Paper ref:	TB (11/19) 021

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Quality Plan: Action plans		
Sponsoring Executive	David Carruthers, Medical Director		
Report Author	David Carruthers, Medical Director		
Meeting	Public Trust Board	**Date**	7th November 2019

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The Quality Plan looks to improve care across many domains in the Trust, reaching across all Groups and into primary care. Targets for improvement in most of the projects have previously been presented. The thoughts and approaches to addressing individual plans are shown here.

Now we will support those plans that are most advanced, finalise those plans that have solid proposals and help develop those that require more thought. We would expect to have all plans completed by early February 2020, such that our investment priorities for 2020-2022 can reflect our 2020 vision. In the meantime those with advanced plans will see funding determinations made during November through the executive.

2. Alignment to 2020 Vision *[indicate with an 'x' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	
Quality Plan	x	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Q+S Oct 2019, Trust Board August 2019

4. Recommendation(s)

The Trust Board Committee is asked to:

a.	**REVIEW** the proposals for action for each of the QP
b.	**SUPPORT** other lines of enquiry where relevant
c.	**DISCUSS** timelines for delivery

5. Impact *[indicate with an 'x' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register								
Board Assurance Framework	X	SBAF3						
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 7th November 2019

Quality Plan: action plans

1. Introduction or background

1.1 Previously we have presented the improvement targets for the Quality Plan projects. Here for discussion are the current plans to address each project aim. All plans are at different stages of development with the aim now of confirming all action plans over the coming months.

1.2 As a reminder the areas under review here within the quality plan are :

Well developed projects:

1.2.1 QP3: We will coordinate care well across different services so that patients who are discharged are cared for safely at home and don't need to come back for an unplanned further hospital stay.

1.2.2 QP6: We will reduce the number of stillbirths and deaths in the first week of life so that we are providing a better service than others in the West Midlands.

1.2.3 QP7: Patients at the end of their lives will die in the place they choose, receiving compassionate end of life care.

Partial developed projects:

1.2.4 QP2: Cancer patients that we treat will have some of the best health outcomes in the UK, with SWBH being among the top 20% of comparable NHS Trusts.

1.2.5 QP4: We will deliver outstanding quality of outcomes in our work to save people's eye-sight, with results among the top 20% of comparable NHS Trusts in the UK.

1.2.6 QP8: We will ensure the wellbeing of the children we care for, in particular reducing lost days of school as a result of hospital care; and ensuring the safe transition of care to adult services at the appropriate time.

Projects where proposal needs more support:

1.2.7 QP5: More Sandwell and West Birmingham residents will take up the health screening services that we provide than in other parts of the West Midlands

1.2.8 QP9: Patients will report that their health is better following treatment with us than elsewhere in England, ranking SWBH in the top 20% of NHS Trusts for patient-reported outcomes.

1.2.9 QP10: We will work in close partnership with mental health care partners to ensure that our children's, young people's, adult and older people's crisis and ongoing care services are among the best in the West Midlands.

The focus will differ for these 3 groups to help them develop and deliver the projects with support from the improvement team and regular review through Group reviews and MD office. This will also involve defining the timeline for delivery.

2. QP3: We will coordinate care well across different services so that patients who are discharged are cared for safely at home and don't need to come back for an unplanned further hospital stay.

	Unplanned readmission
Current	8.4% (n = 8500)
Target	7.4% (n = 7500)

2.1 Initial thoughts - review some of the initiatives that were already in place (hot clinics for post discharge patients) and plans for a 48 hour review of discharged patients from PCCT. Look at the discharge data initially to see if we can identify any trends in patient readmissions based on: see tables 2 and 3

- Specialty from which they were discharged
- Underlying diagnosis from coding data
- Source of readmission – via GP into SPA or via re-presentation to A+E
- Place of discharge (home v nursing/care home)
- Compare those specialties with high v those with low readmission rates

2.2 Other data to look at:

- Readmissions from hot clinic after review
- Readmissions from OPAT service

2.3 These data points would then allow a focus to be had on specific clinical areas or diagnoses where we can look at the pathways in more detail to identify if there are patterns in the causes of readmissions. PCCT have started on their 48 hour review, including engagement with groups such as the redcross to support the objectives of the reviews.

2.4 Initial steps:

- In comparison to peer group – look at any areas where SWB have readmissions and peer group have 0 to ascertain if this is a recording issue
- Target top 9 areas where SWB have the greatest readmissions compared to peer group
- Look at specific pathways where PCCT can directly influence e.g. Cellulitis, DVT, falls

2.5 MIS

- Promote services provided to enable patients to receive their treatments as an outpatient rather than staying in hospital or being admitted to hospital for their treatments. As well as providing a service which enables patients to receive their

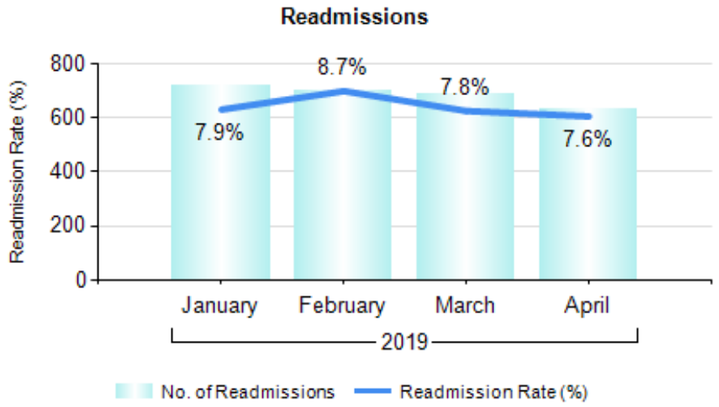
treatment in a way that works for them and their families it also helps with patient flow, length of stay and reducing readmissions.

