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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		
Meeting	Public Trust Board	**Date**	6th May 2021

1. Suggested discussion points *[two or three issues you consider the Baoard 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.

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.

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?]*

Quality and Safety Committee: 30th April 2021

4. Recommendation(s)

The Quality and Safety Committee is asked to:

a.	**CONFIRM** support for the approach presented to prepare for inspection
b.	**NOTE** the progress made with the ward self-assessments
c.	**SUPPORT** the planned in-house inspection programme

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: 6th May 2021

CQC Inspection Preparedness Update

1. Introduction

1.1 Our last inspection by the CQC was in 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 COVID-19 Pandemic, and there have been some changes to the CQC approach.

1.2 Whilst we are not sure when we will next be inspected, the CQC have conducted unannounced visits at a number of local NHS Trusts recently. They have stated that, although their visits have a different approach and will be shorter in duration, they will continue to inspect any Trust rated as Requires Improvement or where they have specific safety concerns. Given that we are currently rated as Requires Improvement, have had a Whistleblowing alert from the CQC, and a high HSMR, there is a high likelihood that they will inspect us in the very near future. We should continue to prepare on the basis of imminent inspection.

1.3 The internal approach being taken is one of continuous quality improvement where 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 form part of bi-monthly Performance Reviews.

1.4 Due to the second wave of the pandemic with all wards and clinical areas having a COVID-19 status of either amber or red throughout the Autumn and Winter period, we have had to utilise new ways of working and consider alternative opportunities to learn from current experiences. All wards and clinical teams have been asked to undertake a Self-Assessment review and the findings from these will be triangulated with the findings from our in-house unannounced Inspection visits which will be re-commencing in May 2021.

2. CQC Insight Report

2.1 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.

2.2 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.

2.3 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.

2.4 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.

2.5 The latest report published is for March 2021 and data exceptions show the following:

Change	Indicator
3 indicators have improved	• Data Quality Maturation Index Percentage Score – monthly • PROMs: Primary Hip Replacement EQ-5D finalised score • PROMs: Primary Hip Replacement Oxford finalised score
8 indicators have newly triggered	• Safety Culture • Staff Engagement • Admissions waiting 4-12 hours from the decision to admit (%) • Ambulances remaining at hospital for more than 60 minutes (%) • Emergency readmissions: Chronic obstructive pulmonary disease and bronchiectasis • Never events in Surgery • Cancer - First treatment in 31 days of decision to treat (%) • Cancer - Seen by specialist in 14 days of urgent GP/dentist referral (%)
6 indicators have declined	• Equality, diversity and inclusion • A&E Attendees spending more than 12 hours from decision to admit to admission • Patients spending less than 4 hours in any type of A&E (%) • Patients spending less than 4 hours in major A&E (%) • Emergency readmissions: Acute myocardial infarction • In-hospital mortality: Pneumonia

2.6 **Annex 1** shows the exception areas taken from the CQC Insight Report published in March 2021 and contains the response and updated actions from each Group. This increasingly needs to be the focus of scrutiny.

3. CQC Provider Information Return

3.1 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.

4. Self-Assessment Programme

4.1 The in-house developed self-assessment toolkit was distributed across the Trust towards the end of last year. Groups were asked to support their clinical teams to complete the self-assessment and uptake has been very good.

4.2 Primary Care, Community & Therapies, Medicine & Emergency Care, and Women & Child Health have embraced the self-assessment process which has been rolled out across these Groups with the first round now being completed and returned at the end of March 2021. Surgery are currently working through their self-assessments and hope to have their first drafts available at the end of Quarter 1 2021.

4.3 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 inspectors when they visit.

4.4 We are now in the process of drawing themes of good practice and areas for improvement which will be shared at the Executive Quality Committee, CLE, Quality and Safety Committee and the Trust Board. Clinical teams have produced action plans within their Groups and will work to implement the improvement work that they have identified over the next three months. They will be asked to revisit their self-assessment next quarter and to provide an update to action plans which will demonstrate progress and how their improvement journey is taking shape. Progress with the self-assessment programme is shown at **Annex 2**, together with a note of teams' current ratings.

4.5 Findings taken from the first round of the self-assessments will be triangulated with the in-house unannounced inspection visit programme so that in-house inspectors can check the improvements are being made, progress is embedded and sustained, and can verify that the evidence to support improvement is available.

4.6 Initial findings from the self-assessments show that wards and clinical teams have already identified a number of areas for improvement and work is currently underway to deliver the required changes. Action plans are being monitored at Group level. Examples of some of the improvement work currently taking place is as follows:

- Additional training for staff on reporting incidents, grading of incidents, safeguarding, duty of candour, and Mental Capacity Act;
- Review of the Housekeeper's role in Medicine & Emergency Care in respect of infection prevention and control and keeping the environment clean and tidy;
- Identification of medicines management link nurses;
- Introduction of a dedicated Pharmacy Technician for Paediatrics;
- Development of a safer staffing acuity tool;
- Development of a welcome leaflet for patients which is available in a number of different languages;
- Wider promotion of the 'Get up, get dressed, get moving' campaign;
- Introduction of e-learning updates in community midwifery.

5. In-House Unannounced Inspection Visits

5.1 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.

5.2 The Trust wide programme of in-house unannounced inspection visits is scheduled to re-commence from 3rd May 2021 with at least one visit taking place each week for the remainder of the year. Dates for the next six months are included at **Annex 3.** Further dates for inspection visits at Rowley Regis Hospital and Leasowes are to be added shortly.

5.3 For the wards having already been inspected in 2020, they have prepared action plans to address areas identified for improvement. These areas will be re-visited as part of the current schedule of visits where inspectors will be checking that actions identified have been implemented and progress with these has been sustained.

