Paper ref:	TB (07/21) 009

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	**we**Assure Programme Update (CQC Preparedness)		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author(s)	Ruth Spencer, Associate Director of Quality Assurance Kam Dhami, Director of Governance		
Meeting	Public Trust Board	**Date**	1st July 2021

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

The Trust Board is asked to examine the work in relation to our **we**Assure programme. This programme focusses on quality assurance against CQC domains and assurance on quality improvement. It includes readiness for CQC inspection. It aims to further strengthen and refine evidence summation to provide greater assurance of progress or risk on our journey to being good or outstanding in everything we do.

The paper provides an update on progress with the programme of work that is currently underway in order to prepare ourselves for inspection through the following:

- the creation of an evidence vault on directorate, service and group quality assurance, learning and quality improvement;
- practical examples and illustrations of what the evidence will look like;
- how self-assessment and in-house unannounced inspection results are to be triangulated with evidence collected; and
- how we will provide assurance and triangulation via our current quality governance structure and to Board.

It will be important to discuss how we bring this process to life for local leaders and how we ensure it has proportionate place in the work of the leadership over Quarter 2.

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?]*

n/a

4. Recommendation(s)

The Trust Board is asked to:

a.	**COMMENT** on the improved approach to quality assurance at all levels in the organisation
b.	**RECOGNISE** the emphasis on large bed-holding teams
c.	**NOTE** the intention to consider Well-Led work following the internally commissioned governance review.

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: 1st July 2021

weAssure Programme Update (CQC Preparedness)

1. Introduction and context

1.1 The Trust has had three scheduled CQC inspections in the last ten years (2014, 2017, 2018), and whilst the majority of services (70%+) are rated as Good and the Trust is outstanding for Caring, we are overall rated as Requires Improvement (RI). Our acute and emergency services are lower rated than the rest of the organisation. Our Well-Led rating fell back in 2018 to RI, having been good in 2017.

1.2 Looking towards any upcoming re-inspection under the new focussed CQC inspection regime, the Board needs a candid assessment of our performance, whether we have remedied prior weaknesses, and whether any better rated services have regressed. Public View data would suggest that the Trust has seen declining performance since April 2020 and implementation of the 2019/20 Board well-led improvement plan was paused during the pandemic.

1.3 This paper outlines our priorities for the next three months and the additional work streams we are putting into place to ensure that we can provide visibility and assurance on outputs and outcomes, not simply actions or processes. Crucial to that will be local teams being supported to prioritise this work and that remains the key change needed over the coming month.

2. Creation of an Evidence Vault

2.1 Having the evidence collated into a vault will both allow internal testing of progress and offer material readily available to inspectors. The exact format of the next CQC inspection remains uncertain, with an expectation that more reliance will be placed on data and patient feedback and less on site visits, with even greater emphasis on board to ward leadership clarity.

2.2 Our evidence will be collected at service, directorate, group and Trust level and will be added into the evidence vault which will be accessible to all Trust staff and our Board members via Connect (the intranet). We will index this information into the service domains of the CQC as well.

2.3 A template has been developed to enable collection of documentary evidence which will go into the evidence vault. The template includes each of the questions from the CQC's Key Lines of Enquiry (KLOE) and will require teams to attach documentary evidence for each question in support of their assertions about performance.

2.4 The template will allow clinical teams to identify any gaps and to explain how they intend to mitigate these by setting out their plans to address them, including evidence of what quality improvement work streams are planned, or already in progress.

Capturing the outcome of that action planning and improvement work will clearly be critical.

2.5 The evidence template will be re-visited by clinical teams each quarter when they will be expected to update their evidence.

2.6 The template provides specific examples of each type of evidence required, together with a statement of what a good service looks like. An illustration of the evidence collection template is provided at **Annex 1** of this report.