- Approaches being explored to advertise the service
- Staff training for mid lines which would allow patients to come to MIS to have their mid line inserted and then receive their first treatment at the same time which in some instances would reduce their length of stay or avoid a readmission for the mid line to be fitted.
- Patient feedback.
- Expanding to blood/iron infusions

See tables 2 and 3 on next pages

Emergency Readmissions (within 30 days) Overall (exc. Deaths and Stillbirths)

CYear	CMonth	Readmissions	Discharges	% Readmitted	
2019	January	716	9089	7.88%	
	February	702	8038	8.73%	
	March	685	8768	7.81%	
	April	629	8319	7.56%	
Total		2732	34214	7.99%	



Link To Patient Detail

Readmission By Specialty

Link To Patient Detail

		Readmissions					Discharges					ReadmitRate				
		2019					2019					2019				
Speccode	Treatment Specialty	January	February	March	April	Trend	January	February	March	April	Trend	January	February	March	April	Trend
100	GENERAL SURGERY	56	56	85	72		598	579	665	604		9.36%	9.67%	12.78%	11.92%	
101	UROLOGY	25	26	21	25		349	286	313	322		7.16%	9.09%	6.71%	7.76%	
103	BREAST SURGERY			1			76	62	69	67		0.0%	0.0%	1.45%	0.0%	
107	VASCULAR SURGERY		1	1			28	12	22	12		0.0%	8.33%	4.55%	0.0%	
110	TRAUMA & ORTHOPAEDICS	16	25	17	19		538	530	561	579		2.97%	4.72%	3.03%	3.28%	
120	ENT	15	15	10	11		224	189	179	179		6.7%	7.94%	5.59%	6.15%	
130	OPHTHALMOLOGY	8	13	21	9		135	119	124	200		5.93%	10.92%	16.94%	4.5%	
140	ORAL SURGERY	1	1	1	1		258	220	229	211		0.39%	0.45%	0.44%	0.47%	
160	PLASTIC SURGERY	1	1	1	2		28	33	40	22		3.57%	3.03%	2.5%	9.09%	
171	PAEDIATRIC SURGERY									1					0.0%	
180	ACCIDENT & EMERGENCY		1				2		2	1		0.0%		0.0%	0.0%	
191	PAIN MANAGEMENT	6	6	4	1		352	272	324	292		1.7%	2.21%	1.23%	0.34%	
192	CRITICAL CARE MEDICINE						1			1		0.0%			0.0%	
300	GENERAL MEDICINE		3	15	10		1	39	83	42		0.0%	7.69%	18.07%	23.81%	
301	GASTROENTEROLOGY	28	25	24	27		277	230	304	258		10.11%	10.87%	7.89%	10.47%	
302	ENDOCRINOLOGY			1			1	7	15	9		0.0%	0.0%	6.67%	0.0%	
303	CLINICAL HAEMATOLOGY	11	11	22	18		563	448	453	444		1.95%	2.46%	4.86%	4.05%	
305	CLINICAL PHARMACOLOGY		3	1	4		51	25	34	36		0.0%	12.0%	2.94%	11.11%	
307	DIABETIC MEDICINE	1			1		1	3	7	4		100.0%	0.0%	0.0%	25.0%	
314	REHABILITATION	2	1	4	2		8	16	28	12		25.0%	6.25%	14.29%	16.67%	
316	CLINICAL IMMUNOLOGY		1	2			129	134	136	110		0.0%	0.75%	1.47%	0.0%	
318	INTERMEDIATE CARE	60	69	51	57		247	228	209	221		24.29%	30.26%	24.4%	25.79%	
320	CARDIOLOGY	53	37	26	33		323	318	324	325		16.41%	11.64%	8.02%	10.15%	
326	Acute Medicine - Internal Only	192	154	154	117		1,449	1,200	1,327	1,189		13.25%	12.83%	11.61%	9.84%	
328	Stroke Medicine	5	5	1	2		56	59	52	73		8.93%	8.47%	1.92%	2.74%	
330	DERMATOLOGY	3		2	1		261	260	218	172		1.15%	0.0%	0.92%	0.58%	
340	RESPIRATORY MEDICINE	41	38	35	38		271	217	213	264		15.13%	17.51%	16.43%	14.39%	
361	NEPHROLOGY		3	1			6	9	11	9		0.0%	33.33%	9.09%	0.0%	

400	NEUROLOGY	1		1	2		12	12	15	10		8.33%	0.0%	6.67%	20.0%	
410	RHEUMATOLOGY	2	2	3	2		168	127	157	140		1.19%	1.57%	1.91%	1.43%	
420	PAEDIATRICS	52	55	50	45		754	689	806	740		6.9%	7.98%	6.2%	6.08%	
422	NEONATOLOGY	3	4		2		41	35	46	33		7.32%	11.43%	0.0%	6.06%	
424	WELL BABIES	19	12	23	21		404	352	387	393		4.7%	3.41%	5.94%	5.34%	
430	GERIATRIC MEDICINE	89	113	93	86		500	461	462	418		17.8%	24.51%	20.13%	20.57%	
501	OBSTETRICS				1		441	386	447	378		0.0%	0.0%	0.0%	0.26%	
502	GYNAECOLOGY	19	20	11	16		304	274	292	318		6.25%	7.3%	3.77%	5.03%	
503	GYNAECOLOGICAL ONCOLOGY	6	1	1	2		62	52	70	65		9.68%	1.92%	1.43%	3.08%	
560	MIDWIFE EPISODE						132	116	119	136		0.0%	0.0%	0.0%	0.0%	
800	CLINICAL ONCOLOGY (previously RADIOTHERAPY)						1					0.0%				
810	not a Treatment Function						28	34	19	24		0.0%	0.0%	0.0%	0.0%	
811	INTERVENTIONAL RADIOLOGY	1		2	2											
830	not a Treatment Function						9	5	6	5		0.0%	0.0%	0.0%	0.0%	

Next steps: Review the support needed to obtain data to establish areas of highest impact

3. QP6: We will reduce the number of stillbirths and deaths in the first week of life so that we are providing a better service than others in the West Midlands.

