Paper ref:	TB (08/20) 013

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	CQC Improvement Plan Update		
Sponsoring Executive	Kathleen French, Interim Chief Nurse		
Report Author	Ruth Spencer, Associate Director of Quality Assurance		
Meeting	Trust Board (Public)	**Date**	6th August 2020

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

The Trust is due a follow-up CQC inspection sometime this year given our current overall provider rating of 'Requires Improvement'. Visits have been on national pause during the pandemic but are restarting on a risk-based approach which should put the Trust at a low level, so not top of the list, however this is not certain.

The attached paper sets out a programme of work to prepare ourselves for inspection, and includes completing the work to address the outstanding 20 areas for improvement identified by the inspectors in 2018. At the same time quality checks will be undertaken to ensure compliance has been achieved and maintained in all other areas.

An overall provider 'Good' rating is achievable if our medical wards and Emergency Departments unannounced inspections and Well-led assessments are successful. Staff preparedness and engagement is key and will feature strongly in plans.

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

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

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

Clinical Leadership Executive.

4. Recommendation(s)

The Trust Board is asked to:

a.	**Note** the plans to prepare for CQC inspection
b.	**Review** the insight report and provider information return plans
c.	**Comment** on plans for getting staff prepared for a CQC visit

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

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 6th August 2020

CQC Improvement Plan Update

1. Introduction and background

1.1. Whilst the CQC have temporarily paused inspections due to the COVID-19 pandemic, the Trust is still working on being ready for inspection when the programme is re-commenced, and this paper updates the Trust Board on the progress being made.

1.2. From September 2020 the CQC will be introducing a transitional methodology. This will draw on the five key questions it asked previously [safe, caring, effective, responsive and well-led] but will be much shorter. It will involve some visits and some remote assessment of data. Frequency of inspections and type of rating system has not been decided yet, but the CQC are preparing to engage with public and provider groups over the autumn.

1.3. The Associate Director of Quality Assurance, Ruth Spencer, is now in post, working closely with the Executive Directors and the clinical Groups to oversee successful implementation of the Trust's CQC Project Delivery Plan. Over 70% of the Trust's services are rated as Good or Outstanding, so efforts will target the remaining areas whilst checking / monitoring performance does not slip elsewhere.

1.4. Good relationships have been established with our local CQC Inspectors, with them having spent time with Executive and Group Directors, meeting frontline staff and going on walkabouts across the sites. This engagement has been paused since the pandemic but will hopefully resume shortly, even if remotely.

2. Project Delivery Plan

2.1. The CQC Project Delivery Plan forms part of the **we**Assure programme, a copy of the plan is included at **Annex 1** and presents the work streams underway to prepare the organisation to achieve a Good rating upon a return visit from the CQC.

2.2. Work streams contained within the Project Delivery Plan focus on monitoring the information that the CQC hold about our Trust (Insight Report and PIR); inspection preparedness; staff preparedness; learning from others; and ensuring the actions in the CQC Improvement Plan have been addressed, improvements are embedded and sustained and are now complete.

2.3. The Use of Resources assessment and Well-led review are part of the CQC's inspection regime and both have a current 'Requires Improvement' rating. The work taking place to achieve a 'Good' rating in both will be included within the overall delivery plan, rather than reported separately as has been the case to date.

3. CQC Improvement Plan (Action Plan)

3.1. The Board has previously received updates on the full CQC Improvement Plan, including details of the completion dates for each of the 115 must do and should do actions, as well as the methods to be used to evidence successful delivery. Presented at **Annex 2** is a RAG rated list of the actions showing their updated delivery status.

3.2. Of the 115 must do and should do actions, all actions have now been and are compliant across Critical Care, Maternity and Community Inpatients core services. The overall current position for each core service is set out in the table below.

Core Service	Number of Actions		
	Green	Amber	Red
Urgent and Emergency Care	15	4	0
Medicine	26	6	0
Children and Young People	23	10	0
Maternity	10	0	0
Critical Care	2	0	0
Community Inpatients	9	0	0
TOTAL	**85**	**20**	**0**

3.3. Where actions have been deemed as compliant, the Project Delivery Plan includes a checking process via unannounced in-house inspection visits and gathering of robust evidence and success measures to ensure that actions are complete and are being sustained.

3.4. There are 20 ongoing actions rated as Amber across Urgent and Emergency Care, Medicine, and Children and Young People's Services. Improvement plans are in place for any outstanding actions as set out below.

Urgent and Emergency Care

There are two amber must do actions, and two amber should do actions for Urgent and Emergency Care:

MD9 at Sandwell General Hospital, and MD15 at City Hospital: The trust must ensure there is sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of patients 24 hours a day.

- The group have reduced the number of vacancies over the last 12 months and actively strive to retain staff and recruit.
- A nursing workforce establishment review has taken place in 2020 to ensure staffing is safe.
- Recruitment has taken place utilising innovative approaches and all health care support worker vacancies have been filled.

- At the end of each shift the nurse in charge completes a safer nursing proforma which indicates staffing and patient ratio inclusive of dependency for monitoring and assurance purposes.
- We are taking part in the Trainee Nursing Associate (TNA) programme and have TNAs in each clinical area.
- An Advanced Clinical Practice (ACP) programme is commencing to ensure a skilled workforce in light of medical vacancies as we move into the Midland Metropolitan Hospital.

SD3: The trust should review its current measures for improving compliance against national targets, for example the four hour target to see and discharge, admit or transfer patients, and ensure they are fit for purpose. To address this finding, ED has an improvement plan which involves work streams surrounding streaming, triage, ambulatory pathways and COVID-19 streaming. This also includes work within the AMUs regarding patient flows and ability to exit to ward in a timely manner.