2.7 The template is currently being socialised with local teams and may therefore alter slightly in form or format to meet their needs. We know from prior inspections and lessons learned exercises that 'translation' between local language and CQC terminology is a really important part of preparation. We know too that inspectors often focus on weaknesses not strengths and therefore it is for our teams to feel confident and enabled to share their best work in the process. By honing that work now we would expect to make that more likely.

3. Triangulation of Information

3.1 Teams will be required to complete their self-assessment within the same evidence collection template. They will have the opportunity to explain how and what they are doing in order to achieve compliance with each KLOE question, as well as attach their documentary evidence in support of their performance. In return they will be able to see the data for their area which is held centrally by the Trust. This is an important reciprocity and one that will be assisted by the Public View material we have now, which we did not have sight of before 2019.

3.2 The approach will be supplemented by our longstanding in-house unannounced inspection visits, the results of which will also be shown alongside the self-assessment results, and documentary evidence. **Annex 2** is a sample extract from the toolkit to demonstrate the types of evidence collected as part of the in-house unannounced inspection visit toolkit. We will very much look to ensure that some inspections take place "out of hours".

3.3 A scoring system will take into account what clinical teams have identified as part of their self-assessment, together with their submitted evidence, and the outcomes and findings from their in-house inspection visits. The scoring system will then provide an overall rating for each service against each domain.

3.4 We would expect local directorate and Group leaders to be actively discussing these results and introducing both shared learning and competition between local and neighbouring teams. This will be essential in Medicine and Emergency Care, which historically has been the lowest rated part of the Trust, and in Surgery where the disruption and churn of the pandemic has been very significant to prior norms and standards.

3.5 The above three strands of information will populate the **we**Assure dashboard which will show an evidence-based picture of how the Trust, its wards and clinical teams are performing against each of the five CQC domains. An example of the dashboard, which will display information both at Trust and service / ward level, is included at **Annex 3** of this report.

4. Opportunities for Learning and Quality Improvement

4.1 The above approach provides opportunities for learning for clinical teams through a greater understanding of the CQC requirements, Key Lines of Enquiry, and what good looks like. It also tries to mimic something of what an inspection could be like. It will be really important that knowledge of the material is not only available to senior managers but is, at the very least, understood by local team leaders if not, realistically, all employees.

4.2 Wards and clinical teams will identify gaps and set out what work streams are required to mitigate and address areas that are falling short of the required standards. They will be able to provide examples of planned and current quality improvement work in support of addressing these issues, together with any outcomes already achieved by that work.

4.3 Wards and clinical teams will also be given the opportunity as part of this process to identify areas of outstanding practice which can be shared via our Learning from Excellence programme and at TeamTalk. We will encourage teams to submit quality improvement posters within our annual **we**learn contest which launches in July.

4.4 It will be important to fuse this learning into our approach to knowledge management and find the right balance between labelling matters 'for the CQC' and making it day to day business. The Executive has given a clear steer that the latter is preferred as an approach – as what we are doing is good quality governance not prepping for an inspection.

5. Providing visibility and enabling assurance

5.1 The findings and outcomes from the above triangulated information will be shared via the **we**Assure dashboard. Clinical teams will be supported to form an action plan to address areas for improvement. The ratings and action plans will be discussed by clinical teams at their ward meetings and Quality Improvement Half Days (QIHDs), and will be managed by the directorates and groups at their management board meetings. Clinical teams will also be invited to present their action plans to an Oversight Group which will meet monthly.

5.2 A new Executive-led forum is being established that meeting monthly will triangulate how clinical services rate themselves against the KLOEs, scrutinise the evidence being relied upon and establish what happens in practice through the in-house inspections and data sources such as Public View and patient feedback. The quality of plans to improve performance will be challenged and delivery monitored.

5.3 Progress with the **we**Assure programme will be a standard agenda item at Board Quality and Safety Committee and at the monthly Executive Quality Committee. We will also consider whether risk registers accurately reflect any significant considerations arising from the material collected. Importantly in Performance Review meetings with the Executive and in Clinical Leadership Executive we will be discussing the dashboard and its implications.