	Adjusted Stillbirth rate (per 1000 births)	Adjusted perinatal mortality rate
Current	4.0	5.4
Target	3.8 by 2020 2.8 by 2025	5.0 by 2020 3.6 by 2025

3.1 The data to be used is annual Adjusted Stillbirth, Neonatal death and Perinatal Mortality rates - these are expressed as deaths per 1000 births. This data is produced by the Directorate yearly and dates back to 2013.

3.2 The adjusted rates (which excludes births <24 wks gestation, births <400g or births complicated by lethal fetal congenital abnormality) are a truer picture of changes in perinatal mortality for our population.

3.3 Data shows that from 2015-2018

- the adjusted SB rate has fallen by 40%
- the adjusted neonatal death rate has fallen by 22%
- the adjusted perinatal mortality rate has fallen by 36%

3.4 National targets are a reduction in these rates (+maternal mortality) by **20% by 2020 and by 50% by 2025**.

3.5 I would recommend that we use 2015 as our baseline figure as that is the year the DOH announced these national targets and there was funding made available to the NHS to prioritise projects to reduce perinatal mortality - which has gradually developed into the Saving Babies Lives care bundle, for which we were a Wave 1 Pilot Unit.

3.6 I feel that we should stick to the national targets and not be setting higher targets to reach since :

a) the rates can change and fluctuate year on year even though the maternity services provided may be the same or improving (as we are dealing with small numbers of losses overall)

b) truer rates can be analysed by rolling 3yearly averages which flattens out changes in rates year to year

c) to achieve these rate reductions will be a major achievement and will not be reached by many Units and may not be reached Nationally.

3.7 Therefore we are aiming to reduce all three local rates by at least 20% by 2020 compared to 2015 rates and by 50% by 2025. We should also be aiming to reduce the MBRRACE-UK figures for SWBH by the same rates. Their adjusted figures are different to our local figures as they adjust in a different way and take more account of the demographics of our population. This does allow direct comparison with other units (esp of similar size and status of neonatal unit) each year. It is more challenging to reduce these rates for us as MBRRACE does not exclude for lethal congenital anomalies.

3.8 As well as using MBRRACE -UK annual data to compare regionally and nationally we will be able to use LMS data to compare to our nearest neighbouring units. The first meaningful data from the LMS regarding stillbirths or perinatal mortality will not be published until 2020.

3.9 Therefore continue with the current models of care and changes that were implemented in the last few years should enable us to reach/exceed these targets within the Quality plan. This will be a very great achievement as are the reductions in cases we have seen in the last 3 years and puts us significantly ahead of other Maternity Units in the West Midlands.

3.10 Leads for Perinatal Mortality will document service changes, care pathway changes that have and are planned to occur. Review approach to communication with GP for early referral of mothers with co morbidities e.g. hypertension/diabetes/renal disease.

Next Steps: Define the changes that are already underway, those that need to be introduced and the resource and timeline to achieve this.

4. QP7: Patients at the end of their lives will die in the place they choose, receiving compassionate end of life care.

	Recognised as dying in Acute hospital & Supportive Care Planning in place
Current	30%
Target	60%

4.1 The overall purpose of the project - This project will normalise high quality end of life and palliative care for people living and dying with palliative diagnosis wherever they are. This will aim to bring SWBH in line with the Six National Ambitions for End of Life Care so that for people we look after in their last year of life and the people around them can have the best possible experience.

4.2 The project will address gaps in provision of quality end of life care in the SWBH hospital in-patient setting which have been highlighted in the National Care of The Dying Audit 2019. It was shown that SWBH failed to meet 8/9 recommendations falling well below our Black Country peers in line with the Black Country STP Quality Metrics

Key issues which will be addressed are:

a) Improve recognition of the possibility of imminent death - early recognition that a person may be dying enables an individual care plan to be developed,
b) Consistent Advance Care Planning discussions with the patient and families to take place,
c) Appropriate Treatment escalation decisions to be made and the needs of the family to be considered

(Adapted from One Chance To Get It Right Priority 1, NICE QS144 Statement 1).

4.3 Measurable Quality outcomes of project:

1. Reduction in hospital admissions in last 90 days of life.
2. A Supportive Care Plan in place when death is expected to guide personalised care.
3. We will know where people want to die and enable this to happen.
4. Upskilled motivated clinicians better equipped to care at the end of life with a shared understanding that death is a normal part of life and confidently offering their patients positive options with fewer unwanted, unhelpful interventions.
5. Improved results in national audits therefore demonstrating high quality care at the Trust.

6. Reducing Complaints about poor communication and lack of choice by recognising when patients are at risk of dying and providing personalised care.

4.4 Overarching objectives

1. We will be one of the top 20% for providers nationally for high quality EOL & Palliative Care as evidenced by in the National Care of the Dying Audit.
2. Maintain 'excellent' CQC report for end of life.
3. Develop an academic faculty focusing on wellbeing, communication and practice behaviour change.

4.5 Scale of the issue - Social context:

1. Approximately 1% of the UK population are thought to be in their last year of life at any time and 60% of these deaths are thought to be predictable.
2. Since 2011 the number of deaths per annum has increased and ONS forecast that this upward trend will continue for the foreseeable future with a 25% increase in annual deaths by 2039 (NHS England). This implies that demand for end of life care has been comparatively low in recent years but will rise considerably in the years ahead.
3. Deaths in the over 85s and from frailty and degenerative conditions are projected to rise rapidly, whilst deaths in other age groups and from cancer, organ failure and sudden deaths will remain stable or reduce.
4. Dying is often recognised very late, reducing the opportunities to change the patient experience by fast track discharge home from hospital, or preventing admission to hospital from care home or home when no escalation of medical care is appropriate.
5. Most people would prefer to be cared for at home, using acute services only when they are going to improve their quality of life

4.6 Locally in Sandwell and West Birmingham - Key figures:

1. In 2018/19 there were 1413 deaths in SWBH hospital beds with multiple clinical areas having over 100 deaths per annum, particularly those looking after older adults, the critical care units and the acute medical wards.
2. SWBH's community-facing Connected Palliative Care service (CPC) has a track record of keeping people at home. At time of writing there are 680 people registered on our End of Life Register.
3. Circa 80% of people registered with CPC achieve their place of choice to die.
4. Only 35-40% registrations with CPC are for people with non-cancer diagnosis, whereas we know 66% of population deaths are from a non-cancer cause which suggests that people are missing out on palliative care and the opportunity to plan their future care.
5. There were 194 care home residents who died in SWBH 06/18-06/19 who generated 500 admission spells up to their death.

