QUALITY
ACCOUNT 2018/19

LEARNING THROUGH BEING OPEN

Quality and Performance Analysis

Our Quality Account 2018/19

Welcome to our quality account for 2018/19. As with previous years, this account is published as part of the Trust's Annual Report and Accounts and reflects our performance in relation to quality, safety and patient care as well as looking to the future with our quality priorities for the year ahead.

In 2018/19 we embedded our safety plan within our patient services. The safety plan sets out core checks that are carried out with every patient within 24 hours of them receiving our care. Every morning our senior team check that these measures have been carried out and if not, have a system in place to ensure that all checks are completed within 48 hours of admission. These checks aim to give patients confidence in the care that we provide as well as improving the safety of our patients and provision of harm free care.

Our quality plan has had renewed emphasis this year under the leadership of the Trust's Medical Director, Dr David Carruthers. During the year we have focused on our quality plan's top priority – to reduce avoidable mortality – through our focus on sepsis screening with an increase in patients who are screened for sepsis and thereby followed through with appropriate sepsis care to save lives.

Quality performance has scrutiny through our executive-led Performance Management Committee, Executive Quality Committee, and the Board's Quality and Safety Committee, chaired by a non-executive director. This committee reports to the Trust Board on a monthly basis. Our integrated quality and performance report contains all of our key performance indicators and is reviewed by our Clinical Leadership Executive and executive committees as well as within the public Trust Board meetings.

The Care Quality Commission visited some of our services on September 2018 and, whilst the overall rating remains "requires improvement", distinct improvement was noted in some key areas including our critical care services and community inpatient facilities. We are committed to continuing to address the need for consistent standards across our adult acute services and emergency departments

and during the year we will make some changes to paediatric and neonatal care, providing more capacity for neonates and co-locating our paediatric assessment unit with the emergency department at City Hospital.

Ahead of our delayed move to the Midland Metropolitan Hospital we will also look to consolidate respiratory medicine onto a single site that will, in turn, provide greater medical input to our acute assessment units. Preparation for Midland Met will ensure we can provide seven day service compliance from 2020.

The year ahead will continue our focus on amenable mortality and sepsis management with quality improvement work within areas where there are higher than expected mortality rates. This will particularly focus on infection related deaths. The introduction of our new electronic patient record, Unity, will enable us to further improve quality and safety with routine acknowledgement of investigation reports and alerts for quality plan priority areas such as VTE assessments.

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

The Midland Metropolitan Hospital due to open in 2022.

Priorities for Improvement in 2019/20

Priority 1

Improving quality of care for patients by tackling sepsis more effectively and reducing amenable mortality in line with our long term Quality Plan.

Sepsis is an important cause of patient morbidity and mortality. We have much improved the recognition of deteriorating patients on our wards, indicated by a National Early Warning Score (NEWS) of greater than five, and we are now looking at the whole pathway of management of these patients. Over the coming year we will be focussing on ensuring that more patients who are identified with sepsis are treated in line with the 'Sepsis 6' bundle guidance where we will make sure they receive appropriate antibiotics and fluids within an hour of the assessment taking place.

Deteriorating patients who have high NEWS which is not due to sepsis also need appropriate management decisions made within an hour based on their underlying clinical diagnosis. Development of ward based programmes to monitor and feedback performance to allow quality improvement work to be identified will happen this year. This may be Trust-wide or ward specific.

In addition, over the last year we have increased our understanding of the effect that clinical coding, palliative care documentation and changes in patient pathways for acute admissions have on our mortality data. We are also aware of those clinical areas that have a higher than expected mortality and have analysed this data as part of the quality plan.

Over the coming year we will introduce changes to improve our clinical recording of data which will be supported by the introduction of our new electronic patient record system (Unity). The quality improvement work identified for those areas with a higher than expected mortality will commence this year with a major focus on infection related deaths. A task force to examine the management of pneumonia has been created to identify components of the patient pathway where improvements can be made.

Progress on this work will be reported and monitored through the Executive Quality Committee and the Quality and Safety Committee. We will also continue to prospectively monitor mortality data which may identify other areas for quality improvement work. This will be done through the Learning from Deaths Committee.

Priority 2

Ensuring safe and resilient systems of care through deploying better IT infrastructure, embedding Unity, and maintaining Safety Plan compliance.

Stabilisation of our IT infrastructure is essential for safe deployment of our single electronic patient record system (Unity). Significant work has been undertaken this year to prepare for this and our infrastructure has improved in readiness for this change. A comprehensive training programme is underway with all groups in the Trust now showing over 90 per cent of staff having received training on Unity.

Acknowledgement that results of investigation reports have been seen and acted on is an important part of clinical practice. In Unity there is a facility to ensure this practice is routine for safe and effective care. We are embedding the Unity model in our current working practice in readiness for the move to Unity with a focus on acknowledgement of radiology reports within existing IT systems and will continue with this over the coming months.

Unity will provide improved recording and alerts for routine safety and quality plan elements such as VTE and sepsis assessments, which will link into prompts to aid clinical teams with treatment decisions. Over the coming year we will use intelligent reporting from Unity to review the effectiveness of our care and compliance with our safety plan standards. Any areas of concern highlighted in these reports will be addressed with appropriate quality improvement initiatives.

Progress on this work will be reported and monitored through the Executive Quality Committee and the Quality and Safety Committee.

Priority 3

Supporting improved acute care by implementing strong people management improvements, addressing configuration issues in advance of Midland Met, and ensuring seven day service compliance from 2020.

The delay in completion of our new hospital, Midland Met to 2022 has required consideration of safe and effective service models that will be required in the interim period. These models of care will also need to map on to how clinical services will be delivered in the new hospital. This work will focus on acute care, particularly in adult and paediatric services.

Over the next year we will examine and instigate necessary change to support acute paediatric A&E and acute admission services on our City site. We will also look at how adult acute assessment teams/units can be supported by general medical specialist services. This will require change in how medical teams will work together now but will also reflect how our services will be delivered in Midland Met across a seven day working model.

Investing in addressing the management bandwidth issues faced by our organisation is a priority. Succession plans for key leaders are now in place, and moving forward a strong deputy director and group cadre of leaders will be supported to take on a more visible leadership role within the Trust.

Progress on this work will be reported and monitored through the Executive Quality Committee and the Quality and Safety Committee.

The Paediatric team get to grips with Unity. (Left to right) Jez Jones, Matron, Avnash Nanra, Ward Manager, Paediatrics Assessment Unit Cross-site, Linda Eyre, Operations Manager, Diane Moran, Ward Clerk, and Oneka Berry, Healthcare Assistant.

How we performed in 2018/19

Progress on 2018/19 Priorities
Priority 1 - Improved outcomes for patients presenting with signs and symptoms of sepsis.

Reporting of the number of patients screened for sepsis on our wards has improved significantly over the year and is regularly achieving compliance rates of over 90 per cent. Those patients with a high National Early Warning Score (NEWS) of greater than five need review for assessment for either sepsis management or review of their underlying medical condition that may be leading to the elevated warning score. Quality improvement work is underway to assess the actions that come from the elevated trigger score, with a particular focus on timeliness of giving antibiotics and appropriate application of intravenous fluids as part of the 'Sepsis 6' treatment bundle. Trust mortality data is closely monitored to identify changes in data associated with infection related deaths.

Administration of antibiotics in patients with suspected neutropenic sepsis (infection associated with low white cell count) continues to be monitored closely, identifying reasons for any delay in antibiotic provision. The data for 2018/19 shows that 84 per cent of patients receive antibiotics within one hour of arrival (range 72 per cent to 92 per cent) for an average of 40 patients presenting per month. Data analysis identifies that the delays are often of less than 10 minutes with the main factors being either in delay of prescription or administration of antibiotics.

Individual staff review occurs after all breaches with weekly reports to the relevant departments and involvement of the acute oncology team to identify areas for improvement.

Priority 2 - Achieving a good rating under the framework of the CQC assessment.

The inspection of some of the Trust's services took place during the period 4 September to 11 October last year which reveal the overall rating for the Trust remains the same at 'requires improvement'.

The Trust has committed to continuing to make improvements and has already made changes to ensure that patients receive high quality care across all parts of the organisation. As well as making recommendations, the CQC report notes a number of outstanding practices with the overall 'outstanding' rating for being caring.

In urgent and emergency care across both City and Sandwell hospitals, the services were rated as 'requires improvement' with an 'outstanding' rating for the critical care service.

Good practice that the inspectors singled out for praise included:

- The domestic violence advocacy service in our emergency department.
- An initiative to cut pressure sores that has been successful in winning local awards.
- Dedicated listening time for stroke rehabilitation relatives and patients.
- Conversation cards in the infant feeding team to provide vital information for new mums.

We are pleased that no safety concerns remain in our ratings table. Obviously our work to achieve a Trust-wide Good rating continues, and our community services for both children and adults reach that mark already. We know that for acute services we have more room for improvement.

Most pleasingly, we have maintained our Outstanding rating for Caring. This is a tribute to the hard work and compassion of our teams across the organisation. Since the CQC inspectors visited last year we have made a number of improvements including:

- A focus on recruitment to fill vacancies.
- New resuscitation trolleys that are more secure.
- Supporting all our staff to be compliant with mandatory training requirements.

We continue to make improvements in the services we provide to our patients and we will:

- Ensure that all our staff are fully aware of the requirements under the Mental Capacity Act.
- Continue to encourage an open culture so that all colleagues feel supported in raising any issues of concern through our many speak up routes.
- Focus on clear ways to share learning.
- Make sure that the way we understand and manage risks is well-understood in all services and departments.

Priority 3 - We will improve the consistency of care provided to patients while on our wards.

Having the right documentation completed at the right time and 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 are important to maintaining high quality care. We monitor the following information at our weekly consistency of care meetings which are chaired by the Director of Governance and attended by executive and group leaders.

