NHS
Sandwell and
West Birmingham
NHS Trust

70 YEARS OF THE NHS 1948 - 2018

QUALITY AND PERFORMANCE ANALYSIS - OUR QUALITY ACCOUNT 2017/18

2017–2018

CONSISTENCY OF CARE

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Staff Nurse Kosir Maroof went through the Safety checklist.

Our Quality Account

Chief Executive's Statement

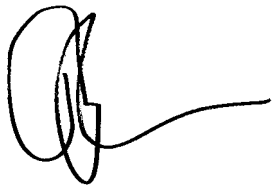
Our Quality Account includes information on our performance against a range of quality and safety indicators. Our main achievements in the year include our success in embedding the safety plan and engaging medical ward teams on our Consistency of Care programme. Both of these schemes have aimed to ensure that the basics of good care are always in place for every patient, every day and every shift. We are beginning to see improvements in patient outcomes as a result of the efforts of the ward team.

We chose to focus on our quality plan in 2018/19 and are looking forward to the changes we can make to achieve our ambitions to be among the best in the region or the best in the country for certain health conditions, services or treatments.

I am pleased that inspectors from the Care Quality Commission recognised the strides we have taken in improving safety and quality and have rated us good or outstanding in over 70 per cent of our service areas. The inadequate rating for safety has been removed and we achieved outstanding ratings for the caring domain and our innovative end of life care service, delivered in partnership with different providers – a truly integrated service.

I am looking forward to the year ahead and with that another inspection visit where, if we deliver our plans as described in this document, we should achieve a "good" rating from the Care Quality Commission, which will be a well-deserved reflection on the improvements our committed staff are making in safety and quality.

The data within this report is drawn from our performance dashboard that is reported to our Trust Board monthly, in public. To the best of my knowledge the information within this report is accurate.



Toby Lewis, Chief Executive

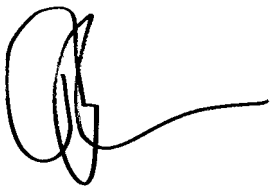
Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2012 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011). In preparing the Quality Account, directors are required to take steps to satisfy themselves that:
The Quality Account presents a balanced picture of the Trust's performance over the period covered;

- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable and conforms to specified data quality standards and prescribed definitions, and is subject to scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

Richard Samuda, Chairman



Toby Lewis, Chief Executive

Priorities for Improvement in 2018/19

We have made great strides in ensuring our Safety Plan is embedded across our Trust. During the year we will continue to progress our Consistency of Care programme and we will make progress on objectives within our quality plan. Listening and learning from the experience of patients in our care and their relatives and carers is a priority for the year.

Priority 1

Improved outcomes from patients presenting with signs and symptoms of Sepsis as a first step in delivering our Quality Plan

Rationale and measurement

Patients presenting with or developing infection while in hospital have an increased risk of prolonged hospital stay, poor health outcomes and a higher mortality. Early identification of sepsis with appropriate assessment of those at risk and prompt commencement of antibiotics is key to successful management. Our Safety Plan has contributed to improvements in the care of sepsis but there is room for improvement, particularly in the management of those receiving cancer or immunosuppressive treatment who, as a consequence, are at risk of neutropenic sepsis.

Patients with suspected neutropenic sepsis should receive antibiotics within an hour of arrival in AandE and achievement of this target will be monitored.

In addition we will monitor the percentage of patients who are assessed for sepsis who have triggered on the wards for an assessment to occur (early warning NEWS score of >5) using the Sepsis Action Tool.

Reporting

The outcomes of sepsis management will be reported and monitored by clinical leaders at the Executive Quality Committee and for the Board by our monthly Quality and Safety Committee.

Priority 2

Achieving a good rating under the framework of the CQC assessment

Rationale and measurement

The Trust was inspected in 2014 and 2017, and the latest report demonstrates material progress in very many services. More than 70% of our services are now rated as good or outstanding.

We have a well-developed and detailed plan for improvement which is closely monitored. We aim to deliver that plan during Q1 of 2018/19 and spend the balance of the year testing and retesting our compliance. In particular we need to see significant changes in:

- our A&E departments
- urgent and emergency admitted care wards
- Birmingham and Midland Eye Centre (BMEC)

Reporting

Progress against our improvement plan is reported and monitored by clinical leaders at the Executive Quality Committee and for the Board by our monthly Quality and Safety Committee.

Priority 3

We will improve the Consistency of Care provided to patients while on our wards and sustain our Safety Plan delivery

Rationale and measurement

Having Consistency of Care provided is very important both with respect to having the right documentation completed at the right time, but also when considering consistency of staff involved in making those care decisions. Making sure that the correct documentation and risk assessments are completed on all patients at the time they are admitted to our wards is part of providing Consistency of Care.

Actions based on these assessments, particularly around patient safety, are important to maintaining high quality care. A regular ward based team, particularly around senior decision makers supports the consistency model. Changes in junior staff rostering to improve care in our assessment unit also provides more consistency on the ward.

The new initiative of consultant of the week, along with the changes in junior staff working allow closer cooperation with nursing and therapy teams to plan care more effectively, improving communication to patients and relatives and planning for timely discharge. Links with community teams to make sure that clear handover for ongoing care are a crucial part of this aim.

We will regularly review completion of documentation so that Consistency of Care can be achieved and monitored. This will allow us to make sure that every time we are getting the basics right. Having an expected date of discharge is an important part of planning care so that families and staff can work towards a safe and supported discharge. Improvements in achieving this target date will be monitored.

For those patients recognised to be in the last months, weeks or days of their life, application of the supportive care pathway will be monitored.

Reporting

These initiatives will be reported and monitored by clinical leaders at the Executive Quality Committee and for the Board by our monthly Quality and Safety Committee.

D11 and D26 at a Listenning into Action event to promote their best practices in implementing safety plan.

Quality Plan 2017 – 20	
1	We will reduce deaths in hospital that could be avoided so that we are among the top 20 per cent 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 will have early access to diagnostic services to support their management pathway as the new models of cancer service provision at SWBH develop.
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 eyesight, with results among the top 20 per cent 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 per cent 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.

Care Quality Commission Inspection

Over 50 inspectors from the Care Quality Commission (CQC) visited parts of the Trust in March 2017 over three days, followed by unannounced visits. They met, observed and talked to colleagues, patients and family members. The inspection reports were published in October 2017.

Although the overall Trust rating, 'requires improvement' has not changed, there are significant improvements in our service and domain ratings, in fact 70 per cent of our services are now rated as 'good' or 'outstanding'. The CQC rated our End of Life Care as 'outstanding' which is a distinctive achievement; very few such services UK-wide have that accolade. Our Surgery and Imaging services moved into a 'good' rating. Recognising the compassion of our workforce, the CQC rated us as 'outstanding' in the caring domain. The safety domain is now rated as 'requires improvement', better than the previous 'inadequate' rating. Disappointingly, the CQC rated our community inpatient wards as 'inadequate' following their visits to Rowley Regis Hospital. The teams have taken the criticism, as well as the positive comments, on board and already addressed most of the areas called out for attention.

The Board is pleased with the success recognised by the CQC and real improvements made since the previous inspection in 2014, but acknowledges there is work to do. The Trust's successes in embedding the Safety Plan and putting in place the Consistency of Care programme on our medical and community wards provides the key strands in the Trust's plans to achieve an overall 'good' rating in the next CQC inspection.

How we performed against external measures

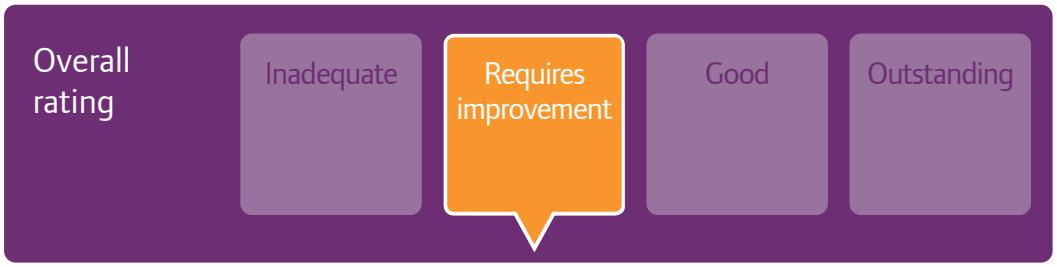
131 actions were detailed in the CQC report from our March 2017 inspection, which was published in October 2017. The aim was to deliver the planned actions by March 2018. A formal 'closeout' report will be presented to the May 2018 Trust Board confirming the position, but the indications are that the majority of concerns raised by the CQC have been addressed. The two actions which are proving challenging to complete within the set times are:

1. Addressing the requirement for substantive middle grade staff overnight in the Emergency Departments.
2. Working with other Trusts to implement a SLA to provide Paediatric Ophthalmology cover out-of-hours and substantive posts in hours

In respect of middle grades in ED, these are being advertised externally although it is recognised that there is a national shortage. A plan is in place being overseen by the Chief Operating Officer. The Medical Director is pursuing the plan with respect to ensuring adequate Paediatric Ophthalmology out-of-hours cover is in place. Both of these issues are being actively managed and progress will continue to be monitored by the Clinical Leadership Executive until resolved.

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 and West Birmingham Hospitals NHS Trust during 2017/18 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

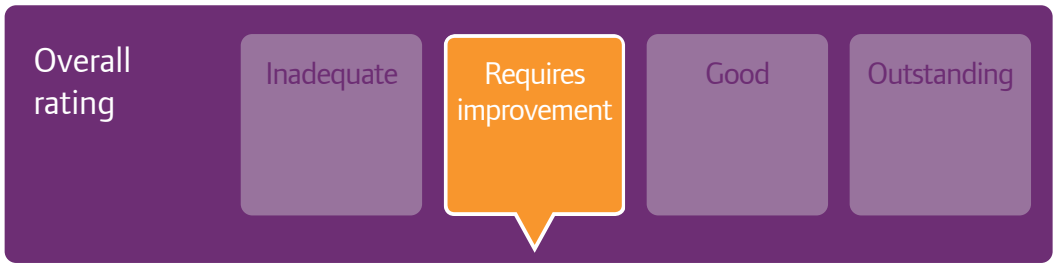
Sandwell and West Birmingham Hospitals NHS Trust



Are services

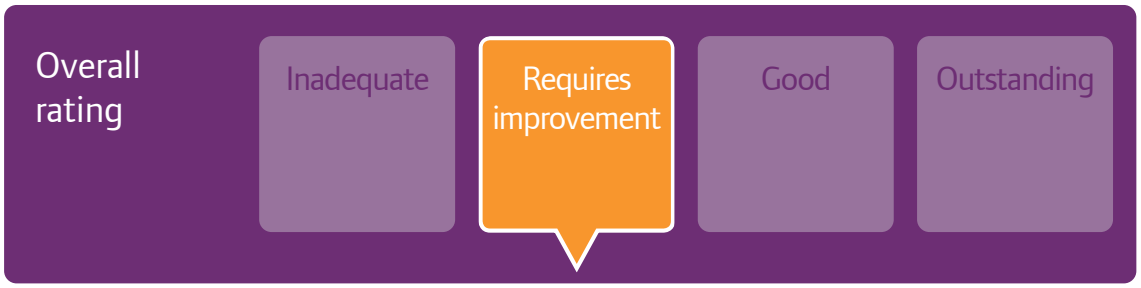
Safe?	Requires improvement
Effective?	Requires improvement
Caring?	Outstanding ☆
Responsive?	Requires improvement
Well led?	Good

City Hospital



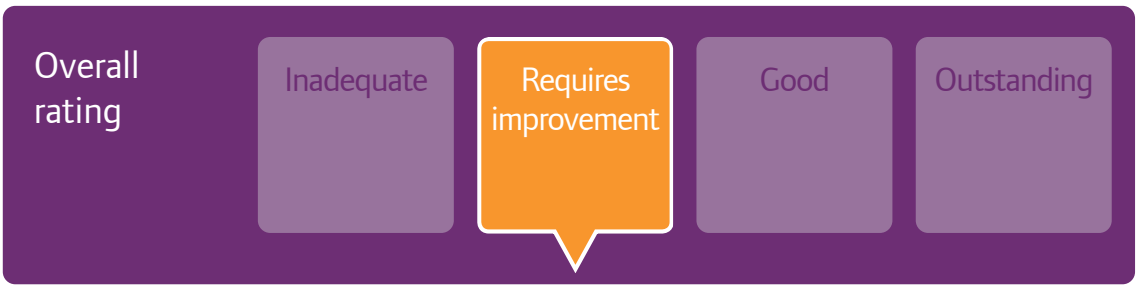
	Safe	Effective	Caring	Responsive	Well led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Medical care (including older people's care)	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Urgent and emergency services (A&E)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Requires improvement	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
Services for children & young people	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
End of life care	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆
Outpatients	Good	Not rated	Good	Good	Good	Good

Sandwell General Hospital



	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Urgent and emergency services (A&E)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
Services for children & young people	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Outpatients	Good	Not rated	Good	Good	Good	Good

Sandwell and West Birmingham Hospitals NHS Trust (Community)



	Safe	Effective	Caring	Responsive	Well led	Overall
Community health inpatient services	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
End of life care	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆

How we measure quality

We review our performance against external frameworks, primarily the NHSi Single Oversight Framework effective from September 2016, which sets out how trusts are overseen using one consistent approach, and CQC Framework. We also set internal performance targets on a broad range of indicators published in our Integrated Quality and Performance Report (IQPR). The IQPR 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 Group Management meetings, overseen by dedicated Group Performance Review meetings.

We also audit the quality of clinical care we provide against a number of national standards that are published by external organisations for example National Institute for Clinical Excellence (NICE), National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) and specialty specific bodies for example; National Bowel Cancer Audit Programme (NBOCAP), National Hip Fracture Database (NHFD) and Sentinel Stroke National Audit Programme (SSNAP).

Data quality improvement aproach

The Trust has taken the following actions to improve data quality. We have implemented a performance indicator assessment process, the data quality kitemark, which provides assurance on underlying data quality published in the IQPR. Each indicator is assessed against seven data quality domains to provide an overall data quality assurance

rating, which is included in the IQPR. We have an annual audit 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 IQPR. Our audit plan is a rolling programme covering all performance and quality indicators. We have established a Data Quality Committee whose scope is to identify and implement data quality improvements and address data quality issues as they are found and monitor their improvement to a compliance standard. Each Group is represented by a data quality lead.

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

Hospital Episode Statistics

The Trust submitted records during April 2017 – January 2018 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data;

- which included the patient's valid NHS number was 98.1% for admitted patient care; 99.6% for out-patient care; and 97.7% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was 98.89% for admitted patient care; 99.28% for out-patient care; and 97.13% for accident and emergency care.

Services provided and / or subcontracted

During 2017/18 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 2017/18 represents 100 per cent of the total income generated from the provision of NHS services by Trust.

How we performed in 2017/18

In 2016/2017 we launched important development plans to improve safety and quality. The Safety Plan was introduced in 2017 and takes a multi-disciplinary approach to ten evidence based clinical standards that have now become a standard part of care in the Trust. By improving the safety culture, the care provided to patients is improved and the risk of harm reduced. The Quality Plan, which aims to build on this Safety Plan, has elements that are specialty specific and those that cut across all disciplines in the Trust. It aims to improve evidence based care across the organisation by producing measurable and meaningful outcomes for patients. Full implementation of the ten objectives of the Quality Plan will be relaunched in 2018/19 on the foundation of the Safety Plan and in parallel with the introduction of our new electronic patient record and service plans for a new single site hospital.

Safety Plan - 99.6% of all safety checks completed

During the year our Safety Plan has been deployed within all assessment and ward based areas (43 areas in total). Input of data has become part of the ward's daily core business – evident by daily reports showing significantly improved input compliance. Our wards have exhibited sustained compliance by completing more than 98 per cent of all checks within the first 24 hours of admission. On average, 1.5 checks per day are missed out of an average of 2,500 total checks. Daily reporting continues and includes information on missed checks, allowing senior staff and ward managers to check, challenge, address and complete any missed checks within the next 24 hours on a shift by shift basis.

Our Safety Plan Standards

	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 ten 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 acquiring a hospital aquired 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 . Early warning scores are recorded (vital Pac or paper)– EWS were acted upon and this is evidenced in the patient's health care records.
5.	Care Plans signed by patients and carers/family	Nursing care plans are in place and individualised; reflecting risks identified (physical, social and psychological) through discussion with the patient /carer.
6.	Focused care /John's 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 HCP 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.	Expected date of discharge (EDD) and home care package	Accurate EDD and 48 hour follow up.

We are beginning to see improved outcomes which, whilst limited, show statistically significant improvements in key areas of patient safety such as falls, with a moderate to strong correlation with completing the safety checks and reduced falls with injury. Since 5th June 2017, compliance with the Safety Plan has increased from 96.8 per cent to 99.6 per cent on average. During the same period, falls with injury have decreased on average from 7.2 (per week) to five per week.

Commissioning for Quality and Innovation (CQUINs) 2018/19

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 and Performance Report, which is discussed in our public board meetings. The NHS Commissioners are informed of progress on a quarterly basis.

Some CQUINs are part of a two year agreed target for 2017/19. The target period has been indicated against each initiative in the table below.

CQUINs for 2018/19		Target Periods
National	Staff Health and Wellbeing - annual staff survey results to improve by five per cent in two of the three NHS annual staff surveys: on health and well-being, MSK and stress.	2017/19
	Staff Health and Wellbeing - Maintain the four outcomes that were implemented in 2016/17. Introduce three new changes to food and drink provision in year one, 17/18 : 70 per cent of drinks stocked must be sugar free, b) 50 per cent of confectionary and sweets do not exceed 250 kcal c) 60 per cent or pre-packed sandwiches and other savoury pre-packed meals available contain 400kcals or less and do not exceed 5.0g saturated fat.	2017/19
	Staff Health and Wellbeing - year one - achieving update of flu vaccination for frontline clinical staff of 75 per cent.	2017/19

	CQUINs for 2018/19	Target Periods
National	Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Timely identification of sepsis in emergency departments and acute inpatient settings - the percentage of patients who met the criteria for sepsis screening (needed it) and were screened for sepsis (applies to all adult and child patients arriving in ED and IP wards).	2017/19
	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely treatment for sepsis in emergency departments and acute inpatient settings - the percentage of patients who were found to have sepsis and received IV antibiotics within one hour (applies to all adult and child patients arriving in ED and IP wards).	2017/19
	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic review - assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	2017/19
	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Reduction in antibiotic consumption per 1,000 admissions - there are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions.	2017/19
National	Improving services for people with mental health needs - Improving services for people with Mental Health needs who present to AandE.	2017/19
National	A&G support should be provided either through the NHS e-Referral Service (e-RS) or local solutions where systems agree this offers a better alternative.	2017/19
National	Supporting proactive and safe discharge - increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within seven days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).	2017/19
Local	Improving the assessment of wounds - the indicator aims to increase the number of wounds which have failed to heal after four weeks that receive a full wound assessment.	2017/19
National	Personalised Care / support planning - this CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.	2017/19
National	Preventing ill health by risky behaviours - tobacco screening.	2018/19
	Preventing ill health by risky behaviours - tobacco brief advice .	2018/19
	Preventing ill health by risky behaviours - tobacco referral and medication offer.	2018/19
	Preventing ill health by risky behaviours - alcohol screening.	2018/19
Specialised Services	Improving haemoglobinopathy pathways through Operational Delivery Networks (ODN).	2017/19
Specialised Services	Paediatric networked care to reduce recourse to critical care distant from home.	2017/19
Public Health	Bowel Screening - improving access and uptake through patient and public engagement.	2017/19
Public Health	Bowel Scoping.	2017/19
Public Health	Breast Cancer Screening - Improving access and uptake through patient and public engagement.	2017/19

CQUINs (Commissioning for Quality and Innovation)

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. We were contracted to deliver the CQUIN schemes in the table below during 2017/18 which had a value of £8.8m on delivery. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at https://www.swbh.nhs.uk/about-us/trust-board/public-trust-board-papers/2017-2/

CQUINs for 2017/18			
National	1a	Staff Health and Wellbeing - annual staff survey results to improve by five per cent in two of the three NHS annual staff surveys: on health and well-being, MSK and stress	**No**
National	1b	Staff Health and Wellbeing - Maintain the four outcomes that were implemented in 2016/17. Introduce three new changes to food and drink provision in year 1, 17/18 : 70 per cent of drinks stocked must be sugar free, b) 50 per cent of confectionary and sweets do not exceed 250 kcal c) 60 per cent or pre-packed sandwiches and other savoury pre-packed meals available contain 400kcals or less and do not exceed 5.0g saturated fat	✓
National	1c	Staff Health and Wellbeing - Year one - achieving update of flu vaccination for frontline clinical staff of 75 per cent	✓
National	2a	Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis): Timely identification of sepsis in emergency departments and acute inpatient settings - The percentage of patients who met the criteria for sepsis screening (needed it) and were screened for sepsis (applies to all adult and child patients arriving in ED and IP wards)	**Partial**
National	2b	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely treatment for sepsis in emergency departments and acute inpatient settings - The percentage of patients who were found to have sepsis in 2a and received IV antibiotics within one hour (applies to all adult and child patients arriving in ED and IP wards).	**Partial**
National	2c	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic review - Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.	✓
National	2d	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Reduction in antibiotic consumption per 1,000 admissions - There are three parts to this indicator. 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions	**No**
National	4	Improving services for people with Mental Health needs - Improving services for people with Mental Health needs who present to AandE	✓
National	6	Offering advice and Guidance (AandG) - Providers to set up and operate AandG services for non-urgent GP referrals; AandG support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	✓
National	7	NHS e-Referrals CQUIN – GP referrals to consultant-led first outpatient services only and the availability of services and appointments on the NHS e-Referral Service.	✓
National	8	Supporting Proactive and Safe Discharge - Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within seven days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).	✓

CQUINs for 2017/18			
National	10	Improving the assessment of wounds - The indicator aims to increase the number of wounds which have failed to heal after four weeks that receive a full wound assessment.	✓
National	11	Personalised Care / support planning - This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers.	✓
Specialised Services		Improving Haemoglobinopathy Pathways through ODN Networks	✓
Specialised Services		Paediatric networked care to reduce recourse to critical care distant from home	✓
Specialised Services		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.	**Partial**
Public Health		Secondary care dental - sugar free medicines audit - A prospective audit and re-audit of day-case activity carried out in the department in accordance with the terms of reference issued by the service commissioner.	**No**
Public Health		Bowel screening - Improving access and uptake through patient and public engagement.	✓
Public Health		Bowel scoping	✓
Public Health		Breast cancer screening - Improving access and uptake through patient and public engagement.	✓

The bowel cancer screening team. (left to right: Clair Millard, Ange Johnson, both Specialist Screening nurses, Maggie Preston, Programme Manager and John Rudge, Administrator.