6. We have an established individualised care plan for people in their last year of life – the Supportive Care Plan however is used inconsistently across inpatient settings wards with only circa 30% of all people dying having a plan of care in place (Appendix 3) (vs 90% of people dying at home) . This indicated a large section of people dying in hospital never having any conversations about their wishes or opportunity to choose their place of death.
7. Eight of our wards have over 90 deaths per year. With particular clusters of multiple admissions in the three months leading up to death on specific wards.
8. There is wide variation within S&WB CCG Primary care practice's use of end of life register with variation in list sizes for practices from 0.1%-1.96%, with expected national standard level being 1%. This in part reflects a lack of consistent messages from specialist clinicians who have had contact with patients whilst in hospital to enable identification of those for whom the register is appropriate which then prompts advance care planning and management of any palliative and end of life care
9. Population trends for admissions in the last 3 months of life in SWBCCG have shown a reduction in the percentage of deaths with three or more emergency admissions in last three months of life, from 9.5% in 2015 (peer average 8.3%, national average 6.9%) to 6.4% in 2017 (peer average 6.3%, national average 5.4%) (NHS England).

4.7 Opportunities for impact - NHS England data demonstrates significant savings to be made modifying the pathways for people with palliative diagnosis, particularly in acute care, with 40% cost savings across multiple conditions to be made. By moving our organisation with a focus on quality of end of life care with an environment where clinical teams work together, recognising, acknowledging and informing earlier in the patient journey when cure is not possible, we will open up options to patient and clinicians to make positive choices about their care, and allow a shift in care towards quality of life rather than automatic escalation.

4.8 How we will do this - We will develop an enhanced multidisciplinary Palliative and End of life care working group, identifying the barriers and implement interventions needed to implement the Sandwell and West Birmingham recommendations from the National Audit of End of Life Care audit outcomes to implement a sustainable quality improvement process with key performance indicators for each area.

4.9 Core Team requirements (new posts):

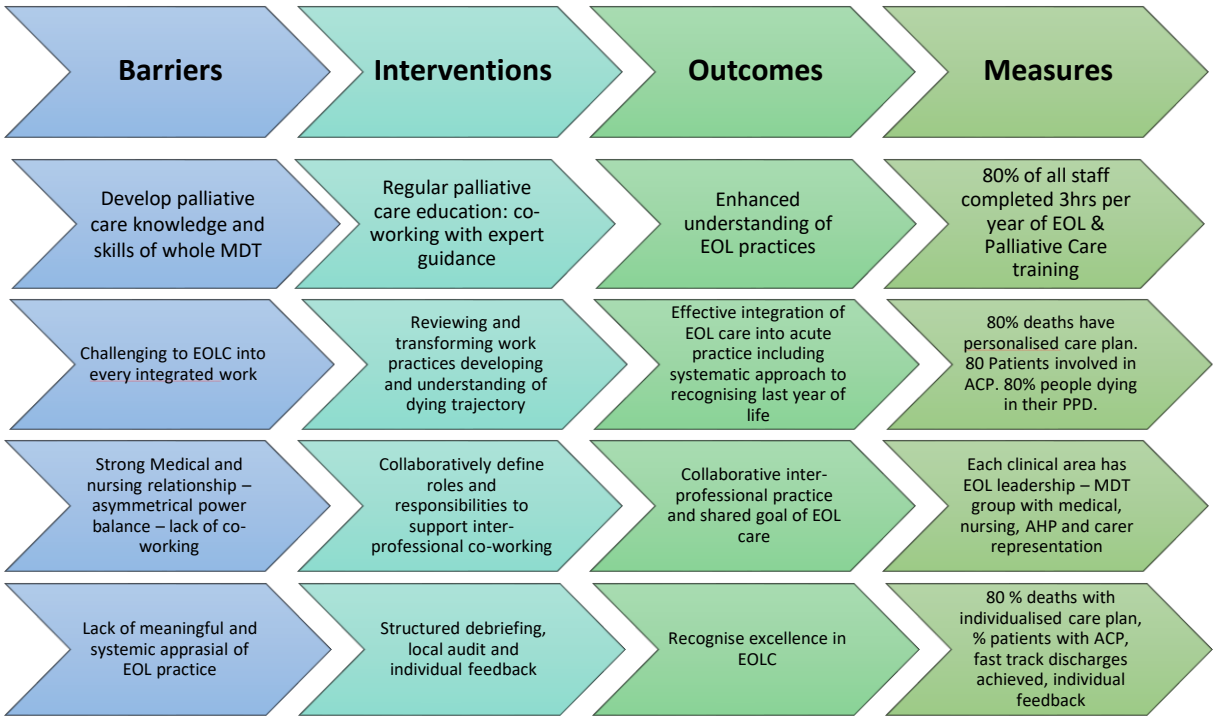
1. Additional Palliative Medicine Consultants (2 FTE): bringing total SWBH palliative medicine consultant workforce in line with Royal College of Physicians Palliative Medicine workforce recommendations
2. Staff Grade 0.5FTE with focus on Education and Wellbeing
3. Dedicated Acute End of Life Care Facilitator (Band 6 nurse)
4. Band 4 admin support (1FTE)

4.10 Extended team:

1. Nominated EOL MDT leads for each identified high need clinical area
2. GP: working with affiliated SWBH practices
3. Chaplaincy
4. Bereavement team
5. Psychology
6. Patient/Carer representative
7. Volunteer services

4.11 Service Development method

Evidence is that normalising high quality end of life care takes a whole system approach addressing each barrier to change with specific interventions, to deliver the desired outcomes (adapted from Noble et al).



