QUALITY ACCOUNT 2019/20

NHS
Sandwell and West Birmingham
NHS Trust

Annex to Integrated Annual Report and Accounts 2019/20

Foreword

Welcome to our Quality Account for 2019/20. This report is published as an Annex to our Annual Report and Accounts and reflects our performance in relation to quality, safety and patient care as well as looking to the future with our quality priorities for the year ahead.

We have continued this year to drive forwards the ambitions set out in our quality plan beginning with addressing mortality through improvement sepsis management, which was our number one quality priority for the year. Throughout the year we have seen improvement in the proportion of patients who were screened for sepsis, reaching 95%. Our inpatient wards continue to monitor and improve their sepsis screening rates and ensure that antibiotics are administered within one hour when indicated.

The introduction of our new electronic patient record, Unity, in September 2019, has improved the safety and quality of patient care, reducing paper notes and duplication. Electronic prescribing now provides improved medicines management and a reduction in medication administration errors. Safety plan compliance is being monitored daily so that any missed checks can be completed within 48 hours of a patient being admitted to hospital. Our community services have developed the safety plan to meet the needs of patients who are seen at home rather than in a health care facility.

We have made changes during the year to improve the quality of patient care and to prepare for services moving onto a single site when the new acute hospital, the Midland Metropolitan University Hospital, opens in Smethwick in 2022. We created a respiratory hub at City Hospital that opened in November 2019. This provides a specialist centre for respiratory care on a seven day a week basis. We have also improved the neonatal unit, extending and enlarging the facility, to provide more space between our neonatal cots and reduce infection risk. Our paediatric assessment unit at City Hospital has changed and the new unit, co-located with our emergency department is due to open in May 2020.

The Care Quality Commission has not inspected our Trust services in 2019/20. Since the last published report we have progressed our improvement plan and continue to work towards consistent standards of care across our acute adult services and in our emergency departments. We are also committed to ensuring that we retain good or outstanding ratings for the 70% of services who have been awarded this quality standard.

We have continued to invest in quality improvement, providing all Trust teams with protected time each month to share learning and improve patient care. Teams are now progressing through our quality improvement half day (QIHD) accreditation programme. Our welearn poster competition has once again demonstrated the broad range of "excellence" projects across the Trust and the welearn programme this year will ensure that learning is shared within and across directorates and teams.

Much of the last month of the year focused on our response to the COVID-19 pandemic and, as we delivery our restoration and recovery plans, we will ensure that we retain our commitment to quality improvement, delivering better outcomes for all our patients.

Toby Lewis, Chief Executive

Statement of directors' responsibilities in respect of the Quality Account

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

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

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

Richard Samuda, Chairman

Toby Lewis, Chief Executive

(L-r) Reif Henry, charge nurse, Renee Clarke, staff nurse, Rachel Currie, junior sister.

Priorities for Improvement in 2020/21

Priority 1

Safely managing patient's Covid-19 care and ensuring that national best practice is the minimum standard deployed at the Trust.

Rapid change in our clinical service was necessary in mid-March to cope with COVID-19 patients. Transformation of intensive care and medical services was built on trajectories for number of cases and national guidance. The need to redeploy staff required rapid introduction of training packages for staff both in relation to COVID-19 disease but also in systems they would need to use in their new environment. Best practice guidance produced by NHSE/I has been reviewed by relevant teams and actions for SWB services identified. Pathways for management of COVID-19 patients have been developed at SWB and brought together for optimisation of patient care.

Learning from the care we provide is important and our developing medical examiner system is reviewing the care provide to all COVID-19 patients who have died identifying areas of good practice and where care could be improved. Since March we have reviewed all deaths with COVID-19 within the Trust and this data is creating a body of evidence with which to make informed judgments about quality of care. Our evaluation approach has been positively reviewed by NHS Midlands and we have also presented information to the Birmingham Health and Wellbeing Board relating to the issues faced by BAME residents given disproportionate incidence and mortality ostensibly being visible in some national and local data.

We remain focused on our governance with our Trust board meetings and sub-committee meetings taking place virtually and our integrated quality performance reporting continues to provide an overview of performance. Optimisation data continues to be collated to allow us to reinitiate strong use of Unity, our electronic patient record system, in later months of 2020. This continuity of data is important when we consider the governance of recovery. The outcome analysis we have undertaken since the start of March will be used to consider

a) How our care pathways have compared to best practice and what next?

b) How our outcomes compare to neighbouring providers and why?

c) How well all populations served by the Trust have been treated with COVID-19 to date, and anything we need to change in June and July?

Our findings will formulate improvement plans for quality of care. In addition to the above three points we will be launching an innovative follow up project to track patients who decline to be conveyed to hospital after ambulance service attendance to try and improve uptake of care. To support our recovery plans we will be introducing a local 'Place-led' implementation of a tracing and support strategy for the most vulnerable local residents.

We will continue to monitor and respond to changing circumstances to maintain best care for COVID-19 patients presenting to SWB and ensure staff safety with identification of personal risk factors and provision of correct PPE for specific working environments.

Progress on all work here will be reported and monitored through the Quality and Safety Committee. We will also continue to monitor mortality data through the Learning from Deaths Committee.

Priority 2

Restoring local services from primary care to tertiary specialties, with public confidence in the safety and quality of what we do.

Significant changes in our services occurred in primary and secondary care to manage COVID-19 patients. The recovery of normal services will be a gradual process as we rebuild clinical teams and restore patient confidence in the safety of services and our infection control processes. There are components of service changes that will be an advantage to keep and develop due to benefits in patient care. This is particularly around remote consultation by phone or video. Some aspects of how teams work together, particularly in the emergency department, will also be developed and maintained. Our communication and co-working with primary care partners to save unnecessary patient referral will also be an area we will focus on.

Use of aspects of the estate that can be utilised as non COVID-19 areas with strict infection control procedures will help restore patient confidence and restart some services such as imaging and routine short stay surgery. The Birmingham Treatment Centre (BTC) will be the focus for this and now has a separate 'blue' non-COVID-19 entrance. The BTC will work differently in the future as we work to make it what it was always supposed to be: An elective centre able to work with optimal efficiency.

The return of our cancer service from private providers will follow including tertiary gynae-oncology surgery. Any new models of care will fit with our vision for services at the Midland Metropolitan University Hospital but also be responsive should there be a secondary surge in COVID-19 cases.

Progress on our restorative work will be reported and monitored through the Quality and Safety Committee and Clinical Leadership Executive Committee.

Priority 3

Implementing our 2020 Quality Plan, with a first focus on tackling unplanned re-admissions to hospital and ensuring choice for patients at the end of their life.

The Quality Plan will have a renewed focus this year having established plans to reduce amenable mortality with sepsis and pneumonia as a priority. We have commenced in-depth work on the other aspects of the Quality Plan with input from all clinical and operational teams.

Review of the current service position for each of the quality plans has allowed targets to be set for improvement and action plans put in place. Most improvement plans require work across several clinical groups and within primary as well as secondary care.

Community services are an important part of these proposals, particularly with our initial focus on end of life care allowing more patients to die in a place of their choice, and reducing readmissions where community support and follow up of discharged patients will be pivotal to achieving improvements. We have already invested in increasing our senior palliative care team to support their Quality Plan proposal.

Progress on our 2020 Quality Plan will be reported and monitored through the Quality and Safety Committee and discussion with the Clinical Leadership Executive Committee.

(L-r) Amy Crumpton, occupational therapist, Siobhan Whitehouse, staff nurse, and Lee-ann Currie, student nurse, on one of the interactive stations at the patient enablement event which showed how we are addressing patient falls and frailty.

Progress on 2019/20 quality priorities

Priority 1 - Improving quality of care for patients by tackling sepsis more effectively and reducing amenable mortality in line with our long term Quality Plan.

We have been able to reduce our mortality indices over the last 12 months with a combined focus on improving care particularly that associated with sepsis and pneumonia but also by focusing on documentation and coding of patients admissions.

We have achieved 95% for undertaking sepsis screening for those patients who require it based on their physiological measurements. Monitoring and recording activity through Unity, our electronic patient record system, has aided this process. Antibiotic provision as part of the sepsis six, and a drive to always have antibiotics administered within one hour is an important ongoing area of work. The sepsis focus will move to local ward based quality improvement work where they will be able to monitor progress through data provided on a performance dashboard.

Our pneumonia task force constructed of an interdisciplinary team has reviewed patient case records and from that there has been learning. This has led to a change in guidance particularly around antibiotic provision for patients presenting with community as opposed to hospital acquired pneumonia.

Our Learning from Death process has matured over the last 12 months and an increase in review of our mortality cases by medical examiners has allowed identification of cases where more in-depth review is needed, thus identifying not only good practice but also areas where care can be improved. These cases are discussed through the Learning from Deaths Committee and with specialty mortality leads.

Priority 2 - Ensuring safe and resilient systems of care through deploying better IT infrastructure, embedding Unity, and maintaining Safety Plan compliance.

Unity, our electronic patient record system, was introduced at the end of September 2019. This was implemented over a two week period and now all patient records are reviewed and recorded electronically. The effectiveness and use of the system is monitored via cutover and optimisation reports. These allow identification of areas where service improvement or training needs are required.