Performance against our priorities for 2017/18

Strategic Plan	Priorities	Delivered?
Quality	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. Implement the improvement plans to reduce avoidable mortality in surgery, cardiology, deaths due to sepsis and perinatal mortality.	✔ Partially
Safety	Improve care in medicine by comprehensive implementation of Consistency of Care in all of our inpatient wards. Implement the Safety Plan in all inpatient areas (including community wards) so that patients have all safety checks as standard. Complete targeted recruitment for our hard to fill nurse roles that will create fully staffed teams reducing reliance on temporary workers.	✔ ✔ ✔
Service performance	Meet our four hour AandE waiting time commitment to patients sustainably in Q4. Reduce length of stay by increasing the number of morning discharges and cutting delayed transfers of care Deliver reductions in wait time and improved productivity through successful execution of our annual production plan for elective care.	X X ✔
Our people	Cut sickness absence to below 3 per cent. Create a more engaged workforce through promoting opportunities to speak up, make suggestions and listen to colleagues. Implement the changes needed to meet our workforce plans for 2018 – 2020. Deliver our Aspiring for Excellence: New PDR process.	X Partially X ✔
Digital workstream	Successfully implement our new electronic patient record during the Autumn supporting our journey towards a paper-free environment. Fully embed digital dictation and speech recognition, reducing time taken for patients and healthcare professionals to receive Trust correspondence. Ensure robust, improved infrastructure for our technology.	X Partially Partially
Our places	Finalise and publish our final location plans for services in the Sandwell Treatment Centre. Exit 2017/18 with delivery plan for Midland Met on track and seven day service model developed, costed and agreed.	X X
Long-term financial plan	Reduce agency spend by £10m during the year. Meet financial commitments to generate a surplus by year end with all groups meeting their income and expenditure budgets. 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.	✔ Partially X

Priorities we did not fully deliver

We chose to focus on embedding the Safety Plan this year and the programme around delivering our quality plan will be refreshed in 2018/19 which will mean that we will see improvements in avoidable mortality in cardiology, stroke, surgery and deaths from sepsis. We are working with others across the Black Country on doing more to reduce perinatal mortality. Along with other trusts in the NHS, our performance on four hour waits for treatment in our emergency departments have not reached the standard we planned for by year end. Throughout the year we put plans in place to improve the patient journey through from emergency admission to discharge so that we could minimise delays for patients. The benefits of those plans are yet to be fully realised. Our length of stay has also not improved at the rate needed and we have had to staff additional beds to care for patients. We plan to return to our sustainable bed base by Q1 of 2018/19 and continue to progress improvements in patient flow that will have an impact on our time to see and treat patients at the front door.

We have held a number of engagement activities with our colleagues including Listening into Action events and our

Speak Up Day to ensure that colleagues feel heard and valued within the organisation. Our health and wellbeing offer is extensive and the services are well-used. In 2018/19 we will create even more opportunities for colleagues to feel engaged and empowered.

Our long term workforce plans for 2018-2020 are currently being finalised to ensure that they meet our long term financial plan and enable us to have the right skilled staff in the right places in preparation for our move to a new hospital and single site working for some teams. Each group is looking at their own workforce plans so that we can build the right training support and workforce change programmes. We have more to do to further reduce absence due to sickness and will in the year ahead put in place a dedicated programme of support for colleagues experiencing mental ill-health.

We delayed the implementation of the electronic patient record to 2018 to ensure we were ready to implement well this large-scale change that touches the majority of our workforce who are involved in clinical care. Our Trust has introduced a number of improvements to our infrastructure and hardware and continues to drive forwards the digital infrastructure plan. We were not affected by the cyber-attack that impacted on many NHS organisations and we ensure the security and safety of our systems are robust.

Case note scanning went live during the year as preparation for electronic patient notes. Despite a difficult start, the system is now working reasonably well and has enabled the paper notes on site to be dramatically reduced. We continue to experience difficulties with the system for digital dictation and speech recognition and recognise that, when fully functioning, it will save considerable time for our clinicians and their support staff.

The Midland Metropolitan Hospital has experienced a pause in construction work due to the regrettable liquidation of our construction partner, Carillion. We continue to work with others to find a solution to complete this vital new hospital. This delay has impacted on our ability to finalise the Sandwell Treatment Centre locations as well as our seven day working model within the new hospital.

We met our financial commitments during the year, with a small surplus at year end. Not all groups met their group income and expenditure budgets. Our work with Black Country partners has continued as part of the Sustainability and Transformation Partnership. Acute providers have worked together on shared pathology services to form a hub and spoke model with the hub provided at New Cross Hospital, Wolverhampton. The business case has been reviewed by all four trusts in the Black Country who have committed to moving forwards on this exciting new venture.

District nurse Rebecca Vivian looked after patient Hanif Harvey at his home.

Seven day hospital services

Working towards the same standards of care for patients over seven days is vital in ensuring that our patients receive consistent care no matter what day of the week they are admitted and whether they are staying in hospital or discharged.

Ten clinical standards have been identified that define what a seven day service should achieve. Of those ten standards, four have been identified as priority standards to be achieved by 2020.

- **Standard 2**: Time to first consultant review. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
- **Standard 5**: Access to diagnostic tests. Consultant-directed diagnostic tests and completed reporting will be available seven days a week with a 24-hour turnaround time. For urgent requests this reduces to within one hour for critical patients and within 12 hours for urgent patients.
- **Standard 6**: Access to consultant-directed interventions. Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.
- **Standard 8**: Ongoing review by a consultant twice daily for high dependant patient's, daily for others. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

In March 2017 we completed a self-assessment survey which covered the management of patients admitted as an emergency, measured against the four priority standards. Our results from this survey are shown in the table below.

Trust Achievement of Priority Seven Day Service Standards (March 2017)				
	Standard 2	**Standard 5**	**Standard 6**	**Standard 8**
Weekday Results	73%	100%	100%	94%
Weekend Results	85%	95%	100%	83%
Seven Day results	77%	97%	100%	92%

This baseline information has informed our improvement focus and service development. This year we have established a Non Invasive Ventilation Unit and level one - two high dependency for surgery. Once we have implemented our new electronic patient record system, Unity, during 2018 we will be able to have a live data set on standards two and eight.

We planned to achieve standards two, five and six by March 2018. The delay to the new hospital, the Midland Metropolitan, will impact on our ability to achieve standard eight as we expect to be only able to fully meet this when we move to a single acute site. We have two service development and improvement plans agreed with the Sandwell and West Birmingham Clinical Commissioning Group for seven day urgent care and respiratory services.

NHS Staff Surveys

The NHS Staff Survey provides an opportunity for organisations to survey their staff in a consistent and systematic way. This makes it possible to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups. Obtaining feedback from staff, and taking account of their views and priorities, is vital for driving real service improvements in the NHS.

The results are primarily intended for use by organisations to help them review and improve their staff experience so that their staff can provide better patient care. The Care Quality Commission use the results from the survey to monitor ongoing compliance with essential standards of quality and safety. The survey will also support accountability of the Secretary of State for Health to Parliament for delivery of the NHS Constitution.

The key finding below show a selection of results for our Trust (SWBH) compared with other combined acute and community trusts. We have included three core indicators required for the Quality Account and our highest three and lowest three results.

NHS Staff Surveys	2016 Survey	2017 Survey Results					
	SWBH 2016	SWBH 2017	National Average (Median score)	Threshold for below average	Threshold for above average	Lowest Trust	Highest Trust
Core Indicators							
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	86	80	85	82	88	71	93
Percentage experiencing harassment, bullying or abuse from staff in last 12 months (lower is better)	20	21	24	23	25	20	32
Staff who would recommend the Trust as a provider of care to their family and friends - performance is based on staff who agreed or strongly agreed as part of the NHS Staff Survey	59	58	69	N/A	N/A	N/A	N/A
SWBH Highest 3 Indicators							
Percentage reporting most recent experience of violence	82	82	67	65	70	59	82
Percentage agreeing that their role makes a difference to patients/service users	89	93	90	89	91	86	93
Percentage able to contribute towards improvements at work	66	74	70	68	71	60	77
SWBH Lowest 3 Indicators							
Percentage attending work in last three months despite feeling unwell because they felt pressure (lower is better)	56	60	53	52	54	47	60
Percentage feeling unwell due to work related stress in last 12 months (lower is better)	33	44	38	36	40	30	45
Quality of appraisals	2.95	2.97	3.11	3.05	3.14	2.87	3.46

Data Source: National NHS Staff Survey Co-ordination Centre
The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by implementing our nursing escalator programme, a dedicated development scheme to support health care assistant and nursing careers for bands 2-6. The programme offers bespoke training and support to enable colleagues to progress through the bands. Band 5 nurses who take part in the programme will also benefit from a bonus paid at the start and on successful completion of the scheme.

We are committed to a focused programme of engagement during the year so that colleagues are empowered to act to make improvements in their area of work. We expect to improve our staff engagement score to that of the national average by the end of the year.

During the year we held a Speak Up Day to raise awareness of the various ways for colleagues to speak up if they have a concern at work. Although predominantly about safety concerns we recognise that through continued promotion of the different routes to raise concern we can hope to address bullying and harassment behaviour. Our trade union colleagues are valuable sources of support and challenge to the Trust.

Responsiveness to personal needs of patients

This indicator measures hospitals' responsiveness to inpatients' personal needs based on a selection of five questions from the National Inpatient Survey. Each question describes a different element of the overarching theme, "responsiveness to patients' personal need". The survey is completed by a sample of patients aged 16 years and over who have been discharged from an acute or specialist trust, with at least one overnight stay.

An average weighted score (by age and sex) is calculated for each of the questions and Trust scores are calculated from a simple average of the question scores.

Responsiveness to inpatients personal needs	SWBH 15/16	2016-2017			
	SWBH 15/16	SWBH 16/17	National Average	Highest Trust	Lowest Trust
The Trust's responsiveness to the personal needs of its patients during the reporting period.	69	64.9	68.1	85.2	60.0

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to collect patient experience information first hand to help improve patient care. This is one of our quality improvement priorities for 2018/19.

Patient Stories

During 2017/18 we have continued to include patient stories as part of our Trust board meetings. There has been considerable changes and actions taken during the last year in response to a series of very impactful patient stories. We are currently considering how we might better disseminate the valuable learning and insight, as well as the resulting actions, amongst our employees. The table below shows the actions that have been undertaken from patient stories this year.

Patient Stories 2017/18

Month	Key focus	Actions taken
April 17	Presentation from LGBT network Lead	• Numerous awareness raising sessions throughout the year including LGBT history month and the participation in Birmingham's Pride event. Diversity lead appointed; Transgender policy approved. The LGBT networks have been represented at a variety of recruitment events to raise awareness of the Trust's commitment to supporting diversity. • The Trust has become a Stonewall Diversity Champion thereby improving access to key resources. • The Trust has benchmarked against the Workplace Equality Index with a view to submitting to Stonewall in 2018 with an ambition to eventually being ranked within the top 100 employers.
May 17	Transition Diabetic services – young people to adult	• Appointment of Children's and Young Peoples Champion to lead on transition arrangements within the Trust. • Transition policy approved with agreed standards for young people who are in the process of transition between children's/adult services. • Ready, Steady, Go checklist introduced Trust-wide to assess readiness of young people for transition.
Jun 17	A patient who had experienced care within our Critical Care service and had subsequently stepped down to ward based care. The patient had experienced issues when receiving care from temporary staff members	• The Trust has worked proactively to reduce reliance on temporary staff – largely driven by a very successful recruitment campaign, addressing vacancy gaps. • More recently, we have introduced a checklist to check the competence of temporary staff at the start of every shift.

Month	Key focus	Actions taken
Jul 17	Spanish patient who spoke English but lost language skills during health crisis	• A trial involving clinicians and patients wearing an ear piece which would translate speech, the use of which would be monitored especially when translating complex medical jargon. • The interpreter service has renegotiated contracts which have increased the diversity of languages available via our translators.
Aug 17	Staff member presented a story on behalf of an end of life care patient for whom service provision was complicated due to cross boundary issues	• Equipment needs raised and rectified at time of event.
Sept 17	Paediatric patient with severe allergies	• Appointment of one nurse consultant, now in post. • The Trust has agreed to support appointment of another Consultant paediatrician with interest in allergy. • The service is currently supporting the in house development and training of a Band 5 nurse who will progress to the role of a Band 7 CNS on completion of training. • All of the above roles will enhance and extend service provision to meet the growing demand for this service.
Oct 17	We heard from a hearing and visually impaired patient who had experienced difficulties when arranging and accessing outpatient appointments	• Patient letter templates have been changed to ensure that the number for the contact centre is more clearly visible. • All template letters further adjusted to include the following wording: Please let us know if you require any support or have any disabilities that you would like to make us aware of. If you would like to discuss this please contact us on… • The Equality and Diversity (EandD) lead has met with all members of the contact centre team to raise awareness around requests for reasonable adjustments. Arrangements are in place to signpost those patients with specific individual requirements to the EandD team who will support the planning and facilitation of reasonable adjustments for these patients where necessary. • The Primary Care Liaison Manager is working with GPs to raise awareness about signposting patients with disabilities on referral letters. • All eye appointments printed on yellow paper. The Trust is exploring the potential for all outpatient appointments to be sent on yellow paper. • 140 staff have received deaf awareness and/or Basic Sign Language (BSL) training during last 12 months. Funding secured to continue BSL training in 2018/19 • Assistance dogs: Policy revised and agreed.
Dec 17	A Video was presented highlighting how patients learn techniques to deal with panic attacks, anxiety, and anger within the Fatigue, Anxiety and Breathlesness clinic.	No actions identified.

Month	Key focus	Actions taken
Jan 18	Maternity/Cardiology. A patient described her experience as a recent new and breastfeeding mother admitted to an area outside of Maternity showing the determined efforts made to ensure that mother and baby were not separated.	• New infant feeding policy about to be put on the intranet promotes zero separation when a mother is admitted to any area of the Trust. This will be promoted in all areas when it is on the intranet. • The Infant Feeding Team are producing posters (currently with medical illustration) to be put up in all areas of the trust where a mother may be cared for - signposting to local resources and support on all aspects of infant feeding. The emphasis of the poster, being that Health Care Practitioner's should not be the reason a woman stops breastfeeding. • Active social media campaign established to raise awareness of the Trust's commitment to supporting breastfeeding.
Feb 18	An elderly gentleman described his experience when transferred between our hospital sites out of hours	• Work to reduce the non-clinical patient bed moves out-of-hours will be focused in orthopaedics as this is a focal point in the data set and in medicine to increase morning discharge rates to 35 per cent - this will improve daytime bed moves from the assessment unit to the wards and address the avoidable non-clinical out-of-hours patient moves. • A review of our transport services in Q1 may also give opportunity for improvement.
March 18	Story from a patient who had used our recently established Level one care service	• The Group are monitoring the impact of this service on the release of ITU capacity.

Complaints

Our 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.

Patient complaints

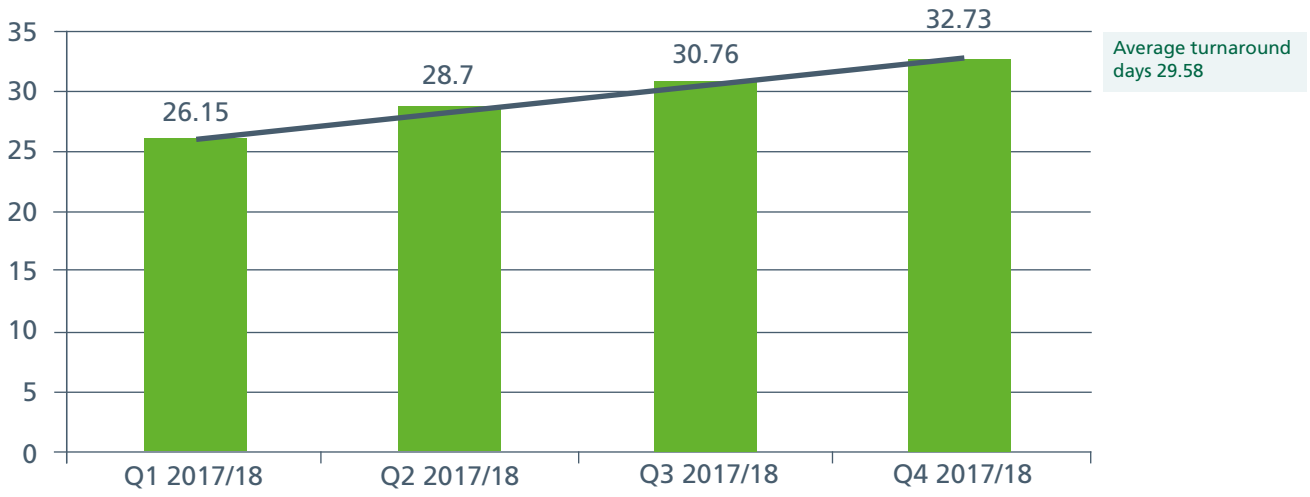
Patient experience	2016/2017	2017/2018
Complaints received- Formal	1176	1037

Of note, this total figure is made up of 990 new complaints made to the Trust (67 of which have since been withdrawn) and 127 were reopened complaints. This resulted in 876 new complaints being actively managed by the Trust, which is a decrease of formal complaint numbers managed. Whilst most of the Clinical Groups and Corporate Directorates have seen decreased numbers the most significant decrease is in Surgery. The KPI result for complaint resolution returned to a stronger result of 92% of formal complaints being responded to in time, with the average turnaround time for all cases presented to the Trust in 2017/18 being 29.58 days.

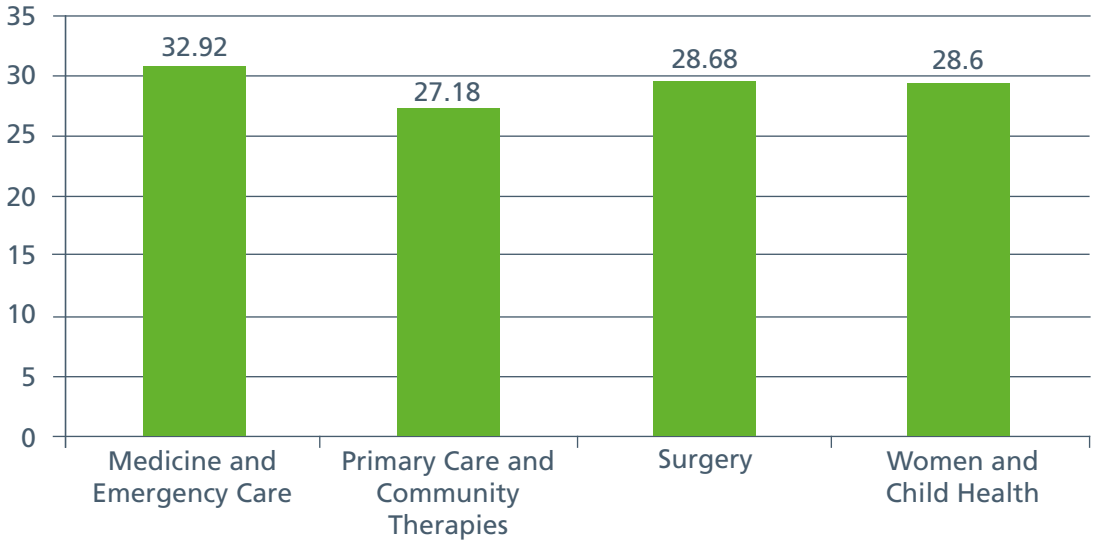
Our Trust recently launched the a new initiative, Purple Points, that allow patients and relatives to contact us more quickly if they have a complaint or want to compliment staff.

