Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account

2011-2012

Where EVERYONE Matters

Part 1: Chief Executive's Statement

This is the third Quality Account for Sandwell and West Birmingham Hospitals NHS Trust (SWBH). It focuses on what we have done during 2011/12 to improve the quality of the care we give to our patients. In it we've included evidence that our work is of a high standard, and that we are continuing to get better.

The report begins with a description of our priorities for improvement in 2012/13 (part 2). Broadly, these will remain the same as those identified in our previous quality account, to give us an opportunity to build on the solid foundations that we laid during the course of this last year. In section two of this report we set out how we plan to do that and how we will go about measuring, monitoring and reporting our progress.

Our priorities for improvement, and the plans we have, were developed by working closely with the people we serve and those who have an interest in our trust; our stakeholders. Stakeholders and those who purchase our services on your behalf (commissioners) have been engaged at various points in the process, with their representatives and the Sandwell LINk involved in narrowing down the long list of options for quality priorities for 2012/13.

Throughout 2011 we also talked directly to the people we serve. In particular, we met with patients and local people and discussed what our priorities should be for the coming year. We also contacted over 7,500 members by post, sought input at the Annual General Meeting and used the local media to engage with local people.

As well as asking our patients, we've also talked to the people that work for us. We asked their views during a dedicated 'Team Brief', and these discussions were disseminated across the organisation, and discussed by the Trust Board. Finally, we included our own analysis of patient and staff surveys, service performance data, as well as other concerns that emerged throughout the year.

The third section of this year's quality account provides a review of our performance in 2011/12. The priorities we set focused on ensuring that we continue to provide safe, high quality care to our patients. As an organisation, this is our primary objective and everything else we do underpins this goal. This section recounts these objectives, and how well we performed against the plans we set.

As well as performing well against our priorities, we did a considerable amount of work on quality improvement that was not specifically set out in our last Quality Account. I would like to draw your attention to some of this now:

We achieved significant improvements in all of the quality objectives agreed with our local PCTs through the Commissioning for Quality and Innovation (CQUIN) schemes. By the end of the year, we fully met all the agreed targets in all 22 objectives. More details on this are contained in part 3.2 of this report.

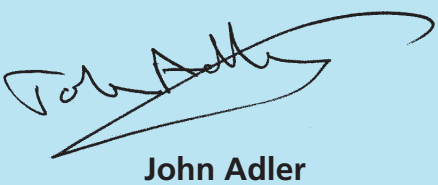
The Care Quality Commission (CQC) has visited our trust during the past year. There has been a lot of publicity about it. They carried out several visits and I am glad to report that they have satisfied themselves that patients are receiving the standards of care they should expect. They have graded the trust as compliant with expected standards. Further information on this can be found in section 2.2.8.

In addition, during December 2011, a clinical review team from Sandwell PCT carried out a visit looking into the care of patients at both Sandwell Hospital and City Hospital. They commended the staff on both Trust sites on the development of high quality stroke services. They also commented that the patient and carer group made positive and constructive comments about their experience of care at both sites and the discharge arrangements from hospital.

Whilst we have made great steps in the right direction with stroke services, we have again made this one of our top priorities this year and will continue to improve the stroke services we offer.

The Quality and Safety Committee has been established to measure and monitor all aspects of quality in the trust. This group actively reviews and monitors progress and action plans associated with improving the service we provide. We are also making good progress with producing a monthly quality report which is seen by the Trust Board.

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 in 2012/13 and statements of assurance from the Board

In section 2 you will find a description of how we decided on our priorities for the coming year and who we have involved in making these decisions.

Section 2.1 sets out the priorities for 2012/13 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.

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.

Section 3 contains a review of Quality Performance in the Trust. It is in this section that you will find how we met the plans that we had from 2011/12. In addition, we describe our performance against other measures of quality.

2.1 Priorities for Quality Improvement in 2012/ 13

2.1.1 How we decided on the priorities for our Quality Account for 2012/13

Sandwell and West Birmingham Hospitals NHS Trust is always passionate about engaging with the people it serves. We began engaging with patients and local people about the 2012/13 Quality Accounts in September 2011 when Trust members and local people were invited to a discussion with the Chief Executive about progress on priorities in 2011/12 and priorities for the coming year. We promoted the event in letters to our 7,500 members and through local media.

Members of the public were asked for their input again at the Annual General Meeting and through a series of postcards that were returned and the feedback reviewed by the Trust Board in November, along with feedback from patient surveys and other patient engagement. Frontline staff were also asked for their views through a team briefing discussion topic that was disseminated across the organisation and this feedback was also discussed by the Trust Board.

Stakeholders and commissioners have been engaged at various points in the process, with the lay representatives and the Sandwell LINk involved in narrowing down the long list of options for quality priorities for 2012/13. Stakeholders have had the opportunity to comment before the report is finalised.

The Trust has continued to work on the development and implementation of its Quality and Safety Strategy. This is as outlined in our 4th Priority for last year.

Our Quality Accounts in 2011/12 were subject to audit and external feedback. Following a review of the feedback received in 2011/12 it was concluded that our priorities for improvement in 2012/13 should be presented in a format that aligns with the corporate priorities identified in the Quality and Safety Strategy.

With this in mind, it is proposed that, although the areas for improvement will remain generally the same in 2012/13, the objectives will be presented and monitored under the headings of Patient Safety, Clinical Effectiveness, and Patient Experience.

To establish what should be our highest 3 priorities this year, we have looked at our performance data from last year and have decided to increase our understanding further by adding more measures of our performance. This will help us to understand the needs of our patients even better, keep them safer, and improve their experience whilst under our care. Our performance will be reported in the Quality Report, once it has been finalised, to the Trust Board every month.

2.1.2 The priorities for improvement in 2012/13

In our Annual Plan 2012/13 we have identified our quality& safety priorities under the three domains described in our Quality and Safety Strategy:

Patient Safety	To reduce adverse events which result in avoidable harm	=	We do no harm to patients
Clinical Effectiveness	To reduce avoidable mortality and morbidity	=	Fewer patients dying and fewer having complications
Patient Experience	To increase the percentage of patients who would recommend the Trust to family and friends	=	Improved patient satisfaction

The 2012/13 Quality and Safety priorities are set out in Table 1. Although all the areas in Table 1 are key priorities, in this Quality Account we have selected four topics for particular focus and more detailed description. These topics are:

- Continuing to Improve the Stroke & TIA Services (Patient Safety);
- Essential Standards of Nursing Care (a combination of Patient Safety, Effectiveness of Care, and Patient Experience):
- Mortality reporting and analysis (Clinical Effectiveness);
- Improving Accident & Emergency Department Safety and Performance (Patient Safety).

Table 1. Quality & Safety Priorities 2012/13

Patient Safety
Improvements in Stroke services and outcomes and in the way in which we deal with Transient Ischaemic Attacks (TIA).
5 Steps to Safer Surgery – improvement in monitoring and assurance systems.
Reduction in avoidable weight loss in elderly patients (acute and community).
Delivery of national and local standards for reducing hospital acquired infections
Harm-free care in 4 key areas – pressure damage, falls with harm, venous thrombo-embolism (VTE), catheter associated infection.
Improvement in the safety and performance of our Accident & Emergency Departments (A&E).
Clinical Effectiveness
Improvement in outcomes for Trauma & Orthopaedic surgery.
Exceed CQUIN target for mortality reporting and analysis.
Improvement in awareness and diagnosis of Dementia.
Improvement in mortality of patients with pneumonia – avoiding admission where possible.
Patient Experience
Improvement in responsiveness to personal needs of patients.
Improvement in the experience of patients at the end of life.
Offering health improvement opportunities to expectant mothers who drink alcohol and smoke.
Introduction of the 'friends and family test' and establishment of real time monitoring and response to patient views.
Eradication of grade 2, 3 and 4 hospital acquired avoidable pressure ulcers.
Continuation of roll out of alcohol prevention strategy to specified outpatient specialties.

Focus Topic - Continuing to deliver service improvement and outcomes in Stroke and Transient Ischaemic Attacks (TIA) Services (Patient Safety)

We aim to maintain our stroke services in the top 25% nationally, and continue this performance long-term through 2012/13 and beyond. In 2011/12 we made good progress in this work, which we will build on through the Integrated Stroke Development Plan, which is linked to our Stroke and Transient Ischaemic Attack (TIA) Service Reconfiguration Project.

The improvements we intend to make are:

- Continuously deliver safe, timely care for stroke and TIA resulting in a reduction in long term complications including death
- Agree a preferred option for a reconfigured Stroke & TIA Service

- Continue to develop and implement our Stroke Strategy
- Improve the discharge arrangements for patients admitted with a stroke
- Achieve a target of early supported discharge for 40% of patients with Stroke by the end of March 2013
- Develop systems to monitor and respond to the experience of patients receiving treatment under our care
- Develop a monitoring system for stroke nursing competency training by the end of March 2013
- Carry out daily assessment of patients by specialist consultant clinicians for stroke
- Deliver value for money by ensuring delivery of stroke care that consistently achieves the expected quality indicators required to attract the Best Practice Tariff for Stroke. This means that the better care we give, the better the reimbursement from our commissioners, as set out in the Best Practice Stroke Tariff.

We will do this by:

- Participating in national and local audits of our stroke services
- Focusing and developing the Stroke and TIA pathways
- Completion of the public consultation and confirming the preferred option for the future
- We will meet all the main targets, some of which are new and are higher than last year, on the stroke dashboard and continue to improve the stroke discharge pathway which we achieved in 2010/11.

Table 2. This table shows the targets we plan to meet in 2012/13 which will indicate an improvement in our stroke care.

Main Stroke Targets	Target
Patients spending at least 90% stay on Acute Stroke Unit	80%
Patients admitted to Acute Stroke Unit within 4 hours	90%
Patients receiving CT Scan within 24 hours of arrival	100%
Patients receiving CT Scan within 24 hours of admission	90%
Patients receiving CT Scan within 1 hour of arrival	50%
TIA (High Risk) Treatment within 24 hours from initial presentation	60%
TIA (High Risk) Treatment within 24 hours of referral received by Trust	60%
TIA (Low Risk) Treatment within 7 days from initial presentation	60%
TIA (Low Risk) Treatment within 7 days referral received by Trust	60%
Stroke Discharge (meeting set criteria)	90%
Early supported discharge for stroke patients	40%

Monitoring, Measuring and Reporting

Our performance will be measured using a continuous stroke notes audit process, and using the stroke performance dashboard.

Performance will be measured and monitored by the Stroke Action Team, Trust Stroke Reconfiguration Project Board and Trust Management Board, in the Quality Report to Trust Board, and to the Quality & Safety Committee.

Focus Topic - Essential Standards of Nursing Care (Patient Safety, Clinical Effectiveness & Patient Experience)

We intend to continue to improve the safety and experience of our inpatients through specific attention to the reduction of harm events and through efforts to measurably improve the care we deliver.

We have given this priority the name of 'Essential Standards of Nursing Care' because it covers several of the quality priorities; reducing avoidable weight loss in elderly & vulnerable patients and health care associated infections (HCAIs) to below national and local standards; increasing harm-free care, including reducing pressure damage, falls with harm, VTE, catheter associated infection, dementia awareness and assessment. The indicators have been split in the sections below so that they can be linked to the indicators in the Annual Plan.