Results endorsement is one such area with targets for endorsing all inpatient tests within three days and outpatient tests within three weeks so that any important results are not missed and acted on with appropriate communication to patient and GP's. Reports from Unity provide performance information at department and individual level, highlighting areas of good performance and areas where change is required. Currently 75% of reports are endorsed. We have identified some process issues where orders are not being placed through Unity, meaning these results are available in Unity but do not require endorsements. This is a current focus of the safety work we are doing.

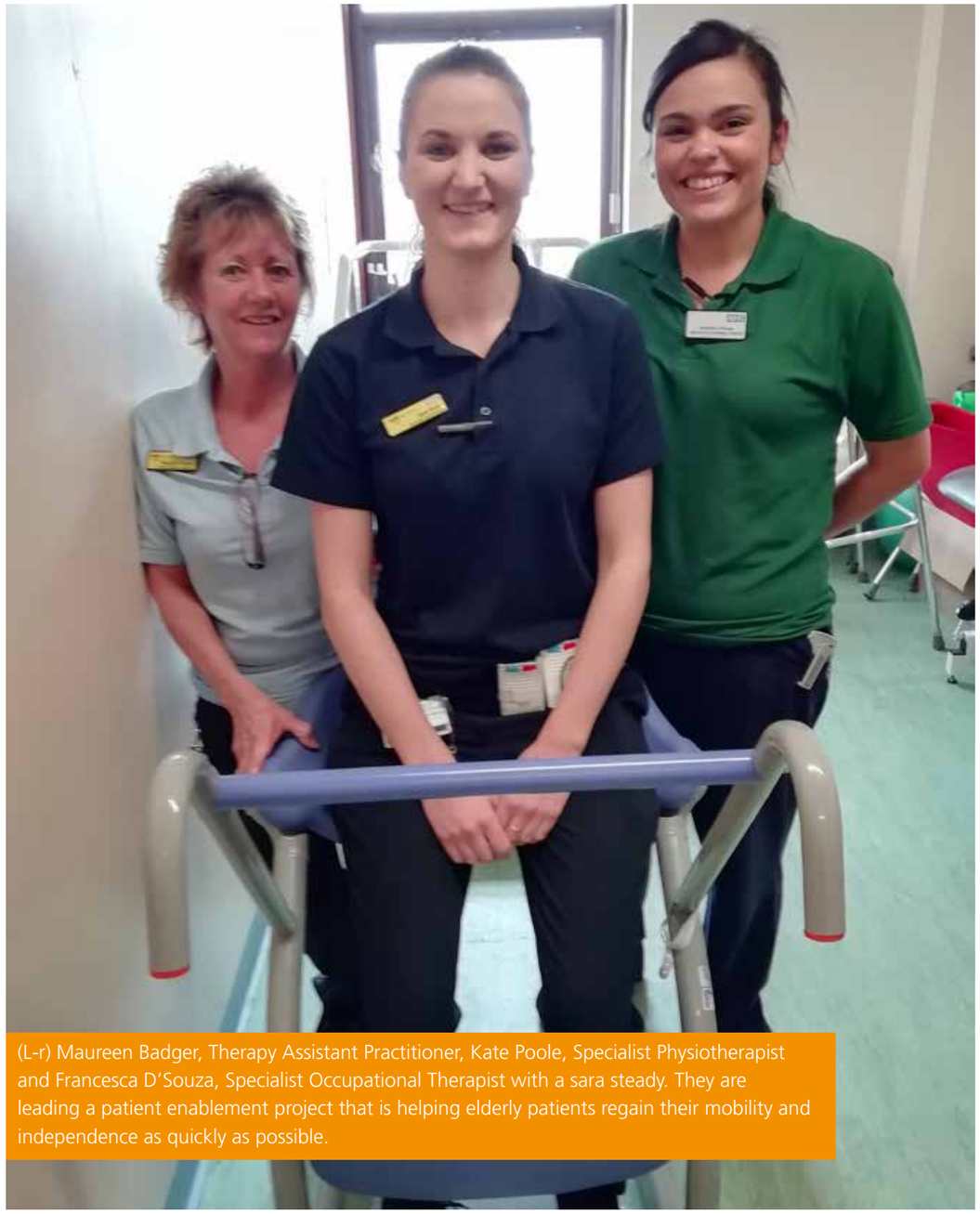
Compliance with the assessment of risk for venous thromboembolism (VTE) has been consistently above 95% with Unity allowing the assessment and prescription of blood thinning medicine to now be completed at the point of admission. This has reduced potential harm from missed prescription of appropriate medication. The regular review of patients presenting or acquiring thromboembolic problems while in hospital has allowed us to feed back to clinical teams where an individual risk assessment was not undertaken or where there are other issues with provision of treatment for thrombo-prophylaxis.

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

Work is progressing with our plans to complete Midland Metropolitan University Hospital (MMUH) by Spring 2022. Any changes in clinical services across our current estate must reflect future service models appropriate for MMUH.

As part of our improvement work to help acute admissions we have relocated respiratory services at City site allowing a focus of respiratory expertise for patient care as well as providing support for acute admissions. Elderly care service will develop more on Sandwell site, providing greater support to acute admissions this way.

Our paediatric services at City have been improved by co-locating the acute assessment unit with the admission unit which should improve the experience of patients presenting to City emergency department. Those requiring longer admission will be transferred through to Sandwell. Both of these models are in line with our working model for MMUH.



(L-r) Maureen Badger, Therapy Assistant Practitioner, Kate Poole, Specialist Physiotherapist and Francesca D'Souza, Specialist Occupational Therapist with a sara steady. They are leading a patient enablement project that is helping elderly patients regain their mobility and independence as quickly as possible.

Moving to a seven day consultant ward cover and service provision will be important for how we provide care in the future. Some of the rapid changes that have been needed for the recent COVID-19 pandemic do reflect seven day senior cover and seven day service accessibility, some of which will be maintained in the interim period to the opening of MMUH improving patient experience over the next two years.

Safety Plan update

In the last year we have welcomed the arrival of Unity, our electronic patient record system. Since the installation of Unity reported compliance with safety plan checks has reduced. Real time data is used for elements of the safety plan and we will be focusing on ensuring correct documentation in Unity, using agreed workflows, to ensure that safety plan data is captured and therefore reported correctly. With regards to measuring time the 'clock' now starts ticking in the emergency department at the 'decision to admit' time.

To maintain safety and optimise the use of our electronic system senior nurses and managers have undertaken additional training and visiting ward areas to ensure a pro-active safety culture. Reporting methods have been redesigned with live real time data reports now being used as a tool to support ward safety checks, handover and team huddles. Day to day activity is also supported by standard operating procedures and quick reference guides.

A 24/48 hour retrospective report illustrating any missed checks provides the opportunity to review patterns and trends to facilitate training needs and improvement activities. Over the coming year we will continue the work we have started with a focus on ensuring the safety plan elements are consistently recorded in Unity to provide reliable reporting and use our retrospective reporting to drive forward with patient safety improvements.

Quality Plan update

The ambitious Quality Plan developed in January 2017 aims to reduce amenable mortality with a focus on sepsis, other infective causes of death and cardiac and cerebral vascular events. It also aimed to undertake nine other projects to improve care provided to our patients.

The 10 components of the plan have undergone rigorous review and we have revised plans in place to progress over the next 12 to 24 months with outcome targets defined. Within the plan there are projects that are already embedded within our Trust's working practices and others that require further development work.

Initial focus will be on improving end of life care and reducing hospital readmissions. Separate project groups will also ensure that progression in other areas of the plan continue such as improving neonatal outcomes, reducing lost days at school through hospital attendance, reducing loss of vision and improved cancer outcome. We will also continue with our work on patient related outcome measures, increasing screening rates and improving care of patients with mental health problems presenting or being admitted within the organisation.

The critical care team are full of pride at being rated outstanding by CQC.

Care Quality Commission

The overall rating for the Trust remains the same at 'requires improvement' following their inspection of some of the Trust's services during the period 4 September to 11 October 2018. The Trust is committed to continuing to make improvements and has completed the changes identified to ensure that patients receive high quality care across all parts of the Trust. As well as making recommendations, the CQC report notes a number of outstanding practices with the overall 'outstanding' rating for being caring.

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

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

Sandwell and West Birmingham NHS Trust is registered with the Care Quality Commission and has no conditions attached to that registration. The Care Quality Commission has not taken enforcement action against Sandwell & West Birmingham NHS Trust during 2019/20 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Sandwell and West Birmingham Hospitals NHS Trust Overall rating grid

Overall rating	Inadequate	**Requires improvement**	Good	Outstanding
Are services **Safe?**		**Requires improvement**		
Are services **Effective?**		**Requires improvement**		
Are services **Caring?**				**Outstanding ☆**
Are services **Responsive?**		**Requires improvement**		
Are services **Well led?**		**Requires improvement**		
Use of resources		**Requires improvement**		
Combined rating for quality and use of resources	Inadequate	**Requires improvement**	Good	Outstanding

A number of GP practices joined our Trust in early 2019/20. The CQC have undertaken a remote review of these practices in March 2020 and due to the significant change in leadership the practices will be re-inspected when CQC inspections resume. The most recent CQC information for the practices is show below.

Malling Health @ Great Bridge now known as Great Bridge Health Centre

Overall rating	Inadequate	Requires improvement	Good	Outstanding
			✓	

Are services	
Safe?	Good
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

Summerfield GP and Urgent Care Centre now known as Heath Street Health Centre (Note only the GP element has joint SWB Trust.)