SD6: The trust should improve recording within patient records including documentation around completing safeguarding and mental capacity proforma and improve staff understanding around mental capacity assessments. This is much improved with the implementation of Unity and is monitored on the 15 step challenge, but work is still ongoing.

<u>Medicine, and Children and Young People</u>

Details of the improvement work underway to complete the remaining amber actions for these two core services is set out in **Annex 3** of this report.

3.5. The Groups have been asked to work with the Associate Director of Quality Assurance to ensure that the remaining 20 amber actions are completed and closed down before the end of September 2020.

4. CQC Insight Report

4.1. The CQC publish a monthly Insight report that brings together and analyses the information which they hold about our Trust. The Insight report contains indicators that monitor potential changes to the quality of care that the Trust provides. This report helps the CQC to decide what, where and when to inspect our services.

4.2. The Insight report provides an indication of performance, including a comparison with similar Trusts, changes over time and whether latest performance has improved, deteriorated or is about the same as the previous equivalent period.

4.3. The clinical Groups are encouraged to review all sections within the Insight reports and are also provided with an exception report containing indicators showing performance as worse or much worse against the national comparison. The clinical Groups are then asked to provide a monthly update to Executive Quality Committee (EQC). The exception reporting template has recently been amended to include details of the specific actions the Groups are undertaking in order to address any outlying areas,

with a timeline for when they expect to see an improvement in performance. This revised template will be in use from August 2020. The June 2020 exception report is available at **Annex 4**. We will continue to closely monitor the Insight report and to provide a monthly update at EQC.

4.4. A work stream is in progress to highlight any areas where the Trust's performance is shown to be better or much better than the national average, and to communicate this Trust-wide via our established routes of communication.

5. Provider Information Return (PIR)

5.1. The CQC will request the Provider Information Return (PIR) prior to an upcoming inspection. The content requested includes key data in relation to the five key questions: Is the service safe, effective, caring, responsive and well led. This pre-inspection return will inform the basis as to which services or areas the CQC will choose to visit during their inspection.

5.2. Ordinarily most Trusts wait until the request for information comes in from the CQC which can then result in a last minute rush to gather together the data, narrative and supporting documents required for the return. It has been agreed therefore to keep the PIR updated on an ongoing quarterly basis to ensure that it contains the most recent, accurate data and good quality supporting narrative so that we will be ready to submit as soon as required.

5.3. This process will also enable the Trust to monitor performance against these key data sets, and address any areas requiring further investigation or improvement as soon as they become apparent.

6. Inspection Preparedness

6.1. Work streams identified in order to prepare the organisation for inspection include the setting up of a Trust CQC Improvement Team. The Team will comprise representatives from Corporate and each of the Clinical Groups who will act as CQC Leads. Each Group is requested to nominate a representative to join the CQC Improvement Team.

6.2. The Trust is looking at learning from other organisations recently rated 'good' and work is already underway to forge links with colleagues in other Trusts to find out what 'good' looks like, and to map out our route to an improved rating.

6.3. Our schedule of in-house unannounced visits will be resumed as soon as is reasonably possible following the COVID-19 pandemic, which has meant there have been difficulties in non-clinical staff being able to access clinical areas to carry out the visits. A plan is in place, should the pandemic continue to affect our ability to access clinical areas, whereby appropriate clinical staff will be requested to conduct the visits and feedback their findings so that actions can be implemented and monitored where necessary.

6.4. A series of initiatives are being worked-up currently in order to prepare staff for a forthcoming inspection to include: an electronic toolkit containing videos and useful information; positive sharing of good performance within the ward / clinical area to ensure staff are fully briefed on examples of excellent practice; staff focus groups to provide a good understanding of what to expect and to address any queries or concerns that staff may want to raise; and a communications package aimed at keeping staff regularly updated and informed.

7. Recommendations

The Trust Board is asked to:

a. Note the plans to prepare for CQC inspection
b. Review the insight report and provider information return plans
c. Comment on plans for getting staff prepared for a CQC visit

Ruth Spencer
Associate Director of Quality Assurance

23rd July 2020

Annex 1: CQC Project Delivery Plan
Annex 2: CQC Improvement Plan (Action Plan)
Annex 3: CQC Improvement Plan – Update on Amber rated actions
Annex 4: CQC Insight Report – Trust Exception Report

Annex 1

WeAssure Programme: Project Delivery Plan

Project Delivery Plan for the Implementation and Quality Assurance of CQC Improvement

Action Status Key:		
	1	Action complete and evidence available
	2	Action underway and will complete to timescale
	3	Action not on track and subject to escalation
	4	Action scheduled

Ref	Work Stream	Actions and Approach	Implementation Timeline 2020						Expected Completion Date	Status
			July	August	September	October	November	December		
1.	**Identify Trust CQC Leads** Develop a dedicated team to facilitate and oversee the improvements.	• Identify specific CQC Leads within each Clinical Group to form the Project Delivery Team. • Set dates for the Team to meet monthly. • Identify task and finish groups as necessary to address any specific issues requiring action.							July 2020	1
2.	**Must Do & Should Do Actions** Deliver the actions relating to the findings of the last CQC inspection.	• Re-visit the Must Do & Should Do action plan to ensure the successful completion of each action. • Establish what new work has been undertaken since the report was published and where we are better / stronger. • Identify the success measures that provide assurance of completion for each action. • Address any actions outstanding or requiring further work in order to be signed off as complete.							September 2020	2

