Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account

2010-11

Where EVERYONE Matters

Part 1: Chief Executive's Statement

Providing **Safe High Quality Care** is the primary objective for all of our clinical services and all of our clinical staff. Everything else we do underpins this goal. In this report, the second **Quality Account** for Sandwell and West Birmingham Hospitals NHS Trust (SWBH), we describe the work we have done during 2010/11 to improve the quality of the care we give to our patients.

Our first **Quality Account** identified five priorities for improvement and described our plan to achieving high quality in each of those areas. Part 2 of this report describes the work done in 2010/11 and our main achievements in each of our priority areas. Part 3 describes our priorities for improvement in 2011/12, the plans we have and the procedures for measuring, monitoring and reporting progress for each of the objectives we have identified.

It is important to note that these plans were not developed in isolation, but grew out of our continuing dialogue with all of our stakeholders. We combined the feedback we got with our own analysis of patient and staff surveys, service performance data and other concerns that emerged throughout the year. During September 2010, we consulted with our membership as part of our process for developing a long list of potential priorities for the organisation. Further input was obtained from members of the public and staff during the autumn. In November 2010 the results were refined by the Board into the list of objectives for 2011/12.

With these objectives in mind, the Board reviewed the priorities identified in our 2009/10 report and determined that our priorities for improvement in 2011/12 should broadly remain the same as those outlined in our first **Quality Account**. Therefore, we are not formally retiring any of the priorities described in last year's report, although we have decided that two of the priorities should have a broader scope than was previously identified. The rationale for this decision is explained in Part 2 of this report.

We have done a considerable amount of work on quality improvement that was not specifically set out in our last **Quality Account**. During the year 2010/11, for example, our work on achieving **Safe High Quality Care** has included the following:

- We have continued to invest in and develop both consultant-led obstetric care and midwifery-led delivery units for the populations of Sandwell and West Birmingham Hospitals NHS Trust. May 2010 saw the successful opening of the Serenity Suite – a midwife-led birthing centre at City Hospital. This unit has attracted considerable interest and praise, both locally and nationally. It has further allowed us to develop our expertise in the area of maternity care. We will use this expertise to support the development of a midwife-led maternity unit in the borough of Sandwell.
- The obstetric service was also enhanced and strengthened by consolidating consultant-led births at the redeveloped maternity unit at City Hospital. Following months of careful planning, the transition from a two-site service took place in January 2011 without incident.
- This year saw the conclusion of the very successful pilot RAID which sought to improve the care given to patients with mental health needs. The service received very positive feedback from staff across the whole Trust as well as from patients. The success of this project has been reported nationally and is often cited as example of best practice. The service will now continue to evolve and develop and remains a priority area for the Trust.
- We achieved significant improvements in all of the quality objectives agreed with our local PCTs through the Commissioning for Quality and Innovation (CQUIN) Programme. By the end of the year, we fully met the agreed targets in all but one of the 17 objectives. The work done in this area is presented in detail in the Part 3 of this report.
- Last year, I reported that we had maintained our annual health check rating of good quality of services for the third successive year. Although there has been no formal assessment of performance by the Care Quality Commission this year, the Trust has continued to monitor its performance against a well-established range of quality indicators, and has demonstrated continued improvement against the majority of these.
- We have also successfully maintained our excellent performance in respect of infection control. Cases of hospital acquired MRSA Bacteraemia dropped from 61 in 2006/7 to 5 in 2010/11.

- The risk team, led by the Director of Governance, has worked hard to streamline the process for reporting incidents. This work has included ensuring that all serious incidents are thoroughly investigated, reported to the Board and action plans are pursued to conclusion.
- Our new Head of Risk has strengthened risk management at the Directorate level by providing specific training to doctors, nurses and managers in Root Cause Analysis and Incident Investigation. The whole Executive Team continues to encourage all staff to report any incidents, errors, or near misses to ensure that we can make our clinical services as safe as possible.
- The last year has seen an enormous increase in the data available about all aspects of our services. We currently monitor more than 400 measures of quality, efficiency, and activity. Performance across a range of measures is discussed quarterly with our divisions and clinical directorates, with a particular emphasis on those relating to quality and safety.
- We have also worked very hard in the last year to develop our Service Quality Strategy. This will ensure that our clinical systems and processes are all working closely together with a common purpose to deliver **Safe High Quality Care**.

Finally, I would like to draw your attention to Part 3 of this report, which contains a wealth of information on all of the other work that we are doing on quality.

I confirm that to the best of my knowledge all of the information contained in this quality account is accurate.

John Adler
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board

The performance in respect of the 2010/11 priority areas for quality improvement is reported in section 2.1.1 below. Section 2.1.2 sets out the priorities for 2011/12 and explains the rationale for selecting those priorities. This section also identifies how progress in each of the areas will be monitored, measured and reported in 2011/12. Section 2.2 contains the statements of assurance from the Board. The purpose of these is to provide assurance to the public that SWBH is performing to essential standards, that we have appropriate systems to measure our clinical processes and performance, and that we are committed to implementing projects and initiatives aimed at improving quality. These statements are set out in a standard format to allow comparison with other similar providers.

2.1.1 Report on Quality priorities for 2010/11

Our 2009/10 Quality Account identified 5 priority areas for improvement in 2010/11. These were:

1. Stroke
2. Basic Nursing Care
3. Mortality
4. Implementation of the Quality Management Framework
5. A&E Departments

Priority 1: Stroke

In our 2009/10 Quality Account we said:

> *"Over the past twelve months several important pieces of guidance have been issued on Stroke Care. These have been drawn together into a set of Quality Standards by the West Midlands Cardiac and Stroke Networks.*
>
> *The Quality Standards follow the patient pathways in each of the relevant Service Specifications and aim for the highest quality of care at each stage of the patients' journey.*

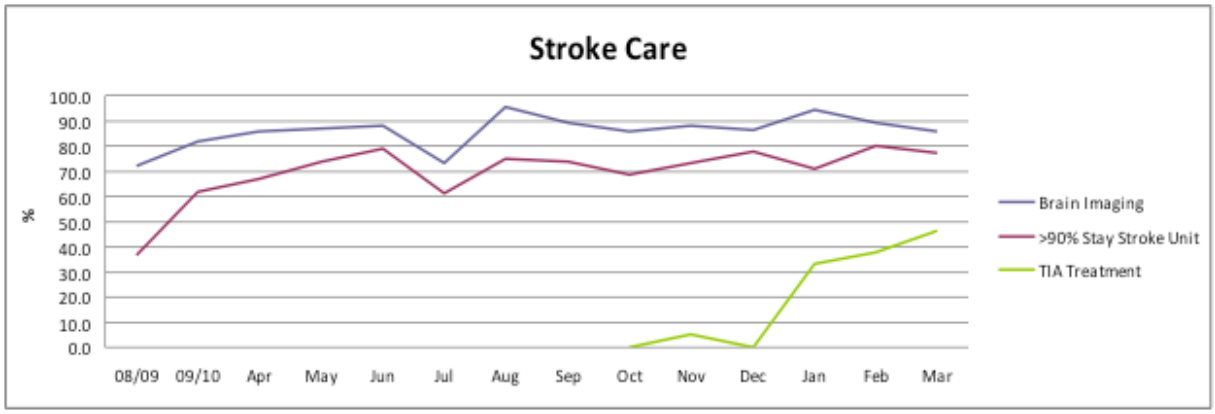
SWBH has developed an action plan which aims over the course of the next five years to achieve these standards.

There will be an independent review by the West Midlands Quality review service at the end of 2010/11 to measure our progress. We will publish a summary of the results in our 2010/11 Quality Accounts."

In 2010/11 our Stroke Action Team has been very effective in improving the standards of care given to patients with this devastating condition. The Trust has invested time and resource in further developing care pathways. In the 2008 Sentinel Stroke Audit, this Trust was in the middle half of Trusts across the range of indicators. The results of the 2010 Sentinel Stroke Audit showed that, even though standards continued to improve nationally, the improvement across this trust was sufficient to move both of the acute sites into the top quartile overall.

National Sentinel Stroke Audit 2010 Round 7				
		Received All Key 9 Indicators in 2008	Received All Key 9 Indicators in 2010	Received All Key 12 Indicators in 2010
	National Results	17%	32%	16%
	SWBH-City	16%	52%	50%
	SWBH-Sandwell	16%	38%	42%

The Stroke Action Team has developed a clinical dashboard that captures the key measures of performance in "near real-time". In 2010/11, this dashboard has allowed pathway failures to be identified and addressed whilst patients are still in hospital. In 2011/12, we hope to implement an electronic and text alert system in order to address problems before they occur. The chart below shows the improvement in performance over the last couple of years. There has been a major focus in the last few months on the care of patients presenting with transient ischaemic attacks (TIA) or "mini-strokes".



The Trust Board was particularly pleased to note the successful deployment of the most modern treatments, particularly thrombolysis. The Board was also pleased to receive the positive feedback from the West Midlands Quality Review Service (WMQRS), about the progress made to date. It also identified the areas requiring further improvement.

In summary, the WMQRS review of Stroke services at SWBH concluded that the services were provided by enthusiastic teams who worked well together and with other colleagues. As well as identifying good practice, the review highlighted a number of concerns. These included the amount of time it takes to treat patients requiring thrombolysis at City Hospital, only having one dedicated stroke consultant and the perception that nursing staff did not always have the competencies they needed. There was also concern about the out-of-hours coverage that is provided, as well as about weekend or bank holiday provision of senior doctor ward rounds, occupational therapy, speech and language therapy services, and physiotherapy.

It was recommended that the sustainability of the current configuration of services should be considered, given that achieving the expected Quality Standards on two hospital sites would be difficult. There were also recommendations in respect of guidelines and protocols, patient information, early supported discharge, avoiding unpredicted transfers, and the training programme for general medical registrars and consultants.

The work of the Stroke Action Team will continue until we have achieved the highest possible standards of care for these patients. Performance on the Stroke Clinical Dashboard will remain a priority area of attention for the Board and the Senior Management Team.

Priority 2: Basic Nursing Care

In our 2009/10 Quality Account we said:

"We intend to continue to improve the experiences of our patients by focusing on basic nursing care and standards of privacy and dignity. Specifically we will undertake:

- *Essence of Care audits of nursing standards twice a year ***
- *Observations of care audits twice a year***
- *Malnutrition Universal Screening Tool (MUST) nutritional audits twice a year*
- *Privacy and Dignity audits twice a year*
- *Patient surveys in real time plus annual national inpatient survey*
- *Twice yearly ward reviews – improved standards will be a mark of success"*

**Please note that there was an error in the version of this plan that was uploaded to the NHS Choices website and that our Chief Nurse has advised that monthly audits of all wards and departments in this detail would be counter-productive, although, in the end, quarterly reviews were implemented. The plan above was the plan that we consulted on and that was approved by the Board during the drafting stage. We apologise for this error and will endeavour to ensure that it does not happen again.

In 2010/11, Observations of Care and Nursing Quality Audits were conducted for the whole trust quarterly. They are led and quality assured by the Nursing Division but the auditors are senior nursing 'peers'. The audits reflect a records audit of a variety of assessments we expect to see, together with observation of actual care given. In an ideal world the records will reflect the care given but doing both a notes audit and observation audit allows for good care to be recognised even if the record keeping is poor and vice versa.

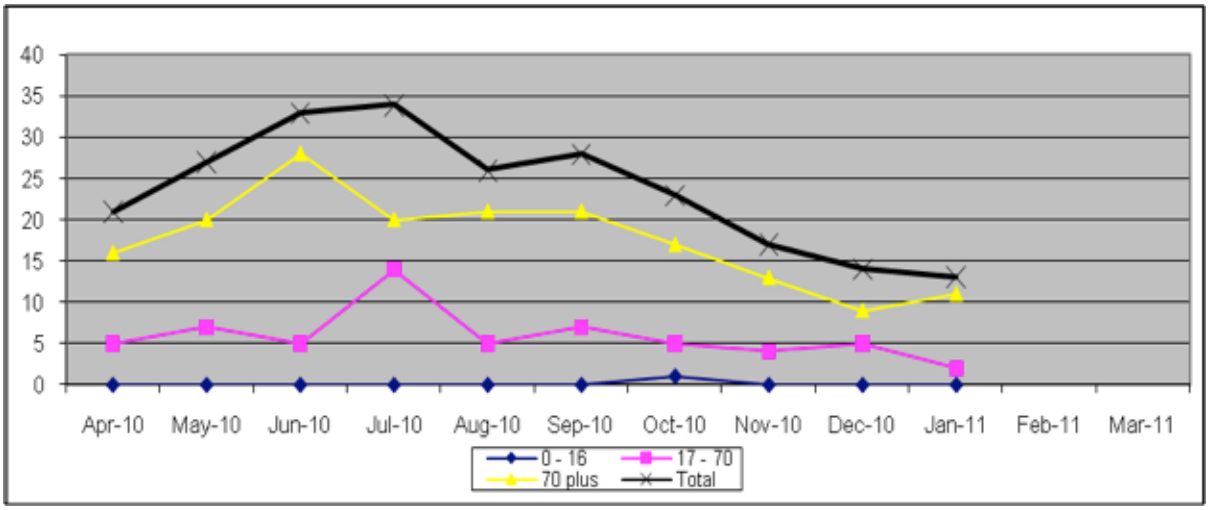
There has been an improvement every quarter for the past two years across all areas. The table below shows the improvement across the first half of 2010/11. Having seen the initial results from our most recent audits, we believe that improvement is continuing. Of note is the change of order of 'best to worst' which demonstrates improvements in areas that we have focused on this year. Nutrition and fluid balance has, to date, been separately audited but from February 2011 has been included.

