record. In addition, to then use the findings to inform the design of a new lumbar puncture (LP) kit and the development of a checklist to act as a prompt and which can then be filed in the patient's notes.	**Action** To introduce a lumbar puncture 'checklist' to be completed before any LP to act as a prompt and to ensure that all of the required information is documented. In addition, to introduce a standard pack for lumbar puncture.
Global Rating Scale Audits **Audit description** Annual audit programme mandated by the National Joint Advisory Group (JAG) for Endoscopy for service accreditation.	**Action** To monitor the outcomes as part of the revalidation criteria for procedurists. In addition, to review the data on a regular basis with the gastroenterology multidisciplinary team (MDT) in clinical governance meetings.
WHO Checklist Compliance Audit **Audit description** To assess the compliance with the "Five Steps to Safer Surgery" in the Trust. This includes use of the Surgical Safety Checklist. All patients undergoing interventions, surgical procedures or treatments (defined as the intervention provided by a team in an operating theatre or procedure room) should have the 3 sections in the Safer Surgery Checklist completed (Sign in, Time out, Sign out). A brief and debrief should also conducted for relevant lists.	**Action** Further work is required to ensure that in all relevant lists a debrief session is recorded at the end of theatre lists.
Healthcare Records Audit **Audit description** An audit to assess whether entries in the case notes comply with the basics of record keeping in that they are: • written in black ink • legible • dated • timed • signed • name of author clearly printed • designation of author recorded	**Action** To raise awareness of the need to improve the timing of entries through learning alerts.
Audit of Patient Consent **Audit description** An audit to assess compliance with Trust policy, in particular, in that consent is taken by clinicians who are capable of performing the procedure or have received specific training to do so and that risk and benefits are fully explained.	**Action** To perform some further analysis by Directorate to determine the types of procedure where it is not being recorded whether the patient is being supplied with an information leaflet on the consent form and where consent is being taken on the day of surgery, so that targeted action can be taken.

Audit topic	Actions
Thromboprophylaxis Audit **Audit description** An audit to assess compliance with the Trusts guidelines on thromboprophylaxis, in particular, that all patients assessed to be at high risk of developing a VTE are prescribed thromboprophylaxis.	**Action** To take steps to ensure that all the relevant Directorates participate in the audit. Also, to add a patient identifier (RXK number) to the data collection form so that the data can be linked with the root cause analysis conducted into hospital associated venous thromboembolisms.
An audit of antibiotic prescribing on the Medical Assessment Unit **Audit description** An audit to assess the compliance with standards (derived from the trust antibiotic guidelines). In particular: 1. All drug charts should have an allergy status documented. 2. Where an allergy status is documented, the nature of the reaction should be described. 3. All prescriptions should have a documented indication 4. All prescriptions should have a documented antibiotic review date or treatment length	**Action** It was reported that as E-prescribing was planned for the future, a new redesigned drug chart with an improved layout to prompt the recording of the key requirements would be introduced in the meantime
An audit of the assessment of cognitive status in patients with a fractured neck of femur. **Audit description** The aim of the audit was to assess whether an AMT (abbreviated mental test) scoring is being conducted in patients with a fractured neck of femur (over the age of 60) from April – June 2013. This is recommended in the relevant Quality Standards from NICE.	**Action** It was reported that a new clerking pro-forma for patients with fractured neck of femur was introduced in September 2014 to improve compliance still further. In addition, it was identified that there was a need to increase the awareness amongst junior doctors and nursing staff of the need to conduct the test. A further action was to redesign the discharge summary to ensure that information is shared with Primary Care to assist with future planning.
Re-audit of compliance with the Society for Acute Medicine standards. **Audit description** An audit to assess compliance with the standards based on those from the Society for Acute Medicine (SAM). In particular, that patients: • Observations are recorded within 15 minutes of admission. • Are clerked and have a management initiated within 4 hours. • Have consultant review within 6 hours during day (8am-8pm) • Have consultant review within 12 hours overnight (8pm – 8am)	**Action** To consider adding the observations generating the Early Warning Score to the first page of the clerking documentation so as to prompt the documenting of observations within 15 minute of admission. In addition, to ensure that all doctors on medical rota are made aware of SAM quality standards through relevant induction sessions.
Audit on medication errors in Paediatrics **Audit description** An audit to evaluate the effectiveness of actions taken to reduce medication errors in paediatrics	**Action** It was reported that a 12 Step action plan was already in place. Additional actions identified included, redesigning the Paediatric Drug Chart and to continuing to run workshops and education sessions for prescribers.