Ref	Work Stream	Actions and Approach	Implementation Timeline 2020						Expected Completion Date	Status
			July	August	September	October	November	December		
3.	**Insight Report** A monthly report published by the CQC that brings together and analyses the information they hold about our Trust. Includes a comparison with other similar Trusts and sets out whether we are much better, better, worse or much worse in terms of our current performance.	• Continue to closely monitor the Insight report and provide a monthly update to Executive Quality Committee highlighting any indicators where the Trusts performance has deteriorated, or where we are shown as being worse than the national comparison. • Groups to provide an update on the specific actions they are taking in order to address any outlying areas with a timescale for when they expect to see an improvement. • Celebrate indicators where we are better or much better via the Trusts established routes of communication.							Ongoing Monthly	**2**
4.	**Provider Information Return** The information return that the CQC will request prior to an upcoming inspection. The information contained within it will inform the basis as to which services / areas the CQC will choose to visit.	• Ensure the PIR is updated with the most recently available data and good quality supporting narrative on a quarterly basis (or monthly where possible). • Maintain an up to date repository of supporting documentation that will also be required for submission. • Ensure we are ready to provide all required information in a timely manner as soon as requested by the CQC, thereby preventing any last minute rush which could potentially impact on the quality of the return.							Ongoing Quarterly	**2**

Ref	Work Stream	Actions and Approach	Implementation Timeline 2020						Expected Completion Date	Status
			July	August	September	October	November	December		
5.	**Identify Risks** Mitigating any areas of concern or issues which may prevent the successful delivery of this plan.	• Identify any 'hot spot areas' or areas of concern which will require immediate improvement and share these with the Group Leads to facilitate the changes at service level. • Identify any risks that could potentially prevent the Trust from achieving an improved rating, and set out what we will do in order to mitigate these risks.							September 2020	**2**
6.	**Learning from Others** Establish links within other Trusts in order to identify best practice.	• Identify other similar Trusts recently rated as good and establish links with these colleagues. • Liaise (or visit wherever possible) to establish what 'good' looks like and to share their experience and lessons learned from the inspection process. • Set out the characteristics of an outstanding Trust and what this looks like - map our route to 'good'.							October 2020	**4**
7.	**Inspection Preparedness** Ensure the organisation and our staff are prepared in readiness for a forthcoming inspection.	• Resume our in-house unannounced visits as soon as is reasonably possible (paused due to COVID-19 pandemic). Consider utilising clinical leads to undertake the visits and feedback the findings if it is still not possible or appropriate for non-clinical staff to visit the clinical areas going forward.							Ongoing monthly	**4**
		<u>Staff Preparation:</u> • Develop an electronic toolkit containing videos and lessons to share with staff.							October 2020	**4**

Ref	Work Stream	Actions and Approach	Implementation Timeline 2020						Expected Completion Date	Status
			July	August	September	October	November	December		
		• In order to help staff to identify areas of good practice in their clinical area and to articulate their achievements and successes – produce and circulate 'My Ward' sheets to demonstrate several areas of good performance particular to each clinical area – clinical lead / ward manager to provide narrative on how they have achieved the improvements. Include a section for staff to share what they are proud of, and also one area where performance is not so good with plans for how they will address this to facilitate improvement.							Ongoing monthly	**4**
		• Hold a series of staff focus groups to discuss the inspection process, what to expect, and to address any queries or concerns staff may have.							Ongoing monthly	**4**
		• Develop a communications package to keep staff informed including regular updates via: * Heartbeat magazine; * Chief Executive's Friday message; * Daily email bulletin; * My Connect; * A dedicated intranet page.							Ongoing monthly	**4**

Annex 2

Our CQC Improvement Plan

An update to the findings of the Care Quality Commission Inspection

Core Services Inspected:

- Urgent and Emergency Care
- Medical Care
- Children and Young People's Services
- Critical Care [at Sandwell General Hospital]
- Maternity [at City Hospital]
- Community Inpatients

July 2020

[NB: CQC reports published on 29 March 2019]

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Care Quality Commission Inspection: Improvement Plan

RAG Status as at July 2020

Status:	G	Action complete	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set

Ref		CQC Finding	Status
For the overall Trust			
1.	MD1	Ensure compliance with the requirements of the fit and proper person's regulation.	
2.	MD2	Ensure the effectiveness of governance arrangements and the board is consistently informed of and sited on risks.	
In Urgent and Emergency Care at Sandwell General Hospital			
3.	MD3	The trust must ensure that records and personal information is secure at all times, in line with the General Data Protection Regulations and Data Protection Act 2018.	G
4.	MD4	The trust must ensure that the emergency department is clean and staff are assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated.	G
5.	MD5	The trust must ensure that the premises are suitable for the purpose for which they are being used, including in the treatment of children and young people.	G
6.	MD6	The trust must ensure that a robust plan is in place to maintain the safety and security of children and young people overnight when the children's 'majors' area is not open.	G
7.	MD7	The trust must ensure that service users are treated with dignity and respect, and ensure the privacy of service users whilst under the care of the department.	G
8.	MD8	The trust must ensure the proper and safe management of medicines, ensuring intravenous fluids are tamper proof and the ordering and rotation of medication prevents a lack of supply or out of date medication available for use.	G
9.	MD9	The trust must ensure there is sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of patients 24 hours a day.	A
10.	MD10	The trust must ensure a robust system to manage risk and performance across the service.	G
11.	SD1	The trust should ensure that all staff have received an appraisal appropriate to their role.	G
12.	SD2	The trust should review how staff competencies are delivered and assessed across the department.	G