Reduction of avoidable hospital-acquired weight loss in elderly patients and vulnerable adults

Specifically we will:

- Introduce 'intentional rounding' (senior nurse ward rounds every 1-2 hours where a checklist of questions are asked, answered and documented) to ensure patients' essential care requirements are not missed
- Improve meal time experience
- Ensure patient hydration requirements are met
- Protect patients' dignity at all times

Monitoring, measuring and reporting

We will monitor progress/compliance through our ward performance review process. Data to support performance review will come from:

- Quarterly quality audits,
- Monthly audits of meal times and fluid balance recording,
- Point prevalence audit of avoidable weight loss in vulnerable adult wards (stroke and elderly care)
- Meal time, malnutrition universal screening test (MUST) assessment and fluid balance audits.

Specific measurable metrics:

- 90% or above achieved across all nursing quality measures recorded in quality audits
- 90% or above scores on meal time, malnutrition universal screening test (MUST) assessment and fluid balance audits
- Establish baseline (Quarter 1, 2012/13) and achieve 10% reduction by Q4 2012/13
- Ensure compliance with the CQC standards.

HCAIs - Control of Infection

We will continue to meet agreed standards and targets for infection control. This will include:

- Meet target set for C. Difficile (C. Diff)
- Meet target for Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia
- Monitor and record methicillin-sensitive Staphylococcus aureus (MSSA) and Escherichia Coli (E. coli) cases
- Monitor 30 day mortality for C. Diff
- Reduce the use of antibiotics associated with C. Diff
- Maintain Patient Environment Action Team (PEAT) scores at good or excellent
- Achieve hand hygiene standards
- Achieve MRSA screening targets
- Comply with CQC standards

We will monitor and measure our achievement by:

- Carrying out infection screening and ensuring that C.Diff mortality rates are monitored and reported monthly to Trust Board, Trust Management Board and the Infection Control Committee
- Carry out surveillance of MSSA & E-coli
- Monitoring cleanliness by carrying out audits and reporting to the Infection Control Committee
- Antibiotic usage is reported to Infection Control Committee and will be reported to the Trust Board and Trust Management Board on a monthly basis via the Quality Report
- Hand hygiene rates are monitored at Infection Control Committee.

Specific Metrics:

- The targets we have been set are that there will be no more than 2 incidences of MRSA bacteraemia, and 57 incidences of C.Diff during 2012/13
- MRSA screening target 2012/13 = 90% (to be finalised)
- Hand hygiene target to demonstrate a greater than 90% compliance
- Achieve an excellent rating against our PEAT assessment
- Demonstration of a reduction of antibiotic use based on Q1 baseline.

Increase harm free care across inpatient areas and District Nurse caseloads in 4 key areas

We intend to continue to improve the safety and experience of our inpatients through specific attention to the reduction of harm events and through efforts to measurably improve the care we deliver.

Specifically we intend to:

Introduce the Department of Health 'Safety Thermometer' (ST). This is a tool which will enhance our understanding of the totality of harm or harm free care experience of patients in 4 specific areas:

1. Pressure ulcers
2. Falls
3. Catheter-associated Urinary Tract Infections
4. Venous Thromboembolism (VTE).

Specifically we will achieve this through:

- Aiming to eradicate hospital acquired avoidable pressure ulcers grade 2, 3 and 4
- Reducing falls and associated harm
- Reducing hospital acquired avoidable weight loss in vulnerable adults
- Protecting patients' dignity at all times
- Introducing 'intentional rounding' as described above
- Increasing the number of patients on supportive care pathways (SCP) at end of life. This means keeping people well cared for at the end of their lives.

Monitoring, measuring and reporting

We will monitor progress/compliance through our ward performance review process. Data to support performance review will come from:

- Quarterly quality audits
- Incident reporting of pressure ulcers and falls

- Monthly ST completion on all patients staying in our hospitals
- Increasing the number of patients on the SCP – end of life audits

All of the above measures are already or will be included in the monthly Quality Report which goes to Trust Board, Quality and Safety Committee and Governance Board. More detailed reports go to the Trust Senior Nursing Forum and to divisional nurse cluster meetings and divisional governance meetings.

Performance is managed via the ward performance review process and directorate/ divisional reviews.

Specific measurable metrics:

- 90% or above achieved across all nursing quality measures recorded in quality audits
- 10 point improvement on net promoter score
- Eradication of hospital acquired avoidable grade 2, 3 and 4 pressure ulcers
- Reduction of 10% in falls with harm
- Completion of the 'Safety Thermometer' for all inpatients. Improvement in harm free numbers based on April baseline
- 60% or more relevant patients on supportive care pathways
- Achievement of privacy and dignity action plan and improvements in patient satisfaction relating to dignity, respect and inclusion in care and decision making.

Dementia awareness and assessment

We intend to raise dementia awareness and assessment by:

- Delivering a trust-wide campaign to raise awareness.
- Carrying out assessments of all people over the age of 75 who are admitted as emergencies who staying in more than 72 hours.
- As part of the 2 levels of the assessment a referral may result to a consultant or GP ensuring better care.

Focus Topic – Mortality Reporting & Analysis (Clinical Effectiveness)

We intend to continue to develop a system wide improvement in our knowledge and understanding of the Trust's mortality performance and the factors that influence deaths in our hospitals. We will use the Hospital Standardised Mortality Rates (HSMR) and Summary Hospital Mortality Index (SHMI), aiming to improve the Trust's performance. These measures allow us to measure our performance in comparison to other trusts' performance across the country. By adopting effective systems, processes

and practice at every level we aim to reduce avoidable harm and death.

The improvements we intend to make are:

1. Reduce mortality in the Trust
2. Understand the causes of deaths in our hospitals better, including in A&E Departments
3. Continue to review the agreed % of deaths in each month for all directorates using our Mortality Review System and learn from our findings
4. Develop an internal trigger system to alert specialties to trends or concerns in mortality
5. Broaden the tools we use to analyse the mortality data.

Specifically, we will:

- Review more than 60% of deaths that occur in our hospitals. This will be done by a senior doctor
- Ensure that any death that is identified as being potentially avoidable will undergo a root cause analysis to understand the issues further
- Review mortality with the Divisional and Directorate teams as part of the Quarterly Divisional Review process
- Continue with the introduction of the 'Sepsis Adult Care Pathway Proforma'
- Add the SHMI to the range of tools that we use to analyse mortality data
- Continue to develop our programme of Enhanced Clinical Audit of outlier areas which are identified by SHMI/HSMR data and our Mortality Review System.

Monitoring, measuring and reporting

Compliance against mortality reviews standards are communicated to Clinical Directors on a weekly basis. Performance is reported as part of the Quality Management Framework (QMF) to the Mortality and Quality Alerts Committee, Trust Surviving Sepsis Committee, Governance Board, Quality and Safety Committee, and Trust Board.

Focus Topic - Improving Accident & Emergency Department Performance (Patient Safety)

Whilst we do consider that progress has been made within our A&Es, we do feel that we could still do better. We intend to work to improve in all 3 domains of our Quality & Safety Strategy, but mainly in Patient Safety.

We intend to:

- Improve the flow of patients through our A&Es
- Ensure that alternatives to A&E are appropriately used
- Reduce the incidence of serious incidents and consequent harm to patients
- Increase the A&E workforce
- Ensure safer and more consistent clinical practice.

Specifically, we will:

- Continue to recruit more middle and consultant grade doctors to the A&Es
- Continue to develop and monitor systems to ensure that clinical care is of a consistently high standard
- Continue to closely analyse incidents and take action to eliminate identified root causes
- Ensure that there is a process in place for any deaths in A&E to be reviewed by senior doctors
- Support the delivery of the Integrated Development Plan for our A&E Departments, working in partnership with the commissioners
- Improve the Information Technology systems to support the development of automated clinical dashboards
- Continue work with our partners in Primary Care to ensure patients who do not need to be treated in the A&E Departments are appropriately redirected
- Continue to meet national standards in respect of 4 hour waits, and perform better against the other national standards for A&E Departments
- Ensure protocols/guidelines are being followed to provide a consistent level of high quality care.

Monitoring, measuring and reporting

Performance will be measured and monitored through the Emergency Department Action Team, reporting direct to the Trust Board. This is an action group, chaired by the Chief Executive, which is responsible for monitoring actions against the Integrated Development Plan. Compliance audits will be carried out to assess the level of compliance with agreed protocols.

Specific metrics are available via the national 4 Hour measure and A&E Clinical Indicators. All have target levels of performance.

2.2 Statements of Assurance from the Board

2.2.1 Statement of Directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National health Service (Quality Accounts) Regulations 2012 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

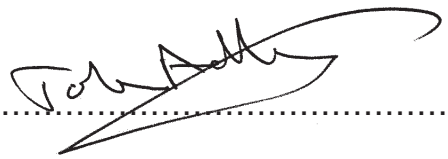
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable and conforms to specified data quality standards and prescribed definitions, and is subject to scrutiny and review;
- The Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief that the have complied with the above requirements in preparing the Quality Account.

By order of the Board

28/06/2012 ..... Date  ..... Chair

28/06/2012 ..... Date  ..... Chief Executive

2.2.2 Annual Governance Statement

This Statement sets out for our staff and stakeholders of Sandwell & West Birmingham Hospitals NHS Trust the way in which it is governed and managed, and how it is accountable for what it does. The Governance Statement is Appendix 1 which can be found in the Quality Account 2011/12 appendices at www.swbh.nhs.uk/about-us/publications.

2.2.3 Review of Services

During the period 2011/12 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 it on the quality of the care in all 46 of these services. Where the trust has subcontracted any activity, it would only be to a provider which was registered with the CQC. Agreements between the Trust and the subcontracted providers require that the same high standards of care given by SWBH are maintained when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust.

The income generated by the NHS services reviewed in 2011/12 represents 100% per cent of the total income generated from the provision of NHS services by Sandwell and West Birmingham Hospitals NHS Trust for 2010/11.

2.2.4 Participation in Clinical Audits

During 2011/12, Sandwell & West Birmingham NHS Hospitals Trust has participated in 41 (provisional) national clinical audits and 2 national confidential enquiries covering NHS services which the Trust provides.

The Trust has reviewed all the data available to it on the quality of care in all of these services.

During that period Sandwell and West Birmingham Hospitals NHS Trust participated in 98% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in. The reason SWBH did not participate in 2% of audits was because the Trust did not provide the service or procedure required for inclusion in the audit.

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 2011/12, 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 (Table 3).

Table 3.