Overall rating	Inadequate	Requires improvement	Good	Outstanding
			✓	

Are services	
Safe?	Good
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

Malling Health @ Parsonage Street now known as Lyndon Health Centre (Note only the GP element has joint SWB Trust.)

Overall rating	Inadequate	Requires improvement	Good	Outstanding
			✓	

Are services	
Safe?	Good
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

Sandra Cole Medical Records Clerk, helping out as part of our cleaning brigade.

How we measure data quality

We review our performance against external frameworks (primarily the NHS TDA Accountability framework 2014/15, CQC and Monitor's published Quality Governance Framework) as well as internal targets on a broad range of indicators published in our Integrated Quality & Performance Report (IQPR). The IQPR is published monthly to a number of senior committees (including the Quality and Safety Committee) as well as the Trust Board. Performance is managed through our group performance review programme.

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

Data quality improvement approach

The Trust has taken the following actions to improve data quality. We have implemented a performance indicator assessment process, the data quality kitemark, which provides assurance on underlying data quality published in the Integrated Quality Performance Report (IQPR).

Each indicator is assessed against seven data quality domains to provide an overall data quality assurance rating, which is included in the IQPR. We have an annual audit data quality improvement plan in place to ensure that the quality of our performance information continues to improve. Our audit plan is a rolling programme covering all performance and quality indicators. We have established a Data Quality Committee whose scope is to identify and implement data quality improvements and address data quality issues as they are found and monitor their improvement to a compliance standard. Each group is represented by a data quality lead.

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

Hospital Episode statistics

The Trust submitted records during April 2019 – January 2020 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data;

- which included the patient's valid NHS number was 97.11 per cent for admitted patient care; 99.60 per cent for out-patient care; and 91.74 per cent for accident and emergency care.
- which included the patient's valid General Medical Practice Code was 99.9 per cent for admitted patientcare; 99.7 per cent for outpatient care; and 98.5 per cent for accident and emergency care.

Services provided/subcontracted

During 2019/20 we provided and/or subcontracted 43 NHS services. We have reviewed all the data available on the quality of the care in these services. Where we have subcontracted any activity, it would only be to a provider who, like us, was registered with the Care Quality Commission (CQC) but has no conditions attached to that registration. Contracts between the Trust and the subcontracted providers require that the same high standards of care are given when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust. The Income generated by the NHS services reviewed in 2019/20 represents 100 per cent of the total income generated from the provision of NHS services by the Trust.

Commissioning for Quality and Innovation (CQUINs)
A proportion of SWBH income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between SWB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at www.swbh.nhs.uk/our-performance/

Seven day hospital services

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

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

	Definition	SWB Performance
Clinical Standard 2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	**Weekday = 87%** **Weekend = 80%**
Clinical Standard 5	The availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales, which is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.	**100%**
Clinical Standard 6	Timely 24-hour access seven days a week to nine consultant-directed interventions.	**100%**
Clinical Standard 8	Ongoing consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment. The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition.	**Weekday = 79%** **Weekend = 90%**

We are not yet meeting the compliance target of 90% for standard 2 and standard 8. There has been a significant amount of development work which will positively impact on 7 day service standard compliance going forward which includes:

- Introducing acute medical staff at weekends (historically GIM consultants only covered the acute medical assessment unit).
- Surgical ambulatory care unit avoiding admissions.
- Introduction (in progress) of MRI 7 day services for inpatients.
- Progression on an ambitious radiology request to result project which will deliver a maximum 24 hour turn around by end Q2, exceeding the national standards.
- Implementation of our 48 hour post discharge follow up for all patients at risk of readmission by community services has been implemented seven days a week to support patients adapting and resolve any discharge issues at the outset.
- Reconfiguration projects are underway for paediatrics and respiratory services. They have been consolidated to a single site which will strengthen clinical pathways and initial asessment compliance.
- Our electronic patient record went live in September 2019, which will improve documentation clarity and reporting.
- Development of a draft seven day dashboard to inform further improvement opportunity.

Speaking Up

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

We held two Speak Up days in 2019/20 to remind everyone about the many different ways to raise concerns, to meet our Freedom to Speak Up Guardians and other leaders and discuss what was on their mind. At our April Speak Up day, we launched a short survey to gather feedback on creating a speak up culture, whilst in September the theme was the newly launched 'Managers Code of Conduct'.

In encouraging colleagues to raise their issues be it through our Speak Up events, posters, the CEO's Friday Message

or the FTSU guardians, everyone is made aware that they will be praised for doing so and not disadvantaged. Feedback is provided to colleagues who speak up and we started to strengthen our processes during 2019/20 to check that this happens consistently and well.

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

Rota gaps

In order to monitor our rota gaps we maintain a monthly record of current vacancies for both training and non-training grades. This is reviewed monthly and active measures are taken to try to recruit to all trainee vacancies. Junior Specialist Doctor (JSD) posts have been established since August 2017, and are used to replace gaps in our rotas and also create new posts where additional service needs have been identified. We currently have 79 of these posts.

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

Educational development in addition to NHS exposure has been valued by our doctors over the last 18 months with some continuing in post and others moving on to training positions within the NHS. Work is in place to make Sandwell and West Birmingham NHS Trust a popular place to work and therefore aid recruitment with all posts being reviewed to see if other activities can be introduced in to their job specification eg teaching, again to make each post more attractive.

NHS Staff Surveys - Encouraging advocacy

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

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

Every three months a quarter of the organisation are asked to feedback on our services via the NHS staff friends and family test and our 2019 results are shown below.

NHS Staff Surveys	2018	2019 Survey Results	
	SWB 2018	SWB 2019	National Average (Median score)
Staff who would recommend the Trust as a provider of care to their family and friends - Performance is based on staff who agreed or strongly agreed as part of the NHS Staff Survey	60.2%	61.9%	71.0%
Staff who would recommend our organisation as a place to work	55.7%	57.0%	64.0%

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

Kerry Painter, Sonographer and Sophia Binns, Imaging Support Worker with Chief Finance Officer Dinah McLannahan on Speak Up Day.

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

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

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

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

Data security and protection toolkit (DSPT) attainment levels

The Data Security and Protection Toolkit includes 10 mandatory standards which comprise 179 evidence items (116 mandatory and 63 non mandatory) an overall increase of 30 evidence items on the 2018/19 Data Security and Protection Toolkit. Due to the COVID-19 pandemic, NHSX has moved the final submission date for the Data Security and Protection Toolkit to September 2020.

As at 31 March 2020 we are compliant across 88% of the mandatory standards and 17% of the non mandatory standards for the 2019/20 toolkit and are well on the way to achieving the remaining mandatory standards by September 2020.

General Data Protection Regulation

Work continues to ensure that data protection obligations are implemented and monitored for all processing activities across the Trust. Particular focus continues to be on ensuring that all proposed new, or changes to existing processing activities are fully reviewed for compliance prior to implementation, and appropriate action is taken to ensure that standards continue to be met.

Incident reporting

A positive safety culture remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting and Learning System (NRLS) which is publically available and provides comparative data with like-sized trusts. This data shows that since the same period the year before, we have had an increase in incidents report per 1000 bed days.

Date		Average rate of reporting per 1000 bed days	Best reporter/ 1000 bed days	Worst reporter/ 1000 bed days	Number of incidents resulting in severe harm	Per centage of incidents resulting in severe harm	Number of incidents resulting in death	Per centage of incidents resulting in death
2017/18	**Apr 17 to Sept 17**	47.98	111. 69	23.47	2	0.0	1	0.0
	Oct 17 to Mar 18	34.61	124	24.19	3	0.07	1	0.02
2018/19	**Apr 18 to Sept 18**	34.3	107.4	13.1	7	0.2	1	0.0
	Oct 18 to Mar 19	53.8	95.9	16.9	13	0.22	3	0.05
2019/20	**Apr 17 to Sep 19**	51.2	103.8	26.3	8	0.1	0	-

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

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

The Trust intends to take the following actions to improve the quality of its services by ensuring that all incidents are reported on and managed in a timely way which should see an improved position over the next two NRLS reporting periods. Patient safety incidents resulting in moderate harm or above that do not meet external reporting criteria are investigated at clinical group or corporate directorate level.

The number of serious incidents reported in 2019/20 is shown in the following table. This does not include pressure ulcers, fractures from falls, ward closures, some infection control issues, personal data, IT or health and safety incidents.

2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs (by date reported as SI)	0	3	3	4	0	2	4	3	3	2	2	0

Falls Champion and senior sister Dorothea Sekhonyana, with falls prevention specialist nurse Mary Parker and senior ward sister Lady Ann Ordona, who have worked hard in preventing falls on McCarthy ward at Rowley Regis Hospital.

Never events

During 2019/20 three never events were reported. A never event is a serious untoward incident that has either caused or has the potential to cause serious harm that should never happen if robust controls are in place to prevent them from happening.