Ref		CQC Finding	Status
13.	SD3	The trust should review its current measures for improving compliance against national targets, for example the four hour target to see and discharge, admit or transfer patients, and ensure they are fit for purpose.	A
14.	SD4	The trust should ensure that any IT systems in use across the organisation are fit for purpose and allow staff to undertake their roles without jeopardising or delaying.	G
In Urgent and Emergency Care at City Hospital			
15.	MD11	The trust must ensure that records and personal information is secure at all times, in line with the General Data Protection Regulations and Data Protection Act 2018.	G
16.	MD12	The trust must ensure that staff are up to date with all mandatory training.	G
17.	MD13	The trust must ensure that all doors are kept locked to ensure all staff and patients are kept safe within the department.	G
18.	MD14	The trust must ensure clinical waste and infection control policy is adhered to around disposal and usage of sharps bins.	G
19.	MD15	The trust must ensure that sufficient numbers of substantive staff are on each shift to ensure patients and staff are kept safe.	A
20.	SD5	The trust should ensure all staff are up to date with their yearly appraisal.	G
21.	SD6	The trust should improve recording within patient records including documentation around completing safeguarding and mental capacity proforma and improve staff understanding around mental capacity assessments.	A
In Medicine at Sandwell General Hospital			
22.	MD16	The trust must ensure that staff are up to date with all mandatory training including basic life support and safeguarding training.	G
23.	MD17	The trust must take steps to ensure infection control techniques are safe, robustly monitored and that staff adhere to trust standards.	G
24.	MD18	The trust must ensure that resuscitation trollies are tamperproof and any risks associated with storing medications are mitigated and risk assessed.	G
25.	MD19	The trust must ensure that sufficient numbers of substantive staff are on each shift with the correct skill mix to ensure patients are safe.	A
26.	MD20	The trust must ensure that root cause analysis investigations are robust and include action plans that are reviewed and that these are signed by staff of the appropriate authority.	G
27.	MD21	The trust must ensure systems are in place to prevent avoidable mixed sex breaches where patients are not receiving specialised care.	G
28.	MD22	The trust must ensure whenever possible patients are not in mixed sex bays. When this is necessary policies must contain information around keeping patients safe.	G
29.	MD23	The trust must ensure IV fluid bags and potassium bags are clearly labelled and stored in a way that minimises the risk of any confusion.	G
30.	MD24	The Trust must ensure patient records are kept secure including patient notes and those on the computer system.	G
31.	MD25	The trust must ensure that discharge summaries are completed, forwarded to the appropriate people and that the situation with discharge summaries is sufficiently monitored to ensure people are safe.	G
32.	SD7	The trust should improve on the time taken to investigate complaints so that it is in line with trust policy.	G
33.	SD8	The trust should improve recording within patient records.	G
34.	SD9	The trust should aim to improve staff understanding around mental capacity assessments and best interest decisions, including ensuring assessments and best interest decisions are recorded in medical notes when there is a doubt about a person's capacity to make a decision around their future care and treatment.	A

Ref		CQC Finding	Status
35.	SD10	The trust should ensure all staff are up to date with their yearly appraisal.	G
36.	SD11	The trust should ensure that all policies are up to date.	A
37.	SD12	The trust should ensure actions are recorded, implemented and available when an area has been identified as in need of improvement.	G
38.	SD13	The trust should ensure that risk registers contain all relevant risks and are reviewed within agreed timescales and that they are complete.	G
In Medicine at City Hospital			
39.	MD26	The trust must ensure systems are in place to prevent avoidable mixed sex breaches where patients are not receiving specialised care.	G
40.	MD27	The trust must ensure whenever possible patients are not in mixed sex bays. When this is necessary policies must contain information around keeping patients safe.	G
41.	MD28	The trust must ensure emergency resuscitation trolleys and contents, including medicines, are suitable for their purpose at all times.	G
42.	MD29	The trust must ensure emergency call pulls are suitable for purpose and properly maintained.	G
43.	MD30	Where risks are identified the trust must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people who use the service.	G
44.	MD31	The trust must ensure that patients records are kept secure including patient notes and those on the computer system.	G
45.	MD32	The trust must ensure that sufficient numbers of substantive staff are on each shift with the correct skill mix to ensure patients are safe.	A
46.	MD33	The trust must ensure that staff are up to date with all mandatory training including basic life support and safeguarding training.	G
47.	MD34	The trust must take steps to ensure infection control techniques are safe, robustly monitored and that staff adhere to trust standards.	G
48.	SD14	Systems should be in place to provide and monitor that staff have regular supervisions with senior staff.	G
49.	SD15	The trust should improve recording within patient records.	G
50.	SD16	The trust should aim to improve staff understanding around mental capacity assessments and best interest decisions, including ensuring assessments and best interest decisions are recorded in medical notes when there is a doubt about a person's capacity to make a decision around their future care and treatment.	A
51.	SD17	The trust should ensure there is effective pain management and psychological support in place for patients with sickle cell and thalassemia.	G
52.	SD18	The trust should act on feedback from relevant persons on the services provided in the carrying on of the regulated activity.	G
53.	SD19	The trust should ensure that all patients, when required have the appropriate assessments to keep them safe including assessments for delirium, lying to standing blood pressure and vision assessments.	A
In Children and Young People's Services at Sandwell General Hospital			
54.	MD35	The trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.	A
55.	MD36	The trust must ensure that there is a robust record and audit of medications to assure that they are within date.	G
56.	MD37	The trust must ensure it records medication fridge temperatures every day on Priory Ground.	G
57.	MD38	The trust must ensure it operates a cleaning schedule appropriate to the care and treatment being delivered by the equipment and monitor the level of cleanliness.	G
58.	MD39	The trust must ensure that 'ligature free' rooms are ligature free or make staff aware of the risks in the rooms.	G
59.	MD40	The trust must ensure the risk register is fully completed and updated regularly.	G

