

# PARTNERSHIPS WITH A PURPOSE



Quality Account 2016/17

*Sandwell and West Birmingham Hospitals NHS Trust*

## Quality Plan

Our Vision for 2020 is to provide care with patient measurable outcomes that are equal to or exceed the best in the NHS, across all the services we provide. We will do this by doing the right things in the right way, by facilitating innovation and ensuring our teams base their practice on the best available evidence in a learning environment committed to continuous improvement.

This vision sees us delivering safe high quality care for all clinical services with a determined focus on the effectiveness

of the care we provide for patients and the outcomes our services achieve for patients.

The aim of the Quality Plan is to produce measurable, patient meaningful outcomes, to improve on these continuously and to do so with an ambition that puts us amongst the best organisations in the NHS. The Quality Plan will be achieved over the period 2017/20 through the following objectives:

### Quality Plan Objectives

1	We will reduce deaths in hospital that could be avoided so that we are among the top 20% of comparable NHS Trusts in the UK. We will take action to cut avoidable deaths from Sepsis, Hospital Acquired Venous Thromboembolism, Stroke, Acute Myocardial Infarction (Heart Attack), Fractured Neck of Femur and High Risk Abdominal Surgery.
2	Cancer patients that we treat will have some of the best health outcomes in the UK, with SWBH being among the top 20% of comparable NHS Trusts.
3	We will coordinate care well across different services so that patients who are discharged are cared for safely at home and don't need to come back for an unplanned further hospital stay.
4	We will deliver outstanding quality of outcomes in our work to save people's eye-sight, with results among the top 20% of comparable NHS Trusts in the UK.
5	More Sandwell and West Birmingham residents will take up the health screening services that we provide than in other parts of the West Midlands.
6	We will reduce the number of stillbirths and deaths in the first week of life so that we are providing a better service than others in the West Midlands.
7	Patients at the end of their lives will die in the place they choose, receiving compassionate end of life care.
8	We will ensure the wellbeing of the children we care for, in particular reducing lost days of school as a result of hospital care; and ensuring the safe transition of care to adult services at the appropriate time.
9	Patients will report that their health is better following treatment with us than elsewhere in England, ranking SWBH in the top 20% of NHS Trusts for patient-reported outcomes.
10	We will work in close partnership with mental health care partners to ensure that our children's, young people's, adult and older people's crisis and ongoing care services are among the best in the West Midlands.

This quality plan focuses on clinical effectiveness and the patient's experience of care as the objectives are linked to patient measurable and meaningful outcomes.

Typically outcomes are collected through retrospective audit in many cases through large national audit programmes. These often publish many months after the audit period. Our aim is to get outcome data that is important to patients available as quickly as possible and have that information displayed in a visually appealing and meaningful way.

In the future all of our patients and carers, if asked, will describe their experience at Sandwell and West Birmingham Hospital (SWBH) as being of a good quality, regardless of the time, the location or the staff group that they received their care from. As a minimum each patient will be able to say that the quality of care they received at SWBH was the best that they could possibly want and the Trust ranking will be within the top 20% nationally for delivering good quality care.

Embedding the 10 Quality Objectives is fundamental to ensuring this future state. The assignment of objectives has been set through the Clinical Leadership Executive and while some of the objectives are specialty specific, some, such as management of sepsis, completion of mortality reviews and Venous Thromboembolism (VTE) assessment compliance are crosscutting.

The delivery of the quality plan has been split into four waves. Wave 1 is underway with five mortality initiatives included covering maternity, stroke, general surgery, trauma and orthopaedics and cardiology. Two of the plans covering maternity and general surgery are ready to commence in April 2017 with the other three undergoing modifications to their proposals.

The process for wave 2, which includes cancer, is in the planning stage and it is expected that plans will be submitted for review / approval in June 2017.

## Safety Plan

In 2016 SWBH published its Safety Plan. Roll out of the plan commenced in February 2017. This Safety Plan is the Trust's focused and organised commitment to patients and their carer(s) to significantly reduce or ambitiously remove patient avoidable harms, through formalising must do safety-checking actions across the trust. There are areas where this is done well, but there is more to do.

The Trust-wide Safety Plan embeds 10 multidisciplinary, evidenced-based clinical standards and ensures their

compliance. The 10 standards will become part of current everyday clinical processes upon which the associated Quality Plan can build. Every patient will have their safety needs assessed, planned for, implemented and continuously reviewed in real time, as part of routine practice, thus significantly avoiding harms we call these our "always events".

The standards and outputs of the plan are summarised below:

	Standard	Output
1.	Ten out of Ten – The starting point for safety risk assessment of which care plans are then built upon	A safety checklist made up of 10 sub-standards that must be completed for every admitted patient within 24 hours.
2a.	Pressure Ulcer	A plan of care is in place for patients identified to be at a tissue viability risk.
2b.	Falls	A plan of care is in place for patients identified to be at a risk of a fall.
3.	Infection Control	A plan of care is in place for patients identified to be at a risk of a acquiring a Healthcare Acquired infection (HAI) or having a HAI on admission to be managed.
4.	Observations – Early Warning score (EWS) reporting and management	Monitoring vital signs as clinically required - taking in time appropriate action(s) to prevent an avoidable deterioration in a patient EWS are recorded (vital Pac or paper)– EWS were acted upon and this is evidenced in the patient's health care records.
5.	Care Plans and signed by Patients and Carers/Family	Nursing care plans are in place , individualised; reflecting risks identified (physical, social and psychological) through discussion with patient / carer.
6.	Focused care /Johns Campaign	A plan of care is in place for patients identified at risk from falls, absconding, self-harm, challenging behaviour or acutely unwell to ensure appropriate level of supervision with appropriately skilled Healthcare Professional and reflecting partnership working with carers..
7.	Antibiotic review every 72 hours	Reduction in inappropriate prescribing of antibiotics - An assessment has been done and the outcomes are documented of all patients on IV/ oral antibiotics after 72 hours that reflects appropriate or inappropriate use.
8.	Reduced Omissions	Patient's drugs are prescribed, correctly given and taken within a window that is deemed to be the right prescribed time. That a clinical omission for not giving the drug is recorded in the designated area.
9.	Informed Consent	All elective patients undergoing invasive procedures have been consented in accordance to policy.
10.	EDD and home care package	Accurate Expected Date of Discharge and 48hr follow up.

The 10 standards are fundamental to the patients' health and social care wellbeing. These are not new standards and processes and should be a core part of routine care. What we will achieve is a formalised approach to doing these routine activities to ensure that they are fully and always undertaken at the right time, consistent with recognised trust standard practice. Within the Trust there are 43 ward/ specialised areas; the Safety Plan is being rolled out to these wards incrementally during 2017.

In the future patients and their carers will be increasingly informed and included in care planning and will know what our safety standards are in layman terms. They will know what to expect, enabling them to identify when it is not

quite right and how to bring it swiftly to our attention for corrective and preventative action.

The aim of the plan is to continually improve our safety culture and reduce harms to patients – this may include falls, pressure ulcers and infection. Each patient is assessed to determine any care needs they may have. The safety standards checklist ensures all standards are completed for all patients within 24hrs of admission. This is reviewed by the senior nurse and multi-disciplinary team (MDT) on a shift by shift basis and any non-compliance is rectified immediately. Subject experts and senior 'buddies' support areas to improve practice by coaching, supporting and problem solving.

## How we measure quality

We review our performance against external frameworks and internal targets on a broad range of indicators published in our Integrated Quality & Performance Report (IPR). The IPR is published monthly to a number of senior committees (including the Quality and Safety Committee) as well as the Trust Board. Performance is managed through our Groups via our group performance review programme. We also audit the quality of clinical care we provide against a number of national standards that are published by external organisations for example the National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) and specialty specific bodies for example the National Bowel Cancer Audit Programme (NBOCAP) and the National Hip Fracture Database (NHFD).

## Data quality improvements

We have implemented a performance indicator assessment process, the data quality kitemark, which provides assurance on underlying data quality. Each indicator is assessed against seven data quality domains to provide an overall data quality assurance rating which is included in the IPR. We have a data quality improvement plan in place to ensure that the quality of our performance information continues to improve. During the year we have improved data quality as reported in the IPR. Our audit plan is a rolling programme covering all performance and quality indicators. We have established a Data Quality Group whose scope will be to identify and implement data quality improvements and address data quality issues as they are found and monitor their improvement to a compliance standard.

The Trust's SUS (Secondary Users System) data quality is benchmarked monthly against others via the NHS Digital SUS Data Quality Dashboards which are used to monitor compliance with mandatory fields and commissioning sets.

During 2016/17 we provided data to secondary users for inclusion in Hospital Episode Statistics (HES) as follows:

April-December 2016

	Percentage with valid NHS number	Percentage with valid GP practice
Inpatients	98.8	100.0
Outpatients	99.5	100.0
Emergency Patients	97.1	99.0

## NHS Peer Group

The peer group we have used for benchmarking 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.

- Bradford Teaching NHS Foundation Trust (BTH)
- Kings College Hospital NHS Foundation Trust (KCH)
- Royal Liverpool and Broadgreen University NHS Foundation Trust (RLB)
- The Royal Wolverhampton Hospitals NHS Trust (RWH)
- University Hospital Bristol NHS Foundation Trust (UHB)
- Worcester Acute Hospital NHS Foundation Trust (WAH)
- Northumbria Healthcare NHS Foundation Trust (NHN)

Sandwell and West Birmingham Hospitals NHS Trust is registered with the Care Quality Commission and has no conditions attached to that registration.

The Care Quality Commission has not taken enforcement action against Sandwell & West Birmingham Hospitals NHS Trust during 2016/17 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.



Medical Director Roger Stedman launching the Quality Plan.

## Services provided / subcontracted

During 2016/17 we provided and/or subcontracted 44 NHS services. We have reviewed all the data available on the quality of the care in these services. Where we have subcontracted any activity, it would only be to a provider, who like us was registered with the CQC but has no conditions attached to that registration. 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 2016/17 represents 100% of the total income generated from the provision of NHS services by the Trust.



(Left to right) Patient Dennis Hill, and Dr Chetan Varma.

How we performed in 2016/17:

In the eyes of our patients

During the year we have actively encouraged concerns, complaints and feedback from patients and carers that has enabled us to make improvements in the care we provide.

#### Family and Friends Test

The Family and Friends Test (FFT) would recommend scores give important feedback regarding Trust services. Different methods are used to support patients including: electronic tablets, SMS texting, cards and more

recently we now send messages via landlines.

Some of the improvements in 2016/17 have included the re-launch of sleep packs following a successful initial campaign, training of volunteers to support activity provision for patients with cognitive disorders, exploration of staff knowledge regarding sensory disability and provision of communication aids as a result of the survey and placing a flag on the records of patients with learning disabilities to support seamless care.

Family and Friends Test (FFT) – would recommend scores April 2016 – February 2017

SWBH Inpatient Score	National Average	National Lowest	National Highest
89.9%	96%	74%	100%

SWBH ED Score	National Average	National Lowest	National Highest
79.4%	86%	48%	100%

SWBH Outpatients Score	National Average	National Lowest	National Highest
88.2%	93%	73%	100%

#### National Patient Surveys

The national survey programme is used to measure patient experience and perceptions across the NHS and this Trust. We are continually striving to ensure that the quality of care provided meets expectation and we respond to the needs of patients, including listening to patients, the need for privacy, information and involving patients in decisions about their care.

The Board heard from the mother of a patient with a learning disability who had been admitted several times over the last year with artificial line feeding (PEG) complications resulting in breathing problems. The individual patient was reviewed and care actioned at the time but the executive team initiated a review of the PEG service and a review of caring for patients with learning disabilities within the hospital setting.

#### Patient Stories

During 2016/17, patient stories have continued to form a key part of every SWBH NHS Trust Board meeting. The introduction of video patient stories has widened the reach of these stories so more teams and services are now able to learn from the themes that are raised and apply them to improvements in their own areas.

#### Complaints

Complaints management remains effective and timely, focusing on the needs of complainants. Establishing the outcomes sought from complainants upfront, and offering resolution meetings alongside, or instead of written responses continues to be a focus of the complaints team.

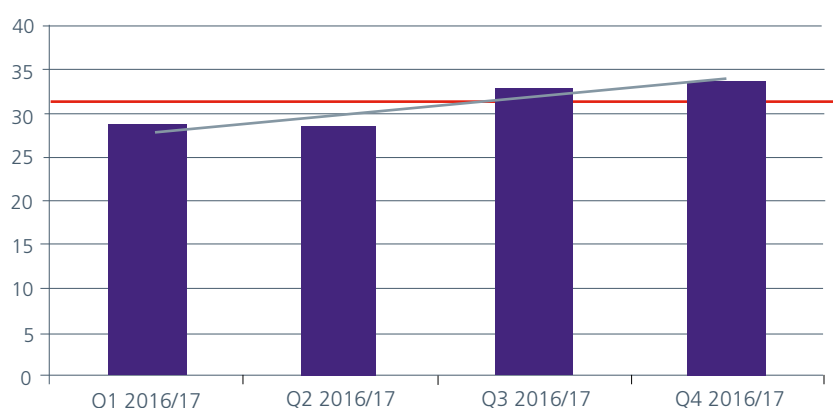
Table showing this year's complaints vs last year

Patient experience	2015/2016	2016/2017
Complaints received - Formal%	871	1026

It was recognised that there was an opportunity to streamline the work that the PALS and Complaints do, and as such the team as a whole has been restructured. This restructure has coincided with other changes across the Trust and has

had some impact on the KPI results. Complaints were still responded to by their target date, 81% of the time, and the average number of days they took to complete was 31 days.

Average number of days to respond to complaints by quarter



## Most common themes of complaints comparing 2015/16 – 2016/17

The most common themes	2015/2016 %	2016/2017 %
All aspects of clinical treatment	53	48
Appointment delay/cancel (outpatient)	16	16
Attitude of staff	12	14
Communication/info to patient	6	7
Personal records	3	2
Appointments delay/cancel (in patient)	2	2
Admissions/ discharges, transfers	1	4
Transport services	1	1

Where learning can be evidenced, this is shown to the complainant even if this is sometime after the complaint is closed. The following are examples of learning that has taken place as a result of complaints.

- Communication between the District Nursing (DN) team, and patient's family improved through the use of a "Communication Sheet".
- New referral pathway established by a Professor in Neurology where all patients with a suspicion of a genetic diseases will now have access to counselling at the earliest opportunity.
- A change in clinical practice where it is now policy that arterial and venous cannulas are not placed too close together, and sharp scissors are no longer used to remove dressings.

- In light of the difficulties experienced by some, patient transport bookings can now be taken over the phone without the need to complete a form. This in turn has ensured equal access to appointments for all patients including those with disabilities.

### PALS - Patient Advice and Liason Service

Local resolution is encouraged, on the basis that wards and outpatient teams are well placed to deal with issues that arise on a day to day basis. Where this cannot be achieved, and where a formal complaint is not necessary, PALS provide an essential liaison service between the patient and service. They can also support patients who need clarification, additional information about our services or where they are concerned about an aspect of care, but not yet sure if a complaint is warranted. During 2016/17 we received 2592 queries into our PALS team

### Themes of PALS enquiries

Theme	2015/2016 %	2016/2017 %
Appointment issues	25	28
Clinical issues	25	27
Complaints advice or referral	5	5
Communication	14	13

### 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.

NHS Digital publishes 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 following show the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared to the average for England.





Patient Lakvinder Kaur Sangha tries out the new Cardiac Rehabilitation Gym at City Hospital.