Ian McGarry from Sandwell Heathwatch.

Average number of days to respond to complaints by quarter



Average response time by Groups



Purple points

Our Purple Points initiative has been launched across our sites. Working with Healthwatch Sandwell, the Purple Points are a new way that inpatients and their relatives can address concerns they have, whilst they are still being treated in hospital. Patients and their loved ones can use the phone to call our Purple Point team and talk about any issues they may have, or they can compliment excellent care they have experienced.

The phones are located at 'Purple Points' which are near inpatient ward areas across our hospitals, so that concerns can be dealt with as quickly as possible. The Purple Point team will be answering these calls and facilitate a safe and quick resolution. In getting this right, we will be responding to issues as they arise and resolving problems before they escalate. This means we can make a difference at the time, rather than when our patients have gone home.

Lessons learned from complaints are still actively reported and when learning opportunities are identified they are recorded in order that they can be monitored for implementation. Learning from informal complaints and from Purple Point enquiries will also be added to this report in 2018/19.

Most common themes of complaints comparing 2016/17 – 2017/18

The most common themes	2016/2017 %	2017/2018 %
All Aspects of Clinical Treatment	48	57
Appointment Delay/cancel (outpatient)	16	11
Attitude of Staff	14	12
Communication/Info to Patient	7	6
Admissions/ discharges, Transfers	4	3
Privacy And Dignity	1	2
Personal Records	2	2
Patients Property And Expenses	1	2

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

As a result of a misunderstanding as to how fetal tissue is investigated following early pregnancy loss, a new patient leaflet is being developed explaining this in informative and sensitive terms. The leaflet is aimed at providing information about the purpose of investigating the fetal tissue so as to support women at this difficult time, but be clear that this is not to establish why the early pregnancy loss occurred but to ensure that the miscarriage is complete.

- A patient suffered a fall down the escalators in the Birmingham Treatment Centre and it was also reported that the signage to the lifts (their preferred mode of transporting from floor to floor) was not clear enough, resulting in them not knowing where the lifts were. They thought they had no alternative but to use escalators even though they knew that might mean risking a fall. There is now improved signage around the lift areas, and signage highlighting where the lifts are.
- A complaint was received about the fact that one of the Trust Patient Transport drivers did not actively support a patient who became very unwell in the Trust car park. The driver had the word Ambulance written on the back of their High Visibility jacket. It has since been recognised that this was a misleading indicator that the driver may have been able to offer clinical support, like that of a paramedic. The jackets with Ambulance written on them are no longer in use to avoid, this confusion in the future, and the resultant distress this caused both the patient's family, and the driver themselves.

PALS (informal complaints)

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 and is indeed emphasised even more now through the Purple Points. Where local resolution cannot be achieved, and where a formal complaint is not necessary, an informal complaint can be logged so that the complainant can get support from the PALS/complaints team to provide an essential liaison service between patient and the Trust. 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.

Total number of enquiries made to PALS 2016/17- 2017/18

The most common themes	2016/2017 %	2017/2018 %
Appointment issues	28	28
Clinical Issues	27	15
Communication	13	18
Attitude of staff	6	5

Engaging with patients and the public

During the year we have introduced increasingly innovative ways to engage with our communities. A series of Facebook Live events have engaged patients and the public with some of our leading clinicians on subjects such as the importance of bowel screening, paediatric medicine and heart health care.

Our carers group was established during the year and has helped to inform our carers' strategy which aims to better support relatives or carers whilst their loved one is receiving care within our Trust. Areas of improvement have included our support for John's Campaign, allowing people to stay in a bed alongside their relative and open visiting hours on all our wards.

Members' Leadership Group

We are privileged to have the support of many committed individuals who are part of our Members' Leadership Group. During the year, this group has supported many of our key initiatives and plans such as transport for the new Midland Metropolitan Hospital, our CQC inspections and improvement plans, our volunteer service and our safety plan. During 2018/19 we intend to work closely with other partners to better join up our formal patient engagement activities.

Local Interest Group

Our Local Interest Group (LIG) monitors and influences inclusion within our workplace for all protected characteristic groups including age, sex, race, religion, disability, sexual orientation, gender reassignment, marriage, civil partnership, pregnancy and maternity.

The LIG is made up of senior colleagues from our organisation including the leads from each of our staff networks and chaplaincy service and members of the public who have a desire to improve the diversity and inclusion within our organisation. The group works with the Trust to ensure a co-ordinated approach to service improvement to meet the needs of the protected characteristics and disadvantaged groups.

The public members of the LIG provide a critical role to the organisation, making sure we're being inclusive of all and promoting the ethos of diversity of thought. They do an amazing job that is purely voluntary and they are a fantastic sounding board for the Trust.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs)				
	Health Status Questionnaire Percentage improving			
	Finalised data for April 15– March 16 (Published November 2017)		Provisional data for April 16– March 17 (Published February 18)	
	National	SWBH	National	SWBH
Hip replacement	89.6%	90.6%	88.8%	89.7%
Knee replacement	81.6%	77.5%	80.9%	82.1%

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

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

	Health Status Questionnaire Average adjusted health gain							
	Finalised data for April 15– March 16 (Published November 2017)				Provisional data for April 16– March 17 (Published February 18)			
	National	SWBH	Highest National	Lowest National	National	SWBH	Highest National	Lowest National
Hip replacement	0.438	0.435	0.495	0.348	0.437	0.467	0.508	0.366
Knee replacement	0.320	0.253	0.373	0.229	0.323	0.311	0.384	0.264

SWBH below England average

SWBH above England average

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and SWBH data is consistent with trust reported data.

The finalised data for 2015/16 and the provisional data for 2016/17 shows that there are areas where the reported outcome is above the average for England, however there are some areas for improvement. The Trust is not an outlier against national data in any of the measures.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by: Hip and knee replacement; Pre-operative questionnaires and an information leaflet explaining the importance of completing the pre-operative PROMs booklets are posted to patients at home with their admission letter for completion and return on the day of surgery. Information on the expected outcomes from surgery are communicated in a variety of formats. Patients attend a 'joint club' where advice and information is imparted. This includes discussion with patients so they are fully aware of the risks and benefits, as well as expected outcome. A contact point after discharge is provided if there are any problems and there is direct access to clinic if needed. Patient information regarding the importance of completing PROMs is displayed on waiting room TV screens in both fracture clinics cross site. Focused data gathering has also improved the return of completed questionnaires from patients.

How we performed in 17/18 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2016/17 positon	2017/18 positon	Comments
Cancer – 2 week GP referral to first out patient	%	=>93.0	94.6	95.3	Full year
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	=>93.0	95.7	96.5	Full year
Cancer – 31 day diagnosis to treatment all cancers	%	=>96.0	98.0	97.8	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (excluding rare cancer)	%	=>85.0	86.2	86.2	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (including rare cancer)	%	=>85.0	86.7	81.4	Full year
Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral	%	=>90.0	95.5	97.1	Full year
Emergency Care – 4 hour waits	%	=>95.0	87.2	83.4	Full year
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92.0	93.1	92.0	Full year
Acute Diagnostic waits < 6 weeks	%	<1.0	1.32	1.16	Full year
Cancelled operations	%	0.8	1.1	1.2	Full year
Cancelled operations (breach of 28 day guarantee)	Number	0	10	8	Full year
Delayed transfers of care	%	=<3.5	2.1	2.3	Full Year
Outcome Metrics					
MRSA Bacteraemia	No	0	1	0	Full Year
C Diff	No	<30	21	29	Full Year
Mortality reviews	%	=<90	61	44	As at end Jan 2018
Risk adjusted mortality index (RAMI)	RAMI	<100	104	109	3 months in arrears
Summary hospital level mortality index (SHMI)	SHMI	<100	101	108	3 months in arrears
Caesarean Section rate	%	<=25.0	26.3	25.6	Full Year
Patient safety thermometer – harm free care	%	=<95	94.3	94.5	Full Year
Never Events	No	0	4	3	Full Year
VTE risk assessment (adult IP)	%	=>95.0	95.4	96.1	Full Year
WHO Safer Surgery Checklist (all 3 sections)	%	=>100	99.9	99.8	Full Year

Quality Governance Metrics					
Mixed sex accommodation breaches	No	0	51	314	Full year
Staff sickness absence (rolling 12 months)	%	=<2.5	4.67	4.50	Full Year
Staff appraisal (PDR)	%	=>95	87.9	81.9	Full Year
Medical staff appraisal and revalidation	%	=>95	84.9	81.4	Full year
Mandatory training compliance	%	=>95	87.2	91.5	Full year
Clinical Quality and Outcomes					
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	94.5	92.8	To be validated
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	78.4	75.2	To be validated
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50.0	72.0	72.2	To be validated
Stroke care – Admission to thrombolysis time (% within 60 minutes)	%	=>85	67.4	66.1	To be validated
TIA (High Risk) Treatment within 24 hours of presentation	%	=>70	98.0	94.9	Full year
TIA (Low Risk Treatment within 7 days of presentation	%	=>75	97.2	95.6	Full year
MRSA screening elective	%	=>80	91.2	89.0	Full year
MRSA screening non elective	%	=>80	93.0	91.4	Full year
Inpatient falls reduction – acute	No	<804	654	577	Full year
Inpatient falls reduction – community	No		340	366	Full year
Hip fractures – operation within 36 hours	%	=>85	74.7	69.4	Full year
Patient Experience					
Complaints received – formal and link	No	N/A	1176	1037	Full year
Patient average length of stay for all patients excluding elective day cases	Days	N/A	3.56	4.21	Full year
Coronary heart disease - primary angioplasty (<150 mins)	%	=>80	96.1	95.9	Full year
Coronary heart disease – rapid access chest pain (<2weeks)	%	=>98	99.7	100.0	Full year

Data in the table above is subject to final validation and year end results when available.

Children's Safeguarding

We continue to work closely with Sandwell and Birmingham Multi-agency Safeguarding Hubs (MASH) to raise awareness of safeguarding children among our frontline staff so that they are aware of their individual responsibilities. Our safeguarding team provide a programme of targeted training, advice and support. Currently our compliance rates for safeguarding training is over 85 per cent for key groups such as health visitors, midwives and emergency care staff. During the year the Emergency Department (ED) Domestic Abuse Advocacy Partnership Project with Black Country Women's Aid continues to prove to be a positive venture in increasing the visibility of domestic abuse in ED. We have seen an increase in Emergency Department Practitioner response, identification and onward referral to the Independent

Domestic Violence Advisors (IDVA) based in Sandwell and City Hospital's for victims of domestic violence and abuse. Analysis of current data demonstrates that there are an increased number of victims being identified from Black and Minority Ethnic Groups which have previously not been represented in groups accessing domestic abuse services. Data shows that 77 per cent of victims have accepted ongoing support following initial referral into the project.

Our Domestic Abuse Lead Nurse Team continues to contribute to the Multi-Agency Domestic Abuse Screening Process in MASH to ensure that information relating to risk is shared with health professionals involved with the victim and children in order to protect, safeguard and reduce the negative impact that domestic violence and abuse poses.

The team have delivered specific training to staff across the Trust on Safe Lives (formerly CAADA/DASH Risk Assessment) and domestic abuse training forms part of our Safeguarding Children and Adult Safeguarding Mandatory Training requirements. Earlier this year a domestic violence and abuse leaflet was distributed to all employees.

Identifying Child Sexual Exploitation (CSE) remains a high priority for our organisation and during the year we have continued to deliver bespoke CSE training jointly with Barnardo's to our Emergency Department teams, paediatric ward staff, front line community nurses and allied health professionals. The training aims to raise the profile of CSE ensuring they are alert to the signs and triggers. We have good representation at Sandwell and Birmingham's CSE Health Groups from the paediatric areas including our Integrated Sexual Health Services, Safeguarding Team and ED.

We flag all children and young people who are known to Sandwell CSE Team as being at risk of CSE on our clinical systems. Audit has shown an improvement in ED practitioner response to a flag and in contacting Children's Social Care to share information on ED attendance and ensure appropriate support is in place.

The Child Protection Information Sharing (CP-IS) Project is embedded within our EDs and audit has shown that staff are reviewing systems to check for this information to inform their assessment. We currently manually flag our systems for Sandwell children where there is a child protection plan in place as the local authority are not currently live with CP-IS to ensure that this information is equally available.

We are currently developing systems in maternity services to ensure information in relation to female genital mutilation risk is available and are working closely with NHS England to implement Female Genital Mutilation Information Sharing system (FGM-IS).

Priorities for 2018/19 will continue to focus on CP-IS integration with our new electronic patient record (EPR), Unity, and implementation of the FGM-IS system across maternity services ensuring this information is integrated into Unity to inform risk. We will continue to maintain current compliance with mandatory safeguarding children training to ensure we have a skilled and knowledgeable workforce and focus on domestic violence and abuse with a view to secure substantive funding for our Advocacy project post June 2018.

Adult Safeguarding

We changed the adult safeguarding team during the year and now we have an Adult Safeguarding Lead Nurse and the appointment of a second Adult Safeguarding Nurse to provide visibility and operational support to frontline staff and patients.

Our dedicated Tissue Viability team includes a continence specialist nurse and we are excited to be recruiting a nurse dedicated to falls prevention. The adult safeguarding team are supported by other specialists such as learning disability, and dementia. Our new dementia, delirium and distress pathway aims to improve care for patients with cognitive impairment and promote least restrictive care. 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.

We have focused on Deprivation of Liberty applications for those patients, with training for 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 initial data is encouraging. We applied for more than double the Deprivation of Liberty safeguards during the year 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 safeguards. PREVENT duties within the Trust continue to develop with participation at multiagency meetings (Channel Panel) contributing to individual case management. We participate 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.

Readmission rates

The table below details our readmission rates. This excludes deaths and stillbirths. The information is collected during a financial year period and we now measure readmission within 30 days (previously 28 days). Readmission reduction remains a priority for the Trust.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to monitor performance through group management meetings and group performance review meetings.

Age 0 – 15 years

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2017/18	16145	934	5.8%
2016/17	16367	998	6.1%
2015/16	16015	1105	6.9%
2014/15	16058	1382	8.6%

Age 16 and over

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2017/18	95113	8997	9.5%
2016/17	96427	8789	9.1%
2015/16	98232	9930	10.1%
2014/15	100662	9831	9.8%

All Ages

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2017/18	111258	9931	8.9%
2016/17	112794	9787	8.7%
2015/16	114247	11035	9.7%
2014/15	116720	11213	9.6%

Quality Improvement Half Days (QIHDs)

2017/18 saw the continued development and expansion of Quality Improvement Half Days (QIHDs), our unique approach to staff involvement, with over 1,000 colleagues across the organisation 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.

April saw the introduction of 'ward' QIHDs, two hours of protected time for the team to spend together to consider how best to improve the quality of services provided to patients and staff on the wards. The use of this time has had mixed success with some wards finding it challenging to organise their QIHDs while others have embedded this into their routine so they have a known time when they can come together to talk about service improvements. A review has reconfirmed support for ward QIHDs so help is being provided to create the right environment for these sessions to succeed everywhere.

A new accreditation system was launched this year to allow teams to put themselves forward for recognition that their QIHDs are achieving quality improvement through staff involvement. Teams meeting the entry level can then put themselves forward for bronze, silver or gold status. The palliative care team led the way and impressed the awards panel and earned themselves a silver award. Imaging, health visiting, newborn hearing services, obstetrics and gynaecology, rheumatology, elderly care, stroke and neurology and governance celebrated too after their hard work on quality improvement gained them a bronze award. Moving forward the aim is to have all teams rated in 2018/19.

Learning from deaths

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 Data) System which reports the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI).

Hospital Standardised Mortality Ration (HSMR)

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. This information is derived from the HED system, which is rebased monthly to providing the most up to-date-data.

Our HSMR is currently 122 (December 2017) for the Trust and outside statistical confidence limits. There is ongoing scrutiny and oversight of mortality statistics at the Mortality and Quality Alerts Committee (now the Learning from Deaths Committee). A report was commissioned with HED (Healthcare Evaluation Data), analytics provider which concluded Sandwell General Hospital is a statistically significant HSMR outlier and City Hospital remains within expected limits. A Trust-wide investigation of the following diagnoses groups was conducted:

- Pneumonia
- Pleurisy
- Respiratory failure; insufficiency; arrest (adult)

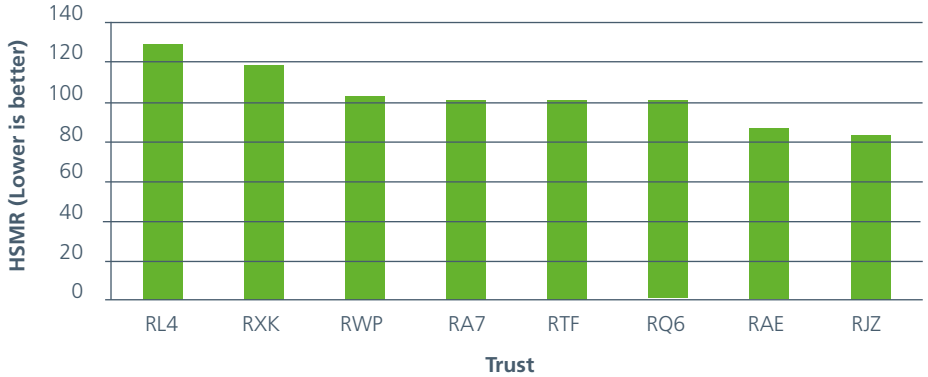
There were no significant quality of care issues identified. The broadening gap between HSMR for weekend and weekday admissions is subject to close monitoring at the monthly Learning from Deaths committee to identify actions to improve this position.

Changes in Palliative Care practice, i.e establishment of the Connected Palliative Care Hub and the coding of this change, look to be impacting on SWBH's HSMR. This is demonstrated by the HSMR model without palliative care. This is being addressed by:

- Reviewing the numbers of patients being seen in hospital by the palliative care team to ensure that HES coding accurately reflects practice.
- Ensuring that the appropriate distinction between supportive care and palliative care is being made during coding.

Further investigation and external audit was commissioned by the Trust information team which concluded that the coding practices at SWBH is robust and is inclusive of multiple co-morbidities in all spells of care. However there is ongoing close monitoring of Palliative Care coding practice to understand the reason for the reduction and establishing if this is consistent with the 'on the ground' view of patients seen at the Trust.

Hospital Standardised Mortality Ration (HSMR)



KEY

RL4 – The Royal Wolverhampton Trust
RXK – Sandwell and West Birmingham Hospitals NHS Trust
RWP – Worcestershire Acute Hospitals NHS Trust
RA7 – University Hospitals Bristol NHS Foundation trust
RTF – Northumberland Healthcare NHS Foundation Trust
RQ6 – Royal Liverpool and Broadgreen University Hospitals NHS Trust
RAE – Bradford Teaching Hospitals NHS Foundation Trust
RJZ – King's College Hospital NHS Foundation Trust

Risk Adjusted Mortality Index (RAMI)

This is a methodology developed by Caspe 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 (January 2018) is 109 and outside of statistical confidence limits. It is also above the National HES peer RAMI of 88. The aggregate RAMI for the City site is within statistical confidence limits with a RAMI of 98, and the Sandwell site with a RAMI of 116, which is outside of statistical confidence limits. Mortality rates for the weekday and weekend low risk diagnosis groups are within or beneath the statistical confidence limits.

Summary Hospital-level Mortality Indicator (SHMI)

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 of discharge. Our SHMI score is currently 108 (November 2017) for SWBH Trust. This data is derived from HED (Healthcare Evaluation Database) for the Summary Hospital Level Mortality Indicator (SHMI).

Mortality comparisons using highest SHMI against national results: July 2016 June 2017

Indicator	Lowest	Highest	SWBH NHS Trust
Score (SHMI)	0.726	1.228	1,036
Observed	554	1291	2029
Expected	763	1052	1958

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 two 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 2017/18 we set ourselves a target of reviewing 90 per cent of all hospital deaths within 42 days and 100 per cent 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 Quality Standard for 2017/18. We have not been able to achieve this target due to a number of contributing factors. In the forthcoming year, new targets will be set as well as rolling out a new review method, Structured Judgemental Review methodology, recommended by Learning From Deaths Guidance March 2017.

2017/18

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	101	105	120	326	134	111	106	351	130	115	164	409	176	138	139	453	1539
Reviewed	51	50	67	168	63	45	46	154	44	45	74	163	79	55	39	173	658
% Reviewed	50	47	55	51	47	40	43	43	33	39	45	39	44	39	28	38	42
% Cumulative Reviewed	50	49	51	51	50	48	47	47	45	44	44	44	44	44	42	42	42

Data highlighted in red has not been finalised for year end.

Chief Executive Toby Lewis speaking with clinicians about our Trust's Safety Plan at a Listening into Action Event.

Sister, Lynne Hackett talks to patient, Sarah Meanley.

During 2017/18 Q1 to Q3, 1591 of SWBH NHS Trust's patients died in hospital. 347 deaths in Q1, 360 deaths in Q2, 421 deaths in Q3, 463 in Q4.