Ref		CQC Finding	Status
60.	MD41	The trust must ensure it has systems in place to communicate how feedback from complaints has led to improvements.	A
61.	MD42	The trust must ensure it implements a robust engagement plan with staff, patients, their families and carers.	A
62.	MD43	The trust must ensure that the nurse staffing skill mix reflects the appropriate national guidance for staffing the specialty reviewed.	G
63.	MD44	The trust must not include unqualified Band 4s in qualified staff roles.	G
64.	MD45	The trust must ensure it has enough medical staff to meet the requirements of the Facing the Future: Standards for Acute General Paediatric Services.	G
65.	MD46	The trust must ensure that staff receive appropriate training including mandatory training updates and supervision.	G
66.	MD47	The trust must ensure it trains staff in mental health, learning disability or autism to reflect the patients that are being cared for.	A
67.	SD20	The trust should ensure that staffing levels are planned so that staff do not work excessive hours and are able to take designated breaks in line with the European working times directive.	G
68.	SD21	The trust should ensure it has sufficient numbers of play specialists to meet patients care needs.	G
69.	SD22	The trust should ensure managers have protected time to carry out their managerial duties.	N/A
70.	SD23	The trust should consider it has a formal agreement with the local children and adolescent mental health services.	N/A
71.	SD24	The trust should consider developing a robust strategy for children and young people.	N/A
72.	SD25	The trust should consider having greater visibility and support of the children and young people service from the executive leadership team.	G
73.	SD26	The trust should consider implementing team meetings including paediatric mortality and morbidity meetings and enable the release of staff to attend.	G
In Children and Young People's Services at City Hospital			
74.	MD48	The trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.	A
75.	MD49	The trust must ensure that there is a robust record and daily audit of the medication fridges' temperatures.	G
76.	MD50	The trust must ensure that there is a robust record and audit of medications to assure that they are within date.	G
77.	MD51	The trust must ensure it operates a cleaning schedule appropriate to the care and treatment being delivered by the equipment and monitor the level of cleanliness.	G
78.	MD52	The trust must ensure that it has a robust risk register including updated and measurable actions with clear deadlines.	G
79.	MD53	The trust must ensure it has systems in place to communicate how feedback from complaints has led to improvements.	A
80.	MD54	The trust must ensure that the nurse staffing skill mix reflects the appropriate national guidance for staffing the specialty reviewed.	G
81.	MD55	The trust must ensure that the medical staffing skill mix reflects the Facing the Future: Standards for Acute General Paediatric Service.	A
82.	MD56	The trust must ensure staff are trained in mental health, learning disabilities and autism to reflect the patients that are being cared for.	A
83.	MD57	The trust must ensure that staff receive appropriate training including mandatory training.	G
84.	SD27	The trust should ensure that managers have protected time for their managerial duties.	N/A
85.	SD28	The trust should ensure it has sufficient numbers of play specialist staff to meet patient's care needs at City Hospital.	N/A
86.	SD29	The trust should ensure it has systems in place to communicate how feedback from complaints had led to improvements.	A
87.	SD30	The trust should ensure it implements a robust engagement plan for engagement with staff and service users.	A

Ref		CQC Finding	Status
88.	SD31	The trust should ensure it operates a cleaning schedule appropriate to the care and treatment being delivered by the equipment and monitor the level of cleanliness.	G
89.	SD32	The trust should ensure that staffing levels are planned so staff do not work excessive hours and are unable to take their designated breaks. European Working Times Directive 2003.	G
90.	SD33	The trust should consider developing a strategy for services for children and young people.	N/A
91.	SD34	The trust should consider implementing team meetings including paediatric mortality and morbidity meetings and enable the release of staff to attend.	G
92.	SD35	The trust should consider having greater visibility and support of the children and young people service from the executive leadership team.	G
In Community Inpatients			
93.	MD58	The trust must ensure all staff have regard for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010 when assessing patients and delivering care, including ensuring mental capacity assessments are detailed, compliant with legislation and best practice, and is undertaken in a way and at a time that recognises patient's abilities.	G
94.	MD59	The trust must ensure that resuscitation trollies are tamperproof.	G
95.	MD60	The trust must ensure that nurses always take urgent action to review the care of the patient and call for specialist help when necessary.	G
96.	MD61	The trust must ensure ward risk registers reflect all risks in the area and that mitigating actions are adhered to.	G
97.	SD36	The trust should improve on the time taken to investigate complaints so that it is in line with trust policy.	G
98.	SD37	The trust should ensure all staff are up to date with their yearly appraisal.	G
99.	SD38	The trust should ensure staff achieve uniformly high standards in recording and communicating decisions about Cardiopulmonary resuscitation and that Do Not Attempt Cardiopulmonary Resuscitation" DNACPR forms are in line with the Resuscitation Council (UK) guidance for recording DNACPR decisions, 2009.	G
100.	SD39	The trust should ensure care plans are person centred.	G
101.	SD40	The trust should assess whether patients needing to be seen by specialist team such as the diabetes team are seen in a timely manner.	G
In Critical Care at Sandwell General Hospital			
102.	SD41	The trust should ensure that where HIV testing is undertaken under best interests, there is robust follow-up care and support available.	G
103.	SD42	The service should continue to explore suitable alternatives to expand the isolation areas available.	N/A
104.	SD43	The service should ensure that the systems in place for identifying and reporting theft and tampering of the paediatric trolley is as robust as those that are in place for the adult resuscitation trolleys.	G
In Maternity at City Hospital			
105.	SD44	The service should ensure all parts of the maternity department have sufficient staff to provide safe care and treatment to patients.	G
106.	SD45	Ensure regular infant abduction exercises are conducted to check for any gaps in the process and assess staff awareness of their role.	G
107.	SD46	Ensure staff are given sufficient protected time to complete court reports when required.	N/A
108.	SD47	Ensure staffing levels are consistently met in all areas of the maternity department.	G
109.	SD48	Ensure patients who need one-to-one care on both the midwifery led unit and delivery suite consistently receive it.	G
110.	SD49	Ensure the maternity dashboard includes all required performance indicators and local or national targets.	G