March 2010 Compliance		
1	Generic	91%
2	Patient ID	89%
3	Uniform	85%
4	Record Keeping	84%
5	Promoting Health & Well Being	70%
6	Environment	55%
7	Oral Hygiene	48%
8	Safety/Falls	43%
9	Manual Handling	40%
10	Pressure Ulcers	39%
11	Pain	37%
12	Bladder & Bowel Care	30%
13	Mental Health	24%
14	Communication	22%

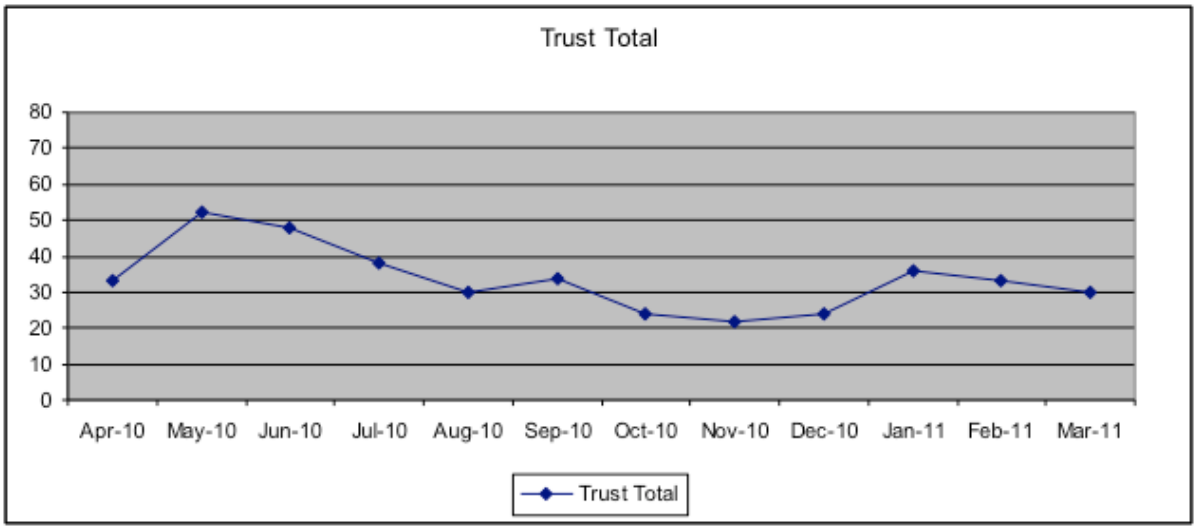
November 2010 Compliance		
1	Generic	94%
2	Uniform	94%
3	Safety/Falls	93.6%
4	Pressure Ulcers	92.5%
5	Patient ID	92%
6	Bladder & Bowel Care	91.7%
7	Oral Hygiene	90.6%
8	Personal Hygiene/Self Care	90.4%
9	Pain	88.9%
10	Manual Handling	88.7%
11	Record Keeping	86.5%
12	Environment	79%
13	Promoting Health & Well Being	78%
14	Mental Health	77%

Further insights into our work on Basic Nursing Care can be found in the Nursing Quality Report to the April 2011 Trust Board. It is clear from the charts below, however, that the attention to basic standards has led to significant improvements in outcomes, particularly in respect of Falls and Pressure Sores. The apparent rise in the first part of these graphs is due to improvement in the numbers of incidents being reported.

Incidence of Falls(by age group) across the trust using Nurse Sensitive Outcome Indicator



Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2010 – February 2011



In the last year the trust achieved a 40% reduction in the incidence of hospital acquired pressure ulcers measured against pressure ulcer incident rates in 2009/ 10. This was the result of campaign to raise awareness and continued training and education in the prevention and management of pressure ulcers.

Given the importance attached to basic nursing care by all of our stakeholders, the Trust Board and our Commissioners were very pleased to note the improvements in performance during 2010/11. This work will continue in 2011/12

Priority 3: Mortality

In our 2009/10 Quality Account we said:

> *"In 2009/10, SWBH implemented an audit system which will ultimately result in a senior medical review of all hospital deaths. The object is for the Trust to receive assurance that all deaths in hospital are reviewed appropriately and that lessons are learned if necessary.*
>
> *In 2010/11, this audit will extend to 80% of deaths by year end.*
>
> *Lessons learned from the reviews are summarised and reported to our Mortality Steering Committee."*

The Medical Director and his team have, in addition to the standard approaches for monitoring mortality used in most hospitals, developed an innovative system that ultimately aims to ensure that all deaths are subjected to senior medical review. The implementation of the system has been slower than expected, largely because it transpired that a complete reorganisation of several departments was needed, together with the integration of bereavement services across all of our hospital sites in order to facilitate the delivery of relevant records to the appropriate specialists. The Trust has made significant investments in staff and technology to facilitate this process. In 2010/11, 27% of deaths were reviewed and the Board was very impressed with the information and understanding that this audit provided.

The new mortality process involves a qualitative overview of each death by a senior doctor who was not directly involved in the patient's care. Each case is examined for errors in care and then categorised as expected or unexpected and preventable or unpreventable. Any significant errors are logged and trigger a more detailed investigation through the Risk System, unless an incident form has already been raised.

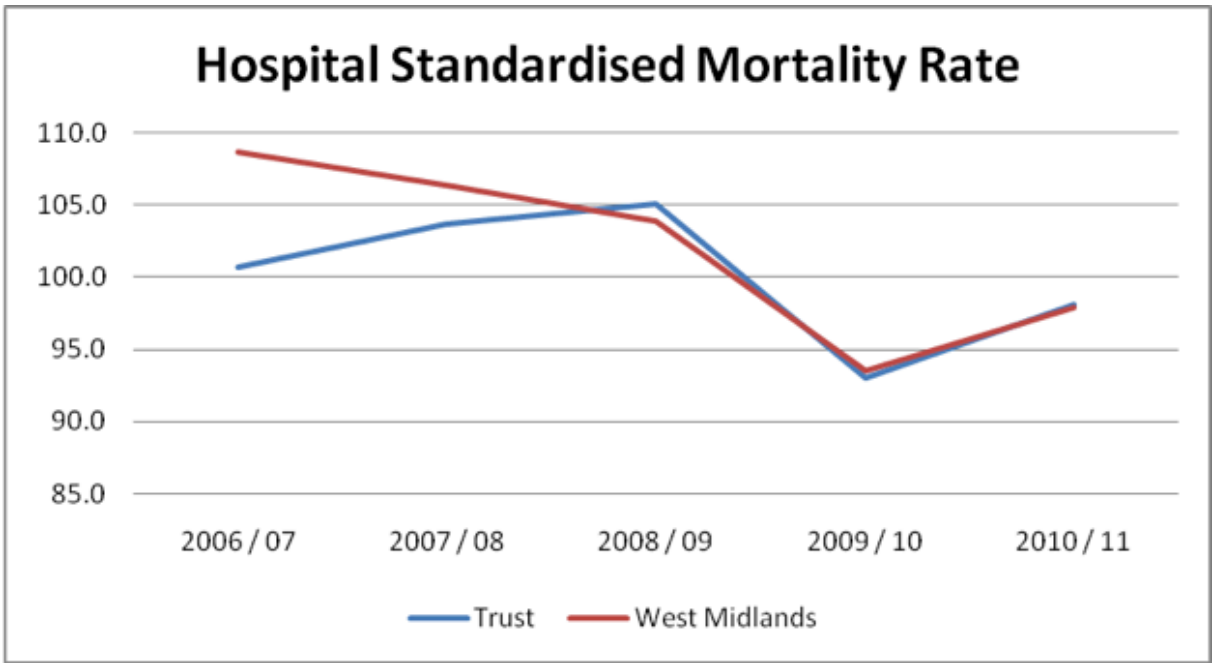
The table below illustrates some of the information that the new system can provide. The detailed findings of the Mortality audit are considered regularly at the Mortality and Quality Alerts Committee, although each Clinical Directorate also reviews its own deaths and data in local mortality or governance meetings.

Categorisation of deaths using Mortality Audit Form (1/12/09 – 30/06/10)

Description	Total
Due to terminal illness	39
Following cardiac or respiratory arrest before arriving at hospital	6
Expected death which occurred despite the health service taking preventive measures	215
Unexpected death which was not reasonably preventable with medical intervention	58
Misdiagnosis (preventable)	1
Delayed diagnosis (preventable)	7
Grand Total	**326**

Out of the 326 deaths examined during 2010/11, 215 were expected and occurred despite staff taking appropriate preventative measures, 39 were due to terminal illness, 58 were unexpected but not reasonably preventable, 6 were due to cardiac or respiratory arrest before arriving at the hospital, and 8 (2%) were thought to have factors which might have been preventable, which required further investigation. In no case did we find that the death could have been avoided completely.

The other key task of the Mortality Committee is to monitor performance in respect of the Hospital Standardised Mortality Rate (HSMR) and to identify any deviations from the expected performance at the specialty level. The chart below demonstrates the performance of this Trust over the last 5 years in comparison with the West Midlands average.



The work in respect of Mortality will continue in 2011/12. Our Commissioning PCT has recognised the importance of continuing to develop the mortality audit and has included this objective in the CQUIN framework for 2011/12.

Priority 4: Implementation of the Quality Management Framework

In our 2009/10 Quality Account we said:

"In 2009/10, we implemented a Clinical Directorate structure. From October 2009 the Medical Director and divisional management teams have held quarterly directorate reviews with the information available at directorate level.

In 2010/11 we intend to formalise our quality system to bring together all that we can do to maintain and improve our quality of care.

Specifically we intend to:

- *Develop a Quality and Governance framework*
- *Establish governance systems and structures at the directorate level*
- *Directorate QMF reviews will be undertaken at least quarterly by all clinical divisions and the information available at directorate level will be increased"*

Throughout 2010/11, the development and implementation of the QMF has continued. The implementation process has been subjected to a detailed audit by CW Audit Services, the Trust's internal auditors. This audit concluded:

In July 2010, Monitor published "Applying for NHS Foundation Trust Status – Guide for Applicants" which sets out their definition of quality governance. Our review has confirmed that the Trust is making adequate progress towards complying with Section 4 of the framework which covers "Measurement of Quality".

The QMF contains indicators that meet the reporting requirements of the Department of Health Operating Framework, the NHS Performance Framework, Monitor Compliance Framework, Commissioning for Quality and Innovation (CQUIN) schemes and local operational needs. We selected those quality measures and indicators highlighted by Monitor, in their publication mentioned above, for detailed testing. Our testing confirmed that the information relating to these was available and was being used in the Trust's current performance monitoring processes, but not all information was available yet through the QMF dashboard. The reasons for this varied but in the majority of cases the Information Team is working with suppliers of various information systems to enable this information to be added to the QMF.

Conclusion
The audit did not highlight any weaknesses that would materially impact on the achievement of the QMF system's key objectives. The audit found that the development of the Framework is progressing according to plan although the dashboard is not yet fully populated nor fully operational. As a result, **significant** assurance can be given on the design and operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives.

The Clinical Directorate review process has evolved and become embedded. Our longstanding quarterly divisional review process has been redeveloped and, from the first quarter of 2011/12 will be integrated with the directorate process using the QMF. These changes will significantly improve the quality of the information that the Board receives about quality and performance in our wards, clinics, diagnostic areas, and operating theatres.

In line with the increasing emphasis on providing high quality care for all, the Trust Board has approved a new five-year Quality and Safety Strategy. This strategy takes account of the external context and its role in driving the Trust's work to continuously improve the quality of services provided.

The strategy encompasses and co-ordinates current practice in one overarching document and sets out the Trust's aims, objectives and priorities for achieving year on year quality improvement. To ensure the delivery and performance management of the quality and safety agenda, existing structures and processes have been strengthened. A new Quality and Safety Committee has been established to enhance Board oversight of quality performance.

The three overarching objectives for the next five years outlined in the Quality and Safety Strategy are:

- To reduce adverse events which result in avoidable harm
- To reduce avoidable mortality and morbidity
- To increase the percentage of patients who would recommend the Trust to family and friends

It is the intention of this Trust to be in the top quartile of all Trusts, particularly in respect of these key objectives, by 2015.

Priority 5: Accident & Emergency Departments

In our 2009/10 Quality Account we said:

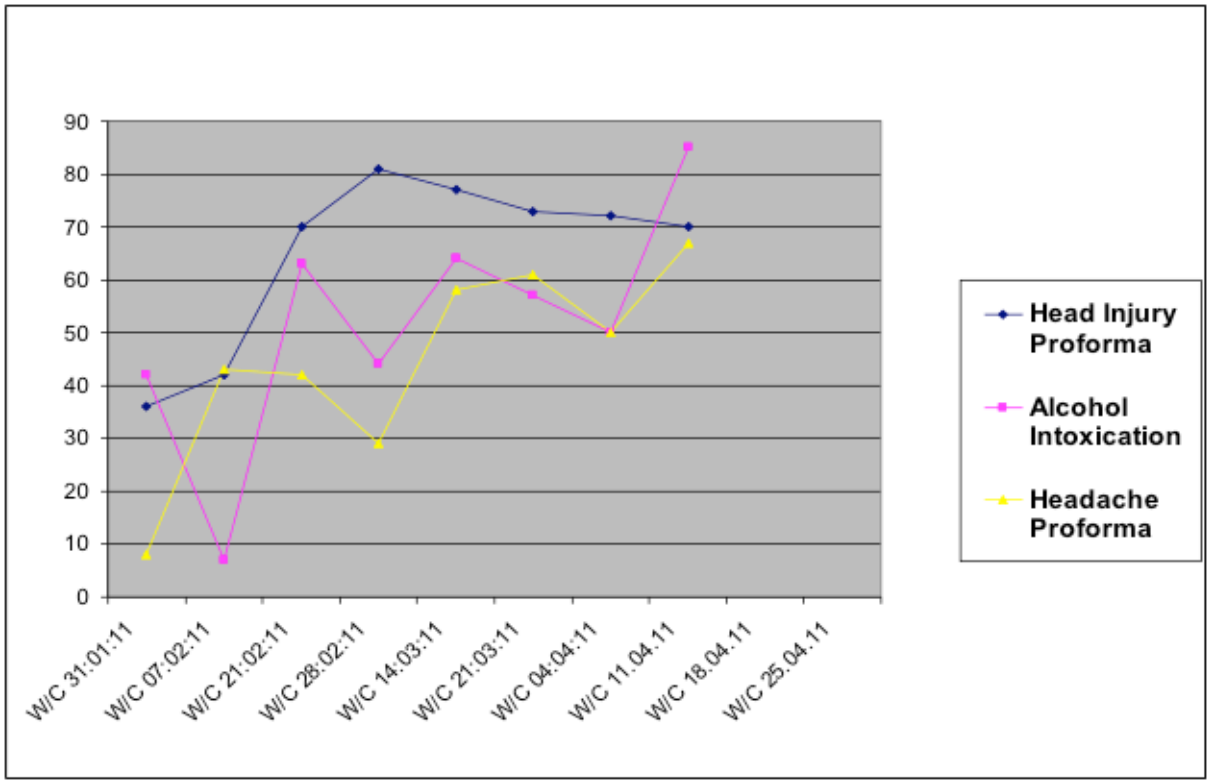
"In 2010/11 we will continue working to improve the quality of service and safety within our Accident & Emergency Departments. Specifically we plan to achieve:

- *Successful integration of both A&Es*
- *Introduction and monitoring of relevant national guidelines and standards*
- *Systematic review and learning from adverse events*
- *Improvement in indices of quality of care and/or patient safety*
- *Maintenance of 4hr targets"*

In 2009/10 we identified the A&E departments at City and Sandwell Hospitals as an area for priority attention. This was following feedback from patients and staff, as well as concerns about incidents and near misses. We were particularly concerned about difficulties in recruiting skilled senior medical and nursing staff, and about over-reliance on locum doctors and other temporary staff. Throughout 2010/11, the Emergency Department Action Team has continued to work with the A&E departments on both sites to secure the above objectives. The separate departments were formally merged into one Directorate in April 2010 and work on integrating the medical, nursing, and managerial teams has progressed steadily since then.

