Paper ref:	TB (02/21) 015

Sandwell and West Birmingham Hospitals NHS Trust

Report Title:	CQC Inspection Preparedness Update		
Sponsoring Executive:	Kam Dhami, Director of Governance		
Report Author:	Ruth Spencer, Associate Director of Quality Assurance and Kam Dhami, Director of Governance		
Meeting:	Public Trust Board	**Date**	4th February 2021

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 COVID-19 pandemic but are restarting. Each inspection since 2014 has seen ratings improvement but the Board has been unambiguous in our ambition to reach 'Good'. Three service domains were our agreed focus: Medicine, Emergency Care and Paediatrics. However, we need to be mindful to not see fall-back in other service areas some of which have not been functioning fully during the pandemic (such as elective surgery).

The attached paper provides an update on progress with the programme of work that is underway in order to prepare ourselves for inspection, and includes detail around specific areas of work being undertaken as part of our weAssure Improvement Delivery Plan. The Board has previously been briefed on this.

As identified in 2019, there is work to be done on staffing and on employee engagement if we are to reach the standards that we want, and the CQC would expect. The recruitment position reported to the Board in closing 2019/20 has not delivered reductions on nurse staffing gaps, and the pressures of COVID-19 are immense. We are discussing with the CQC how their inspection methodology will take account of this.

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

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

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

Clinical Leadership Executive 26th January) and Quality and Safety Committee (29th January)

4. Recommendation(s)

The Trust Board is asked to:

a.	**CONFIRM** support for the approach presented to prepare for inspection
b.	**CONSIDER** any 'at risk' services with current Good/Outstanding ratings
c.	**DISCUSS** how to approach the reported 'speak up' issues cited herein

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

Trust Risk Register	x	Various					
Board Assurance Framework		n/a					
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: 4th February 2021

CQC Inspection Preparedness Update

1. Introduction

1.1 We do not yet know when we will be inspected by the Care Quality Commission (CQC). Our last inspection was 2018, with the report being received in April 2019. Ordinarily 'Requires Improvement' rated sites would then be reinspected within 2 years. However, since then we have had the ongoing Pandemic, and there are some changes to the CQC approach under consultation currently. We should continue to prepare on the basis of inspection during 2021.

1.2 The internal approach being taken is one of continuous quality improvement were upon we are self-assessing against the CQC key lines of enquiry. The standard being reviewed is part of our business as usual approach to quality improvement. It will from part of bi-monthly Performance Reviews.

1.3 Due to the current wave of the pandemic with all wards and clinical areas having a COVID-19 status of either amber or red, we are utilising new ways of working and alternative opportunities to learn from current experiences. We are using the findings from the work already undertaken over the Summer and Autumn of 2020 to continue to facilitate improvement across the organisation through a variety of work streams set out in this paper.

2. In-House Unannounced Inspection Visits

2.1 The Trust wide programme of in-house unannounced inspection visits that commenced in the Autumn of 2020 was progressing, with eight wards having had their first visit and receiving their full, detailed written report following the visits. The decision was taken by the Interim Chief Nurse at the start of November to pause the visits due to the increasing numbers of patients present in the Trust testing positive for COVID-19 with all wards becoming either red or amber. The intention of this pause was to protect both patients and the workforce from the risk of spread of transmission.

2.2 For the wards having already been inspected, they have been asked to continue to prepare their action plans to address areas identified for improvement. These wards will be invited to the monthly Oversight Group to present progress with their action plans in the coming weeks.

2.3 The temporary pause in unannounced inspection visits will be reviewed on an ongoing basis with the hope that visits can resume again from May 2021, as soon as it is safe and reasonable to do so. Before then we are exploring how we can progress non-ward based areas.

2.4 The Trust's CQC ratings as per the last inspection are included in **Annex 1** of this report and show how we are currently rated: 73% of rated domains are Good or Outstanding. The list of 115 'Must Do' and 'Should Do' actions from the previous inspection have all been implemented and closed, however ongoing monitoring of these has been built into the in-house unannounced visits and the self-assessment programme.

3. Self-Assessment Programme

3.1 The in-house developed self-assessment toolkit has been widely distributed to all Groups who have been asked to support their clinical teams to complete the self-assessment.

3.2 Primary Care, Community & Therapies Group have embraced the self-assessment process with iCares having already assessed 15 of their teams. They have developed an excel document based on the self-assessment tool which will provide each of the domains with a rating and show their progress as they embark on their improvement journey.

3.3 So far, feedback from the teams and services who have undertaken the self-assessment has been extremely positive, with staff feeding back that they have found the process really useful and intuitive and have been able to use the tool to easily identify specific areas that they wish to focus on in order to drive their improvements, and also areas of good practice that they are proud of and will want to share with the organisation and with the CQC when they visit.

