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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Delivering the Quality Plan objectives		
Sponsoring Executive	David Carruthers, Medical Director		
Report Author	David Carruthers, Medical Director		
Meeting	Trust Board (Public)	**Date**	6th February 2020

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

The Trust has ambitious plans for improving the quality of care provided to our patients. This is reflected in the Quality Plan where the initial objective focuses on improving patient mortality in the Trust, while subsequent projects are more specialty or topic specific. These latter projects have clinical or operational leads allocated to them, link in with existing work streams or reflect the ambition of the clinical specialty to improve care in the defined area.

Progress updates are provided through the 2 monthly Group reviews with support and monitoring via the Improvement Team and Medical Directors Office.

Here an update on the Trust mortality position is provided, currently overseen by the Learning from Deaths Committee. In addition progress on the individual projects is provided showing how work in these areas is developing and how timelines and targets are being defined and progressed.

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?]*

November Trust Board (public)

4. Recommendation(s)

The Trust Board is asked to:

a.	**REVIEW** progress of the Quality plans, including mortality data
b.	**DISCUSS** the timelines for achieving goals of the individual projects
c.	**SUPPORT** the approach to maximise engagement for the individual plans

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 Public Trust Board: 6th February 2020

Delivering the Quality Plan objectives

1. Introduction or background

1.1 The Trust Quality plan aims to reduce mortality and improve outcomes of the care provided to our patients. These are detailed within the 10 plans previously agreed and presented to the Board. Here an update on progress against each of the plans is presented, including a summary of common themes identified across each of the specific projects.

2. Mortality

2.1 There has been an improvement in patient mortality data (SHMi and HSMR to a lesser extent). Improvements in depth of coding now better reflect the health of our patient population and may be one of the influencing factors on improved mortality indices. Palliative care coding is stable but inclusion of non-specialist palliative care coding in the future may influence this data.

2.2 There is regular audit on CV, Stroke and fracture NoF deaths by the respective specialties. The focus on sepsis continues (data on % patients screened and those receiving antibiotics in an hour by each ward area is available and will form part of ward based QI work with support from the improvement team). Learning from Deaths committee, Medical examiner case reviews, the appointment of a medical examiner office r, SJR training and development of specialty mortality lead representation at LfD committee are all contributing to this improvement work

3. Specialty specific projects

3.1 The specifics for each project are summarised here, with the detail available within the attached annex for each project

3.2 **QP2 – Cancer outcomes**. 5 year survival data is not available so data on stage at presentation of each cancer is shown as this aligns with national priorities. Linking in with work across the STP, particularly around GP and patient engagement for early referral, establishing a vague symptom clinic and consideration of data co-ordinators are all part of the plan.

3.3 **QP3 – Readmission reductions**. Lessons from excellence on one Trust site are being learnt and applied cross site. The patient population most at risk of readmission are

being identified to establish reasons for readmission. Where new services have been established to reduce readmission, these are being reviewed for evidence of outcome improvement. Consistency of service for patients between Sandwell and Birmingham is being established.

3.4 **QP4 – Preserve vision**. Initial work on childhood screening is in place and plans worked up for diabetic retinopathy screening and the links with primary care to improve overall diabetic management. Plans for macular disease need more development time.

3.5 **QP5 – Screening**. The approach has been to target patient notification and community engagement to improve attendance for screening. The staffing challenges in breast and GI screening are identified and the national report on changes to screening programmes is being considered. Screening services for asymptomatic and symptomatic patients are considered as different pathways are needed. The required investment has been considered to develop the (breast screening) service.

3.6 **QP6 – Perinatal mortality**. Development of the LMS means comparative data available and regional improvement work engaged with. There is already some reduction in perinatal mortality. Improved communication with primary care for early maternal referral and improved staff training through local and national programmes identified.

3.7 **QP7 – End of Life care**. Programme of work identified, including need for additional medical support for the service. Consultant Palliative Care currently out to advert. Links with National care of the dying audit. Focus will initially be on clinicians caring for patients with cardiovascular and respiratory disease.

3.8 **QP8 – Reduced loss of school days and adolescent care**. Plans in place for surveys to identify reasons for school day loss. Plan is to pick high volume clinical areas initially (e.g. asthma) and link with school nursing teams as an example. Transition work in place for preparation of young people for transitional care to adult services

3.9 **QP9 – PROMS**. Programme in place to improve not only aspects of data collection but also information provided to patients about their procedures and expectations.

3.10 **QP10 – Mental health**. Quality metrics have been identified and a body of work will be needed to identify the cross agency work needed to realise the plan.

4. Summary

4.1 From the work schedules in the annex 2 and the above summary, there are themes emerging where areas of QI work have been identified. This is not a reflection of all the

aspects of service change and QI work identified but the table below summaries what those areas are.

	QP2	QP3	QP4	QP5	QP6	QP7	QP8	QP9	QP10
Working across primary care	X		X	X	X				
Patient engagement		X	X		X	X	X	X	X
Public engagement	X		X	X	X		X		
Service partner engagement	X	X			X		X		X
Responding to National Guidance	X			X	X	X			
Training focus (pt and staff)					X	X	X		X
Across multiple specialties	X	X				X	X		
Data collection required to progress							X	X	
Need for service change identified		X	X			X	X		
Need for investment identified				X		X			

4.2 This therefore shows that there is a need to raise awareness and confirm engagement across the different clinical Groups in Trust and also primary care for certain of these projects to establish best chance of progress. Regular articles in Heartbeat and shared topics at QIHD could be future considerations where clear actions are required or information transmitted to a wider staff group.

4.3 Delivery of information to the public and to patients needs to be considered in a structured consistent format.

4.4 Timelines do need to be defined more clearly with the support of the improvement team and areas where investment is needed identified.

4.5 **Proposal**

- These issues might be addressed by presentations to CLE (for those projects that cross specialties) leading to increase group support;

- Communication out to primary care to focus on the aims of the Quality plan and the co-working that can occur for our patients benefit.

- A co-ordinated approach to patient and public engagement will also be helpful for branding of the Quality Plan work being undertaken.