Ref		CQC Finding	Status
111.	SD50	Ensure medication and medical gases are safely stored.	G
112.	SD51	Ensure processes are in place to store breast milk safely.	G
113.	SD52	Ensure all staff are up-to-date with information governance refresher training.	G
114.	SD53	Ensure all staff are up-to-date with their appraisals.	G
115.	SD54	Ensure all patient information leaflets are up-to-date.	G

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Care Quality Commission Inspection: Improvement Plan

Actions for CQC Findings Rated as Amber

Status:	G	Action complete	A	Action on track to be delivered by the agreed date	R	Action off track and revised date set

Ref		CQC Finding	Status	Action Plan
In Medicine at Sandwell General Hospital				
25.	MD19	The trust must ensure that sufficient numbers of substantive staff are on each shift with the correct skill mix to ensure patients are safe.	**A**	• The group have reduced the number of vacancies over the last 12 months and actively strive to retain staff and recruit. • A nursing workforce establishment review has taken place in 2020 to ensure staffing is safe. • Recruitment has taken place utilising innovative approaches and all health care support worker vacancies have been filled. • At the end of each shift the nurse in charge completes a safer nursing proforma which indicates staffing and patient ratio inclusive of dependency for monitoring and assurance purposes. • We are taking part in the Trainee Nursing Associate (TNA) programme and have TNAs in each clinical area. • An Advanced Clinical Practice (ACP) programme is commencing to ensure a skilled workforce in light of medical vacancies as we move into the Midland

Ref		CQC Finding	Status	Action Plan
				Metropolitan Hospital.
34.	SD9	The trust should aim to improve staff understanding around mental capacity assessments and best interest decisions, including ensuring assessments and best interest decisions are recorded in medical notes when there is a doubt about a person's capacity to make a decision around their future care and treatment.	**A**	• Wide education has taken place and the Unity system allows for ease of recording and audit. Professional challenge is applied in Root Cause Analysis (RCA) and incident recording and reported through governance meetings. Many good case examples.
36.	SD11	The trust should ensure that all policies are up to date.	**A**	• A Trust-wide programme is underway to review any out of date policies and to ensure they are updated by the review date. • The Trust has purchased a new system, **my**Docs, which is in the process of being developed and will be rolled-out to the entire organisation by September 2020. • **my**Docs will provide easy access for Trust staff to all controlled documents, and will allow access remotely on home computers and mobile phones via **we**Connect. • **my**Docs will require staff to ensure they have read, understood, and agree to follow Trust policies by requiring them to complete a short test following reading any new or updated documentation and then making a declaration to say they will follow it. • Managers will receive regular reports on staff compliance and performance will be monitored.
In Medicine at City Hospital				
45.	MD32	The trust must ensure that sufficient numbers of substantive staff are on each shift with the correct skill mix to ensure patients are safe.	**A**	• See point 25 (MD19) above.

Ref		CQC Finding	Status	Action Plan
50.	SD16	The trust should aim to improve staff understanding around mental capacity assessments and best interest decisions, including ensuring assessments and best interest decisions are recorded in medical notes when there is a doubt about a person's capacity to make a decision around their future care and treatment.	**A**	• See point 34 (SD9) above.
53.	SD19	The trust should ensure that all patients, when required have the appropriate assessments to keep them safe including assessments for delirium, lying to standing blood pressure and vision assessments.	**A**	• Assessments are now part of the documentation within Unity. It is also part of the RCA process and that of requests for focussed care, however it is not yet embedded in all areas – therefore work is ongoing.
In Children and Young People's Services at Sandwell General Hospital				
54.	MD35	The trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.	**A**	• There is a requirement for 17 WTE nurses across the paediatric unit to be fully compliant. • 13 of the nursing staff are EPL / APLS trained (76%) (2 out of date). Five Nurses were due to complete EPLS training in May-20 but this was cancelled due to COVID-19. This would have resulted in full compliance. • Further courses in Nov-20 – five staff booked to attend 3 APLS & 2 EPLS.
60.	MD41	The trust must ensure it has systems in place to communicate how feedback from complaints has led to improvements.	**A**	• Work continues - not fully embedded.
61.	MD42	The trust must ensure it implements a robust engagement plan with staff, patients, their families and carers.	**A**	• The Communication and Engagement Plan with staff is being finalised. • **my**Connect programme is in place and teams are supported to participate. • Paediatrics will be put forward to participate in next

Ref		CQC Finding	Status	Action Plan
				program. • COVID-19 has inhibited a Patient and Families Engagement Plan. • We are currently working towards improved Friends & Family Test.
66.	MD47	The trust must ensure it trains staff in mental health, learning disability or autism to reflect the patients that are being cared for.	**A**	• Some training has been delivered – the Eating Disorders Team presented at Quality Improvement Half Day (QIHD). • Child & Adolescent Mental Health Modules have been included in the Training Needs Analysis for 20/21. • Training for de-escalation to be delivered delayed due to COVID-19.
In Children and Young People's Services at City Hospital				
74.	MD48	The trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.	**A**	• See point 54 (MD35) above.
79.	MD53	The trust must ensure it has systems in place to communicate how feedback from complaints has led to improvements.	**A**	• See point 60 (MD41) above.
81.	MD55	The trust must ensure that the medical staffing skill mix reflects the Facing the Future: Standards for Acute General Paediatric Service.	**A**	• A business case has been approved to commence recruitment in October 2020 for an April 2021 start.
82.	MD56	The trust must ensure staff are trained in mental health, learning disabilities and autism to reflect the patients that are being cared for.	**A**	• See point 66 (MD47) above.
86.	SD29	The trust should ensure it has systems in place to	**A**	• See point 60 (MD41) above.