5.4 We currently have a pool of 65 confirmed volunteer in-house inspectors from multidisciplinary backgrounds (doctors, nurses, operational staff, pharmacists, facilities staff, directors, non-exec directors, etc). Dates of the visits are being circulated via the daily communications email and at TeamTalk so that additional staff who are interested in being part of this process can volunteer to take part in a visit.

5.5 Visits will be undertaken in a targeted approach and will focus on areas rated as Requires Improvement or Inadequate with Emergency Departments, Assessment Units, Paediatrics, and Maternity visits taking place as a priority.

5.6 Findings from the visits will be combined with actions from the self-assessments and merged into one action plan for each area. Wards teams will be invited to a monthly Oversight Group to present progress with their action plans to a as soon as the programme is underway.

6. Public View

6.1 The Trust purchased a one year trial of Public View in February 2021. This tool allows us to compare ourselves against other Trusts and to monitor our performance against targets and National benchmarking using Statistical Process Control (SPC) charts. This is now currently being rolled out to staff across the Trust.

6.2 The tool, which contains some 40+ indicators, considers which indicators may most impact CQC ratings and therefore will enable us to decide where we may wish to focus our efforts in order to achieve our objectives.

6.3 Public View allows us to predict a likely CQC rating by combining a number of relevant indicators and assigning a weighting to them. This will work well with the future direction of CQC ratings processes which indicate a move away from physical inspections to a much more data-based ratings process.

7. Staff Engagement

7.1 Following the success of the staff engagement events that took place over the Autumn and Winter of 2020, further sessions are now being scheduled. These events were well attended with a good mix of staff from each of the groups.

7.2 The sessions cover 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 have the opportunity to ask any questions they may have. Dates of these are being circulated via the daily communications email and in TeamTalk.

7.3 An information booklet for staff has been developed and covers many of the questions that staff may have. It contains useful information about the inspection process and provids contact details should staff require further help or support. The booklet will be made available for all staff.

7.4 In addition to the above, a communications package is in place across the Trust and provides staff with regular updates on the CQC work streams. Information is made available across the existing range of communication methods in the Trust. Regular updates are provided through the daily briefing email and at TeamTalk. We have also published several articles in Heartbeat Magazine, for example 'a day in the life of an in-house inspector' and also an article on a team's experience of undertaking their self-assessment and the benefits of doing so.

8. Recommendations

8.1 The Trust Board is asked to:

a. **CONFIRM** support for the approach presented to prepare for inspection
b. **NOTE** the progress made with the ward self-assessments
c. **SUPPORT** the planned in-house inspection programme

Ruth Spencer
Associate Director of Quality Assurance

30th April 2021

Annex 1: CQC Insight Report – Exceptions and Actions
Annex 2: Self-Assessment Programme Update on Progress
Annex 3: Dates for In-House Unannounced Inspection Visits 2021

Annex 1

CQC Insight Report – Exceptions and Actions

NHS
Sandwell and West Birmingham
NHS Trust

CQC Insight Report

Exception report and action plan for improvement

March 2021

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	• Data Quality Maturity Index Percentage Score – monthly
2 indicators have newly triggered	• Safety Culture • Staff Engagement
1 indicator has declined	• Equality, diversity and inclusion
6 indicators have no new data	• Consistency of reporting to the National Reporting and Learning System (NRLS) • Deaths in Low-Risk Diagnosis Groups • Hospital Standardised Mortality Ratio (HSMR) • Hospital Standardised Mortality Ratio (Weekday) • Hospital Standardised Mortality Ratio (Weekend) • Involvement in decisions