For each ward five patient records per day are reviewed (35 per week) and compliance is recorded for those records reviewed.

Medicine 10 standards (15 wards)	Primary Care, Community and Therapies 12 standards (6 wards)
Patient medications are administered as prescribed	Recognition of patient deterioration
Patient medication omissions or delays are coded appropriately	Complete daily care round
Patient observations have been completed with the frequency clearly identified	Individual nutrition assessment
Patient observations have been escalated appropriately and in line with the Trust early warning triggers	Falls risk assessment and plan
Fluid balance chart is completed correctly, has no abbreviations and has the level of monitoring required clearly identified	PA Risk assessment and plan
Falls risk assessment is completed and care plan in place for those at risk	Considered Deprivation of Liberty
MUST (malnutrition universal screening tool) screening has been completed	Dementia/cognitive assessment
Waterlow risk assessment in place and care plan in place for those at risk	Individualised goal
Care rounding frequency has been completed with the frequency clearly identified on the daily care record and daily goals identified	Discharge plan
SAP1 form completed appropriately	Updated rehab goal
	Expected date of discharge
	Safety Plan submission/rolling compliance

Significant improvements have been seen over the past year in the documentation used to support patient care with most wards achieving 100 per cent compliance for their standards.

A regular ward-based team, particularly around senior decision makers supports the consistency of care model. This has been achieved with the new initiative of Consultant of the Week where individual consultants focus purely on leading patient management on the ward. This is done on a two-weekly rota basis within each specialty.

In addition to this changes have been made to junior staff working where junior doctors are rotated for a full six weeks to the acute medical unit wards which allows improved training and more consistent presence on the base wards giving improved consistency of care. All these changes provide closer cooperation with nursing and therapy teams to plan care more effectively, improving communication to patients and relatives and planning for timely discharge.

Safety Plan update

The Safety Plan was introduced in 2017 and consists of 10 evidence based clinical standards that have become a standard part of care in our Trust. By improving the safety culture, the care provided to patients is improved and the risk of harm reduced. In February this year we carried out an audit of the Safety Plan as part of the approved internal audit plan for 2018/19 to gain reassurance of the Safety Plan being embedded in clinical practice. Of the 10 standards the audit focussed on venous thromboembolism, Mental Capacity Act/deprivation of liberty safeguards, estimated discharge date, pressure ulcers/falls, sepsis and do not attempt cardiopulmonary resuscitation.

The internal audit opinion stated: "Taking account of the issues identified, the board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk".

The table below shows the main issues identified and the actions that will be taken to resolve.

Issue	Action
Inconsistencies in completion of the safety plan across the wards audited.	A standard operating procedure will be developed which provides guidance on the completion of the safety plan. This will include the initial assessment and following transfer to the specialty wards.
Discrepancies between the time patients are recorded on the electronic bed management system and actual transfer of the patient. The risk is that unless the time of transfer is in real time all time related actions will be incorrect.	
On some wards members of staff were unsure of when to complete certain parts of the plan.	New staff commencing in the Trust will be given training and refresher training will be reviewed depending on locality.

Quality Plan update

The Quality Plan, developed in January 2017 with the aim of improving health outcomes for our patients and in line with the 2020 vision, has had a focus this year on improving identification and management of sepsis and VTE and identifying amenable causes of mortality in stroke, myocardial ischaemia and fractured neck of femur.

Pathway review of all these areas has occurred with quality improvement work underway in each to improve not only prevention and identification but also management of the condition. Reporting of sepsis screening has improved to consistently achieving over 90 per cent of patients triggering with a high warning score of greater than five (NEWS) and quality improvement work is underway for management of these deteriorating patients, whether due to sepsis or other medical conditions.

After a dip earlier in the year, assessment of risk for venous thromboembolism (VTE) for admitted patients has improved to greater than 95 per cent with new work underway which is looking at decisions on prophylaxis and review of cases of hospital acquired VTE to identify avoidable causes of harm.

Cardiology and stroke have reviewed mortality data identifying the need for more regular review of mortality cases to try and improve care, with a focus in stroke on the whole care pathway. Orthopaedics have had a recent external review of their pathway and care of patients with fracture neck of femur with no major concerns identified but areas to look at for quality improvement.

The focus for 2019/20 is maintaining the progress in quality improvement in these areas while examining work already undertaken in the other components of the quality plan and building projects around the specific aims in most of these areas.

Care Quality Commission

The inspection of some of the Trust's services took place during the period 4 September to 11 October 2018 which reveal the overall rating for the Trust remains the same at 'requires improvement'.

The Trust has committed to continuing to make improvements and has already made changes to ensure that patients receive high quality care across all parts of the Trust. As well as making recommendations, the CQC report notes a number of outstanding practices with the overall 'outstanding' rating for being caring.

In urgent and emergency care across both City and Sandwell hospitals, the services were rated as 'requires improvement' with an 'outstanding' rating for the critical care service.

Since the CQC inspectors visited the Trust last year we have made a number of improvements and we will continue to work with the Care Quality Commission, and with our partners within the STP, to adopt best practice across our Trust.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement →←	Requires improvement →←	Good →←	Requires improvement →←	Requires improvement →←	Requires improvement →←
Community	Requires improvement →←	Good →←	Outstanding →←	Good →←	Outstanding ↑	Good →←
Overall trust	Requires improvement →←	Requires improvement →←	Outstanding →←	Requires improvement →←	Requires improvement ↓	Requires improvement →←

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 2018/19 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Patient John Walker with Sister Komal Bihola.

How we measure data quality

We review our performance against external frameworks (primarily the NHS TDA Accountability framework 2014/15, CQC and Monitor's published Quality Governance Framework) as well as internal targets on a broad range of indicators published in our Integrated Quality & 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 our group performance review programme. We also audit the quality of clinical care we provide against a number of national standards that are published by external organisations for example 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) and National Hip Fracture Database (NHFD).

Data quality improvement approach

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 Integrated Quality Performance Report (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. 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 2018 – January 2019 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 97.71 per cent for admitted patient care; 99.66 per cent for out-patient care; and 97.43 per cent for accident and emergency care.

- which included the patient's valid General Medical Practice Code was 100.0 per cent for admitted patientcare; 99.9 per cent for outpatient care; and 99.4 per cent for accident and emergency care.

Services provided/subcontracted

During 2018/19 we provided and/or subcontracted 43 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 Care Quality Commission (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 2018/19 represents 100 per cent of the total income generated from the provision of NHS services by Trust.

Commissioning for Quality and Innovation (CQUINs)

A proportion of SWBH income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between SWBH 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.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at www.swbh.nhs.uk/our-performance/.

Seven day hospital services

The seven day hospital services programme was developed to support acute providers to deliver high quality care and improve patient outcomes on a seven day basis for patients admitted to hospital as an emergency admission.

There are 10 standards. Four of these standards (shown below) are priority standards to ensure patients have access to consultant directed care, diagnostics and clinical interventions seven days a week:

Clinical Standard 2	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.
Clinical Standard 5	The availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales, which is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.
Clinical Standard 6	Timely 24-hour access seven days a week to nine consultant-directed interventions.
Clinical Standard 8	Ongoing consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment. The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition.

We are compliant with standards 5, 6 and 8 as assessed in the spring audit in 2018. We are not yet demonstrating compliance on the national survey for standard 2 where our spring 2017 survey results showed weekday compliance at 73 per cent and weekends at 85 per cent compliance. Our consultant rotas are compliant in adult services and need minor adjustment in paediatrics at the weekend. The acute medicine model is part of the quality sustainability work in transition to the new hospital.

The documentation standard of clinical notes does not always provide reliable evidence of who was on a ward round and the precise time of the note entry, which has been a challenge nationally. Local clinical audit has encouraged ownership of this issue and the Medical Director will be providing documentation guidance, which will require a minimum documentation standard to be practiced aligning other improvement projects in sepsis and clinical coding.

Other improvement approaches include pathway management and protocols for weekend review to be consistently established. The discharge project supporting the emergency department improvement through early discharge is enabling beds to be available throughout the day in assessment units and the day time emergency admission to be reviewed by consultants in the day time rather than wait over night for a consultant review. Although relatively early on in the improvement cycle it is anticipated this will make a positive improvement to this standard.

Speaking Up

We have a strong track record in encouraging people to Speak Up. There are a range of ways that colleagues can do this including talking to their manager, contacting a trade union representative, raising an incident, writing to our Heartbeat letters page, ringing Safecall which is our external confidential whistleblowing reporting line, or getting help from one of our Freedom to Speak Up Guardians (FTSU).

We held two Speak Up days in 2018/19 to remind everyone about the many different ways to raise concerns, to meet our Freedom to Speak Up Guardians and other leaders and discuss what was on their mind. Our theme for the September Speak Up Day was 'Simple things done well'. We had heard through previous Speak Up events and via other channels that there were sometimes issues that got in the way of being able to provide great care, or doing the job well. Colleagues were invited to vote for the top three things that would make a difference to them. The most votes went to more flexible working practices, improved car parking, better communication about change. A commitment to progress all three has been made as a direct result of staff speaking up and improvements are well under way.

In encouraging colleagues to raise their issues be it through our Speak Up events, posters, the CEO's Friday Message or the FTSU guardians, everyone is made aware that they will be praised for doing so and not disadvantaged.

Feedback is provided to colleagues who speak up but our processes are being strengthened next year to check that this happens consistently and well.

The ways to speak up already mentioned also apply if colleagues have concerns relating to patient safety or feel they are being bullied or harassed. Approaching your line manager or a senior manager is encouraged so that they can investigate the concerns and ensure the required action is taken. At any point someone who has such concerns can, if they wish, directly approach the chief executive or our designated non-executive director for such matters. Contact in this way is welcomed by them.