# Patient Reported Outcome Measures (PROMs)

	Health Status Questionnaire - Percentage improving			
	Finalised data for April 14– March 15 (Published 11/08/2016)		Provisional data for April 15– March 16 (Published 09/02/2017)	
	SWBH	National	SWBH	National
Hernia repairs	50.7%	43.7%	50.9 %	49.2 %
Hip replacement	89.5%	89.3%	89.6%	90.6%
Knee replacement	81.0%	78.1%	81.6%	77.4%
Varicose vein surgery	52.0%	46.7%	52.6%	44.9%

## Average adjusted health gain

	Health Status Questionnaire - Average adjusted health gain							
	Finalised data for April 14– March 15 (Published 11/08/2016)				Provisional data for April 15– March 16 (Published 09/02/2017)			
	National	SWBH	Highest National	Lowest National	National	SWBH	Highest National	Lowest National
Hernia repairs	0.084	0.058	0.107	0.041	0.088	0.075	0.157	0.021
Hip replacement	0.436	0.414	0.495	0.348	0.438	0.435	0.510	0.320
Knee replacement	0.315	0.287	0.373	0.229	0.310	0.325	0.398	0.198
Varicose vein surgery	0.094	0.087	0.161	-0.021	0.095	0.077	0.149	0.018

	SWBH below England average
	SWBH above England average

The finalised data for 2014/15 and the provisional data for 2015/16 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken the following action:

Procedure	Action taken
Hip & Knee replacement	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. Patient information regarding the importance of completing PROMs will be displayed on waiting room TV screens in both fracture clinics cross site.
Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation. Patients are offered another booklet if they forget to bring it with them on the day of surgery. All patients have a discussion regarding risk and benefits and information leaflets have been updated to include more information on PROMs and on what symptoms to expect post operatively and in what time frame.
Groin hernia repair	Patients are offered another booklet if they forget to bring it with them on the day of surgery. A PROMS lead within General Surgery is now in place, and PROMs Champions have been identified on both City and Sandwell Day Surgery Units. Patient information leaflets are to be revised to include post-operative expectations for patients. PROMs awareness is included in the training of all new staff on SDU / ASU as part of their induction programme.

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.

Access Metrics	Measure	2016/17	Target
Cancer – 2 week GP referral to first outpatient	%	94.6	=>93.0
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	95.5	=>93.0
Cancer – 31 day diagnosis to treatment all cancers	%	98.0	=>96.0
Emergency care – 4 hour waits	%	87.23	=>95.0
Referral to treatment time – incomplete pathway < 18 weeks	%	93.08	=>92.0
Acute diagnostic waits < 6 weeks	%	1.32	<1.0
Cancelled operations	%	1.1	0.8
Cancelled operations (breach of 28 day guarantee)	Number	10	0
Delayed transfers of care	%	2.1	=<3.5
Outcome Metrics	Measure	2016/17	Target
MRSA Bacteraemia	Number	1	0
C Diff	Number	21	<30
Mortality reviews (complete within xx days)	%	66	=<90
Risk adjusted mortality index (RAMI)	RAMI	104.93	<100
Summary hospital level mortality index (SHMI)	SHMI	104	<100
Caesarean Section rate	%	26.3	=<25.0
Patient safety thermometer – harm free care	%	94.3	=<95
Never Events	Number	4	0
VTE risk assessment (adult IP)	%	95.4	=>95.0
WHO safer surgery checklist	%	99.9	=>100
Quality Governance Metrics	Measure	2016/17	Target
Mixed sex accommodation breaches	Number	51	0
Staff sickness absence (rolling 12 months)	%	4.48	=<2.5
Staff appraisal	%	97	=>95
Medical staff appraisal and revalidation	%	84.9	=>95
Mandatory training compliance	%	87.2	=>95
Clinical Quality and Outcomes	Measure	2016/17	Target
Stroke Care – patients who spend more than 90% stay on Stroke Unit	%	94.5	=>90
Stroke Care – Patients admitted to an Acute Stroke Unit within 4 hours	%	78.4	=>80
Stroke Care – patients receiving a CT scan within 1 hour of presentation	%	72.0	=>50.0
Stroke Care – Admission to thrombolysis time (% within 60 minutes)	%	67.4	=>85
TIA (High Risk) Treatment within 24 hours of presentation	%	98.0	=>70
TIA (Low Risk) Treatment within 7 days of presentation	%	97.2	=>75
MRSA screening elective	%	91.2	=>80
MRSA screening non-elective	%	93.0	=>80
Inpatient falls – Acute	Number	654	<804
Inpatient falls – Community	Number	340	<804
Hip Fractures – Operation within 36 hours	%	74.7	=>85
Patient Experience	Measure	2016/17	Target
Complaints received – Formal and link	Number	1176	N/A
Patient average length of stay	Days	3.56	N/A
Coronary Heart Disease - primary angioplasty (<150 mins)	%	96.1	=>80
Coronary Heart Disease – rapid access chest pain (<2weeks)	%	99.7	=>98

## Children's Safeguarding

In order to safeguard children we continue to work closely with Sandwell and Birmingham Multi-Agency Safeguarding Hubs (MASH) and frontline staff to improve the quality of inter-agency referrals so that children and families receive the most appropriate support and intervention at the right time. We are an active and participatory partner in both Sandwell and Birmingham Safeguarding Children Boards and their sub-group meetings to provide assurance that we are meeting our statutory safeguarding children roles and responsibilities.

Our Safeguarding Children Training Strategy is in place to ensure our staff are appropriately trained to respond to safeguarding children concerns. 72% of staff have received face to face training and 74% of staff in key groups such as midwives, health visitors, sexual health services and emergency department practitioners have received more in depth training on how to recognise and refer safeguarding issues.

We have delivered a rolling programme of 'bite sized' training on Child Sexual Exploitation (CSE) jointly with Barnardo's to emergency department staff, midwives and health visitors so they can recognise risks/triggers and refer to children's social care appropriately. We are a member of both Sandwell's and Birmingham Safeguarding Children Board CSE Health Group to ensure the profile of CSE remains high on our agenda. We currently flag our electronic patient record when it is known a child/young person is at risk of CSE in order to support the practitioner's assessment and response when this vulnerable group accesses our services. We work closely with Sandwell and West Birmingham Clinical Commissioning Group who have hosted two CSE conferences which have been well attended by SWBH staff; the theme being the 'Voice of Survivor' and, following preparation for the first conference prompted the design of the 'CSE Superhero badge and logo' which the CCG has since received national recognition for.

The Safeguarding Team Domestic Abuse Nurses continue to deliver specific Domestic Abuse training across the organisation; the team has designed a domestic abuse leaflet that has been attached to wage slips to raise the profile of domestic abuse and give information on indicators and key contacts for all staff.

Your Trust Charity funded an Independent Domestic Violence Advocate (IDVA) Project to support victims and their children. This continues to prove to be a positive venture with over 181 victims being identified in Emergency Department receiving support and onward referral since the start of the project in November 2015. We have now extended the project into City ED from January 2017. Our Domestic Abuse Policy supports staff in routine enquiry of domestic abuse and the ED assessment paperwork has been amended to record this. We are currently seeking further funding to support the project post December 2017.

We have updated a number of policies against national and local guidance. These include female genital mutilation; paediatric liaison service policy, child death policy and the PREVENT agenda. We continually monitor findings from CQC inspections and review all action plans at our Safeguarding Children Operational Group.

The Child Protection Information Sharing (CP-IS) project went live in October 2016 with Birmingham City Council to share child protection information across unscheduled care settings. We have developed systems so that staff are able to access this information. It is anticipated that Sandwell MBC will go live with CP-IS in September 2017.

Priorities for 2017/18 will continue to focus on CP-IS integration across the local authority areas to inform our patient record, securing further funding for the IDVA project post December 2017, monitoring and delivering our safeguarding children training programme and continuing to raise CSE risk across key areas.



Children's safeguarding team (left to right) Glenn Bradnick, porter, Jayne Clarke, Safeguarding children lead nurse, Tanya Clarke, safeguarding administrator and Noreen Ahmed, specialist nurse for safeguarding children.

## Adult safeguarding

A restructure has been carried out within the Adult Safeguarding team to ensure patients lacking in capacity are properly protected from any harms. This change means the team now consists of an Adult Safeguarding Nurse, Dementia lead, Tissue Viability Lead with Learning Disability Liaison Nurses, who are available at both Sandwell and City Hospitals.

The Trust has focused on Deprivation of Liberty applications for those patients, with training to senior nurses, consultants, senior therapists and managers within the organisation. In addition a tool for assessing capacity and prompt for raising a Deprivation of Liberty application which reinforces the Mental Capacity Act (2005) has been created. Whilst it is recognised that this work is required to continue within the organisation to ensure it is fully embedded to SWBH practice, initial data is encouraging. The organisation applied for more than double the Deprivation of Liberty safeguards when compared with the previous year.

We continue to work closely with Sandwell and Birmingham multi agency safeguarding board participating in work streams for both prevention and protection of shared strategies. We prioritise full cooperation with any identified cases meeting the criteria for public enquiries and we are committed to learning lessons and improving practices around patient/client safeguards. PREVENT duties within the Trust continue to develop with participation at multiagency meetings (Channel Panel) contributing to individual case management. The Trust participates in PREVENT forums chaired by NHS England.

All activities of the Safeguarding Nurse are recorded on a dashboard to ensure trends and themes can be identified to improve and maintain the safety of our patients.

The learning disability service has been expanded to include a specialist nurse based at both Sandwell and City Monday to Friday. An action plan for the Trust has been agreed and is in process and an operational policy is being formulated.

We have appointed two new activity co-ordinators and developed a training programme for volunteers who are attending the wards to provide therapeutic activity for patients with dementia, delirium and learning disabilities during their hospital admission.

## Readmissions

Tackling readmissions remains a focus for the Trust as we strive to ensure we are in a position to provide good quality care that means ensuring patients are cared for in an appropriate environment. We will reduce our readmissions by a further 2% this year by coordinating care well across different services facilitating safe and timely discharges for our patients so that there is not a need for them to return for an unplanned stay in hospital.

We know that our frail patients are at the most risk of being readmitted so significant effort has been made in this area during the last 12 months.

Use of the LACE scoring tool identifies patients with a potential high risk of readmission against the criteria of length of stay, acuity of admission, case mix and the number of attendances to the emergency department in the last 6 months. Action planning is based on a threshold score of 11 which is automatically generated on the electronic bed management system to alert to ward clinical teams. Crucially the score is also auto-generated to the Community Contact Centre. The iCares community team call 100% of consented cases within 24 hours of hospital discharge and this in turn triggers the need for further intervention for a visit or a subsequent call. The coming months will also see the Frailty Early Supported Discharge Service to support continued rehabilitation at home.

We are currently trialing a Community-Acute Alert System where all over 65 year olds known to the Sandwell community teams within the last six months with one of 6 common conditions (asthma, heart failure, dementia, falls, COPD and UTI) are identified electronically and triaged by the Community Contact Centre. This can generate a proactive acute to community management plan to facilitate timely discharges.

The multi-disciplinary working in the Older Person's Assessment Unit at Sandwell includes a comprehensive geriatric assessment for all patients within 14 hours of admission and in development are personalised discharge information packs incorporating valuable information and contact numbers.



The multi disciplinary team working on our Older Person's Assessment Unit (OPAU) at Sandwell Hospital.

## Readmission rates

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).

### Age 0 – 15 years

SWBH	Number of patients	Total number of re-admissions	Percentage of re-admissions
16/17	16257	985	6.1%
15/16	15867	1100	6.9%
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
16/17	90621	6668	7.4%
15/16	92650	7738	8.4%
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
16/17	106875	7653	7.2%
15/16	108517	8838	8.1%
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%

Data April 2016 - February 2017

## Outpatient Care

Outpatient care remains a key focus for improvement. We have halved the number of patients waiting over 18 weeks for treatment largely through improvements in our outpatient pathways and waiting time management. We have continued to roll out partial booking and text reminder services aiming to reduce the Do Not Attend (DNA) rate.

In the year ahead we anticipate there will be many more electronic referrals from primary care which will further enable us to improve the timeliness of our communication and booking processes with patients. This year we will embed electronic communications with our patients by email as well as implement the new electronic patient record in outpatients.

### Community Caseloads

A key focus during the year has been to increase patient contact time by 10% amongst community staff. The adult community teams have introduced a number of new ways of working that benefit patients, are more cost effective and continue to deliver high quality care closer to home.

Working closely with our GP colleagues we have moved towards increased clinic based activity across District Nurse teams to improve productivity. We have introduced a number of new clinics since June 2016 with an intention to implement seven across Sandwell and West Birmingham in the coming months as facilities permit. Feedback from patients is positive and demonstrates that those patients who are not house bound are happy to attend clinics for their treatment and enjoy the social interaction and experience. The success of this clinical model has contributed to the District Nurse Service being able to deliver approximately 20% more activity than last year's baseline.

The introduction of mobile working across the whole adult community workforce provides real time access at the point of care to electronic records reducing the need for paper records. Clinicians do not need to return to base to complete their documentation giving them more time for direct patient contact. The gradual introduction of the lightweight laptops has facilitated live access to patient records in a patient's home resulting in optimal informed decision making, reduced risk and fewer attendances to the Emergency Department.

In the year ahead we will introduce clinicians to work within the Contact Centre who will undertake clinical triage at peak call times with the ability to divert calls to the most appropriate community services or simply advise over the phone.

### Focussed Care

Last year we reported that we would adopt the principles of John's Campaign to promote partnership working with relatives and carers for patients with cognitive disorders to enable the carer to support patients whilst in hospital day or night. This campaign has been implemented in all areas supported by the arrival of a Dementia Specialist Nurse. The nurse has worked in partnership with key wards to promote patient-centered care with the aim of reducing the need to provide extra supervision but to facilitate opportunities for activities and reminiscence. This work will continue into 2017.

### Quality Improvement Half Days

Following the successful launch of Quality Improvement Half Days (QIHDs) in April 2015, this year saw this unique approach to staff involvement develop and expand further across the organisation, with over 1000 colleagues regularly attending each time. The four hour QIHD sessions provide a chance for multi-disciplinary teams to take time away from their normal day-to-day duties to consider how to learn and develop new ideas. Though largely local, they also help tackle cross-organisational learning. On some occasions the learning might be very specific – an incident in one part of our Trust that has implications everywhere - or more general such as a change we need to put in place across our organisation. The synchronisation of ten half days a year and the involvement of all staff groups creates an opportunity for a sea change in approach to quality improvement. Our unique Quality Improvement Half Day (QIHD) process creates time to talk.

Looking ahead, in April 2017 our QIHD programmes feature, for the first time, ward QIHDs, making time for emergency teams to share lessons and learning. In May and June we roll out a voluntary accreditation scheme for teams to put their QIHD time forward for recognition as a role model in quality improvement. This is, above all, a mass movement. A bottom up effort to change results and culture, and the benefits are showing in both team morale and outcomes in our patients' experience of care.

### Mortality

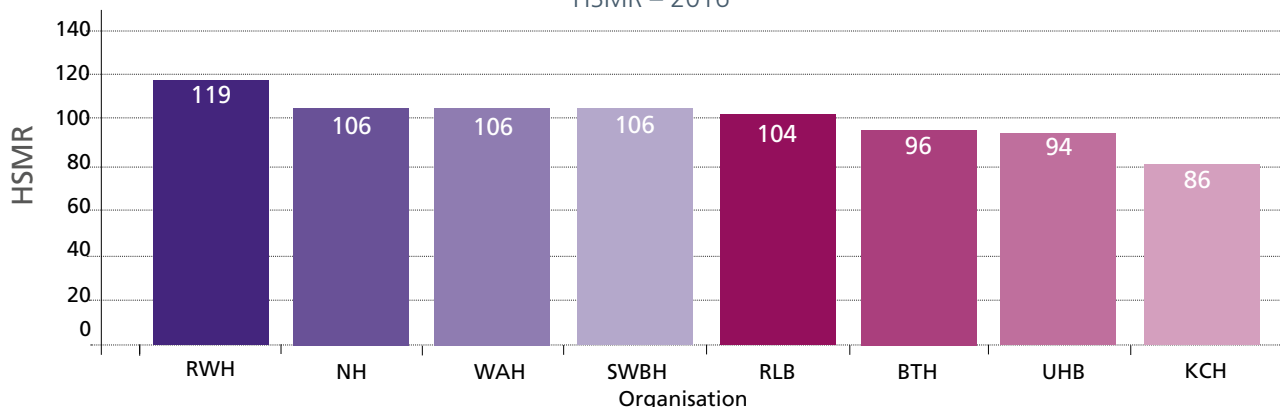
Mortality data is now extracted from the CHKS (Casper Healthcare Knowledge) System, which reports the Risk Adjusted Mortality Index (RAMI) as the principle measure of our organisation's mortality, and the HED (Healthcare Evaluation Database) System which reports the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI).

### HSMR (Hospital Standardised Mortality Ratio)

The HSMR is a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is of observed to expected deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. Our HSMR is currently (February 2017) 106 for SWBH. This information is derived from the HED system, which is rebased monthly to provide the most up to date data.

We also use HSMR as a comparator with our peers. (lower is better)

HSMR – 2016





(Left to right) Community phlebotomist Jayne Burkinshaw, matron for community nursing services Denise Owen and Health Care Assistant Joel Williams.