One early concern was the lack of formal systems to ensure that existing clinical policies and protocols were being followed by medical staff and it seemed as if some policies were not comprehensive or clear. A number of policies were rewritten and new systems were put in place to ensure that these policies were embedded. The Directorate has also implemented a regular monthly audit of the whole of one day's activity (more than 300 cases) to test performance against an agreed set of benchmarks. Some of these benchmarks were developed internally in order to track specific policies and protocols. Others are derived from the College of Emergency Medicine Standards.

If performance on a specific measure falls short of the expected standard, then that measure is "chased" with weekly "spot-check audits" until performance improves. These processes serve the dual purpose of maintaining awareness and providing assurance. The results of recent audits are shown on the next page.



The Trust has committed to major investment (£1.1m in 2011/12) in consultants, senior nursing, and other clinical staff, which should reduce the reliance on locum and temporary staff. In the meantime, the Directorate is developing new systems for the induction and supervision of locum staff and has started developing other permanent staff, particularly Physicians Assistants (PAs), as an alternative to doctors.

The Board was assured, following an external peer review led by the West Midlands Quality Review Service (WMQRS), that no immediate risks were identified, although a number of concerns were noted, which are being addressed.

It is evident that the work of the Emergency Department Action Team has made progress, although the focus on the quality of care has not detracted from the objective of minimising four-hour waits, which is a major component of the patient experience. In 2010/11, our performance against the four-hour standard was 97%, which remains amongst the best in the West Midlands and is comfortably above the revised National standard of 95%.

2.1.2 Priorities for Improvement in 2011/12

The Board has elected not to retire any of the quality improvement priorities, but has asked that two of the priorities should be broadened in scope to better respond to the needs and wishes of our stakeholders.

In the 2009/10 accounts, the implementation of the Quality Management Framework was identified as a priority. The work set out in that objective has progressed well and the development of the quality Management Framework is on track. One objective that was specifically identified in last year's plan was the development of a comprehensive service quality strategy. This strategy has now been approved by the Trust Board. The ongoing work on the Quality Management Framework will form part of this strategy. It is therefore intended that our priority for 2011/12 and beyond is the implementation of our Quality and Safety Strategy.

The Trust Board is also satisfied that the work on improving our A&E Services is broadly on track. The Board considers, however, that other services would benefit from a period of particular focus and attention. It is noteworthy, for example, that our Maternity Service, which was an area of concern some years ago, is now one of our best performing services. The plan for 2011/12, therefore, is to broaden the 5th priority to one of Service Improvement. Every year we will select 2 or 3 services that have been identified as having scope for improvement, either because the specialty team wishes to benefit from additional support and attention, or because they are falling short of national or internal standards in respect of performance or quality.

We have added Trauma and Orthopaedics to the list for 2011/12 on the basis that service users are still having to wait too long for diagnosis or treatment and that the directorate team has ambitious plans that will need additional management support and resource. The five priorities for 2011/12 are, therefore, as follows:

1. Stroke
2. Basic Nursing Care
3. Mortality
4. Quality & Safety Strategy
5. Service Improvement
   - Accident & Emergency
   - Trauma & Orthopaedics

The Board has also signalled that, in next year's Quality Account, priority 2 on Basic Nursing Care could be broadened in scope to reflect the multi-disciplinary nature of modern health care. This would address issues identified by stakeholders during 2010/11 and will be subject to more detailed consultation during 2011/12.

Priority 1: Stroke

Plans for 2011/12

We intend to continue the work of the Stroke Action Team and we remain determined to achieve our goal of providing the best possible Stroke Service within 5 years of our first report. Specifically, we intend to:

- Continue to develop and implement our stroke strategy
- Address the concerns identified by the WMQRS review
- Develop options for consideration in respect of acute stroke and rehabilitation
- Improve the discharge arrangements for patients admitted with stroke
- Develop and implement real-time alerts for the management of patients on stroke and TIA pathways
- Develop systems to monitor and respond to the experience of patients receiving treatment under our care

How progress will be monitored, measured and reported

We will continue to develop the Stroke Clinical Dashboard. This instrument, which is part of the QMF, will be monitored continuously by the Stroke Action Team and by the Senior Management Team.

We intend to perform a further self-assessment against the relevant standards in 2011/12 and will report the findings of that audit to the Board. Indicative performance will be reported in the 2011/12 Quality Account.

Priority 2: Basic Nursing Care

Plans for 2011/12

We intend to improve the experience of our patients by continuing to focus on care at ward level with particular attention to reducing the number of harm events. Specifically, we intend to:

- Further reduce the incidence of tissue damage and falls rates
- Reduce medication errors and improve the reporting of errors
- Improve end of life care by facilitating a greater number of patients dying in their preferred place of death
- Improve the nutrition and fluid intake of patients
- Improve the care offered to patients with learning disability, dementia or mental ill health
- Improve the care offered to deteriorating patients

How progress will be monitored, measured and reported

We will continue to monitor standards of basic nursing care at ward level using the audit and observational tools that have been effective in 2010/11. We will also continue to develop audits and surveys to report the following:

- Monthly tissue damage, falls and nutrition audit reports
- Quarterly reporting on medication errors
- Quarterly reports on end of life care - patients dying in their preferred place
- Incidents affecting patients with learning disability, dementia and mental ill health
- Failure to rescue incidents
- Training on vulnerable adults - quarterly training reports
- Intermediate life support training - quarterly training reports
- Monthly patient satisfaction reports

Priority 3: Mortality

Plans for 2011/12

We intend to continue to develop and implement our mortality audit system and to develop a strategy to reduce our mortality rates (HSMR) to the lowest level possible. We also intend to improve our understanding of how we care for patients at the end of life. Specifically, we intend to:

- Exceed a CQUIN target, agreed with our Commissioners, that, by March 2012, 60% of deaths in our care are reviewed and reported by a senior doctor
- Pilot and report on a project to have deaths in our care reviewed and reported by a senior nurse
- Improve our information coding of patients at the end of life in order to provide a better understanding of the performance of our care pathways
- Develop a Clinical Dashboard to support End of Life care

How progress will be monitored, measured and reported

We will continue to monitor the development and output of the mortality review process through the Mortality and Quality Alerts Committee, whilst refining and improving our understanding of our HSMR at every level. Trust performance in respect of mortality will be reported monthly through the QMF dashboard. A detailed report on mortality will be presented to the Board in 2011/12 and relevant measures of performance will be reported in the 2011/12 Quality Account.

Priority 4: Quality & Safety Strategy

Plans for 2011/12

We intend to enhance Board oversight of quality performance and to ensure that all of our staff are working to deliver our three overarching priorities in the domains of Patient Safety, Clinical Effectiveness and Patient Experience. Specifically, we intend to:

- Establish a new Quality and Safety Committee to enhance Board oversight of quality performance

- Continue the development and implementation of the QMF
- Develop and implement systems to ensure that standards of clinical care at the specialty level are consistently high and regularly audited and monitored through the QMF
- Improve the rates of incident reporting across the Trust
- Develop and implement a strategy to increase the percentage of patients who would recommend the Trust to family and friends

How progress will be monitored, measured and reported

The Board has formally delegated responsibility for seeking assurance that there are effective arrangements for monitoring and continually improving the quality of health care provided to the newly established Quality and Safety Committee and there will be an annual report presented to the Board. The implementation of the Quality and Safety Strategy and the performance of the QMF will be audited by the Trust's Internal Audit services and the results of that will be communicated to the Board. Rates of incident reporting (all grades) and regular patient survey findings will be monitored at specialty level, and relevant measures of performance will be reported in the 2011/12 Quality Account.

Priority 5: Service Improvement

Accident & Emergency

Plans for 2011/12

In 2011/12 we will continue our work to improve the quality of service and safety within our Accident & Emergency Departments. Specifically, we intend to:

- Complete the current work to increase the number of Senior Doctors and Nurses in both departments
- Continue to develop and monitor systems to ensure that clinical care is of a consistently high standard
- Support the production of an Integrated Development Plan for our Emergency Departments
- Improve the Information Technology systems to support the development of automated clinical dashboards

- Continue to meet national standards in respect of 4 hour waits as well as the other new national standards for A&E.

How progress will be monitored, measured and reported

The work of the Emergency Department Action Team will be led by the Chief Executive and performance will continue to be monitored by the Board. Relevant metrics will continue to be monitored using our performance management systems and relevant measures will be reported in the 2011/12 Quality Account. These will include the new national standards for Emergency Department performance.

Trauma & Orthopaedics

Plans for 2011/12

In 2011/12 we will develop a strategy to improve the quality of service and performance of our Trauma & Orthopaedic Directorate. Specifically, we intend to:

- Analyse and understand the current position in respect of quality and safety, user experience, operational standards & targets, and use of resources
- Ask for support from the WMQRS in developing a set of Quality Standards for the service.
- Produce a strategy that will ensure that the service meets those standards
- Work with other organisations, particularly University Hospital Birmingham, to ensure the successful development of Trauma Networks

How progress will be monitored, measured and reported

An Orthopaedic Taskforce has been established under the leadership of the Chief Operating Officer and the activities of this group will be reported to the Quality & Safety Committee. Performance and quality will continue to be monitored using our performance management systems, particularly the QMF, and relevant measures will be reported in the 2011/12 Quality Account.

2.2 Statements of Assurance

2.2.1 Review of Services

During the period 2010-11 the Sandwell and West Birmingham Hospitals NHS Trust provided and/or subcontracted 46 NHS services. The Sandwell and West Birmingham Hospitals NHS Trust has reviewed all the data available to them on the quality of the care in 46 of these services.

The income generated by the NHS services reviewed in 2010-11 represents 100% per cent of the total income generated from the provision of NHS services by the Sandwell and West Birmingham Hospitals NHS Trust for 2010-11.

2.2.2 Participation in clinical audits

During 2010-11, 40 national clinical audits and 2 national confidential enquiries covered NHS services that Sandwell and West Birmingham Hospitals NHS Trust provides.

During that period Sandwell and West Birmingham Hospitals NHS Trust participated in 82% of national clinical audits and 100% of national confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham Hospitals NHS Trust was eligible to participate in during 2010-11 are as follows:

National Audits	Participated Yes/No
Peri – and neonatal	
Perinatal mortality (CEMACH)	Yes
Neonatal intensive and special care (NNAP)	Yes
Children	
Paediatric pneumonia (British Thoracic Society)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Paediatric fever (College of Emergency Medicine)	No
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	See below[1]

Diabetes (RCPH National Paediatric Diabetes Audit)	See below[2]
Acute care	
Emergency use of oxygen (British Thoracic Society)	Yes
Adult community acquired pneumonia (British Thoracic Society)	No
Non–invasive ventilation (NIV) – adults(British Thoracic Society)	No
Pleural procedures (British Thoracic Society)	No
Cardiac arrest (National Cardiac Arrest Audit)	No
Vital signs in majors (College of Emergency Medicine)	Yes
Adult critical care (Case Mix Programme)	Yes
Potential donor audit (NHS Blood & Transplant)	Yes
Long term conditions	
Diabetes (National Diabetes Audit)	Yes
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes
Chronic pain (National Pain Audit)	See below[3]
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes
Parkinson's disease (National Parkinson's Audit)	Yes
COPD (British Thoracic Society / European Audit)	Yes
Adult asthma (British Thoracic Society)	Yes
Bronchiectasis (British Thoracic Society)	No
Elective procedures	
Hip, knee and ankle replacements (National Joint Registry)	Yes
Elective Surgery (National PROMs Programme)	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes
Carotid interventions (Carotid Intervention Audit)	Yes
Cardiovascular Disease	
Familial Hypercholesterolemia (National Clinical Audit of Mgt of FH)	Yes
Acute Myocardial Infarction & other ACS (MINAP)	Yes
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes
Heart Failure (Heart Failure Audit)	Yes
Cardiac Rhythm Management Audit	Yes

Acute stroke (SINAP)	Yes
Stroke care (National Sentinel Stroke Audit)	Yes
Renal disease	
Renal colic (College of Emergency Medicine)	Yes
Cancer	
Lung cancer (National Lung Cancer Audit)	Yes
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes
Head & neck cancer (DAHNO)	Yes
Trauma	
Hip fracture (National Hip Fracture Database)	Yes
Severe trauma (Trauma Audit & Research Network)	No
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes
Blood transfusion	
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes
Platelet use (National Comparative Audit of Blood Transfusion)	Yes
National Confidential Enquiries	
Centre for Maternal and Child Enquiries (CMACE) • National maternal and perinatal mortality surveillance • Maternal death enquiry (ongoing) • Head injury in children (ongoing)	Yes
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) • The Trust participated in the following studies in 2010/11 - Surgery in Children - Peri-operative Care Study - Cardiac Arrest Procedures (Ongoing)	Yes

Explanatory Notes

1	Although the Trust has registered to participate, national data collection was not commenced in 2010/11.
2	The Trust has expressed an interest to participate in the audit, but national data collection was not commenced in 2010/11.
3	Although the Trust has registered to participate, there was no national data collection in 2010/11.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham Hospitals NHS Trust participated in and for which data collection was completed during 2010-11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Percentage of eligible cases submitted
Peri – and neonatal	
Perinatal mortality (CEMACH)	100%
Neonatal intensive and special Care (NNAP)	100%
Children	
Paediatric pneumonia (British Thoracic Society)	96%
Paediatric asthma (British Thoracic Society)	100%
Acute care	
Emergency use of oxygen (British Thoracic Society)	100%
Vital signs in majors (College of Emergency Medicine)	100%
Adult critical care (Case Mix Programme)	100%
Potential donor audit (NHS Blood & Transplant)	100%
Long term conditions	
Diabetes (National Diabetes Audit)	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	74%
Ulcerative colitis & Crohn's disease (National IBD Audit)	100%
Parkinson's disease (National Parkinson's Audit)	100%

COPD (British Thoracic Society / European Audit)	100%
Adult asthma (British Thoracic Society)	100%
Elective procedures	
Hip, knee and ankle replacements (National Joint Registry)	92%
Elective Surgery (National PROMs Programme)	66%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	83%
Carotid interventions (Carotid Intervention Audit)	100%
Cardiovascular Disease	
Familial Hypercholesterolemia (National Clinical Audit of Mgt of FH)	100%
Acute Myocardial Infarction & other ACS (MINAP)	100%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	100%
Heart Failure (Heart Failure Audit)	100%
Cardiac Rhythm Management Audit	100%
Acute stroke (SINAP)	13%
Stroke care (National Sentinel Stroke Audit)	100%
Renal disease	
Renal colic (College of Emergency Medicine)	100%
Cancer	
Lung cancer (National Lung Cancer Audit)	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	100%
Head & neck cancer (DAHNO)	100%
Trauma	
Hip fracture (National Hip Fracture Database)	100%
Falls and non-hip fractures (National Falls & Bone Health Audit)	100%
Blood transfusion	
O neg blood use (National Comparative Audit of Blood Transfusion)	50%
Platelet use (National Comparative Audit of Blood Transfusion)	100%

National Confidential Enquiries	
Centre for Maternal and Child Enquiries (CMACE)	
• Maternal and perinatal mortality surveillance	100%
• Head injury in children (ongoing)	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	
• The Trust participated in the following studies in 2010/11 - Surgery in Children - Peri-operative Care Study - Cardiac Arrest Procedures (Ongoing)	100% 100%

The reports of 5 national clinical audits were reviewed by the provider in 2010-11 and Sandwell and West Birmingham Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Report	Actions
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England <u>Audit description</u> All patients aged 12 or over undergoing elective hip or knee replacement, hernia repair and varicose vein procedures are invited to participate in PROMs and those who consent are invited to complete questionnaire pre and post surgery regarding their health status.	To increase SWBH completion rates for pre-operative PROMs questionnaires through:- • Taking steps to improve the recording of the reasons for non participation by patients in PROMs by clinical teams. • To ensure that compliance data continues to be incorporated in the Quality Management Framework dashboards of the relevant Clinical Directorates, and discussed monthly by clinical teams.
NCEPOD: A Mixed Bag -An enquiry into the care of hospital patients receiving parenteral nutrition (PN) <u>Audit description</u> The NCEPOD report aimed to examine the process of care of patients	• To review local arrangements to ensure compliance with the requirement that all hospitals should have policies on initiating PN to avoid inappropriate use and safe prescribing.