5.4 The Board will also receive a monthly update which will cite any areas of risk, for example where areas are not meeting the KLOE standards, where practice is not as it should be, or where there are safety concerns, with an explanation of how this is being addressed and mitigated.

5.5 Over the next four weeks we will conclude conversations with each Clinical Group about how we fully resource this process. Some new WTE will be needed to make it operate at scale and pace, but it is important that in-line managers take this on too. The whole merit is that this is done by not done to. The Executive team is discussing how to make that happen, as delivering the good quality assurance is the role of the whole leadership team.

6. Recommendations

6.1 The Trust Board is asked to:

a. **COMMENT** on the approach presented to prepare for inspection
b. **RECOGNISE** the emphasis on large bed-holding teams
c. **NOTE** the intention to consider reinvigorating well-led work after the upcoming Board away day

Ruth Spencer
Associate Director of Quality Assurance

Kam Dhami
Director of Governance

23rd June 2021

Annex 1: we Assure Evidence Collection Template [example pages]
Annex 2: In-House Unannounced Inspection Visit Toolkit – Sample Extract
Annex 2: we Assure Dashboard

Annex 1: weAssure Evidence Collection Template [example pages]

weAssure | Evidence Collection Template

Ward X, Sandwell General Hospital

Domain	Question	Ref	Measures	Self Assessment						In House Unannounced Visit		Examples of what 'Good' Looks Like
				Explanatory Text - How we are meeting the standard	Identification of any gaps or where we are not meeting the standard	Example(s) of how we are mitigating any gaps through quality improvement work either planned or in progress	Example(s) of Evidence from Service	Evidence Attached	Self Rating	Visit Observations	Visit Rating	
SAFE	Safeguarding	S1.1	Do staff understand how to identify and report a safeguarding concern and who to contact for advice?	*All staff understand how to raise a safeguarding concern through the correct reporting process.*			*Safeguarding Process, Safeguarding Alerts, Feedback from Local Authority Safeguarding Teams*		Good	Staff had a good knowledge and understanding of the safeguarding process and how to report a concern.	Good	• Staff receive appropriate training for safeguarding adults and children. • There are designated leads for safeguarding. • Staff demonstrate a good understanding of how and when to report safeguarding issues. • Safeguarding concerns are discussed during MDT meetings. • Patients using the service feel safe. • Staff have a good understanding of MCA and DOLs policies. • Staff are aware of the learning disability passport. • Staff are aware of the increased observation policy for patients that may require 'specialing' / 1:1 care. • Evidence of staff training in PREVENT.
		S1.2	Do staff receive appropriate training for safeguarding adults and children?	*All staff have attended the appropriate Safeguarding Training.*			*Training Records.*		Good	Evidence that staff have accessed the appropriate safeguarding training via training records.	Good	
		S1.4	When things go wrong, how do we ensure openness and honesty with patients in line with the Duty of Candour Policy?	*An apology and explanation is given to the patient and / or next of kin. Duty of Candour paperwork is completed at the time of the incident.*					Good	Staff were not able to articulate what is meant by Duty of Candour	Inadequate	
	Safe Staffing	S2.1	How do we ensure that staffing levels are safe with the correct skill mix of staff always available?	*Daily reviews of weekly staffing. skill mix allocated on rota. Short notice sickness managed via acuity, escalating to matron, requesting bank, swapping of shifts etc to ensure safety.* *Full induction process in place for all areas, to include supernumerary status at a length mutually agreed with line manager.*			*Safe Staffing Report, Recruitment Records, Induction Records, Training Records*		Good	The ward felt safely staffed with the appropriate skill mix of staff present. Staff said they had no concerns regarding staffing levels.	Good	• Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times. • Any staff shortages are responded to quickly and adequately.