By 31st January 2018, 492 mortality case record reviews and 22 investigations have been carried out in relation to 25 of the deaths. In 22 cases a death was subject to both a case review and an investigation. The number of deaths in each quarter for which a case record review or investigation was carried out was 170 in the first quarter, 156 in the second quarter, 166 in the third quarter, data for Q4 is not yet available.

Nine patient deaths, representing 0.80% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of four patient deaths representing 0.35% of the patient deaths for the first quarter, two patient deaths representing 0.18% of the patient deaths for the second quarter, three patient deaths representing 0.27% of the patient deaths for the third quarter, data for Q4 is not yet available.

These numbers have been estimated using the SWBH NHS Trust Mortality Review System. The Mortality Review System (MRS) is based on the PRISM methodology. It is in place to ensure that there is a review of the management of a large proportion of patients who have died in our care. On notification of the death to the CARES office, the notes of the patient are scanned into the CDA and a notification is sent to the Clinical Director and a Consultant of the Directorate in which the death occurred. The electronic notification system has been set up to allocate the reviews to a consultant colleague within the Directorate, but not to a consultant who provided care to the patient. A comprehensive review of each case is performed (within 42 days of the death) using the scanned notes of the ultimate, and where appropriate, penultimate inpatient episode.

The MRS allows each case to be examined for excellence as well as errors or deficiencies in care and the death is categorised as expected or unexpected and whether the death was preventable. A MRS report is compiled monthly and scrutinised at the monthly Learning From Deaths committee and any actions arising are also monitored for completion. The purpose of the report is to identify the deaths that have been categorised with preventable codes.

We also use a 'trigger method' to identify the cases not categorised with a preventable code, but where there has been a negative response to a significant number of questions (three or more) relating to the clinical assessment or ongoing management. These are investigated further through the Learning From Deaths committee. The outcome and actions from these incidents are reviewed by the committee to identify quality improvement themes and opportunities. The MRS also provides a report of the lessons learnt where this is recorded for cases reviewed.

Data from the MRS is also used to investigate and respond to external mortality alerts for example CQC alerts and alerts in relation to specific diagnoses/procedure groups. The committee also reviews the outcome of HMC Inquest and from all these sources identifies learning and quality improvement opportunities.

The following areas have been identified as learning points from case record reviews and investigations conducted in relation to the deaths identified in 2017/18 through our MRS and from investigation of other internal and external mortality alerts.

- Compliance with the Sepsis Bundle notably delayed administration of antibiotics.
- Late recognition of AKI and delay in identifying and managing the end of life are some of the more common problems identified.
- Other areas noted for quality improvement are delayed intervention eg commencement of CPAP, suboptimal preoperative assessment, compliance with the head injury pathway, compliance with discharge criteria and delayed diagnosis of subarachnoid haemorrhage.

Examples of the quality improvement projects that have come from our work are:

- Development of the AKI guidelines and outreach acute renal services, supported by electronic flagging system to Nephrology team.
- Revision of the sepsis bundle and trust-wide sepsis audit supported by the sepsis team.
- End of Life Care and Specialist Palliative Care are now coordinated through a palliative care hub covering in and outpatient care.
- The Commissioning of a dedicated NIV unit on the respiratory ward.
- Updated head injury proforma.
- Focused education within ED.
- Participation in the TARN audit.
- Implementation of the NHSI enhanced discharge initiatives e.g. Red to Green and the SAFER flow Bundle.

Action in the reporting period by SWBH to achieve quality improvement in these areas has come through several pieces of work.

- We have implemented a medical examiner service as part of the Trust's Learning from Deaths programme to support accurate death certification and junior doctor training in this area. This team will triage all deaths and identify deaths where review, investigation, reporting to coroner or as incidents very soon after death is needed. The medical examiners will also support and engage relatives and carers to further identify cases for review and learning.

- The acquisition and implementation of the new structured judgemental review method and analysis tool and the participation by trust staff in SJR training internally and externally as tier one trainers.
- A defined trained pool of SJR reviewers is being identified.
- Participation in the National Learning Disability Mortality Review Programme (LeDeR) led by the University of Bristol and notification of Learning Disability Deaths to the LeDeR programme, which went live for submission in October 2018. The Trust also reports monthly in detail on learning disability patients who have died in the preceding month.
- We work accross Black Country Trusts and our mortality lead chairs the NHS England West Midlands Mortality Concordat to learn from regional good practice.
- Learning and news of QI projects are shared through monthly email Learning from deaths e-bulletin, DEATH Matters quarterly newsletter. Each group is represented at LfD committee and SJR reviewers are taken from every specialty.
- Corporate work streams identifying group and specialty quality improvement of end of life care and specialist palliative care are monitored regularly.
- When implemented our new EPR system will ensure reliable medical record review and support for full timely case review of cases identified for review.

Reporting requirements prescribe that a comparison of mortality data for the previous reporting period is included. At SWBH we have a process in place and have this data available for 2016/17, however this has not been mapped with the Learning from Deaths methodology, therefore comparison against previous years data will be reported in future quality accounts.

Our Connected Palliative Care team was rated 'Outstanding' by the CQC.

Deaths of patients with involvement from palliative care services

Diagnostic care coding = Z5.15. The table below provides information relating to the number of deaths at the Trust where there was a diagnosis of Palliative Care made. A Trusts Mortality data is affected by palliative care and specialist palliative coding as well as comorbidity coding. Changes in external mortality data calculation methods and rebasing, changes in palliative care provision (eg focusing on community care) and coding can affect our data and comparison with peer Trusts.

Mortality comparisons against national results: July 2016/17

Total number of Total number of deaths deaths	Palliative Care	Percentage (%)
2029	387	19.1

Venous Thromboembolism (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 per cent) 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 96.1%

Venous Thromboembolism (VTE) risk assessment (National Target 95%)	2016/17	2017-2018 (Apr – Dec)				
	SWBH		SWBH	National Average	Highest Trust	Lowest Trust
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	95.36%	Q1	96.1%	95.1%	100%	51.4%
		Q2	96.4%	95.2%	100%	71.9%
		Q3	96.5%	95.3%	100%	76.1%
		Q4	95.2%	TBC	TBC	TBC

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and SWBH data is consistent with Trust reported data.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to monitor compliance of VTE assessments on admission as part of the Trust's Safety Plan compliance. It is also monitored as part of our Integrated Performance Report which is monitored at our Quality and Safety committee and reported to the Trust Board monthly. We believe the introduction of our new electronic patient record system, Unity, will help us to improve our compliance.

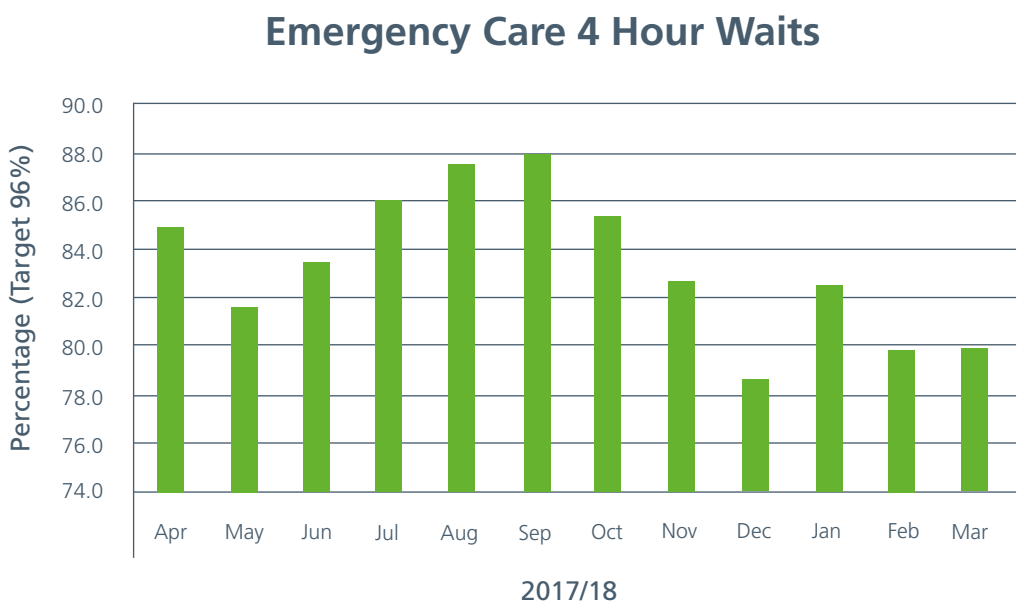
Our Connected Palliative Care team received positive feedback from the CQC.

Emergency four hour waits

In line with the national standard we aim to ensure that 95 per cent of patients will wait for no more than four hours within our Emergency Departments (ED). Although the majority of patients were seen in four hours on average we achieved 83.4% at year end.

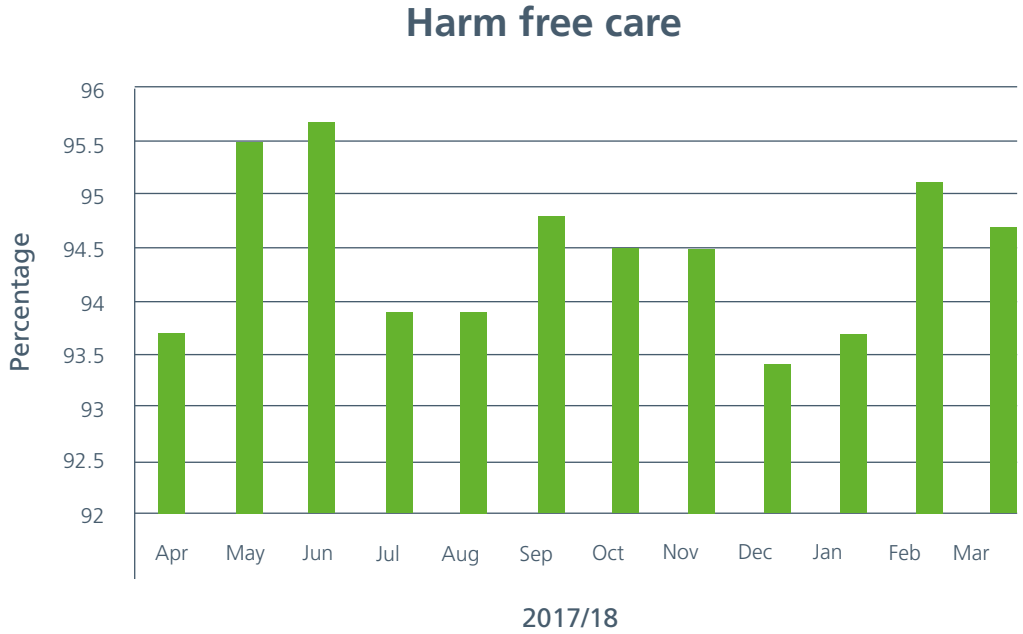
We continue to see good results in ambulance handover time, meaning that ambulance crews can get back on the road more quickly. We remain committed to improving our performance and have expanded our Rapid, Treatment and Assessment (RAT) this year which has shown an improvement in time to treatment.

Percentage of patients waiting four hours or less in Emergency Departments 2017/18
(Higher is better – target 95%)



Harm free care

We continue to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls; catheter related urinary tract infections (UTI) and deep vein thrombosis (DVT). We review harms via the incident reporting framework with lessons learned shared locally and across the organisation.

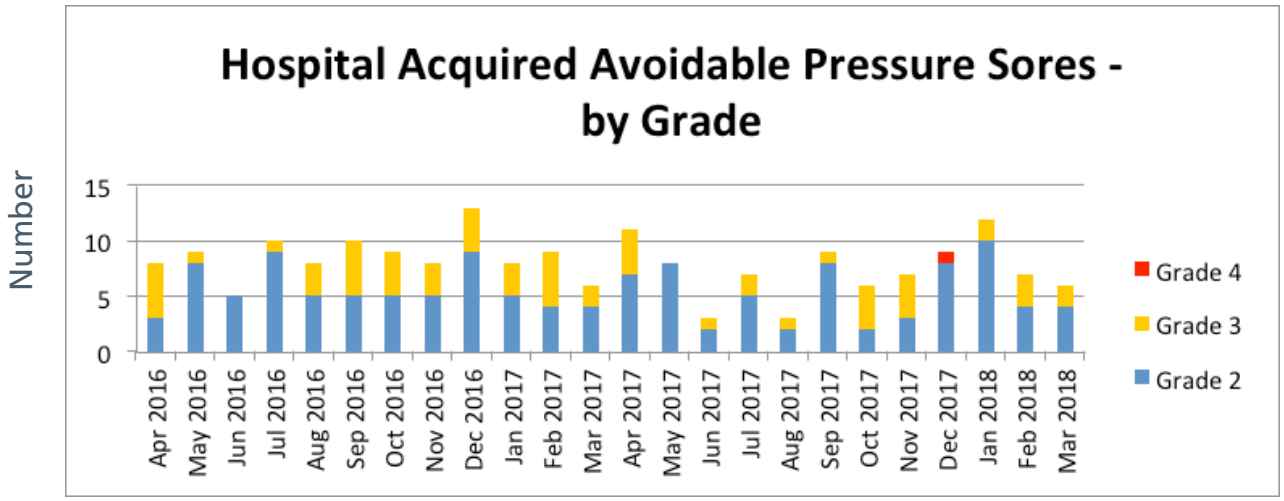


Pressure ulcers

Pressure ulcer prevention remains one of the key priorities in line with the Trust vision to provide patients with safe care. We continue to promote being open with the reporting of pressure damage incidences in order to learn and improve future care for patients.

Pressure ulcer prevention is one of the key parts of our Safety Plan for 2018 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 pressure damage.

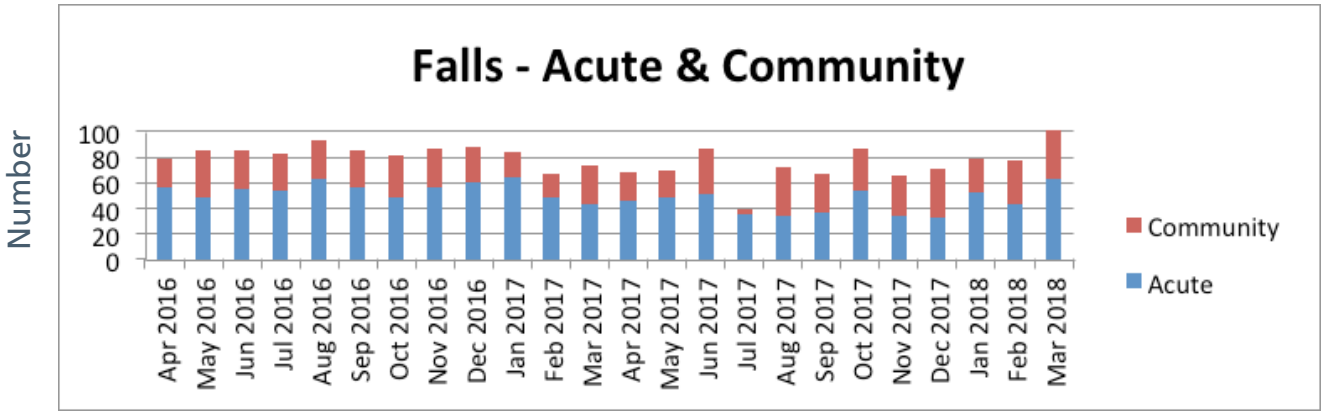
The Tissue Viability service is engaged in the National NHS Improvement 'Stop the Pressure' campaign to eliminate avoidable pressure ulcers within the Trust. The campaign focuses on the early identification of at risk patients and reacting quickly to the early warning signs and preventing pressure damage occurring. This initiative supports any areas in the Trust who are identified as reporting any increases of pressure damage occurring. The campaign has proven effective in a number of areas, supporting staff with education and training in pressure ulcer prevention and has reduced the incidence of reported pressure damage in these areas.



Falls

The number of falls for 2017/18 was 943 with 14 of the falls resulting in serious injury. This is a reduction of 51 falls compared with 2016/17 data. Falls resulting in serious harm have also reduced year on year from 24 to 14.

The Trust remains committed to patient safety and reducing harm occurring to our patients and we will continue to focus on falls prevention with a key emphasis on the assessment of patients and the implementation of preventative strategies to keep our patients safe.



Infection prevention and control

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 HCAIs.

To comply with current legislation and meet the requirements from professional bodies such as: Department of Health, the Care Quality Commission and NHS Improvement [NHSI], we adopt a proactive approach to identification, management and monitoring of infections 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] and standards of cleaning, guidance and recommendations from professional bodies.

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy. 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.

Target for 2017/18	Agreed target/ rate [year end]	Trust rate	Compliant	Comments	
MRSA bacteraemia	0 tolerance	0	Yes	**Pre 48hrs [laboratory identified]** 4	**Post 48hrs [laboratory identified]** nil
				All bacteraemias identified in the laboratory have had a post infection review as per PHE guidance to identify issues and lesson learnt. Of the cases identified 0 has been attributed to SWBH.	
***C.difficile* acquisition toxin positive**	30	28 attributed to SWBH	Yes	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged two or over during the reporting period is 12.85	
MRSA screening - elective [YTD]	85%	89.0%	Yes	Locally agreed target.	
MRSA screening - non elective [YTD]	85%	91.4%	Yes	Locally agreed target.	
Post 48hrs MSSA Bacteraemia *(rate per 100,000 bed days)*	N/A	10 (4.69 per 100,000 bed days)	NA	All post 48 hrs bacteraemias have a post infection review to identify issues and lesson learnt.	

Blood culture contamination rates

(Target = 3% by ward, dept. and site.)

Sit	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
City	2.4%	0.9%	2.3%	1.2%	1.6%	1.9%	1.2%	1.9%	1.9%	1.4%	1.3%	2.6%
S.Well	2.5%	3.3%	2.5%	2.8%	2.3%	3.6%	2.9%	2.4%	3.7%	3.5%	5.4%	2.6%

Overall Trust rate 2.9%. 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 has introduced a training programme for all new doctors to the Trust. This is now managed by the clinical fellows.

We monitor incidences of infections so that we can identify and act on periods of increased incidents [PII]. This includes outbreaks of diarrhoea and vomiting, those attributed to a variety of micro-organisms including: Clostridium difficile [CDI], Extended Spectrum βeta lactamase organisms [ESBL], Carbapenamase resistant organisms [CRO]; Vancomycin resistant enterococci [VRE], MDR Acinetobacter. In all incidences strains have been typed to determine any outbreaks and post infection reviews undertaken and multi-disciplinary and agency meetings held to identify root causes and lessons learnt.

Site	Organism	2017-18 month	PII or outbreak	Ward or bay closure
Sandwell CCS	VRE	June 17	PII	NA
City D15	CDI	July 17	PII	NA
Sandwell P5	CDI	Sept17	PII	NA
Maternity NNU	ESBL	Oct	outbreak	NA
Sandwell P2	CDI	Oct17	PII	NA
Sandwell L4	Norovirus	Dec 17	outbreak	Bays
Rowley Regis	Norovirus	Dec17	outbreak	Bays
City D16	Flu	Dec 17	outbreak	Bays
Sandwell L4	Flu	Dec 17	outbreak	Bays
Maternity NNU	ESBL	Dec17	PII	NA
Sandwell L4	Flu	Feb 18	outbreak	Bay
Rowley Regis	Norovirus	Feb 18	outbreak	Bays
Sandwell P5	Norovirus	Mar 18	outbreak	bay

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and SWBH data is consistent with Trrust reported data.

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continued commitment and compliance with infection prevention and control policies by clinical and non-clinical groups and clinicans. 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 2017/18. The Trust Information Governance Assessment Report overall score for 2017/18 was 93 per cent and was graded GREEN. This means that a minimum Level 2 was achieved for all requirements (as required for the NHS standard contract). We will continue to build on this to strengthen our IG practices and processes and work towards achieving full mandatory compliance with the new data security and protection toolkit which replaces the information governance toolkit in April 2018.

Incident reporting

A positive safety culture remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting and Learning System (NRLS) which is publically available and provides comparative data with like-sized trusts. This data shows as at September 2017, we are in the middle 50 per cent of reporters of trusts with a reporting rate of 47.98 per 1000 bed days.

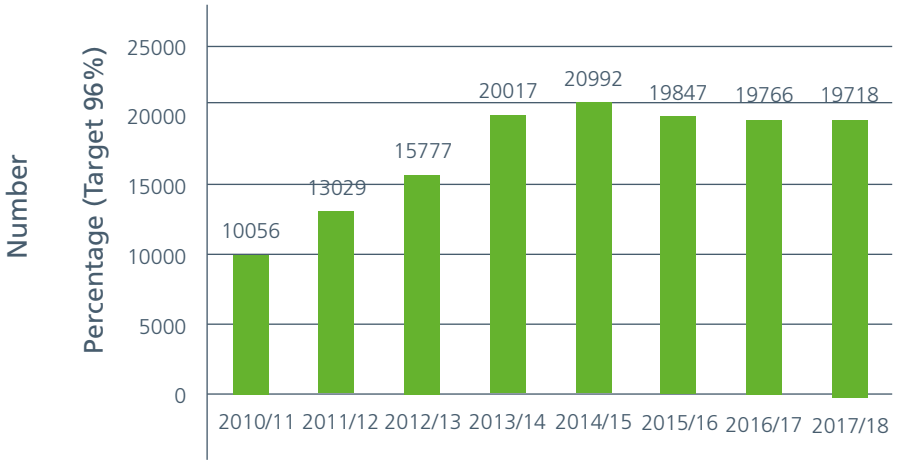
L– R Ward Manager, Tracy Weston and Staff Nurse, Anthea Forsythe complete the Ten out of Ten safety plan checklist.