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Peri – and neonatal		
Perinatal mortality (CEMACH)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	100%
Pain management (College of Emergency Medicine)	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100%
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Yes	100%
Non–invasive ventilation (NIV) – adults (British Thoracic Society)	No	0
Pleural procedures (British Thoracic Society)	Yes	67%
Cardiac arrest (National Cardiac Arrest Audit)	Yes	33%
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	100%
Seizure management (National Audit of Seizure Management)	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit)	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	57%
Chronic pain (National Pain Audit)	Yes	100%
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Yes	100%
Adult asthma (British Thoracic Society)	Yes	100%
Bronchiectasis (British Thoracic Society)	Yes	100%
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	93%
Elective Surgery (National PROMs Programme)	Yes	73%

Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	86%
Carotid interventions (Carotid Intervention Audit)	Yes	100%
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	93%
Elective Surgery (National PROMs Programme)	Yes	73%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	86%
Carotid interventions (Carotid Intervention Audit)	Yes	100%
Cardiovascular Disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	88%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SINAP)	Yes	13%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head & Neck Cancer (DAHNO)	Yes	100%
Oesophago- gastric cancer (National O-G Cancer Audit)	Yes	100%
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	42%
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	95%
Medical use of blood (National comparative Audit of Blood Transfusion)	Yes	100%
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	100%
End of life		
Care of dying in hospital (NCDAH)	Yes	100%

National Confidential Enquiries (Clinical Outcome Review Programmes)		
Maternal, infant and perinatal programme National maternal and perinatal mortality surveillance	Yes	100%
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following studies in 2011/12 - Bariatric Surgery (ongoing) - Peri-operative Care Study - Cardiac Arrest Procedures - Surgery in Children	Yes	Yes Ongoing 23% 100% 100%

The reports of 10 national clinical audits were reviewed by the provider in 2011/12 and Sandwell and West Birmingham Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare we provide:

Table 4. National Audits Reviewed

Report	Findings, Our Learning, & Our Actions
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England Audit description An audit of outcomes reported by patients undergoing hip replacement, knee replacement, varicose vein surgery and surgery for inguinal hernia repair	Key findings/learning The provisional data has shown that improvements are required particularly in relation to procedure specific scores for patients undergoing knee replacement. Action A number of steps are being taken to ensure that patients consider that they are receiving the best service possible. The actions include: • To improve the scope and quality of pre-operative information. • To introduce a patient satisfaction questionnaire for patients undergoing joint replacement. • To expand the scope of the 'enhanced recovery programme. The programme focuses on making sure that patients are active participants in their own recovery' process. It also aims to ensure that patients always receive evidence based care at the right time.

NCEPOD: Are we there yet? Audit description This was an audit conducted by the National Confidential Enquiry into Post-operative Outcomes and Death (NCEPOD) The audit aimed to explore the remediable factors in the processes of care of children aged 17 and younger, including premature babies, who died prior to discharge and within 30 days of emergency or elective surgery.	Key findings/learning The baseline assessment against the key recommendations contained in the report identified some initial actions that needed to be taken. Action The action required includes reviewing the compliance with local transfer policies and to review the local policy on who can operate and anaesthetise children to ensure compliance with best practice.
National Confidential Enquiry into Suicide and Homicide for people with Mental illness - Annual Report 2011 Audit description The enquiry examines all incidences of suicide and homicide by people in contact with mental health services in the UK. They also examine all cases of sudden death in the psychiatric inpatient population.	Key findings/learning The report has been considered and although there are no specific recommendations requiring action, the Trust continues to ensure its systems are robust in order to assess the level of suicide risk and to take action if patients who have self-harmed. Action A Therapeutic Observation Policy which indicates the level of staff supervision dependent on the level of risk has been implemented. In addition, there is access to specialist Mental Health teams on both sites and training is available for a range of challenging Mental Health conditions. There is a tool for reviewing environmental risk to patients who are at risk of suicide and work to reduce ligature points is ongoing. All of the above is monitored via the Safeguarding Steering Group.
Perinatal Mortality West Midlands Perinatal Mortality Institute report: • Birmingham & Solihull and Black Country cluster Infant mortality reports 2010	Key findings/learning The Birmingham and Black Country Cluster areas have for some time recorded stillbirth, neonatal, perinatal and infant mortality rates significantly higher than national averages. This has not improved during 2010 and has historically been associated with social deprivation and ethnicity demographics concentrated in pockets within both

Audit description The report covers the Black Country NHS Cluster and the Birmingham and Solihull NHS Cluster and its constituent Local Authorities and provider units. It contains data with reference to the West Midlands (WM), and includes stillbirth, perinatal and infant mortality data up to 2010.	within both clusters. The Trust continues to serve populations with the highest incidence of these demographics of all the providers in the clusters. Action The Trust identified an action to work to enhance the scope of the risk assessment process undertaken in the community and its linkages with that undertaken in the acute hospital.
NCEPOD: Knowing the risk? This was an audit conducted by the National Confidential Enquiry into Post operative Outcomes and Death (NCEPOD) Audit description The study aimed to carry out a national review of the peri-operative care of patients undergoing inpatient surgery	Key findings/learning The baseline assessment against the key recommendations contained in the report identified some initial actions that needed to be taken. Action These included establishing a continuous audit of patients admitted and managed at a lower level of care because of a lack of capacity. Also to scope the further development of enhanced recovery pathways.
National Neonatal Audit Programme – Annual Report 2010 Audit description The key aims of the audit are: • To assess whether babies requiring neonatal care received consistent care across England in relation to the audit questions; • To identify areas for improvement in neonatal units in relation to delivery and outcomes of care; • To provide a mechanism for ensuring consistent high quality care in neonatal services	Key findings/learning The audit showed that compliance was below the national average for Retinopathy of Prematurity (ROP) screening, parent communication within 24 hours of admission and the antenatal steroid rate. It was considered that this was due in part to inadequate recording on the BADGER database system. Data from BADGER feeds into the national report. Action One of the key areas for action is to ensure that data recording on the system is improved and to audit these areas to check accuracy of results and to take action to improve compliance if this is indicated.

National Joint Registry (NJR) 8th Annual Report 2011 Audit description The NJR aims to improve patient safety and clinical outcomes by providing information to all those involved in the management and delivery of joint replacement surgery, and to patients. This is achieved by collecting data in order to monitor the effectiveness of hip, knee and ankle replacement surgery and prosthetic implants.	Key findings/learning The report encouraged all NHS Trusts and NHS Foundation Trusts to record all hip, knee and ankle replacement operations on the NJR. In addition, to ensure that consent from patients to store their personal details is taken and that the NHS number of patients is submitted in order that the ability to link all operations relating to a single patient is maintained. It was considered that the Trust had good systems already in place to ensure that this happened. The NHS number recording is monitored by the NJR Regional Coordinator and the Trusts compliance for 2010/11 was 98%. Action To continue to ensure that all relevant cases are recorded on the NJR database
National Pain Audit – Phase 1 Report Audit description The National Pain Audit has reported organisational data for the years 2010 – 2011 against a wide range of standards set by the Faculty of Pain Medicine, British Pain Society and International Association for the Study of Pain.	Key findings/learning The report indicated that patient waiting times for treatment needed to be better understood. The Trust currently monitors waiting times and local audits are conducted, however, further work is required to investigate the impact of any waits. The audit also recommended that patients should be provided with multidisciplinary care and that if this cannot be provided then they should be signposted appropriately. It was considered that the Trust provided multidisciplinary treatment but that there was no direct psychology input into the clinic. Action A key action arising from the audit was for the Trust to investigate funding for additional staff in the pain clinic or the provision for shared roles with community staff, mental health services and with GPs. Also to increase the levels of extended practitioner care e.g. nurses

	who are trained in Cognitive Behavioural Therapy (CBT) and to improve patient information leaflets for local service access.
National Diabetes Paediatric Audit Report 2009-2010 Audit description The audit presented the Key findings about the quality of care for children and young people with diabetes in England and Wales the report for the audit period 2009-2010.	Key findings/learning The audit examined the proportion of children and young people with diabetes that were receiving the key processes of diabetes care. The main care process which was low in the Trust was Retinopathy Screening. The audit results also highlighted the need for increased paediatric diabetes specialist nursing input. Action To send parents reminders to take their children for screening in the community and to improve monitoring through improved information technology. Deficiencies in specialist nursing support are due to be rectified with the appointment of a second paediatric nurse specialist. This will help provide more home support for diabetic children and hopefully reduce admissions.
National Bowel Cancer Audit 2011 Report Audit description The audit is run in conjunction with the Association of Coloproctology of Great Britain and Ireland and is designed to assess whether patients with colorectal cancer receive the appropriate treatment for their cancer when it is first discovered.	Key findings/learning The baseline assessment against the key recommendations highlighted that there was good compliance apart from on the recording of complications following surgical resection. This was a national key finding. Action To take steps to improve the recording of any complications following surgical resection.

The reports of 16 local clinical audits were reviewed by the provider in 2011/12 and Sandwell and West Birmingham Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Table 5. Local Audits Reviewed by the Trust

Audit Topic	Actions identified
Acute Pain 'Out of Hours' Audit Audit description To review the escalation of pain issues out of hours and to measure compliance with national standards.'	Key findings/learning Although the sample was small, the audit highlighted the need to raise awareness regarding the escalation of pain issues and to reinforce the guidelines for the management of pain 'out of hours'. Action To present the requirements for 'out of hours' pain management at junior anaesthetist inductions and at pain management study days. In addition to the above, a further action arising from the audit was to explore amending the Trust's shaded observation charts (incorporates psychological triggers for escalation and senior review) to include traffic lights and for alerts to the Emergency Medical Response Team (EMRT), based on pain scores.
Audit on Cranial Ultrasound screening in preterm Audit description To measure the Trust's compliance with South West Midlands Neonatal Network guidelines for cranial ultrasound screening in preterm babies.	Key findings/learning The audit showed that the majority of preterm babies received cranial ultrasound screening in accordance with South West Midlands Neonatal Network guidelines. The audit did highlight that some scans were delayed and that the documentation of the communications with parents needed to be improved. Action • To update cranial ultrasound screening documentation sheets to include a tick box to indicate that parents have been made aware of the results of the scan • Weekly Ward Round Sheet to identify when head scans are due • To emphasize the requirements for head scans during neonatal doctors' induction

Audit of post appendicectomy wound infections Audit description The audit aimed to assess wound infection rates following appendicectomy and to determine whether changes to the antibiotic guidelines and reconfiguration have affected wound infection rates.	Key findings/learning The audit findings indicated that there was some variability of antibiotics prescribing in terms of dose and duration and in the preoperative cleansing of the patients' skin. It also highlighted the need for ongoing staff education to facilitate standardisation of practice. Action To update the appendectomy protocol with a new antibiotic flowchart and to promote this in operating theatres.
Audit of anaesthetic record keeping in Obstetrics Audit description Audit of the documentation of consent, anaesthetic assessment, assessment of regional anaesthetic block adequacy, and chart to measure compliance with the standards set by RCOA & OAA.	Key findings/learning Overall the result demonstrated that there was an improvement in documentation compared to the previous audit findings. Some areas of weakness were found in the recording of preoperative assessment details and in the completion of the post-operative care and instructions sections. Action To make changes to the current documentation to improve the recording of the areas of weakness that were identified.
Audit of outcomes radiofrequency ablation of varicose veins Audit description The audit aimed to examine the patients' intra-operative and postoperative events and to measure compliance with NICE guidance.	Key findings/learning The majority of patients in the audit sample had no post operative complications. In the number that had post op complications, the main complication was phlebitis (inflammation of the wall of the vein). Action The action required as a result of the audit included updating patient information leaflets with further information on the possible side effects and complication rates.