4.12 This project will modelling, training and shared decision-making approach to improve confidence and skills in management of dying people by clinical teams with earlier identification increasing opportunities to change patient outcomes (Clark et al.).

Example project activities:

Setting	Methods	Tools	Key Performance indicators
All	Education Programme Palliative Care team modelling and training in clinical areas	1. Education program for all MDT 2. E Learning – ensure national programme used effectively 3. Schwartz rounds facilitation 4. Wellbeing sessions and support for clinicians specifically around	80% all staff palliative care trained annually

		caring for people who are dying 5. Integrate EOL simulation into trust program 6. Mentoring ACCS to deliver core palliative competencies new curriculum	
Acute Ward areas	Work closely with colleagues across sectors in a. respiratory care, particularly COPD and fibrosing lung disease, b. cardiac disease c. liver failure and d. dementia & frailty.	1. Targeted board rounds on wards (including A&E and critical care), particularly targeted at those areas identified as needing improvement in identification of dying, communication and modification of treatment plans 2. Joint ward rounds, hospital and community MDTs and parallel specialist clinics	80% all deaths have SCP in place 80% of all deaths have Advance Care Planning offered
	Joint work with Mortality team incl. Medical examiners & Clinical Mortality meetings	1. Mortality Group membership 2. Undertake shared reviews of people who die, and support taking that learning back into clinical practice.	
Community liaison	Develop a process for facilitating primary care teams identification of last year of life on a stratification of adherence to best practice such as Gold Standard's framework	1. Audit of practice and outcomes feeding back to practices 2. Set up systems for enhanced communication with primary & care home staff 3. Working with EPOCH project to support advance care planning.	1% population GP EOLC registers % non-cancer diagnosis on CPC register Each area has a Primary Care champions of MDT working in each area
Care Homes	Integrating with the new Trust Care Home Project to keep people in the place of their choice, and following admission ensuring there is a clear treatment escalation plan in place to avoid unwanted admissions.	1. MDT input to Care Home project 2. Improve communication between acute sector and care home teams	% admissions from care homes

Next Steps: Arrange review with palliative care team to define timeline with investment needed to deliver project activities

5. QP2: Cancer patients that we treat will have some of the best health outcomes in the UK, with SWBH being among the top 20% of comparable NHS Trusts.

	1 year outcomes	5 year outcomes
Current	68.2%	Data awaited
Target	72%	Data awaited

5.1 There is difficulty in obtaining survival data with all the national sites, CCGs, West Midlands Cancer Alliance and other key stakeholders have the following:

- Index of survival for CCGs in England – provides 1 year net survival for all cancers combined, for breast, colorectal and lung cancer separately and for these three cancers combined
- Cancer Survival in England - provides 5 year net cancer survival for adults in England, for all cases and by stage at diagnoses, not at a CCG level

5.2 The only local data that could provide crude survival data by tumour site is to review 2013 diagnosed cancers and check for patients who have survived 5 years as the baseline, which will need further discussion or an alternative piece of work internally to achieve 5 year outcomes.

Key Area	Action	BY whom	Timescale for review
Drive down late presentation of patients more patients to present with stage 1 & 2	Audit/benchmark to identify the tumour sites that present at A&E	Ian Charles	October 2019
	Present the finding to GP practices and CCG	Jenny Donovan	November 2019
	Review data of staging by tumour site	Ian Charles	November 2019
	Agree an action plan with primary care i.e. education	Jenny Donovan/ Dr Muralidhar	December 2019
	To consider a vague symptoms clinic	Jenny Donovan/ Diana Webb	January 2019
Work with the CCG & Cancer Research UK Early diagnosis Facilitator regarding patients presenting earlier	Analysis of 1 & 5 year survival date for catchment population/CCG	Ian Charles/ Jenny Donovan	November 2019
	Identifying key tumour sites where survival is in bottom quartile	Ian Charles/ Jenny Donovan	November 2019
	Comparative benchmark of cancer mortality	Ian Charles/ Jenny Donovan	November 2019
	Educate GP communities and patients to spot signs and symptoms	Jenny Donovan/ Dr Muralidhar	January 2019

Work with Public Health to develop local strategies	Local Health and Wellbeing committee to develop strategy for increasing cancer awareness and screening	Jenny Donovan/ Diana Webb	December 2019
	Other patient factors affecting cancer survival e.g. co- morbidity/fitness for curative surgery	Jenny Donovan/ Diana Webb	December 2019
Engage in clinical Trials to increase recruitment to improve outcomes from research data	Gain a report of the trials open and recruitment figures	Jenny Donovan/ Brian Gammon	October 2019
	Discussion with MDT teams of their ambitions of opening trials and challenge	Jenny Donovan/ Brian Gammon	November 2019
	Discussion with Research Team regarding the ambitions and future stock take	Jenny Donovan/ Brian Gammon	December 2019
	Submission of NBOCAP/ COSD/ SACT	Jenny Donovan/ Brian Gammon	December 2019
	Review of pilot band 4 data facilitator in Colorectal & Prostate role to see the increase in data collection and accuracy	Jenny Donovan/ Brian Gammon	December 2019

Next steps: review progress with Cancer Board and relationships with STP and UHB cancer services

6. QP4: We will deliver outstanding quality of outcomes in our work to save people's eye-sight, with results among the top 20% of comparable NHS Trusts in the UK.

