13th May, 2019

Statement from Healthwatch Birmingham on Sandwell and West Birmingham NHS Trust Quality Account 2018/19

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Sandwell and West Birmingham NHS Trust. We make our statement cognizant of the challenges the Trust has faced over the year with the building of the new Midland Metropolitan Hospital.

It is disappointing that the Trust's CQC rating remains 'requires improvement especially as improving this was a priority for the 2017/18 Quality Account. However, we are pleased that the CQC rated the Trust outstanding in the caring domain and for critical care services. We encourage the Trust to continue implementing the actions it has outlined in the Quality Account and should consider including an audit of its clinical and corporate policies to see if they are fit for purpose. This would ensure that practices across the Trust adhere to current statutory requirements, national and NHS Guidelines. This would also clarify key lines of responsibility in ensuring that staff have an adequate understanding of policy and strategy.

Patient and Public Involvement

In the 2017/18 Quality Account, the Trust gave examples of the different ways it listens and learns from the experience of patients and carers. The Trust mentioned,

- 'Facebook live events' where patients could engage with health care staff;
- the establishment of a carers group which we believed was a good resource for the Trust for continued understanding of how best to support relatives and carers;
- the involvement of those within the 'Members Leadership Group' in CQC inspections and improvement plans; and
- the Trust's intention to work closely with other partners to better join up the Trust's formal patient engagement activities.

Healthwatch Birmingham believed that the Trust had the base on which to develop a coordinated and structured approach to the use of patient, service user and carer's experiences and insight. It is disappointing that the current Quality Account does not demonstrate how the Trust engages with patients and how this influences service development and improvement. For instance, the Trust has only provided the key performance indicators for complaints (p18 of the draft Quality Account) under patient experience. The Trust has not provided any indicators for PALs contact or the survey results of the Friends and Family Test (FFT). If these are available, the Trust has not signposted to the relevant page on the website. In addition, the Trust has only shown the number of complaints (which we are happy has reduced from 1037 in 2017/18 to 867 in 2018/19) but the themes from complaints have not been indicated nor how these are used to improve services.

Healthwatch Birmingham believes that for the Trust to improve its score for the 'responsiveness to personal needs of patients' is to understand these needs. This can only be done by listening to what these needs are from patients, service users and carers. We note that 'continuing to collect patient experience first-hand' is one of the actions to be taken to improve patient care. However, we are not sure if the 'patient placemats to support early discharge' initiative will help the Trust understand patient's needs. It is not

clear whether the questions[1] asked under this initiative reflect what patients and their carers have said they want. We note that patients and nursing staff are reviewing this initiative; we would like to read on the outcome of this initiative in the 2019/20 Quality Account.

It is encouraging that the Trust has an engagement strategy for staff that it follows to ensure that staff can feedback and raise concerns. We note the different methods available to involve staff and gather their feedback such as the 'we connect engagement programme', which is aimed at analysing engagement across the Trust to see how to improve future NHS Staff Friends and Family tests. We also note that through the 'Speaking UP' initiative, staff have outlined three changes they would like to see. Of key strategic importance to Healthwatch Birmingham is better communication about change. We would like to read the actions that have been taken to address this and their impact in the 2019/20 Quality Account.

Healthwatch Birmingham believes that this staff engagement strategy can serve as a foundation for developing a Trust-wide patient and public involvement (PPI) strategy. We still believe that the Trust would benefit from developing a Patient Public Involvement (PPI) Strategy that would ensure that engagement activities are equitable and representative of the localities the Trust works in. A PPI strategy would outline:

- Why the Trust is listening?
- What the Trust listens for?
- How the Trust listens?
- Who The Trust wants to hear from (including 'seldom-heard' groups)?
- How the Trust will use what it hears?
- Clear arrangements for collating feedback and experience.

Over the past year, Healthwatch Birmingham has worked with Clinical Commissioning Groups (CCGs) and trusts to benchmark their patient and public involvement (PPI) processes using Healthwatch Birmingham's Quality Standard. Thus enabling them to identify areas of good PPI practice or areas that need to improve. This has led to the development of actions aimed at embedding systems for delivering consistently high-quality PPI. Healthwatch Birmingham has made initial contact with Sandwell and West Birmingham Trust on this issue which we will follow-up in 2019/20. We would like to continue supporting the Trust with its PPI activities.

Regarding the NHS Staff Survey, we note that there has been an improvement on the percentage of staff that would recommend the Trust as a provider of care to their family and friends from 58.2% (2017) to 60.2% (2018). Equally, the percentage of staff who would recommend the Trust has increased from 49.4 % (2017/18) to 55.7% (2018/19). We encourage the Trust to continue implementing the actions outlined in the Quality Account as these scores are still below the national average. We would also like to see how the Trust uses this feedback from staff, especially how it uses it to understand the needs of different staff groups such as those from the BAME community.