Report	Actions
receiving parenteral nutrition (PN) in hospital in order to identify remediable factors in the care received by these patients.	• To review the local PN Proforma to ensure that it includes the requirements set out in the report i.e. Indication for PN; Treatment goal; Risk of and precautions taken against re-feeding syndrome; PN prescription; Weight and Biochemical monitoring.
Perinatal Mortality 2008. (CMACE) Audit description CMACE collects epidemiological and clinical data on all stillbirths and neonatal deaths in England, Wales, Northern Ireland, The Crown Dependencies of the Channel Islands and the Isle of Man.	No specific actions required as there are systems in place both locally and regionally to ensure that perinatal mortality is monitored and appropriately investigated.
National Hip Fracture Database: Annual Report 2010 Audit description The NHFD is a joint venture of the British Geriatrics Society and the British Orthopaedic Association, and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care.	• To take steps to increase the submission of cases to the NHFD by the SCPs helping to ensure hip fracture forms are completed for all patients by liaising with on call consultant to ensure identification of all relevant hip fracture patients • To implement a shared protocol to ensure that all patients with Hip fracture are reviewed by a geriatrician review for within 72 hours of admission. This to include the requirement that all eligible hip fracture patients to be prescribed bone protection medication

Report	Actions
National Dementia Audit 2010 Audit description An audit to assess the care of patients with dementia in general hospitals	The actions required have been incorporated into a comprehensive action plan developed to address the recommendations contained in the National Dementia Strategy, NICE Dementia Standards and the National Dementia Audit 2010. Some of the actions required include:- • Training of staff on Dementia Awareness. This to include the development of information packs and poster for ward areas • To work to ensure that appropriate information is available, signposting to services and timely discharge planning is undertaken. • To audit delays in transfer in care and readmission rates of patients with dementia need to be undertaken to monitor the provision of services.

The reports of 13 local clinical audits were reviewed by the provider in 2010-11 and Sandwell and West Birmingham Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Audit topic	Actions identified
Healthcare Records Audit Audit description To examine the content and quality of information that is documented by clinicians in the healthcare record and to measure compliance with the Trust's quality standards.	• To take steps to improve the physical quality of records through continued introduction of a more robust folder • To continue to intercept records in the poorest physical condition and replace with the new type of record • To circulate information on the key aspects of good practice to all

Audit topic	Actions identified
	staff handling or using healthcare records, sent on behalf of the Healthcare Records Steering Committee • To continue to develop the systems to support the ongoing monitoring of compliance with the basics of record keeping through the Trusts Quality Management Framework (QMF)
Consent Audit Audit description To measure compliance with the Trust's own policy with reference to Consent and with the NHS Litigation Authority's requirements that relate to the process of taking consent	• Where consent has been provided prior to admission, confirmation of consent needs to be checked prior to surgery. Divisional directors and matrons to reinforce this requirement to their teams. • Patients need to be offered a copy of their consent form. Practitioners undertaking consent need to actively ask patients if they would like their copy and document the patient's response. • The provision of patient information leaflets prior to surgery needs to be improved and leaflets provided documented on the consent form. Coordinated communications around the types of information available on the EIDO system to be undertaken. • Divisional directors to undertake an organisational gap analysis of the reasons for taking consent on the day of admission and to develop a plan to reduce the number of "on the day" consents taken.

Audit topic	Actions identified
National Joint Registry Compliance Report Audit description To monitor compliance with the following requirements:- **Compliance** – the percentage of records submitted to the NJR compared with the total number of hip and knee replacement operations carried out in England and Wales, also referred to as 'case ascertainment' – ***target 95%*** **Consent** – the percentage of records submitted to the NJR with consent given by patients for use of their personal information – ***target 90%***	• NJR consent to be added to the new theatre checklist document. • To place posters in Theatres prompting completion of the relevant documentation • To provide regular monitoring data to T&O consultants indicating their compliance with the requirements.
End of life care audit Audit description The aim of the review was to provide data with regards to aspects of 'end of life' care within the Sandwell and West Birmingham Hospitals NHS Trust (SWBH).	• To review the actions that could be taken to reduce inappropriate admissions for cancer and non-cancer patients, with a particular focus on admissions from care homes. • To examine the steps that can be taken to reduce the length of hospital stay, if acute setting not appropriate. • To enhance the 'end of life' care in the hospital setting for cancer and non cancer patients, including through the use of the SCP and training to improve skills.

Audit topic	Actions identified
Essence of Care Audits & Observation of Care audits <u>Audit description</u> A biannual audit of records and a practical observation of care on the wards. The audit covers 7 categories: • Respect and dignity • Eating and drinking • Bladder and bowel care • Safety • Self Care (hygiene, mouth care, mobility) • Pressure ulcers • Environment and staff	All wards and divisions are presented with individual performance data and action plans are developed to address specific areas of poor performance against the standards being measured. Audit results are fed into ward reviews and discussed with ward staff as a feedback session. A number of trust wide actions have been identified:- • To provide training to staff in aspects of self harm and managing challenging behaviour • To develop and implement a tool to enhance the communications between healthcare professionals
Hand hygiene audits <u>Audit description</u> As part of Trust's ongoing initiatives for the reduction and prevention of healthcare associated infections. All clinical areas are required to undertake hand hygiene audits.	Any ward /department whose score falls below 95% are required to undertake the audit weekly until 95% compliance has been achieved.
Mortality audits <u>Audit description</u> • Audits of specific diagnostic groups to determine whether any quality of care issues are present • Audits conducted by specialties to review deaths that occur under their care	Some actions identified from the audit of mortality in specific diagnostic groups have required:- • Development of local guidance to assist in the management of patient groups • Further audit to understand aspects of care in more detail

Audit topic	Actions identified
• Reviews of data collected under the Initial Medical Review System to determine whether there are any lessons that can be learnt.	• Review of coding practice to ensure that the most accurate information about a patient's diagnosis is recorded. Actions required to enhance the system for the initial medical review of deaths include:- • Developing existing infrastructure to create a Bereavement Team coupled with modern scanning facilities for collection, collating and scanning of deceased patient's case notes, Coroner's PM report and Coroner's final determination. • To produce an updated information pack to assist/inform clinicians conducting reviews
Saving lives Audits Audit description The Trust has implemented the revised Saving Lives High Impact Interventions (HII's) audit tools since 01.04.04. To enable the wards, departments and the Trust to monitor compliance against the HII's the Trust has developed a database to facilitate the inputting, collating and reporting of data.	• Any clinical areas where clinical practice/interventions outlined in the audit are undertaken are required to complete the audit by the end of the first week of each month. If compliance scores achieved are below 95% there is a requirement for audits to be completed weekly until compliance above 95% is achieved.
Emergency department audits Audit description A series of specific audits covering the use of proformas to be used with patients presenting with a head Injury or alcohol intoxication and the use of a stamp for patients presenting with a headache.	Some specific actions arising from these audits have included:- • To develop a specific Proforma for use with patients presenting with a headache to replace the stamp • To ensure that the use of the proforma and stamp is included the induction of locum doctors to the Emergency Department.

Audit topic	Actions identified
West Midlands Regional Audit of Paediatric/ Neonatal Transfusion Practice	• To update local documentation to ensure that the indications and benefits for each transfusion are recorded • To update local guidelines regarding the threshold Haemoglobin combined with clinical features.
Patient falls Audit description To assess compliance with risk assessment requirements and fall prevention strategies.	Actions have been focused on: • Falls awareness training in high and very low reporting areas • Inclusion of falls awareness on the Staff Nurse Development Programme and Student Nurse Clinical Training Programme • Purchase of equipment and training around its use • Effective use of the care planning process • In-depth reviews of patient notes following a fall where a fracture is sustained • Support of the areas where high risk patients are admitted • Targeted audits of high risk areas
Pressure sores Audit description To establish the incidence and severity of pressure sore damage	Actions have been focused on: • the provision of ward based training covering in particular the importance of reassessment, including post operatively • use of repositioning charts and reducing reliance on special mattresses • Removal of anti embolic stockings regularly to check skin integrity

Audit topic	Actions identified
	• Purchasing of additional equipment – mattresses, heel troughs and muffs • Enhancing patient involvement and care – encouraging compliance • Conducting targeted audits to further improve compliance
Nutrition Care Audits <u>Audit description</u> A combination of audits assessing the key clinical priorities and national standards	Actions identified through these audits include: • Increased training initiatives particularly regarding MUST (Malnutrition Universal Screening Tool). MUST is a validated 5 step screening tool to identify adults who are malnourished or at risk of malnutrition or obesity • Ensuring that nutrition and fluid balance status routinely forms part of the handover process and is acknowledged on the bed plan. • Requiring adherence to protected meal times where all non-urgent activity ceases allowing patients to eat without interruption and receive assistance when required

2.2.3 Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by Sandwell and West Birmingham Hospitals NHS Trust in 2010-11 that were recruited during that period to participate in research approved by a research ethics committee was 980 for National Institute for Health Research (NIHR) Portfolio studies and approximately 600 for non-NIHR Portfolio studies.

Sandwell & West Birmingham Hospitals NHS Trust was involved in conducting over 200 clinical research studies during the 2010/11 period. Sandwell & West Birmingham Hospitals NHS Trust used national systems to manage the studies in proportion to risk. Of the 92 studies given permission to start, 82% were given permission by an authorised person less than 30 days from receipt of a valid complete application. 76% of the studies were established and managed under national model agreements and 100% of the 7 eligible studies involved used a Research Passport. During 2010/11 the NIHR supported 61 of these studies through its research networks.

2.2.4 Goals agreed with commissioners

Use of CQUIN payment framework

A proportion of Sandwell and West Birmingham Hospitals NHS Trust's income generated from 2010-11 was conditional on achieving quality improvement and innovation goals agreed between Sandwell and West Birmingham Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Payment Framework.

Further details of the agreed goals for 2010-11 and for the following 12 month period are available electronically at *http://www.swbh.nhs.uk/trust-board* and are also included in part 3 of this Quality Account.

The amount of SWBH's income in 2010/11 that was conditional upon achieving quality improvement and innovation goals was £4.445m and the Trust received £4.445m in payment.

2.2.5 What others say about us

Statements from the CQC

Sandwell and West Birmingham Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is without conditions.

The Care Quality Commission has not taken enforcement action against Sandwell and West Birmingham Hospitals NHS Trust during the period 2010-11.

2.2.6 Data quality

Statement on relevance of Data Quality and our actions to improve our Data Quality

Sandwell and West Birmingham Hospitals NHS Trust will be taking the following actions to improve data quality:

- Our data quality metrics and achievements fully support the veracity of our other statements on quality
- We provide reports showing compliance with National, Regional & Local indicators and CQUIN targets
- Our actions in 2011/12 will include:
  - The inclusion of data quality reports on the QMF
  - Feedback to Clinical Directorates in respect of coding accuracy and the accuracy of information supplied locally to the PAS
  - Continuing work to ensure the removal of any duplicated patient registrations

NHS Number and General Medical Practice Code Validity

Sandwell and West Birmingham Hospitals NHS Trust submitted records during 2010-11 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 98.5% for admitted patient care;
- 99.3% for outpatient care; and
- 95.8% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

We measure our data quality performance against regional and national performance. A report is generated every two months and submitted to the Information Governance Steering Committee. This, in turn, is sent to the Governance Board.

Information Governance Toolkit attainment levels

Sandwell and West Birmingham Hospitals NHS Trust Information Governance Assessment Report overall score for 2010-2011 was 81% and was graded GREEN.

Clinical coding error rate

Sandwell and West Birmingham Hospitals NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnosis Incorrect 7.0%
- Secondary Diagnosis Incorrect 4.7%
- Primary Procedure Incorrect 3.1%
- Secondary Procedure Incorrect 7.4%

This performance is in line with other acute trusts. According to the Audit Commission's June 2010 report to Sandwell PCT on our Admitted Patient Care Clinical Coding, "The Trust is performing excellently compared to the overall performance of trusts in 2008/09. The overall coding error rate of 5.3 per cent was better than the 2008/09 national average of 12.8 per cent.

Part 3: Review of Quality Performance 2010/11

This part of the 2010/11 Quality Account is intended to provide additional evidence of our performance in respect of the quality of our services and the care delivered to our patients during the last 12 months. Most of the data presented here is available in other reports and documents, particularly those presented at our Trust Board throughout the year. The detail behind many of the figures has been scrutinised by our commissioners and other stakeholders and the most critical indicators are discussed with our commissioners during monthly Quality Review Meetings, which also explore specific issues or concerns arising throughout the year.