3.4 Clinical teams have been given a deadline of getting the self-assessments completed and returned by the end of February 2021 to enable us to draw themes of good practice and areas for improvement. These will be reported up to the Executive Quality Committee, CLE, Quality and Safety Committee and the Trust Board.

3.5 There is work to do jointly with the new Chief People Officer on the workforce position in each team. We know from prior inspections that employee morale at a local level has a major impact on how the visits go, and that staffing numbers (actual or perceived) form a critical part of that dynamic.

4. Staff Engagement

4.1 A series of staff engagement events consisting of drop in sessions and WebEx opportunities took place across October, November and December 2020. The sessions covered the inspection process, what staff can expect during an inspection, how to prepare fully, and who to contact if they require further information or support. Staff also had the opportunity to ask any questions they had.

4.2 These events were well attended with a good mix of staff from each of the different groups attending in person or joining a WebEx. A number of initiatives were discussed in relation to quality improvement for bespoke areas, and also ideas for improving practices Trust wide.

4.3 Future sessions are currently being booked to take place for this year across all sites and also on WebEx for those staff who are not able to attend an event in person. Dates will be circulated via the daily communications email and also via TeamTalk. However, we will try and make these sessions 'Group led' with support from the governance team so that local managers feel ownership of the process.

4.4 One of the themes coming from the in-house unannounced inspection visits was that some staff feel unsure in speaking up about their issues or concerns, or that they raise concerns locally within their ward environment but managers are not always able to address the issues raised. This is often also feedback on incident reporting. As a result of this CLE needs to consider holding a series of focus groups where staff will be given the opportunity to attend and share their concerns or worries with Clinical Group leads, and potentially members of the Executive Group, who can listen to what staff have to say and endeavour to help address any issues or fix problems that have not been resolved wherever possible.

5. CQC Engagement Meetings

5.1 Prior to Q2 2020/21 we had established a productive process of engagement work with the local CQC team building on the dialogue with the deputy Chief Inspector initiated by Richard Samuda and Toby Lewis in 2018/19. Before the pandemic it had included site visits by the CQC team to specific services, providing both parties with insight into how services operate here and crucially how management works at a directorate and Group level, not merely at Board level.

5.2 During the pandemic the CQC have been talking to providers largely on the basis of risks monitored through information from commissioners and their normal enquiries from members of the public. This has been their way of keeping in touch but not adding to the stress that everyone is experiencing.

5.3 They are, however, now moving away from that and planning to introduce a new approach to engagement and monitoring of trusts, called Transitional Monitoring Activity (TMA), which is just out to consultation. Contact is awaited from our local inspectors on what this means in terms of our relationship with them and the best way to move forward.

5.4 We will discuss within that work how aspects of the inspection process will now be approached. The Board will recall our intent to Improve our Use of Resources rating because the prior visit used 2016/17 data. With enormous changes to the financial flow regime for 2020/21 and perhaps beyond we need to understand whether our 2019/20 position will be used and if not how the methodology has been adapted.

5.5 With the advent of System First a similar set of questions surround the KLOEs for Well-Led. The Trust dropped from 'Good' in 2017 to 'Requires Improvement' in 2019 and we commissioned specific work with GGI to think through our approach to that. The pandemic has interrupted work on our Well-Led improvement plan, albeit the implementation of Unity addresses some of the key underlying difficulties. The

pandemic and management absences will certainly impact this area of inspection, and we will seek to discuss with the CQC how they envisage this being assessed.

6. CQC Provider Information Return

6.1 We continue to collect data in support of the PIR on a quarterly basis so that we can be ready to submit our return as soon as the CQC request we do so. This was not our practice before 2019 and should provide visibility for clinicians and managers about the data that the inspection team are using to view their services. If we assume that self-assessment submissions to the CQC remain part of their methodology the data will help to calibrate our approach.

7. CQC Insight Report

7.1 The CQC continue to publish their Insight Report every two months. This report brings together and analyses the information which they hold about our Trust. The report provides an indication of performance, including a comparison with other Trusts, changes over time and whether the latest performance has improved, deteriorated or is about the same as the previous equivalent period. The Board is aware of our recent poor infection rating and the major fall in our SHMI and we are discussing with the CQC how they view those matters.

7.2 The data contained within this report is our data taken from a variety of national sources and is often historic, for example some information comes from the National Staff Survey which is only published once per year. Indicators remain in the report until more current data becomes available. Part of our Engagement work with the CQC is seeking to validate data and volunteer local data where they will accept this as valid.

7.3 The clinical Groups are required to review all sections within the Insight Report and are provided with an exception report containing indicators showing performance as worse or much worse against the national comparison.