Ref		CQC Finding	Status	Action Plan
		communicate how feedback from complaints had led to improvements.		
87.	SD30	The trust should ensure it implements a robust engagement plan for engagement with staff and service users.	**A**	• See point 61 (MD42) above.

CQC Insight Report

Exception report and Trust response

July 2020

Key to performance:
- Improving
- About the same
- Declining

Compared to the National Average:

MB	Much better
B	Better
S	About the same
W	Worse
MW	Much worse

Urgent & Emergency Care

KLOE Ref	Indicator	National Average	Insight Data	Current position	Initial Group Response and Planned Actions
E2	**Unplanned re-attendance to A&E within 7 days (%)** *NHS Digital – A&E Quality*	8.9%	15.8% (Apr-20)		Monthly ED re-attendance MDT with third sector, social services, toxicology, ED, mental health team to review vulnerable patients and support needed to be put in for them.
R3	**Patients spending less than 4 hours in A&E (%)** *NHS England – A&E SitReps*	92.9%	91.6% (May-20)		Strengthening streaming at the front door with senior nurse and clinical decision maker to ensure patients who require same day emergency care are streamed to the appropriate service (medical and surgical ambulatory care, primary care, hot clinics). Segregation of Minors stream away from main ED footprint led by ENP service and support from Trauma and Orthopaedics for patients presenting with minor injuries.
R3	**Admissions waiting 4-12 hours from the decision to admit (%)** *NHS England – A&E SitReps*	4.0%	5.0% (May-20)		Consultant ward and board rounds on assessment unit for early decision making. Review of arrival to DTA within 2 hours (City 51.5% and SGH 50.4%) to ensure early identification of need of bed for patients arriving in ED.

Medicine

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response
E1	**SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator** *Royal College of Physicians – Sentinel Stroke National Audit Programme (SSNAP) – Sandwell General Hospital*	N/A	 Level D (Oct-19 – Dec-19)		
E2	**Emergency readmissions: Acute bronchitis** *Hospital Episode Statistics – HES – Readmissions by CCS group*	100	 124.4 (Jan-19 – Dec-19)		Newly triggered indicator in the July 2020 Insight Report.
E2	**Emergency readmissions: Fluid and electrolyte disorders** *Hospital Episode Statistics – HES – Readmissions by CCS group*	100	 128.5 (Jan-19 – Dec-19)		
E2	**Emergency readmissions: Urinary tract infections** *Hospital Episode Statistics – HES – Readmissions by CCS group*	100	 102.0 (Jan-19 – Dec-19)		
E2	**Mortality outlier alert: Acute bronchitis** *Care Quality Admission – CQC – Outliers*	N/A			
E2	**Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse** *Care Quality Admission – CQC – Outliers*	N/A			An extensive review of this took place a year ago and essentially most of it was: The 1a) Death certificate cause was usually something else, the pulmonary disease was in part 2, and none of the deaths were preventable. Inappropriate coding of 'pneumonia' as cause of deaths was also identified. A 'pneumonia taskforce group was established as a consequence and educational work surrounding coding and the writing of death certificates was included within this. In addition: • Establishment of twice weekly pleural clinic. • Pleural clinical nurse specialist role (a new role that was introduced in 2020). • Daily respiratory in reach to AMU by respiratory physicians and clinical nurse specialists.

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response
E2	**Mortality outlier alert: Urinary tract infections** *Care Quality Admission – CQC – Outliers*	N/A			All professional development nurses within Medicine and Emergency care have this as a Trust quality theme to deliver in their educative roles this is inclusive of the wider MDT. Posters surrounding good practice are being placed around the Trust to raise awareness of the diagnostic process for UTI. A Trust UTI steering group has been established to steer the operational implementation of good practice. Work surrounding frailty and the front door will also encompass UTI.
E2	**Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%)** *NHS England – RTT Admitted*	82.8%	 92.2% (May-20)		<u>Haematology:</u> Service has continued to meet the 92% target as the service has maintained activity utilising virtual clinics. <u>Neurology:</u> Performance has dropped due to redeployment of resources for COVID response. A recovery plan is being worked through to utilise re-triaging of referrals so that patients are cared for in the most appropriate setting. In addition, external providers, community MDTs and GP education initiatives are being developed. <u>Cardiology:</u> The service has switched activity from face to face to virtual where possible and is now looking to implement a triaging pathway so that referrals are more appropriately managed and waiting lists can be reduced. Cardiology Diagnostics should have worked through their backlog in the next month. <u>Respiratory:</u> Performance has dropped due to redeployment of resources for COVID response. The service has switched activity from face to face to virtual where possible and is now working on returning diagnostic testing back to 100% activity to reduce waiting times. <u>Gastroenterology/Endoscopy:</u> Performance has dropped due to redeployment of resources for COVID

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response
					response. The service has switched activity from face to face to virtual where possible. Endoscopy has resumed service and is increasing activity. Additional private sector support is being utilised to help to work through reducing the backlog of patient to be seen.