3.1 CQUIN

Having successfully achieved all six of the Commissioning for Quality and Innovation (CQUIN) targets agreed with our commissioners in 2009/10, the Trust agreed 14 CQUIN goals with our commissioners, including three specific objectives with specialised commissioners. The 2010/11 goals are listed below:

- *We will deliver VTE assessments to at least 90% of adult inpatients including specialised services patients.*
- *We will increase the numbers of mothers breastfeeding when leaving hospital after giving birth.*
- *We will reduce pressure sores acquired as inpatients.*
- *We will reduce the incidence of falls in hospital leading to fracture.*
- *We will ensure at least 90% of stroke patients have brain imaging within 24 hours of admission.*
- *We will increase the proportion of patients receiving surgery for hip fracture within one day of admission.*
- *We will refer outpatients identified as smokers in selected clinics to receive cessation advice.*
- *We will implement standards for safer prescribing of Warfarin.*
- *We will improve our performance in respect of patient experience in the national patient survey.*
- *We will commence the implementation of the "Think Glucose"*

programme for unidentified diabetics across our inpatient wards.

- *We will produce a 2009/10 annual report for specialised services.*
- *We will increase the proportion of parents able to discuss the neo-natal care of their baby with a senior clinician within 24 hours of admission.*
- *We will increase the proportion of babies offered breast milk during their neo-natal stay*
- *We will implement home delivery schemes for herceptin related chemotherapy.*

The table below is derived from the 2010/11 year end Corporate Performance Report (Trust Board Papers April 2011) and demonstrates the year end position for all 17 CQUIN targets. This is more than the original number agreed, because two of the goals (Pressure sores and Reduction in falls) had more than one component.

NATIONAL AND LOCAL PRIORITY INDICATORS		To Date (*=most recent month)
CQUIN	VTE Risk Assessment (Adult IP)	**90.88% (Q4)**
	Breast Feeding (At D'charge from M'wife)	**81.8% (Q4)**
	Tissue Viability - assessment <12hrs	**92% (Q3)**
	Tissue Viability - HospAcq'd Grade 2/3/4	**-40.4%**
	Tissue Viability - TTR of Grade 3/4	**100.0%**
	Inpatient Falls Assessment	**93.6%***
	Inpatient Falls reduction	**-17.9%**
	Inpatient Falls - TTR of all Fractures	**100.0%**
	Brain Imaging for Em. Stroke Admissions	**90.4% (Q4)**
	Hip Fracture Op's <24 hours of admission	**64.7% (Q4)**
	Smoking - Brief Intervention in OP	**2041**
	Safer Prescribing of Warfarin	**70.2% (M12)**
	Patient Experience	**67.3**
	Think Glucose	
CQUIN (Specialised Commissioners)	Parent's consultation with senior clinician	**81 (Q3 & Q4)**
	Neonates Offered Breast Milk	**93 (Q3 & Q4)**
	Herceptin Home Delivery	**65%***

It will be seen that, of the seventeen quality goals, we achieved the agreed objective in all but one case. The achievements in respect of Pressure Sores (Tissue Viability) and Inpatient Falls have been explained in Section 2 of this report, because they are important indicators of the quality of basic nursing care, which was a priority area for improvement in 2010/11. Similarly, brain imaging for Stroke has also been explained in the section dealing with that improvement priority.

Other CQUIN performance is explained more fully below.

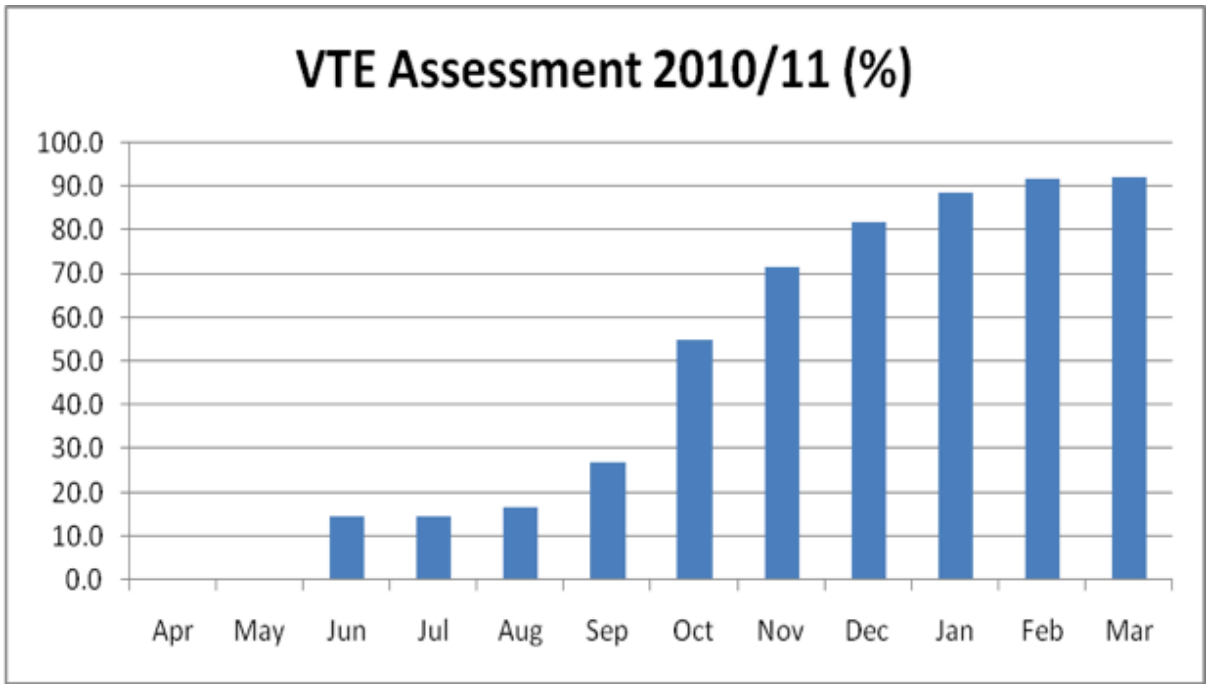
3.1.1 VTE

- *We will deliver VTE assessments to at least 90% of adult inpatients including specialised services patients.*

Venous thrombo-embolism (VTE) is the term used to describe deep vein thrombosis (clots in the leg) and pulmonary embolism (where clots can break off and block the lung). This has long been recognised as a major problem that can affect patients whose mobility is impaired either by illness or following certain types of surgery. Doctors have, for many decades, included an estimate of the risk of developing deep vein thrombosis in certain patients and provided preventive treatment where the risk was deemed to be high.

In recent years, a committee of the House of Commons assembled and reviewed all of the relevant scientific evidence and concluded that all patients should undergo a structured risk assessment and that prophylactic treatment would be based on that risk assessment. This decision translated into a nationally mandated CQUIN target for 2010/11 that required every Trust to achieve VTE assessment rates of 90% in admitted patients. For many Trusts, including SWBH, the approach taken was to introduce computerised risk assessment forms in order to ensure that the risk assessment was documented for as many patients as possible and that the Trust could be assured that every ward, team, and directorate was working to deliver this objective.

The challenge for this Trust was that an entirely new system had to be developed and communicated to more than 700 doctors and that our computer systems had to be adapted to monitor and track the status of more than 100,000 admissions per year.



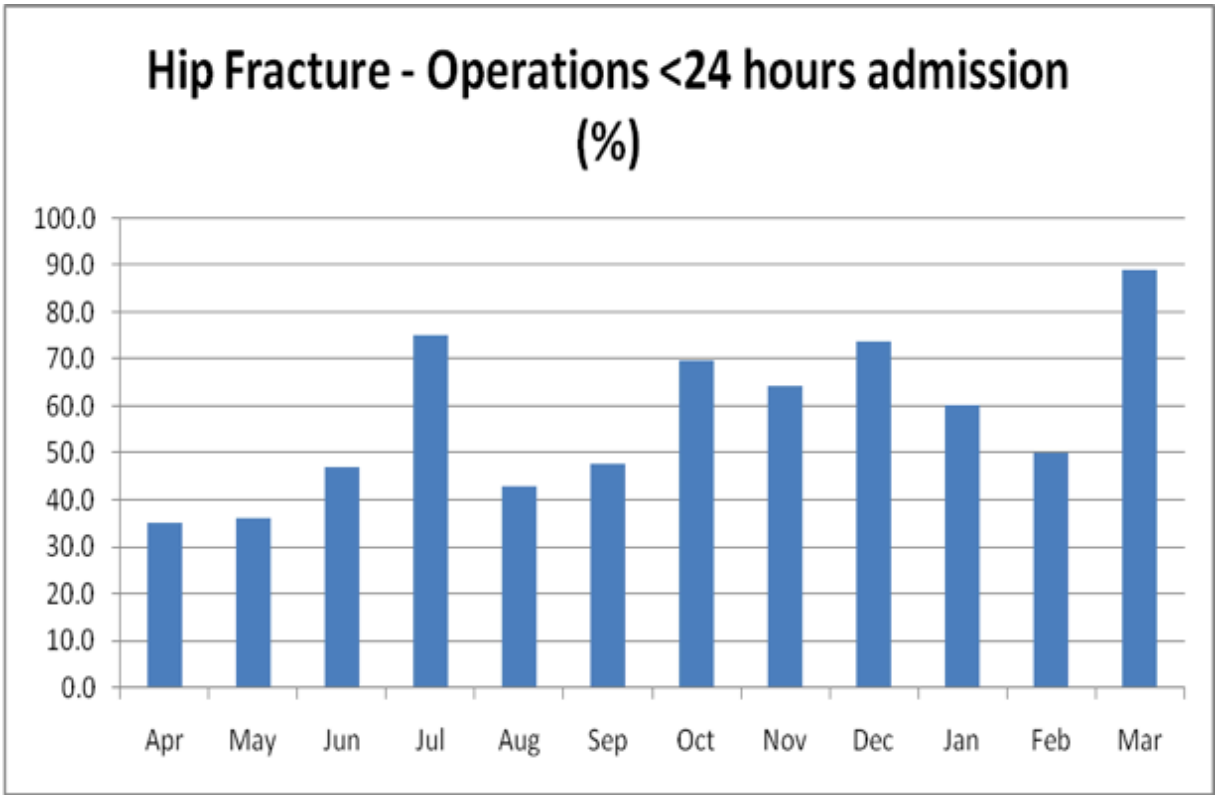
The chart above demonstrates the improvement trajectory following the introduction of the new system in June 2010. The Trust Board was very pleased to note the achievement of the 90% objective across the whole of the fourth quarter of 2010/11. A small proportion of patients are still slipping through the net, although these are largely very short stay admissions, often waiting for investigations or test results and usually discharged from hospital within a matter of hours. Work will continue in 2011/12 to further improve and refine this system.

3.1.2 Hip Fracture

- *We will increase the proportion of patients receiving surgery for hip fracture within one day of admission.*

The one CQUIN target in which we did not fully achieve our goal was in respect of undertaking hip fracture surgery within 24 hours of admission. There is a balance to be struck between operating quickly and ensuring that every patient is optimally prepared for surgery. The consensus is that earlier surgery is associated with improved outcomes and a less complicated recovery period, although many of our fracture patients are quite frail and need a lot of work before the operation to ensure that they are as fit for surgery as possible. There can also be times of peak demand for surgery when we have not had enough capacity available, especially over the winter.

The Board did note that the target we agreed was more ambitious than the national standards, that we have demonstrated a 10% improvement over the 2009/10 figures and that the figure for March was close to 90%.

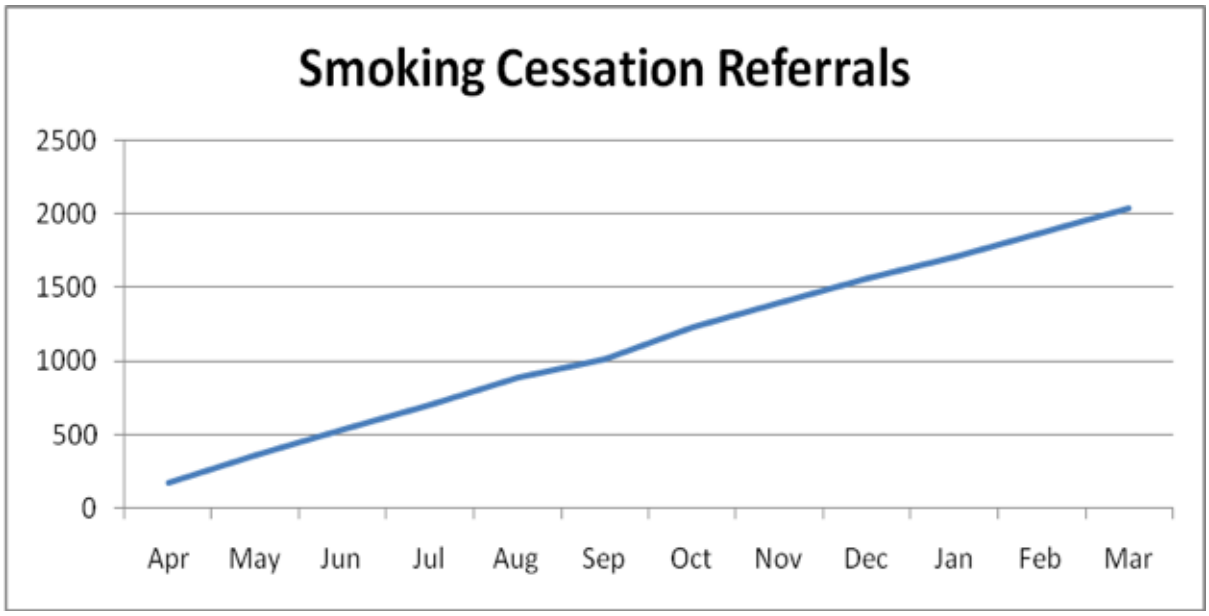


The chart above demonstrates our performance throughout the year and does show a rising trend, although performance during some months was disappointing. The Division of Surgery is working hard to understand the variations in performance, particularly during the winter, and intends to continue working to improve performance in 2011/12. Time to hip fracture surgery is not planned as a CQUIN target in 2011/12 but performance will continue to be monitored as part of the service improvement work with trauma and orthopaedics, which has been identified as a quality improvement priority for 2011/12.

3.1.3 Smoking Cessation

- *We will refer outpatients identified as smokers in selected clinics to receive cessation advice*

The Trust has done much work in the last two years in the area of healthy lifestyles. We were one of the first trusts to agree a CQUIN target with commissioners in respect of smoking referrals in 2009/10. That target was achieved. In 2010/11, we agreed to almost double the number of referrals to smoking cessation services. This target was also achieved. The cumulative monthly performance is shown in the next chart.