7.4 The exception report contains specific actions that the Groups are undertaking in order to address any outlying areas, with a timeline for when they expect to see an improvement in performance. There is also a section for Groups to include their current performance data against that published in the CQC report, which enables them to demonstrate how things have moved on.

7.5 At the time of writing this report, the latest report published was for November 2020 and data exceptions show the following:

Change	Indicator
7 indicators have improved	• CAS alerts closed late in the preceding 12 months • Unplanned reattendance to A&E within 7 days • A&E attendees spending more than 12 hours from decision to • admit to admission • Admissions waiting 4-12 hours from decision to admit • Patients spending less than 4 hours in any type of A&E • Patients spending less than 4 hours in major A&E

Change	Indicator
	• Emergency readmissions: Fluid and electrolyte disorders
5 indicators have newly triggered	• Hospital Standardised Mortality Ratio (Weekend) • Whistleblowing alerts • In-hospital mortality: Pneumonia • In-hospital mortality: Septicaemia (except in labour) • Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks
6 indicators have declined	• Deaths in Low-Risk Diagnosis Groups • Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks • Cancer – First treatment in 62 days of urgent national screening referral • Patients waiting over 6 weeks for diagnostic test • Referral to treatment, on incomplete pathways, within 18 weeks • Referral to treatment, on non-admitted pathways, within 18 weeks
2 new indicators have been added to the report	• Risk adjusted 90 day mortality ratio for knees (excluding tumours) • Participation in the ICCQIP – Neonatal critical care services

7.6 **Annex 2** shows the exception areas taken from the CQC Insight Report published in November 2020 and contains the response and updated actions from each Group. This increasingly needs to be the focus of scrutiny.

7.7 A further report has been published by the CQC for January 2021 which shows the following further updates:

Change	Indicator
4 indicators have improved	• Stability of non-clinical staff • Unplanned reattendance to A&E within 7 days • Patients spending less than 4 hours in any type of A&E • Patients spending less than 4 hours in major A&E
5 indicators have newly triggered	• Sick days for other clinical staff • Turnover rate for other non-clinical staff • Data Quality Maturity Index Percentage Score – monthly • Total median time in A&E (all patients) • Emergency readmissions: Acute myocardial infarction
4 indicators have declined	• Hospital Standardised Mortality Ratio (Weekend) • A&E Attendees spending more than 12 hours from decision to admit to admission • Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%) • Stabilised and risk adjusted extended perinatal mortality rate (per 1,000 births)

7.8 These updates will be investigated by the Groups and responses will be shared with Quality & Safety Committee on 26th February 2021.

8. Recommendations

8.1 The Trust Board is asked to:

a. **CONFIRM** support for the approach presented to prepare for inspection
b. **CONSIDER** any 'at risk' services with Good/Outstanding ratings
c. **DISCUSS** how to approach the reported 'speak up' issues cited herein

Ruth Spencer
Associate Director of Quality Assurance

Kam Dhami
Director of Governance

25th January 2021

Annex 1: CQC Inspection Ratings
Annex 2: CQC Insight Report – Exceptions and Actions

Annex 1

Our Current CQC Inspection Ratings (April 2019)

Sandwell General Hospital

Overall rating	Inadequate	**Requires improvement**	Good	Outstanding

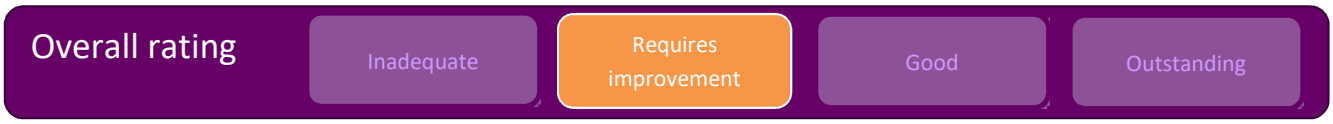
	Safe	Effective	Caring	Responsive	Well led	**Overall**
Medical care (including older people's care)	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Outstanding	Good	Outstanding	Outstanding
End of life care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Urgent and emergency services	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Community Services

Overall rating	Inadequate	**Requires improvement**	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well led	**Overall**
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community health inpatient services	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Community end of life care	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Community health services for children, young people and families	Good	Good	Outstanding	Good	Outstanding	Outstanding

City Hospital



	Safe	Effective	Caring	Responsive	Well led	**Overall**
Medical care (including older people's care)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children & young people	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Outstanding	Good	Outstanding	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Maternity	Good	Good	Good	Good	Good	Good