Trust-wide

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
S6	**Consistency of Reporting to the National Reporting and Learning System (NRLS)** *NHS Improvement – NRLS OPSIR - Combined*	N/A	 4 months (Oct-19 – Mar-20)		*No new data reported in the last two CQC reports.* 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) 		*No new data reported in the last two CQC reports.* 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 patients from this group were admitted and died		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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
					UTI: 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	 131.8 / 127.3 (Jul-19 – Jun-20)		*No new data reported in this CQC report.* Improving HSMR: HSMR score takes into account palliative care and is also based on diagnosis in the first and second finished consultant episode. This is why there is a big discrepancy between our SHMI and HSMR with the SHMI being lower. There are two strategies to improve the HSMI and SHMI. One is to focus on clinical care. To this end we have set up alerts so that we can investigate when we have more than expected deaths. The second strategy is to improve process/coding and documentation issues that are artificially increasing our HSMR. QI Projects and Clinical Assurance Reports in response to alerts:	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
					UTI Project: • 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 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. Sepsis Project: • 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 accounted 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. Pneumonia Task Force: • QI project regarding Mouth Care, data shows 50% reduction in incidence of HAP across the		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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-19. Business case being worked on. • Other Actions which have been completed include updating guidelines and raising awareness on difference between HAP / CAP, updating microguide app. 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. <u>Recent reviews include:</u> **Report on lung cancer deaths Sep-19 – Aug 20. Presented Mar-21 – 20 deaths (10.84 deaths expected):** • 7/20 had stage 3 lung cancer at presentation • 13/20 had stage 4 lung cancer at presentation – 10/13 were too frail for either Ix or Rx – 2/13 had rapid deterioration and poor		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					response to palliative chemo – 1/13 had safeguarding issues • 4 patients didn't have palliative input – 1x Safeguarding issues – 2 x Quite quick deterioration in hospital – 1 x awaiting further palliative chemo Themes • Patients presenting with late stage disease • Patients presenting too frail for further Ix/ Rx • Early input of palliative care • Nil to suggest investigations/ treatment delayed by pandemic • Nil to suggest any clinically significant systemic delays in triage, diagnostic or treatment pathway Key Action to be discussed: Public campaign to encourage early recognition of symptoms **Colorectal cancer deaths Feb-19 – Mar-20. Presented Mar-21** HES identified 26 deaths with the colorectal cancer diagnostic code. Notes were investigated electronically. 1 elective death (1/135=0.7% mortality) (national rate=2%). The rest were admitted as emergency (bar 1 who died while waiting to see oncology). 2 of these appear to have had opportunities for earlier diagnosis missed.		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					• Mean age 72- median 76 (range 46-88) • 11M:15F • Ethnicity 15 White, 3 Caribbean, 2 Indian, 1 African, 4 unknown • In comparison with Sandwell census data Black pts over represented (approx double expected) but 4 unknowns make it difficult to say • Mean LOS 11 days Median 10 (range 0-39) • 11 coded as palliative (but actually they probably all should have been) • 11 cared for by surgeons 15 by medicine • All had appropriate dnacpr and scp notation • All surgical patients were discuss at M+M • Almost all presented with advanced cancers in obstruction or with perforation • 5 had emergency operations (NELA targets hit in all cases) Elective Death: 65m, multi comorbid. P possum risk of death 18.3%. Pt and family were aware of the risk and even wrote the surgeon a thank you card for his care Emergency operations: • 5 patients – Mean age 82 (mean los 15 days- range 4-38) – All had high NELA risk of death – All were discussed at M+M and no problems with care identified (there is no hard futility point- these operations		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					were often carried out to treat pain) – No on table deaths. Issues identified in review: • 2 potential missed cases: BSG guidance (2011) for investigation of anaemia was not followed in both cases Action: Gastroenterology team reviewing cases Conclusion: • The overwhelmingly common story was of late presentation with advanced disease • Both med and surgical teams acted appropriately to palliate • Late presentation is associated with deprivation- 15 pts in quintile 1(worst), 5 in 2 • 4 patients in quintile 6! (how can you have a 6th quintile-does that mean no data??) Key Action: Public campaign to encourage early recognition of symptoms. **PCCT Reporting Period Dec-20 – Feb-21** Number of deceased patients in the last 3 months 76 (+20 from previous Q) 94% of these at Leasowes typically (Covid deterioration) This makes up 16% of deaths across the trust Within PCCT 2 patients put forward for tier two review in this period. Issues:		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					• Recognising and acting on deterioration • Need for discharge plan from acute to GP needs to be explicit • Depart letters – medicine safety • Need for greater oversight at community and primary care level re frequent ED attendances QI and Actions: • Team level learning with GP/Leasowes re TEP and reacting to deterioration • DN review in to community input with actions re recognising and responding to both husband and wife deterioration • Learning event in community **–** • Strengthened the communication with in community beds • Identified the need to roll out work undertaken with Sheldon team to Leasowes re recognising and managing deterioration • DN and AA activity re safe prescribing **Gastroenterology Reporting Period Jan-20 – Dec-20 (12m). Reported Jan-21. Number of deceased patients discussed in last 12 months: 150. Number of deceased patients referred to specialty for second tier review: 13** Key Themes: • Management of End of life for admitted patients. • Specialty Gastroenterology management of outlier patients.		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					• Management of advanced liver disease patients. • Patient safety for interventional endoscopic procedures. • Ward Communication with families and relatives. • Palliative care patient achieving preferred place of care/death in a timely way. • lack of SJR trained staff Areas of good practice: • Established weekly Cirrhosis MDT accessible to all in patient and out patient liver disease management teams. Assessment, clinical guidance, access to tertiary referral and in patient and community palliative care for advanced and complex chronic liver disease patients. Unity referral access • Ambulatory/Day case therapeutic paracentesis ward based service. • Specialty patient management of EoL care. Learning points to be addressed: • Prevent delay in interventional endoscopic procedures. • Interventional procedure management omissions. • Early specialist gastroenterology involvement in in patients. • Communication with relatives and carers • Specialty SJR training • Promoting learning into QIP and actions		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					QI projects implemented: • Liver Disease: - Cirrhosis Weekly MDT - New IBD Patient referral seem by specialist within 4 weeks - Elective paracentesis service • In patient Gastro - Gastroenterology In patient outlier monitoring shared lists. • Endoscopy - Specialty customised WHO checklists eg ERCP • IBD - New IBD patient referral 4w to specialist review. - IBD Biologic Annual safety check - Complex IBD nutrition management **Critical Care Medicine Reporting Period 2020. Reported Dec-20. Number of deceased patients discussed in the last 12 months: 7. Number of deceased patients referred to specialty for second tier review: 18** Key Themes and Learning: • Unexplained tachycardia in a background of Covid may represent pulmonary embolism. • Severe acidosis which is not responding to initial treatment needs consideration for renal replacement therapy. • If there is a delay in ICU review of a		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					referred patient, the reason must be documented in patient records. • Rare presentations discussed – NG tube perforation of stomach, Cold agglutinin haemolysis. **Gynaecological Oncology reporting period Jan-20 – Oct-20. Reported Nov-20. Number of deceased patients discussed in last 12 months: 2. Number of deceased patients referred to specialty for second tier review: 0** Key theme: 1 case of post op COVID and I case unresectable bowel cancer. Areas of Good Practice: Standard of care provided with multidisciplinary input and continuous contact with family. Learning points to be addressed: • Unfortunately, there is no possible way to distinguish between ovarian or bowel cancer on imaging in similar circumstances. The suspected diagnosis was ovarian cancer until the biopsy prove bowel origin. • This operation was done during the initial phase of the first wave of coronavirus pandemic. At that time, no preventive measures (isolation, swabbing) were in place in the NHS. QI and actions Taken since: Robust preventive measures have been in place		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					since, to prevent postoperative COVID19. We performed nearly 200 major cancer surgeries since April 2020 with zero COVID19 developing postoperatively. **Complaints relating to deceased patients received during Quarter 2 2020/21 – the Trust received 35 complaints in relation to the care of a deceased patient, compared to 37 received during Quarter 1 2020/21** Outcome of complaints: • Cases with outcomes of Upheld (0) or Partially Upheld (3) should have actions allocated for service improvement or to ensure such events do not happen again. An example of an action that has arisen during Quarter 2 is detailed below: • C20/0207 A far reaching complaint was raised by the family of a poorly patient into their care and treatment prior to death. An action arising was that a discussion into the issues raised by the family has taken place by the clinicians and wards involved in the patient's care with a view to heightening awareness of how the patient's care was perceived by the family. **Elderly Care reporting period Oct-19 – Oct-20. Reported Oct-20. Number of deceased patients discussed in last 12 months: 25. Number of deceased patients referred to speciality for second tier review: 25**		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Areas of good Practice: • excellent end of life care • holistic/pragmatic decision making in complex cases • good communication when encountering unrealistic family expectations Issues identified: • Early recognition of dying phase and switching to palliative approach • Need to review records in complex cases – full medical history, previous admissions, previous DNACPR/treatment limitations discussions • Missed opportunities to consider SCP and advance care plans in our frailest patients with re-admissions • Early DNACPR decisions in frail and multi-morbid patients • TEP forms are sometimes unrealistic – e.g. DNACPR but left 'still for NIV and dialysis' when frail and abundantly would not be appropriate. • Better communication with families in deteriorating patients **PCCT reporting period Jul-20 – Sep-20. Reported Oct-20** Number of Deceased patients in the last 3 months 56 (53 Leasowes 3 Rowley) Number of Tier one reviews within 28 days 80% Number no Tier one review – 5%		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Number still in timeframe for 28 day completion – 15% Number of Deceased patients referred to Specialty for 2nd Tier Review: 8 Areas of good Practice: • Partnership working between bed teams YHP and Palliative care • Some excellent examples of tenacious GPS navigating complex pathways internal and external to trust • Plenty examples of positive end of life care within Leasowes Learning points to be addressed • The need to increase the consistency within nursing workforce in relation to recognising and managing deterioration. Contributing factors (identification and prioritisation of system wide issues): • The dependency and acuity of patients appears to have increased, an audit of admission and transfers to be undertaken in group to pull out specific themes (audit Q2 this year and compare with previous years) to feedback Dec quality and Safety committee QI implemented as a result: • First dose antibiotic launched October 2020 • SCP training and audit of KPIS- ongoing • MDT with palliative care at Leasowes • Enhanced training on Eliza Tinsley on		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Managing the deteriorating patient to be rolled out to all units • Enhanced training planned for Macarthy Nurses in relation o management of diabetes • All band 7 and 6 nurses completed level three safeguarding training (previously was 8a level) • Discussion point re ensuring in nurse led services there is a b6 leading every shift/site **Haematology / Oncology deaths 4/19 – 7/20: 38 deaths reviewed. Presented Sep-20** Key themes: • Late presentations of lymphomas noted in the Covid era which has led to deaths • There were 4 deaths due to late presentations of a lymphoma that arguably could have been prevented had patient presented a good month at least prior – • Relapse numbers seem higher – again patients not coming forward – virtual clinics – are we missing information ? • Covid possibly hastened 3 deaths due to known disease , with 7 in total thought to have been caused solely by Covid BUT a patient with relapse hgnhl did survive covid (died later due to nhl) Examples of good practice: Early referrals for palliative care and scp, weekly discussions as a team on all haem onc inpatients to discuss resusc.		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Key Learnings: • Review drug cards daily especially for outliers • Avoidance of moving acutely ill patients at night • Ensure ues checked regularly for patients going on pca • Chase biopsy requests on outliers • Ensure correct shielding information given to patients review of all deaths, myeloma, Poisons / Toxicology, post-surgery. Deaths due myocardial infarction, intestinal obstruction, COVID deaths. Action plans: • Have discussed with team over last few months due to IRs to ensure drug cards reviewed daily- complex meds especially require daily reviews by senior clinicians QI projects implemented as a result: • Chemocare plan onto unity to help prescribing ancillary meds. • Common haematology referrals document uploaded onto intranet **Trauma & Orthopaedic Deaths – Reporting Period Nov-19 – Sep-20. Reported Sep-20. Number of deceased patients discussed in last 12 months: 23. Number of deceased patients referred to specialty for second tier review: 20** Issues identified: • Post elective THR intestinal obstruction		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					• VTE prophylaxis in spinal injury • Key Learnings to be addressed • Education of the Juniors • Early identification of critically ill patients • ROTA changes • VTE override in UNITY • Early decision making with VTE prophylaxis in spinal injury Action points: • Early escalation • Role of AccP established and recruitment formula and number to be worked out • Electronic + Physical VTE white board QI project implemented as a result: • Bowel preparation pathway worked out by Mr Gulati and Elective ward team **Cardiac Arrest Reviews from Apr-19 – Mar-20. Presented Oct-20** • The DP&RT found 121 patients had a Cardiac Arrest (CA), 98 of who died. • This continues to be a lower than average national CA number. Survival rates are above national average at 25% with the NCAA data set. Challenges: • System changes altering data collection methods. • Data collection has altered significantly from a nurse led audit form to an EMRT document		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					on Unity. The Compliance was at over 90% and is now below 50%. • Data collection around DNACPR/TEP has changed due to Unity and relies on the correct forms being completed. <u>Second Strategy to improve HSMR is to improve processes, coding and documentation issues:</u> Numerous non clinical 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 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		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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. • Reviewing documentation to increase number of deceased patients with CCI scores of more than 6 • Reducing number of finished consultant Episode/spell The plan is to work towards embedding this into group operational meetings so they can be monitored as KPI 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.		
E2	**Hospital Standardised Mortality Ratio (Weekend)** *Dr Foster - HSMR*	100.0	 143.3 (Jul-19 – Jun-20)		*No new data reported 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.*		
C2	**Involvement in decisions**	N/A	6.5 		*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
	Care Quality Commission – CQC Inpatient Survey		(Jul-19)				
W3	**Equality, diversity & inclusion** *PICKER – NHS staff survey themes and questions*	9.0	 8.6 (Sep-20 – Dec-20)		*Performance against this indicator has shown a decline.* 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-20 – Dec-20) 		*Performance against this indicator has remained about the same.* The national staff survey results have been shared with Trust Board, CLE and People and OD Committee. The results have also been shared with all staff through the comms channels. Four priority areas have been identified: - Health and wellbeing - Equality, Diversity and Inclusion - Team Communication	Ruth Wilkin, Director of Communications	Dec 2021