District Nurse Clinical Lead for Tipton, Andy Churm (central) is leading on the mobile working project.

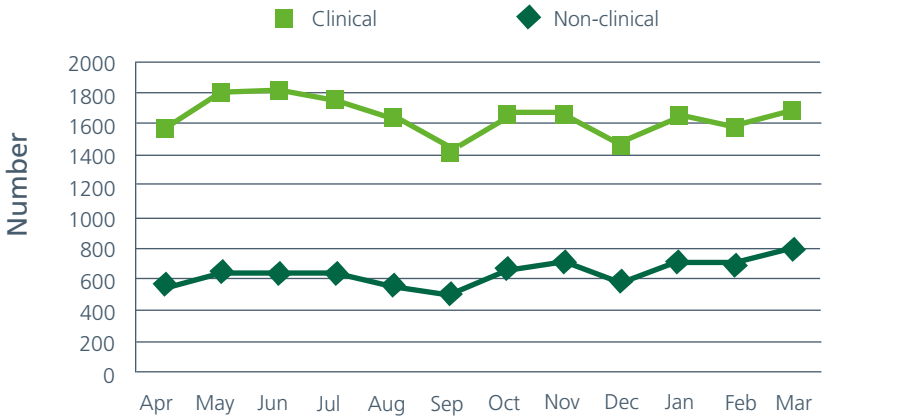
Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	Worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82	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
Date	**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 (April 16 to Sep 16)	44.48	73	22	8	0.2	1	0.0
2016/17 (Oct 16 to Mar 17)	47.93	70	23	4	0.1	3	0.1
2017/18 (Apr 17 to Sep 17)	47.98	111.69	23.47	2	0.0	1	0.0

The latest data (April 17 - September 17) shows an overall position of reduced incidents resulting in severe harm or death.

Total incidents reported by financial year



Total incidents reported during 2017/18 split by Clinical and Non-clinical



Incidents are generally categorised into clinical (patient safety) and non-clinical and then further categorised dependant upon their causative factor. The chart on page 57 shows the data for the main types of incidents throughout the year, month on month. Serious incidents continue to be reported to the CCG. The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by continuing to facilitate investigations and learning through 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 2017/18 is shown in the following table. This does not include pressure sores, fractures from falls, ward closures, some infection control issues, personal data or health and safety incidents.

2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs (by date reported as SI)	0	3	1	0	3	4	1	2	2	3	1	3

General Data Protection Regulation

The General Data Protection Regulation (GDPR) will replace the Data Protection Act (1998) from 25th May 2018.

Like all NHS trusts we are in a good position due to the work undertaken as part of the Information Governance toolkit. We have an action plan in place to review our information processes, particularly with regards to children's information and transfer to non EU countries.

Never Events

During 2017/18 three 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.

Never events reported in 2017/18

Specialty and Date	Type of Never Event	Root Causes	Changes made
T and O Theatres/ Anaesthetics	Wrong site block	Failure to complete WHO Safe Surgery "Sign In"	Mandatory sign in part of Safe Surgery Checklist use and responsibilities reinforced Mandatory stop before you block standard operating procedure and the SOP updated reinforced Stop before you block video has been circulated to all anaesthetists Process in place for practitioner performing a procedure is present for the whole process Reprinted stop before you block poster in A3 size
BMEC	Wrong eye lasered	Failure to follow the correct procedures	We have amended our standard operating procedure for the practice of consenting sequential procedures. We have introduced a modified WHO checklist for use in BMEC OPD procedures. We have produced a standard operating procedure requiring site marking and inclusion in the WHO surgical safety checklist.
Dermatology	Wrong patient biopsied	Failure to follow positive patient identity procedure	Our Positive Patient Identification (PPID) video has been recirculated to all staff as reminder of its importance. All staff in Dermatology have attended a training session on PPID and use of WHO checklists. We have introduced patient ID bracelets for those attending outpatient (OPD) theatre sessions in dermatology.

Duty of Candour

The Trust has a robust method, through use of the electronic incident reporting system, to identify those incidents which, by the nature of the degree of harm, trigger the statutory duty of candour.

When incidents are reported which identify that the level of harm to a patient is moderate, severe or they have died due to care issues clinicians are engaged in discussions to clarify that the outcome meets the recognised definitions to trigger this level of candour, recognising that being open and the professional duty of candour continues to happen at all or no level of harm.

The Incident reporting system allows for capture of the duty of candour conversations taking place. Since 1 April 2017 453 incidents have met the statutory requirements and of those 95 per cent (430) are evidenced as being complete. The remaining 23 are being reviewed.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 3850. Of these, in excess of 3400 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 450 were recruited into non-NIHR portfolio studies.

The numbers of patients involved in research at the Trust have increased year on year over the last four years, reflecting the Trust's ongoing commitment to support and develop research. Through this we continue to improve the quality of care offered to patients locally, ensure that our staff remain abreast of the latest treatment possibilities and make important contributions to the wider health environment.

There are over 385 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 2017/18, 60 new studies have been given Trust approval to commence (46 NIHR portfolio studies and 14 non NIHR portfolio studies). 104 NIHR portfolio studies have actively recruited research participants in 2017/18.

During 2017/18, patient recruitment was highest in cardiovascular disease, ophthalmology and rheumatology although research activity has taken place across a full range of disciplines including stroke, diabetes, gastroenterology, surgery, dermatology, maternity, obstetrics and gynaecology, paediatrics, respiratory, orthopaedics and physiotherapy and cancer (breast, lung, colorectal, and haematological, gynaecological, and urological malignancies).

Important new developments in 2017/18 include:

- Increasing the internationally recognised excellence of our research portfolio: We are for example a key partner in the new Arthritis Therapy Acceleration Programme (https://www.kennedy.ox.ac.uk/about/translational-research/atap) linking universities and hospitals in Oxford and Birmingham. Some of our leading researchers have secured major highly prestigious grants and awards including the NIHR Senior Investigator award to Prof Greg Lip.
- Increasing the breadth of our clinical research portfolio with new research initiatives in a range of areas including sickle cell disease, critical care, maternity and orthopaedics.
- Increasing the range of health care professionals contributing to our research portfolio: physiotherapists have made major contributions to our research, and we have seen important developments in the involvement of clinical nurse specialists and laboratory scientists in the development and delivery of research and innovation. We have created secondment opportunities to allow clinical nurses/midwives to gain exposure to research.
- Translating research into better and safer care: Our researchers have been involved with/led the development of national/international clinical guidelines for a range of diseases over the last 12 months including Systemic Lupus Erythematosus.
- We are actively working to enhance the quality of space for research and development activities at the Trust. Some of our team have recently moved into new space in theBirmingham treatment centre and we are in detailed discussion about the creation of enhanced space at the Sandwell site.

Participation in Clinical Audits

During 2017/18, Sandwell & West Birmingham NHS Hospitals Trust has participated in 53 national clinical audits and 3 national confidential enquiries covering NHS services which the Trust provides. The Trust has reviewed all the data available to them on the quality of care in these services.

The national clinical audits and national confidential enquiries that the Trust participated in and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
Women's & Child Health		
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) - Perinatal Mortality surveillance	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) – Perinatal Mortality and Morbidity	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) – Maternal Mortality Surveillance	yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (CORPS) – Maternal Morbidity confidential enquiries	yes	100%
National Neonatal Audit Programme (NNAP)	yes	100%
British Thoracic Society: Paediatric Bronchiectasis	yes	100%
National Paediatric diabetes Audit	yes	100%
National Maternity and Perinatal Audit (NMPA)	yes	100%
National Pregnancy in Diabetes (NPID) Audit	yes	100%
Acute care		
Hip, knee and ankle replacements (National Joint Registry)	yes	100%
Severe trauma (Trauma Audit & Research Network)	yes	50%
Intensive National Care Audit (ICNARC)	yes	100%
Surgical Site infection Surveillance – Hip and Knee	yes	100%
Sentinel Stroke and Stroke Improvement – National Audit Programme	yes	>90%
Royal College of Emergency Medicine Audit – Sepsis	yes	100%
Royal College of Emergency Medicine Audit – Consultant Sign Off	yes	100%
Royal College of Emergency Medicine Audit – Asthma	yes	100%
National Emergency Laparotomy Audit	yes	100%
Long term conditions		
National Inpatient Diabetes Audit	yes	100%
National Pregnancy in diabetes	yes	100%
National COPD Audit (Pulmonary Rehabilitation)	yes	100%
National COPD Audit (Secondary Care Audit)	yes	100%
National COPD Registry (Secondary care Audit)	yes	100%
National Audit of Dementia	yes	100%
UK Parkinsons Audit	yes	100%
National Diabetic Footcare Audit	yes	100%
Inflammatory Bowel Disease (IBD Registry)*	no	
Cardiology		
Myocardial Infarction (MINAP)	yes	100%
National Heart Failure Audit	yes	77%
National Audit of Percutaneous Coronary Interventions	yes	100%
National Audit of Cardiac Rehabilitation	yes	100%
ICNARC NCAA – Cardiac arrest	yes	100%
Rhythm Management	yes	100%
Cancer		
Oesophago-gastric Cancer Audit (NAOGC)	yes	>90%
National Prostate Cancer Audit	yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	yes	100%
Head and Neck Cancer Audit	yes	100%

National Audits	Participated Yes /No	Percentage of eligible cases submitted (Provisional)
National Lung Cancer Audit	yes	100%
(NBCP) Colorectal Cancer Audit	yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	yes	100%
National Comparative Audit of Blood Transfusion: 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	yes	79%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	yes	100%
Falls and Fragility Fractures Audit Programme – Fracture Liaison Service Database	yes	100%
Falls and Fragility Fractures Audit Programme – Inpatient Falls	yes	100%
(BAUS) - Nephrectomy Audit - Percutaneous Nephrolithotomy - Stress Urinary Incontinence Audit - Urethroplasty Audit	 no yes yes no	 Procedure not currently performed 100% 100% Procedure not currently performed
Other		
Patient Reported Outcome Measures (PROMS) Varicose Vein - terminated September 2017	yes	75%
Patient Reported Outcome Measures (PROMS) Groin Surgery – terminated September 2017	yes	68%
Patient Reported Outcome Measures (PROMS) Hip and Knee Surgery	yes	76%
National Ophthalmology Audit	yes	81%
Endocrine and Thyroid National Audit	yes	on going
National Audit of Intermediate Care (NAIC)	yes	100%
National Confidential Enquiries (Patient Outcome Data)		
Chronic Neurodisability	yes	90%
Young People's Mental Health	yes	83%
Acute Heart Failure	yes	45%

*The IBD registry was not participated in due to difficulties with resourcing. Measures taken to improve compliance 2018-19 are; Recruitment of administration staff, support from the Clinical Effectiveness department and integration between the Unity EPR system and the Registry.

The Emergency Gynaecology Assessment Unit team achieved 100% safety checks for patients. L-R Kuldip Manak, CNS Emergency Gynaecology, Lis Hesk, Matron for Gynaecology and Annette Black, Cancer Nurse Specialist.

Healthcare Assistant Sandra Burton with patient Carol Potter.

Partner statements
Healthwatch Birmingham

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

Given examples of patient experience and feedback, and how these are used to develop solutions that improve the quality of services.

- Demonstrated how the Trust learns from complaints and actions taken based on these lessons.
- Demonstrated how staff, patients and carers are involved in decision-making and activities within the Trust.

Patient and Public Involvement

It is positive to see that listening and learning from experience of patients in the Trust's care and their relatives or carers is a priority for 2018/19. We note the varied ways in which the Trust has engaged with patients and the public.

Firstly, by holding Facebook live events where members of the public can engage with clinicians on various subjects such as heart health care. This is an innovative way of sharing information with patients and the public that they might not have time to ask in a consultation. Equally, the Trust can use these events to understand patients' needs about what they expect from services based on their experiences.

Secondly, we welcome the establishment of a carers' group during the year that has informed the development of the Trust's carers' strategy. This is a good resource for understanding how best to support relatives and carers. We note that some action has already been taken in relation to carers, such as allowing people to stay in a bed alongside their relative and open visiting hours on all wards.

Thirdly, we note the initiatives of the Members Leadership Group. For instance, involvement in the Care Quality Commission inspections and improvement plans, and the supporting safety plan. We welcome that in 2018/19 the Trust intends to work closely with other partners to better join up the Trust's formal patient engagement activities.

Lastly, we welcome the work of the Local Interest Group to ensure inclusion within the workplace for all people who might otherwise be discriminated against. It is positive to see that the Local Interest Group (which is made up of leads from staff networks, chaplaincy service, and members of the public) works with the Trust to ensure that there is a coordinated approach to service improvement in order to meet the needs of those with protected characteristics and disadvantaged groups.

In our response to the 2016/17 Quality Accounts, we asked the Trust to consider developing a strategy for involving patients, carers and the public in decision-making. Our examination of the various initiatives around patient and public involvement, shows that the Trust has the foundation on which it can develop such a strategy. As we argued in our previous response, such a strategy should clearly outline how and why patients, the public and carers are to 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. To be effective, the strategy needs to be understood by all staff, promoted, and arrangements for collating feedback and experience should be clearly outlined.

In our response to the 2016/17 Quality Account, we asked the Trust to provide examples of changes or improvements to services and practice that have occurred as a result of that feedback. We also hoped to read how the Trust uses patient feedback and experiences to understand barriers different groups face. We are pleased to see examples of these in the 2017/18 Quality Account. We note the appointment of a diversity lead and implementation of awareness raising sessions on LGBT issues. In addition, the implementation of an 'infant feeding policy' that promotes zero separation from the mother when admitted in areas outside of maternity. Lastly, changes to templates for patient letters (e.g. making writing more visible; printing appointment letters on yellow paper) and deaf awareness training for staff.

We look forward to reading more about the impact of feedback, and we would like to read how the Trust communicates with patients about how they are using their feedback to make changes. At Healthwatch Birmingham, we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback as service users and the public will know that their views matter and lead to actual changes/improvement to services.

In our response to the Trust's 2016/17 Quality Accounts, we expressed concern that the number of formal complaints the Trust receives had increased from 871 in 2015/16 to 1026 in 2016/17. We are pleased to see that the number of formal complaints has reduced from 1026 (2016/17) to 825 (2017/18). We also note that complaints responded to within the target date has increased, from 81% (2016/17) to 92% (2017/18). However, the average number of days the Trust takes to respond to complaints steadily increased over the year. The most common themes of complaints has remained the same for the past three years. Complaints are mainly about clinical treatment, appointment delay or cancelations, communication and discharge and transfers. We note the lessons learnt from complaints and actions taken. However, we believe that the Trust needs to take innovative action in order to identify where the problems are, for instance in the discharge process, and understand and address these issues.

Staff and PPI (Patient and Public Involvement)
We note that the Trust did not meet its target to improve by 5% the percentage of staff responding to two of the three NHS staff survey. We welcome that the staff survey indicates improvement in the percentage of staff who believe that their role makes a difference to patients and service users.

It is positive to see the varied ways that the Trust is engaging staff. For instance, the Listening into Action events and Speak up Day, to ensure that staff feel heard and valued. We particularly welcome the 'Quality Improvement Half Days' that the Trust holds for staff to consider how to learn and develop new ideas. In addition the introduction of ward quality improvement days, where for two hours a team comes together to consider how best to improve the quality of services they provide within their wards. We would like to read in the 2018/19 Quality Accounts ideas from these meetings that have been taken up.

We believe that these Quality Improvement Days present an opportunity for staff delivering care to discuss issues around the effective use of patient feedback, and also as a means to communicate patient feedback to staff delivering care. Quality Improvement days can also be used to inform staff how feedback from patients/service users has been used to make informed decisions within their department/directorate. We believe that the basic approach of Healthwatch Birmingham's Quality Standard for PPI has some questions that might help the Trust to develop this further. The Quality Improvement Days can discuss whether:

- there is a clear strategic approach for PPI that staff understand across the Trust?
- staff understand what their responsibilities are in relation to PPI?
- they have set objectives for PPI that are regularly monitored?
- they understand how PPI informs decision-making in their service area to make improvement and address inequality? and,
- they understand that improvements or changes made as a result of feedback should be shared with patients and the public?

Trust Performance against standards and CQUIN
Similar to our response to the 2016/17, we are concerned 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. We note that there has been some improvement in falls, and falls with injuries, due to improvement in safety checks and assessments. However, there are other key areas where the Trust has failed or partially achieved its target. Such as:
Meeting the four hour A&E waiting times commitment to patients

- Cutting delayed transfers of care
- Implement the improvement plans to reduce avoidable mortality in surgery, cardiology, deaths due to sepsis and perinatal mortality
- The percentage of patients who met the criteria for sepsis screening, and were screened for sepsis, and the percentage of patients found to have sepsis following a screening and received IV antibiotics within one hour
- Creating a more engaged workforce
- Implementing an activation system for patients with long term conditions, such as HIV, to enable better outcomes (activate patients knowledge, skills and capacity to manage their own condition).

Regarding inspections, we note that the Trust was inspected in March 2017 by the CQC and a report published in October 2017. The Trust is still rated 'requires improvement'. We recognise that 70% of services are rated good or outstanding (i.e. end of life care is outstanding; imaging and surgery services is good; caring domain is outstanding). Equally, the safety domain has improved from inadequate to requires improvement. However, community inpatient wards have now been rated inadequate.

We note that the Trust has worked to address the actions detailed in the CQC report. Although the aim was to deliver actions by March 2018, we see that the Trust is facing problems with the following:

- Addressing the requirement for substantive middle grade staff overnight in A&E departments
- Working with other Trusts to implement Service Level Agreements (SLA) to provide paediatric ophthalmology cover out of hours and substantive posts in hours.

Healthwatch Birmingham is particularly concerned about the impact delays in the building of the Midland Metropolitan hospital is having on access and quality of services. For instance, failure to finalise Sandwell Treatment Centre locations and the seven day hospital service. More concerning is that failure to move to the new hospital means that high dependency patients cannot receive ongoing reviews by a consultant. Considering that the opening of the new hospital might be further delayed (reports says until 2022), the Trust needs to develop a plan to ensure that access to services and quality of care does not suffer. Alongside this, the Trust should ensure that they are prepared for the new hospital with the right staff skills mix and numbers.

We look forward to reading about improvement on these in the 2018/19 Quality Account, in addition to the missed targets above.

In our response to the 2016/17 Quality Account we were concerned that the Trust had only carried out 68.3% mortality reviews against a target of 90%. We argued that reviews are an important tool for ensuring that learning occurs and helps improve the quality of care. We note that mortality reviews have further decreased to 44% in 2017/18 from 61% in 2016/17 (against a target of 90%). We also note that there have been three never events against a target of zero, and mixed sex accommodation breaches have increased from 51 in 2016/17 to 314 in 2017/18.

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

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

The Trusts Priorities for 2018/19

Healthwatch Birmingham has taken note of the Trust's priorities for 2018/2019. We believe that a continued focus on improved outcomes for patients with signs and symptoms of sepsis; improving the consistency of care (correct documentation and risk assessments); and listening to patients experiences to help improve patient care are important. In particular, plans under the listening to patients priority, namely to listen and act on experiences heard through PALS, complaints and friends and family test. Including plans to complement this by introducing 'Purple Points' which are a phone based system accessible from all in-patient areas. This will enable patients and carers to raise concerns or compliments about the care or information provided to them at that time.

To conclude, Healthwatch Birmingham would like to commend the Trust for taking action in response to some of our comments on the 2016/17 Quality Accounts. It is positive to see examples of the use of feedback to make changes, learning from complaints and death, and actions taken in response. We would like to see further improvements in these areas in the 2018/19 Quality Account.

As per our role, Healthwatch Birmingham is running various projects to support providers in Birmingham to meet their statutory role of consulting/engaging with patients and the public. Consequently, ensuring that Trusts are using public and patient feedback to inform changes to services, improve the quality of services and understand inequality in access to services and health outcomes. We have worked with some Trusts to review their patient and public involvement process (PPI), identify areas of good PPI practice and recommend how PPI practice can be made more effective. We would welcome the opportunity to explore how we can support the Trust to improve in the year ahead.

Sandwell and West Birmingham CCG

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 2017/18 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 improvement schemes during the year, including: The 'Purple Points' initiative, which improves the way patients and carers can raise issues or concerns about patient care; and the continuation of Quality Improvement Half Days (QIHDs), which provide opportunities for multi-disciplinary teams to develop innovations or improvements to service. The Trust has also seen a significantly reduction in the number of complaints it has received, and has also seen a significant improvement in PROMS (Patient Reported Outcome Measures).