	Deteriorating Patients	S3.1	How do we carry out and document risk assessments to identify the individual needs of patients and make sure these are always up to date?	*All patients assessed by trust safety standards on admission. Appropriate care plans are flagged. Staff follow through with appropriate referrals i.e. if high nutrition risk refer to dietitian.* *If high risk of falls appropriate risk assessment carried out depending on risk focused care maybe put in place*			*Effective Handover, MDT Meeting Minutes*		Good	Risk assessments are completed on admission to the ward and reviewed as required according to Trust Policy.	Good	• There are effective handovers and shift changes to ensure that staff can manage risks to patients. • Staff recognise and respond appropriately to changes in the risks to patients • Risks to safety from changes or developments to services are assessed, planned for and managed effectively. • Arrangements are in place to respond to emergencies and major incidents. These are regularly practiced and reviewed. • Staff are aware of the Trust's major incident policy and know how to access it.
		S3.2	Are resuscitation trolleys accessible and tidy, and are they checked regularly?				*Resus Trolley Check Lists*		Requires Improvement	The resuscitation trolley was clean and tidy and evidence to show that it is checked daily.	Good	
		S3.4	Are arrangements in place to respond to medical emergencies and major incidents, and are they regularly practiced and reviewed?				*Business Continuity Plans for:* ** Seasonal fluctuations* ** Adverse weather* ** IT failure* ** Fire* ** Infectious disease outbreak* ** Terrorist attack*		Requires Improvement		Requires Improvement	
	Incident Reporting	S6.1	Are staff able to describe how and when to report an incident?	*All incidents are reported on Safeguard. Staff are able to self-report as and when required.*					Good	Staff had a good understanding of how to report and incident and said they felt supported by their manager to do so.	Good	• Monitoring and reviewing activity enables staff to understand risks and gives a clear, accurate and current picture of safety. • Performance shows a good track record and steady improvements in safety.
		S6.3	How is safety performance information (e.g. falls, pressure ulcers) shared with staff?				*Dashboards*		Inadequate	There are no local dashboards or information displayed or given to staff on safety performance.	Inadequate	
	Lessons Learned	S7.1	How is learning and feedback from incidents shared with staff?	*Learning is highlighted and fed back to staff via email.*			*Incident Investigation Reports including learning and improvement, Agendas / Minutes of Supervisio, Evidence of effective communication with staff*		Requires Improvement	Staff said that learning from incidents is shared with them via email, but not all staff were accessing these emails in a timely manner.	Requires Improvement	• Openness and transparency about safety is encouraged. • Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses; they are fully supported when they do so. • When something goes wrong, there is an appropriate thorough review or investigation that involves all relevant staff. • Lessons are learned and communicated widely to support improvement in other areas where relevant, as well as services that are directly affected • Improvements to safety are made and the resulting changes are monitored.
		S7.2	Are staff involved in undertaking Root Cause Analyses (RCAs) and can they describe the process?	*Staff are supported by the local Manager and Matron to under take RCAs.*			*Root Cause Analysis Documentation*		Good	Staff stated that they were not directly involved with undertaking RCAs and this is done by more senior staff.	Requires Improvement	
		S7.3	How do we monitor the quality and safety of the service as a team through the review of complaints, incidents, audits, etc., and how is this information used to improve how we work?	*Weekly and monthly audits are in place and the results, themes and trends of these are discussed at monthly MDT meetings. Learning from incidents and complaints is discussed at monthly Governance meetings.* *The Matron carries out weekly spot checks.*			*Learning Alerts* *MDT Meeting Minutes* *Safety Huddle Reports*		Good			