CQC Insight Report

Exception report and action plan for improvement

November 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

Changes in this report	
1 indicator has improved	• CAS alerts closed late in the preceding 12 months
2 indicators have newly triggered	• Hospital Standardised Mortality Ratio (Weekend) • Whistleblowing alerts
1 indicator has declined	• Deaths in Low-Risk Diagnosis Groups
5 indicators have no new data	• Speaking to staff about worries and fears • Involvement in Decisions • Equality, diversity and inclusion • Morale • Stability of non-clinical staff

Trustwide

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
S6	**CAS alerts closed late in the preceding 12 months** *MHRA – CAS Alerts*	N/A	<25% (Oct-19 – Sep-20)		*Performance for this indicator has shown an improvement for the second consecutive time.* Safety Alerts sent from the Central Alerting System are now overseen and monitored by Risk Management Committee. New alerts are shared at RMC and action plans revised following presentation (as required)	Dally Masaun, Head of Health & Safety	

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Blocks in addressing actions are escalated through RMC to appropriate managers/Executives.		
S6	**NRLS - Consistency of reporting** *NHS Improvement – NRLS OPSIR - Combined*	N/A	 4 months (Oct-19 – Mar-20)		*Performance for this indicator has remained about the same.* Groups are advised of incidents not actively managed on a weekly basis for them to address and through Risk Management Committee. Patient Safety team are looking to upload incidents on a daily basis to improve timeliness of reporting.	Sindeep Chatha, Head of Patient Safety & Risk	
E2	**Deaths in Low-Risk Diagnosis Groups** *Dr Foster – Mortality in low risk conditions*	0.75	 1.51 (Apr-19 – Mar-20)		*Performance for this indicator newly triggered in the last report and has shown a further decline.* On review of the data, some of the key areas flagged as concerning under the low risk diagnostic basket include: <u>Malaise & Fatigue:</u> Historically we have alerted for deaths under malaise and fatigue. Following review it was determined that patients identified as frail and elderly where coded as malaise and fatigue, due to there being no other appropriate clinical code. The issue arose as the code was applied in the primary position. Practices have now been amended so that the sign / symptom of malaise and fatigue is no longer logged in the primary position and our mortality indices have consequently improved. <u>Poisoning:</u> A review was conducted into the deaths under this cohort which identified that 5 of the 10		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					patients from this group were admitted and died of non-toxicological causes, bringing the actual deaths in line with the expected figures. We are currently exploring why these cases were flagged inappropriately as deaths due to poisoning. Care delivery at large was appropriate, and cases flagging any concerns are for escalation to SJR. <u>Acute Bronchitis:</u> A comprehensive review was conducted into deaths attributed to the 125-acute bronchitis CCS group. On investigation, it was found that patients coded as J22X unspecified lower respiratory tract infection mapped to the 125-acute bronchitis CCS group giving rise to the alert. On further investigation it was found that a large majority of the patients had x-ray evidence of pneumonia and should have been coded J18X. It was also noted that 61.8% of patients were known to the palliative care team, but only 23.5% were coded as receiving palliative care. Actions arising from this review include: • Education around importance of complete and accurate documentation. • Education programme regarding SCPs. • Targeted board rounds on wards and joint ward rounds with hospital and community MDTs. • Reduction in pneumonia deaths via pneumonia task force. • Discussion of MCCDs with the medical examiners.		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					<u>UTI:</u> An investigation into the deaths under the CCS group for UTI found that there were no specific clinical concerns for the cases which had undergone medical examiner scrutiny. 97% of the patients had a DNACPR directive in place, with 9% having an SCP and only 2/23 cases had UTI as a cause of death on the MCCD. As a means to address UTI deaths, the UTI project was initiated, looking into appropriate testing, hydration and antibiotic use. Chronic Ulcer of the skin and Pancreatic disorders (not diabetes) are both currently under investigation.		
E2	**Hospital Standardised Mortality Ratio (HSMR); and** **Hospital Standardised Mortality Ratio (Weekday)** *Dr Foster - HSMR*	100.0	121.7 / 120.5 (Apr-19 – Mar-20)		*Performance for this indicator has remained about the same.* <u>Improving HSMR Task & Finish Group:</u> Numerous factors having been identified as contributing to the rising HSMR score, and the improving HSMR task and finish group was initiated in November 2020 to address the various factors. The actions include: • Regular review of COVID deaths to ensure coding can be applied to the correct episode and position. Weekly reports are sent to the clinical leads. • Primary diagnosis: getting it right first time. A campaign was launched to raise awareness of the need to use correct terminology; this is due to the strict criteria enforced by the national clinical coding standards. New	Dr Chizo Agwu, Deputy Medical Director and Angharad MacGregor, Head of Clinical Effectiveness	