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					- Line manager development Directorates have received their own reports and been asked to complete an action plan. The Trust has asked, via Team Talk, for feedback and suggestions on what action should be taken. During May a series of listening events will take place for any colleague to share their thoughts and ideas. An action plan will be confirmed in June 2021.		
W3	**Safety Culture** *PICKER – NHS staff survey themes and questions*	6.8	 6.6 (Sep-20 – Dec-20)		*This indicator has newly triggered in this CQC report.*		
W3	**Sick days for nursing and midwifery staff (%)** *Electronic Staff Record - ESR: Sickness Absence by Staff Group*	5.15%	 6.50% (Jan-20 – Dec-20)		*Performance for this indicator has remained about the same in this CQC report.*		
W3	**Sick days for other clinical staff (%)** *Electronic Staff Record - ESR: Sickness Absence by Staff Group*	5.55%	 6.96% (Jan-20 – Dec-20)		*Performance for this indicator has remained about the same in this CQC report.*		
W3	**Stability of non clinical staff** *Electronic Staff Record - ESR: Stability*	0.88	 0.86 (Jan-20 – Dec-20)		*Performance for this indicator has remained about the same in this CQC report.*		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
W3	**Staff Engagement** *PICKER – NHS staff survey themes and questions*	7.0	6.8 (Sep-20 – Dec-20)		*Performance for this indicator has newly triggered in this CQC report.* The national staff survey results have been shared with Trust Board, CLE and People and OD Committee. The results have also been shared with all staff through the comms channels. Four priority areas have been identified: - Health and wellbeing - Equality, Diversity and Inclusion - Team Communication - Line manager development Directorates have received their own reports and been asked to complete an action plan. The Trust has asked, via Team Talk, for feedback and suggestions on what action should be taken. During May a series of listening events will take place for any colleague to share their thoughts and ideas. An action plan will be confirmed in June 2021.	Ruth Wilkin, Director of Communications	Dec 2021
W3	**Turnover rate for other non-clinical staff (%)** *Electronic Staff Record - ESR: Stability – Turnover Leavers*	11.6%	14.7% (Jan-20 – Dec-20)		*Performance for this indicator has remained about the same.*		
W3	**Whistleblowing alerts** *Care Quality Commission – OBIEE Notifications / Whistle Blowing / Complaints*	N/A	1 or more (Mar-21)		*Performance for this indicator has remained about the same.*		
W6	**Data Quality Maturity Index Percentage**	89.7%	86.1%		*Performance for this indicator has improved in*		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
	Score – monthly *Monthly Data Quality Maturity Index*		(Nov-20)		*this CQC report.*		