During the 2017/18 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 Trust's success in achieving their strategic priorities in relation to: Implement the safety plan in all inpatient areas (including community wards) so that patients have all safety checks as standard; Deliver reductions in wait time and improved productivity through successful execution of our annual production plan for elective care; and Reduce agency spend by £10m during the year. The CCG also wish to acknowledge the Trust's moderate success in achievement against most National CQUIN schemes for 2017/18.

The CCG also wishes to recognise and acknowledge the challenges faced by SWBH to: improve Mortality Index scores; to achieve the emergency care 4 hour wait target; 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 the challenges faced by the Trust due to the pause in construction work of the Midland Metropolitan Hospital and the impact this has had across the organisation. The CCG wishes to acknowledge the CQC inspection of March 2017, which led to an overall Trust rating of 'requires improvement', but recognises the significant improvements that have been made as well as the excellent rating awarded to the End of Life Care service, which received a score of 'Outstanding'.

Looking forward, the CCG welcome the Trust's Quality Plan Objectives for 2017-20, its aspiration to: reduce avoidable deaths in hospital so Trust is in the top 20% of comparable Trusts; deliver better quality outcomes, so that Trust is in top 20%; continue to improve Patient Reportable Outcome Measures so that the Trust falls within the top 20% of comparable organisations nationally; implement the electronic patient record; and ensure that work continues in relation to achieving 'Seven Day' hospital standards.

Trust response

We welcome the comments from our partners relating to our Quality Account. Understanding and improving the experience of our patients, their carers and families is really important to us. We look forward to working with our partners over the next 12 months as we work to continue to improve the services we provide for our patients through the delivery of our Safety Plan and our quality and safety priorities for 2018/19.

Independent Practitioner's Limited Assurance Report to the Board of Directors of Sandwell & West Birmingham NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Sandwell & West Birmingham NHS Trust to perform an independent assurance engagement in respect of Sandwell & West Birmingham NHS Trust's Quality Account for the year ended 31 March 2018 ("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, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- rate of clostridium difficile infections;
- percentage of 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 Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement 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 and NHS Improvement guidance.

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("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 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 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners dated 25/05/2018;
- feedback from local Healthwatch organisations dated 21/05/2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated Quarter 1 2017/18, Quarter 2 2017/18, Quarter 3 2017/18 and Quarter 4 2017/18;
- the national patient survey dated 2017;
- the national staff survey dated 2017;
- the local staff survey dated June 2017 and March 2018;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 04/05/2018;
- the annual governance statement dated 25/05/2018; and
- any other information obtained during our limited assurance engagement.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of Sandwell & West Birmingham 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 & West Birmingham NHS Trust for our work or this report, except 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;

- limited testing, on a selective basis, of the data used to calculate the indicators tested against 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 that can result in materially different measurements and can affect 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 of these criteria, 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 and NHS Improvement. 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 limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sandwell & West Birmingham NHS Trust.

Our audit work on the financial statements of Sandwell & West Birmingham NHS Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Sandwell & West Birmingham NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Sandwell & West Birmingham NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Sandwell & West Birmingham NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Sandwell & West Birmingham NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Sandwell & West Birmingham NHS Trust and Sandwell & West Birmingham NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018

- 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 identified as having been 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.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Birmingham

25 May 2018

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Our priorities for 2017/2018

The reports of 12 National Clinical Audits were reviewed by the provider in 2017-18 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
RCPH National Paediatric Diabetes Audit (NPDA) Audit Definition The NPDA aims to improve the care provided to children with diabetes, their outcomes and the experiences of patients and families. This audit cycle investigated hospital admissions and complications. Admissions to hospital among children and young people with diabetes place a large burden on NHS resources and patient and family wellbeing, and can be considered as a quality of care or performance indicator.	Key Findings/Learning The most recent report from the NPDA was published in July 2017. The audit report investigated acute emergency hospital admissions where the primary diagnosis is related to diabetes in children and young people. Key findings included; • Admission rates were stable between 2012-2015 - Increases in number mirrored increases in the numbers of children and young people with Diabetes. • Increased admission rates were observed in females, teenagers, and those living in deprived areas. • >90% of all admissions were of children and young people with Type 1 diabetes. Actions The assessment against the key recommendations contained in the report found there was excellent compliance and working practices associated with the recommendations.
Royal College of Emergency Medicine (RCEM) Consultant Sign off Audit Audit description The following four high-risk patient groups should be reviewed by a consultant prior to discharge from the Emergency Department (ED). • Standard 1 - Atraumatic chest pain in patients aged 30 years and over. • Standard 2 - Fever in children less than 1 year of age. • Standard 3 - Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. • Standard 4- Abdominal pain in patients aged 70 years and over. The aim of the audit is to benchmark current performance in EDs against the standards above, allow comparison nationally/between peers and to identify areas in need of improvement.	Key Findings/Learnings The results from the audit were mixed. • Standard 1 –Not met. • Standards 2 and 3 – No eligible patients during the audit period. • Standard 4 – Partly met. Actions To improve consultant sign off within the ED the following actions were undertaken; • Staff sensitisation – Department flyers, email reminders and induction training. • Incorporation of sign off onto Casualty cards is planned, but has been delayed by the introduction of the new Electronic Patient Record system. • The audit will be repeated annually to measure improved outcomes for patients.
Royal College of Emergency Medicine (RCEM) Severe Sepsis and Shock Audit description The purpose of the audit was to monitor documented care against the standards published in June 2016. The audit was designed to drive clinical practice forward by helping clinicians examine the work they do day-to-day and benchmark against their peers, and to recognise excellence.	Key Findings/Learnings The results from the 2017 report found that the Trust was performing well, and in many areas above the national average. Key recommendations included; • Patients to be reviewed by a senior doctor before leaving the ED department. • All patients with suspected sepsis and a National Early Warning Score (NEWS) of 3 should undergo screening.

Report	Findings, Our Learning, & Our Actions
	• Information should be communicated to patients and their relatives regarding Sepsis. Actions • 24/7 cover by Senior Doctors in ED is now provided to review suspected Sepsis patients. • There is a bleep holder at both sites. • Both EDs have a Sepsis lead. • A new Sepsis pathway has been designed as per RCEM guidelines and was launched in February 2018. This prompts staff for appropriate use of oxygen, serum lactate measurement, obtaining blood cultures, fluid administration, and antibiotics administration as part of the treatment for Sepsis. • A patient leaflet regarding Sepsis is currently being designed. • A Snap shot audit will take place during March 2018 to measure effectiveness of the new pathway.
National Audit of Cardiac Rehabilitation (CR) Audit description The National Audit of Cardiac Rehabilitation is a British Heart Foundation strategic project which aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with Cardiovascular Disease.	Key Findings/Learnings The trust was found to be performing well against national findings. Key recommendations were; • Programmes should aim to recruit a greater proportion of eligible female patients. • A much bigger proportion of eligible heart failure patients should complete their CR. • Programmes should seek to have their service accredited as part of the National Certification Programme for CR be referred to CR and supported to take up the offer. Actions Trust programmes are highly-patient centred. A menu of options is offered to patients including morning, afternoon evening, group-based, home-based, one-to-one, female-only and community-based classes. Application for National certification is in progress.
National Heart failure Audit Audit Definition The National Heart Failure (HF) Audit was established to monitor the care and treatment of patients in England and Wales with acute heart failure. The audit reports on all patients discharged from hospital with a primary diagnosis of heart failure, publishing analysis on patient outcomes and clinical practice. Audit findings can be used to measure the implementation of contemporary guidelines for the clinical management of heart failure from the National Institute for Health and Clinical Excellence (NICE) and the European Society of Cardiology Heart Failure Association (ESC HFA).	Key Findings/Learning • Patients with HF should have early, continued access to a specialist team. • Treatment after stabilisation is routinely following the recommendations from the audit and using evidence based practice to guide treatment. • The community team support and facilitate early discharge. • Prescription rates for evidence based therapies locally are above the national average and associated with better survival in the audit report. • Data is recommended to be shared widely both internally and externally. Actions • The team at the Trust is meeting or almost meeting all recommendations.

Report	Findings, Our Learning, & Our Actions
	• There is excellent provision, and the team aim to continue proactive work. • Audit Figures are presented at least six monthly at Quality Improvement (QI) meetings. • Team to consider sharing successful QI initiatives nationally.
National Neonatal Audit Programme (NNAP) Audit Definition The key aims of the audit are: • To assess whether babies admitted to neonatal units (NNUs) receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. • To identify areas for quality improvement in neonatal units in relation to the delivery and outcomes of care.	Key Findings/Learning The results from the 2017 report showed some areas where the performance of the trust was below the national rates. This included; • 40% of babies had a temperature in the target range in the first hour compared to a national figure of 61%. • 84% 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 90%. Actions In order to improve compliance with temperature target ranges, thermometers were available for the first time at each resuscitaire for use in babies <32 weeks gestation to facilitate early temperature recording. This will enable early changes in thermal care to be made if needed, to help reach the target range within the first hour. Audit is currently in process to understand whether we are now achieving this target or not and to facilitate an action plan if not. In addition it was planned to re-introduce NNAP cards for parent communication to act as a reminder for staff that senior communication was required.
National Diabetes Foot Care Audit (NDFA) Hospital Admissions 2014-2016 Audit Definition The audit seeks to address three key questions: • Are the nationally recommended care structures in place for the management of diabetic foot disease? • Does the treatment of active diabetic foot disease comply with nationally recommended guidance? • Are the outcomes of diabetic foot disease optimised?	Key Findings/Learning The findings from the 2017 report highlighted the importance of early expert assessment of new diabetic foot ulcers as this is associated with lower ulcer severity. All recommendations to implement this were in place other than increasing the availability of clinic access for new patients. The audit also recommended that to reduce the number of severe diabetic foot ulcers joint visits with community teams were appropriate to identify and seek early referral to the Multi-Disciplinary team. Actions The number of multi-disciplinary clinics and available outpatients appointments for new foot ulcer patients has been increased; this was recently implemented in February 2018. In order to reduce the number of severe diabetic foot ulcers the trust is expanding on current collaborative working with the Tissue Viability team and the district nursing service.
National Ophthalmology Database Audit Audit Definition The audit is intended to outcomes assure NHS cataract surgical services for patients. This will be achieved through	Key Findings/Learning • The trust was found to be fully compliant regarding almost all recommendations. • Information is made easily accessible regarding treatment and opportunities for quality

Report	Findings, Our Learning, & Our Actions
assessing key indicators of cataract surgical quality within the frames of data completeness and access by centre and deprivation. Should performance fall short of what can reasonably be expected by NHS patients this will be highlighted.	improvement identified and undertaken. • Patient pathways could be reviewed in order to maximise the recording of both pre-and postoperative Visual Acuity (VA) data. Actions • Friends and family feedback was initiated, admission time moved forward by 15 minutes to reduce delays and pharmacy increased opening hours. • 100% of pre-op VA data is being performed. • Improvement required for post-operative VA data as final best corrected visions are performed in the community.
Oesophago-gastric Cancer Audit (NOGCA) Audit Definition NOGCA collects prospective data on adult patients diagnosed in England and Wales with either invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach, or high grade dysplasia (HGD) of the oesophagus.	Key Findings/Learning The Trust is the local specialist centre for Oesophago-gastric cancer. • The trust is fully meeting the management of patients as per national recommendations. • One of the aims of the audit is to see a decline in the number of HGD patients presenting. Of those patients presenting locally diagnosis was confirmed by 2nd pathologist in 59.5% of cases. These findings were in opposition to trust knowledge - believing it is standard practice for pathologists to have a 2nd opinion before the MDT. • Patients reported to have had an initial staging CT scan was reported locally as 65.1% (Nationally 88.5%). Again local knowledge disputed these findings. Actions There are potentially some data entry issues. In order to address this a clinician will review data submissions to ensure there is no mis-reporting occuring.
National COPD Audit (Pulmonary Rehabilitation) Audit Definition The pulmonary rehabilitation audit 2017 ran a snapshot audit of organisation and resources of pulmonary rehabilitation services, as well as a snapshot audit of clinical care.	Key Findings/Learning Key recommendations from the audit were; • Staff should be aware of the association between completion of Pulmonary Rehabilitation (PR) and better patient outcomes, and support eligible patients to complete PR programmes wherever possible. • Services should enabe patients to rejoin programmes if attendance is interrupted for any reason. • Staff should work with patient organisations and charities to improve awareness of the beneficial health outcomes resulting from completion of PR. Actions • The trust was fully meeting the first two recommendations. • Patients are able to re-join PR programmes when necessary.

Report	Findings, Our Learning, & Our Actions
	• Staff have worked with the Clinical Commissioning Group to offer education to the GPs and Practice Nurses regarding the importance of PR. • Staff hold a public awareness day plus a winter awareness campaign every year. • Actions from the audit include contacting local charities and organisations to discuss how to increase awareness of PR.
National audit of Dementia Audit Definition The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.	Key Findings/Learning Main recommendations; • Ensure hospitals have robust mechanisms in place for assessing delirium in patients with dementia. Assessment of patients across sites was 81.5%. • Nutrition was 87.5% across sites, above national average. • Discharge procedures and preparation was 63% across sites. • Staff perception of communication was 58% across sites. • Recommendation for dementia champions available to support staff 24 hours day/ 7 days. • To ensure that there is an activity program which provides opportunities for social interaction for people with dementia. Actions • To address delirium assessment – promotion and awareness and training of all clinical teams. • To promote the importance of the nutrition need of older people with dementia via training sessions. • To increase communication around discharge a heading for discussions with relatives/ carers within the patient notes/ healthcare records was added, and ensure staff are aware of its purpose. • Seven day dementia champions are being implemented by ensuring that people in roles such as Site Nurse Practitioners and Bed Managers have expertise in dementia care. • Activity programmes are in place and fully meeting recommendations.
Falls and Fragility Fractures audit Programme (FFFAP) Fracture Liaison Service Database (FLS-DB) Audit Definition FFFAP has four overarching aims: 1. To improve outcomes and efficiency of care after hip fracture. 2. To improve services in acute and primary care to respond to first fracture and prevent second fracture. 3. To improve early intervention to restore independence.	Key Findings/Learning • All patients aged 50 years and over with a new fragility fracture or a newly reported vertebral fracture will be systematically and proactively identified – Trust fully meeting recommendations. • Patients will have a bone health assessment, and their need for a comprehensive falls risk assessment will be evaluated within 3 months of the incident - As a trust there has been delay in the reporting of x-rays this has greatly impacted on the FLS database. FLS looked to obtain access

Report	Findings, Our Learning, & Our Actions
4. To work in partnership to prevent frailty, preserve bone health and prevent accidents in older people. The FLS-DB aims to evaluate patterns of assessment and treatment for osteoporosis and falls across primary and secondary care.	lists, but not feasible as then needed to go into a further system to look at A&E records. Delays on X-ray reporting were reported as a clinical incident and included on Risk Register. Reporting has now improved. • Patients will have a bone health assessment within 3 months of an incident fracture – Current wait for a Bone Density Scan is 3-4 weeks. Patients are contacted to offer screening within this time frame and are given the opportunity to attend bone health screening. • Older people who present for medical attention because of a fall or report recurrent falls in the past year should be offered a multifactorial falls risk assessment – Fall risk assessment done in 96% of eligible patients. • Patients who are recommended drug therapy to reduce risk of fracture will be reviewed within 4 months of fracture to ensure that appropriate treatment has been started – Some trust data and uploading issues. Liaison with National Osteoporosis society and business development unit has taken place and plans in place to resolve. The FLS-DB is now operating a version 2; this may affect some of the uploading as the trust will only use one template.

The reports of 65 Local Clinical Audits were completed and reviewed by the provider in 2017-18 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided;

Report	Findings, Our Learning, & Our Actions
Assessment and management of delirium in older patients admitted to orthopaedic wards. Audit Definition To assess whether older patients admitted to orthopaedic wards are assessed for risk of delirium and managed as per NICE guidelines to reduce the risk of delirium and treat as soon as diagnosed. This included assessing the knowledge of staff in orthopaedic wards using questionnaires.	Key Findings/Learning Educating multi-disciplinary staff as well as using a check list/pathway would improve the diagnosis and management of delirium on the orthopaedic wards. Actions • A delirium pathway/check list was introduced and the multidisciplinary team were educated in its use. • Information has been provided to patients and relatives via leaflets and posters on wards. • Re-Audit planned for 2018.
Oesophageal Stenting (OS) in Benign and Malignant Disease Audit Definition The aim was to audit the practice of oesophageal stenting in the trust by looking at the appropriateness of the selection of patients, type of stent used, procedure-related immediate complications, 30-day mortality and long term outcomes of patients undergoing stent insertion.	Key Findings/Learning Overall rate of major complications associated with OS in the Trust is low and is well within the national and international standards. Success rate of stenting was 98%. The 30-day mortality especially in patients with repeat stenting was 28% (although within published best practice standards). The majority (63%) of patients with 30-day mortality were elderly and had metastatic cancer. Although this audit was the first of its kind for OS in the Trust, the number of patients in the audit was relatively small and the values/percentages of the outcomes may not reflect the real picture. A re-audit with larger number of patients/procedures should provide more statistically significant data.

Report	Findings, Our Learning, & Our Actions
	Actions • Formulation of local trust guidelines for Oesophageal Stenting in progress. • Data regarding patients with OS and their outcomes was made available for regular review by endoscopists. • Re-audit in 2 years is planned with larger numbers.
Use of non-invasive Computerised Tomography (CT) Coronary Angiograms to identify coronary artery disease (CAD) - re-audit. Audit Definition To assess the adherence to NICE (National Institute of Clinical Excellence) guidelines on the use of CT coronary angiogram, following the implementation of actions to improve practice since the previous audit.	Key Findings/Learning • The Trust was found to be 97% compliant with NICE guidelines. • There was an 88% improvement in the appropriate request for the test which increased the total numbers of scans performed to almost double the year before. • The Trust is performing far more CT angiography than other centres locally. Actions • To continue streamlining and improving the requests for CT Coronary Angiograms. • Re audit was scheduled for 1 year to re-assess the compliance with the new NICE guidelines. • A patient satisfaction survey of the one stop service, led by the Radiology/Cardiology department was proposed to ensure high levels of patient satisfaction. • Re audit planned.
Intravenous (IV) fluid therapy in older adults in Hospital (re-audit) Audit Definition The aim of the audit was to discover if intravenous fluids are prescribed and monitored in accordance with NICE guidelines. The audit also examined whether the actions implemented following the previous audit been effective in improving patient care, in line with standards.	Key Findings/Learning • An IV fluid stamp for the notes, when used was found to increase appropriate fluid prescribing. • Overall, standards were not being completely met with regards daily monitoring of fluid balance (65% average) and twice weekly weight. • Patients were often not given the recommended treatment which could be because doctors had not been given the right information on how to prescribe IV fluids in accordance with NICE guidelines. Actions • A checklist was created to ensure a robust handover for junior doctors. • They continue to use the IV fluid stamp and its use has been extended. • Ongoing training is now delivered to medical/ nursing staff.
Average waiting time for a cardiology bed for emergency admissions Audit Definition To highlight the number of emergency cardiology admissions and the average length of wait for an inpatient cardiology bed for a specific cohort of patients broken down by gender and month.	Key Findings/Learning Male cardiology patients at Sandwell Hospital were found to have slightly longer waiting times for inpatient beds than female patients. On average over the period audited 89% of female patients were transferred within 48 hours, compared to 85% of male patients within the same time period.

It was expected that this audit would highlight a difference in length of wait for a cardiology bed based on gender, and consequently a difference in length of hospital stay.	Actions • Action was taken to reduce waiting times for cardiology beds for male patients to equal that of female patients. • Patients reviewed daily cross site and prioritised according to clinical need and wait time. • The team initiated more effective triaging and prioritisation of patients e.g. 'flexing' beds and use of the cardiology day case unit in order to reduce waiting times for investigations. There is still a higher demand for male capacity.
8-day re-admission following endoscopy (re-audit) Audit Definition To compare 8-day readmission rates following endoscopy to national guidelines and compare the results to the 2016 audit data.	Key Findings/Learning During the audit period there were 21 readmissions, 0 requiring laparotomy. Three possible complications related to procedure; • 1 x post procedure bleed. • 2 x post procedure infection. • The readmission complications were comparable to previous years. Actions No specific action required to improve practice, as guidance met. Current practice continued. Re audit planned.
Assessing Oxygen Prescription for Inpatients Audit Definition The aim of the audit was to assess oxygen prescription in the trust against national standards (British Thoracic Society 2008). The audit specifically asked: • Have all patients on oxygen on the ward (except for emergencies) had a valid prescription for oxygen? • Do all prescriptions contain target saturations? • Has oxygen been signed for on the drug chart? • Is the oxygen delivery appropriate for the target saturations?	Key Findings/Learning • British Thoracic Society guidelines recommend 100% of patients receiving oxygen should have a prescription except in emergencies. • The audit identified that 55% of patient records complied with this. • All drug charts with a prescription for oxygen had the target saturations documented on the drug chart. • 50% of prescriptions had been signed; however, oxygen was given despite a lack of a signature on the drug chart. • All patients with target saturations documented had appropriate methods of oxygen delivery. Actions The variation in prescribing practice was addressed. • Doctors and nursing staff were educated by means of tutorials and teaching sessions to highlight the importance of oxygen prescription and signing of oxygen. • Plans were made to explore further whether the trust drug chart could be amended to include a box for target oxygen saturations and place more emphasis surrounding oxygen prescription. • Re audit planned.