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					practices are to also be incorporated into junior doctor induction. • Work in progress with Unity to find a technical solution to the issue of terminology. • Virtual palliative care consultations are now coded in additional to the in person reviews. • GP palliative code now in effect. Previously end of life patients in a community bed were under the intermediate care specialty code which was having a detrimental impact on the HSMR score. The new code will allow patients to be recorded under a specialty code for palliative care whilst under a GP. • Promotion of SCP e-learning. • Discussion in progress with Unity to raise the visibility of the SCP on Unity. • Increasing finished consultant episode length. Agreement reached to use AMU admission as a single episode and admission to the base ward as the second episode. The aim of this change is to ensure adequate episode length to record an accurate diagnosis. Training is planned for all ward clerks. <u>UTI Project:</u> • NICE guideline will be available on connect. • Training package and assessment tool developed for use in care homes for UTI prevention and management. • Quiz developed for staff to test and measure their knowledge. • Comms package includes development of		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					preventing dehydration leaflets, learning on the loo posters, a video regarding testing and management as part of the wider strategy to change practice and raise awareness. • Presentations planned at QIHD. • Reintroduction and update of the catheter passport. <u>Sepsis Project:</u> • The sepsis project has demonstrated an improvement in the number of patients receiving antibiotics within the golden hour. • The transformation team have made some adjustments to the data capture to ensure all appropriate antibiotics are counted for. • Performance will be monitored at the weekly safety huddles dashboard once implemented. • In community beds, broad spectrum antibiotics are now in use to meet targets. <u>Pneumonia Task Force:</u> • QI project re. Mouth Care, data shows 50% reduction in incidence of HAP across the 4 pilot wards, in addition to a reduction in the use of antibiotics (29%) and 34% reduction in the use of Nystatin. The project is planned for roll out across the Trust, but has been delayed due to COVID. • Other Actions which have been completed include updating guidelines and raising awareness on difference between HAP / CAP, updating microguide app.		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Other areas undergoing improvement activity include: Palliative care team are working with informatics to identify patients on EoL care pathways, so that SCPs can be completed and shared with coding. Structured Judgement Reviews are analysed for themes and lessons learnt are which are shared with all teams All Specialties are timetabled to present at Learning from Death committee, highlighting cases reviewed, any lessons learnt and actions completed. Audit / Review of groups of patients where we have been alerted that we have higher than expected deaths are done for assurance and identify any learning. Recent reviews include review of all deaths, myeloma, Poisons / Toxicology, post-surgery. Deaths due myocardial infarction, intestinal obstruction, COVID deaths.		
E2	**Hospital Standardised Mortality Ratio (Weekend)** *Dr Foster - HSMR*	100.0	 125.6 (Apr-19 – Mar-20)		*Performance for this indicator has newly triggered in this CQC report.* The weekday / weekend data shows significant variance month on month. Moving forward a quarterly analysis will be undertaken to determine the organisational factors influencing the data.		
C1	**Speaking to staff about worries and fears** *Care Quality Commission – CQC Inpatient Survey*	N/A	 4.91 (Jul-19)		*No new data reported in this CQC report.*		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
C2	**Involvement in decisions** *Care Quality Commission – CQC Inpatient Survey*	N/A	6.5 (Jul-19)		*No new data reported in this CQC report.*		
W3	**Equality, diversity & inclusion** *PICKER – NHS staff survey themes and questions*	9.1	8.8 (Sep-19 – Dec-19)		*No new data reported in this CQC report.* Achieved level 2 disability confident employer status. Rated as number 232 in UK in Stonewall Equality Index. Continued momentum with BME network group. Added 'unconscious bias' to Accredited Managers Training in 2018. Have LGBT and Disability & long term conditions network groups. Achieved SILVER TIDE status from Employers Equality and Inclusion network. Diversity on interview panels in place and monitored. Increased BAME staff at band 8a and above from 19.7% to 23%. Target is 25%. Transgender policy launched in 2018. Support for specific events related to specific groups.	Estelle Hickman, Equality & Diversity Adviser	
W3	**Morale** *PICKER – NHS staff survey themes and questions*	6.2	6.0 (Sep-19 – Dec-19)		*No new data reported in this CQC report.* weConnect pioneer teams have completed their programme with around half demonstrating improved engagement scores. The last quarterly survey was completed in October and directorate have their own results and have submitted two or three key actions to deliver. The national staff survey non-benchmarked results are available to us now with benchmarked	Ruth Wilkin, Director of Communications	Nov 2021