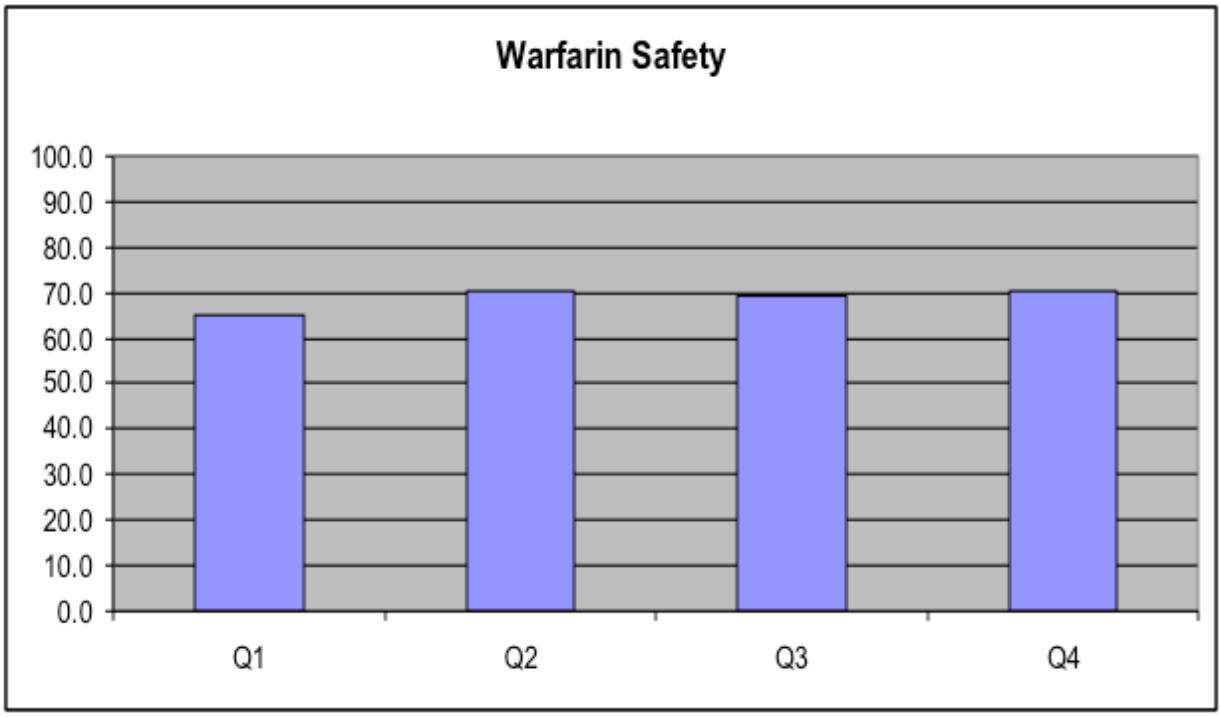


We intend to continue with our focus on healthy lifestyles during 2011/12 with a particular emphasis on alcohol and smoking. We will report progress in both of these areas in next year's Quality Account.

3.1.4 Warfarin Safety

- *We will implement standards for safer prescribing of Warfarin.*

Warfarin is a blood-thinning drug that is used for a variety of conditions including pulmonary embolism, deep vein thrombosis, and some cases of atrial fibrillation (irregular heart-beat). It is, however, a drug with significant side-effects and needs to be carefully prescribed and carefully monitored. The drug dose is calculated to ensure that the risk of bleeding is not too high, whilst ensuring that the blood is thin enough to reduce clotting risk. The test used is called the International Normalised Ratio (INR) and the results of this test have to be kept within defined limits for as much of the time under treatment as possible. Our target in 2010/11 was to ensure that more than 65% of patients were kept within the target range.



The chart above shows the result of audits conducted during each of the 4 Quarters in 2010/11 (May, September, December and March) and is expressed as a percentage of tests conducted during each of the Audits.

3.1.5 Patient Survey

- *We will improve our performance in respect of patient experience in the national patient survey.*

The National Patient Survey is conducted on behalf of the Care Quality Commission (CQC) and is intended to explore all of the key aspects of the patient experience. The findings of this survey, which can be viewed at *http://www.cqc.org.uk/PatientSurveyInpatient2010*, are carefully reviewed by the Board and are seen as an extremely important indicator of the quality of care we deliver. In 2010, we agreed with our commissioners that we would attempt to reverse a relative decline in some critical elements of our performance, particularly in respect of our responsiveness to personal needs.

The target agreed was a 2 point improvement on our performance in 2009, based on a composite indicator calculated from 5 survey questions.

Each describes a different element of the overarching theme "responsiveness to personal needs" :

- Involved in decisions about treatment/care
- Hospital staff available to talk about worries/concerns
- Privacy when discussing condition/treatment
- Informed about medication side effects
- Informed who to contact if worried about condition after leaving hospital

Our performance in the 2009 Survey was calculated as 64.4

Our Target for 2010 was 66.4

Our score for this benchmark for 2010 was 67.3

This achievement is not, however, grounds for complacency or satisfaction. The Trust intends to continue monitoring our performance in this area using a variety of techniques and surveys.

3.1.6 Think Glucose

- *We will commence the implementation of the "Think Glucose" programme for unidentified diabetics across our inpatient wards.*

"Think Glucose" is a national initiative produced by the National Institute of Innovation and Improvement. The "Think Glucose" project at SWBH was intended to improve inpatient diabetes management Trust wide by 31 March 2011 and deliver the 2010/2011 CQUIN target. The CQUIN target was to develop an action plan and to provide evidence of implementation. The primary objective was to improve inpatient care for patients whose diabetes is a secondary reason for admission. Further information on this programme can be found at *www.institute.nhs.uk/thinkglucose*.

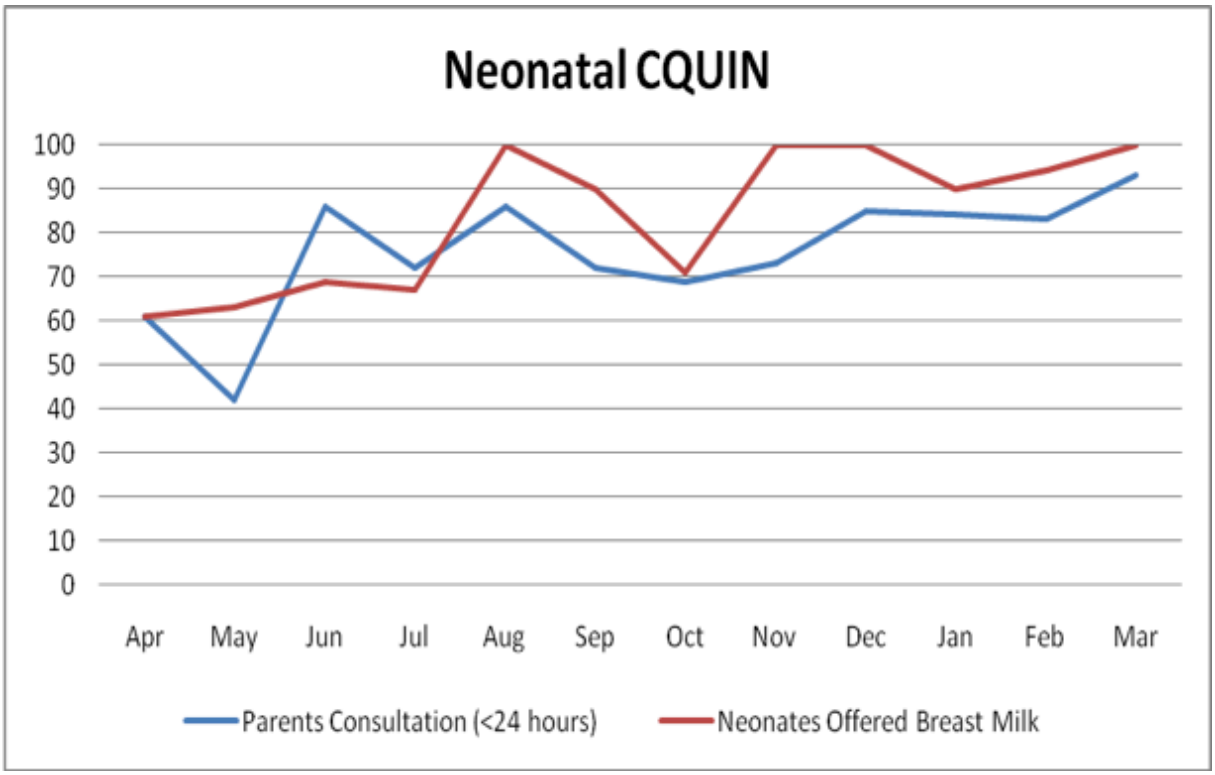
This project at SWBH was a single success, largely because enthusiasts outside the pilot areas quickly identified the benefit of specialist support in the management of patients with diabetes, even when the diabetes is not the main reason for admission. Patients with diabetes are now routinely identified on admission and a flag is raised on the Electronic Patient Record, which can then

generate a referral either to a specialist nurse or to a consultant. We were very pleased with the success of this pilot project and intend to continue building on this work through 2011/12.

3.1.7 Paediatrics & Neonates

- We will increase the proportion of parents able to discuss the neo-natal care of their baby with a senior clinician within 24 hours of admission.
- We will increase the proportion of babies offered breast milk during their neo-natal stay

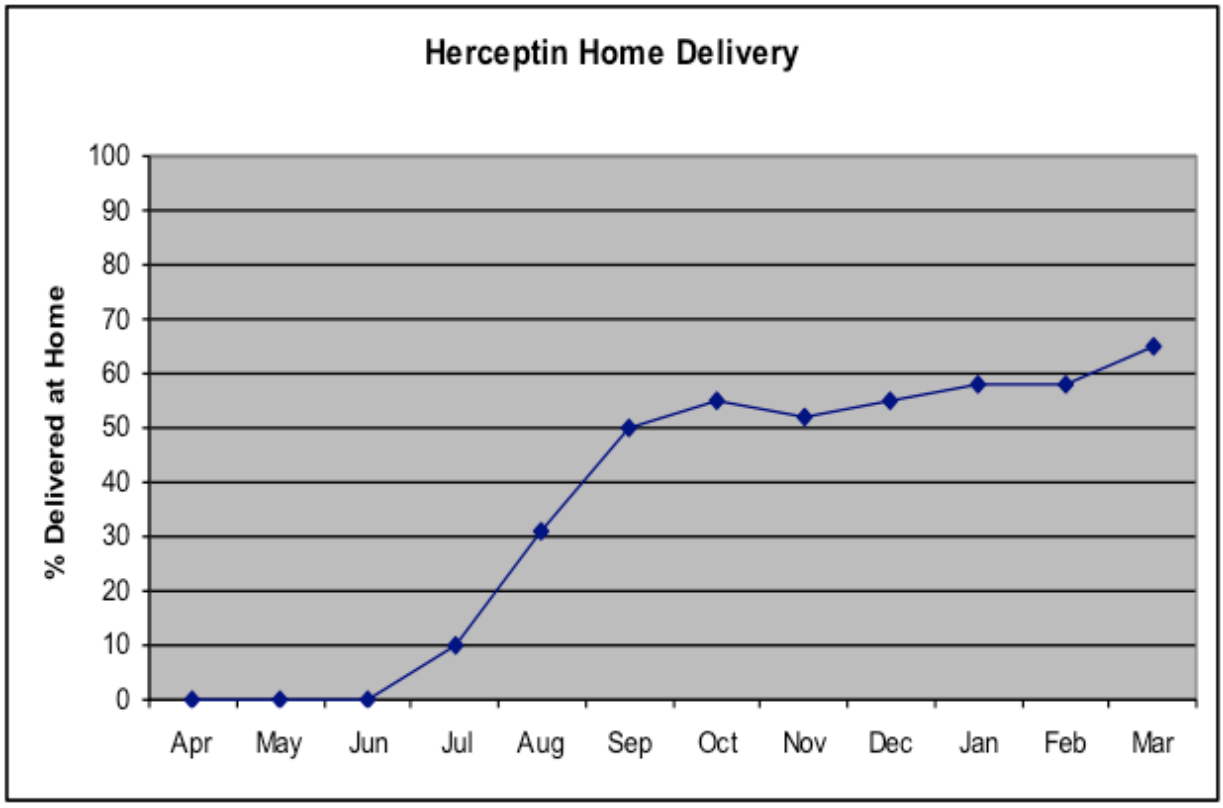
Two of the CQUIN targets required by specialised commissioners related to the care of children and newborn infants. Of these, the first (parents meet with a senior clinician within 24 hours), resonated strongly with what our own stakeholders had told us. The second target reflects our determination to give infants born in our care the best possible start in life. The chart below tells the story.



3.1.8 Herceptin at home

- *We will implement home delivery schemes for herceptin related chemotherapy.*

There has been an increasing emphasis on the delivery of specialist and more complex care either at home or in centres closer to home but outside the hospital setting. This shift is one of the major themes of Right Care Right Here and is central to the future plans for SWBH. We therefore welcomed this initiative from the specialised commissioners for the delivery of certain types of chemotherapy at home and our Cancer Team quickly set up a new service that launched in June 2010.



This chart shows how rapidly the service became the main pathway for treatment in the group receiving herceptin treatment for their cancer. Not all cancer chemotherapy can yet be delivered safely outside the hospital setting, but it is clear that much more can be done through good co-ordination of services and excellent liaison between primary and secondary care.