An Audit of Visual Fields Requests Audit description An audit to measure the compliance with aspects of NICE clinical guideline 85 (Glaucoma).	Key findings/learning The audit highlighted the need to improve documentation to ensure that the outcomes of visual field tests are always recorded in patient records and in GP letters. Action To circulate reminders to junior doctors of the need for this to be documented and for the compliance to be monitored going forward.
An Audit of Neuropenic Sepsis Audit description To assess whether the door to needle time with intravenous (IV) antibiotics is achieved within the target of 1 hour for patients with neutropenia or suspected neutropenia.	Key findings/learning The audit found that not all patients received antibiotics within the recommended time frame and that the use of the Shift Coordinator reduced the door to needle times. Action • To continue education sessions for staff in A&E Departments to reduce times further • Chemotherapy and MDS alert cards to be issued to patients to carry with them, reinforcing the symptoms and the use of the helpline. • To monitor compliance on a rolling basis. This audit to be completed every 20 patients or 3 months, whichever occurs sooner.
An audit of patient consent Audit description To assess compliance Trust policy on obtaining consent to treatment.	Key findings/learning The audit found that although in the majority of cases the clinician taking consent for elective procedures prior to admission was a Consultant, Associate Specialist or Specialist Registrar grade doctor, there was need to reinforce with Directorates that to take delegated consent the appropriate training and authorization is required. The audit also found that the formal recording of whether the patient had

	been supplied with a copy of the consent form and whether they had been provided with an information leaflet needed to be improved. Action To implement a rolling audit to monitor compliance with local policy and to further scope the availability of national information leaflets in patient areas.
Essence of Care Audits & Observation of Care audits Audit description 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	Key findings/learning The most recent results demonstrated ongoing improvement against most standards in both the observations of care and in the record keeping of care. Action All wards and divisions are presented with tailored performance reports and action plans are developed to address specific areas of unsatisfactory performance against the standards being measured. Audit results are fed into the Ward Review process and are discussed with ward staff at a feedback session.
Hand hygiene audits Audit description As part of Trust's ongoing initiatives for the reduction and prevention of healthcare associated infections, all clinical areas are required to undertaken hand hygiene audits.	Key findings/learning Results for 2011 showed that overall there was an improvement in most standards compared to the year 2010. Ward/Department Hand Hygiene Audit scores ranged from 88% to 100% in 2011 (Mean 94%). Action Any ward /department whose score falls below 95% is required to undertake the audit weekly until 95% compliance has been achieved.

Mortality audits Audit description 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. Reviews of data collected under the Initial Mortality Review System to determine whether there are any lessons that can be learned.	Key findings/learning The audits have identified areas where care processes and the recording of care can be enhanced. Action Some actions identified from the audits of mortality in specific diagnostic groups have included: • Development of local guidance to assist in the management of patient groups • Further audit to understand aspects of care in more detail, including compliance with policies • 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: • Adding supplemental questions for specific diagnosis groups • Developing systems to evaluate and enhance the depth of clinical coding
Saving lives Audits Audit description The Trust has implemented the revised Saving Lives High Impact Interventions (HIIs) audit tools since 01/04/04. To enable the wards, departments and the Trust to monitor compliance against the HIIs the Trust has developed a database to facilitate the inputting, collating and reporting of data.	Key findings/learning The audit data continues to show good overall compliance (98% Feb 2012). Action Any clinical area where clinical practice/ interventions outlined in the audit are undertaken is 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.

Accident & 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, alcohol intoxication or a headache.	Key findings/learning The spot check audits continue to show good compliance at greater than 90%. Action Instances of non compliance are addressed. Reminders are issued and training is provided if required.
World Health Organisation (WHO) Checklist Compliance Audit Audit description To assess the compliance with the "Five Steps to Safer Surgery" in the Trust. This includes use of the Surgical Safety Checklist.	Key findings/learning The Trust conducted an audit that indicated that the checklist was not completed and filed in the records of all patients where it was considered relevant. As a result a system was introduced to monitor compliance on an ongoing basis. Results now show good compliance with completion of the three sections on the checklist. Action Further work is required to ensure that a debrief session is recorded for all qualifying lists. The Trust is also working to ensure that all relevant procedures are included in the calculation of compliance data and that the WHO checklist process is quality assured.
An audit of readmission following discharge from an acute medical admission Audit description The aim of the audit was to determine the appropriateness of decisions to discharge patients admitted with acute medical conditions using emergency readmissions within 28 days as a proxy.	Key findings/learning The rate of readmissions that were considered to be definitely avoidable by the reviewers was low in this sample. The audit found that the recording of discharge decisions could be improved. In addition, steps needed to be taken to improve the recording of the clinician making the decision to discharge a patient and to ensure that the identification of the responsible consultant for each patient is accurately recorded at all times. Action • To scope the development of a real-time system to identify and alert to readmissions.

	• To take measures to ensure the full recording of discharge decisions • To ensure that the identification of the responsible consultant for each patient is accurate at all times.
Nutrition audits <u>Audit description</u> There are a number of audits aimed at monitoring compliance with nutritional standards. These include a rolling monthly audit to assess whether a target of 75% patients are nutritionally assessed using the MUST tool within 12 hours of admission, and to assess whether there is at least 80% compliance protected meal times for patients	<u>Key findings/learning</u> The data has shown that as for the 2011/12 financial year at January 2012, only 3 areas failed to achieve in excess of 85% with MUST assessments and all wards are achieving at least 80% compliance with protected meal times (based on snapshot audits). The audit also has demonstrated good compliance with the use of various risk mitigation actions, e.g. red trays was good at around 99% compliance. Food diaries are completed in 98% of patients who require them and Fluid Balance Charts are completed in 96% of patients requiring them. <u>Action</u> The results from the audits are fed into the Ward Review process and where required an action plan is developed to address the areas where practice is required to be improved.

2.2.5 Participation in Clinical Research

The number of patients receiving NHS services provided or subcontracted by SWBH in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1372 for National Institute for Health Research (NIHR) Portfolio studies and approximately 750 for non-NIHR Portfolio studies

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered, and to making a contribution to wider health improvement. Engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest treatments and techniques. If further ensures that clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Sandwell & West Birmingham Hospitals NHS Trust was involved in conducting over

280 clinical research studies during the 2011/12 period, of which 200 were UK Clinical Research Network (UKCRN) portfolio studies. Research is undertaken across a wide range of disciplines including Cancer (breast, lung, colorectal, haematology, gynaeoncology, urology), Rheumatology, Ophthalmology, Stroke, Neurology, Cardiovascular, Diabetes, Gastroenterology, Surgery, Dermatology and Women and Children's Health. Sandwell & West Birmingham Hospitals NHS Trust uses national systems to manage the studies in proportion to risk and implements the NIHR Research Support Service standard operating procedures.

As an example of the benefits that research can bring to our patients, one of our Rheumatology Research teams, led by a clinical nurse specialist, linked with the manager of Birmingham Arthritis Resource Centre and established a rheumatoid arthritis service with volunteers and colleagues. This was tailor–made for patients of South Asian Origin, and was a direct result of the team's research. The group raised awareness of treatments and helped patients manage their conditions. Community leaders trained local people as patient educators. The service developed multilingual educational material and established a helpline staffed by relevant language speakers. This work led to a National 'Nursing Standard Nurse Award' for Innovation in Rheumatology and Rheumatoid Arthritis at the end of April 2011.

2.2.6 Goals agreed with Commissioners for 2012/13

Use of the CQUIN payment Framework

The Trust has been working closely with the commissioners to develop a whole raft of quality schemes which are summarised in the table below. They are a combination of national and local priorities and some of them are included within our highest priorities and have been described in more detail at the beginning of our Quality Account.

The process of developing the schemes for inclusion in this year's CQUINs has been through discussion with the commissioners. As we indicated earlier in the report, we are continuing with some of the CQUINs from last year amongst our highest priorities. We are doing this with the approval of our commissions and we believe that patients will really benefit from this added attention and focus, particularly with regard to the nursing indicators. As you will recall from the Chief Executive's statement, the CQC carried out visits to the Trust and we have put action plans in place to address their findings. Things such as responsiveness to personal needs, the Safety Thermometer, the Net Promoter, nutrition and weight management and Stroke care will enhance patient care across the whole Trust, with benefit beyond the services identified in the CQC visit.

A proportion of SWBH's income is conditional on achieving quality improvement and innovation goals agreed between the commissioning clusters 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 Framework. In 2012/13 it will be 2.5% of our total income.

Table 6. This table describes an outline of the schemes which the Trust has agreed with the commissioners, to work on.

Goal Name	Description of Goal	Quality Domain
VTE Risk Assessment Acute and Community	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
Appropriate use of warfarin	Warfarin audit	Safety
Composite Indicator on Responsiveness to Personal Needs	Improve responsiveness to personal needs of patients	Patient Experience
Dementia	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	Effectiveness
Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, UTI infection in those with a catheter and VTE	Safety
Net Promoter	Patient Experience	Patient Experience
Use of antibiotics - Antimicrobial Stewardship Acute and community	Reduce the incidence of healthcare-associated infections	Safety
Reducing avoidable pressure ulcers	Reduction of avoidable pressure ulcers for all in-patients	Safety
Mortality review	Every death that occurs within the hospital will be subject to a mortality review involving senior medical staff. Root causes will be identified and avoidable deaths will be identified and learning propagated to the rest of the hospital teams	Effectiveness
Nutrition and weight management	Effective implementation of NPSA naso gastric tube guidance to ensure zero Never Events. Reducing avoidable hospital acquired weight loss in elderly care and stroke in 8 named wards caring for this patient group	Safety, Effectiveness, Patient Experience,

End of life care (EOL)	Improve the percentage of patients receiving effective EOL care from the integrated SWBH palliative care team, including dying in the place of their choice	Patient Experience
Safe surgery	To take measures to ensure zero Never Events for wrong site surgery and retained foreign object post-op to include policy, process, audit and reporting	Safety
Every contact counts - Alcohol	To improve the health of the population by ensuring that all patients who drink at harmful levels are identified and provided with brief advice by trained staff	Effectiveness, & Innovation
Every contact counts - smoking in pregnancy	To improve the health of the population by ensuring that all expectant mothers are provided with brief advice by trained staff and ensuring that expectant mothers who drink at harmful levels and those who smoke are identified and offered help and support	Effectiveness
Stroke	To ensure rapid access to diagnostics, swallow screens are undertaken in a timely manner, and antiplatelets and anticoagulants are prescribed	Effectiveness

2.2.7 What others say about us

2.2.71 Statement from The Care Quality Commission - Registration and Compliance

SWBH is required to register with the Care Quality Commission (CQC)

- Sandwell and West Birmingham Hospitals NHS Trust is registered without conditions with the CQC, the independent regulator of health and social care in England.
- The CQC has not taken enforcement action against the Trust during the period 1 April 2011 to 31 March 2012.
- The Trust has participated in the following reviews by the CQC:

  a) In June 2011 the CQC undertook a review of the Trust's compliance with Outcome 17: Complaints of the essential standards of quality and safety.

At that time they judged that there were minor concerns in how complaints were being managed. A compliance action was issued. In response the Trust submitted an improvement plan to the CQC. An updated action plan was forwarded to them in December 2011 which showed that the key objectives had been achieved. In March 2012 the CQC notified the Trust of their judgment that the organisation was compliant with Outcome 17.

b) In 2011 the CQC carried out reviews at City Hospital and Sandwell General Hospital as part of a targeted inspection programme in acute NHS hospitals to assess how well older people were treated during their hospital stay. The review included unannounced visits to both hospitals. The judgments arrived at by the CQC through this process are summarised in table 7 and were:

Table 7.	**Hospital**	**Inspection Date**	**CQC Judgment**
Outcome 1 Respecting and involving people who use services [dignity and respect]	City Hospital	May 2011	Compliant
	Sandwell General Hospital	March 2011 August 2011 December 2011	Moderate concerns Moderate concerns Compliant
Outcome 5 Care and welfare of people who use services [meeting nutritional needs]	City Hospital	May 2011	Minor concerns
	Sandwell General Hospital	March 2011 August 2011 December 2011	Major concerns Minor concerns Compliant

c) An improvement plan was put in place by the Trust to address the concerns identified by the CQC. This included reconfiguration of wards and stroke provision at Sandwell General Hospital. In December 2011 the CQC carried out a review to check whether the planned improvements at Sandwell General Hospital had been made. The evidence gathered during this review confirmed compliance with both outcome areas.