Never events reported in 2019/20

Speciality	Type of Never Event	Root Cause	Changes Made
General Surgery	Wrong site Surgery	Failure to document the exact location of the sinus to be operated on: Consent form, ORMIS (operation management system) or pre-operative checks with patient.	The Safety Policy for invasive procedures and interventions is being reviewed and will now include sequential steps for procedural verification and site marking prior surgery.
Ophthalmology	Retained Foreign Object	Failure to perform an accurate swab and sharps count at the end of the procedure, because of inadvertent loss of situational awareness by the surgeon and scrub team. This led to the mistaken belief that all instruments have been taken out of the eye and the final closing count was correct.	To reinforce the importance of accurate counting an audit of adherence to surgical instrument counting and checks to be undertaken across all 4 theatres at BMEC and carrying out audits on the quality of the various components of the WHO check within theatres. The trust swab policy is also being reviewed and updated.
Women and Child Health	Retained Foreign Object	Failure to maintain swab counts correctly.	Ensure presence of training systems to monitor and support staff training, and follow the swab counting process and policy in a robust manner. A new trainer is now in place to provide support across three sites and this will be monitored on a monthly basis through audits. In addition we recommend that all gynaecology operations conclude with a visual inspection of the vagina, by the surgeon in charge and again this will be audited.

Responsiveness to personal needs of patients

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

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

Responsiveness to inpatients personal needs	2017/18	2018/19			
	SWB 2017/18	SWB 2018/19	National Average	Highest Trust	Lowest Trust
The trust's responsiveness to the personal needs of its patients during the reporting period.	61.6	60.9	67.2	85.0	58.9

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

To support the continuous improvement of our patients experience we have explored how to support our inpatients getting a good night's sleep. This has involved looking at the levels of noise on the wards and reducing the level with techniques such as reducing the volume of ward telephones and door entry systems, introduction of quiet closing bins throughout the trust, proactive maintenance of door hinges and handles to prevent 'squeaks' and reduction of patient movement after 22:00 hours unless it is essential to patient flow.

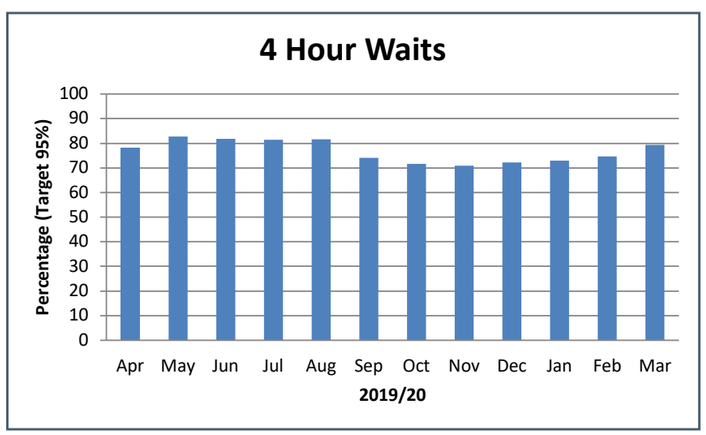
In addition to noise reductions we have also looked at other techniques and tools to aid getting a good night's sleep including reduction in brightness of lights both inside and outside our buildings. A curtain replacement programme has also been delivered to support this programme.

Emergency four hour waits

In line with the national standard we aim to ensure that 95% of patients will wait for no more than 4 hours within our Emergency Departments (ED). In 2019/20 on average we achieved 76.8%

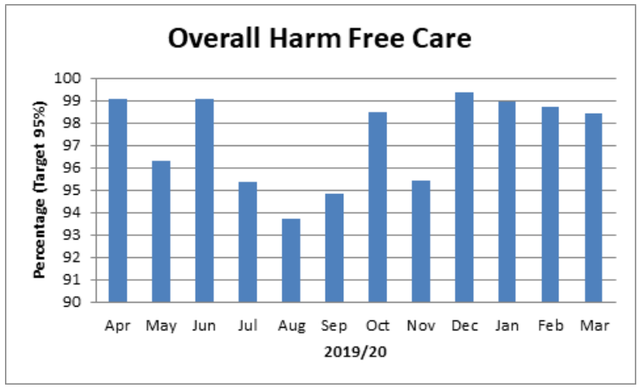
You can see that following the implementation of Unity, our electronic patient record system there was a drop in performance towards the end of September and into October. We saw this slowly improve as understanding and learning on the new system took effect. We have gradually seen the performance improve as new recruits embedded and we delivered against our emergency department improvement plan. As these plans fully embed and as the real time data, that is being developed currently, becomes visible to all staff we aim to improve our performance in 1920/21 by over 10%.

Patients waiting 4 hours or less in Emergency Departments
(Higher is better – target 95%)



Harm Free Care

We continue to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls; catheter related UTIs and DVT- We review harms via the incident reporting framework with lessons learned shared locally and across the organisation.



Patient Reported Outcome Measures (PROMs

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

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

Patient Reported Outcome Measures (PROMs)								
	Health Status Questionnaire Per centage improving							
	Finalised data for April 17– March 18 (Published February 2019)				Finalised data for April 18 -March 19 (Published February 2020)			
	National	SWB			National	SWB		
Hip replacement	90.0%	91.0%			90.1%	89.4%		
Knee replacement	82.6%	81.9%			82.6%	80.9%		
	Health Status Questionnaire Average adjusted health gain							
	Finalised data for April 17– March 18 (Published February 2019)				Finalised data for April 18– March 19 (Published February 2020)			
	National	SWB	Highest National	Lowest National	National	SWB	Highest National	Lowest National
Hip replacement	0.458	0.416	0.549	0.357	0.457	0.459	0.546	0.348
Knee replacement	0.337	0.323	0.405	0.253	0.337	0.325	0.406	0.262
SWB below England average		SWB above England average						

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

The finalised data for 2018/19 shows that the reported outcome for the average adjusted health gain for hip replacements is marginally above the nationally average for England which is an improvement on the previous year, however knee replacements are marginally below when compared to the national average. There are areas for improvement however the trust is not an outlier against national data in any of the measures.

This information was presented to the Trust board in November 2019 as part of the quality plan and the Trust intends to take the following actions to improve.

- Preoperative THR / TKR PROMs questionnaires to be posted to 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.
- 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. Orthopaedics department has now instituted the booking team to send and sign that the questionnaire has been sent out to the patient. The ward sister will be responsible for ensuring the questionnaire is completed. A monitoring form has been introduced improving the pathway for both procedures on the ward.
- Trauma and Orthopaedics department to follow standard guidelines including PLCV guidance for joint replacement to ensure appropriateness of patients listed for surgery. Adherence to guidance will be audited to ensure appropriate patient selection.
- 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 one physiotherapy appointment post TKR and will be offered an optional course of six weeks physiotherapy dependent on patient needs.
- Revision of patient information leaflets to ensure that they are clear and easy to understand so that patients are fully aware of the risks associated with hip and knee replacement surgery. Accompanying videos in fracture clinic out patient department (OPD) will be produced.
- 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 will be part of the enhanced recovery programme.
- To introduce measures to ensure the early identification of wound infection. On discharge from the ward patients are given information on who to contact and how to arrange an urgent clinic appointment should they have any concerns that there is a potential infection developing.
- Introduction of arthroplasty nurse based on the ward to support enhanced recovery and patient outcomes.
- Electronic board in clinic for patient education on the importance of PROMS.
- Use clerk to contact patients prior to second booklet completion date (six months after surgery).
- Visit high performing peer hospital for improvement ideas.

How we performed in 2019/20 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2018/19 positon	2019/20 positon	Comments
Cancer – 2 week GP referral to first out patient	%	=>93	97.0	97.1	Full Year
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	=>93.0	96.5	97.3	Full Year
Cancer – 31 day diagnosis to treatment all cancers	%	=>96	97.8	96.9	Full Year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Excluding Rare Cancer)	%	=>85	86.5	85.7	Full Year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Including Rare Cancer)	%	=>85	86.5	85.8	Full Year
Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral	%	=>90	93.9	95.4	Full Year
Emergency Care – 4 hour waits	%	=>95	81.5	76.8	Full Year
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92	93.0	91.4	Full Year
Acute Diagnostic waits < 6 weeks	%	<1.0	2.0	1.8	Full Year
Outcome Metrics					
C Diff	No	<41	15	35	Full Year
MRSA Bacteraemia	No	0	1	2	Full Year
Never Events	No	0	3	3	Full Year
WHO Safer Surgery Checklist 3 sections (% patients where all sections complete. Main theatres only)	%	=>100	99.9	99.8	Full Year
VTE Risk assessments (adult IP)	%	=>95	94.8	95.8	Full Year
Clinical Quality and Outcomes					
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	93.7	90.8	Up to end Feb 2020
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	66.7	59.4	Up to end Feb 2020
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50	71.5	70.7	Up to end Feb 2020
Stroke care – Admission to Thrombolysis Time (% within 60 minutes)	%	=>85	75.9	71.9	Up to end Feb 2020
TIA (High Risk) Treatment within 24 hours of presentation	%	=>70	98.5	82.6	Up to end Feb 2020
TIA (Low Risk) Treatment within 7 days of presentation	%	=>75	98.3	85.1	Up to end Feb 2020
MRSA screening elective	%	=>85	86.2	79.6	Full Year
MRSA screening non elective	%	=>85	85.4	78.2	Full Year
Hip Fractures – operation within 36 hours	%	=>85	81.6	75.7	Full Year
Patient Experience					
Complaints received – formal and link	No	N/A	867	1003	Full Year
Coronary heart disease - primary angioplasty (<150 mins)	%	=>80	95.2	87.8	Full Year
Coronary heart disease – rapid access chest pain (<2weeks)	%	=>98	100.0	100.0	Full Year

Infection prevention and control

The Health and Social Care Act 2008 requires all Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection (HCAI). The Trust's nominated Director of Infection Prevention and Control (DIPC) is currently the Chief Nurse who has Board level responsibility and chairs the Infection Control Committee.