#### RAMI (Risk Adjusted Mortality Index)

This is a methodology developed by Casper Healthcare Knowledge Systems (CHKS) to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of deaths to the expected number of deaths that occur within a hospital. The Trust's RAMI for the most recent 12 month cumulative period is 104.93 and outside of statistical confidence limits which is above the National HES peer RAMI of 92. The aggregate RAMI for the City site is within statistical confidence limits with a RAMI of 96, and the Sandwell site with a RAMI of 119, which is outside of statistical confidence limits. This reflects a decreasing trend in hospital deaths with a palliative care code as a consequence of our drive for patients to receive such care in a place of their choosing other than in hospital. 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).

#### SHMI (Summary Hospital-level Mortality Indicator)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. Our SHMI score is currently 104 for SWBH Trust.

Mortality comparisons against national results

	Lowest	Highest	SWBH
Observed	526	4514	2196
Expected	758	4674	2127
Score (SHMI)	0.6939	0.9658	1.0322

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 NHS Digital, 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 NHS Digital website.

## Trust Mortality Review System

For the year 2016/17 we set ourselves a target of reviewing 90% of all hospital deaths within 42 days and 100% of all hospital deaths within 60 days. By reviewing the care provided we can identify areas where learning can take place to improve outcomes for our patients. Mortality Review

compliance has been set as a local CQUIN for 2016/2017. Although there has been an improvement in the number of deaths reviewed within 42 days, achievement of this target has been sporadic and we will continue to keep this as a priority for 2017/2018.

2016/17

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	140	115	124	379	121	100	86	307	103	128	134	365	168	134	96	398	1449
Reviewed	84	87	85	256	84	60	47	191	79	96	109	284	103	71	62	236	967
%	60	75	68	67	69	60	54	62	76	75	81	77	61	52	64	59	66
Reviewed																	
%	60	67	67	67	68	66	65	65	66	67	69	69	68	66	66	66	66
Cumulative Reviewed																	

## Deaths of patients with involvement from specialist palliative care services

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	%
2196	571	26

Diagnostic care coding= Z5.15.

End of life (Palliative) care

What we are doing to reduce avoidable deaths:

- We will review 90% of deaths within 42 days.
- Top 3 learning points
  1. 100% compliance with the Sepsis Bundle
  2. Timely management of Acute Kidney Injury (AKI)
  3. Early implementation of the Supportive Care Plan
- Enhanced revision of the current mortality review system in readiness for migration to the new EPR.
- Incentive for reviewers who complete 100% reviews.
- Participation in the National Mortality Retrospective Case Record Review (NMRCRR) commissioned by HQUIP as an early implementer site.
- Participation as a Tier 1 training site for the NMRCRR.
- Participation in the National Learning Disability Mortality Review Programme (LeDeR) managed by the University of Bristol.
- Working with the Black Country Alliance and NHS England West Midlands Mortality Concordat to collaborate, share good practice and quality improvement based around Learning From Deaths in our region.
- Corporate work streams identifying Group and Specialty Quality Improvement of End of Life Care and Specialist Palliative Care.



Connected Palliative care team (left to right) Aimee Hughes, end of life care facilitator, and Zoe Chappell, specialist palliative care nurse.

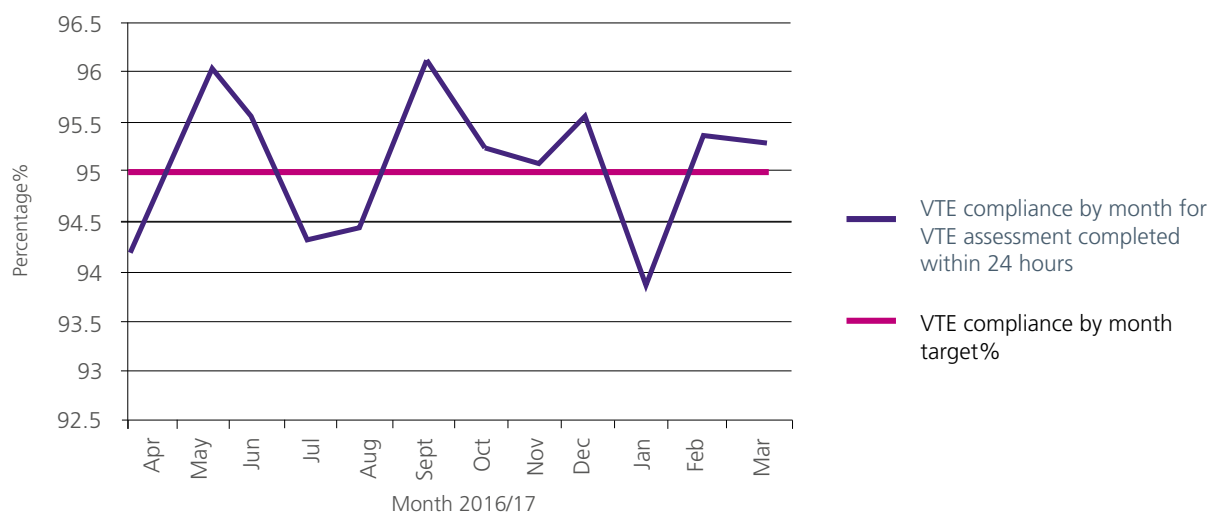
## Venous thrombo-embolism (VTE)

A Venous thrombo-embolism (VTE) is a blood clot that forms in a vein. A calf vein is the most common site for this to occur but occasionally pieces of the clot can break away and flow towards the lungs and become a pulmonary embolism (PE). The Department of Health requires all Trusts to assess patients who are admitted for their risk of having a VTE. This is to try and reduce some of preventable deaths that occur

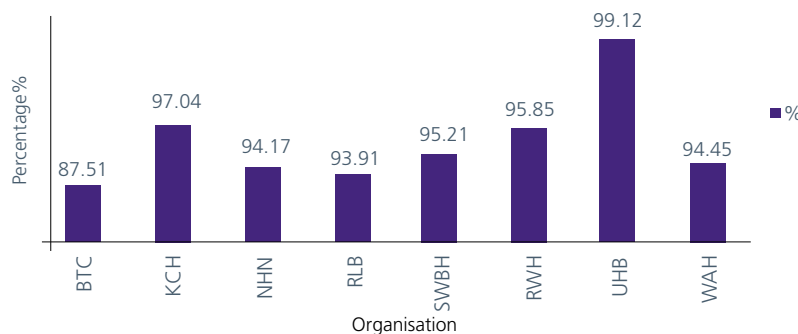
following a VTE while in hospital.

We report our achievements for VTE against the national target (95%) and report this as a percentage. The calculation is based on the number of adults admitted to hospital as an inpatient and of that number, how many had a VTE assessment within 24 hours. Our year end position is 95.4%.

VTE assessments completed within 24 hours 2016/17



VTE assessments compared to peers (higher is better)



Data from NHS England - reporting period April 2016 to Dec 2016.

## VTE Assessments

Lowest/highest average - Data from NHS England - reporting period April 2016 to Dec 2016

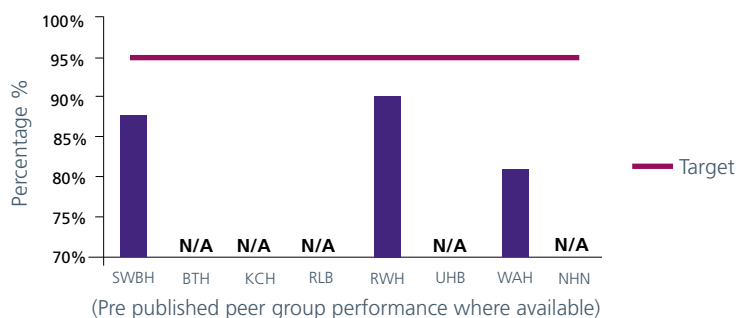
Lowest	Highest	Average
82%	100%	95.55%

## Emergency four hour waits

In line with the national standard we aim to ensure that 95% of patients will wait for no more than 4 hours within our Emergency Departments (ED). Although the majority of patients were seen in 4 hours on average we achieved 87.22%.

We continue to see good results in ambulance handover time, meaning that ambulance crews can get back on the road more quickly. We remain committed to improving our performance and have implemented Rapid, Treatment & Assessment (RAT) this year which has shown an improvement in time to treatment.

Percentage of patients waiting 4 hours or less in Emergency Departments 2016/17  
(Higher is better – target 95%)



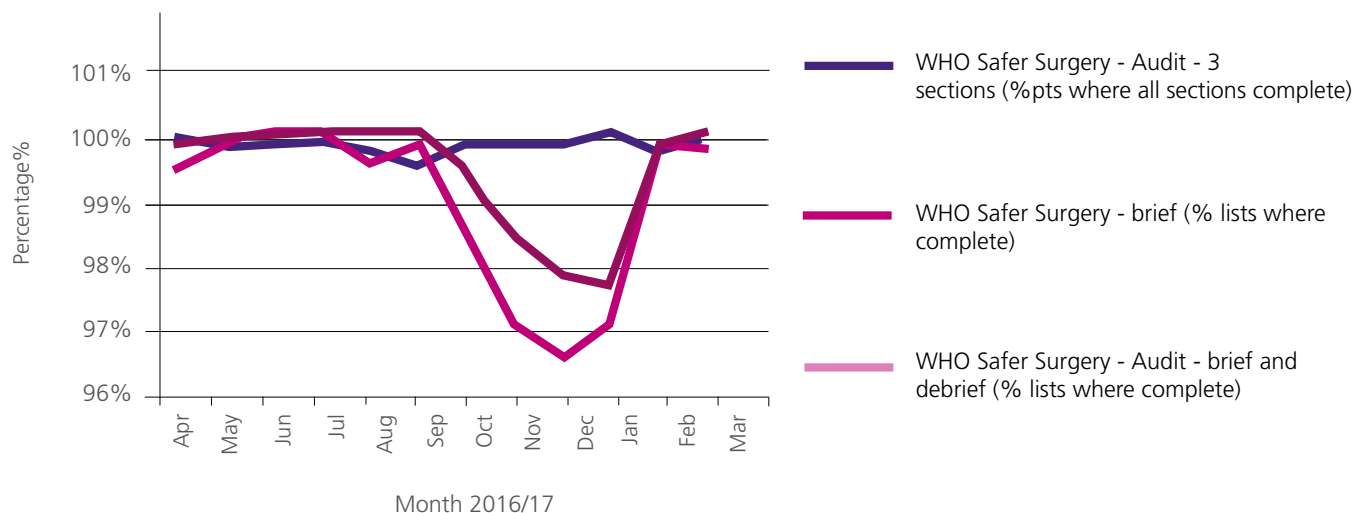
(Pre published peer group performance where available)

## WHO Safer Surgery Checklist

Compliance with the WHO safer surgery checklist is monitored through our monthly Theatre Management Board. Clinical directors are core members of the group.

Surgical Services have a monthly governance meeting where they discuss the audits on the WHO checklists. At the meetings they identify actions that will improve compliance.

Compliance with WHO Safer Surgery checklist 2016/17 -

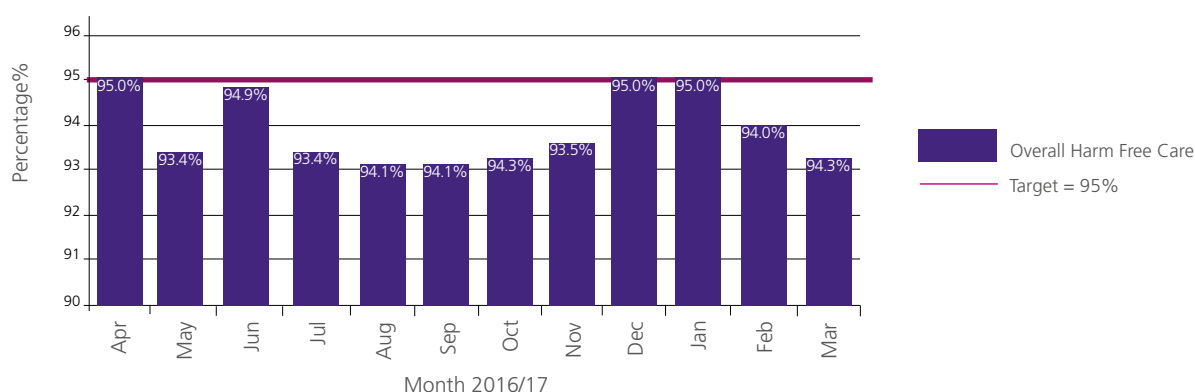


## Harm free care

We continue to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls, catheter related UTIs and DVT. We review harms via the incident reporting

framework with lessons learned shared locally and across the organisation.

Harm free care



## Pressure ulcers

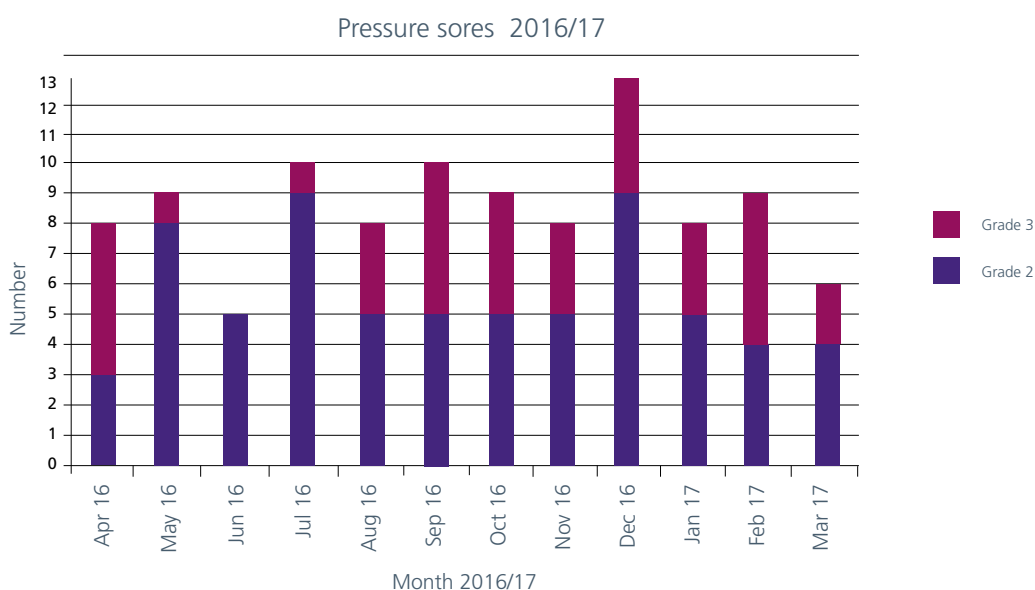
Pressure ulcer prevention remains one of the key priorities within the Trust and is incorporated within the Trust Safety Plan for 2017 which focuses on ensuring consistency in identifying when our patients are at risk of developing pressure damage and ensuring they have all the preventative strategies in place to reduce the risk of our patients going on to develop pressure damage.

In line with our vision to provide patients the safest care possible the Trust continues to promote being open with the reporting of pressure damage incidences in order to learn from mistakes and improve future care for patients. With continued ongoing monitoring and review of grade 3 pressure ulcers the Trust strives to keep our safety promises by learning from incidents, changing care when required and reducing harm to our patients.

The Trust has sustained our previous improvements in the reduction of avoidable pressure damage; however pressure

damage still occurs in low levels. In the coming year the Tissue Viability service will be engaged in the National NHS Improvement Stop the Pressure Campaign to eliminate avoidable pressure ulcers within the Trust. The campaign will focus on the early identification of at risk patients and reacting quickly to the early warning signs and preventing pressure damage occurring. This initiative will support the Trust Safety Plan with a huge focus on preventing harm occurring to our patients.