Audit topic	Actions
Audit of Heavy Menstrual Bleeding. **Audit description** A re-audit to review the management of women with heavy menstrual bleeding who have been referred to secondary care, looking specifically at demographics and the investigations and treatment offered as indicated in the relevant NICE Quality Standards.	**Action** To develop a clear referral pathway with a pre-referral checklist to aid GP's. In addition, to examine developing this in an electronic format.
An audit of the acknowledgement of electronic radiological reports in Paediatrics. **Audit description** Each clinical area is responsible for having a system in place to ensure that an appropriately skilled member of the team reviews results for prescribing appropriate care. The audit aimed to assess practice with acknowledgement of radiological results in paediatrics.	**Action** It was reported that a report system had been established with IT to assist with the monitoring of compliance. A further action was to review the Trust policy underpinning the audit and in particular the need for all Directorates to audit results acknowledgement.
Oxygen prescribing re-audit **Audit description** A re-audit to assess compliance with the British Thoracic Society (BTS) guideline for emergency oxygen use in adults. In particular, with the requirement that oxygen should always be prescribed.	**Action** The main action was to take steps to facilitate better oxygen prescription by making this a prominent feature on the front page of a new prescription chart. A further action identified was to raise the awareness of oxygen prescribing at Junior Doctors meetings.
Allergy recording audit **Audit description** An audit undertaken in Acute Medicine to determine how well allergy status and the nature of the allergy is documented.	**Action** It was recommended that there needed to be alterations made to the prescription chart in order to further facilitate the documentation of allergy status and the nature of the allergy.
Audit of swab counts in maternity **Audit description** An audit to determine compliance with local clinical guidelines in place to ensure that swab and instrument checks are correctly documented.	**Action** To ensure that the 'white boards' is used in the delivery room for swab and instrument checks and that there is evidence of 2 signatures within the notes. In addition, to re-audit practice once the new Maternity Electronic Record System had become embedded.
Re-audit of the assessment of nasogastric feeding tube insertion in the paediatric department. **Audit description** An audit to assess the management of the patient when inserting nasogastric tubes (NG's) and comparing this to the recommended guidance from the National Patient Safety Agency. Also, to compare findings with an earlier audit after which a Nasogastric Insertion Form was created.	**Action** No specific action was identified apart from the requirement for Individual ward mangers to continually monitor the completion of all NG charts.

Audit topic	Actions
An audit of depression screening in children and young people. **Audit description** A re-audit to assess if all 12 year olds admitted to the trust are screened for depression. To assess that this is documented in the notes and that appropriate action is taken based on the initial assessment; i.e. diagnosis of depression, informing patient and carer, further questioning and referral to CAMHS as necessary	**Action** To design a new comprehensive admission document/ booklet to be used for those patients presenting with depressive symptoms, overdose or self harm. To include all depressive screening questions and the assessment proforma for self harm. This is to improve the assessment of the risk of a depressive illness within this group of patients.
Caesarean Section Audit **Audit description** NICE Quality Standards focus on improving the decision-making process and the information available to women who may need, request or have had a caesarean section. The standards also focus on reducing potential risks or complications for the woman and the baby. The audit aimed to measure current practice against the quality standards.	**Action** To ensure that a proforma is completed postnatally either by the surgeon or medical staff discharging the patient that gives full written information of the reason for caesarean section, any events during surgery and on future pregnancy & delivery.
An audit of the action taken after DNA (Did Not Attend) for children under 16 **Audit description** A baseline audit to determine the rate of adherence by clinicians to the Trust's DNA policy with respect to their response to children under 16 who are not brought for their appointments and who then are discharged. The audit focused on paediatric clinics.	**Main findings/learning.** All children who are not brought for their appointments within the Trust and who are then discharged should have a response in the form of a standard letter sent to their GP. The audit found that a standard letter was sent in 63% of cases. **Action** To continue to improve adherence with the guidelines in paediatrics and to conduct further audits of non-paediatric areas to assess compliance.
An audit of nutritional support in adults referred for home enteral feeding **Audit background** The aim of the audit was to establish out whether adults in Sandwell receive a defined level of dietetic care in the community whilst receiving Home Enteral Tube Feeding (HETF).	**Action** The dietetic team to determine whether the 6 monthly reviews by the nurse specialist was a necessary requirement and if so to ensure that there is an appropriate service agreement in place.
An audit of NICE Quality Standard 12 relating to Breast Cancer. **Audit description** An audit to assess compliance with quality standard that people with recurrent or advanced breast cancer have access to a 'key worker', who is a clinical nurse specialist whose role is to provide continuity of care and support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services.	**Action** In order to improve compliance further it was identified that there was a need to design and implement a patient information leaflet/letter to reiterate keyworker details and the support networks that are available.