5. Recommendations

5.1 The Trust Board is asked to:

a. **Review** progress of the Quality plans, including mortality data
b. **Discuss** the timelines for achieving goals of the individual projects
c. **Support** the approach to maximise engagement for the individual plans

David Carruthers
Medical Director

27th January 2020

Annex 1

QP1 – reduction in Trust mortality - Mortality Dashboard December LfDC

Standard Indicator Set: Activity Overview	Trust Performance		
Indicator	**Current**	**Previous**	**Change**
Number of mortalities (12 mth rolling) HES Inpatients (Nov 2019)	2,852 (Sep 2018 - Aug 2019)	2,957 (Aug 2018 - Jul 2019)	-105
Number of mortalities occurring in-hospital (12 mth rolling) HES Inpatients (Nov 2019)	1,451 (Sep 2018 - Aug 2019)	1,449 (Aug 2018 - Jul 2019)	2
Number of mortalities occurring post-discharge (12 mth rolling) HES Inpatients (Nov 2019)	1,401 (Sep 2018 - Aug 2019)	1,508 (Aug 2018 - Jul 2019)	-107

Trust Mortality Compliance data

	Total Number of deaths	%of deaths that had 1st Tier Mortality Reviews	Number of Deaths Reviewed at CAPROM	Number with Avoidability score of 3 or less suggesting a more than 50:50 likelihood of Avoidability
Jan	114	77%	4	**0**
February	134	80%	5	**0**
March	114	78%	2	**0**
April	132	83%	7	**0**
May	110	84%	1	**0**
June	115	75%	1	**1**
July	106	81%	3	**1**
August	114	77%		**0**
September	110	78%	4	**0**
October	132	77%	3	**1**
November	130	76%	3	**0**
December	139	73%	3	**1**

Comparative Data Mortality Data

Definition: The (Summary Hospital-level Mortality Indicator) SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes death up to 30 days post discharge and does not adjust for palliative care. SHMI above 1 is higher than benchmark

NHS DIGITAL QUATERLY DATA

	October 2017-September 2018	Jan 2018- Dec 2018	April 2018 – March 2019	July 2018-June 2019
SHMI (Trust wide)	**114**	**107**	**1.06**	**1.05**
City		**0.97**	**0.95**	**0.99**
Sandwell		**1.14**	**1.11**	**1.07**
Rowley and Leasowes data*		**1.71**	**1.81**	**1.63**
Palliative Care coding	**21.5%**	**22.1**	**22.9%**	**22.43**
Deaths within 30 days of elective procedure	**0.6%**	**0.58**	**0.77%**	**0.71**
% of deaths in most deprived	**63.8%**	**61.4%**	**61.1%**	**60.75%**
% of deaths where coding is a symptom	**13.8%**	**13.9%**	**14.3%**	**14.24%**
Mean depth of coding for elective	**4.3%**	**4.9%**	**5.2%**	**5.37%**
Mean depth of coding for Non elective	**4.3%**	**4.7%**	**4.9%**	**5.1%**

***undergoing review to understand influence of high number of palliative care patient deaths in this figure for Leasowes. Data to be separated in future to have Rowley mortality data separate from that of Leasowes.**

Monthly SHMI Q2 July and August 2019: 98

HSMR rebasing period up to September 2019: 113

Weekend/Weekday data

Definition

Risk Adjusted Mortality Index (RAMI) is a statistical tool by which an estimate is made of probability of death for all admitted patients. It does not include deaths after discharge. It adjusts for palliative care and procedures. 100 is average

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
RAMI - Monthly	94.0	106.0	102.0	121.0	116.0	114.7	88.55	107.43	90	107	111	111.51
RAMI - 12 month cumulative	102.0	100.0	98.0	98.0	99.0	107.0	104.84	104.85	103.7	102.86	103.67	106.1
RAMI peer - 12 month cumulative	93.0	92.0	91.1	90.7	89.9	89.9	89.59	89.43	88.93	89.33	89.04	88.79
RAMI - weekday 12 month cumulative	106.3	104.4	102.4	103.7	104.6	107.0	104.74	105.41	104.39	104.12	103.41	105.28
RAMI peer - weekday 12 month cumulative	90.7	89.7	88.8	88.4	87.7	87.5	87.24	87.26	86.63	87.06	86.84	86.57
RAMI weekend - 12 month cumulative	115.4	112.9	109.2	88.4	106.9	105.4	105.14	103.15	99.2	99.14	104.51	108.58
RAMI peer - weekend 12 month cumulative	100.5	99.6	98.4	88.4	97.2	97.4	96.97	97.73	96.2	96.2	96.4	95.83

Quality Plan data:

	October 2017 – September 2018	Jan 2018 – Dec 2018	April 2018 – March 2019	July 2018 – June 2019
Sepsis	**Observed 172** **Expected 151**	**Observed 189** **Expected 162**	**Observed 195** **Expected 172**	**Observed 200** **Expected 178.9**
Stroke	Observed 91 Expected 90.1	**Observed 91** **Expected 96**	**Observed 89** **Expected 99.4**	**Observed 97** **Expected 105**
Myocardial infarction	**Observed 46** **Expected 42.3**	**Observed 44** **Expected 41**	**Observed 49** **Expected 39.3**	**Observed 49** **Expected 38.5**
Fracture Neck of femur	**Observed 32** **Expected 43.3**	**Observed 22** **Expected 29.7**	**Observed 24** **Expected 27.8**	**Observed 20** **Expected 26.2**
VTE deaths	**No data**			

External Early warning alerts

Alert	Alert Period	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score	Alert Level
CUSUM	Sep 2019	2 - Septicemia (except in labor)	120.61	155	825	6.07	-
CUSUM	Sep 2019	122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	189.17	228	1844	5.02	-
CUSUM	Sep 2019	14 - Cancer of colon	9.57	14	129	3.94	-
CUSUM	Sep 2019	154 - Non-infectious gastroenteritis	1.48	2	58	3.72	-
HSMR	Oct 2018 - Sep 2019	2 - Septicemia (except in labor)	120.61	155	825	128.52	Red
SHMI	Sep 2018 - Aug 2019	40 - Multiple myeloma	2.87	9	26	313.95	Red
SHMI	Sep 2018 - Aug 2019	252 - Malaise and fatigue	11.29	24	250	212.6	Red

• *HSMR alerts for red outliers (upper 99.8% limit) for 56 CCS groups only*

Annex 2

Quality Plan Update Template
Leads - Jenny Donovan, Liam Kennedy

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

Quality Plan Target

	1 year outcomes	Staging 5 year
Current	68.2%	N/A
Target	72%	N/A

Although it would be ideal to compare one year survival with 5 year survival this has not been possible as presently the data for 5 year data is not available. It has therefore been decided record staging data at five years in line with the NHS Long Term Plan ambitions for cancer: "By 2028, the proportion of cancers diagnosed at stage one and two will rise from just over half now to three quarters of cancer patients."