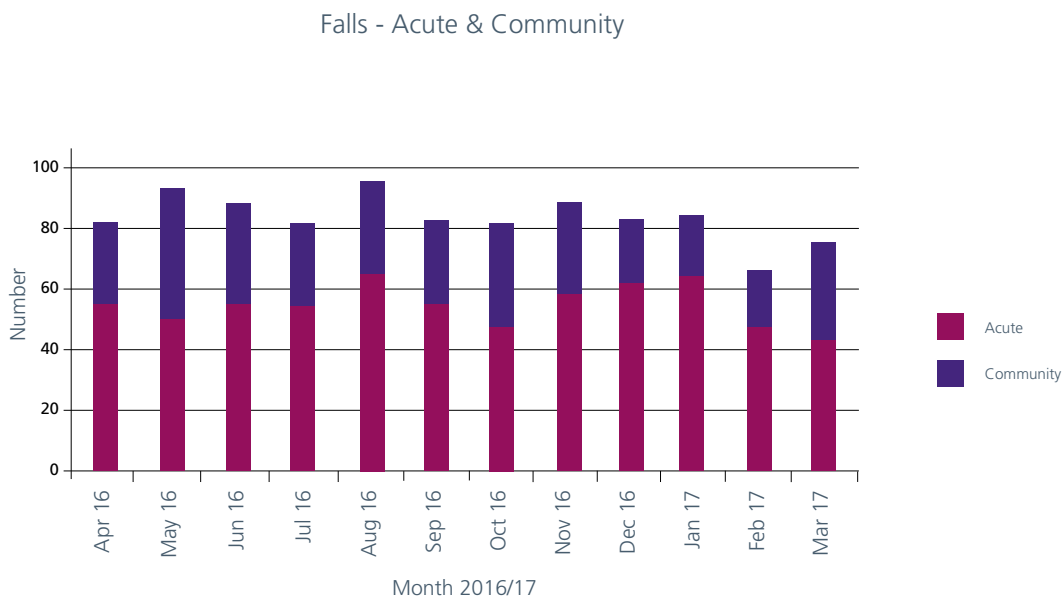
During 2016 our focus on community pressure ulcer prevention has continued with a new initiative working in partnership with West Midlands Fire Service as part of their Safe and Well project, offering fire safety advice to patients in their own homes using pressure relieving air flow mattresses. The first event in April 2017 included raising awareness within our District Nursing teams of the need to consider the risk of fire and to offer patients a referral for advice from the West Midlands Fire Service.



## Falls

The number of falls in 2016/17 was 994. All incidents with a slip, trip or fall indicated are automatically highlighted and collated on a monthly basis to provide a monthly / quarterly

and annual report. We review this information to try to reduce the risk to our patients.



The aim of the Infection Prevention and Control Service (IPCS) is to develop, utilise and promote infection prevention and control practices that are cost effective, safe and efficient, minimising the risk of patients acquiring infections, during or as a result of their stay in hospital. Working in partnership with health care professionals across the health economy, the Trust is committed to a zero tolerance ambition to eliminate all avoidable HCAs.

To comply with current legislation and meet the National demands from professional bodies such as the Department of Health (DH), the Care Quality Commission (CQC) and NHS Improvement (NHSI), the IPCS adopt a proactive approach to the identification, management and monitoring through education, training, surveillance, and monitoring of clinical

and non-clinical practices in line with national standards such as National Institute for Health and Care Excellence (NICE) guidance, Patient Lead Assessment in the Clinical Environment (PLACE), national standards of cleaning and guidance and recommendations from professional bodies.

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy. The IPCS is a fully integrated service incorporating the acute, community and intermediate care. Partnership working with the Clinical Commissioning Groups (CCG), NHS Improvement (NHSI), Health Protection Unit (HPU) and Public Health England (PHE) through the Health Economy Groups for Infection Prevention and Control continues to thrive.

#### Infection Performance for 2016/17

Target	Agreed target/rate [Year end]	Trust rate [End Mar 2016]	Compliant	Comments	
MRSA bacteraemia	0	2 (1 attributed to SWBH on HCAI data base)	No	Pre 48hrs [laboratory identified] 1= Sandwell * 1 = City	Post 48hrs [laboratory identified] 1= Sandwell 1 = City
				All bacteraemia's identified in the laboratory have had a post infection review as per PHE guidance to identify issues and lesson learnt. Of the cases identified 1* has been attributed to SWBH.	
C.difficile acquisition toxin positive	30	21 attributed to SWBH	Yes	12 =Sandwell site 9 =City site	
MRSA Screening - Elective [YTD]	85% (locally agreed)	91.2%	Yes		
MRSA Screening - Non Elective [YTD]	85% (locally agreed)	93.0%	Yes		
Post 48hrs MSSA Bacteraemia (rate per 100,000 bed days)	N/A	15 (7.18 per 100,000 bed days)		All Post 48 hrs bacteraemias have a post infection review to identify issues and lesson learnt.	

#### Blood culture contamination rates

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Blood culture contamination rates	City	2.5%	3.0%	2.7%	3.9%	3.2%	2.5%	3.0%	2.3%	2.1%	1.5%	2.5%	3.3%
	SGH	3.7%	3.8%	3.9%	4.1%	8.0%	3.3%	4.6%	4.6%	1.9%	1.8%	0.9%	6.1%
(Target = 3% by Ward, dept. and site.)	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 Aug 2014 the IPCS have introduced a training programme for all new doctors to the Trust.												

During the period April 2016 – March 2017 two wards closed (Leasowes and Rowley Regis) due to Norovirus which was confirmed and five bay closures (Sandwell 3, Rowley Regis 2) with Norovirus confirmed in two of these. There were four outbreaks of flu at Sandwell resulting in one ward closure and bay closures in the other areas. Two wards at City were closed with flu during February.

In addition to outbreaks of D&V, due to the emergence of multi resistant organisms, national guidance, increased surveillance and microbiological screening of patients the Trust has identified an increasing number of periods of increased incidence and outbreak attributed to a variety of micro-organisms to include: - Clostridium difficile [CDI] two PIs one confirmed as an outbreak, Extended Spectrum Beta lactamase organisms [ESBL], one PII, Carbapenamase resistant organisms [CRO]; Vancomycin resistant enterococci [VRE] one PII confirmed as an outbreak at Sandwell, MDR Acinetobacter one PII confirmed as an outbreak at Sandwell. In all incidents post infection reviews have been undertaken and multi-disciplinary and agency meetings held to identify lessons learnt and outcome of lessons learnt.

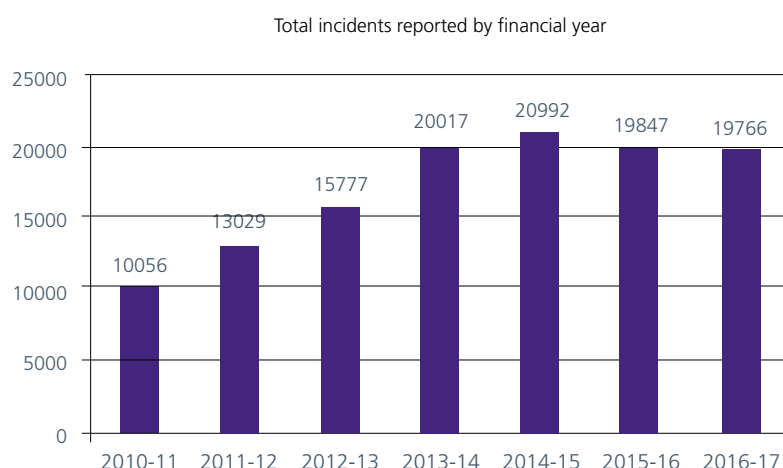
Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by clinical and non-clinical groups and healthcare personnel. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

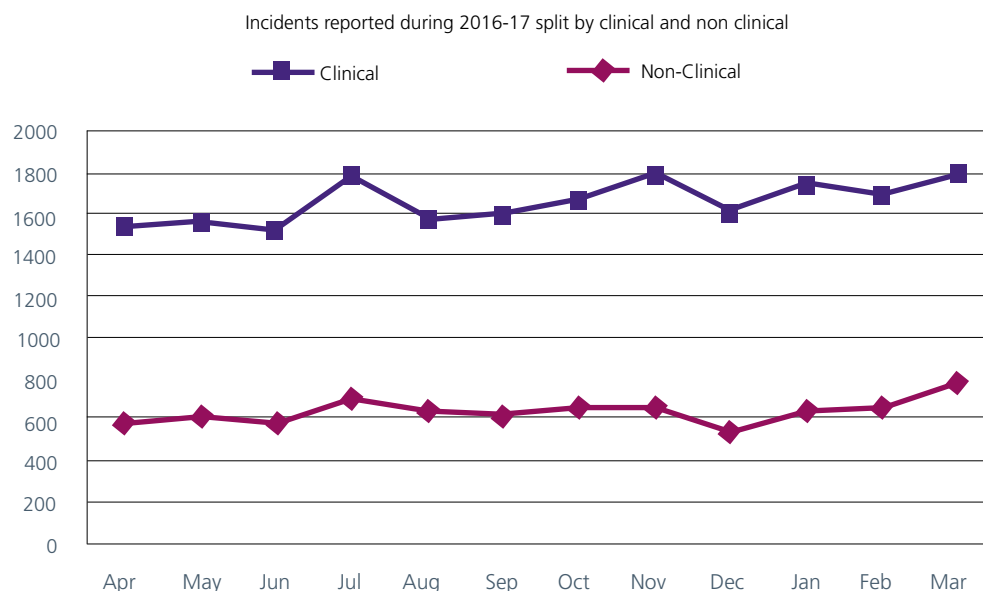
Information Governance Toolkit (IGT) attainment levels  
We are compliant across the Information Governance Toolkit requirements for 2016/17. We successfully achieved 91%, which is a "Satisfactory" (GREEN) level, according to the NHS Digital IG Toolkit grading scheme. "Satisfactory" means that a minimum Level 2 was 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.

Incident reporting  
A positive safety culture remains essential for the delivery of high quality care. We continue to submit our incident data to the National Reporting & Learning System (NRLS) which is publically available and provides comparative data with like-sized Trusts. This data shows that as at the September 2016 report we are in the middle 50% of reporters of Trusts with a reporting rate of 44.48 per 1000 bed days.

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	11.67	12.46	1.72	24	0.2	16	0.1
	Average rate of reporting per 1000 bed days	Best reporter/ 1000 bed days	Worst reporter/ 1000 bed days	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
2014/15	56.19	84	7	28	0.32	7	0.1
2015/16	50.1	76	16.5	20	0.2	6	0.1
2016/17 (up to Sep 2016)	44.48	73	22	8	0.2	1	0.0

The latest data (April to September) shows an overall position of reduced incidents resulting in severe harm or death.





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. Patient safety incidents

resulting in moderate harm or above that do not meet external reporting criteria are investigated at clinical group or corporate directorate level. The number of serious incidents reported in 2016/17 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, personal data or health and safety incidents.

Serious incidents reported in 2016/17

2016/17	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs	1	2	3	2	1	0	3	1	1	1	4	5



Dr Jonha Rizkalla, Emergency Department Consultant.

## Never Events

During 2016/17 four never events were reported. 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 robust controls are in place to prevent them from happening.

Incident	What Happened	Where it happened	What we learned
Maternity (June 2016)	Retained item at surgery	Failure in documenting the correct number of packs left in situ. Failure of handover.	Developed a SOP for sign out and introduced wrist band per pack in situ process. Amended practice (packs must be tied together). SBAR handover now in place.
T&O (June 2016)	Retained item at surgery	Failure to identify that the drill device was left in the operation site due to an incorrect instrument count.	Introduced a surgical pause for operations that take place under xray control. Procedure changed re. counting of instruments. Visual and verbal instrument count by scrub nurse. MHRA contacted about making the drill guide a different colour. Tray standardisation is ongoing.
Ophthalmology (November 2016)	Wrong site surgery	The root cause was identified as a failure to correctly follow positive patient identification procedure.	Reinforce positive patient identification and strengthen consent process. Review and implement where feasible changes to clinic waiting areas. Introduce wristbands for patients attending for an invasive procedure. Review IT system to incorporate ability to flag up patients attending on the same day with same/similar names. Updated SOP.
Gynaecology (February 2017)	Retained item at surgery	The root cause was identified as variance in practice due to inadequate awareness of updated policy.	Ensure the updated policy is made available electronically and all staff to be made aware the changes. Permit use of ribbon gauze as clinically indicated but stop use of Jelonet and blue gauze. Stop removal of packs overnight. Reinforce completion of "Sign out" part of Safe Surgery Checklist.

## How we performed against external measures: Our Care Quality Commission Improvement Plan

Positive progress has been made this year in delivering the outstanding actions for improvement identified by the CQC as part of their inspection in October 2014. Of the 67 areas requiring attention the majority have now been addressed with positive results for patients, relatives and staff. Some of the improvements include: medicines trolleys widely installed to improve security and safety, outpatient clinic templates comprehensively re-set to what patients need, ward night staff changed qualified ratios and an increased number of patients dying in their preferred place.

The balance of unresolved actions are associated with our

medical wards where unreliable practices exist in relation to, for example, ward nursing care plans, fluid balance monitoring and patient agreements with care and treatment remain. An Executive-led 12-week improvement plan is in place to achieve consistency of care on our medical wards by June 2017.

The Trust's in-house inspections continued throughout the year with up to 30 colleagues and external partners at a time visiting wards, theatres, outpatients and services across our sites to observe practices, review clinical records, interview staff and speak to patients and relatives. The key aim of the inspections is to validate that the improvements made have actually taken place. Valuable insight is gained from this approach so the visits will continue in 2017/18.

## CQUINs (Commissioning for Quality and Innovation)

The Trust is contracted to deliver a total of 22 CQUIN schemes during 2016/17. Seven schemes are nationally mandated, a further seven have been agreed locally, three identified by the West Midlands Specialised Commissioners, four by Public Health and one in Secondary Care Dental. The table below details the contracted schemes and indicator of

whether the scheme has been achieved during this period of time. A proportion of Sandwell and West Birmingham Hospitals NHS Trust income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between Sandwell and West Birmingham CCG, Specialised Commissioners and Public Health.

CQUINs for 2016/17			
1	National	Staff Health & Wellbeing - Introduction of health & wellbeing initiatives	Partially met
2	National	Staff Health & Wellbeing - Healthy food for NHS staff, visitors and patients	✓
3	National	Staff Health & Wellbeing - Improving uptake of flu vaccination	✓
4	National	Sepsis - A&E Screening & Review	Partially met
5	National	Sepsis - Inpatient Screening & Review	Partially met
6	National	Antimicrobial Resistance and Antimicrobial Stewardship - Reduction of antibiotic consumption	✓
7	National	Antimicrobial Resistance and Antimicrobial Stewardship - Review of antibiotic prescribing	✓
8	Local	Cancer - Audit of 2ww cancellations	✓
9	Local	Cancer - Cancer Treatment Summary Record in Discharge Care Plans	✓
10	Local	Cancer - Cancer VTE Advice	✓
11	Local	Safeguarding CSE - Production of a CSE awareness video that is used in staff training sessions	✓
12	Local	Mortality - Achieve an improvement in the % of avoidable and unavoidable death reviews within 42 days	Partially met
13	Local	Discharges - Implementation of transfer of care plans	✓
14	Local	Discharges - Reduction in Readmission Rate (Adults)	✓
15	Spec.	Preventing term admissions to NIC	X
16	Spec.	Haemoglobinopathy improving pathways	✓
17	Spec.	Activation systems for patients with long term conditions	X
18	Public Health	Breast Screening - improvement in uptake - Local information collection on reasons for non-participation in screening amongst the general population	✓
19	Public Health	Breast Screening - improvement in uptake - Promotion of screening programme	✓
20	Public Health	Bowel Screening - improvement in uptake - Local information collection on reasons for non-participation in screening amongst the general population	✓
21	Public Health	Bowel Screening - improvement in uptake - Promotion of screening programme	✓
22	Secondary care Dental	Sugar Free Medicines Audit	✓

## External Visits

### Care Quality Commission Inspection

The Care Quality Commission visited the Trust at the end of March 2017 to carry out a routine re-inspection following their previous visit in October 2014. Not all, or even most, of our services were re-inspected. Community services were largely excluded, given a rating of good or outstanding from the last review, as were children's services. But adult acute services in both hospitals, end of life care and our community inpatient areas were visited by around fifty professionals and expert patients. In the verbal feedback we were advised that since the last inspection in 2014 the CQC saw significant improvements to the overall service provision. Across all of our 3 sites (City, Sandwell and Rowley Regis Hospitals) and in the community they saw care delivered by kind and caring staff. Some practices in need of attention were found but nothing that was reported as a patient safety concern requiring immediate action. The final report is expected in the summer.

### Pathology - UKAS 21-24 February, 13-17th March, 3-4th April

A comprehensive quality assurance visit for Pathology at both City and Sandwell took place recently. At the end of the second week of inspections (with Toxicology still to be inspected) feedback was received from the UKAS inspectors. The overwhelming theme was that this has been a good experience for both the lab and the inspectors and "there are no alarm bells" and "no show stoppers". Most of the findings and recommendations were typical of a lab transitioning from CPA to ISO15189 namely some aspects of verification, traceability and measurement of uncertainty.

The final feedback session took place following two days of inspection in Toxicology. Once again the feedback was positive with all of the assessors stating their willingness to return for future surveillance visits. Two recommendations were made:

1. That the laboratory maintains CPA accreditation until March 2018 when this standard ceases to exist.
2. That accreditation to ISO15189 (2102) is awarded subject to validation of the report by an independent assessor.