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MB	Much better
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W	Worse
MW	Much worse

Changes in this report		
Urgent & Emergency Care	2 indicators have newly triggered	• Admissions waiting 4-12 hours from the decision to admit (%) • Ambulances remaining at hospital for more than 60 minutes (%)
	3 indicators have declined	• A&E Attendees spending more than 12 hours from decision to admit to admission • 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 newly triggered	• Emergency readmissions: Chronic obstructive pulmonary disease and bronchiectasis
	2 indicators have declined	• Emergency readmissions: Acute myocardial infarction • In-hospital mortality: Pneumonia
	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
R2	**Total median time in A&E (all patients)** *NHS Digital – A&E Quality*	1.1	 0.8 (Dec-20)		*Performance against this indicator has remained about the same.*		
R3	**A&E Attendees spending more than 12 hours from decision to admit to admission** *NHS England – A&E SitReps*	N/A	 23 (Jan-21)	0 (Mar-21)	*Performance for this indicator has shown a decline in performance for the second consecutive time.* Zero 12 hr DTAs since January. January position greatly reflects the challenges in managing patient flow in winter pandemic pressures.	Rachel Clarke / Saurav Bhardwaj	
R3	**Admissions waiting 4-12 hours from the decision to admit (%)** *National Ambulance Information Group – Ambulance Turnaround*	26%	 44% (Jan-21)	84% (Mar-21) Trust Total	*Performance for this indicator has newly triggered in this CQC report.* Improving picture month on month from January. Improvement work streams identified, reporting into Urgent Care Board monthly.	Rachel Clarke / Saurav Bhardwaj	
R3	**Ambulances remaining at hospital for more than 60 minutes (%)** *NHS England – A&E SitReps*	11.5%	 10.9 (Jan-21)	2.02% (Mar-21)	*Performance for this indicator has newly triggered in this CQC report.* January position reflects the challenges in managing patients in winter pandemic pressures.	Rachel Clarke / Saurav Bhardwaj	
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*	76.3% / 70.0%	 69.1% / 63.1% (Jan-21)		*Performance for these two indicators have both shown a decline in performance.* January position reflects the challenges in managing patients in winter pandemic pressures. Improvement work streams identified, reporting into Urgent Care Board monthly.	Rachel Clarke / Saurav 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 this CQC report.* This has improved and work in terms of the stroke pathway is taking place inclusive of enabling a COVID-19 positive and non-positive stroke unit to maintain and support the stroke pathway.	Kamel Sharobeem / Michael Brennan	August 2020
E2	**Emergency readmissions: Acute myocardial infarction** *Hospital Episode Statistics – HES – Readmissions by CCS group*	100	167.5 (Oct-19 – Sep-20)		*Performance for this indicator has shown a decline in this CQC report.* This indicator triggered in the November 2020 Insight Report.		
E2	**Emergency readmissions: Chronic obstructive pulmonary disease and bronchiectasis** *Hospital Episode Statistics – HES – Readmissions by CCS group*	100	121.1 (Oct-19 – Sep-20)		*Performance for this indicator has newly triggered in this CQC report.*		
E2	**In-hospital mortality: Pneumonia** *Hospital Episode Statistics – CQC – HES Mortality*	100	127.0 (Oct-19 – Sep-20)		*Performance for this indicator has shown a decline in this CQC report.* The trust is launching mouth care matters in May which has demonstrated a reduction in hospital acquired pneumonia during the pilot of the project		
E2	**In-hospital mortality: Septicaemia (except in labour)** *Hospital Episode Statistics – CQC – HES Mortality*	100	137.5 (Oct-19 – Sep-20)		*Performance for this indicator has remained about the same.*		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
E2	**Mortality outlier alert: Acute bronchitis** *Care Quality Admission – CQC – Outliers*	N/A	Dec-20		*There is no new data for this indicator 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	Dec-20		*There is no new data for this indicator 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 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.	Guy Hagan / Steph Coates	January 2021
E2	**Mortality outlier alert: Urinary tract infections** *Care Quality Admission – CQC – Outliers*	N/A	Dec-20		*There is no new data for this indicator 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	Annabel Bottrill / Surav Bhardwaj	January 2021