Rota gaps

In order to monitor our rota gaps we maintain a monthly record of current vacancies for both training and non-training grades. This is reviewed monthly and active measures are taken to try to recruit to all trainee vacancies. Junior Specialist Doctor (JSD) posts have been established since August 2017, and are used to replace gaps in our rotas and also create new posts where additional service needs have been identified. We currently have 49 of these posts.

In additional to conventional routes, we have used alternative methods for recruitment including using external companies where needs were high and undertaking skype interviews. We have been successful in recruiting new doctors to the UK and trainees wishing to do interim years, eg 'Foundation Year 3'. We have also increased the numbers of certificates of sponsorship through the Home Office and will have the annual allocation reviewed in April 2019.

Educational development in addition to NHS exposure has been valued by our doctors over the last 18 months with some continuing in post and others moving on to training positions within the NHS. Work is in place

to make Sandwell and West Birmingham NHS Trust a popular place to work and therefore aid recruitment with all posts being reviewed to see if other activities can be introduced in to their job specification eg teaching, again to make each post more attractive.

A clinical observership policy which formalises the process for overseas doctors to observe NHS practices within our Trust has recently been developed and it is hoped that this will encourage more overseas doctors to apply for appropriate vacant positions. We are also finalising a policy for associate specialist and Trust appointed doctors to ensure they receive appropriate support and assistance to develop their skills and knowledge and have the opportunity to undertake further professional development activities.

NHS Staff Surveys - Encouraging advocacy

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.

Every three months a quarter of the organisation are asked to feedback on our services via the NHS staff friends and family test and our 2018 results are shown below.

NHS Staff Surveys	2017	2018 Survey Results	
	SWBH 2017	SWBH 2018	National Average (Median score)
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	58.3%	60.2%	69.9%
Staff who would recommend our organisation as a place to work	49.4%	55.7%	61.1%

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.

This feedback is encouraging as we continue to implement our engagement strategy to ensure colleagues have an opportunity to feedback and raise concerns. Mechanisms such as organisation-wide Speak Up days allow colleagues to meet our Freedom to Speak Up Guardians and learn of ways they can raise a concern.

We have introduced a new quarterly weconnect survey which enables us to have a more in depth look at engagement within the organisation. The first survey was launched in November 2018 to a quarter of the organisation and saw response rates of over 30 per cent (higher than any other survey in recent years). Teams within the samples have now developed action plans from the findings.

As part of the weconnect engagement programme, 15 teams have been selected to be part of our pioneer engagement teams. This new programme is about supporting teams so that they can go from being good to being a great team. Teams will embark on a six month journey which will include dedicated support from specially trained colleagues to ensure they achieve their engagement goals. We also continue to raise awareness of our employee well-being and staff benefits offer.

It is hoped that these initiatives will have a continued positive impact on future NHS staff friends and family tests.

Data security and protection toolkit (DSPT) attainment levels

We are compliant across the majority of the Data Security and Protection Toolkit mandatory assertions

for 2018/19. Due to the addition of new requirements over and above those which were in the previous Information Governance Toolkit, large organisations have been allowed to submit an improvement plan where they have met the majority of assertions.

Scoring on the new Data Security and Protection Toolkit has changed. Scores are now based on whether the Trust has met all mandatory assertions or not. It is anticipated that some assertions which are currently non-mandatory will be upgraded to mandatory for next year's submission. We will continue to build on, and strengthen our IG practices and processes and work towards achieving full compliance against the current mandatory assertions by June 2019.

General Data Protection Regulation

The General Data Protection Regulation (GDPR), together with the Data Protection Act 2018 replaced the Data Protection Act (1998) on 25 May 2018.

Building on the activities previously undertaken to comply with the requirements of the Information Governance (IG) Toolkit, planned work is continuing, to ensure that GDPR and Data Protection Act 2018 obligations are fully understood, implemented and monitored across all personal data processing activities undertaken by the Trust. Particular focus is on ensuring that data protection obligations are fully considered from the start for all new, or changes to existing processing activities, the handling of children's personal data, strengthening the management of supplier compliance and the handling of data subjects' rights.
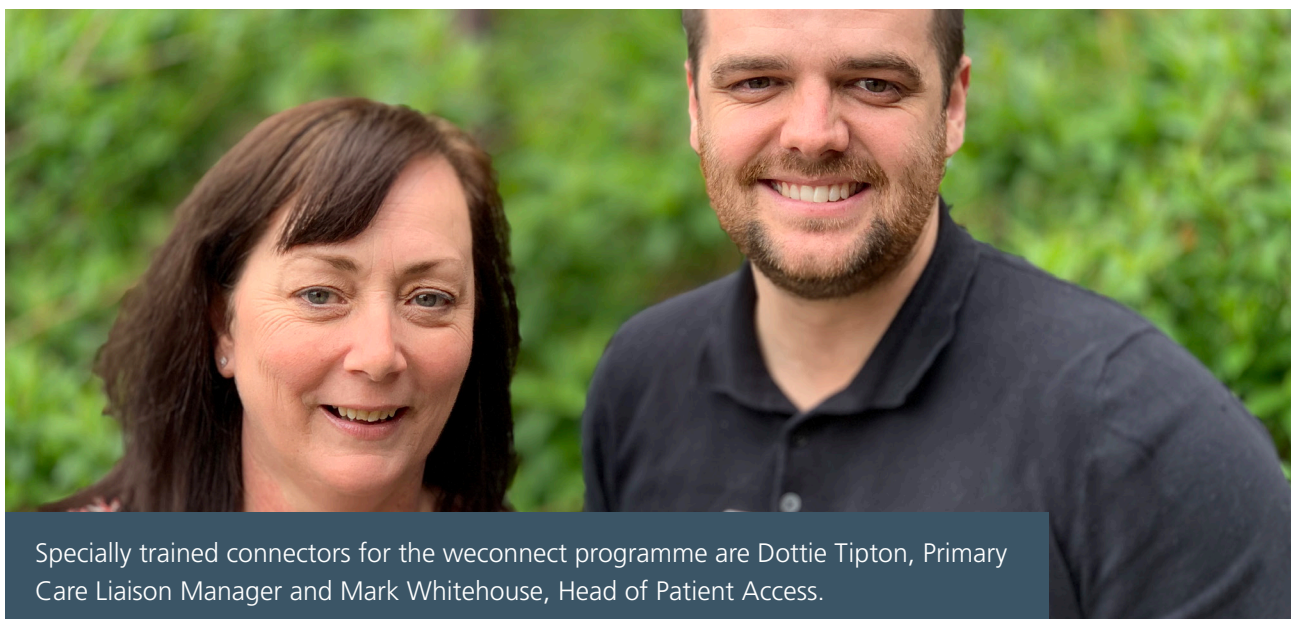
Specially trained connectors for the weconnect programme are Dottie Tipton, Primary Care Liaison Manager and Mark Whitehouse, Head of Patient Access.

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 that since the same period the year before, we have had a drop in incidents report per 1000 bed days. This may in part be due to a month's less data being sent to NRLS.

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	Per centage of incidents resulting in severe harm	Number of incidents resulting in death	Per centage of incidents resulting in death
2016/17	Apr 16 to Sept 16	44.48	73	22	8	0.2	1	0.0
	Oct 16 to Mar 17	47.93	70	23	4	0.1	3	0.1
2017/18	Apr 17 to Sept 17	47.98	111. 69	23.47	2	0.0	1	0.0
	Oct 17 to Mar 18	34.61	124	24.19	3	0.07	1	0.02
2018/19	Apr 18 to Sept 18	34.3	107.4	13.1	7	0.2	1	0.0

The Trust considers that this data is as described for the following reasons: It is consistent with incident data submitted to the National Reporting and Learning System (NRLS).

Incidents are generally categorised into clinical (patient safety) and non-clinical and then further categorised dependent upon their causative factor. Serious incidents continue to be reported to the CCG.

The Trust intends to take the following actions to improve the quality of its services by ensuring that all incidents are reported on and managed in a timely way which should see an improved position over the next two NRLS reporting periods. 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 2018/19 is shown in the following table. This does not include pressure ulcers, fractures from falls, ward closures, some infection control issues, personal data, IT or health and safety incidents.

2018/19	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs (by date reported as SI)	1	2	0	4	1	1	3	3	4	0	2	1

One of our state-of-the-art Siemens Definition Scanners based at Sandwell Hospital.

Never events

During 2018/19 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 2018/19

Speciality	Type of Never Event	Root Cause	Changes Made
Cardiology	Retained guidewire	Introduction and withdrawal of Terumo™ wire via a femoral needle rather than a sheath.	Terumo™ wires must only be introduced through sheaths and not through needles. Angioseals must not be used in arterial grafts; instead manual pressure is to be applied. The radial route is to be used preferentially to the femoral route whenever possible in patients with femoral grafts.
Ophthalmology	Wrong eye injection	Failure to follow Standard Operating Procedure.	Hard stops/challenging have been reiterated to all staff during Huddles/QIHD. Staff will always be supported when calling a hard stop. Injections in Progress – DO NOT DISTURB signs have been added onto the doors when a procedure is in progress. All injection staff have been on training on how to access/read the Management Plan. Doors are locked internally when an injection is taking place. **Changes in Progress** All injectors and assistants to go through annual audit of practice to assure the Directorate of safe and consistent practice. To review the requirement for a qualified nurse for Medisoft checking. Encourage near miss reporting and discussion at local governance meetings. Review supply of lucentis® for injection lists.
Critical Care	Retained guidewire	Failure to complete the WHO surgical safe checklist for the vascath second line insertion.	High visibility reminder for guide-wire removal has been added on the CVC insertion kit. High visibility reminder for guide-wire removal in Doctors' room in ITU. A two-person approach to visually confirm removal and correct disposal of the guide wire has been enforced. An ongoing weekly audit of mandatory WHO checklist compliance. **Changes in Progress** Review and update CVAD insertion policy. Educational material for ITU clinicians about CVC insertion and complications (including Simulation training). Same educational material for all anaesthetists to cover other areas where this procedure is done e.g. theatre and emergency department To discuss the report in QIHD.