- The Trust is legally required to continually monitor and ensure compliance with the essential standards of quality and safety to maintain registration.
- A number of new processes have been developed to enable the Trust to monitor compliance with the essential standards, such as local 'mock' CQC inspections. These build on the existing assurance structures.

In 2012/13 the Trust plans to implement an organisation-wide electronic compliance framework designed to provide a mechanism to continuously monitor compliance with the 16 essential standards of quality and safety defined by the CQC.

2.2.8 Limited Assurance Report

The External Auditors have provided the Trust's management with a signed limited assurance report. This report can be found in the Quality Account 2011/12 appendices at www.swbh.nhs.uk/about-us/publications.

2.2.9 Data Quality & Information Governance

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

We take data quality very seriously. We need to know that we are counting, recording and storing information about people's care very carefully. During 2011/12 we undertook the following activities at organizational level to assess and improve our data quality.

The Board asked the Audit Committee to consider recent developments in data quality assurance as informed by the Audit Commission's publication "Taking it on Trust" and work undertaken elsewhere within the NHS. In considering its approach it was mindful of opportunities to learn from other organisations particularly those that had undergone a systematic approach to improving and strengthening assurance.

In one such case the committee identified the benefit of placing a rating on key performance indicators and specifically the data source on which it was based. The intended outcome is that the reader of the information could draw conclusions as to the degree of reliance to be placed on the data and well as provide a marker for improvement or further investigation.

The approach adopted focused on 200 plus performance indicators which currently comprise the Trust's Corporate Performance Report. For each of these the data source a 'supplying' individual within the organisation is indicated as is the format in which the data is received and/or made available to the author of the report, the Head of Planning and Performance Management.

The various indicator lines were assigned a Level (1, 2 or 3) of consequence:

- Level 1 indicators comprise those which feature within National and SHA assessment frameworks and those which comprise the range of CQUIN schemes agreed between the Trust and its commissioners
- Level 2 indicators are locally focused on areas such as clinical quality, workforce, patient experience, finance, activity, referrals and performance against contracted activity plans
- Level 3 indicators comprise a varied range of other local indicators, many complementary to other indicators, relevant to the corporate performance of the Trust.

At this stage a self-assessment has been conducted, initially of all Level 1 indicators, and a number of criteria used to identify a data quality risk rating of between 1 (high risk) to 5 (low risk). These numbers were chosen to mirror Monitor's range of Financial Risk Ratings. In assigning an initial scoring, the criteria and questions used included:

- Is the data quality of an indicator independently verified as part of any local and/ or national review process?
- Has the data previously been subject to a Care Quality Commission validation as part of the Annual Health Check process with the process for capture and data extraction not changing in the interim?
- Does the flow of data continue to follow a well-established process through the organisation?
- Are there well-established systems in place for data capture which are supported by a robust operational policy?
- Is the performance reported a composite of multiple data and / or is it a derived calculation?
- The magnitude of any volatility in terms of actual performance reported between periods.

In order to test the validity of this approach the committee agreed that, prior to completing this stage of the work, it should test the validity of the approach taken as the ultimate intention is to publish a DQ indicator alongside KPIs within the corporate performance report. Consequently, Internal Audit is to ensure that a programme of testing selected indicators is undertaken. Once complete the committee will consider the findings and formulate recommendations for providing assurance to the Trust Board and wider stakeholders.

In addition to the above overarching programme, our actions during 2012/13 will also include:

- A specific programme of work to assess the reliability of 18 week performance reporting following recent data quality concerns
- The inclusion of data quality reports on the Quality Management Framework
- Feedback to Clinical Directorates in respect of coding accuracy and the accuracy of information supplied locally to the Patient Administration System
- Continuing work to ensure the removal of any duplicated patient registrations
- Providing data and information to support Service Line Management

NHS Number and General Medical Practice Code Validity

Below is the National, SHA and Trust performance on validity of these data items as published through the Information Centre through Secondary User Service Data Quality Dashboard – Provider Based using 2011/12 financial month 9 data, which is the latest we have.

It shows we remain above the national benchmarks in line with all of the indicators.

NHS Number

	National	SHA	SWBH
Inpatients	98.7%	99.03%	98.7%
Outpatients	99.0%	99.28%	99.4%
A&E	92.9%	94.83%	96.2%

General Medical Practice Code

	National	SHA	SWBH
Inpatients	99.9%	99.97%	100%
Outpatients	99.7%	99.28%	100%
A&E	99.4%	99.97%	100%

Clinical Coding Error Rate

The latest final Payment by Results external clinical coding audit shows the trust has a 7.3% error rate against national error rate of 9.1%.

The overall error rate is 5.6% for clinical diagnosis coding, and 4.2% for clinical treatment coding.

Information Governance Toolkit (IGT) attainment levels

Sandwell and West Birmingham Hospitals NHS Trust Information Governance (IG) Assessment Report overall score for 2011-2012 was 85% and was graded unsatisfactory (RED) according to the IGT Grading Scheme, which was anticipated. This is because the Trust did not achieve Level 2 attainment across all IGT requirements. The Trust anticipates a satisfactory achievement status by the 31st December 2012.

The Trust is working towards IGT requirements attainment Level 2 in sections:

- 110 - Formal contractual arrangements that include compliance with information governance requirements are in place with all contractors and support organisations.
- 112 - Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained.
- 324 - This requirement will be achieved by default on attainment of level 2 for requirements 110 and 112.

Part 3: Review of Quality Performance 2011/12

3.1 Report on Quality Priorities for 2011/12

In last year's Quality Account, five priorities were identified for 2011/12. They were:

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

The Board wanted the scope of priority 2, Basic Nursing Care, to be broadened to reflect the multi-disciplinary nature of modern health care. This was done so that issues identified by stakeholders during 2010/11 and during 2011/12 consultations would be taken into consideration further.

3.1.1 Priority 1: Stroke

Plans for 2011/12

Last year we said that we intended to continue the work of the Stroke Action Team and we remained determined to achieve our goal of providing the best possible Stroke Service within 5 years of our first report. Specifically, we intended to:

- Continue to develop and implement our stroke strategy
- Address the concerns identified by the West Midlands Quality Review Service (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

What we have achieved:

Strategy (Service Redesign) and actions on the WMQRS Review

Last year the WMQRS raised some concerns about the sustainability of continuing to deliver acute stroke care at our two acute sites and highlighted some aspects of stoke care in our Trust that required further development. We have taken these comments on board and a Reconfiguration Project Steering Group and Project Board were set up. The Project Board, working with our stakeholders including patients and clinical staff appraised a long list of options and reduced them to a short list using a carefully designed scoring process. This shorter list of options has been agreed and has gone out to public consultation after being approved by the Trust Board, the Overview and Scrutiny Committee, the NHS Gateway review team and the National Specialised Commissioning Team (NCAT).

In the meantime, the Trust Management Board has committed a comprehensive investment to support service development and quality improvement in all aspects of the stroke service (£397K May 2011). This has been achieved through improving the speed and delivery of the service for acute stroke, making sure our patients spend a maximum amount of their inpatient stay on our stroke wards and improving the speed of assessment and scanning for patients with transient ischaemic attack (mini strokes with a high risk of progressing to full stroke). These changes were also designed to ensure we improved in areas of performance to attract the Best Practice Tariff for Stroke.

The investment means that we have increased capacity in stroke medicine, imaging and data management to meet local and national quality outcomes for 2011/2012, delivered the CQUIN target for Stroke Discharge and supported the necessary work for consultation and planning for the reconfiguration of stroke services so that all acute work will be based at one of our hospital sites.

The Stroke Action Team has continued to focus on developing the capabilities and competence of its medical and nursing staff involved in stroke care. An additional consultant specializing in stroke care has been recruited to the City site and an existing consultant has become much more involved in the stroke pathway. There has also been continued provision of specialist-led training programmes for consultants and specialist registrars in general medicine who will continue to participate in the stroke pathway at least until reconfiguration of stroke services occur.

Following the concerns identified by the CQC about standards of nursing care in the Acute Stroke Unit (Newton 4), the service has been reconfigured at the Sandwell site by splitting acute stroke care (Priory 1) from stroke rehabilitation care (Newton 4) and focusing further on addressing concerns on the nursing establishment, training, the acquisition of key competencies and delivery of the required standards of care (WMQRS standards). Additional therapist support for the stroke wards has been provided at weekends.

The nursing and therapy leaders are working hard to ensure consistency of patient information and have developed systems to feedback suggestions for improvement to our clinical teams from our patients and carers. Recent patient survey data has been positive in this regard.

The National Sentinel Stroke Audit for 2010 is the most recent national audit for which the results have been released.

Table 8. 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%

In the last report we explained that the Trust performed in the top 25% in comparison to national benchmarks for the delivery of key indicators for stroke care and in 2011/ 2012 our performance in a range of measures designed to reflect the quality of stroke care has continued to improve.

Improved Discharge Arrangements

Led by a senior physiotherapist, the Stroke Action Team has established a project group linked to our community teams to develop Early Supported Discharge. Our patients and carers told us early and safe discharge to their own homes was important. By being linked with our community teams the service will improve patient experience.

You told us that you wanted better information about stroke and to feel more supported after discharge. We have worked hard on improving the quality of information given to patients as part of discharge planning. We set ourselves a target of ensuring that everyone being discharged will have a copy of the agreed discharge plan, including community and social care contacts and a follow-up clinical contact within 24 hours of discharge. The Trust has achieved a performance for this target of 95%.

Clinical Dashboard

The Stroke Action Team has continued to develop its clinical dashboard that captures the key measures of performance and quality of stroke care and has begun to track performance in a number of new areas so as to continue our drive to reliably deliver excellent care for our patients. Work is in progress to develop and implement real-time alerts for the management of patients with stroke and Transient Ischaemic Attacks (TIAs) or mini strokes.

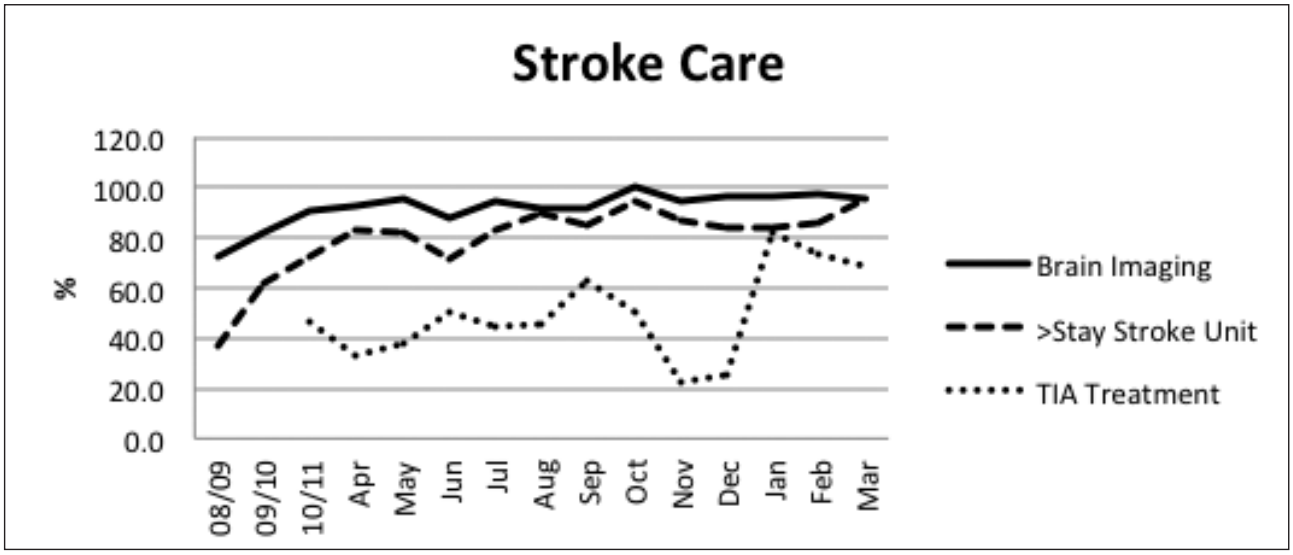


Table 9. This shows that performance against the main stroke targets for stroke care has improved during 2011/12. The figures show that the Trust is now more reliable at ensuring our aim that all patients with acute stroke are admitted directly to an acute stroke unit with a CT scan on the way to the ward and that our performance for mini strokes (TIA) has improved.