In order to be accredited the Trust will have 12 weeks from 4th April 2017 to evidence that the findings have been cleared.

### Birmingham and Midland Eye Centre

As a part of the on-going assurance for the Birmingham and Midland Eye Centre based within Sandwell and West Birmingham footprint a planned unannounced visit was agreed by Sandwell & West Birmingham Clinical Commissioning Group (CCG). The purpose of the visit was to gain assurance across the elements of a range of quality and safety measures. The visit took place on 24th November 2016. Overall the visit was a very positive experience.

In the Emergency Department/Urgent Care Centre, feedback to the inspectors from patients regarding their experience of past and present experiences within the department was extremely positive and praise was extended to the staff for

their care delivery and expertise. The visitors spoke to patients and their families, some of whom had been attending for many years and therefore were a good barometer of the consistency of the care delivered. It was noted all patients gave positive feedback of their experience of the department and the treatment that they had received.

In outpatients, the team encountered exemplary care for patients in both the reception area and in the treatment room with a patient that had been shadowed from 'self-check in' to treatment. Excellent knowledge and skills were observed in the treatment room regarding procedures and checklists and overall the inspectors were very impressed with the level of professionalism and expertise displayed by the nurses throughout the procedure.

The visiting team highlighted some recommendations for improvements including the location of the triage function and records management, however there were no serious concerns identified during the visit.

### 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 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 once within the last year in November, looking at the Medical training provided in Medicine. The visiting panel noted that there is a 'strong education ethos' within the Trust which is providing trainees with a good training environment and supported by supervisors who were engaged in education and training and described by trainees as friendly and supportive. It was reported that there is strong educational governance within the Trust and board level engagement, support for education and training and a positive and proactive approach to quality improvement with both trainees and trainers engaged in the process. There were some areas highlighted for improvement which included improved simulated procedural skills training for core medical trainees.

All trainees who met the visiting panel recommended their training post and recommended the Trust as part of the friends and family test.

### Revalidation – NHS England Revalidation Assurance

In 2016 NHS England visited SWBH for a quality assurance inspection of our appraisal and revalidation process for doctors. The visiting team met with the Responsible Officer, Appraisal Lead, Head of Medical Staffing and Revalidation Lead for the Trust and reviewed revalidation associated documentation prior to the visit.

The team were content that Sandwell & West Birmingham Hospitals NHS Trust's existing policies, processes and procedures for appraisal and revalidation were adequate and met requirements of the current processes. It was noted that the Responsible Officer had a good team in

place that complied with obligations for the completion and timely submission of quarterly reports to NHS England along with the Annual Organisational Audit and Statement of Compliance. The Responsible Officer is a member of the board and presents an annual report prepared by the Head of Medical Staffing which also includes their Statement of Compliance for approval.

It was noted that some of the documentation was due for

review and the visiting team suggested the review would be an opportunity to strengthen policy documents in terms of process and consequences. The recommendations included documenting the escalation process and consequences of non-engagement, the responsibilities of both the appraiser and the appraisee. It was also recommended that a scheme of delegation put in place to make it clear who has delegated responsibility to process recommendations on GMC Connect on behalf of the Responsible Officer.



Thalassaemia patient Abdul Alim.

## Participation in clinical audits

During 2016/17, Sandwell & West Birmingham NHS Hospitals Trust has participated in 40 national clinical audits and 3 national confidential enquiries (Clinical Outcome Review Programmes) covering NHS services which the Trust provides. SWBH has reviewed all the data available to them on the quality of care in all of these services.

During that period Sandwell and West Birmingham NHS Trust participated in 100% 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 NHS Trust participated in and for which data collection was completed during 2016/17, 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.

	Participated Yes /No	Percentage of eligible cases submitted
<b>National Audits</b>		
<b>Women's &amp; Child Health</b>		
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Paediatric pneumonia	Yes	Ongoing
Cystic Fibrosis Registry	Yes	100%
<b>Acute care</b>		
Hip, knee and ankle replacements (National Joint Registry)	Yes	96%
Severe trauma (Trauma Audit & Research Network)	Yes	50%
Adult Critical Care (Case Mix Programme)	Yes	100%
National COPD Audit (Secondary Care)		
- Pulmonary rehabilitation	Yes	100%
- Secondary care	Yes	63%
National Emergency Laparotomy Audit (NELA)	Yes	62%
Asthma (paediatric and adult) care in emergency departments	Yes	100%
Severe Sepsis and Septic Shock – care in emergency departments	Yes	100%
Consultant sign off (Not included in list/ spreadsheet)	Yes	100%
<b>Long term conditions</b>		
Diabetes (National Diabetes Audit) Adult		
- Diabetes (National Foot Care Audit)	Yes	100%
- National Diabetes Inpatient Audit	Yes	100%
- National Pregnancy in Diabetes Audit	Yes	100%
- National Core Diabetes Audit	Yes	100%
Adult asthma (British Thoracic Society)	Yes	96%
Inflammatory Bowel Disease (IBD) programme/IBD Registry	Yes	Ongoing
<b>Heart</b>		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	90%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SSNAP)	Yes	90%
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
<b>Cancer</b>		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
National Prostate Cancer Audit	Yes	100%
Oesophago- gastric Cancer (National O-G Cancer Audit)	Yes	100%
Head & Neck Cancer Audit	Yes	100%

National Audits	Participated Yes /No	Percentage of eligible cases submitted
<b>Blood and Transplant</b>		
National Comparative Audit of Blood Transfusion (Audit of patient blood management in scheduled surgery)	Yes	100%
National Comparative Audit of Blood Transfusion (Use of blood in haematology)	Yes	100%
<b>Older people</b>		
Falls and Fragility Fractures Audit Programme		
- (FFFAP) – National Hip Fracture Database	Yes	100%
- Fracture Liaison Service Database	Yes	100%
National Audit of dementia	Yes	61%
British Association of Urological Surgeons Audits (BAUS)	Yes	Ongoing
- Nephrectomy Audit		
- Percutaneous Nephrolithotomy		
- Stress Urinary Incontinence Audit		
<b>Other people</b>		
Elective Surgery (National PROMs Programme)	Yes	71%
National Ophthalmology Audit	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
Breast & Cosmetic Implant Registry	Yes	100%
<b>National Confidential Enquiries (Clinical Outcome Review Programmes)</b>		
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD)		
The Trust participated in the following studies in 2016/17		
- Physical and mental health patient in acute hospital	Yes	90%
- Non-invasive ventilation	Yes	100%
- Cancer in children, teens & young adults	Yes	Ongoing
Maternal, infant and newborn clinical outcome review programme	Yes	100%
Child Health Clinical Outcome Review Programme		
- Chronic neurodisability	Yes	Ongoing
- Young people's mental health.	Yes	Ongoing

### Participation in clinical research

Approximately 3200 patients receiving NHS services provided or sub-contracted by SWBHT in 2016-2017 were recruited during that period to participate in research approved by a research ethics committee and/or the Health Research Authority. Of these, in excess of 2,750 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 450 were recruited into non-NIHR portfolio studies.

Participation in clinical research demonstrates our ongoing commitment to improving the quality of care offered to patients and to making a contribution to wider health improvement. Furthermore, it ensures that clinical staff remain abreast of the latest treatment possibilities.

There are over 300 research studies being undertaken across the Trust in various stages of activity, from actively recruiting participants into new studies to those in long term follow-up. In 2016/17, 60 new studies have been given Trust approval to commence (42 NIHR portfolio studies and 18 non NIHR portfolio studies). 95 NIHR portfolio studies have actively recruited research participants in 2016/17.

During 2016/17, patient recruitment was highest in cardiovascular disease, ophthalmology and rheumatology although research activity has taken place across a full range of disciplines including cancer (breast, lung, colorectal, and haematological, gynaecological, and urological malignancies), stroke, diabetes, gastroenterology, surgery, dermatology, maternity, obstetrics & gynaecology, paediatrics, respiratory, orthopaedics and physiotherapy.

Important new developments in 2016/17 include:

- Increasing the internationally recognised excellent of our research portfolio: we have received major funding from sources including the MRC, Arthritis Research UK and the EU for research into a range of disease areas including corneal scarring, early arthritis, Bechet's disease and atrial fibrillation.
- Increasing the breadth of our of clinical research portfolio with new research initiatives in a range of areas including clinical immunology, respiratory medicine and orthopaedics.

- Increasing the range of health care professionals contributing to our research portfolio: physiotherapists and speech and language therapists have made major contributions to our research and we have seen important developments in the involvement of clinical nurse specialists contributing to research delivery.
- Translating research into better and safer care: SWBH researchers have been involved with or led the development of national / international clinical guidelines for a range of diseases including Parkinson's disease, Early arthritis, Rheumatoid arthritis, Atrial fibrillation, Gynaecological cancers and pregnancy and rheumatic diseases.
- We have integrated research into a number of our community based clinics.
- We have continued our efforts to make R&D more visible within the organisation and to its patients for example through patient representation on the R&D committee and the use of social media channels to promote R&D activities.

### Duty of Candour

The statutory Duty of Candour requires the Trust's commitment to put systems in place to ensure that communication between healthcare staff and patients, and/or their carers, is open and honest when a patient has suffered harm as a result of healthcare treatment, and that this is documented. The regulations apply to incidents which result in moderate or severe harm to the patient, patient deaths as a result of the patient safety incident and where an incident has resulted in prolonged psychological harm (28 days or more). A duty of candour has always existed as part of the code of conduct for registered healthcare professionals but became legal in 2014. The Trust has in place robust arrangements to recognise incidents applicable to the duty of candour, informing and caring for the patient and initiating an investigation.

Every incident reported and confirmed as moderate, severe harm or where the incident has led to death of the patient, must have a duty of candour discussion documented on the Duty of Candour Proforma. Results for February and March 2017 show 100% compliance (32 and 38 incidents



Thalassaemia patient Harsha Ladva.

## Our Priorities for 2017/18

Strategic Plan	Priorities
<b>Quality</b>	<ul style="list-style-type: none"> <li>Review our Care Quality Commission report that is due during the year and implement our action plan to continue improving safety standards and quality of care.</li> <li>Implement the improvement plans to reduce avoidable mortality in surgery, cardiology, deaths due to sepsis and perinatal mortality.</li> </ul>
<b>Safety</b>	<ul style="list-style-type: none"> <li>Improve care in medicine by comprehensive implementation of consistency of care in all of our inpatient wards.</li> <li>Implement the safety plan in all inpatient areas (including community wards) so that patients have all safety checks as standard.</li> <li>Complete targeted recruitment for our hard to fill nurse roles that will create fully staffed teams reducing reliance on temporary workers.</li> </ul>
<b>Service performance</b>	<ul style="list-style-type: none"> <li>Meet our four hour A&amp;E waiting time commitment to patients sustainably in Q4.</li> <li>Reduce length of stay by increasing the number of morning discharges and cutting delayed transfers of care</li> <li>Deliver reductions in wait time and improved productivity through successful execution of our annual production plan for elective care.</li> </ul>
<b>Our people</b>	<ul style="list-style-type: none"> <li>Cut sickness absence to below 3%.</li> <li>Create a more engaged workforce through promoting opportunities to speak up, make suggestions and listen to colleagues.</li> <li>Implement the changes needed to meet our workforce plans for 2018 – 2020. Deliver our Aspiring for Excellence: New PDR process.</li> </ul>
<b>Digital workstream</b>	<ul style="list-style-type: none"> <li>Successfully implement our new electronic patient record during the Autumn supporting our journey towards a paper-free environment.</li> <li>Fully embed digital dictation and speech recognition, reducing time taken for patients and healthcare professionals to receive Trust correspondence.</li> <li>Ensure robust, improved infrastructure for our technology.</li> </ul>
<b>Our places</b>	<ul style="list-style-type: none"> <li>Finalise and publish our final location plans for services in the Sandwell Treatment Centre.</li> <li>Exit 2017/18 with delivery plan for Midland Met on track and seven day service model developed, costed and agreed.</li> </ul>
<b>Long-term financial plan</b>	<ul style="list-style-type: none"> <li>Reduce agency spend by £10m during the year.</li> <li>Meet financial commitments to generate a surplus by year end with all groups meeting their income and expenditure budgets.</li> <li>Work with the Black Country Alliance and STP partners to deliver efficiency savings including across corporate back office functions and in procurement of supplies and services.</li> </ul>

## CQUINs (Commissioning for Quality and Innovation (CQUINs) 2017-18

The following CQUIN (commissioning for quality innovation) targets are agreed with our NHS commissioners. We assign CQUIN leads on clinical and operational levels to appropriately support each CQUIN. We publish monthly data on how we are doing against milestones and this is published in the Trust's Integrated Quality & Performance Report, which is discussed in our public board meetings. The NHS Commissioners are informed of progress on a quarterly basis.

Strategic Objective	Goal Name	Description of Goal
Goal Number	NHS Staff Health & Well Being	Achieving an improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress
	Reducing the Impact of Serious Infections	Antimicrobial Resistance and Sepsis
	Improving services for people with Mental Health needs	Improving services for people with Mental Health needs who present to A&E
	Offering advice and Guidance (A&G)	Set up and operate A&G services for non-urgent GP referrals
	NHS e-Referrals CQUIN	GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service
	Proactive and Safe Discharge	Improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS)
	Preventing ill Health	Preventing ill Health by risky behaviours (alcohol and tobacco)
	Improving the assessment of wounds	Increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment
	Personalised Care / support planning	Embedding personalised care and support planning for people with long-term conditions
Specialised Services	Inpatient Paediatric Services	Improve Paediatric Intensive Care (PIC) capacity utilisation.  In some cases children could be better managed by providing high dependency care closer to home but more needs to be done to understand demand particularly in relation to care delivered in acute hospitals.
	Activation System for Patients with Long Term Conditions – HIV	Activate patients (the knowledge, skills and capacity to manage their own condition) to enable better outcomes including reduced frequency of exacerbations and associated high cost interventions.
	Improving Haemoglobinopathy Pathways through ODN Networks	Organising Haemoglobinopathy care be organised on a clearly defined network basis. This is set out in published standards produced by specialist societies for sickle cell disease and thalassaemia.
Public Health and Dental	Breast Cancer Screening	Improving access and uptake through patient and public engagement.
	Bowel Cancer	Improving access and uptake through patient and public engagement.
	Secondary Care Dental	Sugar Free Medicines Audit.

### Healthwatch Sandwell

Thank you for asking us to comment on the 2016/7 Quality Accounts of Sandwell and West Birmingham Hospitals NHS Trust.

The report contains the ambitious plans for improvements in a number of areas of great importance to local people. These include improvements in cancer treatment, reduction in rates of stillbirth and improvements in management of young adults moving from children's to adult services. These are all important areas where the Trust has to work with other provider organisations or deal with difficult socioeconomic conditions. There are clear plans for improving processes. Later in the report they show the difficulties in assessing outcome measures where Patient Reported Outcomes may indicate very different outcomes from measurements of health gains.

The Trust has had visits by the Care Quality Commission this year to Sandwell, City and Rowley Regis Hospitals and the Birmingham Medical Eye Centre. The initial reports were all good. The thorough investigation of a Never Event at Birmingham Medical Eye Centre showed the Trust's commitment to investigate such events and improve processes even when the Care Quality Commission does not identify any problems.

The Trust has continued to monitor the development of a number of multi-resistant organisms, which pose potential major problems of untreatable infections in the future. Screening of patients for colonisation by MRSA was carried out on 85% of patients, which is at a lower rate than the target.

The Trust continued to carry out research and 3200 patients were enrolled into research projects carried out by clinicians, specialist nurses and other allied health professionals. A large number of audits were carried out and improvements in management were instituted as a result. These included improved care of the elderly requiring abdominal surgery, restricting use of antibiotics in acute pancreatitis, earlier use of orthotics in management of diabetic foot ulcers and venous thromboprophylaxis following lower limb injuries. The Trust is also planning to become increasingly digitised. It plans to increase the number of electronic referrals despite some initial teething problems. They also plan to go paperless, presumably when they are confident of not being at risk of disruption by international hacking!

The report identifies two areas of great concern, namely high readmission and mortality rates. A plan to reduce readmissions by using the LACE scoring toolkit to identify elderly patients at risk of readmission ensures that staff are aware of the risk and also arrange improved care in the community by iCares after discharge. Addressing the high mortality rates requires in-depth investigations of the causes of death so that these can be analysed and improvements made. At present only 60% of deaths are followed by mortality reviews and until this figure increases analysis and improved care is unlikely to occur.