[1] Questions include: If I am recovering well, when will I be discharged? Do I know what my diagnosis is or what tests are being carried out to determine this? What will happen over the next 24 hours with my treatment and care? What do I need to achieve to go home?

Regarding the complaints data, the Trust should consider including in this Quality Account the most common themes of complaints it has received, lessons learnt from these complaints and actions taken.

Trust Performance in 2018/19

Improved outcomes for patients presenting with signs and symptoms of sepsis
We welcome that the Trust has been able to consistently identify and screen 90% of its patients for sepsis and manage those identified as needing further treatment, over the last year. We note that 84% of patients receive antibiotics within one hour of arrival for an average of 40 patients presenting every month. The Trust has identified that delays are usually a result of delays in prescription or administration of antibiotics. We would like to read in the 2019/20 Quality Account, the actions taken in relation to the prescription process and the changes that have been made as a result.

Improve the consistency of care provided to patients while on the hospital's wards
We note the initiatives that have been implemented to ensure the delivery of consistent care. For instance, the 'Consultant of the Week' where individual consultants focus on leading patient management on the ward and the rotation of junior staff to improve training. We are pleased about this as over the last year patients have shared with us some poor experiences of care (e.g. assessments). We, therefore, encourage this initiative and would like to read, in the 2019/20 Quality Account, about its impact on patient experience.

Implementing the Safety Plan
We note that an audit of the safety plan (which includes 10 evidence-based clinical standards) was carried out in February 2019. The audit found that assurance controls to manage risks are suitably designed and consistently applied. However, issues were identified, such as:

- Inconsistencies in completion of the safety plan across the wards audited.
- Discrepancies between the time patients are recorded on the electronic bed management system and actual transfer of the patient. The risk is that unless the time of transfer is in real time all time-related actions will be incorrect
- On some wards, members of staff were unsure of when to complete certain parts of the plan.

We welcome the development of a standard operating procedure to provide guidance on the completion of the Safety Plan and training for new staff. However, we believe that refresher training should be made available to all health care staff if this is to become embedded into the Trusts practice. We look forward to reading, in the 2019/20 Quality Account, the impact of the steps taken to address these issues and the number of staff trained.

Seven Day hospital Services
We are pleased that the Trust is compliant with three of the four priority standards aimed at ensuring that patients have access to consultant directed care, diagnostics and clinical interventions seven days a week. The Trust has not been compliant in clinical standard two '*All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital'*. Compliance is 73% weekday and 85% weekends. We would like to

read in the 2019/20 Quality Account how the discharge project has helped improve this standard.

Incident reporting
We note that the Trust has had 21 serious incidents in 2018/19 and three never events were reported. We note the various changes that are taking place, such as annual audits of injectors and assistants to ensure safe and consistent practice and education across the Trust on WHO Surgical safe checklist. We ask the Trust to continue implementing initiatives that ensure robust controls are in place to prevent never events occurring. We would like to read the impact these changes have had on practice in the 2019/20 Quality Account.

Emergency four-hour wait
We note that the Trust continues to face challenges in meeting the national target of 95% for the emergency four-hour wait. The Trusts performance on this standard has fluctuated over 2017/18 and has been below the national target. As of March 2019, this was at 85.9%. One of the main issues we hear from the Trust's patients is around waiting times in A&E; we documented these in our recent report regarding both Birmingham City Hospital and the Birmingham and Midland Eye Centre. The focus of the report is on people's experiences of waiting times, the environment, communication, accessibility, and dignity and respect. We believe that the findings of this report can complement the actions the Trust plans to take to improve this performance and people's experiences as they wait to receive treatment. The report can be found here: http://bit.ly/2H1ZKMD

Learning from deaths
During 2018/19, 1059 Trust patients died and by end of January 2019 569 mortality case record reviews and 11 investigations were carried out. Eleven of these cases were subject to a case review and investigation. These were judged by the Trusts review process to have occurred due to problems in the care provided to the patient. In 2017/18, twelve deaths were judged to be due to problems in care received. We encourage the Trust to outline the key steps that they will take to reduce this and share learning across the Trust. We would like to read in the 2019/20 Quality Account how UNITY has helped the Trust make improvements, and examples of these.

The Trusts Priorities for 2018/19

Healthwatch Birmingham has taken note of the Trust's priorities for 2019/20, which reflect the experiences people tell Healthwatch Birmingham. A key element of these priorities is that they are setting the necessary foundations for the Trust, such as developing guidance, improving the single electronic system — UNITY to aid assessments and support quality/safety planning — and examining how services will be delivered at the Midland Metropolitan Hospital. We believe that the Trust should also focus on developing a strategy for listening to and acting on patient experiences to help improve patient care.

Andy Cave, CEO
Healthwatch Birmingham