Staging Data

The data presented below compares SWBHT and Bolton Hospital which is classified as a comparable Trust. The tables are data from 2013 to 2017 which will be the baseline data by tumour site.

	SWBH							**Bolton**					
2013-17	1	2	3	4	n/k	Unstageable		1	2	3	4	n/k	Unstageable
BREAST (C50)	41.5	40.93	8.37	4.24	4.29			51.33	34.44	8.81	2.88	2.03	
Lung (C34)	10.8	6.75	21.3	57.06	3.81			14.51	7.68	18.41	50.24	9.15	
C54 corpus uteri	54.79	13.03	15.16	6.65	7.18	3.19		24.45	7.49	16.77	41.92	9.18	0.2
C56 Ovarian	43.97	5.2	29.3	13.48	7.57	0.47		14.21	7.27	20.37	47.25	10.9	
C61 Prostate	40.93	18.44	11.83	20.93	7.86			40.94	14.15	15.91	18.48	10.29	0.23
C18 colon	11.84	25.91	24.93	32.17	5.15			14.08	33.53	22.79	23.37	6.24	
C20 Rectum	23.84	29.36	19.77	22.38	4.65			28.24	23.59	24.25	17.94	5.98	

2013-17	1	2	3	4	n/k	Unstageable		1	2	3	4	n/k	Unstageable
C10-C13 Pharynx	0	8	10	70	8	4		9.09	6.06	24.24	51.52	3.03	6.06
C15 oesophagus	11.57	20.66	28.1	26.45	12.81			11.52	10.6	31.34	41.94	4.61	
C16 Stomach	10.13	13.66	15.86	40.09	19.82	0.44		15.06	24.1	16.27	39.16	5.42	
C67 Bladder	41.57	29.02	4.71	15.29	9.41			29.57	32.17	5.65	11.74	20.43	0.43

Key Points	Action	Update on progress, Next steps and Timeline
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	A more structured piece of work will commence February 2020 with the CCG & West Midlands Cancer Alliance.
	Present the finding to GP practices and CCG	Awaiting the piece of work in the grid above to commence
	Review data of staging by tumour site	Review of data from 2013- 2017 by tumour site staging has been undertaken
	Agree an action plan with primary care i.e. education	Black Country & WB STP are planning training sessions for early detection of cancer with GPs
	To consider a vague symptoms clinic	Dudley is a pilot for the Rapid Diagnostic centre with SWBHT piloting from Summer 2020. In preparation key stakeholders attended a Dudley event for GPs to learn about their model. A task and finish group is being pulled together with the first meeting on 18th February.
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	Changed to staging data at five years in line with the Long Term Plan
	Identifying key tumour sites where survival is in bottom quartile	Reviewing comparative data
	Comparative benchmark of cancer mortality	Reviewing comparative data
	Educate GP communities and patients to spot signs and symptoms	Black Country & WB STP are planning training sessions for early detection of cancer with GPs. Cancer Community Facilitator to commence with the remit

Key Points	Action	Update on progress, Next steps and Timeline
		to go out to hard to reach communities and discuss screening Cancer Champions advertised via Healthwatch. Training programme agreed across the BC& WB STP and to commence first training mid-February 2020
Work with Public Health to develop local strategies	Local Health and Wellbeing committee to develop strategy for increasing cancer awareness and screening	
	Other patient factors affecting cancer survival e.g. co-morbidity/fitness for curative surgery	
Engage in clinical Trials to increase recruitment to improve outcomes from research data	Gain a report of the trials open and recruitment figures	Meeting with the newly appointed Head of Research and Development planned 23rd January 2020 to improve communication and data flows
	Discussion with MDT teams of their ambitions of opening trials and challenge	Meet with MDT teams with the data for recruitment and what opportunities are available on site and local Trusts
	Discussion with Research Team regarding the ambitions and future stock take	Ask research team to be represented at the MDT meeting above
	Submission of NBOCAP/ COSD/ SACT	Cancer Patient Trackers support the collection of data although this is a huge pressure during periods of vacancies and sickness plus new targets that need tracking is the priority. The Cancer data Facilitator has demonstrated the improvement of data i.e. NBOCAP
	Review of pilot band 4 data facilitator in Colorectal & Prostate role to see the increase in data collection and accuracy	**NBOCAP(Colorectal) 2017 – 18 data** Headlines: Achieved >100% case ascertainment (nationally 95%) Achieved 96% data completeness for & audit items required for accurate risk adjustment (Network 82%, nationally 86%) Major resection rates in potentially curative patients 92% (network 88%, nationally 86%)

Key Points	Action	Update on progress, Next steps and Timeline
		12+ Lymph node yield 86% (network 77%, national 84%) Laparoscopic attempted 89% (network 74%, nationally 69%) LoS >5 days 53% (network 58%, nationally 62%) Rectal cancer CRM negative 86% (network 80%, nationally 80%) **The colorectal team believe having a data facilitator has significantly improved the data collection and accuracy. The post is a pilot for 12 months and the need to review the sustainability of the role for prostate and colorectal.**

Quality Plan Update Template
Leads - Liam Kennedy, Mel Roberts

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.