Report	Findings, Our Learning, & Our Actions
Assessing if all patients on Priory 5 are receiving Venous Thromboembolism (VTE) prophylaxis in line with NICE guidance Audit Definition The audit was undertaken to assess compliance in prescribing VTE prophylaxis. The audit also aimed to determine whether these standards were being adhered to, and implement changes to address them if necessary.	Key Findings/Learning • Not all patients had VTE prophylaxis prescribed. • Only a third of patients had a reason for not prescribing documented. • Patients were not always reassessed. • Not all doses of anti-coagulants were given and reasons not always documented. • Anti-Embolism stockings were not generally prescribed or used as recommended. Actions Training and communication was delivered to nursing and medical staff on the ward in order to ensure that all the issues identified from the audit were addressed and that practice on the ward was improved. Re-Audit scheduled for March 2018 to determine improved compliance with standards.
Contrast induced Nephropathy (CIN) in patients with renal impairment, undergoing elective Coronary Angiography (re-audit). Audit Definition The purpose of the audit was to determine the number of selected patients who had received post-procedural advice regarding omitting nephrotoxic medication given and had post-procedure repeat creatinine levels.	Key Findings/Learning Patients were not always being adequately monitored for contrast induced nephropathy and pre/post-hydration was not routinely being carried out. The majority of patients had not had repeat creatinine levels taken after 72 hours. This re audit data demonstrated a lack of compliance with the trust's CIN prevention guidelines. Actions The Cardiology Team discussed the findings at the monthly Quality Improvement meeting and decided that current guidelines have been updated. The Multi-Disciplinary Team developed new post procedure guidance. New Electronic Patient Recording system is being developed and any options to optimise the Coronary angiography requesting system will be implemented to improve patient outcomes.
Establishing if inpatients are receiving Smoking Cessation advice Audit Definition To identify if patients who smoke are being given advice and information on smoking cessation. • To identify if smoking status is documented on admission. • To improve the proportion of patients who stop smoking. • To review clerking documentation, identify if patients have smoking status recorded and if smokers, has smoking cessation advice been given in initial plan.	Key Findings/Learning Smoking status was not being documented or acted upon as frequently as it should be. Actions • Auditors discussed with the informatics department the ability to automate the prescription of nicotine replacement therapy to all in-patient smokers. • It was also investigated whether the inclusion of a tick box on discharge summaries could be included to prompt referral to smoking services. • Tutorials were organised for ward staff on the importance of capturing smoking status, and the variety of smoking cessation services and products available. • A member of ward staff was nominated to initiate prescription of nicotine replacement therapy/ discuss available services with patients (smoking cessation champions). • Re audit planned.

Report	Findings, Our Learning, & Our Actions
Assessing if standards are met in Upper GI endoscopy procedures Audit Definition Standards are defined by the British Society of Gastroenterology in their document 'Quality and Safety Indicators for Endoscopy'. The audit measured whether these standards are adhered to and whether compliance was improved from a previous audit, plus identified further areas for improvement.	Key Findings/Learning • The usage of sedation was appropriate and met the target standard. • The rate of successful intubation was just below the standard although very good (91%). • The rate of incomplete endoscopies was high (46%) and below the standard. This may reflect a caseload of difficult/complex cases. An incomplete procedure is not necessarily a failed one (i.e. the information required may have been obtained). Actions • Results were highlighted to endoscopists and they were instructed to document any reasons for incomplete procedures to validate the high rate of failures observed. • Those not meeting the current standard were informed and factors identified (e.g. difficult cases). • Findings were shared at departmental meetings and re audit planned.
Quality Improvement Project: Management of Decompensated Liver Disease in Acute and Ward Settings Audit Definition To audit the performance of the Trust prospectively for the management of decompensated liver disease in the acute and ward setting according to the Decompensated Cirrhosis Care. Bundle and the Local Trust Bundle. The audit assessed the effectiveness of the appropriate management steps undertaken and completion of the Bundle.	Key Findings/Learning It was found that there had been an increase of bundle implementation from 2.9% to 50% of patients. Overall increase of investigation requests from 69% to 78%. There was an increase in plans made from 59% to 90%. No inappropriate use of bundle or excessive investigations for patients were found. Actions • Further education was implemented for all professionals involved in patient care on a four monthly rolling basis. • It was concluded that the bundles have started to make significant changes in working practices. • A larger re audit was planned.
Serial monitoring of left ventricular ejection fraction (LVEF) in patients with haematological malignancies receiving anthracycline-based chemotherapy Audit Definition The aim of the audit was to assess the management of patients receiving anthracycline based chemotherapy with regards to their cardiac function.	Key Findings/Learning The vast majority of patients (96.4%) had a baseline echocardiogram to assess LVEF prior to chemotherapy. However only 34.9% had imaging post-chemotherapy. The audit identified a significant lack of awareness on the monitoring strategies of patients receiving anthracycline-based chemotherapy. This possibly reflected the lack of local guidelines. Actions As a result an algorithm was designed and introduced to guide the management of these patients. This included ensuring a baseline echocardiogram was completed for all cases, plus a repeat echocardiogram for all patients post-chemotherapy.

Report	Findings, Our Learning, & Our Actions
Trust participation in the Regional Antineutrophil Cytoplasmic Autoantibodies (ANCA) Associated Vasculitis management (AAV) Audit Definition The audit was constructed to measure compliance against guidelines from the British Society of Rheumatology regarding management of the above set of rare medical conditions. Data collected included timing of and information given to patients around initial diagnosis, medications used in the treatment plan and information on relapse/remission.	Key Findings/Learning The data collection was part of a regional audit and for this reason the conclusions from the larger piece of work likely had more overall significance. Across the region: There was a low prevalence of structured recording of disease activity at diagnosis or subsequently (<10%), similar rates of remission at 6 months and survival at one year to other published studies. It was identified that adherence to other safety standards for monitoring and prophylactic medication required actions implementing to improve care. Actions • Locally, a GP information letter for patients newly commenced on cyclophosphamide and rituximab was developed. • There were opportunities to improve care by updating the standard operating protocol for cyclophosphamide administration. • The findings were presented and discussed at a Quality Improvement meeting.
Assessing Incomplete excisions of Basal Cell Carcinoma (BCC) Audit Definition As a result of the previous re-audit on completeness and margins of BCC excision, one of the actions recommended at the Clinical Effectiveness Committee, was to audit Incomplete BCC excisions. This audit aimed to assure adherence to the guidelines for excision of BCCs	Key Findings/Learning Incomplete excision rate was in line with national guidelines. Incomplete BCC excisions can lead to further treatment and prolonged follow up. Recommendations were that; • High-risk patients should be identified based on recognised contributing factors. • Avoid more than one procedure for high risk patients. • Consider Mohs microscopic surgery in high risk patients. • Consider biopsy in high risk patients. Actions Findings were discussed in the consultants meeting, communicated to the team and actions implemented. .
Assessing possibility of investigating Clinically Suspected Basal Cell Carcinomas (BCC) in the 2-week-wait skin cancer pathway Audit Definition To compare the Trust standard of assessing and investigating suspected Basal Cell Carcinomas (BCC) and Squamous Cell Carcinomas (SCC) on the appropriate pathway as compared to British Association of Dermatologists guidelines and NICE (National Institute of Clinical Excellence) guidelines, through a retrospective review of case notes/letters, biopsy request forms and histology results	Key Findings/Learning Current practice is that all Basal Cell Carcinomas are biopsied on 2 week wait pathway. From reviewing patients seen over a one year period, 15 of 417 clinically suspected BCCs (0.04%) were diagnosed as SCC. This demonstrates a high visual diagnostic accuracy by clinicians. Actions Patients with suspected BCC should be investigated (biopsied) and treated routinely not on the 2 week wait pathway. This is because the numbers investigated urgently are potentially having an impact on the more urgent cases awaiting surgical assessment (i.e. SCC and malignant melanoma). This was discussed, reviewed and implemented at the Dermatology Performance review August 2017.

Report	Findings, Our Learning, & Our Actions
Appropriate onward referral to skin oncology services, from community extended minor surgery clinic Audit Definition The audit was performed to ascertain if a private community extended minor surgery clinic (Health Harmonie) commissioned by the Sandwell and West Birmingham Clinical Commissioning Group to surgically remove benign lesions were referring onwards to skin oncology services appropriately. Patients who need specialist diagnosis should be referred to a doctor trained to diagnose skin cancer as per NICE guidelines [CSG8].	Key Findings/Learning • None of the doctors performing the procedures had been trained to diagnose skin cancer and general surgeons were performing the surgery. • Lesions had been excised that shouldn't have been. • Follow up was inadequate in 27% of cases. • Surgery clearly should not have taken place in 36% of cases and patients should have been referred to secondary care using the 2-week wait proforma from the outset. Actions Escalated matter to British Association of Dermatologists Clinical Standards Agency by Mr. Nicholas White, Chair NHS England Skin Cancer Clinical Reference Group.
Antibiotic Prescribing in ITU (Intensive Therapy Unit) Audit Definition Antibiotic prescriptions are common on ITU. Guidelines from the microbiology department insist having an indication and duration for each antibiotic prescribed. This helps to limit unnecessary antibiotic use, which in turn helps reduce resistance. The aim of the audit was to investigate whether microbiology guidelines were being adhered to on ITU.	Key Findings/Learning Antibiotic prescribing on intensive care did not fully meet the microbiology recommended standard, despite several senior clinician led ward rounds every day. The recommendations were to review all drugs charts on ward rounds, modify drugs charts and raise awareness on the importance of documentation in antibiotic prescribing. Actions Education was arranged on the importance of drug chart reviews on ward rounds and also on the importance of documentation in antibiotic prescribing. Modification of drug charts is being considered trust-wide.
Enhanced Recovery Following Elective Lower Limb Arthroplasty Audit Definition To assess the current practice of enhanced recovery following elective lower limb arthroplasty. Determine causes for delayed mobility in joint replacement patients - i.e. whether it is related to anaesthetic doses, medications, surgical technique or other causes.	Key Findings/Learning The main reason for delayed mobilisation was hypotension and dizziness. Multiple factors were identified in contributing to this: Failure to provide IV fluid bolus in ward prior to mobilization, possible dehydration and potentially inappropriate spinal doses. Actions Education was provided to anaesthetics and ward staff regarding fluids and hydration. Education to anaesthetics also delivered regarding appropriate does of spinal anaesthetic. The audit was presented in the departmental meeting and prioritised with action points at the monthly Quality Improvement meeting.
Neurophysiological and Computer Tomography (CT) assessment of hypoxic brain injury after cardiac arrest. An audit of compliance with local guidelines. Audit Definition Local guidelines for post cardiac arrest care suggest CT and neurophysiological investigations at defined times in the patients stay. Anecdotally compliance with this part of the pathway is variable.	Key Findings/Learning • No inappropriate prognostication. • Outcomes from cardiac arrest are better than the national average. • The Cardiac Arrest proforma was recommended to be changed to emphasise the timing of CT scanning. Actions The cardiac arrest proforma was updated to reflect new guidance on timing of CT scan and consequently assist in improving clinical outcomes.

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Appropriateness of referrals from Incidental breast lesions detected with computerised tomography (CT) scans Audit Definition Assess outcomes of breast lesions detected on CT, which are usually incidental or when looking for a primary malignancy. Determine if unnecessary workload is being generated for the one stop breast clinic. Inform radiologists of findings and provide education of any CT characteristics that help differentiate benign from malignant disease, using examples from the audit.	Key Findings/Learning 33% of patients referred for assessment at breast clinic for an incidental breast lesion were found to have malignancy. This is comparable to a previously published study (2010 Moyle et al.) By presenting this audit data and the educational presentation to the reporting radiologists, the aim was to reduce the amount of unnecessary over-investigation that patients may go through when an incidental breast lesion is seen on CT scan. Actions Findings were presented at the Imaging QIHD. The breast referrals generated from CT scans are now monitored on an ongoing basis.
Assessing knowledge around identification and treatment of anaphylaxis from intravascular contrast, among staff members in radiology Audit Definition To assess the knowledge and response of staff members in the radiology department in relation to possible anaphylactic reactions. The audit sought to ensure that recommendations and guidance produced by the Royal College of Radiologists (RCR) was being followed.	Key Findings/Learning • 100% of staff were able to recognise the signs of anaphylaxis reaction and locate the anaphylaxis kit. • Less than 100% were aware of how to request urgent help/assistance or where documentation of a contrast reaction is required to be inputted. Actions • Based on the findings signs and posters in several locations were introduced, clearly stating the location of the anaphylaxis kit. • Information was cascaded explaining where to document potential/actual contrast reactions. • A learning session re contract anaphylaxis was delivered and information included in the registrar induction pack. • Further ongoing education continues.
Audit of NICE Guidance - Head injury in children (CG176) and computerised tomography (CT) scan indications Audit Definition The objective of the audit was to discover whether all children presenting with head injury have a CT scan in accordance with NICE guidelines, Royal college of Radiology and Trust head injury proforma. Also to discover how many CT scans were positive for intracranial injury and whether the children were referred onwards for subsequent management.	Key Findings/Learning • CT scanning for head injury in children was being requested outside of the guidelines in some instances. • Vomiting was inconsistently used as an indication for CT scanning. Actions • A Paediatric Head Injury proforma was introduced which included improved observation documentation to prevent unnecessary scanning. • Further education for medical staff regarding CT scan guidelines and indications in children was provided. • The findings were presented at the monthly Quality Improvement meeting. • Re-audit planned.

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Metastatic Spinal Cord Compression (MSCC) - Investigation and Management Audit Audit Definition The objective of the audit was to assess if all MSCC patients were receiving dexamethasone and also a magnetic resonance image of their spine within 24 hours of presentation as per local standards.	Key Findings/Learning • The audit demonstrated that the department was not yet completely compliant with current standards. • Compliance with referral for consideration of treatment was possible, but referral for surgical intervention could take longer than desirable. • The data gathered was unlikely to represent overall compliance due to sampling difficulties. Actions • Ongoing education in department (delivered as part of internal teaching program, already delivered once this year). • Data being better gathered the oncology service, therefore no re-audit required. • A yearly data share with Acute Medicine was arranged.
The use of urine cytology in the diagnosis of patients with suspected urothelial malignancy Audit Definition The audit was undertaken to identify the necessity of urine cytology in the diagnosis of urothelial malignancy. The audit will identify the number of patients that returned positive test results for urine cytology, and were then confirmed to have a diagnosis of urothelial malignancy, which would not have otherwise been detected.	Key Findings/Learning Urine cytology was not found to be a positive clinical test in haematuria evaluation. Actions The Department continued to follow the NICE (National Institute for Clinical Guidelines) pathway.
Use of preoperative magnetic resonance imaging (MRI) in breast cancer surgery Audit Definition In undertaking the audit current adherence of the to 'quality statement 2' within the new NICE (National Institute for Clinical Guidelines) breast cancer quality standard. This involved retrospectively measuring whether correctly indicated patients received a pre-operative MRI scan over the period of a year.	Key Findings/Learning Excellent adherence to national guidelines was found. Actions Continue clinical practice.
Weekend plan re-audit: completion of weekend summary sheets for general surgery in-patients Audit Definition To determine whether weekend summary sheets have been completed for each general surgery in-patient. To assess whether the weekend handover meeting has led to increased compliance in filling out the weekend summary sheets in comparison to the previous audit.	Key Findings/Learning • This audit found 78% of weekend summaries included date of discharge, compared to 7% in the original audit. • 70% of summaries contained whether the patient required venous thromboembolitic prophylaxis on discharge, as opposed to a previous figure of 21%. • On the original weekend handover form there was no space to write the resuscitation status of the patient. Following introduction of a box to document it was completed in 82% of cases. • This improved compliance is likely to reflect a greater awareness of the importance of handover, and a greater understanding of the pertinent issues to hand over to the on-call team following the introduction of the weekend handover.

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	Actions • To include a not applicable section for 'Operation' on the weekend summary sheet - this allows the weekend team to easily see if a patient has had an operation or not. • Designated times introduced on Fridays to complete weekend handover sheets.
What are the ways to improve the prostate target biopsy outcomes? Audit Definition The audit was designed to examine the role that targeted prostate biopsy has in diagnosing patients. By assessing targeted biopsy as a diagnostic tool in diagnosing prostate cancer its usefulness and efficacy can be assessed.	Key Findings/Learning • Targeted biopsies are complemented by magnetic resonance imaging (MRI). • There was an improved diagnosis of patients with increased prostate specific antigen (PSA). Advances in MRI technique and reporting will improve the targeted biopsies outcome further. Actions Radiology team to attend regular training and education meetings to improve the reporting on biopsies.
Perioperative intravenous fluid therapy in gynaecological oncology Audit Definition To assess concordance of fluid therapy with NICE guideline CG174 and to ensure that implemented changes have taken effect.	Key Findings/Learning • IV fluid prescriptions are consistently complete, including rate, volume and type of fluid to be administered. • Only a minority of patients had a comprehensive fluid management for the next 24 hours. • Patients requiring routine maintenance were typically prescribed too much fluid, no glucose, and insufficient potassium to meet daily requirements. Actions Junior doctors on the team completed the 'SCRIPT' module relating to intravenous fluid therapy. (Compulsory during their FY1 year). Findings were communicated to medical staff responsible for day to day patient care on the gynaecological oncology surgery team.
Social Factors and non-attendance at colposcopy Audit Definition To evaluate the demographics of patients who do not attend for colposcopic assessment after being referred either from general practice or the cervical screening service.	Key Findings/Learning • Although the 'did not attend' (DNA) rate for follow up patients was higher than the recommended default, overall there was some improvement in the last quarter. • Appropriate contact was being made by the department with 100% of DNAs, and safety netting was in place with the arrangement of repeat appointments or discharge to GP as needed. • No other social factors regarding patient background and non-attendance were identified. In all relevant cases an interpreter was utilised. Actions • A leaflet entitled "About Your Colposcopy" has been included with the appointment letter in order to fully inform all patients about the procedure.

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	• The department is continuing to collect data at post code level regarding social deprivation of patients. • A Colposcopy staff member contacts each follow up patient prior to appointment and patients also receive a text message reminder.
Investigation audit to determine outcomes for patients in Primary care with suspected deep vein thrombosis (DVT) Audit Definition The audit was carried out to establish baseline data as information held was minimal. Data was collected and measured against NICE guidelines.	Key Findings/Learning • 96% of patients with suspected DVT had all diagnostic investigations completed within 24 hours of the first clinical suspicion. • First scans were well organised and completed in timeframes. • In 58% of cases patients with a suspected DVT were offered an interim dose of anticoagulation therapy if diagnostic investigations were expected to take longer than 4 hours from the time of the first clinical suspicion. Actions The DVT pathway that had been in use was updated to reflect the 4 hour time scale for administering anticoagulation. This change will help to protect patients from the complications of a possible DVT and ensure that the unit works well within the guidelines.
Vessel preservation for cannula patients audit Audit Definition There have been no previous audits identifying the amount of times patients need to be cannulated. This audit was specifically targeted at identifying current cannulation practice and management trends through application of the audit tool and from analysis of the results.	Key Findings/Learning • 93% of patients had a cannula form documenting insertion according to SWBH guidelines. • 27% of patients were found to have had more than 2 attempts at cannulation by one practitioner. • The audit identified that there were some competence and confidence issues within the unit. Actions • To ensure patient experience was improved updates and training were provided to support competence and increase identification of visual veins. By providing extra training resources all staff within the unit are now competent to undertake cannulation. • An Accuvein Finder was purchased to assist with helping to locate hard to find veins.
Implementation of the feeding checklist Audit Definition To assess the implementation of documentation surrounding establishing breast milk expression and the transition to oral feeds and also the recording of donor milk use.	Key Findings/Learning There was an improvement in the use of the feeding checklist from 5% at pre-audit to 45%. However none of the checklists were fully completed, demonstrating the department required more education on the use of the checklist. Actions • It was decided to implement monthly teaching at in service study days and on the unit regarding use and importance of breast milk and expressing milk.