The Trust understands that the patient is at the centre of all their plans for improved care and states that "During the year we have actively encouraged concerns, complaints and feedback from patients and carers that has enabled us to make improvements in the care we provide". Unfortunately the facts that the Friends and Family test is filled in by fewer patients than the national average and that patient engagement shows that many people find the complaint process daunting, fear that their complaint will not produce improvements in the service and may jeopardise their own care suggest that the Trust's laudable aim in this area is not being realised. Corresponding issues with the complaints process were also reported by Healthwatch Sandwell in their recent investigation into care at Sandwell Hospital, a follow-up to an earlier similar investigation, leading to the following recommendation: '...that the entire complaints experience from a patient perspective be reviewed. We are sure that SWBHT have made efforts to improve the process, but this remains a difficult area to change for patients.' It is also of concern that the number of incidents reported by staff has fallen during the last two years. Such reports are a valuable source of plans for improved care and are also a sign of an open culture happy to accept constructive criticism.

### Trust response

We are currently reforming our process of learning from deaths. Our revised process will include a Medical Examiner function who will be responsible for initial review of all deaths on notification to the bereavement office and then triage appropriately to the appropriate investigation stream. This will improve learning from deaths and ensure that families and carers are included in the process.

## Healthwatch Birmingham

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Sandwell and West Birmingham Hospitals NHS Trust 2016/17. In line with our role, we have focused on the following:

- The use of patient and public insight, experience and involvement in decision-making
- The quality of care patients, the public, service users and carers access and how this aligns with their needs
- Variability in the provision of care and the impact it has on patient outcomes.
- Patient Experience and Feedback

Healthwatch Birmingham agrees that improving patient experience should be a key objective as it is linked to meaningful outcomes. That patients and carers should be informed and included in care planning. We note the various ways in which the Trust collects patient feedback, including the Friends and Family Test, surveys and complaints. However, our review of the Quality Account shows no evidence of triangulation of the various methods and of an agreement across the Trust on how and why patients, the public and carers will be engaged in order to improve health outcomes and reduce health inequality. Whilst we acknowledge that there is mention of the use of feedback, in terms of FFT scores and patient stories, the idea of patient experience, insight and feedback does not appear to be embedded in the many decision-making activities the Trust makes. For instance you mention the following in the report:

- Mortality reviews – two plans covering maternity and general surgery are ready to commence in April 2017 with three others undergoing modification to their proposals;
- Wave 2 (Cancer) – this is in the planning stages and it is expected that the plans will be submitted for review/approval in June 2017.
- An executive-led 12-week improvement plan is in place to achieve consistency of care on the trust's medical wards by June 2017 especially concerning patient agreement with care and treatment.
- The Trusts' in house inspections conducted throughout the year.

In these plans, the Trust does not mention how service users, carers and the public will be involved both in the reviews and the development of future plans. In order to make improvements, the Trust needs to ensure that service users are involved from the point of identifying the barrier to improvement in health outcomes including increasing independence and preventing worsening ill-health; and mapping out possible solutions to evaluating options and selecting the optimum solution. To do this effectively, the Trust should consider developing a strategy for involving patients and the public in decision-making. Such a strategy will clearly outline how and why patients, the public and carers will be engaged in order to improve health outcomes and reduce health inequality. This will ensure that there is commitment across the Trust to using patient and public

insight, experience and involvement. It will also make clear arrangements for collating feedback and experience.

We also ask the Trust to not only use service user and carer's insight and experience to identify barriers to improved health outcomes but also to identify and understand health inequality. Therefore the Trust should commit to increasing the number and diversity of people it's hearing from. We therefore welcome the Trusts' work on Children's safeguarding and domestic abuse and on safeguarding adults to ensure patients lacking in capacity are protected from harm. This will help identify any gaps in service provision, the needs of different groups and improve health outcomes, particularly for those that seldom give feedback. Healthwatch Birmingham would like to see the following in next year's report:

- A demonstration of how patient feedback and experiences have been used to develop priorities for the 2018/19 Quality Account in the 2017/18 Quality Account;
- Changes in practice or improvement to services that have been made as a result of patient feedback and experience in the 2017/18 Quality Account. We welcome that there is a widening use of patient stories for learning and we hope to see more examples of this across the Trust;
- An introduction of qualitative questions and demographic questions to the FFT survey that will complement the statistical data the Trust collects and offer greater insight to barriers different patients face to receiving good quality of care;
- A demonstration of how the Trust uses patient insight and experience to understand the barriers different groups face and the impact on health outcomes. Consequently, how this data is used to implement change or improvement that addresses the needs of these groups.

### The Friends and Family Test (FFT)

We welcome the use of different methods (tablets, sms texting, cards) to ensure that patients are able to give their feedback. We note the improvements that have been made as a result of this survey, for instance re-launch of sleep packs; training volunteers to support patients with cognitive disorders, and placing a flag on the records of patients with learning disabilities to support seamless care. However, we observe that the positive recommender score for 2016/17 is below the national average, although not lower than the lowest Trust. The FFT inpatient score is 89.9% (96% national average); Emergency Department score is 79.4% (86% National Average), and for Outpatients it is 88.2% (93% National Average). A comparison of the positive responder rate indicates that this is higher for inpatients, seconded by outpatients and lower for the Emergency department. This shows variability in care based on how patients access services or the location of access to services. Consequently, the report shows that the Trust failed to meet its target of 50 patients expressing satisfaction (FFT) with IP wards and emergency care. Only 15 patients expressed satisfaction.

### Complaints

There was an increase in the number of formal complaints received by the Trust from 871 in 2015/16 to 1026 in 2016/17. Although, complainants were responded to within the target date 81% of the time, the average number of days the Trust takes to respond to complaints steadily increased over the four quarters. The most common themes people complained about remain similar for 2015/16 and 2016/17, with complaints on attitude of staff and admissions/discharges/transfer increasing. Similarly, 2,592 people contacted PALS during the 2016/17 and the top three issues were communication, clinical issues and appointments. We welcome examples of actions taken as a result of learning that has occurred from complaints. We hope to see the impact learning from complaints has had on services and patient experience in the 2017/18 Quality Account.

### Pre- and post-operative surveys

Provisional data for April 2015 to March 2016 indicates that the Trust has performed above the national average for patients reporting an improvement in their health status following a procedure. However, the Trust's performance is below the national average for hip replacement. We welcome the actions taken to make improvements, particularly, the joint club where patients are given advice and information so that they understand the risk and benefits as well as expected outcome.

### Trusts performance against standards and CQUIN

Our review of the Quality report shows that the Trust has failed to meet standards in a number of areas that have the potential to lead to variability in the quality of care leading to poor health outcomes. It is therefore positive that some of these areas are still a priority for the Trust in 2017/18 and we hope to see improvements after the Trust implements the various actions agreed.

### Incident reporting

The report states that the Trust reported 19,766 incidents in 2016/17; 8 of which resulted in serious harm and one in death. The number of serious incidents increased during 2016/17 from 1 in April 2016 to 5 in March 2017. The trust also reported four never events against target of zero. We commend the Trust for ensuring that learning is taking place and actions have been taken to rectify the causes. We hope the Trust meets its target of zero never events in the 2017/18 Quality Account and that lessons learned will become embedded in Trust practice.

### Mortality reviews

The Trust only carried out 68.3% mortality reviews against a target of 90%. Mortality is an indicator of problems with the

quality of care, therefore reviews are an important tool for ensuring learning occurs. Equally, learning improves health outcomes, we therefore welcome the Trust's plan to keep this as a priority for 2017/18.

### Other Comments

Generally, we are concerned that the Trust has failed to meet standards for delayed transfers of care; and the number of patients offered another date for operation in 28 days following a cancelled operation. Most concerning is the Trust reporting 51 breaches for mixed sex accommodation against a target of zero. Equally the Trust has not managed to deliver against five of the agreed Commissioning for Quality and Innovation (CQUINs) schemes. Namely, Sepsis A & E/inpatient screening and review; Mortality reviews; preventing term admissions to NIC; and activation systems for patients with long term conditions. These have the potential to lead to poor patient experience and outcomes. We look forward to reading how you have made improvements in the 2017/18 Quality Account.

Although we have highlighted different areas in this report where the Trust can make improvement, we recognise the Trust's achievements. We congratulate the Trust for introducing the Connected Palliative Care Service which has improved the quality of care for patients at the end of life. Thank you for giving us the opportunity to review the Trust's Quality Account.

### Trust response

We welcome the comments from our partners relating to our Quality Account.

Understanding and improving the experience of our patients and their carers and families is really important to us. As Healthwatch Birmingham identify, we have a number of different ways to gain feedback on our services. We use this feedback to put in place improvements such as the consistency of care programme in our medical wards.

We recognise that performance on certain measures has fallen below our expectations and the standards we wish for our patients and these areas are recognised as priorities for the year ahead.

We would be keen to work with all our partners to see what support they can provide as we continue to improve the service for our patients.

## **Sandwell and West Birmingham Clinical Commissioning Group**

This Quality Account, prepared by Sandwell and West Birmingham Hospitals Trust (SWBH), is a true reflection of the work undertaken by the trust during the 2016/17 contract year.

SWBH engages fully and openly with its CCG commissioners, providing opportunity for dialogue at both a contract and locality level, via CQRM, and CRM meetings.

SWBH has demonstrated its commitment to quality by the introduction of a number of quality improvements schemes during year, including: The appointment of Dementia Specialist Nurses and implementation of the John's Campaign, The End of Life Care Connected Palliative Care Service, Changes to the District Nursing service to deliver 20% more activity via use of the Clinic, the development of Child Safeguarding policies and introduction of the Child Protection Information Sharing project (CP-IS), and the setting up of a steering group to support improvements to Data Quality.

During the 2016/17 contract year, the CCG wishes to acknowledge and congratulate SWBH on their continued reduction of patients experiencing pressure damage and pressure damage resulting in significant harm; their continued progress on reducing hospital acquired infections (with low numbers of C-Diff and MRSA infections acquired by patients in 2016/17; the good result achieved by the Trust in terms of Patient Reported Outcome Measure (PROMs) for Hernia Repairs, Hip Replacement, Knee Replacement and Varicose Vein Surgery, and their performance in relation to VTE assessment completed with 24 hours. The CCG also wish to acknowledge the Trust's moderate success in

achieving most Local Quality Indicator targets and National and Local CQUIN schemes for 2016/17. In addition, the CCG also acknowledges the learning and actions taken by the Trust in regard to complaints but acknowledges that more needs to be done to improve the average time taken to respond to complaints.

The CCG also wishes to recognise and acknowledge the challenges faced by SWBH to: improve Mortality Index scores and the number of mortality reviews taken; to achieve the emergency care 4 hour wait target, to consistently achieve the 95% target for Harm Free Care; to continue to address workforce issues - notably sickness absence and numbers of agency staff; improving safety in relation to patient falls, and to improve average adjusted health gain scores against PROMs indicators. The CCG also wishes to acknowledge that while the Trust have experienced difficulties in achieving their commitments to reduce instances of Mixed Sex Accommodation (MSA), that in the instances where targets have been missed, the reasons why have all been justified by clinical need.

Looking forward, the CCG welcome the Trust's Quality Plan Objectives for 2017-20, its aspiration to reduce readmissions by 2% by coordinating care across organisations and facilitating safe and timely discharges, and its support of the continuation of the SWBH Safety Plan.

### **Trust response**

We thank the CCG for their engagement in our Quality and Safety agenda and look forward to working with them over the next 12 months to deliver our ambitions in the Quality and Safety plans.

## **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 2017 ("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 2017 subject to limited assurance consist of the following indicators:

- The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period; and
- Percentage of reported patient safety incidents resulting in severe harm or death.

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 ("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 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback from the Commissioners dated 30 May 2017;
- feedback from Local Healthwatch (Birmingham) dated 23 May 2017;
- feedback from Local Healthwatch (Sandwell) dated 16 May 2017;
- the 2015 national patient survey published June 2016;
- the latest national staff survey dated March 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017;
- the annual governance statement dated 1 June 2017; and
- the Care Quality Commission's Inspection report dated March 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 Sandwell and West Birmingham Hospitals NHS 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 2017:

- 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.

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1 June 2017



## Appendices

The reports of **16** national clinical audits were reviewed by the provider in 2016-17 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare we provide:

Report	Findings, Our Learning, & Our Actions
<p>National Inflammatory Bowel Disease (IBD) Programme- Biologic Therapy Audit.</p> <p><b>Audit description</b> The UK IBD programme aims to improve the quality and safety of care for people with inflammatory bowel disease throughout the UK by assessing individual patient care and the provision and organisation of IBD service resources.</p>	<p><b>Key Findings/learning</b> The last report from the national audit prior to commencement of the Registry published in September 2016.</p> <p>The audit found that biological therapies are safe and are being used earlier in the disease course in adult patients. The report also recommended considering switching existing patients to the newer biologic treatments.</p> <p>The audit also recommended that clinicians should ensure that complete screening is included in patient pathways before a patient commences treatment and that they should audit practice through participating in the National IBD Registry.</p> <p><b>Action</b> The assessment against the key recommendations contained in the report found that there was good compliance with the screening and other recommendations. Existing patients are reviewed at least annually, where the effectiveness of their treatment can be evaluated. The service has registered to take part in the National IBD Registry.</p>
<p>National Emergency Laparotomy Audit (NELA). Second Annual Report.</p> <p><b>Audit description</b> 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.</p>	<p><b>Key findings/learning</b> The results in the 2016 report for the Trust showed that the performance was above the national rate for the following indicators:</p> <ul style="list-style-type: none"> <li>• CT Scans reported before surgery;</li> <li>• Documentation of risk before surgery;</li> <li>• Pre-operative review by a consultant surgeon and anaesthetist when risk of death was greater or equal to 5%.</li> </ul> <p>Results where the performance of the Trust was below the national rate included for the following indicators:</p> <ul style="list-style-type: none"> <li>• Final case ascertainment;</li> <li>• Ensuring that there is emergency theatre access in all cases through prioritisation ahead of elective patients;</li> <li>• Assessment by an elderly medicine specialist in patients aged 70 years and over.</li> </ul> <p><b>Action</b> To address the recommendations a key action was to introduce a new pathway for Emergency Laparotomy patients. This would also help to improve case ascertainment rates.</p> <p>In order to improve this percentage of patients assessed by an elderly medicine specialist a separate pathway is required to be developed. A review of the policy in theatres was also identified as being required in order to ensure that semi-urgent cases are not booked onto emergency lists.</p>

Report	Findings, Our Learning, & Our Actions
<p>National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report - 'Treat the cause'.</p> <p><b>Audit description</b> The study aimed to identify the remediable factors in the quality of care provided to patients treated for acute pancreatitis</p>	<p><b>Key findings/learning</b> The national report identified some remediable factors in the clinical and organisation of care of patients admitted with acute pancreatitis. One recommendation included in the report was that there needed to be better management of co-morbidity in patients with acute pancreatitis, especially through the involvement of the relevant specialists, as this represented an opportunity to improve overall outcomes. A further recommendation was that antibiotic prophylaxis is not recommended and that all healthcare providers should ensure that antimicrobial policies are in place.</p> <p><b>Action</b> Locally in order to fully comply with the recommendations a new pathway would be designed to ensure appropriate and timely access to specialities. In addition, local guidance the use of antibiotics in pancreatitis would be amended to comply with the recommendation from NCEPOD.</p>
<p>National Neonatal Audit Programme (NNAP) – Annual Report (2016).</p> <p><b>Audit description</b> The key aims of the audit are:</p> <ul style="list-style-type: none"> <li>To assess whether babies requiring neonatal care received consistent care across England;</li> <li>To identify areas for improvement in neonatal units in relation to delivery and outcomes of care;</li> <li>To provide a mechanism for ensuring consistent high quality care in neonatal services.</li> </ul>	<p><b>Key findings/learning</b> The results from the 2016 report showed some areas where the performance of the Trust was below the national rates. This included:</p> <ul style="list-style-type: none"> <li>36% of babies had a temperature in the target range in the first hour compared to a national figure of 62%.</li> <li>80% of cases had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission compared to a national figure of 88%</li> </ul> <p><b>Action</b> In order to improve compliance with temperature target ranges, an action was identified to use thermometers on the Labour Ward in babies under 32 weeks gestation to facilitate early temperature recording. This would enable early changes in thermal care to be made if needed, and help to reach the target range within the first hour.</p> <p>In addition, it was planned to introduce laminated NNAP cards for parent communication which would be included in admission packs so as to act as a visual reminder to staff that a senior communication was required.</p>
<p>National Pregnancy in Diabetes Audit (NPID). Third Round Report.</p> <p><b>Audit description</b> The National Pregnancy in Diabetes (NPID) Audit measures the quality of pre-gestational diabetes care against NICE guideline based on criteria and the outcomes of pre-gestational diabetic pregnancy</p>	<p><b>Key learning/finding</b> Nationally, the NPID audit showed that pre-conception care is not achieving the standards set out in NICE guidance and improvements are required. The potential impact of these findings on patient care includes miscarriage, uncontrolled blood glucose, pre-term deliveries and stillbirths.</p> <p><b>Action</b> Locally improvements are being made which should be reflected in the fourth NPID report which is expected to be published in October 2017. The actions identified in order to address the key recommendations include:</p> <ul style="list-style-type: none"> <li>Development of a rapid referral pathway of women from Primary Care to Maternity;</li> <li>Provision of starter packs on pre-conception care;</li> <li>Continuing with ongoing measures to improve the prescription of folic acid.</li> </ul>