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 needs". 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	2016/17	2017/18			
	SWBH 16/17	SWBH 17/18	National Average	Highest Trust	Lowest Trust
The trust's responsiveness to the personal needs of its patients during the reporting period.	64.9	61.6	68.6	85.0	60.5

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 by continuing to collect patient experience information first hand to help improve patient care.

At the beginning of this year we introduced a trial for patient placemats with supporting early discharge information on them. The placemat is located on bedside tables and details information on what our patients and their loved ones should be asking about their care which includes the following information

- If I am recovering well, when will I be discharged?
- Do I know what my diagnosis is or what tests are being carried out to determine this?
- What will happen over the next 24 hours with my treatment and care?
- What do I need to achieve to go home?

This initiative is currently under evaluation by patients and nursing staff.

Over the coming months we will also be exploring work to ensure our inpatients get a good night's sleep. To achieve this we are looking at models of working that will change how we approach 'flow' after 9pm.

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).

Our performance against the four hour target has shown significant improvement during the second half of the year. Recruitment activity has been strong with many new consultants joining the team and, following investment into our CESR programme for registrars, we have our first graduates from the programme going into consultant posts. We have successfully appointed to the majority of vacant nursing positions.

In November we introduced the single point of access (SPA) for GPs to refer patients with urgent care needs enabling us to appropriate transfer patients to the right specialist and avoid unnecessary attendance and waits in the emergency departments. We avoid 170 attendances per week through this service. Our ambulatory care service has been expanded to include surgical services this year.

We have focused on discharging patients across seven days and increasing our discharge rates before lunchtime to improve bed availability for patients who need to be admitted from ED.

Our SMART pathway has been introduced which provides patients with an assessment by a senior doctor early in the pathway. Patients can then be either directed to appropriate clinical areas outside ED or have timely diagnostics to reduce waits.

The performance in our waiting times for minor injuries and illnesses has also improved through a focus on recruitment and competency development within the team.

Going forward, we will complete our recruitment to vacant posts, and are looking at how we best support acute medicine. We are also making changes to acute and emergency care for children to reduce time and distance of transfer.

Our trajectory is to achieve 85 per cent by the end of the first quarter of 2019/20.

The table below shows the four hour wait performance for 2018/19

Four Hour Waits 2018/19 (Target 95%)											
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
83.9	80.1	81.3	84.1	82.7	83.0	81.1	80.7	75.0	78.0	82.3	85.9

Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently these cover two clinical procedures, knee and hip replacement surgery, 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 per centage 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.

Patient Reported Outcome Measures (PROMs)								
Health Status Questionnaire Per centage improving								
	Finalised data for April 16– March 17 (Published August 2018)				**Finalised data for April 17– March 18 (Published February 19)**			
	National	**SWBH**			**National**	**SWBH**		
Hip replacement	89.1%	92.4%			90.0%	91.0%		
Knee replacement	81.1%	82.9%			82.6%	81.9%		
Health Status Questionnaire Average adjusted health gain								
	Finalised data for April 16– March 17 (Published August 2018)				**Finalised data for April 17– March 18 (Published February 19)**			
	National	**SWBH**	**Highest National**	**Lowest National**	**National**	**SWBH**	**Highest National**	**Lowest National**
Hip replacement	0.437	0.464	0.533	0.328	0.458	0.416	0.549	0.357
Knee replacement	0.323	0.308	0.398	0.237	0.337	0.323	0.405	0.253
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 both 2016/17 and 2017/18 shows that there are areas where the reported outcome is marginally below average for England. There are areas for improvement however the Trust is not an outlier against national data in any of the measures.

The Trust intends to take the following actions to improve,

• An arthroplasty nurse will be appointed to improve the aftercare for our patients and identify early complications.

• Increase the involvement of anaesthetics prior to surgery to improve selection criteria.

• Improve the pathway for both procedures.

• Use the electronic notice board in the waiting area for patient information in outpatient waiting rooms in fracture clinic to focus on the importance of completing the booklets.

How we performed in 2018/19 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2017/18 positon	2018/19 positon	Comments
Cancer – 2 week GP referral to first outpatient	%	=>93	95.3	97.0	Full year
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	=>93	96.9	96.5	Full year
Cancer – 31 day diagnosis to treatment (all cancers)	%	=>96	97.7	97.8	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (excluding rare cancer)	%	=>85	85.8	86.5	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (including rare cancer)	%	=>85	80.6	86.5	Full year
Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral	%	=>90	96.8	93.9	Full year
Emergency Care – 4 hour waits	%	=>95	83.4	81.5	Full year
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92	92.04	93.01	Full year
Acute Diagnostic waits < 6 weeks	%	<1.0	0.56	2.0	Full year
Outcome Metrics					
C Diff	No	<30	29	15	Full year
MRSA Bacteraemia	No	0	0	1	Full year
Never Events	No	0	3	3	Full year
Harm Free Care	%	=>95	94.4	98.0	Full year
WHO Safer Surgery Checklist (all 3 sections)	%	=>100	99.8	99.9	Full year
VTE Risk assessments (adult IP)	%	=>95	96.1	94.8	Full year
Clinical Quality and Outcomes					
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	92.8	93.7	Full year
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	75.2	66.7	Full year
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50	72.2	71.5	Full year
Stroke care – Admission to Thrombolysis Time (% within 60 minutes)	%	=>85	66.1	75.9	Full year
TIA (High Risk) Treatment within 24 hours of presentation	%	=>70	94.9	98.5	Full year
TIA (Low Risk) Treatment within 7 days of presentation	%	=>75	95.6	98.3	Full year
MRSA screening elective	%	=>80	89.0	86.2	Full year
MRSA screening non elective	%	=>80	91.4	85.4	Full year
Hip Fractures – operation within 36 hours	%	=>85	69.4	81.6	Full year
Patient Experience					
Complaints received – formal and link	No	N/A	1037	867	Full year
Coronary heart disease - primary angioplasty (<150 mins)	%	=>80	95.9	95.2	Full year
Coronary heart disease – rapid access chest pain (<2weeks)	%	=>98	100.0	100.0	Full year

Infection prevention and control

The reduction of healthcare associated infections (HCAIs), including clostridium difficile (C. difficile) and methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections remains a priority and it is essential that we continue to do all we can to reduce the risk to our patients of acquiring a HCAI while they are in our care. Infections increase length of stay for patients and cause symptoms ranging from mild diarrhoea to life threatening complications. 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.

What we said we would do in 2018/19

We said we would continue to ensure that we have measures in place to assess the risk of, prevent, detect and control the spread of infections, including HCAIs, as follows:

What we did

- We maintained a strong focus on infection prevention and control strategies to ensure that we maintained our patient safety and added value to our patient experience.
- We appointed a new lead nurse for Infection Prevention and Control who is currently reviewing our strategies to improve Infection Prevention and Control for the organisation across acute and community services.
- We have conducted patient led assessments of the care environment audits in a variety of areas across the organisation to ensure that standards were maintained.

What this means for you as a patient

Our aim is always to reduce the risk of a patient getting a hospital acquired infection while in our care.

How did we perform in 2018/19?

Target for 2018/19	Agreed target/rate [year end]	Trust rate	Compliant	Comments
C.difficile acquisition toxin positive	29	15	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 5.97 (Jan)
MRSA	Zero tolerance	1	No	Unavoidable

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

In accordance with national guidance, the case of MRSA bacteraemia has undergone a detailed review to ensure that the Trust is able to fully understand the cause of the incident and to put in place any measures required to reduce the risk of the incident occurring again. Learning is discussed at our Infection Control Committee and shared across the Trust through our divisions. Where specific actions are identified, these are included and actioned through our Infection Control Annual Plan.

Work is on-going to sustain the reduction in the incidence of avoidable infection in the Trust; we will continue to work towards this goal. The Trust intends to take the following actions to improve the quality of its services:

- An audit program will be developed to help support and sustain improvement.
- Training – All staff will be required to undertake mandatory infection prevention training, the team will also provide bespoke training as required to areas.
- Development of a decontamination assurance framework will be undertaken.
- Review of the hand hygiene audit process to ensure that we are capturing robust and accurate information.
- Continued ongoing surveillance of alert organism.
- Screening program for MRSA.
- Clear identification of any learning and dissemination of learning.

Venous thromboembolism (VTE)

A venous thromboembolism (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 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.

Venous thromboembolism (VTE) risk assessment (National Target 95%)	2017/18		2018/19			
	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.	95.4%	Q1	95.1%	95.6%	100%	75.8%
		Q2	93.9%	95.4%	100%	68.7%
		Q3	94.5%	95.6%	100%	54.7%
		Q4	95.7%	Not Available	Not Available	Not Available

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 the quality of its services:

- Continuing to monitor compliance of VTE assessments on admission as part of the Trust's safety plan compliance.

- Continuing to monitor through our integrated performance report at our quality and safety committee and reported to the Trust board monthly.

- Continuing to monitor centrally through the Medical Director's Office who liaise directly with wards where outstanding VTE assessments need completing.

- We believe the introduction of our new electronic patient record system, Unity, will help us to improve our compliance.

Medical Director, Dr David Carruthers.

Rachel Follos, Physiotherapy Assistant Practitioner, with Patrick Rodriguez, Unity Trainer.

Readmission rates

Readmission reduction remains a priority for the organisation and we have seen a reduction year-on-year in our rates across all age groups. The table below details our readmission rates. The information is collected during a financial year period and we now measure readmission within 30 days (previously 28 days). This excludes deaths and still births.