3.1.2 Priority 2: Basic Nursing Care

We said we would 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 (rescue)

We said we would 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 said we would 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 patients satisfaction reports.

What we achieved:

Reducing incidence of tissue damage and falls rates

We have been successful in achieving a 38.6% reduction in pressure sores against a target of 10% reduction compared to January-March in 2011. We have also been successful in completing risk assessments of 95% of admissions in the acute hospitals.

Reducing medication errors

We have succeeded in reducing omissions of prescribed medications by 16% against a target of 10%. This reflects considerable effort around raising awareness, 'housekeeping' of medicines charts and improved prescribing practices.

Improving end of life care

We have succeeded in improving end of life care by facilitating a greater number of patients dying in their preferred place of choice. Our target was to increase the number of patients achieving preferred place of death by 10% in both the acute hospitals and in the community). This year, 81% of hospital patients achieved preferred place of death. 86% of community patients achieved preferred place of death which is an improvement on last year.

Improving the nutrition and fluid intake of patients

We are assessing our patients' nutritional state within 12 hours of admission. We have been carrying out frequent audits. All wards are achieving at least 80% compliance with protected meal times (based on snap shot audits). We are doing various things to improve compliance such as using red trays. The use of a red tray for serving meals is that this indicates to staff that the patient requires extra help with eating and drinking. This has improved compliance to 96% compliance compared to 69% in June 2010.

Improving the care offered to patients with learning disability, dementia or mental ill health

We have continued to invest in training to ensure that vulnerable adults are protected whilst in our care. The Lead Nurse for vulnerable adults continues to train newly qualified staff nurses and has been asked to teach on the apprentice training scheme. We have met our target for the number of staff undertaking Safeguarding Adults Training level 2, and we continue to improve. The table below illustrates compliance as of the end of January 2012.

Table 10.

Safeguarding Adults Level 2 Mandatory Target	Safeguarding Adults Level 2 Compliant	Safeguarding Adults Level 2 % Compliant
1190	793	66.64

Control of Infection

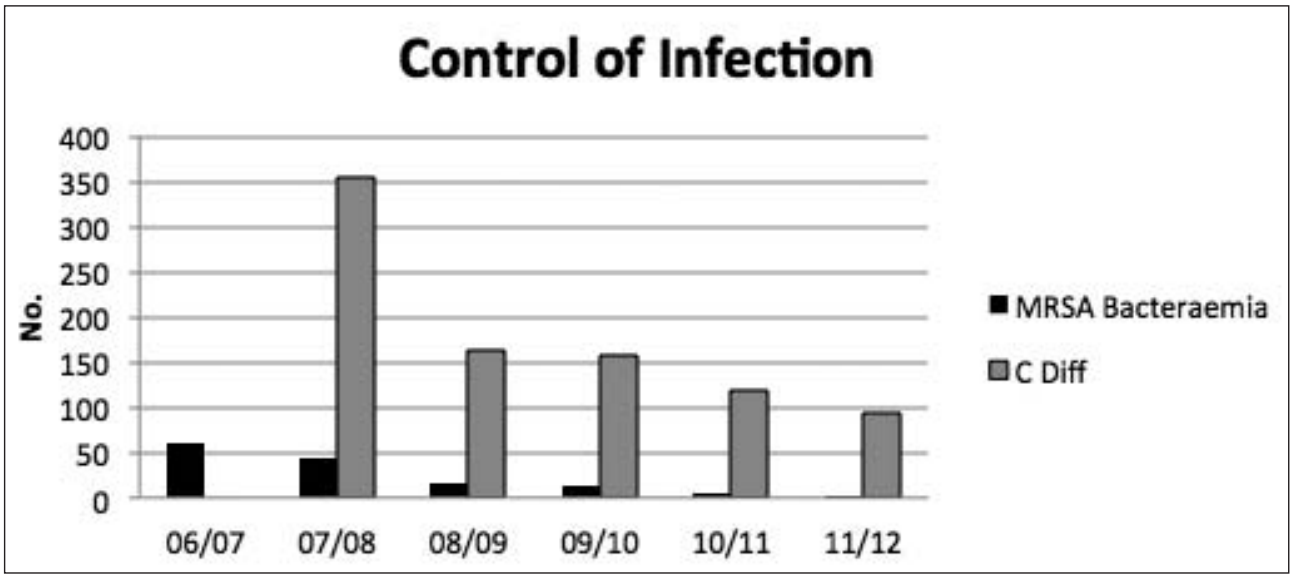
When people enter our hospitals, we make every effort to ensure that they do not catch infections that can possibly be prevented. This is so we can keep people safe from avoidable harm.

We have successfully maintained our excellent performance in respect of infection control, with cases of hospital acquired MRSA Bacteremia being cut from 61 in 2007/8 to only 2 in 2011/12, which is well below the trajectory agreed with the commissioners of 6 in a year.

For Clostridium difficile (C. Dif.) our numbers of reported infections have also seen a significant drop. There has been a reduction from 355 in 07/08 to 95 in 2011/12. These figures help us to reassure those we treat that we take avoiding hospital acquired infection seriously through the work of our infection control team, antimicrobial pharmacists and microbiologists who together promote good antibiotic stewardship.

We are, however, constantly and continuously seeking to improve areas of weakness so that we can continue to develop and progress. The risk team, which is led by the Director of Governance, has introduced an electronic reporting system and has formalized the process of ensuring that all serious incidents are thoroughly investigated and reported to the Board and that all action plans are pursued to conclusion.

Table 11. Control of Infection



MRSA Screening

One of the measures we know helps to reduce the risk of getting an MRSA bacteraemia is to carry out screening tests before patients are admitted to the hospital. MRSA frequently can be found doing no harm to the body.

The Trust carried out 3243 MRSA screening tests on people coming in for planned (elective) surgery during March 2012 and has achieved 35,897 tests across 2011/12 which is ahead of the year-end target of 30,000.

When patients are admitted as emergencies, we still try to ensure that MRSA screening is carried out. The Trust carried out 1687 MRSA screening tests on emergency patients during the month of March 2012 and we have achieved 20,293 tests during 2011/12, against a year-end target of 30,000. However, we are working on improving our performance against this target to meet it by the end of March 2013.

3.1.3 Priority 3: Mortality

During 2011/12 we committed to continuing to develop and implement our mortality review system (MRS). Our aim was for senior doctors to review the case notes of at least 60% of patients who had died so that areas of potential avoidable harm could be identified and lessons learned for what we could do better could be quickly applied. This process was part of our strategy to improve our Hospital Standardised Mortality Rates (HSMR) in comparison to the national average. We also intended to improve our understanding of how we care for patients at the end of life.

Specifically, we said we would:

- 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

What we achieved:

Mortality Reviews

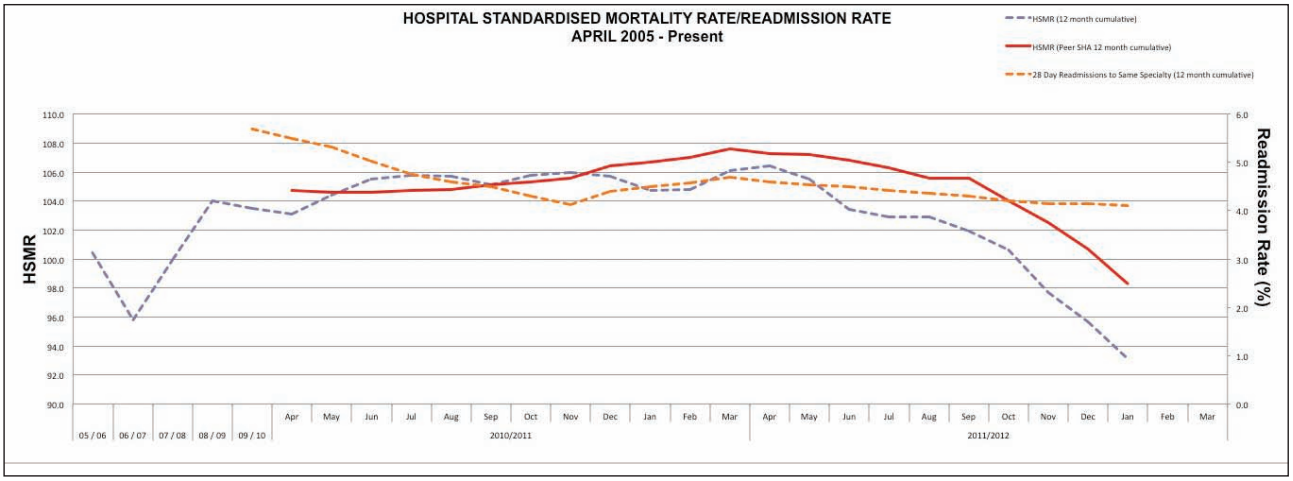
To check that people in our care were not dying unnecessarily, it was agreed with our commissioners that by March 2012 60% of deaths would be reviewed and reported by a senior doctor.

The Trust has been successful in meeting its commitment to our patients and commissioners with the target being exceeded. We met the target in 5 out if the first 8 months of the year (between April and November) and in the last 4 months (December 2011 to March 2012) we have exceeded the target, achieving the target early as we were tasked with reaching this level by the last month of the year. This demonstrates how keen we are to provide excellent clinical care to our patients. We are carrying out these reviews so that we can be sure that our patients are getting the most appropriate care that we can give them. Nurses are often also involved in multi-disciplinary team meetings where deaths have occurred and participate in developing an understanding of whether the death could have been prevented.

Mortality rates

The Trust received notification of two CQC Mortality Outlier Alerts in October 2011. They concerned mortality in hospital where the patient had been admitted as an emergency with a primary diagnoses of pneumonia or cerebrovascular disease. Following the submission of additional information to the CQC, they have now confirmed that they do not wish to take any further action at this stage. Despite that, the Trust undertook closer examination of why an alarm had been raised, and has reported the findings within the internal governance systems.

Table 12.



The table above illustrates that the HSMR has reduced based on the previous 12 months to below 100, which is good (100 being average). This compares favorably with the other trusts in the old West Midlands Strategic Health Authority area. Readmissions of patients, to the same specialty within 28 days, has also decreased implying that their treatment and discharge has been appropriate.

Mortality & Quality Alerts Committee

A new committee of clinical staff has been formed to review the results of the mortality review process and ensure that the necessary actions are taken. The committee review all new alerts triggered by the HSMR so areas of concern are identified and dealt with quickly. This process led to a stroke mortality alert, and a focus on biliary sepsis and those with a primary diagnosis of pneumonia.

We consider that it is very important to understand why patients in our care die as this will help us to improve the safety and effectiveness of the care we provide (two of our three top quality and safety priorities).