Quality Plan Target

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

	Key Points	**Update on progress, Next steps and Timeline**
1	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.	**48hr review completed. Initial data shows a reduction of 2.4% on the medical cohort of patients discharged form Sandwell. Rolled out to PCCT on 1st January. Next steps – discuss with BCHT roll out for city patients – meeting January 2020 and roll out to medicine 1st February 2020** **Review of hot clinics to be completed – February 2020**
	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	**Discharge data now been reviewed and agreed what's required** **Next steps – formally review and identify pathways to work on with highest admissions and attach reduction in readmission target to each one – to be completed by end of February**

	Key Points	Update on progress, Next steps and Timeline
2	Review data for: • Readmissions from hot clinic after review • Readmissions from OPAT service	**Data been requested for both – to be reviewed by mid-February**
3	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	**Data requested for peer group and links to discharge data above** **Next steps as above for target top 9 areas** **Specific pathway work in place for cellulitis, DVT and falls** **Organise improvement team support for top 9 target areas by mid-February 2020**
4	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	**Service promotion work on going – Face to face discussions with ward areas, Advertisement on trust internet, promotion via OPAT quarterly meetings involving GP's and clinical leads, Weekly antibiotic stewardship clinical reviews, Teamtalk briefing session booked 2020 and stand pharmacy staff engagement event for antibiotic awareness week.** **Development of online referral form to be completed by April 2020.** **OPAT service currently provided at City, Rowley Regis and via Sandwell and West Birmingham District nursing service.** **Ongoing discussions with Birmingham Community Trust regarding the provision of OPAT for Birmingham patients in the interim the service is provided by OPAT both at City Hospital and in patient's homes.**

	Key Points	Update on progress, Next steps and Timeline
		HC and DI Leading the trusts midline project role out. W/C 13th January staff engagement commenced. **AMMAR meeting attended to promote admissions to MIS for both blood and Iron infusions.**

Quality Plan Update Template
Leads - Bushra Mushtaq, Hilary Lemboye

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.

Quality Plan Target

	Patients with eyesight loss/ year
Current	Data awaited (audit in progress looking at reduction in CVI Registration after implementation of screening programme)
Target	To await any national data to see scale of improvement

	Key Points	**Update on Progress**
2019 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	Completed August 2019 All letters updated to include further information as per quality plan and QR code to link service users to NHS 'Look after your eyes' website
Project work to achieve target	James Flint – Screening lead for reception age vision testing.	Completed August 2019
Support needed	Alteration to current screening letters to parents. Reinforcement of message by screening orthoptists if parents attend child's appointment.	Completed August 2019
Investment needed	NIL	Completed August 2019
2020	Diabetic retinopathy,	

	Key Points	Update on Progress
Outcome Target	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.	
Project work to achieve target	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.	This will be completed by July 2020
Support needed	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.	This will be completed by August 2020
Investment needed	Funding to be identified. (Discuss with Black Country screening lead)	As above
2020 Outcome Target	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.	Monitoring against the rate of compliance will be undertaken between February and August 2020
Project work to achieve target	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.	This will be completed by July 2020
Support needed	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.	This is co-dependant on an earlier project and will therefore be audited after August 2020 being completed by December 2020
Investment needed	Time to manage project.	
2021-23 Outcome Target	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	No yet started

	Key Points	Update on Progress
Project work to achieve target	Ms Mushtaq - Benchmarked against current achievement from the screening programme data. Review in 6 months and 1 year for evidence of adherence or improvements.	Not Yet started
Support needed	Support from screening lead to provide accurate data. Support from failsafe officers and booking teams to deliver on targets.	Not Yet started
Investment needed	Limited investment as long as capacity remains available for demand.	
2021-23 Outcome Target	M1 – Maculopathy – 70% seen within 6 weeks and treated within 6 weeks of appointment.	Not Yet started
Project work to achieve target	Ms Mushtaq - Benchmarked against current achievement from the screening programme data. Review in 6 months and 1 year for evidence of adherence or improvements.	Not Yet started
Support needed	Support from screening lead to provide accurate data. Support from failsafe officers and booking teams to deliver on targets	
Investment needed	Limited investment as long as capacity remains available for demand	

Quality Plan Update Template
Leads - Jenny Donovan, Liam Kennedy

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

Quality Plan Target

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

There are two recent reports on cancer screening that will influence the Trust in increasing the uptake of health screening. The Independent Review of Adult Screening Programmes in England published a report (October 2019) which is set to change screening over the next decade and to evolve if it's to save more lives. The report has 22 recommendations which are aspirational over the next five years. A quote from the report" Screening programmes are constrained by the size and nature of their workforce, the equipment and facilities available to them, which will act as a barrier to implementing the recommendations" which is locally recognised in all cancer screening services across the SWB footprint. The second report West Midlands Screening Health Equity Audit Report (December 2019) reported evidence of inequalities in cancer screening programmes, and a number of recommendations that could reduce inequalities in the region.

	Key Points	**Update on progress, Next steps and Timeline**		
Key Area	**Action**	**BY whom**	**Timescale for review**	**Update**
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~~ May 2020	~~-~~This approach continues with the GPs in the 11th screening round(2018-2021)

	Key Points	Update on progress, Next steps and Timeline		
	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~~ May 2020	This approach continues with the GPs in the 11th screening round(2018-2021)
2nd DNA patient appointment reminders for 11th 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	This approach continues
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	September 2020	Not commenced need to link with bowel screening for similar areas
	Work with Learning Disabilities health workers to identify key areas for none attendance	Rosemary Isaacs/ Jenny Donovan	~~January 2020~~ May 2020	We have the name of the link for the lead for learning disabilities and arranging a meeting
	Work with hard to reach communities i.e. local communities to identify key areas for none attendance	Rosemary Isaacs/ Jenny Donovan	~~January 2020~~ May 2020	Cancer Community Facilitator to commence with the remit to go out to hard to reach communities and discuss screening
	Link with Cancer Research UK Facilitator regarding common work streams and learning	Rosemary Isaacs/ Jenny Donovan	~~January 2020~~ May 2020	Already working and meeting Cancer Research UK Facilitator need to review the West Midlands Screening Health Equity Audit Report Recommendations to frame work plan with CCG
	Review video for patients who cannot read, write or understand English	Rosemary Isaacs/ Jenny	~~January 2020~~ May 2020	Review of video and need to consider a BC wide video launch