Age 0 – 15 years

SWBH	Number of Patients	Total Number of Readmissions	Percentage of Readmissions
2018/19	15917	968	6.08%
2017/18	16145	934	5.79%
2016/17	16367	998	6.10%
2015/16	16015	1105	6.90%

Age 16 and over

SWBH	Number of Patients	Total Number of Readmissions	Percentage of Readmissions
2018/19	86051	7113	8.27%
2017/18	95113	8997	9.46%
2016/17	96427	8789	9.11%
2015/16	98232	9930	10.11%

All Ages

SWBH	Number of Patients	Total Number of Readmissions	Percentage of Readmissions
2018/19	101968	8081	7.93%
2017/18	111258	9931	8.93%
2016/17	112794	9787	8.68%
2015/16	114247	11035	9.66%

The Trust considers that this data is as described for the following reasons: It is consistent with trust reported data in our Integrated Quality Performance Report which is reported to Trust Board.

The Trust intends to take the following actions to improve the quality of its services by continuing to review and look at ways in which we can improve our position.

Safeguarding Children

Safeguarding children remains a key priority for Sandwell and West Birmingham NHS Trust which is demonstrated by our accountability and reporting structure. We have a dedicated team of a safeguarding children lead and named nurses who support our workforce through a programme of targeted training, advice, support and supervision at the frontline through to our Chief Nurse as the Executive Lead for Safeguarding. We have a robust assurance and quality framework to ensure we are compliant with statutory requirements to safeguard and promote the well-being of children who may come into contact with the wide range of services we deliver across acute and community provision.

We continue to work closely with both Sandwell and Birmingham Children's Trust and are represented at a number of sub groups aligned to the new Multi- Agency Safeguarding Children Partnership arrangements. Our domestic abuse nurse team continue to review cases where there has been a domestic abuse incident within Sandwell Multi-Agency Safeguarding Hub (MASH) to ensure both victims and children are safe. The team has worked with a number of key departments (e.g. sexual health, paediatric wards and occupational health) to raise awareness of domestic abuse, routine enquiry and to promote the hospital as domestic abuse aware. The team also deliver a rolling programme of specialist domestic abuse training across the organisation.

Our emergency department (ED) Domestic Abuse Advocacy Partnership Project with Black Country Women's Aid continues to be a positive venture in identifying victims of domestic violence and abuse in ED. During the year over 220 victims have been referred through to the Independent Domestic Violence Advisors (IDVA) based in Sandwell and City Hospital for support. Data analysis continues to demonstrate that a high number of victims identified are not known to domestic abuse services and also as in previous years a significant number of victims are being identified from black and minority ethnic groups which have previously not been represented in groups accessing domestic abuse services. The project has proved so successful that we have secured part funding from Sandwell Safer Partnership and have been endorsed with the agreement of recurrent funding from our organisation by our Chief Executive and Chief Nurse.

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. Sandwell Children's Trust went live with CP-IS in April 2019 which has enhanced the provision of a safeguarding system to alert practitioners where children may have a child protection plan in place. This includes unborn children and also if the child is a looked after child. In addition to this the system provides an audit trail and will notify children's services when a child has attended unscheduled care settings such as ED or a mother presents unbooked to maternity services.

We have worked closely with Unity, our new electronic patient record (EPR) system and development of the assessment record by adding a number of prompts to ensure that practitioners will access the summary care record to search for any child alerts. This work will be enhanced further during a later development phase of Unity whereby if there is information contained with the summary care record this will integrate within the EPR without having to search for it.

Due to the high number of women who are known to our maternity services who have had female genital mutilation (FGM) performed we are live with the FGM – Information Sharing system (FGM-IS) after working closely with NHS England to implement the system. Midwives will routinely ask all women whether they have had FGM performed and this is recorded within the patient record. At delivery if a female is born an indicator is added to the summary care record to identify the female child as being at risk of FGM. Mothers are advised of the system and informed that an indicator will be added to the child's record. This is to ensure the information is shared across a national system in order to risk assess and prevent the practice of FGM which has been illegal in the UK since 2003. Regular audit is undertaken to ensure our midwives are compliant with this and has demonstrated that this practice is embedded within the service.

We continue to work with ED to raise the awareness of exploitation for children accessing the department and whilst we will flag the record where a child is deemed to be at risk of child sexual exploitation we have broadened this to include all forms of exploitation such as trafficking and slavery. We work closely with our adult safeguarding

team on the agenda of PREVENT and where an adult has been identified as being radicalised we will ensure if there are children involved a multi-agency referral form is completed and shared with our Children's Trust partners in order to inform risk.

Priorities for 2019/20 will continue to focus on CP-IS integration with our new EPR system and FGM-IS compliance. We will also continue to evaluate the emergency department IDVA project to demonstrate its value in identifying and supporting victims of DVA. In addition the safeguarding children team will continue to deliver a programme of specialist safeguarding children training across the organisation.

Safeguarding Adults

The adult safeguarding team provide visibility and operational support to frontline colleagues and patients. The adult safeguarding lead nurse is also responsible for the dementia delirium and distress team (DDD). This team is expanding which will allow for additional training and work alongside relatives and carers to give a more personalised approach to patient care.

There has been input from safeguarding and DDD into several significant work streams including work around acuity and wards, managing the distressed patient work group and the vulnerable adult work group. Our tissue viability team have also now recruited a nurse dedicated to falls prevention who works closely with the DDD Team.

The adult safeguarding team has continued to focus on Deprivation of Liberty Safeguards. Our adult safeguarding nurse has completed the Best Interest Assessor Course at Wolverhampton University which has improved our teaching and support to frontline staff in relation to least restrictive care, best interests and mental capacity assessments.

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 continue to develop with participation at multi agency meetings and participation 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.

Sabina Price-Hickman, Charge Nurse for Adult Safeguarding, with David Cobley, Learning Disabilties Liaison Nurse.

Learning from deaths

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the organisation 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 111 (September 2018). This data is derived from HED (Healthcare Evaluation Data) for the Summary Hospital Level Mortality Indicator (SHMI).

Mortality comparisons using highest SHMI against national results: July 2017- June 2018

Indicator	Lowest	Highest	SWBH
Score (SHMi)	0.698	1.257	1.154
Observed	1450	1213	2199
Expected	2077	965	1905

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 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.

During 2018/19, 1059 of Sandwell and West Birmingham NHS Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 370 deaths in Q1, 346 deaths in Q2, 343 deaths in Q3. Q4 data is not yet available and will be reported in next year's account.

By 31 January 2019, 569 mortality case record reviews and 11 investigations have been carried out in relation to 1059 of the deaths included above.

In 11 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 136 in Q1, 174 in Q2, 259 in Q3. Q4 data is not yet available and will be reported in next year's account.

Eleven cases representing 1.03 per cent 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: 0 patient deaths representing 0 per cent of the patient deaths for Q1, 0 patient deaths representing three per cent of the patient deaths for Q2, six patient deaths representing 1.75 per cent of the patient deaths for Q3. Q4 data is not yet available and will be reported in next years account.

Mortality performance in Q4 2017/18

193 case record reviews and 3 investigations completed after April 2018 which related to deaths which took place before the start of the reporting period.

Three deaths representing 0.65 per cent of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Sandwell and West Birmingham NHS Trust Mortality Review System.

Twelve deaths representing 0.75 per cent of the patient deaths during the 2017/18 reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using our Mortality Review System (MRS). The (MRS) is based on the PRISM methodology. It is in place to ensure that there is a review of the management 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 our clinical database and a notification is sent to the Clinical Director and an independent consultant from the directorate where the death occurred. A comprehensive review of each case is performed within 42 days of the death. 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 and scrutinised at the monthly Learning from Deaths committee, any actions arising are monitored through to completion.

In addition we 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 of the case. These are investigated further through the Learning from Deaths committee. The outcome and actions from these cases are reviewed by the committee to identify quality improvements required. Data from the MRS is used to investigate and respond to external mortality outlier alerts.

Our organisation is undertaking work to understand and improve mortality data looking at both the processes involved in generating mortality data as well as a focus on clinical care in those clinical areas where a higher than expected mortality rate is seen. This forms part of the Quality Plan. The plan will focus on priority areas to begin with which were identified from our mortality data.

Sepsis

The purpose of this quality improvement work is to reduce patient mortality due to sepsis. The priority was to improve sepsis screening compliance for patients who triggered a National Early Warning Score (NEWS) of five or above and pilot a treatment tool. In August 2018 our evidenced (electronically recorded) sepsis screening rate was one in 11 patients (so for every 11 patients that triggered a NEWS of five or above, one patient received screening for sepsis).

The purpose of this work was to improve compliance to ensure that every patient who required screening (sometimes twice daily) received it in a timely fashion. The sepsis screening compliance has improved from a one in 11 (9 per cent) screening rate in August 2018 to November 2018 where we saw an improvement to one in two (50 per cent). This was sustained through the winter and has climbed to a one in 1.1 (90.6 per cent) compliance in March. The aim now is to sustain this improvement and reach a sustained 100 per cent compliance across all wards.

The second stage of the QI work is looking at the assessments after the screening alert and initial work suggests that accuracy of documentation around time of sepsis assessment, administration of oxygen and monitoring of urine output are important data points where recording requires improvement. The audit form

is now being trialled in real time on the wards with the aim that it becomes embedded in ward activity to record how they have dealt with triggering patients. This will then be part of regular ward activities to review this data weekly with education and training where needed and will link into the nursing assessment and learning from missed triggers and the themes that come from that.

Venous thromboembolism (VTE)

Compliance has improved across the year and compliance since the beginning of the year is above 95 per cent. Improving compliance is being addressed by communication to junior staff, work with the chief registrar, pre-weekend messages to on-call teams (senior and junior) to make sure checks are carried out and visits to board rounds to encourage undertaking of uncompleted checks.