Domain	Question	Ref	Measures	Self Assessment						In House Unannounced Visit		Examples of what 'Good' Looks Like
				Explanatory Text - How we are meeting the standard	Identification of any gaps or where we are not meeting the standard	Example(s) of how we are mitigating any gaps through quality improvement work either planned or in progress	Example(s) of Evidence from Service	Evidence Attached	Self Rating	Visit Observations	Visit Rating	
WELL-LED	Leadership and Culture	W1.1	Do you have an inclusive and effective leadership strategy and development programme				*Leadership Development Programme, Succession planning and talent management documents*					• Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed. • Leaders at every level are visible and approachable. • Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme. • The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them.
	Leadership Strategy	W2.1	Does the service have a strategy that is aligned to local plans in the wider health and social care economy and are services planned to meet the needs of the relevant population?	*To provide high quality care in as timely fashion as possible.* *Regularly reviewing service need and nursing skills to provide the best quality of care.*			*Strategy Documentation, Local Financial Plan and Budget, Cost Improvement and Sustainability Plans*					• There is a clear statement of vision and values, driven by quality and sustainability. • The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population. • Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence of this. • Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. • Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.
	Governance Roles and Responsibilities	W3.2	How are staff kept informed of the service's top risks, incident trends or other relevant governance information?									
		W3.3	How does we discuss safety and quality topics and what information does our Quality and Safety Dashboards contain and where can these be found?	*For example, do you have a group which discusses and acts on the following:* ** Operational performance* ** Clinical audit* ** Risk register, incidents & trends* ** Complaints*			*Local Governance frameworks, Agendas / Minutes of Meetings, Dashboards*					
		W3.4	How do we identify any potential risks to our service and how do we escalate these?									
		W3.5	What risks are on our local risk register (service level) and what are we doing to manage and address these?				*Risk Register*					
	Staff and Patient Engagement	W4.1	Do staff feel supported, respected and valued? Do staff feel positive and proud to work in the organisation?	*Our staff have clear goals and aspirations discussed at PDRs and monthly 1-1 meetings with senior teams. Staff receive personal thank you's and email thank you's.*			*Staff Survey Results*		Good		Good	• A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture. • The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture. • The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

Annex 2: In-House Unannounced Inspection Visit Toolkit – Sample Extract

KLOE	Question	Evidence: Patient Observation	Evidence: Staff Engagement	Evidence: Documentation	Comments
SAFE People are protected from abuse and avoidable harm					
Safeguarding					
S1(a)	Do staff understand how to identify and report a safeguarding concern and who to contact for advice?	☐	☐	☐	
S1(b)	Do staff understand how and when to assess capacity?	☐	☐	☐	
S1(c)	Do staff have a good understanding of the Mental Capacity Act and DOLS policies?	☐	☐	☐	
S1(d)	Can staff explain what is meant by Duty of Candour, and describe the process they should follow?	☐	☐	☐	
Examples of Good: • Staff receive appropriate training for safeguarding adults and children. • There are designated leads for safeguarding. • Staff demonstrate a good understanding of how and when to report safeguarding issues. • Safeguarding concerns are discussed during MDT meetings. • Patients using the service feel safe. • Staff have a good understanding of MCA and DOLs policies. • Staff are aware of the learning disability passport. • Staff are aware of the increased observation policy for patients that may require 'specialing' / 1:1 care. • Evidence of staff training in PREVENT.				
Safe Staffing					
S2(a)	What are staff perceptions of staffing levels?	☐	☐	☐	
S2(b)	Are staff aware and can describe how to escalate and manage short staffing levels?	☐	☐	☐	
S2(c)	Are rosters planned to ensure the correct skill mix is always available?	☐	☐	☐	
S2(d)	Has an induction sheet been completed and kept on file for agency nursing and medical staff?	☐	☐	☐	
Examples of Good: • Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times. • Any staff shortages are responded to quickly and adequately.					

Safe Use of Medicines					
S4(a)	Are medicines secure and kept in locked cabinets?	☐	☐	☐	
S4(b)	Are fridge temperatures checked daily?	☐	☐	☐	
S4(c)	Are medicines disposed of correctly and in accordance with Trust policy?	☐	☐	☐	
S4(d)	Are medication incidents (errors / omissions / learning) reviewed?	☐	☐	☐	

Examples of Good:

- Staff meet good practice standards described in relevant national guidance, including in relation to non-prescribed medicines.
- Patients receive their medicines as prescribed.
- The service involves patients in regular medicines reviews.
- Staff manage medicines consistently and safely.
- Medicines are stored correctly, and disposed of safely.
- Staff keep accurate records of medicines.