	Key Points	Update on progress, Next steps and Timeline		
		Donovan		
	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	Need to review the West Midlands Screening Health Equity Audit Report Recommendations to frame work plan with CCG
	Develop Cancer Champion role in the community	Jenny Donovan/ Emma Hunstone	~~December 2019~~ May 2020	Advertised via Healthwatch. Training programme agreed across the BC& WB STP and to commence first training mid-February 2020
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	Ongoing work and monitoring
	Low uptake practices – bi-annual correspondence from screening centre	Claire Millard & Team	March 2020	Ongoing work and monitoring
	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	Ongoing work and monitoring
	GP endorsement banner and digital communications 'ecomms'	Claire Millard & Team	March 2020	Work in progress
	Bowel scope roll out engagement and audit	Claire Millard & Team	December 2019	Rollout of FIT planning was based on worst case scenario of 11% it has hit 50% increase and therefore even with additional capacity the team cannot match

	Key Points	Update on progress, Next steps and Timeline		
				demand. There are leavers and sickness in the team. Pre assessment clinics increased Bowel scope lists by accredited colonoscopist to be converted to BCSP colon lists. Any down lists are being picked up. Third endoscopy room agreed and going through the process of ordering equipment and upgrade of room Training of clinical staff BCSP Colonoscopy accreditation at QE and SWBHT
	Single screening kit request project and audit	Claire Millard & Team	December 20 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	Planning of events across the community
	External advertisement campaigns	Claire Millard & Team	March 2020	Planning stage of campaigns
	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	Planning stage for high areas of foot fall within areas of low uptake
	CRUK Roadshow events. In May 2019, there will be 8 Cancer Research UK Roadshows across the West Midlands region including the screening	Claire Millard & Team	March 2020	Planning with CRUK

	Key Points	Update on progress, Next steps and Timeline		
	centre coverage area.			
	Bowel screening summer party	Claire Millard & Team	March 2020	Completed decided to hold only at significant years i.e. last year 10 year anniversary
CCG engagement	Clinician protected learning time and educational events as hosted by CCG personnel	Claire Millard & Team	March 2020	Discussion with CCG for dates/times
	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	Ongoing
Media engagement	The screening centre sends both written and digital correspondence to practices.	Claire Millard & Team	March 2020	Planning stage
	At least 12 FB/media posts per quarter	Claire Millard & Team	March 2020	Planning stage
	Consider Twitter accounts	Maggie Preston	January 2020	Planning stage
	Review website information	Maggie Preston	~~January 2020~~ March 2020	The website information changes have been updated and awaiting checks in the department before going to staff communication to make the changes
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	J~~anuary 2020~~ May 2020	We have the name of the link for the lead for learning disabilities and arranging a meeting
	Work with hard to reach communities i.e. local communities to identify key areas for none attendance	Claire Millard/ Jenny Donovan	J~~anuary 2020~~ May 2020	Cancer Community Facilitator to commence with the remit to go out to hard to reach communities and discuss screening

	Key Points	Update on progress, Next steps and Timeline		
	Review video for patients who cannot read, write or understand English	Claire Millard/ Jenny Donovan	~~January 2020~~ May 2020	Need to review of video and need to consider a BC wide video launch
	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	Need to review the West Midlands Screening Health Equity Audit Report Recommendations to frame work plan with CCG
	Develop Cancer Champion role in the community	Jenny Donovan/ Emma Hunstone	~~December 2019~~ May 2020	Advertised via Healthwatch. Training programme agreed across the BC& WB STP and to commence first training mid-February 2020

There is a clear correlation of the increase in screening will have an impact on the flow of patients via a 2ww referral and building capacity should not be in isolation, it needs to be a whole system approach. The Breast Service has submitted a paper to the CEO describing the service expansion and growth required in the overall service model and are awaiting the next steps.

Quality Plan Update Template
Leads - Neil Shah

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.

Quality Plan Target

	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

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. 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.

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%

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

	Key Points	Update on progress, Next steps and Timeline
1	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.	To action in 2020 – currently no LMS data available. LMS data dashboards set-up and starting collecting monthly data from 4 Units. MBRRACE data shows comparison PNM data for all UK Trusts - SWBH within top 20% of WM Units (2017) Next Steps : to work with LMS to produce contemporaneous PNM data each year
2	Leads for Perinatal Mortality will document service changes, care pathway changes that have and are planned to occur.	Leads organise input to key multidisciplinary meetings to highlight local data, guideline changes –eg QIHD / Midwifery mandatory training / Quarterly Perinatal Mortality meetings / Antenatal Development Group Key Items – Single Guideline for management of fetal growth restriction (SGA) - staff working in main scan dept/ADAU/FMU trained to ensure correct care pathways activated – done – Jan 2020 Next steps : ensure all Directorate guidelines are uptodate/ within date – Policies & procedures Group – by April 2020
3	Review approach to communication with GP for early referral of mothers with co morbidities e.g. hypertension/diabetes/renal disease.	Met with CCG Maternity rep (local GP) – July 2019. For further meetings to see how closer communication between GPs and Directorate can be fostered – to allow clear pathways for early referral of high-risk women into SWBH in early pregnancy and then seen in right specialist clinic / to ensure all GP practices know how to and importance of early preg booking with CMW / to improve postnatal communication with GPs esp in those women needing medical review or ongoing management. Direct meetings with GP practices aligned to SWBH (PCCT) to ensure high proportion of women referred early to SWBH – led by CD/DOM/DDOM

4	Define the changes that are already underway, those that need to be introduced and the resource and timeline to achieve this.	Changes already in hand – as above/see below In addition - Decant back to refurbished NNU with improved facilities and size should lead to improved neonatal management of the sickest babies, reduced infection rates and reduced outbreaks on NNU To be introduced – a) defined guideline/management pathway for pt DNA's at hospital appts – April 2020 – Action with Antenatal development group / ANC manager b) NNU nursing recruitment and at Band 7 level will lead to better organisation of nursing and skill mix of nursing on shift allowing for right care delivery - Ongoing Action with new recruits to start throughout 2020 – sits with NNU matron / M&P Governance board c) Maternal Mortality Study Day – multidisciplinary/in conjunction with medical specialties – focus on learning from national reports and local experience (AFE) – planned for Mar/Apr 2020 – sits with Risk Lead and Dept for M&P

<u>Additional Data (incl 2019 figures)</u>

Rates and numbers for stillbirth, neonatal losses and perinatal losses have stabilised in 2019 compared to 2018 which was best performing year to date. The % reduction in PNM of 20% 2015-2020 was met in 2018 and continues to be met in 2019 (yearly fluctuations) – overall 30% reduction.