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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*	82.9%	73.2% (Jan-21)		*Performance for this indicator has remained about the same.* Haematology: Service has continued to meet the 92% target as the service has maintained activity utilising virtual clinics. 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	Operational and speciality leads	Feb 2021

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					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 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.		

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Changes in this report		
Surgery	2 indicators have improved	• PROMs: Primary Hip Replacement EQ-5D finalised score • PROMs: Primary Hip Replacement Oxford finalised score
	1 indicator has newly triggered	• Never events in surgery
	6 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 • Risk adjusted 90 day mortality ratio for knees (excluding tumours) • 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	2 indicators have newly triggered	• Cancer – First treatment in 31 days of decision to treat (%) • Cancer – Seen by specialist in 14 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
S5	**Never events in surgery** *NHS Improvement – OBIEE NRLS STEIS*	N/A	2 (Feb-20 – Jan-21)		*Performance for this indicator has newly triggered in this CQC report.* Air delivery meters removed from surgical areas following the event. Caps are being fitted to all air inlets (Group will check with Lawrence Barker for timeframe). Ophthalmology incident service to clearly articulate when requesting radiology what has been retained shape size and material with the radiologist and take two views on X-ray to determine if retained. Retained instrument SOP to be updated.	SR (GD)	05/2021
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 the last three CQC reports.* Regular case note review; QIHD review of outcomes and learning. Awaiting Chris Thompson to provide info.	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 the last three CQC reports.* 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 finalised score** *NHS Digital - PROMS*	N/A	Nil Signific. (Apr-19 – Mar-20)		*Performance against this indicator has improved 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)	

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
E2	**PROMs: Primary Hip Replacement Oxford finalised score** *NHS Digital - PROMS*	N/A	Nil Signific. (Apr-19 – Mar-20)		*Performance against this indicator has improved 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)		*No new data reported for the last two CQC reports.* Planned prospective audit to be undertaken to identify risk factors or trends this will be later in the year as restarting Surgery in May. Audit will be completed in August 2021	MS (Directorate CD)	December 2021
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 for the last five CQC reports.* **NHFD 2019 – Sandwell Hospital 5.5%** Access to theatres Hip Fractures BPT (Operation <36 hours of admissions – 85% previous 4 months Nov – Feb 2021. Implemented 3 x SCP in trauma to co-ordinate the trauma lists and review patients on admission to A/E this has improved the patient journey and decreased the time to theatre from presentation.	CD for Specialist Surgery	
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 for the last six CQC reports.* Continually improving access for elective surgery; • Recovery 100% plan • Established a green ward for Gen surgery, ENT, Urology • Scoping 7 day access to surgical procedures/services • Increasing theatre utilisation in BTC	AM	December 2021

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					• Moved to "virtual" consultation model • Return to a 6,4,2 model of scheduling • Improved Theatre scheduling : Surginet due in May 2021 • May 2021 green elective orthopaedic ring fenced ward on Sandwell site • Increasing volunteers for way finding, co-ordinating visiting • Senior nurses implemented the 15 steps programme to assess wards and support improvement plans • All areas within surgical services are organising patient information boards with photos and names of staff, and information on uniforms so patients can easily identify who is caring for them • Promotion of enhanced recovery from (pre assessment to discharge) to reduce length of stay – patient benefit/reduced complications/hospital acquired infection • Virtual pre-assessment process for majority of patients – patient benefit • Piloting direct admission and discharge to/from theatre for minor ops		
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.* Early access to surgical intervention <36 hrs Cohesive multi-disciplinary working across orthopaedics' including an ortho-geriatrician who works Monday - Friday solely in T&O, plus anaesthetist and surgeon, physios and occupational therapy	Trauma Lead TS/HN	

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					Low LOS for emergency admissions – Increased consultant presence on SAU / established emergency ambulatory model. More effective use of community services post operatively / admission – designing pathways to support stepdown to MFFD and interim care facilities. Implementation of ERAS care plan		
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 for the last five CQC reports.* Exploring the development of PACU facility - paper presented at Critical Care Board. PACU plan to build at risk in MMUH Training programme completed 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 newly qualified registered nurses are completed a 6 week competency package to support level 1 areas across the Trust. All newly qualified nurses in Surgery will complete this package.	SR	
R3	**Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%)** *NHS England – RTT Admitted*	68.7%	 77.0% (Jan-21)		*Performance for this indicator has remained about the same.* Due to the COVID-19 pandemic there has been an increase in RTT due to the unavailability of surgery. Surgical Services have prioritised the patient waiting lists in line with national guidance to identify patients to treat as part of recovery and restoration	MP	