In addition to the above deeper understanding of current IT limitations in recording of data is being reviewed and we are asking for modifications in these systems prior to go live with Unity to facilitate junior staff recording of assessments.

A clinical audit of missed or delayed assessments showed that not all assessments were missed, some were already on anticoagulation and some turned out not to need prophylaxis. However there is still a percentage who have missed assessments. To understand the potential impact of these missed assessments we are looking at all hospital acquired VTE (HAVTE). This will be via incident reporting and cross checking with coding data.

Stroke

Data of deaths in 2017/18 has been reviewed by the stroke team. The expected vs actual mortality rate was not too different but analysis found that there was no increase in mortality for patients admitted on the weekend and there was no preventable deaths identified except one potentially preventable death where mechanical thrombectomy was not available out of hours. This was a retrospective review and therefore the outcome of this work was that the stroke service will set up their own monthly mortality review of all stroke deaths and have better identification of stroke patients admitted.

Child deaths

The paediatric department reviews their child deaths annually and report into the Learning from Deaths committee. Following these reviews the actions that have been undertaken are that a new induction drugs policy has been written and presented at a joint QIHD

session with anaesthetics. The changes are going to be tested in a SIM situation before being rolled out. An issue has been identified with regards to delays in sending out letters to patients. The process has been reviewed, documented on the risk register and is being monitored by the team. All reports from child death reviews are now stored on a shared folder. In addition actions to take forward are to review palliative care coding and to review palliative case provision out of hours.

Neonatal deaths

The neonatal team has a robust system in place which reviews deaths linked to obstetrics and maternity departments and have presented to the Learning from Deaths Committee. The four learning points were:

- The department did not have video laryngoscopy, although the cases benefiting from this would be small it was still thought worthwhile. The team have now purchased one.

- Referral to the coroner remains important and often mandatory despite many parents being against conducting a post mortem. Clarity around conditions for referral and the sensitivity working with the family has been shared within department.

- One review revealed that the team were not clear about massive transfusion policy. A second clear quality improvement outcome has been that the policy and procedure has been updated and shared across the department.

- One case revealed that better knowledge of hypoxic ischaemic encephalopathy management with hypothermia was needed. This case was used to share learning in department.

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 organisation where a diagnosis of palliative care was made. A trust's mortality data is affected by palliative care and specialist palliative care coding as well as comorbidity coding. Changes in external mortality data calculation methods and rebasing, changes in palliative care provision (eg focussing on community care) and coding can affect our data and comparison with peer trusts.

Mortality comparisons against national results: July 2017/18

Total Number of Deaths	Palliative Care	Percentage (%)
2199	481	21.9

Dr Chizo Agwu, Trust Mortality Lead.

External visits

In depth data analysis of cases for fracture neck of femur was undertaken and we received a review from the West Midlands Safety Group. This was due to national data identifying us as an outlier. The review of the data concluded that there was no weekend mortality effect associated with the 31 deaths identified. Several quality Improvement points came from the review with target date of March 2019, spanning multi-specialties.

A subsequent visit from the West Midlands Quality Review Service (WMQRS) in January 2019 to look at the pathway showed no areas of immediate concern over pathways or care. The visit highlighted areas of good practice and areas to re-visit which are outlined below.

Good practice	Areas to re-visit
High morale within the trauma team - clinicians, SCPs, theatre and ward staff	Access to patient records on CDA is not easy and is not in one place
Comprehensive reporting and analysis of the cases	Understanding of Vital Pac among the staff is slightly variable
Concept of Quality Improvement Half Days (QIHD) is excellent	Weekend access to MRI for pathological fractures needs improving
Concept of Black Country Networking to share and learn is very good practice	Our NOF Mortality proforma is mainly T&O based. It may benefit from including the ED and Anaesthesia sides too
Emergency department - good practices in initial NOF management and willingness to work with T&O	Decision on 'Not to Operate' needs a clear SOP/ Process to avoid variations of practice
Role and contribution of (lone) Ortho-Geriatrician	Decision to 'cement' or not also needs to be standardised
Protected NOF Beds and Uniform NOF pathway	'Cement Curfew' / 'Time out' during cementing
'Whatsapp Group' to plan and execute throughout the day, including weekends	'Level 1' facility for NOF patients - where and how?
Nursing leadership in planning, training and monitoring	Consistent communication from ED to Reg on call before NOF admission and transfer to the ward
Desire to replicate/ look into 'Level 1' care	Role or possibility of Frailty Nurse
	Weekend full physiotherapy provision
	'Golden First Patient' to start the list

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 3009. Of these 2504 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 505 were recruited into non-NIHR portfolio studies.

Participation in clinical audits

During 2018/19, 54 national clinical audits and four national confidential enquiries covered relevant health services that Sandwell and West Birmingham Hospitals NHS Trust provide.

During that period Sandwell and West Birmingham Hospitals NHS Trust participated in 100 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham Hospitals NHS Trust was eligible to participate in during 2018/19 are as follows (see table on the following page column 1):

The national clinical audits and national confidential enquiries that we participated in during 2018/19 are as follows (see table on the following page column 2).
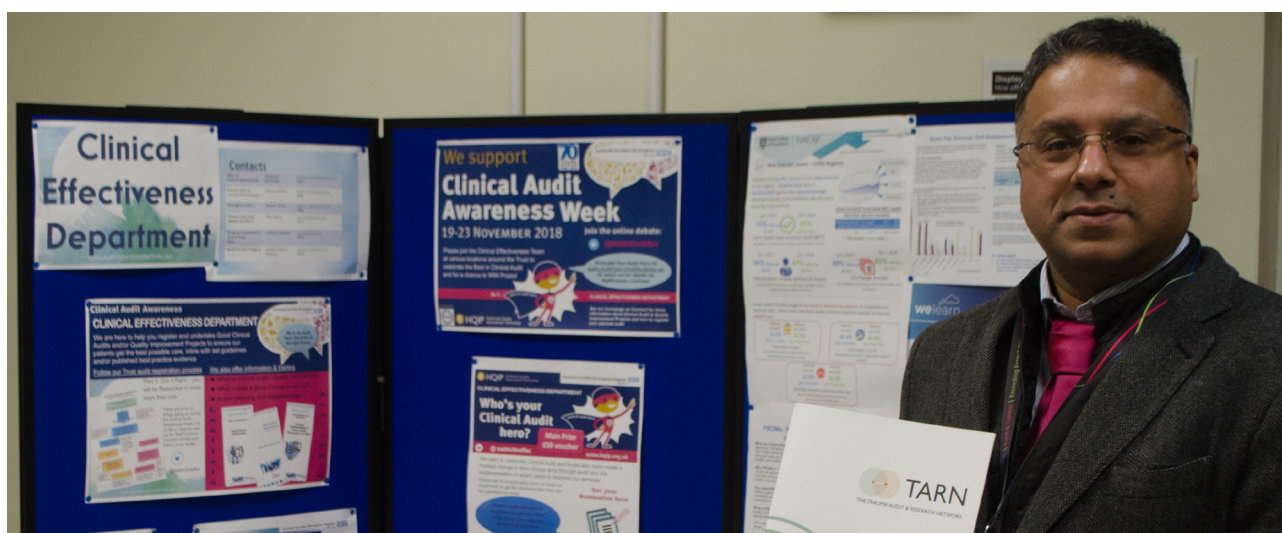
The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust participated in, and for which data collection was completed during 2018/2019, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see below table column 3).

Title	Are we participating in this?	% of eligible cases submitted
7 Day Hospital services self-assessment survey	✓	100%
BAUS urology audits - Female stress urinary incontinence	✓	100%
BAUS urology audits - Percutaneous nephrolithotomy (PCNL)	✓	100%
Adult community acquired pneumonia (BTS)	✓	100%
Non-invasive ventilation – Adults (BTS)	✓	100%
Cardiac rhythm management (CRM)	✓	100%
Case mix programme (CMP)	✓	100%
Falls and fragility fractures audit programme (FFFAP) Inpatient falls	✓	100%
Falls and fragility fractures audit programme (FFFAP) Fracture liaison service database	✓	100%
Falls and fragility fractures audit programme (FFFAP) National hip fracture database	✓	100%
Inflammatory bowel disease (IBD) registry	✓	100%
Learning disability mortality review programme (LeDeR)	✓	100%
Mandatory surveillance of bloodstream infections and clostridium difficile infection	✓	100%
Maternal, newborn and infant clinical outcome review programme	✓	100%
Myocardial ischaemia national audit project (MINAP)	✓	99.52%
National asthma and COPD audit programme (NACAP)	✓	60%
National audit of breast cancer in older people (NABCOP)	✓	100%
National audit of cardiac rehabilitation (NACR)	✓	100%
National audit of care at the end of life (NACEL)	✓	100%
National audit of dementia	✓	100%
National audit of intermediate care (NAIC)	✓	100%
National audit of percutaneous coronary interventions (PCI)	✓	100%
National audit of seizures and epilepsies in children and young people (Epilepsy12)	✓	55 cases
National bowel cancer (NBOCA)	✓	100%
National cardiac arrest audit (NCAA)	✓	100%
National clinical audit for rheumatoid and early inflammatory arthritis (NCAREIA)	✓	165 cases
National comparative audit of blood transfusion programme (NCABT) - Audit of the management of maternal anaemia	✓	100%
National comparative audit of blood transfusion programme (NCABT) - Audit of the management of massive haemorrhage	✓	100%
National comparative audit of blood transfusion programme (NCABT) - Audit of the use of FFP and cryoprecipitate in neonates	✓	100%
National diabetes audit - Adults foot care	✓	100%
National diabetes audit - Adults national core diabetes audit	✓	Partial submission

Title	Are we participating in this?	% of eligible cases submitted
National diabetes audit - Adults national diabetes Inpatient audit	✓	100%
National diabetes audit - National pregnancy in diabetes audit	✓	100%
National emergency laparotomy audit (NELA)	✓	100%
National heart failure audit	✓	87%
National joint registry (NJR)	✓	100%
National lung cancer audit (NLCA)	✓	100%
National maternity and perinatal audit (NMPA)	✓	100%
National neonatal audit programme - Neonatal intensive and special care	✓	100%
National oesophago-gastric cancer (NOGCA)	✓	>90%
National ophthalmology audit	✓	100%
National paediatric diabetes audit (NPDA)	✓	100%
National prostate cancer audit	✓	100%
Elective surgery national PROMS programme (hip and knee surgery)	✓	94%
VTE risk in lower limb immobilisation (care in emergency departments)	✓	100%
Feverish children (care in emergency departments)	✓	100%
Vital signs in adults (care in emergency departments)	✓	100%
Reducing the impact of serious infections (antimicrobial resistance and sepsis) antimicrobial stewardship	✓	50%
Reducing the impact of serious infections (antimicrobial resistance and sepsis) antibiotic consumption	✓	100%
Sentinel stroke national audit programme (SSNAP)	✓	90%
Serious hazards of transfusion (SHOT): UK national haemovigilance scheme	✓	100%
Surgical site infection surveillance service	✓	99.6%
Major trauma audit	✓	80%

Clinical Effectiveness Project Facilitator Bahadur Dehar staffing the Clinical Audit Awareness Week pop up information and advice stand at Hallam Restaurant, Sandwell Hospital.