Report	Findings, Our Learning, & Our Actions
<p>Falls and Fragility Fracture Audit Programme (FFFAP).</p> <p>National Hip Fracture Database (NHFD) Annual Report 2016</p> <p><b>Audit description</b> The National Hip Fracture Database (NHFD) is a clinically led, web-based audit of hip fracture care and secondary prevention.</p>	<p><b>Key findings/learning</b> Results in the 2016 report for Trust showed that the hospital was in the top quartile for the following indicators:</p> <ul style="list-style-type: none"> <li>Admitted to an orthopaedic ward within 4 hrs;</li> <li>Proportion of patients receiving spinal anaesthetic with nerve block;</li> <li>Overall hospital length of stay;</li> <li>Return to usual residence within 30 days.</li> </ul> <p>The results also showed that the Trust was in the lowest quartile for:</p> <ul style="list-style-type: none"> <li>Proportion of arthroplasties which were cemented;</li> <li>A higher than expected adjusted 30-day mortality rate.</li> </ul> <p><b>Action</b> A review of mortality data showed that departmental processes had been followed and that nearly all of the deaths had been expected. In addition, a further action was to review the data on the use cemented prosthesis to determine whether the finding had arisen from inaccuracies in data submission.</p>
<p>National Diabetes Footcare Audit. 2014-16 Report</p> <p><b>Audit description</b> The National Diabetes Foot Care Audit (NDFA) is a continuous audit of diabetic foot disease in England and Wales. The audit enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease</p>	<p><b>Key findings/learning</b> The results in the 2016 report showed that there was good compliance for the Trust apart from the rate of patients who were ulcer free after 12 weeks. Data showed that 39.8% of patients were ulcer free after 12 weeks, compared to a National rate of 50%.</p> <p><b>Action</b> In order to improve rates, a review of the pressure relieving action taken, particularly the role of the timing of orthotic interventions, would be conducted.</p> <p>A further action identified was to review the provision of foot assessment training in Community.</p>
<p>Royal College of Emergency Medicine (RCEM) Audit- Vital signs in children</p> <p><b>Audit description</b> Vital signs are frequently recorded in children presenting at Emergency Departments because, if abnormal, they indicate that a patient has deranged physiology. The detection of abnormal vital signs, appropriate escalation and response can avoid the patients' deterioration and improve patient outcomes. The audit measures compliance with RCEM standards</p>	<p><b>Key findings/learning</b> The results from the retrospective audit were poorer than expected as it is considered that abnormal findings are acted upon and repeated in a timely manner. It was considered that the findings resulted from inadequate documentation of all the elements. One of the key elements contributing to poor results was the recording of CRT which was not included as part of the vital signs documentation.</p> <p><b>Action</b> In order to address these findings it was agreed that a new observation chart needed to be introduced which incorporated CRT, and also to raise awareness of the need for assessment and to include this in training, particularly with new starters.</p>
<p>Royal College of Emergency Medicine (RCEM) Audit -Procedural sedation in adults.</p> <p><b>Audit description</b> The administration of sedative drugs to promote calm or sleep for a medical procedure is common practice in E.Ds. Sedation is an important topic as it can lead to adverse effects if incorrectly undertaken. The audit measures compliance with RCEM standards</p>	<p><b>Key findings/learning</b> The findings from the audit were poor and gave the impression that the proforma already in place was not being utilised as this incorporated many of the standards being measures by the RCEM audit</p> <p><b>Action</b> A re-audit was conducted which confirmed that procedural sedation was being administered in a safe manner. One area identified for improvement in the re-audit was in ensuring that patients are supplied with written advice on discharge. An action for the department was to develop and implement an advice leaflet for patients.</p>

Report	Findings, Our Learning, & Our Actions
<p>Royal College of Emergency Medicine (RCEM) Audit- VTE prophylaxis patients with lower limb immobilization.</p> <p><b>Audit description</b> A significant number of patients attend emergency departments with lower limb injuries each year. Many of these are discharged with the leg immobilised, either in a plaster cast or other forms of splintage</p> <p>If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. The audit measures compliance with this requirement.</p>	<p><b>Key findings/learning</b> The results showed that there had been limited guidance set in place within the ED to highlight the need for thromboprophylaxis. Locally the emergency department had yet to produce an actual proforma and associated scoring/risk tool but practitioners are made aware of methods of assessment of risk.</p> <p><b>Action</b> To develop a proforma for all lower limb casts and assessment of risk in a simple Q+A format.</p> <p>A further recommendation of the audit was to ensure that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE is given to all patients with temporary lower limb immobilisation. Locally, the action identified was to use information from RCEM which is under development.</p>
<p>Falls and Fragility Fracture Audit Programme (FFFAP).-Fracture Liaison Service Database – Facilities Audit 2016.</p> <p><b>Audit description</b> This facilities audit appraises the national situation regarding the organisation of FLSs to build a more comprehensive national picture of secondary fragility fracture prevention, as well as a comparison of service models. The aim of this audit is to identify gaps and shortfalls in the commissioning of FLSs and assist the sharing of best practice, to improve the quality of care and to reduce costs to the NHS incurred from fragility fractures.</p>	<p><b>Key findings/learning</b> The results in the 2016 report showed good compliance with the key recommendations. Patients aged 50 years and over are identified by the Fracture Liaison Service (FLS) and are then assessed and receive treatment for bone health in line with NICE guidance.</p> <p>In addition, all patients that required treatment are offered falls prevention services.</p>
<p>British Thoracic Society - Smoking Cessation Audit Report 2016.</p> <p><b>Audit description</b> The audit examined hospital-based smoking cessation services in UK hospitals from April to May 2016. Part one of the audit focused on the key interventions of identifying people who smoke and offering them help to stop, and part two looked at the organisational infrastructure required to deliver these interventions.</p>	<p><b>Key findings/learning</b> The audit made a number of recommendations. One of the areas identified for improvement locally concerned the provision of Nicotine Replacement Therapy, as the audit had highlighted that there was not a clear pathway for this. In addition, the audit results indicated that there was a need to improve the percentage of patients referred to specialist smoking cessation services.</p> <p><b>Action</b> A key action identified following the audit was to explore with Commissioners whether an outreach service could be supplied so that some specialist smoking cessation input could be provided to inpatients. Further actions included issuing and implementing Nicotine Replacement Therapy guidance and to explore whether referrals could be made more effectively through the Trusts new Electronic Patient Record System when it is introduced.</p>

Report	Findings, Our Learning, & Our Actions
<p>National End of life Audit – Dying in Hospital.</p> <p><b>Audit description</b> This audit comprised of the following two sections.</p> <ul style="list-style-type: none"> <li>• An organisational audit – key organisational elements that underpin the delivery of care.</li> <li>• A case note review – a consecutive, anonymised case note review of all the patients who died within participating sites within a defined time frame.</li> </ul>	<p><b>Key findings/learning</b> The assessment against the key recommendations found overall that there was good compliance. Some areas identified for development included ensuring that:</p> <ul style="list-style-type: none"> <li>• There is at least one lay member with specific responsibility for end of life care on every NHS trust board;</li> <li>• National guidance regarding ICD deactivation is adopted for local use;</li> <li>• A system is in place to alert the End of Life Care Committee of any complaints received about end of life care.</li> </ul> <p><b>Action</b> In addition to actions to address the above, a key action was to commence a trust wide training programme for End of Life Care. This would be a rolling programme and include training for priorities of care, advance care planning, symptoms control and recognition of the dying patient. The programme would be aimed at all clinical staff.</p>
<p>British Thoracic Society - National Paediatric Asthma Audit</p> <p><b>Audit description</b> The audit measures practice against British Thoracic Society (BTS) guidelines. The audit focuses on admission to hospital, management in hospital and discharge arrangements and accordingly allows comparison and identification of any substantial change in the deficiencies which have been identified in previous years.</p>	<p><b>Key findings/learning</b> The results identified that in a number of areas the Trusts performance was above the national rates. For example, the percentage of children recorded as having a written asthma action plan was 94% for the Trust compared to a national rate of 54%.</p> <p>An area of non- compliance identified concerned in ensuring that children discharged have a follow up appointment arranged with their GP arranged within 2 working days.</p> <p><b>Action</b> In order to assess whether there were any impacts from not notifying GPs within 2 working days, it was identified that an audit of readmissions needed to be conducted.</p>
<p>British Thoracic Society - Emergency Oxygen Audit.</p> <p><b>Audit description</b> The audit measures practice against British Thoracic Society (BTS) guidelines. This includes assessing oxygen prescribing, administration and monitoring.</p>	<p><b>Key findings/learning</b> Overall the audit highlighted areas requiring improvement both nationally and locally.</p> <p>Areas for improvement included:</p> <ul style="list-style-type: none"> <li>• In the prescription of oxygen;</li> <li>• In specifying the target saturation to be achieved;</li> <li>• In Health Care Assistants reporting saturations out of target ranges to the Nurse in charge.</li> </ul> <p><b>Action</b> The local action identified to improve compliance included:-</p> <ul style="list-style-type: none"> <li>• Implementing a revised prescription chart which specifies more clearly all of the requirements;</li> <li>• To continue to educate on the importance of oxygen prescribing and to produce a local learning alert to heighten awareness.</li> </ul>

Report	Findings, Our Learning, & Our Actions
<p>National clinical audit for rheumatoid and early inflammatory arthritis</p> <p><b>Audit description</b> The overall aim of the audit is to improve the quality of care provided by specialist rheumatology services in the management of inflammatory arthritis.</p>	<p><b>Key findings/learning</b> The main recommendation against which action needed to be taken to improve compliance concerned ensuring that there was adequate recruitment to the audit. Steps were taken to improve recruitment and this resulted in improved numbers during 2016.</p> <p>The audit also measured the performance against the standard that people with suspected persistent synovitis are assessed in rheumatology service within 3 weeks of referral. This standard was met only in 36% of cases</p> <p><b>Action</b> Action to address the delays to assessment by a rheumatology service have been taken which includes increasing staffing levels in alliance with other providers in the Black Country and also through more actively managing GP referrals through the appointment system.</p>

The reports of **23** local clinical audits were reviewed by the provider in 2016-17 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Audit topic	Findings, Our Learning, & Our Actions
<p>An audit of age related macular degeneration</p> <p><b>Audit description</b> The aim of the audit was to assess aspects of the treatment of patients aged 60 years and over with age related macular degeneration.</p>	<p><b>Key findings/learning</b> In the sample audited it was found that in about 60% of patients their vision remained unchanged or improved.</p> <p>The audit also highlighted that there was a need to improve early referral from optometrists to the macular fast track service as many were still coming via the Eye casualty potentially causing delays to the first review. The review also found that there was a need to change the charts used for measuring visual acuity as newer charts were available which measured this more accurately.</p> <p><b>Action</b> Key actions identified included undertaking some further training of optometrists and nurse injectors to increase the review and injection capacity in order to continue meeting the ever increasing demand on services. In addition to trial the newer charts to assess visual acuity.</p>
<p>An audit of compliance with NICE Quality Standards 30-- Supporting people to live well with dementia.</p> <p><b>Audit description</b> The aim of the audit was to undertake a baseline audit against NICE standards to inform developments.</p>	<p><b>Key findings/learning</b> The audit highlighted that there was a need to improve the documentation around the communication with patients and relatives to evidence fully the discussions that were taking place in offering choice and control. In addition, further staff training around referral to health and wellbeing services in the community was required.</p> <p>The audit also highlighted that greater consideration should be given to how patients are coded, with attention paid to including dementia in the coded diagnosis or reason for admission section of the KMR.</p> <p><b>Action</b> The actions identified following the audit included creating a specific document for dementia that would also assist in further audit and also to ensure that where possible the same therapist reviews the patient. This would assist further in overcoming communication barriers.</p>

Audit topic	Findings, Our Learning, & Our Actions
<p>An audit of the management of acute angina</p> <p><b>Audit description</b> The aim of the audit was to assess compliance with NICE Quality Standards 68 for the management of Acute Coronary Syndromes in order to provide evidence that clinically effective practices are being employed to improve patient outcomes.</p>	<p><b>Key findings</b> Overall, the audit found that there is an appropriate use of diagnostic invasive coronary angiography, but that the Cardiac CT service does not provide Calcium scoring as per NICE guidance. This was because it provides CT coronary angiography instead, as this provides the clinician with more clinically relevant information with less radiation exposure to the patient. It was reported that this small variation to NICE guidance was due to newer evidence on non-invasive assessment of patients being available and that updated NICE guidance would reflect this. It was expected that this would put more emphasis on CT coronary angiography as the non-invasive test of choice with a move away from stress echocardiography and nuclear scanning.</p> <p><b>Action</b> The primary action arising from the audit was to review the service in line with the updated NICE guidance and to formulate a strategy to adopt this with additional consultant sessions for CT, and less utilisation of nuclear imaging.</p>
<p>An audit of the use of Romiplostim in idiopathic thrombocytopenic purpura (ITP).</p> <p><b>Audit description</b> An audit to determine whether high cost drugs which are NICE approved e.g. romiplostim is being used appropriately within haematology/oncology. The audit aimed to determine if all patients were being adequately screened for splenectomy prior to being offered high cost TPO agonists as per NICE guidance.</p>	<p><b>Key findings/learning</b> The audit found that in just over half of the patients there was no documentation that patients were offered splenectomy prior to commencing treatment or if they were unable to have it. It was reported that patients generally present with a relapse/bleeding/low platelet count so that they are unsuitable for splenectomy at that time. In addition, a splenectomy was being undertaken less internationally and nationally due to long term risks of infections in these patients who appear to be immunosuppressed</p> <p><b>Action</b> Action was needed to ensure that a splenectomy is offered to patients if it is not contraindicated, and consideration should be given to undertaking a NM platelet scan to guide management.</p> <p>It addition, steps needed to be taken to ensure that there is fuller documentation of the options when offering treatments, and to include recording of the reasons why particular treatments are not offered.</p>
<p>An re-audit of the management of patients presenting with delirium</p> <p><b>Audit description</b> The aim of the audit was to assess whether when there was evidence of acute confusion the patient was managed in accordance to NICE guidance.</p>	<p><b>Key findings /learning</b> A baseline audit was conducted in October 2014 to assess the management of delirium. A number of interventions were implemented following the audit, including the development of a patient pathway. A re-audit was conducted to assess whether the management had improved.</p> <p>The re-adudit showed some improvements in assessment of risk factors such as medication review and infection and also in coding the diagnosis. The audit also found that although all but one patient had a probable cause for the delirium documented, there was still a need to improve the documentation of this in discharge letters to GPs. In addition, improving in the documentation of the information supplied to relatives and carers was also required.</p> <p><b>Action</b> A key action identified following the audit was to relaunch the pathway and to continue with on-going education to increase awareness for new members of staff and patients through regular teaching sessions. A further action was to consider developing the role of delirium champions in close working with Dementia Lead Nurse.</p>