3.2 Other Indicators of Quality

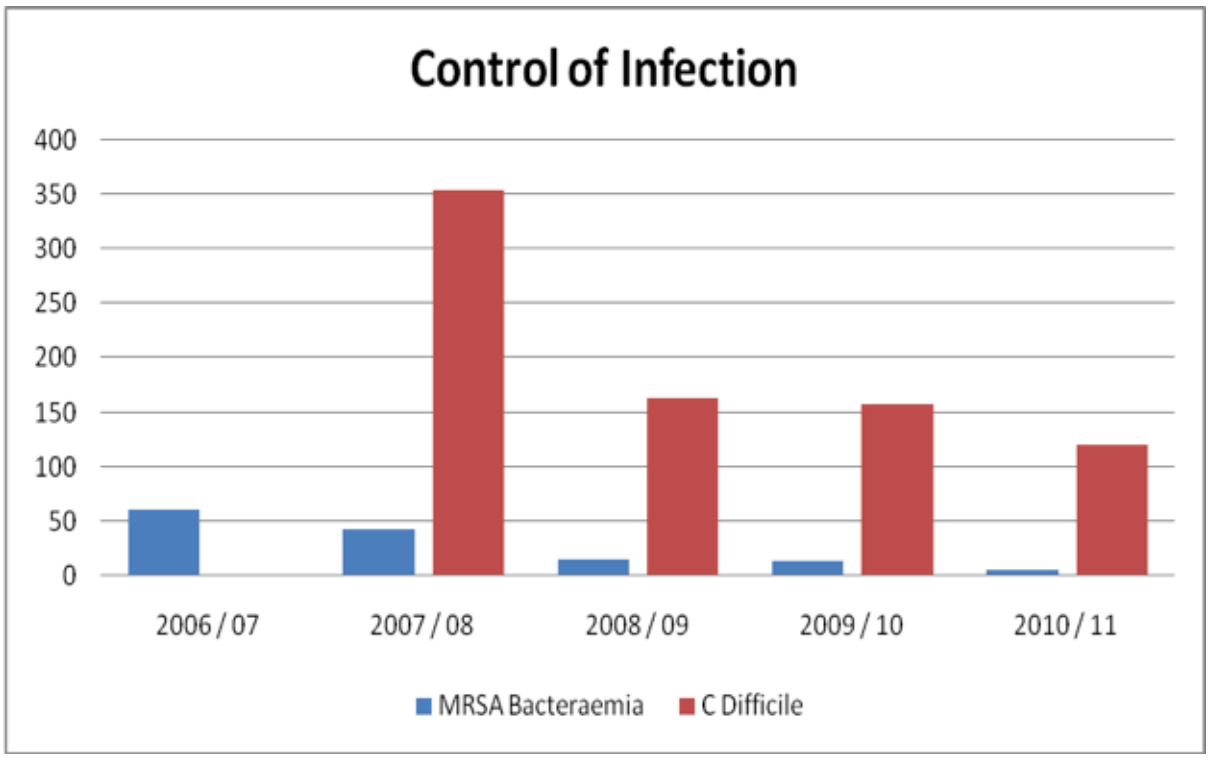
NATIONAL AND LOCAL PRIORITY INDICATORS			Year End (* = most recent month)	10/11 Target
Cancer	2 weeks	%	94.3	=>93
	2 weeks (Breast Symptomatic)	%	94.8	=>93
	31 Days	%	99.7	=>96
	62 Days	%	88.2	=>85
Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.8	<0.8
	28 day breaches	No.	1	0
Delayed Transfers of Care	Total	%	4.6	<3.0
Cardiology	Primary Angioplasty (<150 mins)		90.4	=>80
	Rapid Access Chest Pain	%	100	=>98
	Thrombolysis (60 minutes) (Rarely used at SWBH)	%	0	80
Stroke Care	>90% stay - EXTERNAL (DH) TARGET	%	79.5	60
	>90% stay - INTERNAL TARGET	%	76.9*	80
	TIA Treatment <24 hours from initial presentation	%	46.2*	60
	TIA Treatment <24 hours referral rec'd by Trust	%	61.5*	60
A/E 4 Hour Waits		%	96.99	95 (rev.)
GUM 48 Hours	Patients seen within 48 hours	%	84.5	=>90
	Patients offered app't within 48 hrs	%	100	=>98
Infection Control	C. Diff - EXTERNAL (DH) TARGET	No.	120	243
	C. Diff - INTERNAL TARGET	No.	120	158
	MRSA - EXTERNAL (DH) TARGET	No.	5	6
Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94.5	90
	Maternity HES	%	5.4	<15
Infant Health & Inequalities	Maternal Smoking Status Data Complete	%	99.58	=>98.0
	Breast Feeding Status Data Complete	%	99.98	=>98.0
	Maternal Smoking Rates	%	12.44	=>11.5
	Breast Feeding Initiation Rates	%	63.34	>63.0
RTT Milestones	Admitted Care (RTT <18 weeks)	%	91.0*	=>90.0
	Admitted Care RTT -Specialties <90%	No.	2*	0
	Admitted Care RTT -Backlog	No.	548*	No. Only
	Non-Admitted Care (RTT <18 weeks)	%	97.9*	=>95.0
	Non-Admitted Care RTT -Specialties <95%	No.	0*	0
	Non-Admitted Care RTT -Backlog	No.	117*	No. Only
	Audiology Direct Access Waits (<18 wks)	%	100*	=>95
Mortality in Hospital	Hospital Standardised Mortality Rate	HSMR	97.0	< Lower Confidence Limit
	Peer (SHA) HSMR	HSMR	97.0	
Readmission Rates within 28 days of discharge	Readmission to any specialty	%	9.1	No. Only
	Readmission to same specialty	%	4.1	No. Only
Readmission Rates within 14 days of discharge	Readmission to any specialty	%	6.9	No. Only
	Readmission to same specialty	%	3.2	No. Only

The table on the previous page contains a range of indicators that are monitored regularly by the Board and its subcommittees. Most of these indicators also inform regular reviews and discussions with the Clinical Divisions, Clinical Directorates and various Governance committees. Some of the indicators are particular to the performance of a particular specialty or directorate, such as Cardiology or Maternity. Systems are in place to ensure that data is collected frequently enough to ensure that any lapse in performance is identified and corrected as soon as possible.

Some information, such as the time taken for a patient with a myocardial infarction (heart attack) to receive essential treatment, is measured for every single patient treated and the results are tracked through a national database.

In some cases, where we decide that there is a need for a particular focus or effort, we will set an internal target that is more challenging than those expected of us by external agencies or regulators. An example of this is in stroke, where we have met the expected external standard for length of stay on a stroke unit, but have not yet achieved our internal ambitions.

3.2.1 Control of Infection

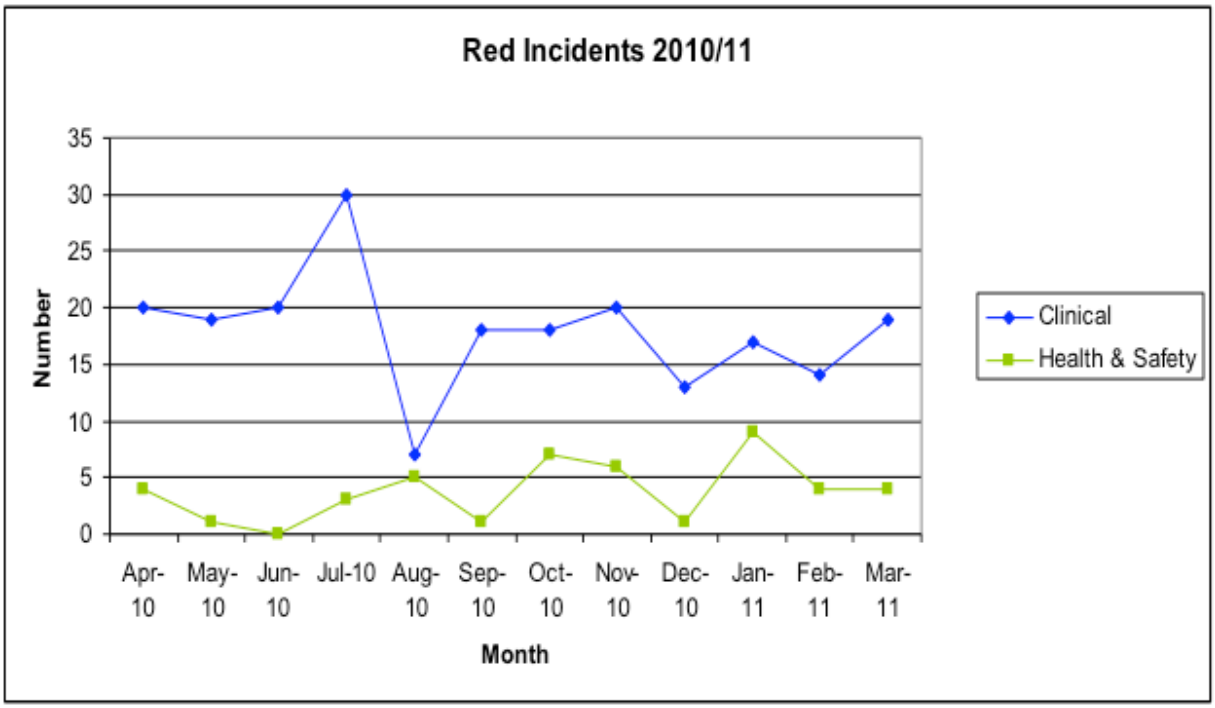


SWBH, along with most other trusts, has invested an enormous amount of effort and resource in reducing the rates of hospital acquired infection. The chart above shows the benefit of that effort over the last 5 years. Of note is the fact that the chance of an individual patient catching MRSA in our hospitals is now miniscule and is comparable with the best performing hospitals in the country. Our performance in controlling Clostridium Difficile is also recognised as excellent, despite the fact that we use a test for this organism that is more sensitive than that currently used by most other hospitals.

3.2.2 Patient Safety

There is one indicator of quality that is not yet reported on most trusts' performance reports, possibly because of difficulties in interpretation and variability in reporting. This indicator relates to patient safety and the response of the trust when mistakes are made. We take errors very seriously and try very hard to live up to our promise to admit to our mistakes and to do everything we can to put things right.

The Trust has a robust system for investigating untoward incidents and learning from our mistakes. All staff are encouraged to report incidents and near misses, whether they directly affect patient safety or they relate to the health and safety of staff and members of the public. Error reporting rates are still not as high as we would expect and wish to see, although the introduction of a new electronic incident reporting system is expected to make the process easier for staff to use and should make feedback to staff about cases they report quicker and more reliable.



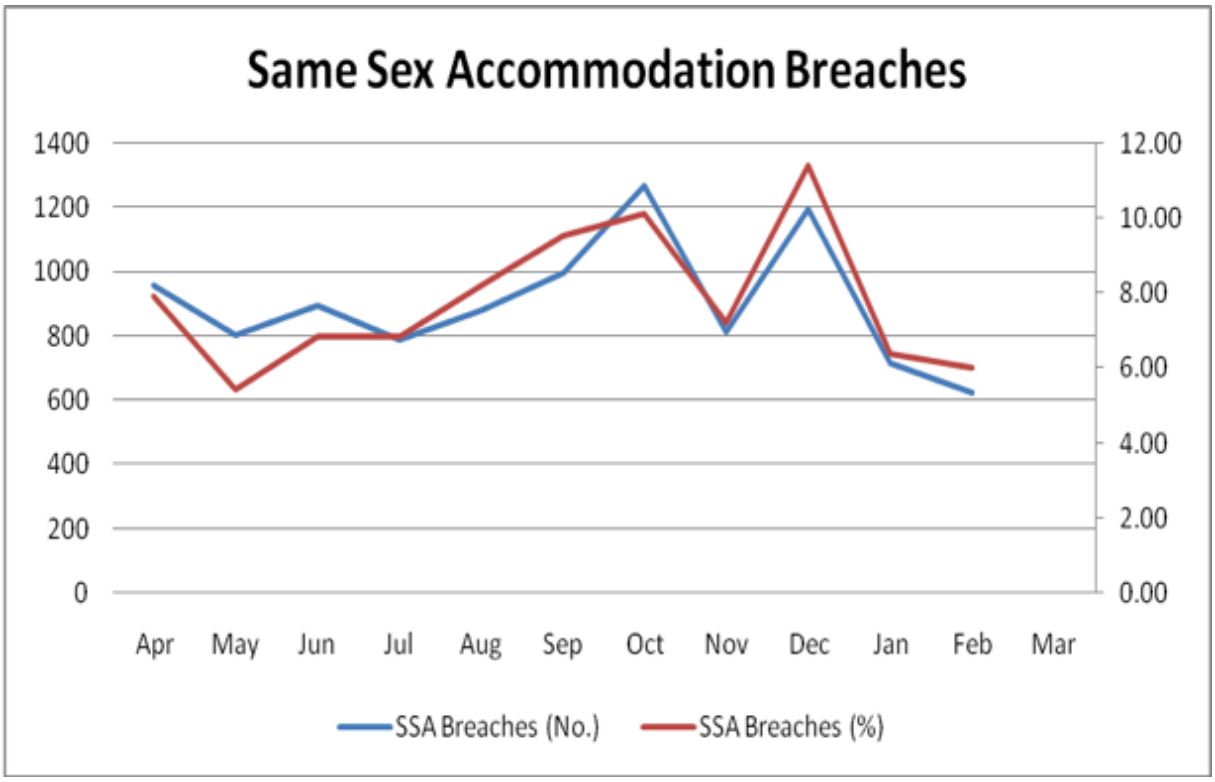
Incidents are categorised according to the severity of the actual or potential harm caused and the most serious errors are reported to the Board, the Department of Health (via the Strategic Health Authority) and our commissioning PCTs. Since April 2010, incidents that had not previously been reported to the Department of Health have been included as Serious Incidents. These include fractures following falls and grade three and four pressure sores. This has had an impact in total numbers of incidents reported.

The chart above shows the numbers of clinical and health & safety incidents classed as Red (Serious) by month through 2010/11. Every serious incident is thoroughly investigated and undergoes a Root Cause Analysis (RCA) or Table Top Review by senior staff supported by the Risk Team. Each case in which system errors are identified has a detailed action plan prepared. This is then checked and monitored by the Adverse Events Committee (AEC), which is chaired by the Chief Executive. All action plans are followed to completion by that committee.

Less serious incidents are also investigated and tracked, although the investigation is generally conducted by the Department or Division in which the incident occurs. They will not be reviewed by the AEC unless a cluster or trend occurs, in which case they will be subjected to the same process as the most serious incidents.

3.2.3 Privacy and Dignity

Everyone who has visited the older parts of our hospitals, particularly on the City Hospital site, will recognise that we face considerable difficulties adhering to modern regulations and standards, particularly those relating to Same Sex Accommodation. We do, however, take Privacy & Dignity extremely seriously and we have recently embarked on a major series of ward reconfigurations and refurbishments in order to minimise the risk of breaching the standards.