Outpatients

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
R3	**Cancer - First treatment in 31 days of decision to treat (%)** *NHS England – Cancer Waits 31 Days All Cancers*	95.6%	91.2% (Oct-20 – Dec-20)		*Performance for this indicator has newly triggered in this CQC report.*		December 2021
R3	**Cancer - First treatment in 62 days of urgent GP/dentist referral (%)** *NHS England – Cancer Waits 62 Days All Cancers*	74.8%	74.0% (Oct-20 – Dec-20)		*Performance for this indicator has remained about the same.*		
R3	**Cancer - First treatment in 62 days of urgent national screening referral (%)** *NHS England – Cancer Waits 62 Days Screening*	85.3%	90.9% (Oct-20 – Dec-20)		*Performance for this indicator has remained about the same.*		
R3	**Cancer – Seen by specialist in 14 days of urgent GP/dentist referral (%)** *NHS England – Cancer Waits 14 Days All Cancers*	87.4%	90.2% (Oct-20 – Dec-20)		*Performance for this indicator has newly triggered in this CQC report.*		December 2021
R3	**Patients waiting over 6 weeks for diagnostic test (%)** *NHS England – Diagnostics waiting times*	29.8%	15.5% (Dec-20)		*Performance for this indicator has remained about the same.*		
R3	**Referral to treatment, on incomplete pathways, within 18 weeks (%)** *NHS England – RTT Incomplete*	65.9%	76.8% (Dec-20)		*Performance for this indicator has remained about the same.*		
R3	**Referral to treatment, on non-admitted pathways, within 18 weeks (%)** *NHS England – RTT NonAdmitted*	80.0%	84.0% (Dec-20)		*Performance for this indicator has remained about the same.*		

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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	5 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 • Participation in the ICCQIP – Neonatal critical care services

Maternity

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
E2	**Stabilised and risk adjusted extended perinatal mortality rate (per 1,000 births)** *MBRRACE-UK Perinatal Mortality Surveillance*	4.8	MW 5.6 (Jan-17 – Dec-17)		*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	W 6.2 (Feb-19)		*No new data reported in the last six CQC reports.* 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	Helen Hurst/ Louise Wilde	

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
					increased sickness.		
C1	**Raising concerns** *Care Quality Commission – Maternity Survey Benchmarking*	N/A	7.2 (Feb-19)		*No new data reported in the last six CQC reports.* 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 the last three CQC reports.* 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)		*No new data reported in the last six CQC reports.* 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 the last six CQC reports.*		

KLOE Ref	Indicator	National Average	Insight Data	Current position	Action / response	Action owner / lead	Date expected to improve
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 the last five CQC reports.* Work with ODN and business case agreed for NCOTS (Community, outreach, service), recruitment commenced project to increase transitional care facility progress paused due to impact of pandemic, TC facility remains in place but with no increased capacity.	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)		*No new data in the last two CQC reports.*		