Incidents					
S5(a)	Are staff able to describe how and when to report an incident?	☐	☐	☐	
S5(b)	Are staff supported by their manager when they report incidents?	☐	☐	☐	
S5(c)	Where risks are identified, have plans been put in place to address these?	☐	☐	☐	
S5(d)	How is safety performance information shared with staff? (e.g. falls, pressure ulcers)	☐	☐	☐	

Examples of Good:

- Monitoring and reviewing activity enables staff to understand risks and gives a clear, accurate and current picture of safety.
- Performance shows a good track record and steady improvements in safety.

Lessons Learned					
S6(a)	Do staff receive learning and feedback from incidents?	☐	☐	☐	
S6(b)	Are staff involved in undertaking Root Cause Analyses (RCAs) and can they describe the process?	☐	☐	☐	
S6(c)	Is there evidence to support any changes to practice or service delivery as a result of incidents?	☐	☐	☐	

Examples of Good:

- Openness and transparency about safety is encouraged.
- Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses; they are fully supported when they do so.
- When something goes wrong, there is an appropriate thorough review or investigation that involves all relevant staff.
- Lessons are learned and communicated widely to support improvement in other areas where relevant, as well as services that are directly affected
- Improvements to safety are made and the resulting changes are monitored.

Annex 2: weAssure Dashboard

weAssure | Dashboard

Trust Level Ratings

Select Site: City Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Medical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Good	Good	Good	Good	Requires Improvement	Good
Critical Care	Good	Good	Good	Good	Good	Good
Maternity and Gynaecology	Good	Good	Good	Good	Good	Good
Services for Children and Young People	Requires Improvement	Requires Improvement	Good	Good	Inadequate	Requires Improvement
End of Life Care	Good	Outstanding	Good	Outstanding	Outstanding	Outstanding
Outpatients and Diagnostic Imaging	Good	N/A	Good	Good	Good	Good
OVERALL	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