To reduce stillbirths to target rates in QP6 requires reduction from current numbers (22/yr) to 2020 target (19/yr) and 2025 target (14/yr) – Directorate on track to meet these targets judging from current trend and interventions in place.

To reduce perinatal deaths to target rates in QP6 requires reduction from current numbers (~30/yr) to 2020 target (25/yr) and 2025 target (18/yr) – Directorate on track to meet these targets given current downward trend and % reductions achieved in last few years.

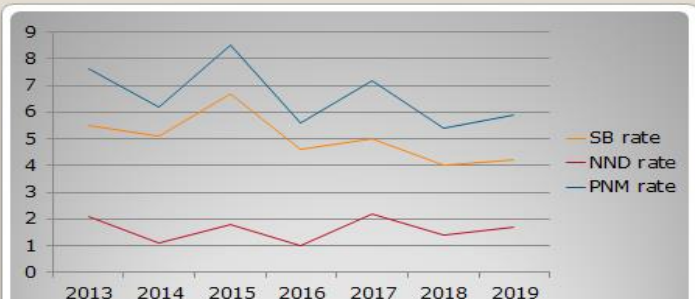
	Dels	Crude SBs	Crude NNDs	Crude PNM rate	Adj SB rate (no's)	Adj NN rate (no's)	Adj PNM rate
2013	6026	39	28	11.1	5.5	2.1	7.6
2014	5577	36	17	9.6	5.1	1.1	6.2
2015	5530	38	10	9.6	6.7 (37)	1.8 (10)	8.5
2016	5779	33	9	7.9	4.6 (26)	1.0 (6)	5.6
2017	5882	33	23	8.7	5.0 (29)	2.2 (13)	7.2
2018	5569	30	16	8.3	4.0 (22)	1.4 (8)	5.4
2019	5194	30	11	7.9	4.2 (22)	1.7 (9)	5.9

SWBH rates 2013-19 (local data)

	% change 2013-19	% change 2015-2019
Adj SB rate	-23.7%	-37.3%
Adj NND rate	-19.0%	-5.5%
Adj PNM rate	-22.4%	-30.5%

Rate reductions (by annual rates)

Changes in actual numbers of losses
2015-2019 reduction : SB -40% (15 cases) / NN -10% (1 case)



SWBH Rates

Key Interventions in plan

a) adherence to effective local guidelines and protocols – guide clinical practice and enable prompt identification of significant maternal or fetal risk factors – wide dissemination of practice changes/ highlighting clinical changes at multidisciplinary meetings (QIHD/ Midwifery mandatory training / PROMPT training) - ACTIVE 2019-20

b) ensuring >90% staff trained in CTG interpretation / Emergency obstetric management (PROMPT) – to reduce early neonatal deaths due to intrapartum hypoxia or obstetric emergencies (cord prolapse / shoulder dystocia – time dependent outcomes) - ACTIVE 2019-20

c) reorganisation of follow-up of pt DNAs during pregnancy – 20-25% of SB cases are associated with pt DNAs at hospital appts as well as in community – to ensure effective intervention in these cases to avoid adverse outcomes occurring when pt not been seen for many weeks – ACTION Apr 2020

d) Development of specialised community midwife teams to target high-risk populations in our community – Asylum seekers/Immigrant women / non-english speaking women - for early identification and ensuring right care provided throughout pregnancy – ACTIVE 2020

e) Focus on Collapsed pregnant pt – via PROMPT training monthly / highlighting pathway for escalation to Cons Obs (pt symptoms/signs) / Active Skills-drills and Simulation sessions for all staff (using PROMPT faculty to run) / introduction of ROTEM and early identification of coagulopathy – all designed to prevent cardiogenic collapse in preg pt or be able to manage such cases in more systematic manner and leading multidisciplinary treatment team - ACTIVE 2020

f) Multidisciplinary training day in Maternal deaths – to run day-long, LMS-wide educational day highlighting causes of maternal deaths, involvement of different medical specialties, focus on AFE and management – PLANNED Mar/Apr 2020

Quality Plan Update Template
Leads - Anna Lock

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

Quality Plan Target

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

Overarching objectives

- 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.
- Maintain 'excellent' CQC report for end of life.
- Develop an academic faculty focusing on wellbeing, communication and practice behaviour change.

	Key Points	**Update on progress, Next steps and Timeline**
1	Arrange review with palliative care team to define timeline with investment needed to deliver project activities.	Investment agreed for 1 additional Consultant. Out to advert currently – interviews are scheduled for 26th February. Investment not agreed for 2nd Consultant, 1 WTE facilitator and 0.5 WTE administrative support
2	Improve recognition of the possibility of imminent death - early recognition that a person may be dying enables an individual care plan to be developed.	Plan for improved recognition will be focusing initially on heart failure and respiratory disease. Engagement with Heart Failure Hospital and Community CNS + Cardiology specialty lead to set up MDT. Requires appointment to palliative care post + administrative support to go live.

	Key Points	Update on progress, Next steps and Timeline
		Respiratory disease – engagement with lead respiratory consultant. MDT dependent on appointment to palliative care post + administrative support. Support to general wards on recognition that a person may be dying would be through the role of the end of life care facilitator – not yet funded. Action plan in place regarding making the supportive care plan work more effectively in Unity. Some rework required on Unity, and training for Doctors. SOP written but not uploaded.
3	Consistent Advance Care Planning discussions with the patient and families to take place.	See above
4	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).	See above New discharge DNACPR form with treatment escalation plan now in place. Plan is for treatment escalation plan to be automatically populated in discharge summary.
5	Develop an academic faculty focusing on wellbeing, communication and practice behaviour change.	Specialty doctor working on national level on wellbeing. Undertaking scoping exercise on training on wellbeing more widely as well as specifically around end of life care. Day organised in April – Narratives in End of Life Care for senior medical clinicians regarding wellbeing.
6	Development of an enhanced multidisciplinary Palliative and End of life care working group.	Plan could be incorporated into mortality meeting or subgroup. Dependent on recruitment to palliative care posts.
7	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.	Action Plan in Place. Cross STP meeting taken place to discuss common issues.
8	Implement a sustainable quality improvement process with key	To be developed depending on recruitment to consultant and

	Key Points	Update on progress, Next steps and Timeline
	performance indicators for each area.	administrative support for MDT + data collection.