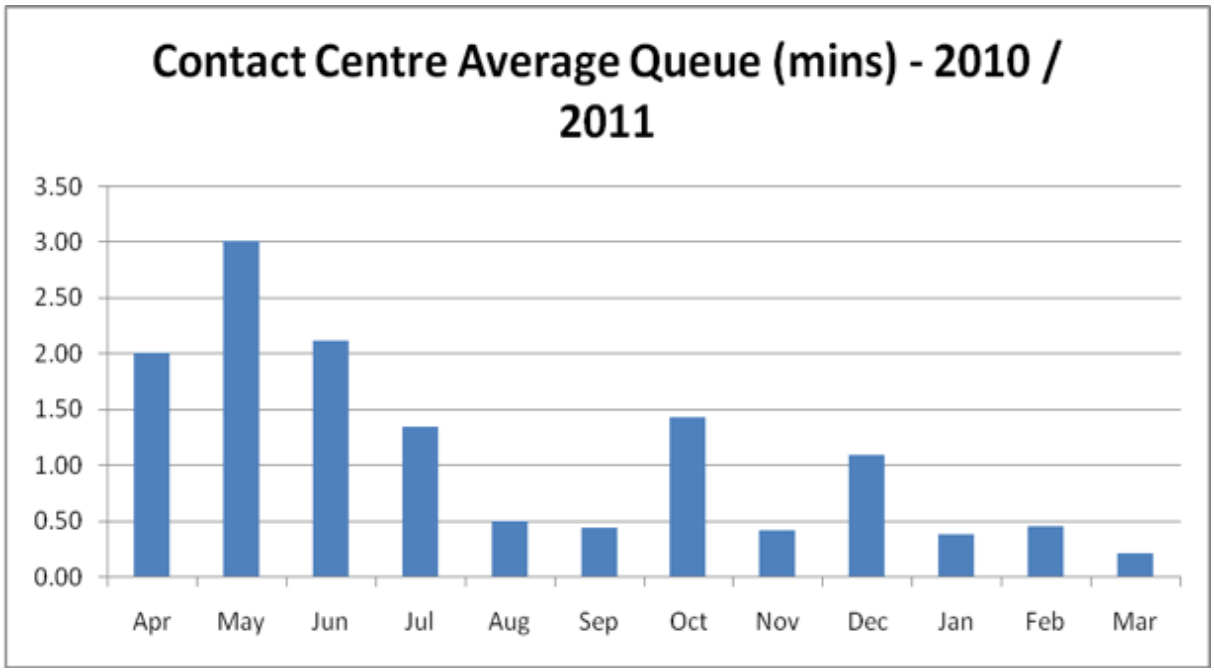
The chart above illustrates our performance during 2010/11. Winter is normally a difficult period, which was made more difficult this year as we had to undertake some major ward reconfigurations in preparation for more stringent regulations. We believe that changing most of our wards at City Hospital to same sex wards in the last few months, along with changes to operational practice and assessment criteria will lead to improved performance in 2011/12. We will continue to monitor the data closely over the next 12 months and will take any necessary steps to resolve any issues as they arise.

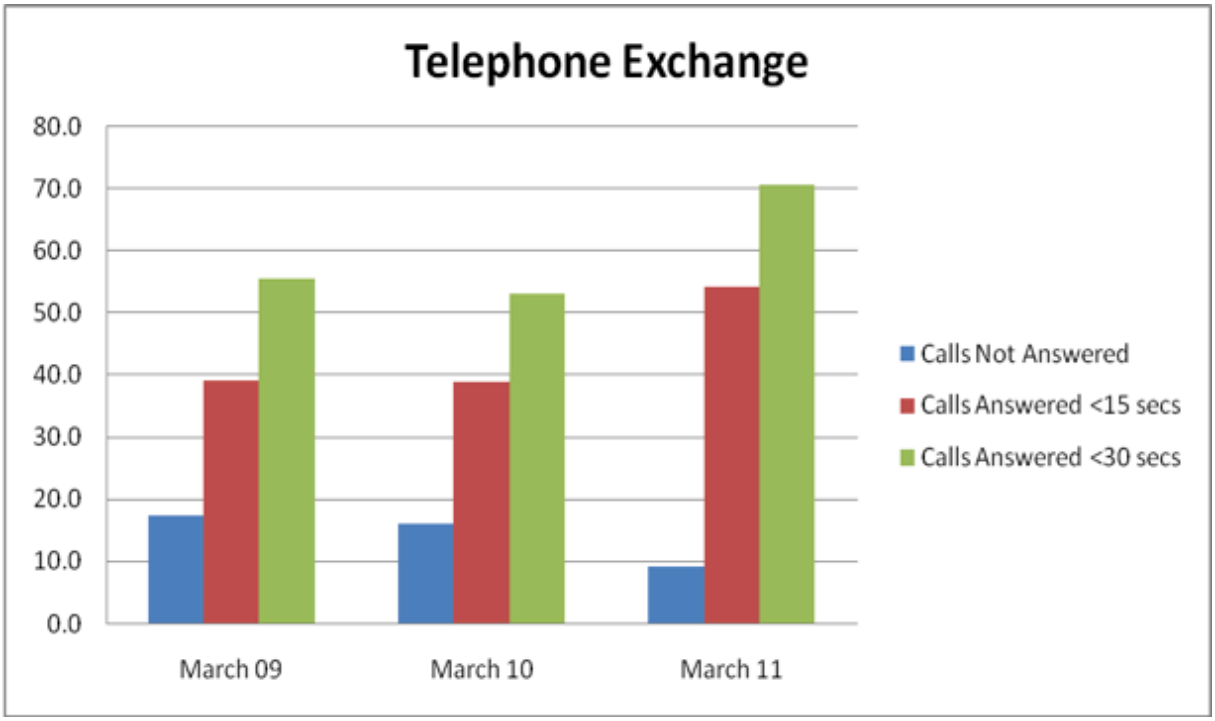
3.2.4 Complaints

The Trust takes complaints very seriously and endeavours to investigate every complaint as thoroughly as possible and to provide a detailed response. In order to enhance existing arrangements the Trust introduced improved and more detailed investigation techniques and an associated investigation report. This change was welcomed by complainants and resulted in fewer follow-up concerns being raised as the result of dissatisfaction with the Trust's response. The process proved more labour intensive and time-consuming than anticipated, however, and we developed a backlog of complaints that has proven difficult to manage. Including its backlog of complaints, the Trust's currently has, on average, a total of 350 active complaints. To deal with this backlog, a target for the number of complaints responses to be sent out in a 21 day cycle has been set at 95. Meeting this primary trajectory should enable the Trust to clear the backlog of complaints by the end of December 2011. The Trust Board receives monthly updates and has been assured that there is a robust plan to address the situation. We have committed additional resources to dealing with the issue and to return to our usual standards of timely responses to complaints.

3.2.5 Contacting our services

We have received a lot of negative feedback from patients, relatives and their doctors about the time it takes to contact our services, either to book an appointment or to get through to a particular ward or department. The Chief Operating Officer and his team have put considerable effort into dealing with this issue during the last 18 months and we have been very proud of the way in which all the involved staff responded to the challenge. The tables below show the results of their efforts.


Contact Centre Average Queue (mins) - 2010 / 2011
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

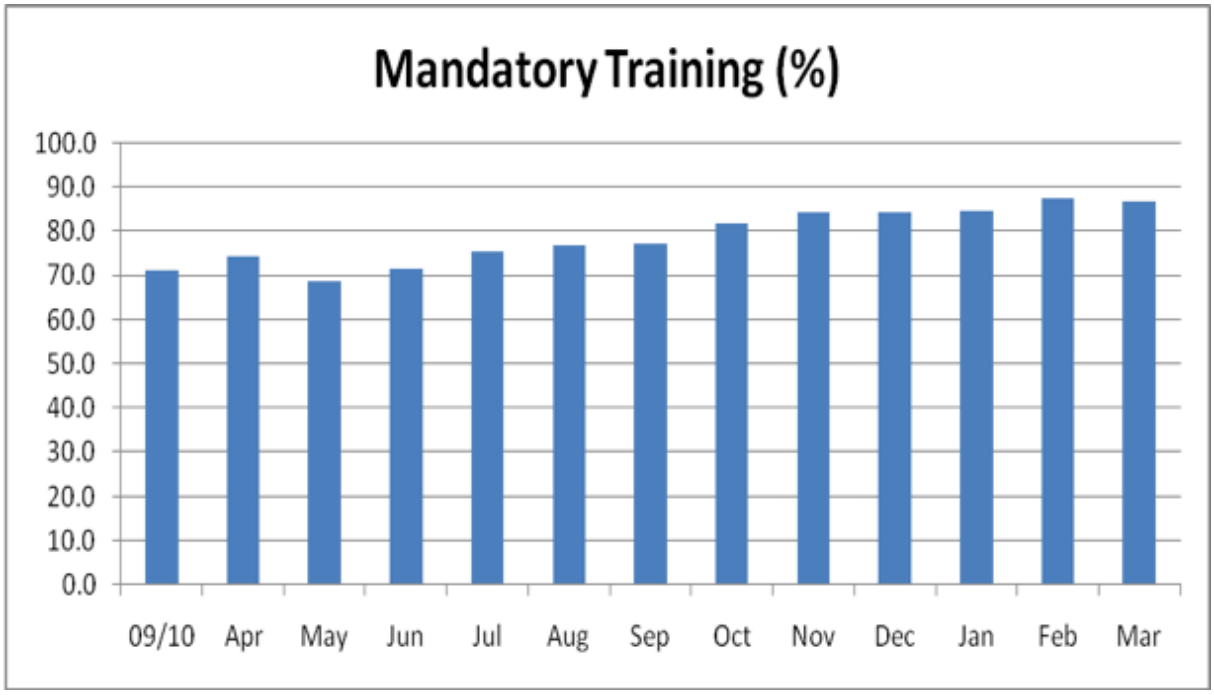

Telephone Exchange
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
March 09
March 10
March 11
Calls Not Answered
Calls Answered <15 secs
Calls Answered <30 secs

3.2.6 Staff Indicators

STAFF INDICATORS			Year End (* = most recent month)	10/11 Target
Sickness Absence	Long Term	%	**3.27 (Q4)**	<2.80
	Short Term	%	**1.06 (Q4)**	<1.20
	Total	%	**4.33 (Q4)**	<4.00
Learning & Development	Appraisals	No.	**4635**	5341
	Mandatory Training Compliance	%	**86.8**	100

High quality care can only be delivered by well trained and highly motivated staff. We pay close attention to staff health and have seen significant improvements in the rates of sickness absence in recent years, particularly in respect of short term absence. Unplanned absence from work increases the workload for other colleagues and can diminish the amount of time available for caring for individual patients.

Training our staff has been a major priority for some time and this is reflected in the chart below. We were one of the best performing trusts in the NHS in 2009/10 and our performance has continued to improve in 2010/11.



3.3 Corporate Objectives

Section 2 of this Quality Account describes our performance in respect of the 5 priority areas for improvement that we identified at the beginning of 2010/11. It is important to remember, however, that this quality agenda is strongly grounded in the wider work of the organisation. All of our Corporate Objectives derive from the ongoing conversation that we nurture with all of our stakeholders. The table below lists those 37 objectives and gives an overview of our performance in 2010/11.

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
1. Accessible and Responsive Care				
1.1 Continue to achieve national waiting time targets				
1.2 Continue to improve patient experience				
1.3 Make communication with GPs quicker & more consistent				
1.4 Improve our outpatient services inc. appointment system				
1.5 Ensure customer care promises part of day to day behaviour				
2. High Quality Care				
2.1 Infection control , cleanliness – continue high standards				
2.2 Formalise quality system – maintain/ improve quality of care				
2.3 Vulnerable children and adults – improve protection and care				
2.4 NHS Litigation Authority – achieve accreditation Level 2				
2.5 Implement outcome of Maternity Review				
2.6 Continue to improve services for Stroke patients				
2.7 Improve quality of service and safety in A&E Departments				

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
2.8 Achieve new CQUIN targets				
2.9 Improve key patient pathways				
2.10 Deliver quality and efficiency projects				
2.11 Implement national Nursing High Impact Changes				
3. Care Closer to Home				
3.1 Make full use of outpatient & diagnostic centre at Rowley Regis				
3.2 Right Care Right Here Programme – make full contribution to projects				
4. Good Use of Resources				
4.1 Deliver planned surplus of £2.0m				
4.2 Improve expenditure by delivery of CIP of £20m				
4.3 Review corporate expenditure in key areas				
4.4 Ensure right amount of wards, theatres and clinic capacity				
5. 21st Century Facilities				
5.1 Continue process to buy land for the new hospital				
5.2 Start formal procurement for construction of new hospital				
5.3 Full involvement with PCTs on design of community facilities				
5.4 Continue to improve current facilities				

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
6. An Effective NHS FT				
6.1 Care Quality Commission registration				
6.2 Embed Listening into Action				
6.3 Implement next stages of new clinical research strategy				
6.4 Implement sustainability strategy				
6.5 Progress plans for new organisational status and structure				
6.6 Embed clinical directorates and service line management				
6.7 Implement our Leadership Development Framework				
6.8 Refresh Workforce Strategy and progress implementation				
6.9 Continue to develop IM&T strategy and improve systems				
6.10 Develop our strategy for medical education and training				
6.11 Improve health and well-being of staff – reduce sickness absence				

At the end of the year, of the 37 objectives, 29 are assessed as green and 6 as amber.

One objective is rated red:

5.2 – The Outline Business Case (OBC) Refresh [new hospital] approval by Department of Health & Treasury is still awaited. Hence, we are unable to start procurement as planned.

3.4 Our CQUIN promises for 2011/12

- *We will deliver VTE assessments to at least 90% of adult inpatients including specialised services patients.*
- *We will provide training to our staff so that they can better advise patients who smoke and we will provide more interventions for people who smoke.*
- *We will improve our performance in respect of patient experience in the national patient survey.*
- *We will increase the numbers of people who, at the end of life, have died in their place of choice.*
- *We will reduce the number of missed doses of medication for inpatients in our hospitals.*
- *We will increase the proportion of admitted inpatients who have had a nutritional assessment.*
- *We will increase the number of patients on the enhanced recovery pathways in Orthopaedics, Colo-rectal Surgery, Gynae-oncology and Urology.*
- *We will improve the discharge process for all patients who are admitted to our hospitals with stroke.*
- *We will ensure that at least 60% of all adult deaths in our hospitals are reviewed by a senior doctor.*
- *We will ensure that we offer appropriate advice and support to those patients identified as being at risk from overuse of alcohol.*
- *We will increase the proportion of children on the Health Visiting Unit who have had a full developmental review at 2 years 6 months.*
- *We will increase the number of active patients on the District Nursing Units who have received a falls assessment.*

3.5 What others think about our Quality Account

After reviewing our Quality Account, Sandwell PCT gave us the following statement:

Sandwell and West Birmingham Hospitals NHS Trust has submitted this Quality Account to Sandwell Primary Care Trust as part of the assurance process.

Sandwell Primary Care Trust is the lead commissioner for Sandwell and West Birmingham Hospitals NHS Trust and, as such, has responsibility for assuring itself of the quality of service delivered. The Primary Care Trust takes this task very seriously and has worked very closely with Sandwell and West Birmingham Hospitals NHS Trust throughout the year to ensure that the services are indeed high quality. Sandwell and West Birmingham Hospitals NHS Trust has taken a proactive approach putting Quality at the heart of their organisation. The Primary Care Trust has undertaken a number of appreciative enquiry visits, both announced and unannounced to ensure that patients are receiving the service that we would expect. Sandwell and West Birmingham Hospitals NHS Trust has been both open and responsive, ensuring that problems are identified at the earliest opportunity and that actions are put in place to address them.

This Quality Account represents an accurate and well balanced view of the services delivered.

And Finally

We hope that you have found this Quality Account useful and interesting. We intend to continue to develop and improve our quality systems and would welcome comments on this document and suggestions for information that would enhance this work in future years.

Quality Account

2010-11

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