Surgery

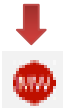
KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response
S5	**Crude percentage of patients documented as not having a pressure ulcer (%)** *Royal College of Physicians – National Hip Fracture Database – Sandwell General Hospital*	95.4%	95.9% (Jan-18 – Dec-18)		Continue to improve through use of Unity to record pressure ulcers and management. Grade 3 incidents undergo TTR and learning is shared across the group.
S5	**Never events in surgery** *NHS Improvement – OBIEE NRLS STEIS*	N/A	0 (Jun-19 – May-20)	0	One Never Event in June 2019; all actions completed. Lessons shared through Group Governance Committee. This indicator will remain on the Insight Report for 12 months from the date of reporting, but there have been no new incidents.
E1	**Crude proportion of cases with preoperative documentation of risk of death** *Royal College of Anaesthetists – National Emergency Laparotomy Audit – Sandwell General Hospital*	74.6%	82.8% (Dec-16 – Nov-17)		Regular case note review; QIHD review of outcomes and learning.
E1	**Crude proportion of high risk cases with consultant surgeon and anaesthetist present in theatre** *Royal College of Anaesthetists – National Emergency Laparotomy Audit – Sandwell General Hospital*	82.5%	83.0% (Dec-16 – Nov-17)		2019/20 Quality Plan – purchase of Open Outcomes software. Exploring use of patient portal pre / post –surgery.
E2	**PROMs: Primary Hip Replacement EQ-5D score (17-18) – Final** *NHS Digital – PROMS*	N/A	Lower 95% (Apr-17 – Mar-18)		2019/20 Quality Plan – purchase of Open Outcomes software. Exploring use of patient portal pre / post –surgery.

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response
E2	**PROMs: Primary Hip Replacement Oxford score (17-18) – Final** *NHS Digital - PROMS*	N/A	Lower 95% (Apr-17 – Mar-18)		As above.
E2	**Risk-adjusted 30-day mortality rate (%)** *Royal College of Physicians – National Hip Fracture Database – Sandwell General Hospital*	6.1%	6.4% (Jan-18 – Dec-18)		
C1	**Patients recommending the trust - Surgery inpatients (%)** *NHS England – FFT Inpatients by Ward*	N/A	89.5% (Jul-19 – Sep-19)		Continually improving access for elective surgery; • Recovery 100% plan • Established cold site (BTC) • Scoping 7 day access to surgical procedures/services • Increasing theatre utilisation in BTC • Vanguard theatre plan for ophthalmology • Continue to reduce ophthalmology backlog (currently 10,500) • Established "hot" site at SGH • Moved to "vitual" consultation model • Improved Theatre scheduling : Surginet • Night time visits by senior nursing team to review Good Sleep protocol Plan in place to improve response rate from Friends and Family Test.
R3	**Crude overall hospital length of stay** *Royal College of Physicians – National Hip Fracture Database – Sandwell General Hospital*	19.5	24.1 (Jan-18 – Dec-18)		More effective use of community services post op / admission – designing pathways to support stepdown to MF and interim care facilities. Implementation of ERAS care plan (requires unity). Low LOS for emergency admissions – Increased consultant presence on SAU / established ambulatory model.
R3	**Crude proportion of highest risk-cases admitted to critical care post operatively** *Royal College of Anaesthetists – National Emergency Laparotomy Audit – Sandwell General Hospital*	86.8%	77.6% (Dec-16 – Nov-17)		Exploring the development of PACU facility at BTC.

Maternity

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response
S5	**Never events in maternity or gynaecology** *NHS Improvement – OBIEE NRLS STEIS*	N/A	 1 (Jun-19 – May-20)	0	Action plan addressed, checking for retained swabs within gynae theatre. This shared learning has been utilised across the Group enhancing the work already undertaken by maternity, who had already pioneered the use of yellow wrist bands for vaginal packs, etc. This indicator will remain on the Insight Report for 12 months from the date of reporting, however there have been no new incidents.
E2	**Stabilised and risk adjusted extended perinatal mortality rate (per 1,000 births)** *MBRRACE-UK Perinatal Mortality Surveillance*	5.0	 5.0 (Jan-16 – Dec-16)		Ongoing monthly review of all cases.
C1	**Being left alone** *Care Quality Commission – Maternity Survey Benchmarking*	N/A	 6.2 (Feb-19)		COVID 19 impacted, one birth partner is being facilitated, 1:1 care in labour is maintained at 93% - during COVID and reduced staffing due to increased sickness.
C1	**Patients recommending the trust - Maternity delivery (%)** *NHS England – FFT Birth*	N/A	 95.3% (Dec-19 – Feb-20)		Reconfiguration of maternity services has commenced to facilitate and improved maternal journey.
C1	**Raising concerns** *Care Quality Commission – Maternity Survey Benchmarking*	N/A	 7.2 (Feb-19)		Initiating patient survey, debrief to all women where required / requested, ward managers encouraged to facilitate local resolution.

Children & Young People

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response
E1	**Case mix adjusted mean HbA1c; blood glucose control** *Royal College of Paediatrics and Child Health – National Paediatric Diabetes Audit (NPDA) – Sandwell General Hospital*	67.5	 63.7 (Apr-17 – Mar-18)		Reduce DNA rates by offering contact to persistent DNA via telephone or video conferencing. Use of Technology to improve engagement including introducing different apps including DEAPP and PIOTA. Offer more children and young people continuous glucose monitoring e.g freestyle libre. Implement new strategies e.g change glucose targets to 3.9-7mmol/l, HBA1c target to 48mmol / mol, limit free snacks to only breakfast snack.
C3	**Parent and carer views on pain management** *PICKER – CQC CYP Survey*	N/A	 7.7 (Nov-18 – Dec-18)		Safety plan metrics implemented for pain assessment, audit to be completed to review.
R1	**Appropriate equipment or adaptations** *PICKER – CQC CYP Survey*	N/A	 8.0 (Nov-18 – Dec-18)		
R3	**Full bed occupancy levels for neonatal intensive care beds** *NHS England – Critical Care Bed Occupancy*	N/A	 3 months of full occupancy (Dec-19 – Feb-20)		Work with ODN and business case formulated for NCOTS (Community outreach service), awaiting feedback, project to reconfigure maternity services to provide increased transitional care cots progressing and expected to be in place by September 2020.