Significant work has gone on to improving our understanding of this, and clinicians are now able to check and change codes assigned to deaths, if necessary, to improve the accuracy of our information. The development of the Clinical Dashboard to support End of Life care teams is still in its early stages.

3.1.4 Priority 4: Quality & Safety Strategy

We said we intended to enhance the Trust Board's oversight of quality issues and 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 said we would:

- Establish a new Quality and Safety Committee to enhance Board oversight of quality performance
- Continue the development and implementation of the Quality Management Framework (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

What we have achieved

The Trust has continued to work on the development and implementation of its Quality and Safety Strategy during 2011/12. We identified the 3 main areas (domains) relevant for quality and safety as:

Patient safety	To reduce adverse events which result in avoidable harm	=	We do no harm to patients
Clinical Effectiveness	To reduce avoidable mortality and morbidity	=	Fewer patients dying and fewer having complications
Patient experience	To increase the percentage of patients who would recommend the Trust to family and friends	=	Improved patient satisfaction

Quality and Safety Committee

As part of the development of the Quality & Safety Strategy in 2010, the decision was taken to replace the existing Governance and Risk Management Committee with a Quality and Safety Committee, as one of the Trust Board's formal subcommittees. The Committee is chaired by a Non-Executive Director and meets six times per year.

The Committee's key agenda items focus on matters to ensure that adequate assurance is provided to the Board that clinical services are appropriately delivered

in terms of quality, effectiveness and safety. It is also to ensure that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance. In addition, it is to provide assurance that where quality and performance falls below acceptable standards, that action is taken to bring it back in line with expectations, and to promote improvement and excellence. It also ensures that service user and carer perspectives on quality are at the heart of the Trust's quality assurance framework.

Quality Management Framework (QMF)

Improving information about our performance both in terms of quantity of work done and measurement of quality of our services is vital for us to understand how well we are doing at providing care. Work has been progressing into developing a performance framework where information is gathered and fed back to staff to help them understand their progress against defined targets. This is called our QMF.

This is taking shape under the title of 'dashboards' which allows teams to look at their own specific collection of indicators which flag up how they are doing.

Led by Clinical Directorate Teams, teams are held accountable for the services they deliver. Clinical directorate teams are responsible to the Divisional Management Teams (Division Director (senior doctor), Senior Nurse & Senior Manager). In turn, they are responsible to the Board.

In addition, The Quality and Safety Committee and Governance Board monitor progress against all quality issues. A new report is being developed for the Trust Board which is totally focused on quality. This report is equally important as the financial reports and general performance reports. The progress of the Quality Account priorities will be included in this report. This is to ensure that patient care remains firmly at the heart of our business and that we remain committed to meeting our quality aims.

Patient Safety & Incident Reporting

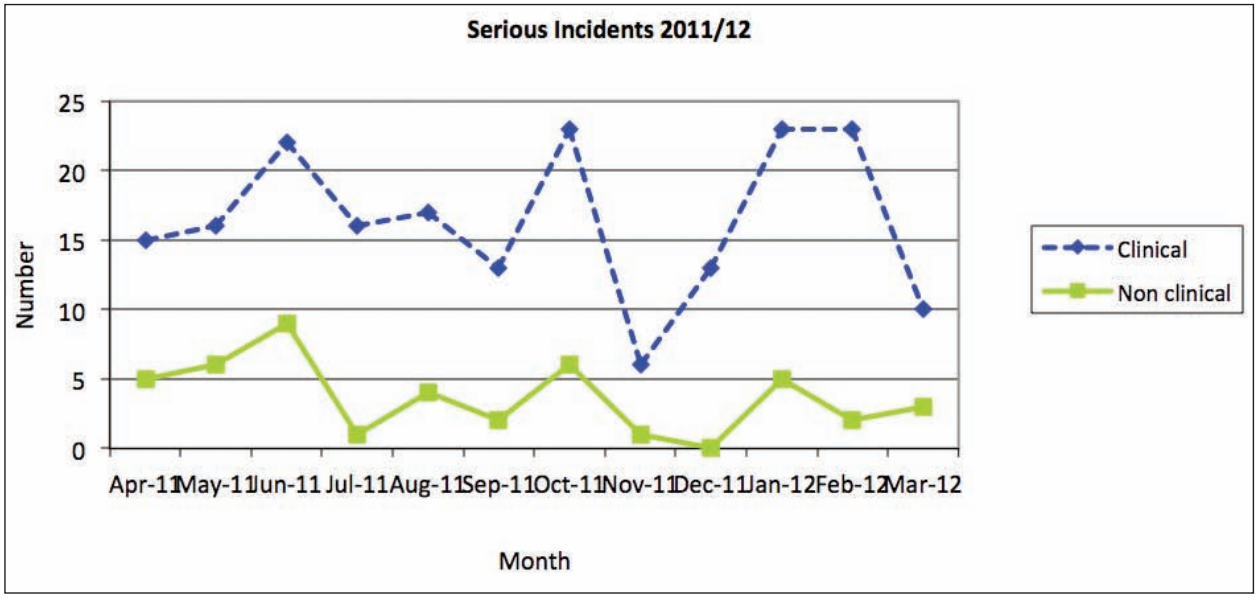
Organisations that report more incidents usually have a better and more effective safety culture. The comparative incident reporting rate, per 100 admissions, for 41 large acute organisations published by the National Reporting and Learning System in March 2012 placed the Trust in the middle 50% of reporters. This is a significant improvement as previously the Trust was in the lower 25%.

The Trust has a system for investigating incidents of all grades and learning from the mistakes. Staff are actively 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.

The introduction of an electronic incident reporting system has improved reporting

rates across some clinical groups, which the previous paper-based system did not support. Where feedback mechanisms are being used by managers in dealing with incident reports, continued reporting is showing an increasing number of reports. Quality of data and information is better since moving to an electronic system.

Table 13.



Incidents are categorised according to the severity of the actual harm caused and the most serious are reported to the Board, the Department of Health (via the SHA) and our commissioners. The Trust uses its reporting system for specific incidents to highlight particular issues and ensure there is an analysis of the incident and resulting action plans. Such incidents currently include some Needlestick injuries and physical violence to staff from patients and visitors.

The chart above shows the numbers of clinical and health & safety incidents classed as serious by month through 2011/12. Every serious incident is investigated and undergoes a Root Cause Analysis (RCA). 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.

'Never Events'

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. We have reported 7 never events since 1 April 2011. Six were related to surgical procedures and one to a misplaced oro-gastric tube. At investigation one of the never events which related to wrong site surgery was declassified from a never event with the agreement of the PCT. This was because on further investigation the biopsy was

appropriately taken based on the clinical findings on the morning of surgery.

One never event involved retention of a guidewire (a wire used during a procedure to make sure a tube goes into the right place). These were not previously part of the count undertaken throughout and at the end of operating lists; however, this has now been adjusted within the theatre policy and processes.

One event was a retained scleral screw during ophthalmic surgery. The WHO surgical checklist was not completed and miscommunication prevented this incident being dealt with appropriately at the time. The WHO surgical checklist is now in full use within the ophthalmic theatre suite.

The remaining three surgical never events related to retained swabs; one in obstetrics, and two in gynaecology. The WHO surgical checklist would not have identified the events in any of these cases. In the obstetric case, the swab count was correct, but an incorrect swab was used during insertion of a cannula. These swabs have now been removed from the department to prevent reoccurrence. In both gynaecology cases the swab was intentionally left in post-operatively, for removal the next day. One event was found to have a causative factor of training and supervision, whilst the second event is currently being investigated.

Less serious incidents are also investigated and tracked, although the investigation is generally conducted by the department, directorate 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. AEC has begun to monitor compliance at division level of completion of review and action planning for incidents graded as amber.

Improving Patient Experience

The Trust seeks patient views through a variety of methods including the national patient inpatient and outpatient surveys, and a trust-generated internal inpatient survey. The internal survey generates around 1000 replies every month, i.e. in excess of 10% of inpatient admissions. The survey is given out on discharge and is available in easy read and other language formats. What we find out from these surveys helps us to shape the services we deliver.

National Outpatient Survey

The Trust has seen an increase in the proportion of outpatients who rated their overall care as excellent over the past two years. 45% of patients said their overall care was excellent, compared to 36% in 2009. A further 36% said their care was very good, 14% good, 4% fair and 1% poor. No patients said their care was very poor. The Trust's overall scores for outpatient care and treating patients with respect and dignity were average.

Table 14. National Outpatient Survey *

Key indicators	2009	2011	Top 20% England (2011)	Lowest 20% England (2011)
Overall outpatient care	82/100	84/100	Above 86/100	Below 82/100
Treating patients with respect and dignity	92/100	94/100	Above 95/100	Below 92/100

*No National Outpatient Survey was carried out in 2010

Table 15. National inpatient survey

Key indicators	2009	2010	2011	Top 20% England (2010)	Lowest 20% England (2010)
Overall inpatient care	77/100	78/100	77/100	Above 81/100	Below 74/100
Treating patients with respect and dignity	82/100	87/100	87/100	Above 90/100	Below 86/100

The Trust's overall scores for inpatient care and treating patients with respect and dignity were average. A number of individual questions saw significant improvement, the largest improvement being patients saying they had enough help from staff to eat meals if needed, which rose from 54% in 2009 to 67% in 2010 and 65% in 2011. We are working to improve on this through our essential nursing care focused work.

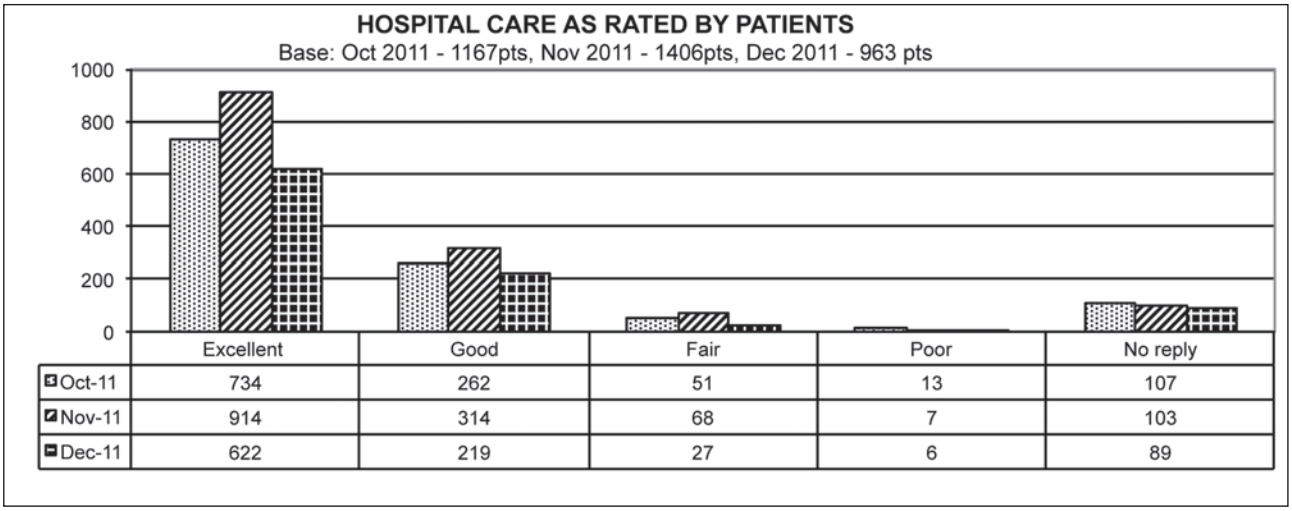
Local patient surveys

Monthly reports are generated for various Trust Committees, including Trust Board. Results are given to individual wards and are used as part of ward performance reviews.