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

What we said we would do 2019/20

- Development of an audit program – We have commenced an action audit program that was progressing well, this program of work has been paused due to the current pandemic however we continue to support clinical areas with maintaining infection prevention and control standards. Areas that have undergone an action audit have demonstrated improvements.
- Training – All staff are now required to carry out annual infection prevention and control audits. Compliance is currently at 93%.
- Decontamination assurance framework – There has been extensive work with regards to decontamination. We have been able to demonstrate a high level of compliance in several areas and work is ongoing.
- Review of hand hygiene processes – We are in the process of a pilot study to look at an electronic solution to monitoring hand hygiene compliance. This work will continue when the Trusts returns to business as usual.
- Surveillance programme – We continue to monitor alert organisms in line with national requirements.

How did we perform in 2019/20?

Target for 2019/20	Agreed target/rate [year end]	Trust rate	Compliant	Comments
C.difficile acquisition toxin positive	41	35	Yes	The rate per 100,000 bed days (post 48 hours) of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period is 16.06
MRSA	Zero tolerance	2	No	Unavoidable Rate per 100,000 bed days (post 48 hours) 0.86

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

What this means for our patients?

We are providing safe and effective care that has a strong focus on preventing healthcare associated infection.

What we will do in 2020/2021

- Continue with the audit program.
- Regroup following the pandemic to ensure that there is learning and improvement.
- Strengthen further our decontamination processes.
- Maintain our surveillance of alert organisms.

Venous thromboembolism (VTE)

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

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

Venous thromboembolism (VTE) risk assessment (National Target 95%)	2018/19		2019/20			
	SWB		SWB	National Average	Highest Trust	Lowest Trust
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	94.8%	Q1	95.6%	95.6%	100%	69.8%
		Q2	95.6%	95.5%	100%	71.7%
		Q3	96.1%	95.3%	100%	71.6%
		Q4	TBC	TBC	TBC	TBC

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

The Trust intends to take the following actions to improve the quality of its services

- Continuing to monitor compliance of VTE assessments on admission as part of the Trust's Safety Plan compliance.
- Continuing to monitor through our integrated performance report at our Quality and Safety Committee and reported to the Trust board monthly.
- Continuing to monitor centrally through the Medical Director's Office.

Readmission rates

The table below details our readmission rates. The information is collected during a financial year period and we now measure readmission within 30 days (previously 28 days).

The results of an external audit on this measure recommended we change the counting method to fall in line with the Secondary Uses Service (SUS) readmission definitions which excludes some activity. The SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

We applied this recommendation to our reporting from July 2019 and as a result of this the numbers are lower particularly in the age 4-15 age group as the SUS definition excludes aged under four. This group was previously reported as 0-15 years.

Age 4 – 15 years

SWB	Number of Patients	Total Number of Readmissions	Percentage of Readmissions
2019/20 (to end Jan)	6747	342	5.1%
2018/19	15917	968	6.08%
2017/18	16145	934	5.8%
2016/17	16367	998	6.1%

Age 16 and over

SWB	Number of Patients	Total Number of Readmissions	Percentage of Readmissions
2019/20 (to end Jan)	69269	5682	8.2%
2018/19	86051	7113	8.3%
2017/18	95113	8997	9.5%
2016/17	96427	8789	9.1%

All Ages

SWB	Number of Patients	Total Number of Readmissions	Percentage of Readmissions
2019/20 (to end Jan)	76016	6024	7.9%
2018/19	101968	8081	7.9%
2017/18	111258	9931	8.9%
2016/17	112794	9787	8.7%

Readmission reduction remains a priority for the Trust.

Readmission reduction remains a priority for the Trust. It is a core part of our Quality plan with key focus and data being delivered through our 48 hour post discharge pathway. You can see from the data provided that year on year we have reduced re-admission rates in all age groups.

Not only are we focusing on preventing re-admissions, but also on ensuring we risk stratify those at highest risk, then through multi-disciplinary team pathways with primary care we ensure their future health needs are met in a more sustainable way.

Safeguarding Children

Safeguarding is embedded into practice across all disciplines and roles in Sandwell and West Birmingham NHS Trust (SWB) from our Chief Nurse, as the Executive Lead for Safeguarding through to our frontline staff. We have a dedicated team of specialist safeguarding professionals led by our Safeguarding Children Lead Nurse, who support our workforce through a programme of targeted training, advice, support and supervision.

As an organisation we are clear that safeguarding is integral to everything we do. We have a robust assurance and quality framework to ensure we are compliant with statutory requirements to safeguard and promote the well-being of children who may come into contact with the wide range of services we deliver across acute and community provision at all hospital sites. This has been enhanced by providing a daily duty nurse rota for advice and support calls.

We continue to work closely with both Sandwell and Birmingham Children's Trusts and have established positive relationships across all relevant agencies in Sandwell and Birmingham that support vulnerable children and families and continue to be active partners in multi-agency safeguarding arrangements with representation on aligned sub-group meetings across Sandwell and Birmingham.

We have worked closely with Unity (electronic patient record system) developers introduced in September 2019 to ensure that the Child Protection Information Sharing (CP-IS) Project is embedded within the system for our emergency departments (ED) and maternity services. Regular audit has demonstrated compliance with checking the Summary Care Record (SCR) for information to determine whether a child has a child protection plan in place, is a looked after child or a pregnant mother has an unborn child protection plan in place. Further work is needed to ensure Unity is developed to facilitate this information being automatically pulled into the record without practitioners needing to manually check the SCR.

Our ED Domestic Abuse Advocacy Partnership Project with Black Country Women's Aid continues to be a positive venture. In ED we have Independent Domestic Violence Advisors (IDVA) providing increased accessibility for victims to access specialist domestic violence and abuse support. NHS England are due to release a four year plan for domestic abuse which supports the roll out of IDVAs across all NHS services which highlights how innovative SWB were in supporting the introduction of the project in 2015. We continue to receive part funding from Safer Sandwell Partnership with our Chief Executive and Chief Nurse supporting SWB funding for the remaining cost of the project. The longer term plan is to make the IDVA service substantive within SWB during the coming year.

Data during 2019/20 has demonstrated that the service is reaching larger numbers of the pakistani and eastern european communities than community services do. During quarter 4, 48% of victims were unknown to Black Country Women's Aid Service. Evaluation of the project over the year has demonstrated positive outcomes for victims referred to the service with:

- 100% saying they now know where to go for support
- 94.44% felt less scared
- 77.77% felt better about their overall situation

Our domestic abuse nurse team continue to review cases where there has been a domestic abuse incident within Sandwell Multi-Agency Safeguarding Hub (MASH) to ensure both victims and children are safe. The team has worked with a number of key departments (e.g. sexual health, paediatric wards and occupational health) to raise awareness of domestic abuse and to promote the hospital as 'Domestic Abuse Aware'. To celebrate October Domestic Abuse Awareness Month the team arranged a conference to share key findings and learning which was well attended with a positive evaluation.

A significant amount of work has been undertaken during the year by the specialist midwife for mental health and well-being to embed the adding of an indicator to the SCR [H1] when women have had female genital mutilation (FGM) performed. Midwives will routinely ask all women if they have had FGM performed recording this in the record. Following delivery of a female child there is a compulsory question asking whether the indicator has been added to the female child's SCR [H2] to identify the child as being at risk of FGM. Quarterly audit has demonstrated an improving picture in compliance from the beginning of the year to 85% with a plan to increase this over 2020/21.

The IDVA service and Domestic Abuse Team received recognition this year via the SWB Star Awards after being nominated by the ED Matron for 'Clinical Team of the Year (Children) Award'

We have reviewed our safeguarding children training package in light of updated guidance released in 2019 and to improve compliance across the organisation. However, given the unprecedented times we found ourselves in, in March 2020 due to COVID-19 we have moved the training onto a virtual platform which commenced in May 2020.

The safeguarding children team expanded further in January 2020 when the MASH Health Nurse Team transferred to SWB from Sandwell and West Birmingham CCG. This has been a positive move ensuring that we provide a comprehensive safeguarding service in response to our working arrangements across the partnership and in MASH.

Priorities for 2020/21 will continue to focus on child protection information sharing (CP-IS) integration with Unity and FGM-IS compliance. We will work towards making the IDVA service substantive and continue to evaluate safeguarding children training and compliance.

Safeguarding Adults

The adult safeguarding team consists of an Adult safeguarding Lead Nurse and an Adult safeguarding Nurse who provide visibility and operational support to frontline colleagues and patients. The Adult Safeguarding Lead nurse is also responsible for the dementia delirium and distress team (DDD). This team now consists of a Mental Health Nurse, a Learning Disability Nurse and a newly appointed Mental Health Nurse and a Therapeutic Intervention Nurse which has allowed for additional training and work alongside relatives and carers to give a more personalised approach to patient care.