weAssure | Dashboard

Ward Level Ratings

	Overall Rating						Number of Indicators per Rating			
Clinical Team / Area	Safe	Effective	Caring	Responsive	Well-led	Overall	Outstanding	Good	Requires Improvement	Inadequate
A&E SGH	Good →	Requires Improvement ↓	Good ↑	Outstanding ↑	Outstanding ↑	Good →	8	50	10	
Lyndon Ground SGH	Requires Improvement ↑	Good ↑	Good →	Good ↑	Requires Improvement ↑	Good →		48	20	
Lyndon 1 SGH	Requires Improvement ↑	Requires Improvement →	Good ↑	Good ↑	Good ↑	Good →		40	28	
Lyndon 2 SGH	Good ↑	Requires Improvement →	Good →	Good →	Requires Improvement ↓	Good ↑		39	29	
Lyndon 3 SGH	Requires Improvement ↑	Good →	Good ↑	Good →	Requires Improvement ↓	Good ↑		42	26	
Lyndon 4 SGH	Requires Improvement ↓	Good ↑	Good →	Good →	Outstanding ↑	Good ↑	6	47	15	
Lyndon 5 SGH	Requires Improvement ↑	Good ↑	Good ↑	Good ↑	Outstanding ↑	Good →	4	44	20	
OPAU SGH	Good ↑	Good →	Good ↑	Good ↑	Requires Improvement ↑	Good →		63	5	
Priory Ground SGH	Good →	Good ↑	Outstanding →	Requires Improvement ↓	Requires Improvement ↑	Good →	15	35	18	
Priory 2 SGH	Good ↑	Requires Improvement ↑	Outstanding ↑	Outstanding ↑	Requires Improvement ↑	Good ↑	14	30	24	
Priory 4 SGH	Good →	Good ↑	Outstanding ↑	Good ↑	Requires Improvement →	Good ↑	5	51	12	
Priory 5 SGH	Good ↑	Outstanding ↑	Outstanding ↑	Good →	Requires Improvement ↑	Good ↑	20	37	11	
Newton 1 SGH	Requires Improvement ↑	Requires Improvement ↑	Outstanding →	Good →	Requires Improvement ↑	Requires Improvement →	5	9	54	
Newton 2 SGH	Outstanding ↑	Requires Improvement ↑	Outstanding ↑	Good →	Requires Improvement ↓	Requires Improvement →	25	9	34	
Newton 3 SGH	Good ↑	Good ↑	Outstanding →	Good ↑	Requires Improvement ↓	Good ↑	5	51	12	
Newton 4 SGH	Outstanding →	Requires Improvement ↑	Outstanding ↑	Good ↑	Requires Improvement →	Requires Improvement →	27	8	33	
Newton 5 SGH	Inadequate ↓	Requires Improvement →	Good ↑	Outstanding ↑	Requires Improvement →	Requires Improvement →	8	5	37	18
AMU A SGH	Good ↑	Good ↑	Good →	Outstanding →	Requires Improvement ↑	Good ↑	8	48	12	
SAU SGH	Requires Improvement ↑	Good ↑	Good →	Good ↑	Requires Improvement ↑	Good →		32	36	
Critical Care SGH	Requires Improvement ↑	Good →	Good →	Good ↑	Requires Improvement ↑	Good ↑		32	36	
A&E City	Requires Improvement ↑	Good →	Good ↑	Good ↑	Requires Improvement ↑	Good →		30	38	
AMU 1 City	Requires Improvement ↑	Good →	Outstanding ↑	Requires Improvement ↑	Requires Improvement ↓	Requires Improvement ↑	5	16	47	
AMU 2 City	Inadequate ↓	Good ↑	Outstanding ↑	Outstanding ↑	Requires Improvement ↑	Requires Improvement ↓	12	15	31	10
CICU City	Inadequate →	Requires Improvement ↓	Outstanding ↑	Good ↑	Requires Improvement ↑	Requires Improvement ↑	5	9	39	15
D5 City	Good ↑	Requires Improvement ↑	Outstanding ↑	Outstanding ↑	Requires Improvement ↑	Good ↑	13	32	23	
D7 City	Good ↑	Requires Improvement ↑	Outstanding ↑	Requires Improvement ↑	Inadequate ↓	Requires Improvement ↑	5	24	29	10
D11 City	Requires Improvement ↑	Good ↑	Outstanding ↑	Requires Improvement ↑	Good ↑	Requires Improvement ↓	4	29	35	
D15 City	Requires Improvement ↓	Requires Improvement ↑	Outstanding ↑	Outstanding ↑	Inadequate →	Requires Improvement ↑	13		43	12
D17 City	Requires Improvement ↑	Good ↑	Outstanding ↑	Good ↑	Outstanding ↑	Good ↑	15	31	22	
D21 City	Good ↑	Good ↑	Outstanding ↑	Outstanding ↑	Good ↑	Good ↑	14		54	
D25 City	Requires Improvement ↑	Good ↑	Outstanding ↑	Good ↑	Good ↑	Good ↑	5	43	20	
D26 City	Requires Improvement ↑	Good ↑	Outstanding ↑	Outstanding ↑	Good ↑	Good →	13	33	22	
D27 City	Requires Improvement ↑	Requires Improvement ↑	Outstanding ↑	Good ↑	Good →	Requires Improvement ↑	4	18	46	
D28 City	Good ↑	Good →	Outstanding ↑	Requires Improvement ↑	Requires Improvement ↑	Requires Improvement ↑	5	38	25	
D30 City	Requires Improvement ↓	Requires Improvement ↓	Outstanding ↑	Inadequate ↓	Requires Improvement ↓	Requires Improvement ↑	4		56	8
D42 City	Inadequate ↓	Requires Improvement ↑	Outstanding ↑	Good ↑	Requires Improvement ↑	Requires Improvement ↑	4	8	34	22
D43 City	Good ↑	Good ↑	Good ↑	Requires Improvement ↓	Good ↑	Good ↑		59	9	
D47 City	Requires Improvement ↑	Good →	Outstanding ↑	Requires Improvement ↑	Good →	Requires Improvement ↑	5	29	34	
Delivery Suite City	Requires Improvement ↑	Good ↑	Requires Improvement ↑	Requires Improvement ↑	Good →	Requires Improvement →		28	40	
Serenity City	Requires Improvement →	Requires Improvement →	Outstanding ↑	Good ↑	Good ↑	Requires Improvement →	4	20	44	
Maternity 1 City	Good ↑	Good ↑	Outstanding ↑	Requires Improvement ↑	Requires Improvement ↑	Requires Improvement ↓	5	40	23	
Maternity 2 City	Good →	Good ↑	Outstanding ↑	Good →	Requires Improvement ↑	Good →	4	53	11	
Critical Care City	Good →	Good ↑	Outstanding ↑	Requires Improvement ↓	Requires Improvement →	Good ↑	5	20	43	