The reports of 48 national clinical audits were reviewed by the provider in 2018/19 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided;

- Review the quality of the information submitted to national audit to ensure that our data reflects the level of service we provide and that we can ensure that our patients and staff benefit from the learning resulting from the audits.

- Liaise with West Midlands Ambulance Services to ensure that all ACS cases are brought straight to City Hospital and not Sandwell.

- Introduce a ward based oxygen training programme on respiratory wards.

- Establish a COPD admission bundle on both sites, to ensure all patients that require oxygen are receiving it and to target saturation.

- Reduce the length of time for a fracture to be reported on the system.

- Following the results from previous National Audit of Emergency Laparotomy's elderly care reviews were introduced on the wards, this has proven to be highly successful and this year we want to ensure this practice is embedded. In addition we would like to improve anaesthetic consultant attendance at emergencylaparotomies.

- Develop a laminated card which will be attached to each resuscitaire on the labour ward as a reminder to check the baby's temperature and to provide appropriate thermal care during transfer to the neonatal unit.

- Develop a business case to purchase baby pods for the transportation of babies with possibility of using charitable funds to purchase these.

- Arthroplasty nurse to be appointed to improve the aftercare for our patients and pick up early complications follow hip and knee replacement surgery. To increase the involvement of anaesthetics prior to surgery to improve selection criteria (improve pathway). To use the electronic notice board to encourage patients to complete their PROMS to be used for patient information in outpatient waiting areas.

- Surgical Site Infection Leaflets are now given to patients on ward to improve post discharge questionnaire completion which includes contact details in case the patient is concerned.

The reports of 114 local clinical audits were reviewed by the provider in 2018/19 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Diphencyprone (DCP) referral proforma to be combined with consent form as a pack and completed by clinicians when referring a patient for DCP. The proforma will be uploaded to the shared drive for clinicians to access.

- Develop a parent information leaflet to raise awareness of suspected sepsis.

- Education of how to escalate when an abnormality is detected/queried in newborn babies. This is to be included as part of departmental induction to increase awareness as well as during Newborn and Infant Physical Examination (NIPE) study days for midwives.

- To develop a clear pathway and expectation for review of paediatric patients out of Ophthalmology Emergency Department. Ensure that the pathway is disseminated and embedded - sharing with general paediatric colleagues.

- Review of our current enhanced recovery pathway to ensure safe use of IV fluids and nephrotoxic drugs.

- Obtain agreement from Birmingham Children's Hospital whether telephone advice can be sought during office hours when Sandwell and West Birmingham NHS Trust paediatric ophthalmologist is on leave.

- Meet with pharmacy Lead to look at current practice and where improvements can be made ahead of the new EPR system to alleviate the differences in current practices within acute and community wards in regards to accepting FP10 for medication to take home from community wards to stop multiple prescriptions.

- New delirium guidelines to be developed to incorporate inclusion of the 4AT scoring.

- Setting up of alcohol team within Sandwell and West Birmingham NHS Trust, increased funding dedicated to alcohol service provision within Sandwell and West Birmingham NHS Trust.

- Repeated attenders multi-disciplinary group to be set up to review (real-time) patients with high emergency department attendance frequency. Group to decide on appropriate support mechanisms to help reduce attendance frequency.

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 make our statement cognizant of the challenges the Trust has faced over the year with the building of the new Midland Metropolitan Hospital.

It is disappointing that the Trust's CQC rating remains 'requires improvement especially as improving this was a priority for the 2017/18 Quality Account. However, we are pleased that the CQC rated the Trust outstanding in the caring domain and for critical care services. We encourage the Trust to continue implementing the actions it has outlined in the Quality Account and should consider including an audit of its clinical and corporate policies to see if they are fit for purpose. This would ensure that practices across the Trust adhere to current statutory requirements, national and NHS Guidelines. This would also clarify key lines of responsibility in ensuring that staff have an adequate understanding of policy and strategy.

Patient and Public Involvement

In the 2017/18 Quality Account, the Trust gave examples of the different ways it listens and learns from the experience of patients and carers. The Trust mentioned,

- 'Facebook live events' where patients could engage with health care staff;
- the establishment of a carers group which we believed was a good resource for the Trust for continued understanding of how best to support relatives and carers;
- the involvement of those within the 'Members Leadership Group' in CQC inspections and improvement plans; and
- the Trust's intention to work closely with other partners to better join up the Trust's formal patient engagement activities.

Healthwatch Birmingham believed that the Trust had the base on which to develop a coordinated and structured approach to the use of patient, service user and carer's experiences and insight. It is disappointing that the current Quality Account does not demonstrate how the Trust engages with patients and how this influences service development and improvement. For instance, the Trust

has only provided the key performance indicators for complaints (p18 of the draft Quality Account) under patient experience. The Trust has not provided any indicators for PALs contact or the survey results of the Friends and Family Test (FFT). If these are available, the Trust has not signposted to the relevant page on the website. In addition, the Trust has only shown the number of complaints (which we are happy has reduced from 1037 in 2017/18 to 867 in 2018/19) but the themes from complaints have not been indicated nor how these are used to improve services.

Healthwatch Birmingham believes that for the Trust to improve its score for the 'responsiveness to personal needs of patients' is to understand these needs. This can only be done by listening to what these needs are from patients, service users and carers. We note that 'continuing to collect patient experience first-hand' is one of the actions to be taken to improve patient care. However, we are not sure if the 'patient placemats to support early discharge' initiative will help the Trust understand patient's needs. It is not clear whether the questions[1] asked under this initiative reflect what patients and their carers have said they want. We note that patients and nursing staff are reviewing this initiative; we would like to read on the outcome of this initiative in the 2019/20 Quality Account.

1 Questions include: If I am recovering well, when will I be discharged? Do I know what my diagnosis is or what tests are being carried out to determine this? What will happen over the next 24 hours with my treatment and care? What do I need to achieve to go home?

It is encouraging that the Trust has an engagement strategy for staff that it follows to ensure that staff can feedback and raise concerns. We note the different methods available to involve staff and gather their feedback such as the 'we connect engagement programme', which is aimed at analysing engagement across the Trust to see how to improve future NHS Staff Friends and Family tests. We also note that through the 'Speaking UP' initiative, staff have outlined three changes they would like to see. Of key strategic importance to Healthwatch Birmingham is better communication about change. We would like

to read the actions that have been taken to address this and their impact in the 2019/20 Quality Account.

Healthwatch Birmingham believes that this staff engagement strategy can serve as a foundation for developing a Trust-wide patient and public involvement (PPI) strategy. We still believe that the Trust would benefit from developing a Patient Public Involvement (PPI) Strategy that would ensure that engagement activities are equitable and representative of the localities the Trust works in.   A PPI strategy would outline:

• Why the Trust is listening?

• What the Trust listens for?

• How the Trust listens?

• Who The Trust wants to hear from (including ' seldom-heard' groups)?

• How the Trust will use what it hears?

• Clear arrangements for collating feedback and experience.

Over the past year, Healthwatch Birmingham has worked with Clinical Commissioning Groups (CCGs) and trusts to benchmark their patient and public involvement (PPI) processes using Healthwatch Birmingham's Quality Standard. Thus enabling them to identify areas of good PPI practice or areas that need to improve. This has led to the development of actions aimed at embedding systems for delivering consistently high-quality PPI. Healthwatch Birmingham has made initial contact with Sandwell and West Birmingham Trust on this issue which we will follow-up in 2019/20. We would like to continue supporting the Trust with its PPI activities.

Regarding the NHS Staff Survey, we note that there has been an improvement on the per centage of staff that would recommend the Trust as a provider of care to their family and friends from 58.2% (2017) to 60.2% (2018). Equally, the per centage of staff who would recommend the Trust has increased from 49.4 % (2017/18) to 55.7% (2018/19). We encourage the Trust to continue implementing the actions outlined in the Quality Account as these scores are still below the national average. We would also like to see how the Trust uses this feedback from staff, especially how it uses it to understand the needs of different staff groups such as those from the BAME community.

Regarding the complaints data, the Trust should consider including in this Quality Account the most common themes of complaints it has received, lessons learnt from these complaints and actions taken.