Audit topic	Findings, Our Learning, & Our Actions
<p>An audit of HER-2 Testing availability.</p> <p><b>Audit description</b> To audit the availability of HER-2 test results at the decision making multidisciplinary meeting. NICE Quality Standard [QS12] indicates that patients with newly diagnosed invasive breast cancer have their ER &amp; HER-2 status assessed and the results made available within 2 weeks so as to allow planning of systemic treatment.</p>	<p><b>Key findings/learning</b> The audit found that there was a median delay of 13 days and therefore that the standard was not met in all cases. This could potentially lead to a delay in optimal treatment. As a result, it was recommended that further consideration should be given to bringing the testing 'in house' so that the standard is met in all cases.</p> <p><b>Action</b> In addition to giving further consideration to providing testing 'in house' it was recommended that opportunities to providing a solution through the Black Country Alliance would need to be explored.</p>
<p>Head Injury Audit</p> <p><b>Audit description</b> An audit to assess whether NICE standards with regards to head injury management are being fully met in the Emergency Department. In addition, to review the effectiveness of head injury proforma covering the key requirements introduced in the City and Sandwell Hospital Emergency Departments.</p>	<p><b>Key findings/learning</b> The audit found that based on the Head Injury Proforma, nearly all patients received the relevant investigation and treatment, but that the head injury proforma was not being used in all cases where it was relevant. In addition, 20% of patients were not being triaged within 15 minutes according to the documentary evidence available. The review also found that there was a need to develop a head injury proforma for use with paediatric patients.</p> <p><b>Action</b> The action to be taken following the audit included taking further steps to reinforce the use of the head injury proforma and to include this in induction checklists for locum. Also to undertake further educational activity for nurses and doctors regarding head injury management, particularly around improving triage times. In addition to undertake a further re-audit in 6 months to evaluate the effectiveness of the intervention to improve practice.</p>
<p>An audit of Fluid Balance Chart completion.</p> <p><b>Audit description</b> The timely and appropriate use of fluid balance observation and recording is an essential tool in determining adequate hydration. The aim of the audit was to assess how well these were being completed.</p>	<p><b>Key findings/learning</b> The audit found that in the sample audited fluid balance charts did not meet all of the requirements for full completion in many cases. The results were partly explained by the fact that charts are included as part of the Daily Care Record and as such are being automatically commenced irrespective of patient need. The audit highlighted the need for ongoing education at ward level to address this.</p> <p><b>Action</b> The action identified following the audit included to discontinue the practice of the routine commencement of charts and for the need for strict fluid balance to be assessed by the multidisciplinary team. This includes also taken action to amend charts when strict fluid balance is not required but where there is a need to monitor a specific element e.g. outputs.</p>

Audit topic	Findings, Our Learning, & Our Actions
<p>An audit of individualised care planning.</p> <p><b>Audit description</b> Shared decision-making is a process in which clinicians and patients work together to make decisions about care and treatment based on both clinical evidence and the patient's informed preferences. The aim of the audit was to assess how well this was evidenced in relevant documentation and by also asking patients about their degree of involvement.</p>	<p><b>Key findings/learning</b> The audit assessed whether a patients or carers signatures were being obtained at the time of admission when an initial assessment of their needs was made. In addition, the audit assessed whether a patient or carers signature was being obtained on care plans which detailed the care for a specific care need.</p> <p>The audit found that these signatures were not being obtained in the majority of the cases audited. Despite this finding, it was established in discussions with patients, that most felt that they were able to ask questions about their care.</p> <p><b>Action</b> It was identified that there was a need to re-energise the use of care plans with ward teams and to encourage patient involvement in the process, but that the need to gain a signature on each care plan for a specific need was not required and should cease. In addition, it was recommended that other methods for encouraging patient involvement needed to be explored.</p>
<p>Audit of health promotion- 'Making every contact count' (MECC)</p> <p><b>Audit description</b> Making Every Contact Count (MECC) is a key initiative to support staff with contact with patients to provide consistent messages about them adopting a healthier lifestyle. The aim of the audit was to assess whether patients are being assessed for smoking habit and alcohol consumption and whether appropriate action is being taken for those who give their consent.</p>	<p><b>Key findings/learning</b> The audit found that in the sample audited nearly all of the patients had their smoking habits and alcohol consumption assessed. Areas for improvement were identified as in a quarter of current smokers it was not documented whether they would have liked to have stopped and in the small number of cases identified where alcohol consumption was identified as being hazardous it was not always documented what advice had been given.</p> <p><b>Action</b> The assessment of lifestyle choices (healthy eating, smoking, alcohol, drug/solvent abuse) and the offering of appropriate support and advice are included as part of the 'Ten out of Ten' Patient Safety Checklist and this is being rolled out as part of the Trusts Safety Plan. This will lead to practice being embedded on priority wards. Further action identified included consider incorporating a specific objective relating to practice into a revised Public Health Plan and explore the opportunities to improve practice with the deployment of the new Electronic Patient Record System.</p>
<p>An audit of the reasons for why medicines are omitted.</p> <p><b>Audit description</b> Whilst only a small percentage of missed or delayed medicines may cause harm or have the potential to cause harm it is important to recognise that harm can arise from the omission or delay of critical medicines. Ensuring that patients are always given their medication at the right time so that no patient will miss out on a dose of medication is a key objective in the Trusts Safety Plan.</p> <p>The aim of the audit was to assess whether critical medicines were being omitted and the extent to which this was due to non – availability.</p>	<p><b>Key findings/learning</b> The audit found that the main reason for the omission of medicines was that patients had refused to take them. A fifth of omissions were due to non-availability but that only a small percentage (7%) of these could be classed as being critical medications. The audit also found that the document for recording omissions needed to be amended so that the action taken in response to an omission could be easily identified. The Trust is planning to implement electronic prescribing in September 2017 and it is considered that this will assist greatly in determining local omission rates, the nature of omissions and the action taken.</p> <p><b>Action</b> In order to reduce the number of critical medicines omitted for reasons of non-availability, an action was identified for Pharmacy to provide further training on how to access critical medicines outside of normal working hours. In addition, further training to avoid omissions would also be undertaken as part of implementation of the Trusts Safety Plan.</p>

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<p>An audit to assess whether the safety net when fractures are missed on initial presentation is working effectively.</p> <p><b>Audit description</b> To mitigate the risk posed by non-specialist ED staff interpreting X-rays, the Royal College of Emergency Medicine advises that departments need to have an appropriate process or 'safety net' in place to identify missed findings so that these are acted upon in a timely way.</p> <p>The audit aimed to confirm whether the 'safety net' in place is effective.</p>	<p><b>Key findings/learning</b> The audit found that in the sample reviewed, where bone injuries had been missed on the initial presentation, appropriate follow up action had been taken. The audit also highlighted that the process for flagging up missed fractures to the Consultants in the Emergency Department needed to be reviewed to ensure that this takes place within 24 hrs.</p> <p><b>Action</b> The main action identified following the audit was to finalising a new process in conjunction with Radiology and to specify this in a written pathway.</p> <p>In addition to the above, other actions included establishing an educational programme for staff to facilitate them reporting their own findings from x-rays, and also to audit the re-attendance of patients with missed fractures who did not receive an x-ray on their first attendance.</p>
<p>An audit of the use of monitored beds in the emergency assessment units.</p> <p><b>Audit description</b> The aim of this audit was to assess whether patients have been assigned the right level of care, and that decisions regarding monitoring were being made by the appropriate team member and are documented and escalated.</p>	<p><b>Key findings/learning</b> Although the audit found that there had been a reduction in inappropriate admissions to monitored beds when compared to the previous audit, the capacity and flows to the assessment units was being impacted upon by some delays in transferring patients to specialty beds, most notably to Cardiology and Respiratory designated beds.</p> <p><b>Action</b> In order to improve patient flow to the cardiology and respiratory wards to include this in ongoing discussions on the provision of Level1 care outside of the monitored beds provided on the assessment units. Additional actions included conducting an audit to establish whether there was any unmet need and also as to whether step-down (de-monitoring) arrangements were being applied.</p>
<p>An audit of readmissions to the Surgical Assessment Unit (SAU)</p> <p><b>Audit description</b> The audit was required to assess current practice and compliance with the discharge of patients from the SAU and to assist with identifying if any further action is required to improve the process.</p> <p>The Trusts Quality Plan document outlines the need for the reduction of emergency readmission rates with a reduction of 2% by 2019. The audit planned in order to provide information to address this target in General Surgery.</p>	<p><b>Key findings/learning</b> The audit identified a headline readmission rate of 9.8%, but that if coding errors were removed, the SAU readmission rate was 4.5% which was within National limits. It was also found that 3.4% of the total readmissions episodes reviewed, were considered to be for potentially preventable reasons</p> <p><b>Action</b> A number of actions were identified. These actions included developing a clear policy for the coding of planned readmissions and particularly for patients on the abscess pathway to ensure that these are booked for an urgent review clinic.</p> <p>An additional action was for the ward contact details to be provided to all patients discharged from SAU so as to potentially address patient concerns via telephone which may otherwise have required them to return to hospital.</p>

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<p>Audit of IV procedural sedation in adults</p> <p><b>Audit description</b> The audit was conducted to assess whether the local findings from the Royal College of Emergency Medicine (RCEM) national clinical audit on the same subject, were valid.</p>	<p><b>Key findings/learning</b> The findings from the national audit were poor and gave the impression that the proforma already in place was not being used. The proforma incorporated many of the standards being measured by the RCEM audit. The audit confirmed that procedural sedation was being administered in a safe manner, but that the awareness of the IV sedation proforma needed to be raised still further. Another area identified for further work was in ensuring that written advice is supplied to all patients on discharge.</p> <p><b>Action</b> The main action was to re-audit compliance following education on use of the sedation proforma and the development of written information for patients on discharge.</p>
<p>An audit of screening for Downs Syndrome.</p> <p><b>Audit description</b> The audit was required to assess current practice and compliance with the standardised communication of antenatal Down's screening test results between health professionals and pregnant women and their families.</p>	<p><b>Key findings/learning</b> Overall, the audit found that women are being offered the Downs Syndrome screening test in the antenatal period, however, that the documentation of written information being given to support the woman's decision was often lacking.</p> <p>The results of the Downs Syndrome screening test results are reviewed and documented on the electronic patient record system (BadgerNet), but the audit found that these are not always discussed with the women by the 16 week appointment with the community midwife.</p> <p><b>Action</b> A key action was to update the electronic patient system (Badger Net) documentation to signpost the need for sharing information. In addition, to implement and evaluate a Standard Operating Procedure for Badger Net entries and to target non-compliance to improve the effectiveness and responsiveness of care.</p>
<p>A re-audit of Parkinson's Disease.</p> <p><b>Audit description</b> A re-audit of the compliance with guidelines for the inpatient management of patients in the first 24 hours who are admitted and who have a diagnosis of Parkinson's Disease (PD).</p>	<p><b>Key findings/learning</b> A local trust audit had previously found some examples of where drugs used in PD had not been given on time and that not all patients were being referred to the Parkinson's Disease specialist. As a result inpatient Parkinson's disease guidelines were developed and put into Trust-wide use in September 2015 in order to give clear guidance on the inpatient management within the first 24 hours and to provide information regarding contacting specialist teams.</p> <p>A re-audit was conducted to assess compliance and progress. The audit found that there had been significant improvements in the prescribing of PD drugs and also in the management of PD since the last audit. Although the numbers were small, it was considered that there was evidence to suggest that there had also been improvement in seeking advice from the Elderly Care team.</p> <p>The audit also found that some staff experienced difficulty in accessing Summary Care Records from the community which could assist in improving prescribing.</p> <p><b>Action</b> The actions identified included increasing the awareness among nursing staff regarding the importance of Parkinson's disease medication administration being on time and to take steps to ensure that all members of admitting teams have access to the Summary Care Record which would help to access a patient's drug history out of hours.</p>

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<p>An audit of Walsall Pressure Risk scoring in the community.</p> <p><b>Audit description</b> The audit was conducted to assess current practice and compliance with the completion and review of Walsall Community Pressure Score Risk assessments.</p>	<p><b>Key findings/learning</b> The audit highlighted that data available from the Electronic Patient Record System (SystemOne), particularly in relation to the timing of interventions, was inadequate to determine the compliance with all standards included in Trust guidelines for the prevention and management of pressure ulcers. The information which was available electronically showed that in 36.1% of cases the Walsall Risk Score had not been recorded on SystemOne.</p> <p><b>Action</b> The action to be taken following the audit included for District Nursing teams to monitor and validate their own data. In addition, to roll out the use of mobile working devices so that District Nurses can readily enter Walsall scores at the time of their assessment in the patient's home. A further action was to explore the possibility of other health professionals with face to face contact undertaking Walsall Risk Scoring assessments.</p>
<p>WHO Checklist Compliance Audit</p> <p><b>Audit description</b> 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. The audit was conducted to assess compliance with these elements.</p>	<p><b>Key findings/learning</b> The audit highlighted that although the steps of the WHO checklist are followed and that no surgical procedure commenced without the WHO Checklist being followed, the complete team was not always in attendance for all of the steps included on the checklist.</p> <p>The audit also showed that further work was required to embed the additional processes of the initial image check, positive image ID and image final check.</p> <p><b>Action</b> The actions required following the audit included:</p> <ul style="list-style-type: none"> <li>• To produce a video to provide education on the positive image ID and final image check.</li> <li>• To create an 'alert' on the image intensifier to alert surgeons to review the image before the swab and instrument count is commenced</li> <li>• To amend the Safe Surgery Policy and WHO Checklist form to state that all team members are required to attend the 'Debrief' step</li> </ul>
<p>An audit of patient consent to treatment.</p> <p><b>Audit description</b> The previous corporately managed audit revealed that patients undergoing surgical interventions (including interventional radiology, cardiology and endoscopy) may have been provided with information verbally and/or in other media formats, but the documentation of this in the healthcare record was not robust or consistent.</p> <p>The audit set out to investigate if following the advent of a confirmatory notation in the electronic patient record that there had been improvement in the recording of the information provided.</p>	<p><b>Key findings/learning</b> The audit found that patients were signing a consent form at the time of discussions around treatment options, risks and benefits, but that they are not always provided with supplementary information in the form of a leaflet, CD or DVD.</p> <p><b>Action</b> The action identified following the audit, included for specialties to review their provision of supporting information and to ensure that it exists for procedures/interventions. In addition, for specialties to audit their documentation of consent discussions and to consider amending consent forms to be clearer about signatures for the provision of information, receipt of information and assent for procedures.</p>

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<p>An audit of excisions for Basal Cell Carcinoma (BCC)</p> <p><b>Audit description</b> An audit to assess the incomplete Basal Cell Carcinoma (BCC) excision rate and to identify if there are any contributory factors to incomplete excision.</p>	<p><b>Key findings/learning</b> Incomplete BCC excisions can lead to further treatment and prolonged follow up. Re-excision of incomplete deep margin is difficult and the recurred tumour can be more aggressive. The audit found that the incomplete excision rate was in line with national guidelines. From the sample audited some contributing factors to incomplete excision were also identified.</p> <p><b>Action</b> The action identified included circulating information in the department to assist in the identification of high risk patients so as to avoid more than one procedure and also to share the findings and recommendations with GPs who undertake these excisions in the community.</p>
<p>An audit of the preferred place of death for patients who are at the end of life</p> <p><b>Audit description</b> The audit was required to assess the impact of the Trusts reconfigured End of Life Service in reducing unnecessary hospital admissions and in enabling patients to die in their usual place of residence.</p>	<p><b>Key findings/learning</b> The audit found that 74% of patients registered on the Trusts Palliative Care Register died in their preferred place during the 6 month monitoring period. This figure improved for each month of the audit, with 84% of people dying in their preferred place during the final month of the audit.</p> <p>The figures were considered to compare favourably with national averages, but as the audit was carried out at the start of the service development when staff and resources were not fully operational, further improvements are expected in the future. As a result a repeat audit was recommended to determine the full impact of the service particularly as the Palliative Care Register becomes more embedded in practice.</p> <p><b>Action</b> The Trusts Palliative Care Register is held on the an electronic patient record and aims to include all people with a Sandwell and West Birmingham GP, who are deemed to be within the last 12 months of life and who provide verbal consent to be on the Register.</p> <p>One of the key actions arising from the audit was to promote the use of the Register, including through staff education. This to include the development of information leaflets for patients and professionals explaining the Palliative Care Register.</p>
<p>An audit of patients presenting with a retinal detachment.</p> <p><b>Audit description</b> The audit was required to assess current practice and compliance with nationally published standards in the management of retinal detachment.</p>	<p><b>Key findings/learning</b> The audit found that the target window for urgent surgery (within 24hrs) was being met and that the primary success rate of 80.9% was comparable to published rates which ranged from 75-90%. In addition, the audit highlighted that whilst the clinical aspects of the service appeared to be performing well, there were areas for improvement, particularly with regard to the quality and consistency of record keeping and in the improving the capture of follow up data on patients repatriated to neighbouring Trusts post-surgery.</p> <p><b>Action</b> The actions identified following the audit included requesting outcomes data from the referring units and in taking steps to ensure that all cases of retinal detachment are recorded on the relevant electronic patient record databases.</p>