Audit topic	Actions
An audit of NICE Quality Standards 52 – Peripheral Arterial Disease **Audit description** The audit aimed to establish whether prior to patients being referred for angioplasty, they have received advice on the benefits of modifying their risk factors.	**Action** To take steps to ensure that leaflets are available in all clinic rooms on risk factor management, medication, intermittent claudication and angioplasty. In addition, to ensure that all discussions are documented and recorded in the letter to patient and to their GP.
Re-audit of the initial care of significant hypoxic-ischaemic encephalopathy (HIE) and passive Cooling. **Audit description** Re- audit to determine if national guidelines for cooling in HIE are being adhered to with regards to diagnosis, criteria for cooling and initial management of patients undergoing cooling	**Action** To undertake a further audit to examine whether there were any babies who met the criteria but that then were not referred for cooling.
An audit of bacterial Meningitis and meningococcal septicaemia in children and young people with reference to NICE Quality Standards 19. **Audit description** An audit to establish whether the paediatric department complies with NICE quality standards, and in particular whether all suspected meningitis patients have the required blood tests, undergo a LP, empirical treatment, and are offered an audiology assessment and a follow up with a paediatrician within 6 months.	**Action** To discuss establishing an 'order set' with pathology for the required blood tests so that those recommended are always undertaken. In addition, to inform Ward Clerks to arrange audiological follow up when booking an outpatient appointment for a patient who has been admitted with meningitis, and to revise the exiting flowchart covering the management of these patients.
Audit of endophthalmitis rates **Audit description** An audit to monitor the endophthalmitis (serious infection inside the eye) rate after any intraocular surgery and comparing the endophthalmitis rates with those published in national and international literature.	**Action** To continue rigorous monitoring with the aim of keeping post-operative rates at 0%.
An audit of dietetic clinical documentation in the Nursing Home setting. **Audit description** An audit to assess compliance with Quality Standard 24 for Nutrition Support in Adults Statement 3 - 'All people who are screened for the risk of malnutrition have their screening results and nutrition support goals (if applicable), documented and communicated in writing within and between settings	**Action** Dietetic team to discuss whether there are better ways to record advice given in nursing and residential homes to overcome: • Inconsistency in the location where dietetic (and other health professional) visits are recorded in nursing home records. • Telephone reviews may not be clearly recorded (or difficult to locate) in care home records (relies on notes recorded by nurse). • Letters are sent to care homes with details of the assessment but the filing of these documents varies between different care homes.

Audit topic	Actions
Glaucoma Service Compliance Audit **Audit description** An audit conducted to ensure that the Trust is providing a high quality glaucoma service and that the quality of the service is maintained.	**Action** To explore further investment in 'virtual clinic' models where patients discuss, or seek advice or regarding investigation or management. In addition, to consider training technicians to perform diagnostic tests to manage service demand going forward.
An audit of CT KUB investigation in suspected renal colic (in-patients only) **Audit description** The audit was conducted to establish whether adaptation to the renal colic pathway may be required. The overall aim is to improve the diagnosis and treatment of patients presenting with acute loin pain by shortening time from referral to CT Scan of kidneys, ureters & bladder (CT KUB).	**Action** To audit the CT waiting times for non-admitted patients and to work with the Imaging department to improve the tracking of CT KUB referrals. In addition, to examine whether CT scanning in females could be reduced given the lower detection rate.
An audit nutrition screening related NICE Quality Standard 24 – Nutrition Support **Audit description** NICE guidance recommends that all out patients should be screened for malnutrition at their first outpatient appointment using a validated screening tool e.g. Malnutrition Universal Screening Tool (MUST). The aim of the audit was to establish how well this was carried out.	**Action** The way in which nutritional screening takes place needs to be redesigned. Emphasis will need to be on nursing staff to screen and inform CNS/consultant on action needed, this will then be incorporated into clinical letter. Once a new pathway has been designed this will be communicated via the nutrition and outpatient leads
Nasogastric Tube (NG) Insertions Audit **Audit description** The aim of the audit was to monitor compliance with National Patient Safety Agency (NPSA) standard for safe NG insertion and also with local standards to ensure that all the systems that have been implemented are robust in order to prevent a 'Never Event' from occurring.	**Action** The action identified included ensuring that staff continue to access the relevant training e.g. nursing staff to obtain Level 1 NGT competencies via QUEST and attendance at the tube feeding study days. In addition, to increase the awareness of the current X ray reviewing criteria and to complete of a 'Never Events' Action video.
Last year of life audit **Audit description** The aim of the audit was to examine whether there was a lack of identification and appropriate management of patients who are in the last year of life.	**Action** The actions identified included to design a training programme about' End of Life' care for senior doctors, and to use established communication channels to further raise the awareness of the identification of 'End of Life' situations.
An audit of the Management of Hypertension in pregnancy related to NICE Quality Standards 35 **Audit description** An audit to assess whether all women who have delivered with pre-eclampsia have had an assessment/management plan undertaken and that this is documented in health records.	Action To take steps to ensure that in a 100% of cases the postnatal management plan is documented in medical records of patients. In addition to take steps to ensure that the administration of parenteral antihypertensive in undertaken in a stepwise fashion as per local protocol in all cases.

Audit topic	Actions
Neonatal Transfer Audit **Background** An audit to measure compliance with the standard that a 100% of babies born at <27 weeks should be transferred to a NICU (level 3 unit) when clinically stable and that Babies needing ITU >14 days require a documented conversation with the NICU regarding transfer.	**Action** To take action to achieve a 100% documentation of the discussions with relevant specialists. This to be addressed in the move to electronic records. In addition, to highlight the need to colleagues for an active discussion with a NICU if babies are ventilated >14 days.