There has been input from safeguarding and DDD into several significant work streams including work around acuity and wards, managing the distressed patient work group and the vulnerable adult work group and three members of the team now actively conduct structured judgement reviews. Our tissue viability teams falls prevention nurse also works closely within the DDD Team and our Therapeutic Intervention nurse is currently assisting with falls to allow a broader spectrum of knowledge.

The adult safeguarding team has continued to focus on Deprivation of Liberty Safeguards. Our adult safeguarding nurse qualified as a 'Best Interest Assessor' which has improved our teaching and support to frontline staff in relation to least restrictive care, best interests and mental capacity assessments and holds twice monthly teaching sessions to qualified nurses which will eventually be expanded to HCA's and student nurses.

We continue to work closely with Sandwell and Birmingham multi agency safeguarding board participating in work streams for both prevention and protection of shared strategies. We prioritise full cooperation with any identified cases meeting the criteria for public enquiries and we are committed to learning lessons and improving practices around patient safeguards. PREVENT duties continue to develop with participation at multi agency meetings and participation in PREVENT forums chaired by NHS England. All activities of the safeguarding nurse are recorded on a dashboard to ensure trends and themes can be identified to improve and maintain the safety of our patients.

Learning from deaths

SWB Mortality Review Process

During 2019/20 our mortality review process was strengthened, with the newly revised Learning from Deaths Policy published in March 2020, outlining the complete pathway and processes.

The mortality review pathway is a multi-step process, which has been designed to provide assurance that deaths receive adequate independent review; ensuring investigations take place when issues with care delivery are identified, and appropriate actions taken to ensure we learn from the death.

In order to facilitate the process, the role of the medical examiners has been strengthened, which includes undertaking tier 1 mortality reviews on the Trust's Mortality Review System (MRS) (which is based on PRISM methodology). These reviews

- identify any deficiencies or errors in care or cases of good or excellent practice.
- ensure the accuracy of the death certificate.
- report matters of a clinical governance nature to support local learning and changes to practice and procedures.
- increase transparency for the bereaved and offer an opportunity to raise concerns.

The medical examiners who undertake the tier 1 mortality reviews also identify cases that require further scrutiny as part of this process. These are escalated to a trained reviewer who utilises the Structured Judgement Review (SJR) tool. This is a case review methodology introduced by the Royal College of Physicians (RCP) which supports reproducibility through use of explicit judgements and was implemented by the Trust in July 2019. To date we have successfully trained 54 professionals since June, across multiple professions including; medical, nursing, midwifery, community, safeguarding and physiotherapy, allowing comprehensive reviews of all facets of care. A Medical Examiner Officer has also been appointed to support the medical examiner function.

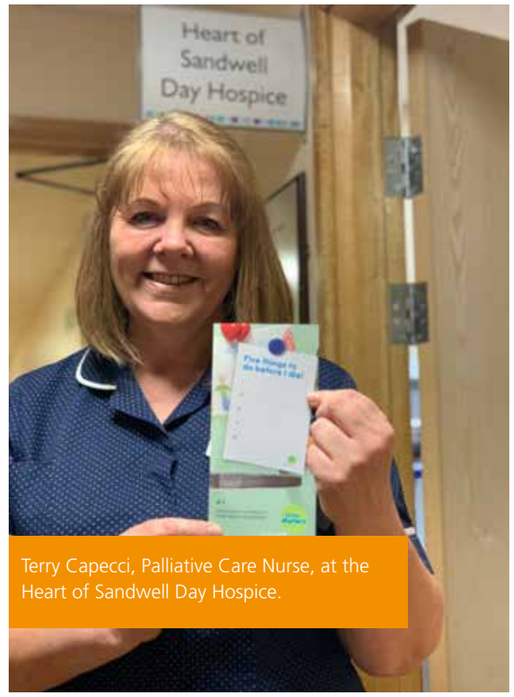
The Clinical and Professional Review of Mortality (CAPROM) panel meeting was introduced in June 2019. Here deaths highlighted as potentially avoidable are discussed by an expert multi-disciplinary, multi-professional panel to conclude if the death was in fact avoidable and to maintain oversight of any quality improvement projects and actions which arise following review.

The Learning from Deaths Committee (LfDC) has seen an increase in engagement from clinicians, with scheduled directorate reports providing assurance to the committee of the continual learning taking place, highlighting issues and challenges in addition to good or excellent practice, quality improvement activity and actions. The committee also presents a valuable opportunity to share practice, promoting cross pollination of learning with clinical colleagues. The LfDC also continues to scrutinise monthly mortality indices and manage emerging trends.

The role of directorate Mortality Leads has been formalised to include management of directorate allocated SJRs requests, chair specialty mortality and morbidity meetings, dissemination of identified learning, monitoring local mortality data and providing reviews where indicated.

A monthly learning document was introduced in December 2019, which aims to highlight learning identified from mortality reviews or themes for dissemination across the Trust providing an engaging means of learning from death. Examples include:

- Drug interactions when treating patients presenting with an overdose of illicit substances.
- Managing anti-coagulation in the elderly population when presenting with a suspected heart attack.
- Compassionate and well planned end of life care.



Terry Capecci, Palliative Care Nurse, at the Heart of Sandwell Day Hospice.

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days of discharge. Our SHMI score has continued to improve such that our 12 month cumulative SHMI score is currently 104. The SHMI data is derived from Healthcare Evaluation Data (HED) system monthly.

Mortality comparisons using Trust SHMI against the highest and lowest national results:

November 2018 – October 2019

Indicator	Lowest	Highest	SWB
Score (SHMI)	68	121	104
Observed	2048	1104	2048
Expected	3008.08	914.92	1968.03

The data above compares our mortality figures against all other Trusts nationally. A Trust would only gain a SHMI value of 100 if the number of actual deaths matches the expected number of deaths which is calculated using a risk adjusted model. The Trust also monitors its SHMI value taken from NHS Digital which is updated quarterly and is reported within various mortality and performance monitoring reports.

During 2019/20, 1577 of Sandwell and West Birmingham NHS Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 357 deaths in Q1, 330 deaths in Q2, 401 deaths in Q3 and 489 in Q4.

Of the 1577 deaths reported during 2019/20, 1231 (78%) underwent a tier 1 mortality review by medical examiners. This equated to 295 reviews in Q1, 274 in Q2, 326 in Q3 and 336 in Q4.

Of these, 204 were referred for further review in the form of an SJR or for panel discussion at CAPROM to determine if they were avoidable. This consisted of 10 cases in Q1, 50 cases in Q2, 67 in Q3 and 77 in Q4. In July 2019 the SJR process was introduced which has increased the number of deaths which receive a more detailed review.

Of the cases which received further scrutiny, 5 cases representing 0.32 per cent of all patient deaths during 2019/20 were judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter this consisted of: one patient death representing 0.28 per cent of the patient deaths for Q1, two patient deaths representing 0.61 per cent of the patient deaths for Q2 and two patient deaths representing 0.5 per cent of the patient deaths for Q3. Q4 data is not yet available and will be reported in next year's account.

Quarterly Inpatient Spells v Mortality Rate

	2018/19	2019/20			
	Q4	Q1	Q2	Q3	Q4
Total Inpatient spells	27,939	27,741	27,427	27,474	24,614
Total deaths	400	357	330	401	489
Avoidable deaths	0	1	2	2	TBC

Mortality performance in Q4 2018/19

A total of 400 deaths were reported in Q4 2018/19, of which 330 underwent a tier 1 review by the medical examiners. Of these cases 11 were escalated for panel discussion at CAPROM to determine if the death was avoidable and to identify any lapses in care, in addition to good practice.

0 deaths representing 0 per cent of the patient deaths during this reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.

A total of eleven deaths representing 0.77 per cent of the patient deaths during the 2018/19 reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.

Pneumonia Task Force

Pneumonia has been highlighted as one of the largest causes of death within the Trust and in response to this the Pneumonia Task Force was set up in April 2019. The aim of the task force is identify the causes and issues contributing to the higher than expected mortality rate for pneumonia and implement quality improvement (QI) strategies to improve care for this cohort of patients.

Key issues identified include:

The diagnosis of hospital acquired pneumonia (HAP) can be especially challenging in the frail and elderly population due to the likelihood of existing changes on chest x-ray and the presentation of clinical symptoms. This can result in a presumptive diagnosis, leading to incorrect antibiotics being prescribed, in some cases community acquired pneumonia (CAP) antibiotics being prescribed for patients with HAP.

The following QI projects have been undertaken reduce the incidence of HAP and improve care management of patients:

- The pneumonia guideline has been updated to improve management of HAP and CAP.
- The Trust has updated the MicroGuide app which is antibiotic decision support software to help ensure the right antibiotic is selected for the right patient.
- The Trust launched an eight week Mouth Care QI Initiative pilot across four wards as supporting patients maintain high standards of oral care has shown to reduce the incidence of HAP, improve nutrition, speech and patient happiness. The primary aim of the pilot is to reduce the incidence of HAP and reduce length of stay by 10%. We are currently awaiting the outcomes of the pilot.
- The Trust participates in the End PJ Paralysis Scheme and secured £75,000 funding through Helpforce to introduce Mobility and Activity Volunteers and purchased 24 new hoists, all to support patient mobility. Immobility in hospitals can lead to muscle deconditioning, loss of functional ability and cognitive impairment, all of which have the potential to increase hospital stays and increase the incidence of HAP.