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					scores to be published nationally Jan / Feb. The Trust has scored slightly lower than the previous years on most measures. January CLE will review results and discuss potential actions. The weConnect programme has now ended so the Trust will look at engagement strategies going forwards. The priority is to focus on national staff survey results.		
W3	**Sick days for nursing and midwifery staff (%)** *Electronic Staff Record - ESR: Sickness Absence by Staff Group*	4.99%	 6.30% (Sep-19 – Aug-20)		*Performance for this indicator newly triggered in the last report and has remained about the same in this CQC report.*		
W3	**Stability of non-clinical staff** *Electronic Staff Record - ESR: Stability*	0.84	 0.77 (Jul-19 – Jun-20)		*Performance for this indicator newly triggered in the last report, but there is no new data in this CQC report.*		
W3	**Whistleblowing alerts** *Care Quality Commission – OBIEE Notifications / Whistle Blowing / Complaints*	N/A	 1 or more (Nov-20)		*Performance for this indicator has newly triggered in this CQC report.*		

CQC Insight Report

Exception report and action plan for improvement

November 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

Changes in this report		
Urgent & Emergency Care	1 indicator has improved	• Unplanned reattendance to A&E within 7 days

Primary Care, Community & Therapies

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
E2	**Unplanned reattendance to A&E within 7 days (%)** *NHS Digital – A&E Quality*	8.6%	3.4% (Aug-20)		*Performance for this indicator has shown an improvement for the second consecutive time.* In addition community admission avoidance, services are developing direct pathways with AMMA and SPA to avoid unnecessary ED and AMMA attendances. This will also include specialist services such as respiratory, heart failure and anticoagulation. PCCT are working in partnership with elderly care to develop a frailty front door and pre front door model involving rapid access MDT clinics to avoid ED (virtual and face to face) and a proactive virtual MDT 48 hour follow service has now been rolled	Tammy Davies	October 2020

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					out across surgical services In addition to MEC and community wards. In response the pandemic, PCCT have commenced the Covid virtual ward with pulse oximeter monitoring and telephone / face to face follow up to support patients post admission with covid. This is intended to improve outcomes and reduce unnecessary hospital admissions.		

CQC Insight Report

Exception report and action plan for improvement

November 2020

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Changes in this report		
Urgent & Emergency Care	5 indicators have improved	• Unplanned reattendance to A&E within 7 days (%) • A&E attendees spending more than 12 hours from decision to admit to admission • Admissions waiting 4-12 hours from decision to admit (%) • Patients spending less than 4 hours in any type of A&E (%) • Patients spending less than 4 hours in major A&E (%)
Medicine	1 indicator has improved	• Emergency readmissions: Fluid and electrolyte disorders
	2 indicators have newly triggered	• In-hospital mortality: Pneumonia • In-hospital mortality: Septicaemia (except in labour)
	1 indicator has declined	• Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%)
	4 indicators have no new data	• SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator • Mortality outlier alert: Acute bronchitis • Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse • Mortality outlier alert: Urinary tract infections

Urgent & Emergency Care

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
E2	**Unplanned reattendance to A&E within 7 days (%)** *NHS Digital – A&E Quality*	8.6%	 3.4% (Aug-20)		*Performance for this indicator has shown an improvement for the second consecutive time.* 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.	Helen Mallard/ Amandeep Tung / Surav Bhardwaj	This has improved since this data was generated and is expected to continue
R3	**Patients spending less than 4 hours in any type of A&E (%); and** **Patients spending less than 4 hours in major A&E (%)** *NHS England – A&E SitReps*	85.8% / 81.6%	 80.3% / 75.8% (Jul-20)		*Performance for this indicator has shown an improvement.* 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.	Helen Mallard/ Amandeep Tung/ Surav Bhardwaj	
R3	**Admissions waiting 4-12 hours from the decision to admit (%)** *NHS England – A&E SitReps*	12.%	 15.% (Sep-20)		*Performance for this indicator has shown an improvement for the second consecutive time.* 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.	Helen Mallard/Amandeep Tung/ Surav Bhardwaj	