Quality Plan Update Template

Leads - Maria Atkinson, Rajesh Pandey, Chizo Agwu

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.

Quality Plan Target

	Specialties with formal Transition pathway	Lost days of school
Current	10/15 = 67%	baseline audit data awaited
Target	14/15 = 93%*	Target is to reduce by 10%

* (to reflect Neurodisability speciality does not have equivalent of Community Paediatrician in Adult Services)

	Key Points	Update on Progress	Next steps and Timeline
	Reducing lost days of school as a result of Hospital Care		
Outcome	**Understand the factors of delays in children returning to School after discharge**		
Required action	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.	• Initial data collected for analysis. Challenges with accessing data from schools due to GDPR.	• Establish data source for capturing return to school data.

	Key Points	Update on Progress	Next steps and Timeline
	Working with our school health nursing services to map and monitor delays in return to school and to establish factors contributing to the delay		
Outcome	**Understand the reasons for readmissions by condition and reduce readmission rates by 10%**		
Required action	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.	• Initial data collected regarding readmission data for school age children during 18/19. • Current pathways have been scoped to review processes with CCN follow ups post discharge.	• Development of new pathways to support post discharge. (End of Q4)
	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. Share best practice across teams where readmission rates are low.	• Initial scoping for Business case for specialist Asthma nurse undertaken. • Reviewed policy for Registrar reviews with aim to keep reviews in the community (GP). • Review of medicines in school policy underway.	

	Key Points	Update on Progress	Next steps and Timeline
	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.		• Develop guidance for health advice during discharge for documenting on patient record. Review condition specific advice leaflets available.
	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.		• GP & CCG engagement around process for follow up referrals.
Outcome	**Reduce length of stay by 10%**		
Required action	Analyse current length of stay data against national guidance. Develop reference guide by condition for expected length of stay to aid discharge planning.	• Initial data collected.	• Guide to be developed.

	Key Points	Update on Progress	Next steps and Timeline
	Develop pathways for transfer caring to community and specialist teams and GPs in relevant cases i.e. Asthma.	• New IV antibiotic pathway developed to enable early discharge.	• Specification and pathways linked to CNS for Asthma to be developed to support business case.
Outcome	**Reduce admission rates**		
Required action	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.	• Increase in rapid access clinics included in plan on approval of 14 hr review by consultant business case. Ambulatory Pathways being reviewed as part of ED/PAU project.	• Pathways to be implemented.
	Increase frequency of follow ups patients at risk of admission for through additional capacity from specialist nurse led clinics.	• Initial scoping for Business case for specialist Asthma nurse undertaken.	
Outcome	**Increased availability of out of school time outpatient clinics**		
Required action	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.	• Survey designed for parents and carers to complete during outpatient visit.	• Review survey results and scope clinic availability from the survey findings.

	Key Points	Update on Progress	Next steps and Timeline
	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.		
Outcome	**Increased availability of community and school based outpatient clinics.**		
Required action	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.	• Survey designed for parents and carers to complete during outpatient visit.	• Review survey results and scope clinic availability from the survey findings.
Outcome	**Reduction in review appointments**		
Required action	Review of the need for follow up appointments – and those children that can be transferred back to the care of GPs.	• Implementation of Asthma clinics taking place in GP surgery following partnership agreement with YHP.	• Further discussions in January with Modality to look at GP located appointments.

	Key Points	Update on Progress	Next steps and Timeline
	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. 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		
Outcome	**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.**		
Required action	Identification of specialty service transition and develop matrix for monitoring progress and transitional care pathways	• Baseline Assessment completed • Transition Key Worker has initially focused "named worker" support on Asthma & Coeliac	Transition Assessment • Implementation of Ready, Steady, Go in the 13 Paediatric specialities

	Key Points	Update on Progress	Next steps and Timeline
	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.	services • Baseline assessment identified whilst 8 paediatric services use a transition assessment, the frequency of use was inconsistent, commenced later than intended & transition plans not devised. See below for next steps. • Paediatric transition databases completed for Asthma, Allergy, Coeliac, Epilepsy & Diabetes allowing for initial denominator data to be determined. Databases in progress for Audiology, Ophthalmology, Haemoglobinpathies & Dermatology. Database includes recording assessment stage & condition specific checklist categories. • Meetings in progress with Unity Team regarding recording of transition information & data • Referral form devised	• HCA's to handout Ready Steady Go on arrival to clinic • Clinicians to discuss responses & advise accordingly involving named worker where necessary • Condition specific checklist to be completed where available • Named Worker to complete transition plan Adolescent Clinics • Adolescent clinics are being planned and will commence by Q1 2020 and be fully implemented by Q2 for Allergy, Asthma and Epilepsy services. These will be separate to the joint transition clinics. Adolescent clinics will allow an opportunity to group patients to allow for greater focus on the needs to prepare young people for transition. Group work • Plan to develop small group activity within appropriate speciality groups to promote peer support alongside transition education & preparation. (Q1 20/21)
	Work is required to provide denominator data with regards to creation of manual database in interim pending future developments within electronic systems.		

	Key Points	Update on Progress	Next steps and Timeline
	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 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.		• A Larger event mid 2020 across specialities (to be determined once numbers across specialities finalised) to address generic adolescent themes to support preparation for adulthood. (Q1 20/21) Database • To continue the development of transition databases identifying the young people where transition planning needs to commence. Meetings to continue with Unity Team to progress electronic recording. (Q4 19/20)
Outcome Required action	**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.	• As far as practicable, databases have been populated for young people who already had transition assessment completed. • Baseline assessment identified given completion of transition assessment & plans was inconsistent, this inevitably impacted on	• The full implementation of transition assessments and plans will allow for actions to be reviewed. (Q3 20/21) • The database will allow named workers to record when reviews are due & taken place.