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	• The audit results were shared with all medical staff working within neonates. • Breast feeding logs were created and printed to be integrated into the unit. • Supplies of the checklist were made freely available and staff informed that they are required to put a copy in the admission box for each admission. • Monthly audits and weekly checks put in place to ensure an improvement in compliance.
Re-audit of swab counting practices after vaginal / caesarean section birth and perineal suturing in and outside theatre Audit Definition To measure the current practice within obstetrics in relation to the documentation of swab and instrument checks following the above.	Key Findings/Learning There was some inconsistency on the recording of the swab count for procedures outside theatre on the Badgernet system. Actions • To continue to measure the current practice within obstetrics in relation to the documentation of swab and instrument checks following vaginal birth including instrumental deliveries on both proformas and Badgernet. • All staff were instructed regarding the importance of following the guideline for swab counting practices to ensure these are undertaken and recorded correctly.
Audit of infants under 6 months with normal vitamin D levels Audit Definition To audit the reasons for vitamin D testing in infants with normal vitamin D levels. To discover the number of infants with large anterior fontanelle with normal vitamin D levels	Key Findings/Learning The audit was performed to look at the indications for vitamin D levels being tested as 53% of the infants with low vitamin D had their levels done due to a large anterior fontanelle. (83%) of patients had reasons for vitamin D testing (64% with clear reasons, 19% with other blood test but had risk factors for vitamin D deficiency) Actions Based on the audits of both low and normal vitamin D levels in infants less than 6 months there was a discussion at the monthly quality improvement meeting. The Obstetric team opted for 'selective screening' on high risk mothers for vitamin D deficiency. There was a discussion about considering universal screening but this would need trust approval for funding.
Are patients with dementia and their carers having their needs and preferences assessed and reviewed in line with NICE guidelines by therapists during their inpatient stay? Audit Definition Therapy input for patients with dementia on acute medical wards was be audited against the NICE (National Institute for Clinical Guidelines) quality standard 30: Dementia: Independence and well-being. Results were compared to those of the audit carried out in 2015 to determine whether any new interventions introduced within the therapy team have been effective in improving assessment and treatment for patients with dementia.	Key Findings/Learning Guidelines state that family and/or carers should be involved in decisions about patients care and kept informed, this was achieved 89% of cases. Significant improvements had been made in goal setting and discussions around discharge needs since the 2015 audit. This something done well within the team and in a timely manner. Actions • Complete social histories and initial assessments for all patients within 48 hours of admission. • Complete cognitive assessments. • Refer to activity coordinator where appropriate.

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	• Always consider engaging community services. • Attempt to engage in meaningful activity. • Re Audit planned 2019.
Outcomes of two week wait urology cancer pathway referrals and ways to improve it Audit Definition To evaluate the effectiveness of two week cancer pathway referrals and formulate ways to improve.	Key Findings/Learning The unit was 91% compliant with two week wait pathways which is slightly above the national average. Actions To further improve patient care the unit will follow more recent 2015 NICE guidelines on cancer referrals.
Procedural sedation in Adults (re-audit) Audit Definition This audit was performed following low compliance scores from the Royal College of Emergency Medicine (RCEM) procedural sedation national audit 2015/16. The audit also aimed to benchmark current performance in emergency departments against national clinical guidelines and identify areas in need of improvement.	Key Findings/Learning There was a significant Improvement in compliance with guidance on procedural sedation in emergency departments against guidelines and in comparison to the initial audit. The findings indicate that the majority of the standards regarding the actual process are being met to achieve safe practice and to minimise risk of unpredictable complications. Actions Lessons were communicated via departmental teaching and the introduction of a revised version of the sedation proforma. Re-audit to be arranged.
An audit of avoidable readmissions in Surgery Audit Definition The audit was undertaken to assess current practice and compliance with the discharge of patients from the surgical assessment unit (SAU). An audit of the coding of readmissions was also undertaken to investigate whether cases are planned or unplanned. The Trust Quality Plan document outlines the need for the reduction of emergency readmission rates of 2% by 2019.	Key Findings/Learning National guidance suggests a target unplanned readmission rate of under 6%. Within general surgery the audit found an unplanned readmission rate of 4.5% with a 3.4% rate of potentially preventable readmissions. This is well within national guidance provided coding is accurate. Improved early access to ultrasound imaging may allow more accurate and timely decision making in specific groups of patients and reduce readmissions in these groups. It was discovered that patients were often booked under the incorrect admission code on readmission. Actions SAU began to provide patients with ward contact details at discharge should they have questions or concerns that may be addressed without necessitating readmission to hospital. An SAU coding policy was agreed and implemented, it was estimated that this would reduce recorded readmissions by 52%.
An audit of completion of Walsall score assessment for patients on initial visit and addition to district nursing caseloads Audit Definition The audit was required to assess current practice and compliance with: • The completion and review of pressure score risk assessments. • Documentation of care plans and assessment for pressure relieving equipment to either reduce the	Key Findings/Learning In all table top reviews the Walsall score had been complete. At the time of the audit the set data fields on System 1 did not provide evidence of compliance with the auditable standards documented in the Trust Guidelines for the prevention and management of pressure ulcers. Documentation of assessments for pressure relieving equipment on System 1 was poor, possibly because it was not a mandatory field. Undertaking this audit demonstrated issues with data completeness/accuracy and highlighted a need to validate data.

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risk of pressure ulcer development or assist healing of an existing pressure ulcer. • Documentation of health education advice.	Actions • System 1 pressure ulcer data was added as a standing agenda item for monthly district nurse (DN) team leader meetings. • The Palliative • Care team were educated to complete Walsall Risk assessments. • A roll out of mobile working devices for DNs to enter Walsall scores in patient homes is underway. • Re audit planned.
Re-audit of thromboprophylaxis in obstetric patients Audit Definition The audits aims were to review the antenatal management of women with venous thromboembolism (VTE) and to compare the care to local and national guidelines.	Key Findings/Learning There was found to be some poor documentation by staff (both doctors and midwives). This led to ambiguity over patient's onward management plans and confusion about the treatment patients were receiving when reviewing the notes. Improved documentation by all staff would increase patients' safety on discharge and make handover of care smoother and safer. Actions Audit findings were presented to medical and nursing teams at a quality Improvement meeting in order to inform them of need for improvement. Re- Audit planned.
Management of babies under 6 months of age with low vitamin D levels Audit Definition To assess if the management of babies under 6 months old with low vitamin D levels are in line with trust, regional and national guidelines.	Key Findings/Learning Treatment of infants with low vitamin D levels needed to be improved as only 50% of deficient infants and 65% insufficient infants were treated appropriately as per the protocol. Actions To raise awareness within the neonatal and paediatric staff regarding management of infants and children with low vitamin D levels the trust protocol was circulated. Pending blood test results are put inserted into the jobs book/folder to be followed up to ensure these are not missed.
An Audit of Improvements to patient safety following surgical assessment unit (SAU) reconfiguration (surgery) Audit Definition The audit sought to discover whether reconfiguration of the SAU onto the Sandwell site had improved patient safety.	Key Findings/Learning The audit methodology could not determine conclusively the impact on patient safety. It established that further work was required to improve compliance with the timing of the required reviews. Actions • SAU operational policy was revised to inform on the requirements. • The clerking proforma was also reviewed and piloted to help reduce potential oversights. • An audit has been conducted to review the effectiveness of the pilot, the results are awaited.

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Are the results of screening for down's syndrome being communicated to mothers in the community setting? Audit Definition The audit was required to assess adherence to the current care pathway and to identifying if further action was required to improve compliance. The audit was also a recommendation from an external review and as a result of local screening incidents, where screening opportunities had been missed.	Key Findings/Learning • The data provided evidence of good compliance with the policy for antenatal screening tests and the management of results. • 99% of women were offered a test at booking. • 100% of the high risk results were reviewed and discussed with the women by the screening team within 1-2 days of receipt of result and offered an appropriate appointment to discuss their results. Actions • In order to improve evidence to demonstrate the information leaflet is provided to all women and discussed by community midwife. • Badgernet documentation was updated to evidence signposting to all methods of information sharing (I.e. Bounty app, patient portal, paper leaflets, etc.) • Audit results were shared across the Multi-Disciplinary Team. • Actions taken to monitor performance and target non-compliance to improve effective and responsive care. • Re-audit planned.
The management of patent ductus arteriosus (PDA) in preterm babies on the neonatal unit Audit Definition The audit aimed to retrospectively audit preterm babies born at less than 32 weeks gestation treated medically with Ibuprofen for PDA on the neonatal unit at City Hospital. The audit assessed if management adhered to the local PDA management guideline.	Key Findings/Learning The audit found that in comparison to the previous audit most standards were being fully met. There were some challenges with data collection. Actions Education and training given at the monthly quality improvement meeting regarding the use of the PDA guideline, management of PDA and the importance of monitoring ibuprofen treatment.
Diagnosis and management of iron deficiency anaemia in obstetric patients. Audit Definition The aim of the audit was to ensure compliance with national and (new) departmental guidelines on the diagnosis and management of iron anaemia in obstetric patients.	Key Findings/Learning Haemoglobin (Hb) was checked at booking and 28 weeks in over 95% of women. 100% of women who were iron deficient were commenced on Iron supplements. Specific areas that could be improved were: • Rechecking of Hb to ensure effectiveness of treatment • Some women requiring treatment had no documentation reflecting that. • Could do better at checking post-partum Hb in those with Hb <105. Actions • It was communicated to staff that they should provide anaemic pregnant women with blood test forms to enable rechecking of Hb two weeks from commencing iron supplementation. • Audit findings were disseminated and importance of following guidance emphasised. • Re audit planned.

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Audit for timing of the surgery for distal radius fracture Audit Definition To assess whether the measures put in place as part of the initial audit have improved surgery times for distal radius fractures. Earlier surgical intervention (within guidelines) is reported by NICE (National Institute of Clinical Guidance) to be associated with better results for patients.	Key Findings/Learning There had been significant improvement in reducing days till surgery since the initial audit. Increase in the 'patch + plan' lists had also helped reduce days to surgery time. The emergency department was found to be consistently referring all fractures appropriately which helped reduce delays. Actions Continue to educate emergency department colleagues on referring this type of fracture to on call Specialist Registrar. More planned lists (aka patch & plan) implemented to accommodate the increasing trauma load.
Clinical psychology input for newly diagnosed Type 1 diabetes patients Audit Definition This audit aimed to identify compliance from staff regarding this new pathway, to discover: • If newly diagnosed patients with diabetes are referred to the psychology service and the patient is seen whilst an in-patient on the ward. • If newly diagnosed patients are seen as an outpatient 3 months later to complete a full psychological assessment.	Key Findings/Learning The results from the audit highlighted the need to design a clearer, more formal referral pathway. This would involve a more streamlined approach to ensuring that patients receive the Psychologist support appropriately, plus a 3 month follow up appointment in children's outpatients. Actions • Meeting held with ward managers to feedback the need for ward staff to inform the clinical psychologist of a new admission of a patient with diabetes by e-mail and phone. • Audit feedback was presented the diabetes team meeting and the quality Improvement meeting. • Re audit required.
Therapeutic drug monitoring of vancomycin (Re audit) Audit Definition The audit was proposed to measure the level of adherence to local antimicrobial guidelines when prescribing, administering and monitoring vancomycin. The audit also assessed the length of time for a vancomycin level result to be made available to the clinical team after taking the sample.	Key Findings/Learning The audit found that the clinical team were almost at the standard for documenting weight, indication in the notes and adjustment based on levels. The results were below 50% for documenting duration/review and taking appropriate pre-dose levels. Vancomycin levels were available within 1 hour of the lab receiving it in 68% of cases. The audit results indicated that some patients were not receiving optimal treatment because they were on occasion not receiving the adequate amount of vancomycin to help treat their infections. Actions • Laboratory staff were communicated with to prioritise returning blood level results to ensure doses were not missed as a consequence. • Education was provided to all staff to increase awareness of the risks and benefits of vancomycin prescribing, and signposted to the online guidelines available. • Re audit planned.
Pre-operative assessment of cataract surgery at the Birmingham Midland Eye Centre compared to Royal College of Ophthalmology (RCO) guidelines Audit Definition The audit aimed to compare the current practice of pre-operative assessment of cataract surgery under local	Key Findings/Learning Five of the domains assessed achieved 100% compliance and no other domain was below 85%. Actions • The audit leads presented the data at quality improvement meetings.

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anaesthetic to guidelines set out by the RCO.	• Posters were placed in pre-operative assessment rooms highlighting the key features of national guidelines to further enhance compliance and improve patient experience. • Re audit planned.
The use of intracameral cefuroxime in penicillin allergic patients during cataract surgery. How safe is it? Audit Definition The audit examined the number of patients who had reported allergic reactions to penicillin and the rates of cross-reactivity when using intracameral cefuroxime. Using this antibiotic during cataract surgery can be proven to significantly reduce the risk of postoperative infection..	Key Findings/Learning This audit found that intra-cameral cefuroxime is safe to use in patients who are penicillin allergic with the exception of anaphylactic reaction. Actions Intra-cameral cefuroxime is recommended during cataract surgery in patients who are penicillin allergic with the exception of those patients with a previous anaphylactic reaction
Are we managing patients undergoing retinal detachment surgery appropriately? Audit Definition The audit was required to assess current practice and demonstrate that the eye centre was meeting nationally published standards in retinal detachment rates, guide practice and also fulfil future requirements to publish Trust surgical outcomes data.	Key Findings/Learning The audit discovered that the eye centre was meeting the target window for urgent surgery; therefore there was no compromising of patient safety. To record contemporaneously whether cases are macula-on or macula-off cases in co-ordinators and emergency log. To start the 24 hour countdown from time of decision to operate made by the surgeon in the eye centre. Actions To further improve patient care all cases of retinal detachment to be recorded on appropriate database (Medisoft). For re audit.
24-months outcomes of fluocinalone acetonide intravitreal implant (ILUVIEN) in the treatment of chronic diabetic macular oedema (DMO) Audit Definition The objectives were to determine visual and anatomical outcomes of chronic DMO treated with Iluvien at 24-months and to assess the safety of ILUVIEN in the treatment of chronic DMO.	Key Findings/Learning Favourable visual and anatomical improvements were achieved by a single Iluvien implant injection, maintaining stable/improved vision in 68% of cases. Actions To continue using Iluvien in the treatment of chronic DMO.
Comparing the length of time from cataract surgery to YAG laser posterior capsulotomy for two different intraocular lens (IOL) implants Audit Definition To identify whether there was a difference in the time taken to develop symptomatic posterior capsule opacification (PCO) requiring YAG laser capsulotomy between two groups of patients with different IOL implants.	Key Findings/Learning green The Rayner C-flex IOL has a lower incidence of posterior capsule opacification, but the time interval to develop symptomatic PCO needing YAG laser is longer with Lenstec Softec IOL. Actions Continue the current practice of using both types of lenses.

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Quality Improvement Plan - Pattern of paediatric attendance in Birmingham and Midland Eye Centre A&E Audit Definition Ascertain range of clinical problems, children present with to Eye A&E and outcomes with a view to developing a specific clinical guidance for assessing paediatric patients.	Key Findings/Learning • The majority of cases were self-limiting and could be discharged. • The quality of documentation was variable. • There was found to be a wide variety of ages and of diagnoses. Actions • Education and training was delivered to all the registrars prior to seeing paediatric patients. • Repeat audit planned with a bigger sample size.
Evaluation and reducing medication errors in paediatrics "A multidisciplinary approach" Re-audit Audit Definition To determine whether current inpatient prescriptions on drug charts adhere to best practice recommendations as set out in the British National Formulary for children	Key Findings/Learning green There was 90% adherence to the first 12 British National Formulary for Children (BNFC) standards. 58% of 'out of medication' errors were due to prescription errors and 37% were due to administration errors. Actions • 12 action plans were implemented such as, " Do Not Disturb" tabards worn by nurses during drug rounds, signing by two qualified nurses. • Root cause analysis of every medication error has helped to reduce medication errors. Any significant findings were discussed at the friday grand round. • A Consultant weekly spot check was also launched on the Paediatric wards.
Extended pharmacological Venous Thromboembolism (VTE) prophylaxis after major cancer surgery (Re-audit) Audit Definition To assess whether patients undergoing resection for colorectal malignancy are being prescribed extended VTE prophylaxis after surgery as per guidelines. Has practice improved, since previous audit in 2015.	Key Findings/Learning Extended VTE prophylaxis prescribing has improved. Guidelines were found to be not yet meeting 100% compliance. Actions • Stickers were placed on drug charts and pharmacy were made aware of their significance. • An email is now sent to incoming Junior doctors regarding the need for VTE prophylaxis in patients who have had surgery for colorectal cancer. • Posters were placed into the doctor's office at Sandwell Hospital again reinforcing the need for these patients to be prescribed extended VTE prophylaxis at discharge.
Length of stay of patients with ankle fractures and cost implication Audit Definition A retrospective audit of ankle fractures treated in Sandwell General Hospital and a review of the length of stay before treatment. The cost implications for the trust was examined and reviewed against national guidelines.	Key Findings/Learning • The number of bed days lost whilst waiting for surgery as per present system was found to be approximately 100 days. • Less than 20% of patients were operated on the next day. • 50% had their treatment in 4 days. This can lead to enormous pressure on beds especially in the current climate. Actions • A pathway was developed for the patients with

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	ankle fracture to be managed safely at home prior to the surgery. • An ankle 'patch and plan' list was initiated for stable ankle fractures where patients are discharged home with a specific day to come in for surgery as a day case. • Re audit planned.
Administration of nerve blocks for fractured neck of femur patients Audit Definition To identify the proportion of fractured neck of femur patients having nerve blocks on admission, in order to improve care for these patients.	Key Findings/Learning There was poor compliance of nerve block administration on diagnosis of neck of femur fractures. Actions • A teaching course was provided for clinicians on how to perform a nerve block. • An awareness poster regarding the importance of nerve blocks, and highlighting the need for medical and nursing teams to hand over the completion of a nerve block. • T&O medical and nursing staff to be made aware of the need to ask if nerve block performed. • Re audit required.
Accuracy of labelling of side for orthopaedic radiographs Audit Definition Wrong side surgery is a never event. Incorrectly labelled or unlabelled radiographs have the potential to lead to surgical mistakes if the wrong side is labelled prior to surgery as directed by radiographic studies. The aim of the audit was to determine if guidelines are being followed.	Key Findings/Learning • 100% of radiographs assessed had a label and laterality marker. • 7% of radiographs were incorrectly labelled and 11% did not have laterality markers on all views. • This was an improvement on the previous audit; however the gold standard was not achieved. Actions • Formal feedback was presented to the radiology lead. • Signposts were produced reminding radiographers to include laterality markers on every view and upload images separately.
Surgical pause audit (Trauma) Audit Definition To assess whether Surgical pause and imaging pause are being observed in trauma theatres for all cases as appropriate.	Key Findings/Learning 100% compliance with surgical pause and imaging pause was achieved in this audit. Actions To continue to follow the good practice. To take appropriate measures to avoid opening incorrect screw lengths, by using depth gazes and screws of the same manufacture.
Quality Improvement: Emergency admission in trauma & orthopaedics and the named consultant: A problem? Audit Definition It was been noted that on a regular basis, patients admitted as an emergency under the orthopaedic	Key Findings/Learning The wrong consultant was used in 31% of emergency admissions in the study period. It was thought possible that this may be due to patients being initially placed on electronic data systems for admission.

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team at the Trust are often admitted under the name of a consultant who is not on-call. This poses a risk to patient safety as it may result in patients not be reviewed, treated in good time or even reviewed by the appropriate clinician.	Actions • Results were fed back to the emergency department (ED) team; recommendations included ensuring that the correct, up to date information is regularly updated on RotaWatch. Plan put in place to ensure that the correct consultant information was displayed more prominently for staff to access. • Awareness raised within the administration teams and the surgical assessment unit regarding the importance of using the correct consultant. • For re auditing.
Retrospective audit of clavicle fracture fixation Audit Definition To asses a single surgeon's practice in relation to this surgery and outcomes.	Key Findings/Learning The audit showed a non-union rate of 7%, slightly above the rates in published literature, however it reflects on the small size of the group. There were no significant complications in this group and patients were discharged after clinical and radiological union. Actions To continue current practice, as open reduction and internal fixation, in displaced clavicle fractures, gives a good outcome.
Management of septic arthritis of the knee Audit Definition Aim to compare current management of septic arthritis of the knee against trust guidelines, for patients who underwent knee washout for septic arthritis of the knee.	Key Findings/Learning Recommendations for improvement: To send all knee aspirates in blood culture bottles and to test all for crystals, blood cultures, ESR and serum uric acid. (60%) To start IV antibiotic as soon as joint aspirated and blood cultures obtained. Actions • The results were communicated via the monthly quality improvement meeting an emailed to all registrars and new juniors when commencing their posts. • Teaching sessions also arranged for juniors on a rolling basis. • Re audit required.
Re - audit of the outcome of anterior cruciate ligament reconstruction done as day cases in surgical day unit Audit Definition To assess the improvement in discharge rate following ACL reconstruction following previous audit.	Key Findings/Learning 79% of patients achieved same day discharge. Following the previous audit these key recommendations were implemented; • Patients seen by physiotherapist pre-operatively and post-operative mobilisation and discharge plans explained. • If post-operative physiotherapy was not available was not available patients were mobilised by the nursing staff who were trained by the physiotherapists. • Patients discharged without a post-operative plan were picked up by physiotherapy the next day.

Report	Findings, Our Learning, & Our Actions
	Actions • To continue implementing the changes to improve the discharge rates. • Ongoing education of the team and patients on a rolling programme.
Blood Transfusion rate after total knee replacement (TKR) Audit Definition To determine blood transfusion rate after TKR procedure.	Key Findings/Learning • There was a 3.8% incidence of blood transfusion and a 1.92% incidence of infection. • 79% of patients were discharged within 5 days post-operatively. • Blood transfusion rate in the study group was less than the published data. Actions The trusts incidence of blood transfusion at 3.8% is acceptable in comparison with the published standards. Continued education and training to maintain the pre-operative screening of the patients is required to maintain patient outcomes.

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