Neonatal deaths

The neonatal and obstetrics teams have a robust system in place to reviews deaths, and a new process has been established to ensure all potentially avoidable deaths are flagged to the LfDC with assurance that concerns have been addressed, in addition to outcomes from Healthcare Safety Investigation Branch (HSIB) investigations.

The neonatal team have been working hard to implement improvement activity to enhance the quality of care delivered to our patients. This includes:

- Updating and implementation of guideline for thermoregulation and purchase of new cooling mattresses.
- Advanced airway equipment have been made available in all areas with an addition of video laryngoscope for use when required.

Following on from this, an audit conducted in 2019 identified that previously 33% of the babies we initially cooled had to be rewarmed as they did not fulfil the criteria for cooling. That figure has now come down to 7%. Previously, temperature management, once within therapeutic range, was poor as 85% did not stay within range, this is now reduced to 23%. There has also been a reduction in mortality rate in this group of babies from 24% to 17%.

Perinatal deaths

The obstetric team presented the perinatal Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) data to the committee and the following learning points were noted:

- Rates and numbers for stillbirth, neonatal losses and perinatal losses have stabilised in 2019 compared to 2018 which is the best performing year to date.
- The percentage reduction in perinatal mortality of 20% by 2020 was met in 2018 and continues to be met in 2019 (with yearly fluctuations).
- A new training package and quality assurance plan has been introduced for community growth scanning midwives.
- PRactical Obstetric Multi-Professional Training (PROMPT) is now in place.
- Cardiotocography (CGT) training is now part of the mandatory training package.
- Avoiding Term Admissions in to Neonatal units (ATAIN) and Prevention of Cerebral palsy in Pre-Term labour (PRECEPT) QI projects have been adopted by the specialty.

Child deaths

The paediatric department reviews all of their child deaths and report into the LfDC annually.

Key findings from an audit conducted are:

- Improvements noted in documentation and compliance with the Sudden and Unexpected Death in Childhood (SUDIC) pathway.
- Improvement in systems to present locally.
- We now have child death team presence during reviews of child deaths in hospital, who can provide feedback on provisional investigations.
- The team now have a new process in place for bereavement follow-up care, giving families the opportunity to liaise with a consultant.
- In 2019, the new Child Death review system was implemented and the guideline updated.

Palliative care services

Providing patients with compassionate end of life care is of vital importance. The Trust is working to ensure that patients recognised as dying have a Supportive Care Plan (SCP) in place, giving them the opportunity to spend their final days in comfort, taking into account their wishes and providing them with the dignity they deserve. To support the function:

- We have developed an enhanced multidisciplinary Palliative and End of Life Care working group. The group aims to identify barriers and interventions needed to implement the Sandwell and West Birmingham recommendations from the National Audit of End of Life Care outcomes and implement a sustainable quality improvement process with key performance indicators for each area.
- Investment in an additional consultant has been agreed.
- Working is taking place to improve recognition of a patient approaching the last year of life.
- There is a new discharge Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form with treatment escalation plan (TEP) now in place. The TEP is to be automatically populated into the discharge summary, with information following the patient into the community, promoting continuity of care.

Palliative Care Deaths: October 2018 - September 2019

Total Number of deaths	Palliative Care	Percentage (%)
2026	435	21.47

Cardiology

Quarterly mortality data produced by NHS Digital demonstrated an excess of expected deaths due to myocardial infarction. In response, the LfD committee has commissioned a review of all myocardial infarction cases, which is underway and will be reported later this year.

The LfDC also received feedback from Myocardial Ischaemia National Audit Project (MINAP) this year. The data demonstrated that the cardiology team are performing above the national average in several areas including; Angiography within 72 hours of presentation, admittance to cardiac ward under a cardiologist and door to balloon achieved within 90 minutes of presentation.

Stroke

NHS Digital data shows that we consistently observe less stroke deaths than expected in our Trust, demonstrating more favourable outcomes for our patients.

Our Sentinel Stroke National Audit Programme (SSNAP) data from April to June 2019 shows that the number of patients directly admitted to SWB was 174, whilst the number of patients discharged or transferred was 163. The Trust has also showed improvement in access to speech and language therapy during the discharge process.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 2419. Of these, 2327 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 92 were recruited into non-NIHR portfolio studies. This information includes recruitment figures up to 26 Feb 2019).

Participation in clinical audits

During 2019/20, 60 national clinical audits and four national confidential enquiries covered relevant health services that Sandwell and West Birmingham NHS Trust provide.

During that period Sandwell and West Birmingham NHS Trust participated in 98 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust was eligible to participate in during 2019/20 are as follows (see Column 1 on page 32).

The national clinical audits and national confidential enquiries that we participated in during 2019/20 are as follows (see column 2 on page 32).

The Clinical Research Facility was officially opened in May 2019. It is the heart of where the Trust conducts research and development, looking to improve care and outcomes for all our patients.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust participated in, and for which data collection was completed during 2019/2020, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see column 3 of the below table).

Title	Are we participating in this?	% of eligible cases submitted
BAUS urology audits - Percutaneous nephrolithotomy (PCNL)	✓	100%
British Thoracic Society (BTS) - Adult community acquired pneumonia	✓	100%
British Thoracic Society (BTS) - National adult non-invasive ventilation	✓	100%
British Thoracic Society (BTS) – Smoking cessation	✓	100%
Elective surgery national PROMS programme (Hip and knee surgery)	✓	99%
Falls and fragility fractures audit programme (FFFAP) Fracture liaison service database	✓	100%
Falls and fragility fractures audit programme (FFFAP) Inpatient falls	✓	100%
Falls and fragility fractures audit programme (FFFAP) National hip fracture database	✓	100%
Inflammatory bowel disease (IBD) audit	✓	552 patients
Intensive Care National Audit and Research Centre (ICNARC) - Case mix programme (CMP)	✓	100%
Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK - National cardiac arrest audit (NCAA)	✓	100%
Major trauma audit (TARN)	✓	17%
Maternal, newborn and infant clinical outcome review programme - Maternal mortality surveillance and mortality confidential enquiries	✓	100%
Maternal, newborn and infant clinical outcome review programme - Maternal morbidity confidential enquiries	✓	100%
Maternal, newborn and infant clinical outcome review programme - Perinatal mortality surveillance	✓	100%
Maternal, newborn and infant clinical outcome review programme - Perinatal morbidity and mortality confidential enquiries	✓	100%
National asthma and COPD audit programme (NACAP) - Paediatric asthma secondary care	✓	100%
National asthma and COPD Audit Programme (NACAP) - Pulmonary rehabilitation	✓	100%
National asthma and COPD audit programme (NACAP) - Adult asthma secondary care	✓	74%
National asthma and COPD audit programme (NACAP) - Chronic obstructive pulmonary disease (COPD) secondary care	✓	75%
National audit of breast cancer in older people (NABCOP)	✓	100%
National audit of cardiac rehabilitation (NACR)	✓	100%
National audit of care at the end of life (NACEL)	✓	100%
National audit of dementia care in general hospitals	✓	100%

Title	Are we participating in this?	% of eligible cases submitted
National audit of seizures and epilepsies in children and young people (Epilepsy12)	✓	82%
National audit of seizure management in hospitals (NASH)	✓	100%
National cardiac audit programme - Cardiac rhythm management (CRM)	✓	100%
National cardiac audit programme - Myocardial ischaemia national audit project (MINAP)	✓	50%
National cardiac audit programme - National audit of percutaneous coronary interventions (PCI)	✓	100%
National cardiac audit programme - National heart failure audit	✓	96%
National early inflammatory arthritis audit (NEIAA)	✓	100%
National diabetes audit (Adults) - Foot care	✓	100%
National diabetes audit (Adults) - National core diabetes audit	✓	Partial submission
National diabetes audit (Adults) - National diabetes inpatient audit (NaDIA) - Reporting on diabetic inpatient harms in England	✓	Did not submit
National diabetes audit (Adults) - National diabetes inpatient audit (NaDIA)	✓	100%
National diabetes audit (Adults) - National pregnancy in diabetes audit	✓	100%
National emergency laparotomy audit (NELA)	✓	100%
National gastro-intestinal cancer programme - National bowel cancer (NBOCA)	✓	100%
National gastro-intestinal cancer programme - National oesophago-gastric cancer (NOGCA)	✓	>90%
National joint registry (NJR)	✓	100%
National lung cancer audit (NLCA)	✓	100%
National maternity and perinatal audit (NMPA)	✓	100%
National neonatal audit programme - Neonatal intensive and special care (NNAP)	✓	100%
National ophthalmology audit	✓	100%
National paediatric diabetes audit (NPDA)	✓	100%
National prostate cancer audit	✓	100%
Perioperative quality improvement programme (PQIP)	✓	100%
Public Health England - Surgical site infection surveillance service	✓	99%
Public Health England - Mandatory surveillance of bloodstream infections and clostridium difficile infection	✓	100%
Royal College of Emergency Medicine - Assessing cognitive impairment in older people (Care in emergency departments)	✓	100%
Royal College of Emergency Medicine - Care of children (Care in emergency departments)	✓	100%
Royal College of Emergency Medicine - Feverish children (Care in emergency departments)	✓	100%
Royal College of Emergency Medicine - Mental health (Care in emergency departments)	✓	100%