	Key Points	Update on Progress	Next steps and Timeline
	Denominator data work is required as above.	the completion/monitoring of annual transition reviews. • The databases now provide a system to record when annual reviews are due. Discussions with Unity team have taken place to progress how this can be completed electronically.	
Outcome	**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**		
Required action	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.	• Databases in progress of being populated with named worker data. Meeting held with Unity Team to progress. • In the services that have Specialist Nurses, they will be the transition named worker. In the services that do not, the Trust Transition Key worker will be the named worker hence addressing this quality standard (with the exception of neurodisability).	• Directorate Management to continue discussions with CCG Re: plan for dedicated Transition Key worker for Neurodisability speciality.
Outcome	**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.**		

	Key Points	Update on Progress	Next steps and Timeline
Required action	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.	• Baseline assessment identified this as our strongest Quality Standard • Within the 13 paediatric services: -7 deliver joint transition clinics -3 services are delivered by clinicians that cover both paediatric & adult services -1 transfers to GP & therefore transition support is to be developed to facilitate this -As one speciality is Neurodisability, there is not a direct equivalent to a Community Paediatrician • Adult services that receive transition patients from external organisations examples include -Haemoglobinopathies- SCAT team attend joint clinics at BCH, followed by invite to SCAT open day with other young people, BCH Sister then attends first appointment at SWBH. -Ophthalmology- Glaucoma team attend transition clinics at BCH -Audiology- planning open day in 2020 for internal & external transitioning patients.	• Establish clearer picture on 3 outstanding services to address if there is a need for joint clinics or development of pathways to GP (Q4 19/20) • Database to be populated as young person meets Adult Consultant. Discussions to continue with Unity Team for electronic recording (Q4 19/20) • Continue to identify & address how the transfer process can be smoother i.e. BCH Rheumatology request their young people to film Instagram style story at City hospital for young people who decline orientation visit (Ongoing)
Outcome	**Young people who have moved from children's to adult's services but do not attend their first meeting or appointment are contacted by adult services and given further opportunities to engage.**		

	Key Points	Update on Progress	Next steps and Timeline
Required action	• System to be introduced prior to transfer for named worker to establish preferred method of follow up 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).	• Focus to date has been on earlier stages of transition pathway. • Identified Adult services within the Trust receiving transitioning patients, routinely offer a further appointment if the young adult DNA's their first appointment.	• The use of transition database will help track this information in the future. • Embed follow up process & evaluation with all named workers (Q2 20/21)

Quality Plan Update Template

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.

Quality Plan Target

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

	Key Points	Update on Progress
1	**Participation in PROMs preoperative data collection**	
1.1	Preoperative THR / TKR PROMs questionnaires to be posted to	Continue to use

	Key Points	Update on Progress
	patients at home with their admission letter for completion and return on day of surgery. An information leaflet accompanying explains the importance of completing the preoperative PROMs booklet is also posted to the patient. If the patient does not bring the completed booklet on the day of admission to the ward, they are asked to complete another one.	
1.2	To measure improvements in THR / TKR preoperative participation rates following introduction of new process of administration. There will be a minimum of 80% completion of preoperative PROMs booklets for patients undergoing THR / TKR surgery. Orthopaedic department has now instituted the booking team to send and sign that the questionnaire to be sent out to the patient. The ward sister with the aid of checklist procedure will be responsible in ensuring questionnaire is filled out. A monitoring from has been introduced on the ward on a daily basis.	Continue to use
2	**Improvements to PROMs Outcome Data**	
2.1	T&O department to follow standard guidelines including PLCV guidance for joint replacement to ensure appropriateness of patients listed for surgery to increase likeliness of benefits. Adherence to guidance will be audited to ensure appropriate patient selection.	To audit appropriateness of patient selection for 10 randomly selected THR and 10 randomly selected TKR patients who have been listed for surgery in January 2014. 100% of patients listed for THR / TKR surgery will comply with T&O department guidance including PLCV guidance for joint replacement surgery.
2.3	Ward staff to ensure that all TKR replacement patients are booked for their first physiotherapy appointment prior to discharge from the ward. All patients will receive a minimum of 1 physiotherapy appointment post TKR and will be offered an optional course of 6 weeks physiotherapy dependent on patient need.	Continue to use
2.4	Revision of patient information leaflets to ensure that they are clear and easy to understand so that patients are fully aware of	Completed by End March 2020

	Key Points	Update on Progress
	the risks associated with hip and knee replacement surgery. Accompanying video's played in fracture clinic OPD will be produced	
2.5	Attendance at hip or knee club is mandatory for all joint replacement patients, but currently the time when patients attend is variable. Attendance will be standardised so that all patients attend the hip and knee club and are pre assessed no sooner than four- six weeks before surgery. This will ensure that there is clarity between journey and timeliness of pathway and patients to be part of the enhanced recovery programme.	To undertake an audit to assess that all THR / TKR patients receive a pre-assessment appointment no sooner than four- six weeks before surgery. 100% THR / TKR patients will receive a pre-assessment appointment a maximum of 6 weeks prior to the date of surgery. Continue to use
2.7	To introduce measures to ensure the early identification of wound infection patients are given information on discharge from the ward of who to contact and how to arrange an urgent clinic appointment should they have any concerns that there is a potential infection developing.	Continue to use
2.8	Introduction of arthroplasty nurse based on ward to support enhanced recovery and patient outcomes.	Formulate Job plan and advertise by end Jan 2020
3	Improvement trajectory	
3.1	Improvement required of 1.5 % per quarter from current data	
3.2	Electronic board in clinic for patient education for importance of PROMS	Sandwell clinic already has screen. Identify staff for video and content by end Jan 2020
3.3	Use clerk to contact patients prior to collection date (6months after surgery)	Implement by Jan 2020
3.4	Visit high performing peer hospital for improvement ideas	March 2020

Quality Plan Update Template

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.

Quality Plan Target

	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

	Key Points	**Update on Progress**
	Key Points	**Update on Progress**
1	Establish key priorities for work with Mental Health Trusts and training needs for current ED staff	• Flowchart developed to support the safe admission of MH patients to AMU – to be finalised w/c 3rd Feb • Meeting to be planned with Solihull + Black Country + FTB in February regarding escalation and flow of mental health patients – to support with timely admission of patients requiring MH admission • 24/7 MHLS input into SGH ED + SGH AMU • Longer term plan regarding training for staff • Mental Health administrator now in place and process when a patient has been sectioned under the mental health act cascaded to all staff.