	Patients with eyesight loss/ year
Current	Data awaited
Target	To await any national data to see scale of improvement

Timeline:	2019	2020	2020	2021 - 23	2021 - 23
QP Outcome target	100% of children within the screening services will have information regarding the importance of attending community optometrists regularly from the age of 4 to support preventable vision loss in our paediatric population	Diabetic retinopathy, Prevention – information will be provided to all patients attending the diabetic screening service on the risk factors that can adversely impact on their vision e.g. signposting through a bespoke leaflet.	Diabetic retinopathy – patients who have been referred into the HES from the diabetic screening programme who are then diagnosed with sub optimal diabetic control as evidenced through advancing diabetic retinopathy (but below treatment threshold) will have a standard referral letter sent to the GP requesting an optimisation review within the current medisoft letter.	Proliferative diabetic retinopathy –(R3 – from Diabetic Screening Programme) 80% of patients will be seen within 2 weeks of referral into the HES and if required, treated within 2 weeks of their appointment	M1 – Maculopathy – 70% seen within 6 weeks and treated within 6 weeks of appointment.

Project work to achieve target	James Flint – Screening lead for reception age vision testing.	Mr Chavan (medical retinal lead) to create project group linking in with range of stakeholders including patients, patient screening programmes, MECs links etc to produce information leaflet and to gain engagement from screening teams to hand out leaflets at each appointment.	Mr Chavan (medical retinal lead) to create project group linking in with range of stakeholders including patients, patient screening programmes, MECs links, GP link, Dottie Tipton.	Ms Mushtaq Benchmarked against current achievement from the screening programme data. Review in 6 months and 1 year for evidence of adherence or improvements.	Ms Mushtaq Benchmarked against current achievement from the screening programme data. Review in 6 months and 1 year for evidence of adherence or improvements.
Support needed	Alteration to current screening letters to parents. Reinforcement of message by screening orthoptists if parents attend child's appointment.	Audit – 100 patients. Qualitative and quantitative results to be reviewed. Supported by trainees to complete audit data and presentation.Working in partnership with the current diabetic support teams / programmes to ensure consistency of messages.	Audit of 100 patients – look at compliance with attending GP and impact on HBLA1C readings and any other systemic risk factors available. Review of qualitative and quantitative data.	Support from screening lead to provide accurate data. Support from failsafe officers and booking teams to deliver on targets	Support from screening lead to provide accurate data. Support from failsafe officers and booking teams to deliver on targets

Investment needed	Nil	Funding to be identified. (Discuss with Black Country screening lead)	Time to manage project.	Limited investment as long as capacity remains available for demand	Limited investment as long as capacity remains available for demand

Next Steps: Review with ophthalmology team and clarify any support that is needed.

7. QP8: We will ensure the wellbeing of the children we care for, in particular reducing lost days of school as a result of hospital care; and ensuring the safe transition of care to adult services at the appropriate time.

	Specialties with formal Transition pathway	Lost days of school
Current	5/17 = 29%	baseline audit data awaited
Target	17/17 = 100%	Target is to reduce by 10%

	Outcome	Required Action	Timescale	Lead	How will successful completion be evidenced?	RAG
Reducing lost days of school as a result of Hospital Care						
1.	**Understand the factors of delays in children returning to School after discharge.**	• An initial survey of families and children, following discharge to identify those children with delayed return to school by ward and/or school nursing services via telephone survey. • Working with our school health nursing services to map and monitor delays in return to school and to establish factors contributing to the delay	Oct 19	RP/JO/SBD	• Response rates to survey. • Factors for delayed return to school identified • Contemporaneous data set	A
2.	**Understand the reasons for readmissions by condition and reduce readmission rates by 10%**	• Analyse readmission data by condition (big 6) to achieve baseline position in relation and set improvement trajectory • Work across acute and community Paediatrics to develop pathways to improve follow up contacts immediately post discharge to avoid readmissions. • Establish the impact of pathway through monitoring readmission rates for those children receiving post discharge follow up. • Improve discharge planning and commence discharge planning on admission, utilising metrics gained through Target Date for Discharge (TDD) within UNITY.	Oct 19 Jan 20 Oct 19 Oct 19 Oct 19 Jan 20	RP/AM RP/AM/PM RP/AM RP/AM RP/JO/MA RP/AM	• Reduction in readmission rates. • Implementation of CNS team for long term conditions. • Inclusion of health advice and expected school return date included in discharge letters. • Implementation of early GP follow ups.	A

	Outcome	Required Action	Timescale	Lead	How will successful completion be evidenced?	RAG
		• Share best practice across teams where readmission rates are low. • Develop a Business Case for Clinical Nurse Specialist post for conditions with high readmission rates such as Asthma. • Provision of specific health advice on return to school following discharge from hospital. • Repeat survey for those children to compare impact on length of time to return to school • For chronic conditions such as asthma, diabetes and epilepsy, a robust school health care plan needs to be in place. • School health nursing team to review during annual care plan audit with further review if care plan changes. • Develop pathways for early GP follow ups.	Apr 20 Jan 20	RP/JO RP/JO/AM		
3.	**Reduce length of stay by 10%**	• Analyse current length of stay data against national guidance. • Develop reference guide by condition for expected length of stay to aid discharge planning. • Develop pathways for transfer caring to community and specialist teams and GPs in relevant cases i.e. Asthma.	Oct 19 Jan 20 Jan 20	RP/JO RP/AM RP/AM/JO	• Implementation of reference guide by condition for expected length of stay. • Improved pathways to community and GP services. • Maintained reduction in length of stay.	A
4.	**Reduce admission rates**	• Development of Rapid Access Clinics to reduce time spent in assessment units and potential hospital admissions to allow elective appointments and potentially avoid hospital admission. Review current ambulatory pathways and scope for potential new pathways.	Oct 19 Jan 20 Apr 20	RP/JO RP/AM RP/JO/MA	• Increased number of Rapid Access clinics available. • Implementation of additional ambulatory pathways • Implementation of and/or use of CNS team for long term	A