Trust Performance in 2018/19

Improved outcomes for patients presenting with signs and symptoms of sepsis

We welcome that the Trust has been able to consistently identify and screen 90% of its patients for sepsis and manage those identified as needing further treatment, over the last year. We note that 84% of patients receive antibiotics within one hour of arrival for an average of 40 patients presenting every month. The Trust has identified that delays are usually a result of delays in prescription or administration of antibiotics. We would like to read in the 2019/20 Quality Account, the actions taken in relation to the prescription process and the changes that have been made as a result.

Improve the consistency of care provided to patients while on the hospital's wards

We note the initiatives that have been implemented to ensure the delivery of consistent care. For instance, the 'Consultant of the Week' where individual consultants focus on leading patient management on the ward and the rotation of junior staff to improve training. We are pleased about this as over the last year patients have shared with us some poor experiences of care (e.g. assessments). We, therefore, encourage this initiative and would like to read, in the 2019/20 Quality Account, about its impact on patient experience.

Implementing the Safety Plan

We note that an audit of the safety plan (which includes 10 evidence-based clinical standards) was carried out in February 2019. The audit found that assurance controls to manage risks are suitably designed and consistently applied. However, issues were identified, such as:

• Inconsistencies in completion of the safety plan across the wards audited.

• Discrepancies between the time patients are recorded on the electronic bed management system and actual transfer of the patient. The risk is that unless the time of transfer is in real time all time-related actions will be incorrect

- On some wards, members of staff were unsure of when to complete certain parts of the plan.

We welcome the development of a standard operating procedure to provide guidance on the completion of the Safety Plan and training for new staff. However, we believe that refresher training should be made available to all health care staff if this is to become embedded into the Trusts practice. We look forward to reading, in the 2019/20 Quality Account, the impact of the steps taken to address these issues and the number of staff trained.

Seven Day hospital Services

We are pleased that the Trust is compliant with three of the four priority standards aimed at ensuring that patients have access to consultant directed care, diagnostics and clinical interventions seven days a week. The Trust has not been compliant in clinical standard two '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'. Compliance is 73% weekday and 85% weekends. We would like to read in the 2019/20 Quality Account how the discharge project has helped improve this standard.

Incident reporting

We note that the Trust has had 21 serious incidents in 2018/19 and three never events were reported. We note the various changes that are taking place, such as annual audits of injectors and assistants to ensure safe and consistent practice and education across the Trust on WHO Surgical safe checklist. We ask the Trust to continue implementing initiatives that ensure robust controls are in place to prevent never events occurring. We would like to read the impact these changes have had on practice in the 2019/20 Quality Account.

Emergency four-hour wait

We note that the Trust continues to face challenges in meeting the national target of 95% for the emergency four-hour wait. The Trusts performance on this standard has fluctuated over 2017/18 and has been below the national target. As of March 2019, this was at 85.9%. One of the main issues we hear from the Trust's patients is around waiting times in A&E; we documented these in

our recent report regarding both Birmingham City Hospital and the Birmingham and Midland Eye Centre. The focus of the report is on people's experiences of waiting times, the environment, communication, accessibility, and dignity and respect. We believe that the findings of this report can complement the actions the Trust plans to take to improve this performance and people's experiences as they wait to receive treatment. The report can be found here: http://bit.ly/2H1ZKMD

Learning from deaths

During 2018/19, 1059 Trust patients died and by end of January 2019 569 mortality case record reviews and 11 investigations were carried out. Eleven of these cases were subject to a case review and investigation. These were judged by the Trusts review process to have occurred due to problems in the care provided to the patient. In 2017/18, twelve deaths were judged to be due to problems in care received. We encourage the Trust to outline the key steps that they will take to reduce this and share learning across the Trust. We would like to read in the 2019/20 Quality Account how UNITY has helped the Trust make improvements, and examples of these.

The Trusts Priorities for 2018/19

Healthwatch Birmingham has taken note of the Trust's priorities for 2019/20, which reflect the experiences people tell Healthwatch Birmingham. A key element of these priorities is that they are setting the necessary foundations for the Trust, such as developing guidance, improving the single electronic system — UNITY to aid assessments and support quality/safety planning — and examining how services will be delivered at the Midland Metropolitan Hospital. We believe that the Trust should also focus on developing a strategy for listening to and acting on patient experiences to help improve patient care.

Trust response

We thank Healthwatch Birmingham for their review of our Quality Account 2018/19 and their valuable comments. We also publish our Quality Account as part of our Integrated Annual Report and Accounts and more detailed information can be found within that report with particular reference to patient feedback including a specific section on learning from our patients.

Healthwatch Sandwell

Healthwatch Sandwell (HWS) is the independent patient champion for health and social care in Sandwell, delivered by Engaging Communities (ECS) CIC. We are pleased to comment about the activities that have taken place by SWBHT during 2018/19.

Our relationship with Sandwell and West Birmingham NHS Trust (SWBHT) has been productive and we have been involved in various projects. We were acknowledged in the Purple Point Initiative (PPI), which was implemented in February 2018 by SWBHT. This is a hotline that has been introduced to respond to concerns of in-patients or their loved ones about their care before the patient is discharged from SWBHT.

SWBHT implemented the PPI as a direct result of work undertaken by HWS on patient experiences at Sandwell General Hospital (during 2015 and 2016) which found patients wanted concerns resolved in a more timely approach.

HWS evaluated patient knowledge and use of the Purple Points in March 2019 and found that the public's awareness was poor. Our investigation found that 92% of the respondents did not know what the PPI was and gave a range of answers, including:

"it's where you assemble when there is a fire alarm"

HWS have made the following recommendations and look forward to receiving a response from SWBHT:

- An effective publicity campaign is undertaken again to inform the public of the initiative.
- An information leaflet about PPI is given to each patient on admission to raise awareness.

HWS continue to have effective relationships with SWBHT, especially with the Communications team, who are always opens and supportive of our visits to the hospitals, especially in relation to survey work, including the NHS Long Term Plan.

HWS have appreciated the receptiveness of SWBHT when we have escalated concerns from the public about the future of services, for example, The Midland Met. Hospital. We believe that this is testament to our effective working relationship.

HWS have regularly signposted patients and their carers

to PALS and have supported them through their journey of raising concerns about their care. Our Engagement and Information Lead Officer is meeting regularly with Head of Complaints at SWBHT and we look forward to developing our partnership in 2019/20 whilst retaining our independence to represent the experience of patients and their carers.

It is pleasing to note that the SWBHT have embedded their safety plan within patient services, which sets out core checks that are carried out with every patient within 24 hours of them receiving care. HWS would endorse that safety of patients is paramount and look forward to this safety plan being evaluated, we will continue to monitor feedback from patients and carers.

During 2018/19 three 'Never events' were reported. HWS would like to commend SWBHT for recording these events and will be monitoring any patient feedback that may be connected to these three events.

HWS appreciate that the delay and the challenges of the completion of the Midland Met. Hospital has resulted in disruption and we look forward to seeing this project becoming a reality. Our representative on the Sandwell and West Birmingham Hospital Trust Board will continue to ensure that the needs and requirements of local people are represented.

SWBHT have listed 3 priority areas in this Quality Account and HWS will be monitoring outcomes of the identified priorities:

Priority 1 - Improved outcomes for patients presenting with signs and symptoms of sepsis.

Priority 2 - Achieving a good rating under the framework of the CQC assessment.

Priority 3 - Supporting improved acute care by implementing strong people management improvements, addressing configuration issues in advance of Midland Met, and ensuring seven-day service compliance from 2020.

In relation to priority 2 we believe that patients deserve services that are "Outstanding", and we look forward to working with the NHS Trust to make this a reality.

One of the three priorities for the Trust in 2018/19 was improving the consistency of care provided to patients while on our wards. This initiative focussed on having the right documentation completed at the right time and making sure that the correct documentation and risk assessments are completed on all patients at the time they are admitted to our wards. As part of this initiative 10 medicine standards were implemented which included standards on administration and omissions of medication.

The Medicines Management and Optimisation Team at **Birmingham and Solihull Clinical Commissioning Group** have commented on this aspect of the Quality account and stated 'It is good to see that ensuring patient medication is administered as prescribed and recording/coding of omissions and delays is a high priority for the Trust. It would be good to understand what is being done with the information about omissions and delays to drive improvement.'

L-R = Rotational Physiotherapist, Tom Mahoney and Physiotherapist, Qivon.

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

We have been engaged by the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust to perform an independent assurance engagement in respect of Sandwell and West Birmingham Hospitals NHS Trust's Quality Account for the year ended 31 March 2019 ("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 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Percentage of patient safety incidents resulting in severe harm or death

- Percentage of patients risk-assessed for venous thromboembolism (VTE)

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 1 April 2018 to 29 May 2019;

- papers relating to quality reported to the Board over the period 1 April 2018 to 29 May 2019

- feedback from commissioners dated 21/05/2019;

- feedback from local Healthwatch organisations dated 13/05/2019 and 24/05/2019;

- 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 2018/19, Quarter 2 2018/19, Quarter 3 2018/19 and Quarter 4 2018/19;

- the national patient survey dated 2018;

- the national staff survey dated 2018;

- the local staff survey dated November 2018 and February 2019;

- the Head of Internal Audit's annual opinion over the Trust's control environment dated 02/05/2019;

- the annual governance statement dated 29/05/2019;

- the Care Quality Commission's inspection report dated 05/04/2019;

- 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 and West Birmingham Hospitals NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Sandwell and West Birmingham Hospitals NHS Trust for our work or this report, 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 and West Birmingham Hospitals NHS Trust.

Our audit work on the financial statements of Sandwell and West Birmingham Hospitals NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Sandwell and West Birmingham Hospitals NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Sandwell and West Birmingham Hospitals 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 and West Birmingham Hospitals 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 and West Birmingham Hospitals 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 and West Birmingham Hospitals NHS Trust and Sandwell and West Birmingham Hospitals 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 2019:

- 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

29 May 2019

NHS

Sandwell and West Birmingham

NHS Trust