Title	Are we participating in this?	% of eligible cases submitted
Royal College of Emergency Medicine - Vital signs in adults (Care in emergency departments)	✓	50%
Royal College of Emergency Medicine - VTE risk in lower limb immobilisation (Care in emergency departments)	✓	100%
	✓	100%
Sentinel stroke national audit programme (SSNAP)	✓	>90%
Serious hazards of transfusion (SHOT): UK National haemovigilance scheme	✓	100%
Society for acute medicine's benchmarking audit (SAMBA) Summer	✓	100%
Society for acute medicine's benchmarking audit (SAMBA) Winter	✓	100%
UK parkinson's audit	✓	100%

The reports of 48 national clinical audits were reviewed by the provider in 2019/20 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided:

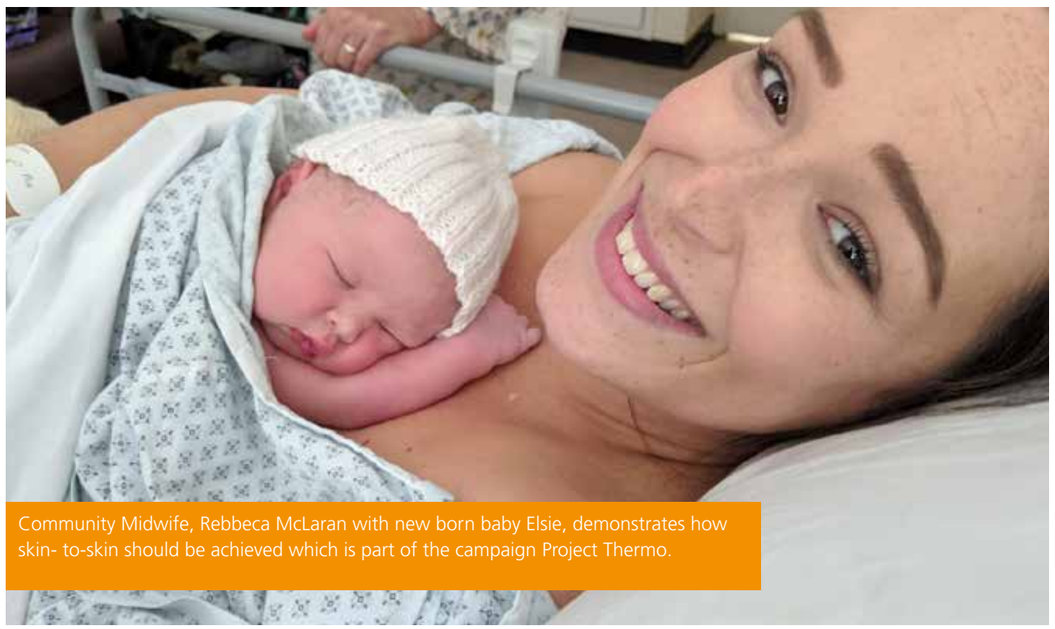
- To develop a pathway for Total Contact Cast (TCC) use by working collaboratively with the orthotics department and MDT as a whole. The Podiatry department to provide the use of soft casting devices for offloading as needed, which is particularly useful for heel wounds and housebound patients that are not able to attend for Total Contact Cast.
- To offer regular classroom and ward based diabetes management education to all nursing staff and junior doctors with an emphasis relating to harms such as correct hypo management. There is ongoing work to identify and give wards a full diabetes accreditation if they meet particular criteria.
- Introduction of routine MDT meetings to discuss all pacemaker generator changes, complex devices and other issues which should also improve data quality.
- Develop a business case for an additional Heart Failure Nurse to see medical outliers that are not transferred to cardiology. Acute heart failure specialty is working with cardiology rehab to look at setting up specialist heart failure classes. This will lead to an improvement in key performance indicators and national targets.
- Discharge drugs are now validated which should see an increased compliance level on prescribing rates of key disease modifying medicines. The discharge dataset on people admitted to hospital due to heart failure is now reviewed prior to input by an audit coordinator to reduce inconsistency and misinterpretation.
- To implement a process to ensure initial assessment for delirium is completed at admission.
- To update the dementia leaftlet and deliver a structured Tier 1 and Tier 2 rolling programme on class room based teaching and ward room based teaching on dementia awareness.
- To recruit to a link nurse to work with families and carers.
- Establish a private space for discussions in the new Midlands Metropolitan University Hospital and to promote John's campaign for out of hours visiting.
- To employ an additional palliative care consultant.
- Develop the ward champion role by offering a high level of end of life care training. Training for all staff in end of life care, with options of training on induction and mandatory training. Train the practice development nurses who are on the medical wards to support with end of life issues.
- Develop a suite of key performance indicators for each clinical area to report back monthly to clinical leads. Develop mechanisms to improve utilisation of existing information leaflets and documentation of conversations. Comfort packs to be developed with a suite of written accessible information on wards for end of life patients and their relatives. Promote early recognition of end of life by use of Supportive & Palliative Care Indicators Tool (SPICT).
- To educate GPs on the referral pathway and what constitutes "suspected Inflammatory arthritis", implement the newly developed triage system, increase capacity in the dedicated early inflammatory arthritis clinics and integrate clinics with rheumatology clinical nurse specialist to help with disease education/rapid drug initiation following a patient's first visit to a rheumatologist.
- Develop a business case to purchase transport incubator for the transportation of babies. Undertake audits to understand current practice on temperatures taken on admission and compliance of consultation with parents within 24 hours of a baby's admission. Matron is to educate all nurses and midwives to encourage parents to attend the ward rounds when babies are on the unit and to be added to effective handover. Implementation of the national PReCePT (prevention of cerebral palsy in preterm babies) programme by giving magnesium sulphate to mums within the 24 hours before delivery as a foetal neuro protective agent. As part of the programme, local monitoring will be undertaken on a monthly basis.
- Create and pilot 100 passports for patients which will include all documentation required for the patient's journey including rehabilitation to ensure that they are brought to all appointments. Implement plastic cards for patients with implants who travel abroad and create a video for hip and knee club which depicts the entire patient journey to give patients an overview of what can be expected.

The reports of 138 local clinical audits were reviewed by the provider in 2019/20 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Actions include ensuring radiographer awareness of importance of eye lens exclusion by use of posters in the CT control rooms, supervision of more junior staff by superintendent radiographers and awareness of clinical factors to improve compliance
- Increase the nursing compliment to account for acuity of patients in Acute Medicine by reviewing nursing staff levels on an ongoing basis. Reiterate at ward round, board round and post-take round to specify oxygen prescriptions. The dependency of patients in each bay is fed back to the coordinator leading the unit
- Non-Invasive Ventilation (NIV) guidelines, proformas and paperwork will be reviewed and a re-audit will be performed to monitor the impact of changes on the appropriateness of commenced Non-Invasive Ventilation
- Acquired a relaxation pod for medical staff
- To implement a Trauma and Orthopaedic handover checklist to ensure that there is a structure for handovers and include a section in the induction programme pack on how handovers should be conducted
- Update the safe environment policy to include the latest guidance, to improve patient information and sign posting on 'Safe sleep' by liaising with medical illustrations and implement junior doctor teaching sessions
- Provide patient information leaflets on anti-embolic stockings post-operatively and consider adding anti-embolic stockings to the prescribing window for the VTE assessment tool on Unity for easier prescription of stockings
- Educate both medical and nursing staff about the importance of maintaining < 32 week gestation babies temperatures between 36.5 - 37.5C. To look into obtaining a suitable transport incubator to transport <32 week gestation babies from labour ward to the neonatal unit. Improve documentation of room temperatures and how this can be improved on labour ward, as well as improving the number of rooms which are at target temperature
- Streamline the Child Protection medical examination report. To consider adding a prompt on the Child Protection proforma to give children the opportunity of speaking alone, and deliver training sessions to colleagues on report writing, using the standard proforma and referencing Child Protection Evidence (RCPCH) in complex cases
- To implement a dedicated surgery list to book patients to avoid delays in treatment
- To set up a dedicated weekly theatre list to perform cholecystectomies on appropriately identified patients and evaluate the effectiveness of the service in the future
- To provide contraceptive advice to all high risk obstetric patients pre-discharge and provide Duty of Candour in appropriate cases. To ensure all decisions to transfer, discussions with the intensive care team and reviews of obstetric patients in ITU is documented on BadgerNet. To complete the High Dependency unit proforma for obstetric patients immediately after admission

- To set up clinics to perform oximetry studies at home for City babies. To ensure the discharge planner has details of the MDT so it takes place with the parents pre discharge. To educate nursing staff regarding discontinuation of continuous O2 monitoring once stable with good sleep study, apart from 4 hourly checks twice weekly. File sleep studies with documentation of results and actions for both inpatients and outpatients. Train staff to ensure all babies discharged home in minimum of 0.1 litres / min with low flow meters. To develop a standardised home oxygen weaning policy. To educate Consultants, neonatal discharge planner and community nurses to improve interpretation of sleep studies with knowledge of when and how frequently to perform them for inpatients and outpatients.

Clinicians can now use a relaxation pod based at City Hospital.



Community Midwife, Rebbeca McLaran with new born baby Elsie, demonstrates how skin- to-skin should be achieved which is part of the campaign Project Thermo.

Terry Ma, Emergency Department Charge Nurse, who was featured on BBC national news to celebrate International Nurses Day on 12 May 2020

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