Medicine

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
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)		*No new data reported in CQC report.* This has improved and work in terms of the stroke pathway is taking place inclusive of enabling a covid positive and non-positive stroke unit to maintain and support the stroke pathway	Kamel Sharobeem/ Michael Brennan	August 2020
E2	**Emergency readmissions: Acute bronchitis** *Hospital Episode Statistics – HES – Readmissions by CCS group*	100	97.5 (Jul-19 – Jun-20)		*Performance for this indicator has remained about the same.* This indicator triggered in the July 2020 Insight Report.	Arvind Rajasekaran/ Steph Coates	January 2021
E2	**Emergency readmissions: Fluid and electrolyte disorders** *Hospital Episode Statistics – HES – Readmissions by CCS group*	100	119.5 (Jul-19 – Jun-20)		*Performance for this indicator has shown an improvement for the second consecutive time.*		
E2	**In-hospital mortality: Pneumonia** *Hospital Episode Statistics – CQC – HES Mortality*	100	124.7 (Jul-19 – Jun-20)		*Performance for this indicator has newly triggered in this CQC report.*		
E2	**In-hospital mortality: Septicaemia (except in labour)** *Hospital Episode Statistics – CQC – HES Mortality*	100	138.1 (Jul-19 – Jun-20)		*Performance for this indicator has newly triggered in this CQC report.*		
E2	**Mortality outlier alert: Acute bronchitis** *Care Quality Admission – CQC – Outliers*	N/A	May-20		*No new data reported in this CQC report.* CNS involvement in pathway and development of pleural clinics	Steph Coates	January 2021
E2	**Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse** *Care Quality Admission – CQC – Outliers*	N/A	May-20		*No new data reported in this CQC report.* 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	Guy Hagan/Steph Coates	January 2021

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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.		
E2	**Mortality outlier alert: Urinary tract infections** *Care Quality Admission – CQC – Outliers*	N/A	May-20		*No new data reported in this CQC report.* 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.	Helen Mallard/ Surav Bhardwaj	January 2021
E2	**Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%)** *NHS England – RTT Admitted*	73.7%	76.0% (Aug-20)		*Performance for this indicator has shown a decline in performance for the second consecutive time.* <u>Haematology:</u> Service has continued to meet the 92% target as the service has maintained activity utilising virtual clinics.	Operational and speciality leads	Feb 2021

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Neurology: 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. Cardiology: 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. Respiratory: 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. Gastroenterology/Endoscopy: Performance has dropped due to redeployment of resources for COVID 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		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					through reducing the backlog of patient to be seen.		

CQC Insight Report

Exception report and action plan for improvement

November 2020

Key to performance:

- Improving
- About the same
- Declining

Compared to the National Average:

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

Changes in this report		
Surgery	1 indicator has newly triggered	• Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%)
	1 new indicator added to this report	• Risk adjusted 90 day mortality ratio for knees (excluding tumours)
	8 indicators have no new data	• Crude proportion of cases with preoperative documentation of risk of death • Crude proportion of high risk cases with consultant surgeon and anaesthetist present in theatre • PROMs: Primary Hip Replacement EQ-5D score (17-18) – Final • PROMs: Primary Hip Replacement Oxford score (17-18) – Final • Risk-adjusted 30-day mortality rate (%) • Patients recommending the trust - Surgery inpatients (%) • Crude overall hospital length of stay • Crude proportion of highest risk-cases admitted to critical care post operatively
Outpatients	4 indicators have declined	• Cancer - First treatment in 62 days of urgent national screening referral (%) • Patients waiting over 6 weeks for diagnostic test (%) • Referral to treatment, on incomplete pathways, within 18 weeks (%) • Referral to treatment, on non-admitted pathways, within 18 weeks (%)
	1 indicator has no new data	• Cancer - First treatment in 62 days of urgent GP/dentist referral (%)

Surgery

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
E1	**Crude proportion of cases with preoperative documentation of risk of death** *Royal College of Anaesthetists – National Emergency Laparotomy Audit – Sandwell General Hospital*	77.3%	87.0% (Dec-17 – Nov-18)		*No new data reported in this CQC report.* Regular case note review; QIHD review of outcomes and learning.	SR (GD)	
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*	83.1%	84.2% (Dec-17 – Nov-18)		*No new data reported in this CQC report.* 2019/20 Quality Plan – purchase of Open Outcomes software. Exploring use of patient portal pre / post –surgery.	SR (GD)	
E2	**PROMs: Primary Hip Replacement EQ-5D score (17-18) – Final** *NHS Digital - PROMS*	N/A	Lower 95% (Apr-17 – Mar-18)		*No new data reported in this CQC report.* **2019-2020 provisional data EQ5D = 85.2%** 2019/20 Quality Plan – purchase of Open Outcomes software. Exploring use of patient portal pre / post –surgery.	Clinical Lead for PROMs (SS)	
E2	**PROMs: Primary Hip Replacement Oxford score (17-18) – Final** *NHS Digital - PROMS*	N/A	Lower 95% (Apr-17 – Mar-18)		*No new data reported in this CQC report.* **2019-2020 provisional data PHR Oxford score 96.7%** 2019/20 Quality Plan – purchase of Open Outcomes software. Exploring use of patient portal pre / post –surgery.	Clinical Lead for PROMs (SS)	Current PROMS data shows above the national average
E2	**Risk-adjusted 90 day mortality ratio for knees (excluding tumours)** *National Joint Registry – NJR Knees*	1.0	2.3 (Aug-14 – Aug-19)		*This is a new indicator which has been added to the CQC report.*		
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)		*No new data reported in this CQC report.* **NHFD 2019 – Sandwell Hospital 5.5%** Access to theatres Hip Fractures BPT (Operation < 36 hours of admissions – 63.5% year to date Directorate is currently looking to implement a ACP model to support enhanced recovery and	CD for Specialist Surgery	