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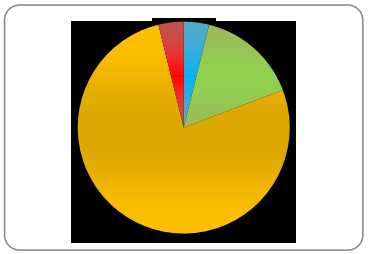
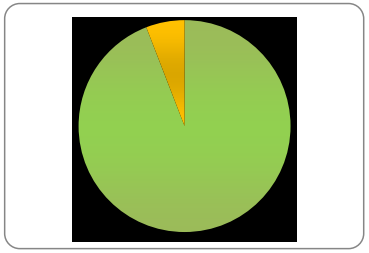
Ward Level

Ward X, Sandwell General Hospital					
	Number of KLOE Questions per Rating				
	OUTSTANDING	GOOD	REQUIRES IMPROVEMENT	INADEQUATE	Total Number of Questions
SAFE	0	4	20	1	25
EFFECTIVE	0	16	1	0	17
CARING	1	4	0	0	5
RESPONSIVE	0	8	1	0	9
WELL-LED	2	8	2	0	12
Total	**3**	**40**	**24**	**1**	**68**

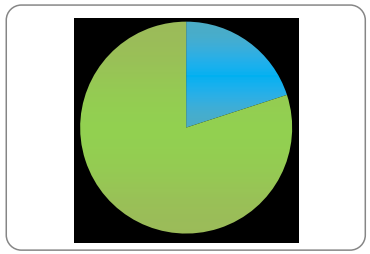
Safe



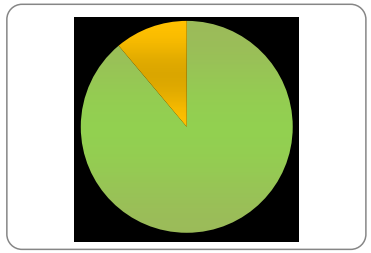
Effective



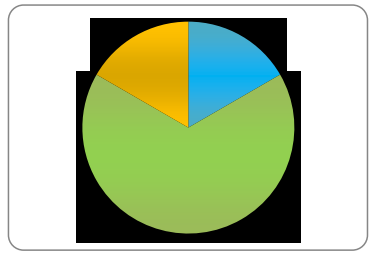
Caring



Responsive



Well-led



Scoring:	Outstanding	Good	Requires Improvement	Inadequate

KLOE Questions Rated as Requiring Improvement or Inadequate

Domain	Question	Measure		Current Rating
SAFE	Incident Reporting	S6.3	How is safety performance information (e.g. falls, pressure ulcers) shared with staff?	Inadequate
	Lessons Learned	S7.1	How is learning and feedback from incidents shared with staff?	Requires Improvement
WELL-LED	Governance Roles & Responsibilities	W3.5	What risks are on our local risk register (service level) and what are we doing to manage and address these?	Requires Improvement