Annex 2

Self-Assessment Programme – Progress Update

Area	Speciality	Directorate	Status	Self Assessment Rating						Action Plan	
				Safe	Effective	Caring	Responsive	Well-Led	OVERALL	In Place?	Received?
Primary Care, Community & Therapies											
AA Therapy		iCares	Complete	Outstanding	Outstanding	Good	Outstanding	Good	Good	Y	Y
CRS		iCares	Complete	Outstanding	Good	Outstanding	Outstanding	Good	Outstanding	Y	Y
Green Team		iCares	Complete	Good	Good	Good	Good	Good	Good	Y	Y
HF		iCares	Complete	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Y	Y
Indigo Team		iCares	Complete	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Y	Y
Red Team		iCares	Complete	Good	Good	Good	Good	Good	Good	Y	Y
Blue Team		iCares	Complete	Good	Good	Good	Good	Good	Good	Y	Y
North Team		iCares	Complete	Outstanding	Outstanding	Good	Req Impr	Req Impr	Good	Y	Y
Care Homes		iCares	Complete	Good	Good	Good	Good	Good	Good	Y	Y
Continence Team		iCares	Complete	Good	Good	Good	Good	Good	Good	Y	Y
South Team		iCares	Complete	Good	Good	Good	Good	Good	Good	Y	Y
Orange Team		iCares	Complete	Good	Good	Good	Good	Good	Good	Y	Y
Violet Team		iCares	Complete	Good	Good	Good	Good	Req Impr	Good	Y	Y
Yellow Team		iCares	Complete	Good	Good	Good	Good	Req Impr	Good	Y	Y
Medicine & Emergency Care											
A&E SGH	Emergency Medicine	Emergency Care	Complete	Req Impr	Inadequate	Req Impr	Req Impr	Inadequate	Inadequate	Y	Y
AMU A SGH	Acute Medicine	Emergency Care	Complete	Req Impr	Req Impr	Good	Good	Req Impr	Req Impr	Y	Y
Lyndon 4 SGH			Complete	Req Impr	Req Impr	Good	Req Impr	Req Impr	Req Impr	Y	Y
Lyndon 5 SGH			Complete	Req Impr	Good	Good	Good	Req Impr	Req Impr	Y	Y
Newton 4 SGH	Stroke	Admitted Care A	Complete	Good	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Y	Y
Newton 5 SGH	Haematology	Admitted Care A	In Progress	Req Impr	Req Impr	Good	Good	Req Impr	Req Impr	Y	Y
OPAU SGH	Elderly Care	Admitted Care B	***Closed***								
Priory 4 SGH	Stroke	Admitted Care A	Complete	Good	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Y	Y
Priory 5 SGH	Gastroenterology	Admitted Care B	Complete	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Y	Y
A&E City	Emergency Medicine	Emergency Care	Complete	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Y	Y
AMU 1 City	Acute Medicine	Emergency Care	Complete	Req Impr	Req Impr	Good	Good	Req Impr	Req Impr	Y	Y
AMU 2 City	Acute Medicine	Emergency Care	Complete	Req Impr	Req Impr	Good	Good	Req Impr	Req Impr	Y	Y
D5 City	Cardiology	Admitted Care A	In Progress								
D7 City	Cardiology	Admitted Care A	In Progress								
D11 City	Elderly Care	Admitted Care B	Complete	Good	Req Impr	Good	Req Impr	Good	Req Impr	Y	Y
D15 City	Respiratory	Admitted Care B	In Progress								
D16 City	Gastroenterology	Admitted Care B	***Closed***								
D17 City	Respiratory	Admitted Care B	In Progress								
D26 City	Elderly Care	Admitted Care B	Complete	Good	Req Impr	Good	Req Impr	Good	Req Impr	Y	Y
D27 City			Complete	Good	Good	Good	Good	Good	Good	Y	Y
D30 City			***Closed***								
Respiratory Hub			Complete	Req Impr	Req Impr	Good	Req Impr	Req Impr	Req Impr	Y	Y
Endoscopy			Complete	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Y	Y
Haematology Service			Complete	Req Impr	Req Impr	Good	Req Impr	Req Impr	Req Impr	Y	Y
Surgical Services											
ITU SGH	Critical Care	Anaesthetics, Critical Care & Pain	Not Known								
Lyndon 2 SGH	General Surgery	General, Breast, Urology & Vascular	Not Known								
Lyndon 3 SGH	General Surgery	General, Breast, Urology & Vascular	Not Known								
Newton 1 SGH	Breast	General, Breast, Urology & Vascular	***Closed***								
Newton 2 SGH			Not Known								
Newton 3 SGH	Trauma & Orthopaedics	T&O and Plastics	Not Known								
Priory 2 SGH	Gastro Surgery	General, Breast, Urology & Vascular	Not Known								
SAU SGH	Urology	General, Breast, Urology & Vascular	Not Known								
SDU SGH	General Surgery	General, Breast, Urology & Vascular	Not Known								
Critical Care City	Critical Care	Anaesthetics, Critical Care & Pain	Not Known								
Cataract Ward City	Ophthalmology	Ophthalmology	Not Known								
D25 City	General Surgery	General, Breast, Urology & Vascular	Not Known								
D27 CSU City	General Surgery	General, Breast, Urology & Vascular	Not Known								
Eye Ward 3 City	Ophthalmology	Ophthalmology	Not Known								
ITU City	Critical Care	Anaesthetics, Critical Care & Pain	Not Known								
Ophthalmic Unit City	Ophthalmology	Ophthalmology	Not Known								
Women & Child Health											
Lyndon Ground SGH	PAU / Adolescent Unit	Acute & Community Paediatrics	Complete	Req Impr	Req Impr	Good	Req Impr	Req Impr	Req Impr		
Lyndon 1 SGH	Paediatric Inpatients & HDU	Acute & Community Paediatrics	***Closed***								
Priory Ground SGH	Paediatric Day Case / Outpati	Acute & Community Paediatrics	In Progress								
Gynae OPE Sandwell	Gynaecology	Gynaecology & Gynae Oncology	In Progress								
D6 City	Paediatric Day Case Surgery	Acute & Community Paediatrics	***Closed***								
D21 City	Gynaecology	Gynaecology & Gynae Oncology	Complete	Req Impr	Req Impr	Good	Good	Good	Req Impr		
D21 E City	EGAU / Gynaecology	Gynaecology & Gynae Oncology	Complete	Req Impr	Req Impr	Good	Good	Good	Req Impr		
CECU City	PAU / Emergency Care	Acute & Community Paediatrics	In Progress								
Paediatric Outpatients			In Progress								
Delivery Suite City	Maternity Acute	Maternity & Perinatal Medicine	In Progress								
Maternity 1 City	Maternity Acute	Maternity & Perinatal Medicine	In Progress								
Maternity 2 City	Maternity Acute	Maternity & Perinatal Medicine	Complete								
Neonatal Unit City	Neonatal	Maternity & Perinatal Medicine	Complete	Good	Good	Good	Good	Good	Good		
Gynae OPD City	Gynaecology	Gynaecology & Gynae Oncology	In Progress								
Serenity City	Maternity Acute	Maternity & Perinatal Medicine	Complete	Good	Good	Good	Good		Good		
Children's Therapies		Acute & Community Paediatrics	Complete	Outstanding	Outstanding	Good	Outstanding	Good	Outstanding		
Health Visiting		Acute & Community Paediatrics	In Progress								
School Nursing		Acute & Community Paediatrics	Complete	Good	Good	Good	Good	Good	Good		
Children's Continuing Care		Acute & Community Paediatrics	In Progress								
Special Educational Needs Team		Acute & Community Paediatrics	In Progress								
Community Children's Nursing Team		Acute & Community Paediatrics	In Progress								
Community Midwifery Teams		Maternity & Perinatal Medicine	Complete	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr	Req Impr		

Annex 3

In-House Unannounced Inspection Visit Programme
Schedule of Dates for 2021

Date	Location
10th May 2021	Sandwell General Hospital
17th May 2021	Sandwell General Hospital
24th May 2021	Sandwell General Hospital
7th June 2021	City Hospital
14th June 2021	City Hospital
21st June 2021	City Hospital
28th June 2021	City Hospital
5th July 2021	Sandwell General Hospital
12th July 2021	Sandwell General Hospital
19th July 2021	Sandwell General Hospital
26th July 2021	Sandwell General Hospital
16th August 2021	City Hospital
23rd August 2021	City Hospital
6th September 2021	Sandwell General Hospital
13th September 2021	Sandwell General Hospital
20th September 2021	Sandwell General Hospital
27th September 2021	Sandwell General Hospital
4th October 2021	City Hospital
11th October 2021	City Hospital
18th October 2021	City Hospital