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

	Outcome	Required Action	Timescale	Lead	How will successful completion be evidenced?	RAG
		• Increase frequency of follow ups for patients at risk of admission through additional capacity from specialist nurse led clinics.			conditions.	
5.	**Increased availability of out of school time outpatient clinics.**	• Initial survey of families and children to identify preferences for clinic availability, with parents of school age children attending clinics • Review current outpatient clinic availability in hospital to scope alignment to survey findings. • Explore the possibility of Telemedicine and Skype clinics to avoid children and young people attending hospital clinics in school hours – with facilities based in the schools.	Oct 19 Jan 20 Apr 20	RP/JO RP/JO/LE RP/JO	• Increased clinic availability in line with the outcomes of initial survey of families. • Implementation of Telemedicine/Skype Clinics	A
6.	**Increased availability of community and school based outpatient clinics.**	• Initial survey of families and children to identify preferences for clinic locations. • Review current outpatient clinic availability in community and school settings to scope alignment to survey outcomes. • Explore the possibility of Telemedicine and Skype clinics to avoid children and young people attending hospital clinics in school hours – with facilities based in the schools.	Oct 19 Jan 20 Apr 20	RP/JO RP/JO/LE RP/JO	• Increased clinic locations based on outcomes of initial survey of families. • Implementation of Telemedicine/Skype clinics	A
7.	**Reduction in review appointments**	• Review of the need for follow up appointments – and those children that can be transferred back to the care of GPs. • Trajectory for reduction to be established following initial review and identification of those children who can be transferred to care of GP. • Increase capacity through development of specialist nurse led clinics.	Jan 20 Apr 20 Apr 20	RP/JO/AM RP/JO/AM RP/JO/AM	• Reduction in current reviews	A

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

	Outcome	Required Action	Timescale	Lead	How will successful completion be evidenced?	RAG
		• Work with the PCNs to review pathways of care and the development of GP specialists to lead on early access GP led paediatric clinics at surgeries local to where children live.				
Ensuring the safe transition of care to adult services at the appropriate time						
8.	**Young People who will move from Children's to adults services to have started planning their transition with health and social care practitioner by school year 9 (aged 13-14) or immediately if they enter service after school year 9.**	• Identification of specialty service transition and develop matrix for monitoring progress and transitional care pathways • Exploration & development of baseline work, agreement will be gained with relevant Consultant leads to which are prioritised in the first instance. • Transition Key Worker (TKW) will Implement the Transition Assessment (Ready, Steady, Go) in the service areas identified who are not currently using it. Data will be collated from services already using "Readiness to Transfer" assessment to determine proportion of YP. Numerator data to be collated. • Implementation of Transition plan in services areas identified as not currently using in practice. Data will be collated from services already using a plan. Numerator data to be collated. • Work is required to provide denominator data with regards to creation of manual database in interim pending future developments within electronic systems. • Database to include Assessment status & differentiate between "Ready "steady" "Go" phases to track progress. • Database to include completion of condition specific competency checklist, • TKW to discuss with Consultants adding Transition	Oct 19 Oct 19 Jan 20 Jan 20 Jan 20 Jan 20 Oct 19	KEF / JO KEF/JO KEF/JO KEF/JO KEF/JO KEF/JO KEF/JO	• Monitoring matrix • Evidence of local arrangements to ensure that YP who will move from children's to adults services start transition planning. • Implementation of database to capture and monitor patient's transition status. • Implementation of referral system and allocation of named workers.	A

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

	Outcome	Required Action	Timescale	Lead	How will successful completion be evidenced?	RAG
		section in to each clinic summary from aged 14 & copied to TKW. • System to be established for TKW to be notified of new referrals aged 14+ with chronic condition to ensure Named Worker is allocated.	Oct 19	KEF/JO		
9.	**Young People who will move from children's to adults services have an annual meeting to review transition planning.**	• Collate data from services where existing transition planning is underway. • Database to record data in interim, until able to develop data entry in to Unity. • Denominator data work is required as above.	Oct 19 Jan 20 Jan 20	KEF/JO KEF/JO KEF/JO	• Evidence of annual meetings.	A
10.	**Young people who are moving from children's to adults services have a named worker to coordinate care and support before, during and after transfer**	• Introduce the term of "Transition Named Worker" terminology to avoid confusion with Transition Key Worker role. • Database will record Named Worker for each YP & identify any gaps. Meet with Unity Team to discuss named worker data entry. • Liaise with Specialist Nurses for their caseload data to update named worker status for those currently receiving support. TKW to be added named worker for those without one.	Oct 19 Jan 20 Oct 19	KEF/JO KEF/JO KEF/JO	• Named workers identified for all young people undertaking transition.	A
11.	**YP who will move from children's to adults services meet a practitioner from each of the adult's service they will move to before they transfer.**	• Baseline assessment will identify services that do not currently have joint clinics & confirm which services need support from TKW. • Format of clinic letters to include transition section will inform this process. • Monitor Transition assessment & plan documentation.	Oct 19 Jan 20 Jan 20	KEF/JO KEF/JO KEF/JO	• Evidence of introduction meetings with adult services pre transition.	A
12.	**Young people who have moved from children's to adult's services but do**	• System to be introduced prior to transfer for named worker to establish preferred method of follow up	Nov 19	KEF/JO	• Evidence of follow up action for patients that do not attend	A

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

	Outcome	Required Action	Timescale	Lead	How will successful completion be evidenced?	RAG
	not attend their first meeting or appointment are contacted by adult services and given further opportunities to engage.	for YP and action accordingly. • Consider system for requesting Adult Services send copy of "Hello to Adult Services" document to TKW (patient consent to be obtained).	Nov 19	KEF/JO	first meeting appointments.	

Next steps: Review progress and any investment needed for delivery of plan

Status	G	Action completed and CQC concern addressed	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set and stated

8. QP5: More Sandwell and West Birmingham residents will take up the health screening services that we provide than in other parts of the West Midlands

	Breast screening	Bowel screening
Current	63%	59%
Target	70%	65%

8.1 Screening will become a larger part of cancer board agenda, link in more with the CCG screening group which feeds into STP group. The recent release of review of adult screening programmes – England which assesses current screening practices and provides recommendations on updating national programmes will help inform the local quality plan and the local plans to improve screening are shown in the tables below.