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					early mobilisation of patients . Improved sepsis compliance results across July		
C1	**Patients recommending the trust - Surgery inpatients (%)** *NHS England – FFT Inpatients by Ward*	N/A	89.5% (Jul-19 – Sep-19)		*No new data reported in this CQC report.* 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.	DE	Achieve above 90% by Dec 2020.
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)		*No new data reported in this CQC report.* 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*	77.5%	66.3% (Dec-17 – Nov-18)		*No new data reported in this CQC report.* Exploring the development of PACU facility - paper presented at Critical Care Board in August 2020.		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Training programme commenced to support Gynaecology ward having a team of level 1 and 2 nurses to staff a local facility managed by Women's and Children Group Upskilling Nursing teams – 12 NS registered nurses are completing a 6 week competency package to support level 1 areas across the Trust		
R3	**Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%)** *NHS England – RTT Admitted*	44.2%	49.0% (Aug-20)		*This indicator has newly triggered in this CQC report.*		

Outpatients

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
R3	**Cancer - First treatment in 62 days of urgent GP/dentist referral (%)** *NHS England – Cancer Waits 62 Days All Cancers*	73.1%	65.8% (Apr-20 – Jun-20)		*This indicator newly triggered in the last report and there is no new data in this CQC report.*		
R3	**Cancer - First treatment in 62 days of urgent national screening referral (%)** *NHS England – Cancer Waits 62 Days Screening*	61.9%	76.1% (Apr-20 – Jun-20)		*Performance for this indicator has declined.*		
R3	**Patients waiting over 6 weeks for diagnostic test (%)** *NHS England – Diagnostics waiting times*	38.8%	40.2% (Aug-20)		*This indicator newly triggered in the last report and performance has declined in this CQC report.*		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
R3	**Referral to treatment, on incomplete pathways, within 18 weeks (%)** *NHS England – RTT Incomplete*	53.5%	 61.0% (Aug-20)		*This indicator newly triggered in the last report and performance has declined in this CQC report.*		
R3	**Referral to treatment, on non-admitted pathways, within 18 weeks (%)** *NHS England – RTT NonAdmitted*	71.8%	 80.1% (Aug-20)		*This indicator newly triggered in the last report and performance has declined in this CQC report.*		

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Changes in this report		
Maternity	3 indicators have no new data	• Stabilised and risk adjusted extended perinatal mortality rate (per 1,000 births) • Being left alone • Raising concerns
Children and Young People	1 new indicator added to this report	• Participation in the ICCQIP – Neonatal critical care services
	4 indicators have no new data	• Case mix adjusted mean HbA1c; blood glucose control • Parent and carer views on pain management • Appropriate equipment or adaptations • Full bed occupancy levels for neonatal intensive care beds

Maternity

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
S5	**Never events in maternity or gynaecology** *NHS Improvement – OBIEE NRLS STEIS*	N/A	↑ 0 (Oct-19 – Sep-20)	0	*Performance against this indicator has remained the same.* 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		All actions complete.

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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)		*No new data reported in this CQC report.* Ongoing monthly review of all cases.	Nikki Rai Risk and Gov lead	
C1	**Being left alone** *Care Quality Commission – Maternity Survey Benchmarking*	N/A	6.2 (Feb-19)		*No new data reported in this CQC report.* 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.	Helen Hurst/ Louise Wilde	
C1	**Raising concerns** *Care Quality Commission – Maternity Survey Benchmarking*	N/A	7.2 (Feb-19)		*No new data reported in this CQC report.* Initiating patient survey, debrief to all women where required / requested, ward managers encouraged to facilitate local resolution.	Matrons	

Children & Young People

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
E1	**Case mix adjusted mean HbA1c; blood glucose control** *Royal College of Paediatrics and Child Health – National Paediatric Diabetes Audit (NPDA) – Sandwell General Hospital*	65.0	60.7 (Apr-18 – Mar-19)		*No new data reported in this CQC report.* 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.		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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)		*No new data reported in this CQC report.* 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)		*No new data reported in this CQC report.*		
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)		*No new data reported in this CQC report.* 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.	Ranjit Rayat . DGM	Current business case with comissioners
Q6	**Participation in the ICCQIP – Neonatal critical care services** *NHS England – Critical Care Bed Occupancy*	N/A	No registered units (Dec-19)		*This is a new indicator which has been added to the CQC report.*		