Key Area	Action	BY whom	Timescale for review
Increase of population served by 1, 876 and need to ensure that patients are reminded of screening appointments	Piloting the GP's sending Breast Screening Appointment text reminders for the 1st appointment and 2nd timed DNA appointment across the whole service	Rosemary Isaacs	March – October 2019
	For those GP's that choose not to participate in the text reminder initiative, the service proposes to send out a GP endorsed pre-screen 1st appointment reminder letter across the service to the prevalent screen cohorts.	Rosemary Isaacs	March – October 2019
2nd DNA patient appointment reminders for 1th screening round 2018 - 2021	The service will continue the sending of the GP endorsed pre-screen reminder letters to the 2nd timed DNA's where the GP is willing to work collaboratively.	Rosemary Isaacs	2018 - 2021
Promote breast screening and identify reason for hard to reach communities none attendance	Increase the Social media aspect of the service i.e. Facebook & Twitter accounts + develop our website information.	Rosemary Isaacs	

	Work with Learning Disabilities health workers to identify key areas for none attendance	Rosemary Isaacs/ Jenny Donovan	January 2020
	Work with hard to reach communities i.e. local communities to identify kay areas for none attendance	Rosemary Isaacs/ Jenny Donovan	January 2020
	Link with Cancer Research UK Facilitator regarding common work streams and learning	Rosemary Isaacs/ Jenny Donovan	January 2020
	Review video for patients who cannot read, write or understand English	Rosemary Isaacs/ Jenny Donovan	January 2020
	Review of the Adult screening Programmes in England recommendations from Mike Richards report to check local compliance and actions	Rosemary Isaacs/ Jenny Donovan	November 2019
	Develop Cancer Champion role in the community	Jenny Donovan/ Emma Hunstone	December 2019

Key Area	**Action**	**BY whom**	**Timescale for review**
Primary Care Engagement **35 practices** within the low uptake category with a cumulative average uptake of 35% or below. This is well below the BCSS 'achievable' range of 60% or over	General GP practices annual correspondence from screening centre	Claire Millard & Team	March 2020
	Low uptake practices – bi-annual correspondence from screening centre	Claire Millard & Team	March 2020
	Primary care visits – The screening centre will liaise closely with the 35 low uptake practices and will be offering practical support, encouraging partnerships between the screening centre, primary care and the Cancer Research UK engagement facilitator	Claire Millard & Team	March 2020
	GP endorsement banner and digital communications 'ecomms'	Claire Millard & Team	March 2020
	Bowel scope roll out engagement and audit	Claire Millard & Team	December 2019

	Single screening kit request project and audit	Claire Millard & Team	December 19
Community Engagement based around the areas of low bowel screening uptake across Birmingham and the Black Country	Community events	Claire Millard & Team	March 2020
	External advertisement campaigns	Claire Millard & Team	March 2020
	April is bowel cancer awareness month campaign. The screening centre will continue this intensive monthly promotion and will be within areas of high footfall within shopping centre and areas of high footfall within the demographic of bowel screening within areas of low uptake.	Claire Millard & Team	March 2020
	CRUK Roadshow events. In May 2019, there will be 8 Cancer Research UK Roadshows across the West Midlands region including the screening centre coverage area.	Claire Millard & Team	March 2020
	Bowel screening summer party	Claire Millard & Team	March 2020
CCG engagement	Clinician protected learning time and educational events as hosted by CCG personnel	Claire Millard & Team	March 2020
	The screening centre will continue on the quorum of screening and early cancer detection forums within Sandwell and West Birmingham CCG. and Birmingham and Solihull (BSOL) CCG.	Claire Millard & Team	March 2020
Media engagement	The screening centre sends both written and digital correspondence to practices.	Claire Millard & Team	March 2020
	At least 12 FB/media posts per quarter	Claire Millard & Team	March 2020
	Consider Twitter accounts	Maggie Preston	January 2020
	Review website information	Maggie Preston	January 2020
Promote bowel screening and identify reason for hard to reach communities none attendance	Work with Learning Disabilities health workers to identify key areas for none attendance	Claire Millard/ Jenny Donovan	January 2020
	Work with hard to reach communities i.e. local communities to identify kay areas for none attendance	Claire Millard/ Jenny Donovan	January 2020
	Review video for patients who cannot read, write or understand English	Claire Millard/ Jenny Donovan	January 2020

	Review of the Adult screening Programmes in England recommendations from Mike Richards report to check local compliance and actions	Claire Millard/ Jenny Donovan	November 2019
	Develop Cancer Champion role in the community	Jenny Donovan/ Emma Hunstone	December 2019

Next steps: Review plan with screening team November 2019

9. QP9: Patients will report that their health is better following treatment with us than elsewhere in England, ranking SWBH in the top 20% of NHS Trusts for patient-reported outcomes.

	PROMS knee % improving (EQ-5D)	PROMS Hip % improving (EQ-5D)
Current	81.9%	91%
Target	87%	95%

Next steps: obtain detailed plan from orthopaedics over interventions that can be undertaken to improve outcome for hip and knee replacement patients.

10. QP10: We will work in close partnership with mental health care partners to ensure that our children's, young people's, adult and older people's crisis and ongoing care services are among the best in the West Midlands.

	Patients with MH problems attending A+E	Patients with MH problems requiring AMU admission
Current	Data awaited	Data awaited
Target	15 - 20 % reduction	15 - 20 % reduction

10.1 The quality metrics will be:

- A reduction in the number of frequent attenders with a primary mental health problem to ED
- A reduction in time patients with a primary mental health diagnosis spend in the ED department
- A reduction in the time that patients with a primary mental health problem spend in a deep admission bed while waiting for a mental health bed.
- The number of Emergency Care staff/paediatrics that are educated in the support and care of those patients with a primary mental health problem
- Time to be seen by CAMHS following referral

Next steps: Establish key priorities for work with Mental Health Trusts and training needs for current ED staff.

11. Recommendations

11.1 The Trust Board is asked to:

a) Review the proposals for action for each of the QP
b) Support other lines of enquiry where relevant
c) Discuss timelines for delivery

David Carruthers
Medical Director
30/10/2019