Care as rated by patients

In the table below, the number of people rating the trust is displayed for October, November & December 2011. Fewer surveys were sent out in December so it appears our performance has not improved. But, if we look at the percentage of people who returned the survey it indicates that people who said their care was excellent or good was 90% in October it, 94% in November and 96% in December. So the percentage of people saying their care was better has gone up. The people who did not return the surveys are not included in the total as we do not know what they thought.

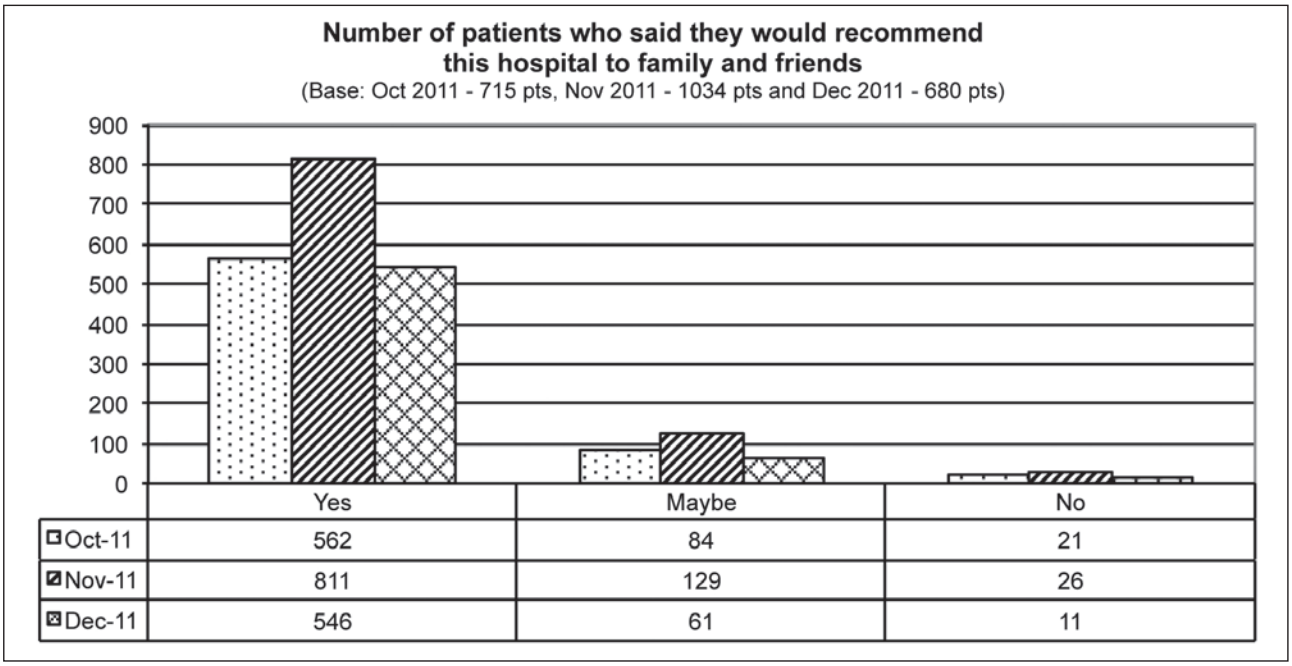
Table 16. Hospital care as rated by patients



	Excellent	Good	Fair	Poor	No reply
Oct-11	734	262	51	13	107
Nov-11	914	314	68	7	103
Dec-11	622	219	27	6	89

In the table below, the number of people indicating whether they would recommend the Trust to their families is displayed for October, November & December 2011. Fewer surveys were sent out in December so it appears our performance has not improved. But, if we look at the percentage of people who said that they would recommend the hospital to to family and friends, rather than numbers, this would show that in December 88% of people said that they would recommend this hospital to family or friends compared to 84% in October and 88% in November. So the percentage of people saying their care was better has gone up.

Table 17. Recommendation to Family and Friends



	Yes	Maybe	No
Oct-11	562	84	21
Nov-11	811	129	26
Dec-11	546	61	11

This year we will be including this these questions in the 'Net promoter' measure so we will ensure that we can compare like-for-like more easily across the year.

3.1.5 Priority 5: Service Improvement

Accident & Emergency Departments

In 2011/12 we committed to continue our work to improve the quality of service and safety within our A&E Departments. Specifically, we said we intended 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 A&E 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 Departments.

What we have achieved:

Throughout 2011/12, the Emergency Department Action Team (EDAT), chaired by the Chief Executive, has continued to work with the A&E Departments at both City and Sandwell Hospital sites to secure the objectives listed above.

Our recruitment programme has continued, in order to increase the number of doctors and nurses in both departments. This has included looking at new and varied recruitment strategies to ensure that we attracted experienced, senior staff to our departments. We have continued to expand our non-medical workforce, particularly Physicians Assistants and Emergency Nurse Practitioners, an excellent alternative to doctors.

As you can see below, the number of clinical staff in the A&Es has changed and we have more consultants and specialist staff.

Table 18. ED specialist staff numbers

Whole Time Equivalent Staff	Mar-11	Mar-12
Consultants	7.6	9.6
Middle Grade Doctors	30.8	28.2
Emergency Nurse Practitioners	7.08	7.6
Physicians Assistants	1	4
Total number of clinical staff	215	220
Total number of staff	251	250

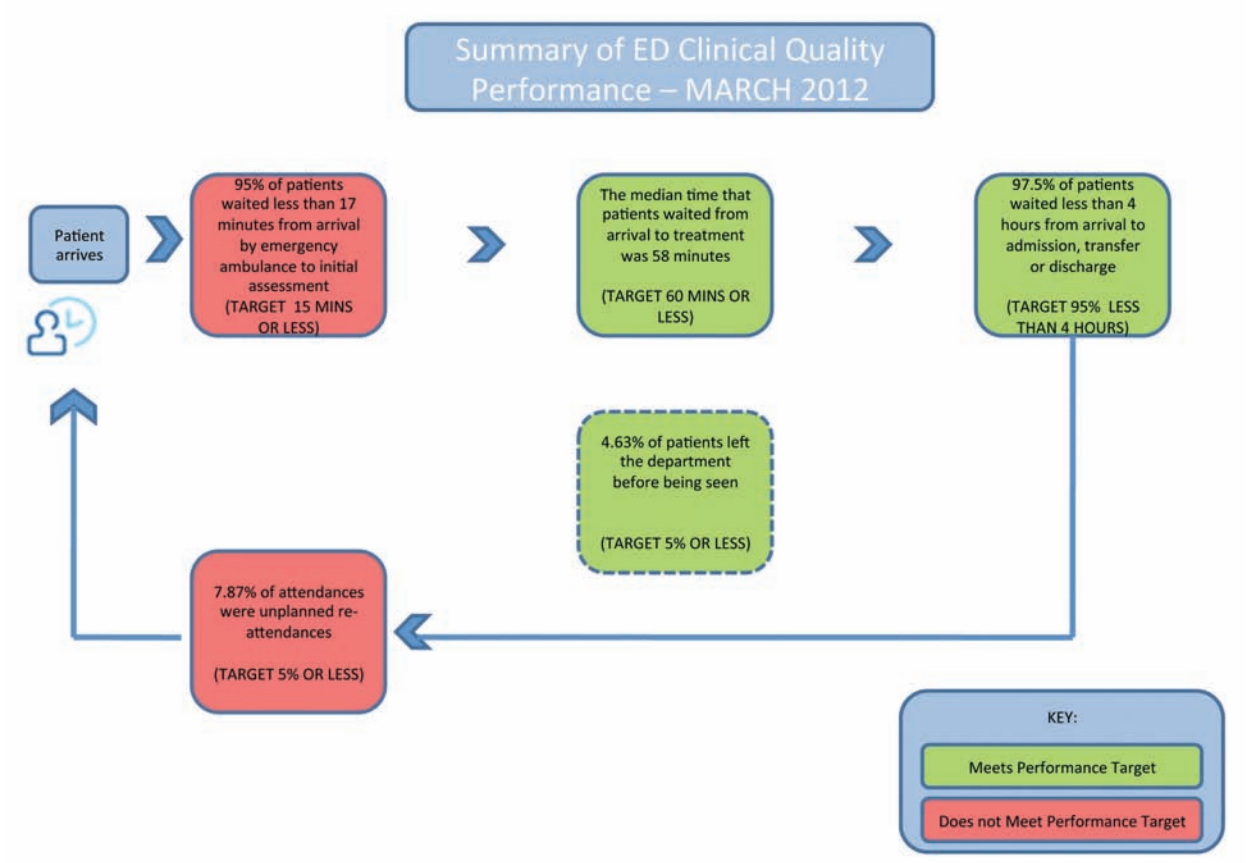
The directorate has continued to develop clinical policies and protocols for both departments, which are monitored through a series of regular audits. The importance

of using these protocols is now embedded amongst staff, leading to much improved audit results.

The EDAT has supported the production of an Integrated Development Plan which focuses on the wide ranging priorities of the directorate, including improving the quality of care we are providing, meeting the national A&E quality indicators and improving patient flow through the departments. The Integrated Development Plan is monitored through Trust Board and is shared with all A&E staff so that they are aware of the work that is being done and can contribute their own ideas.

We have used our current IT system to develop a live clinical dashboard, which displays our performance against the A&E Clinical Quality Indicators on computers within the A&E Department. We have also developed a specification for a new IT system for our A&E Departments. The processes for selecting and establishing the new system will commence in 2012/13.

The EDAT has ensured that the A&E departments continue to minimise the number of people waiting over four hour to be discharged or admitted for care, with performance reaching 97.5% by the end of the year, which is above the national standard. In 2011/12 further ED Clinical Quality Indicators have been introduced nationally. Throughout the year, the directorate has been changing and improving the way it works to improve our performance against the indicators, which is monitored through the Integrated Development Plan. Our most recent performance against these indicators is shown below. We will continue to improve performance in the A&Es and improve patients experience and safety.



Trauma & Orthopaedics

We said that in 2011/12 we would develop a strategy to improve the quality of service and performance of our Trauma & Orthopaedic Directorate. Specifically, we intended 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

What we achieved:

An Orthopaedic Taskforce has been established under the leadership of the Chief Operating Officer and the activities of this group reported to the Quality & Safety Committee. Performance and quality continues to be monitored using our performance management systems, particularly the Quality Management Framework (QMF).

The Trust has established a new clinical lead post to lead the development of the Trauma Unit. The Trust is an active member of the Trauma Network and has a work programme to achieve the Trauma Unit designation criteria by July 2012.

The orthopeadic service has worked in partnership with the 'Right Care, Right Here' programme, redesigning innovative pathways with primary care and community services. The implementation of these will be completed in 2012.

The service has delivered improvements in a number of areas, including a decrease in length of stay for elective and non-elective admissions, and better use of resources by reducing the number of premium rate sessions worked.

The Trust has invested in increased nurse staffing levels this year on the orthopaedic wards. As a result the experience of our patients is seen to be improving through local surveys. Complaints have decreased this year particularly in relation to waits for outpatient appointments where the wait for first appointments has reduced significantly.

Patient Reported Outcome Measures (PROMs)

The Health and Social Care Information Centre published the latest provisional Patient Reported Outcome Measures (PROMs) data in February 2012. Data was published for the period from April 2010 to the end of March 2011 and also for the period from April 2011 – September 2011. As for many Trusts, there were insufficient numbers of records for the Trust to be included in the analysis reported for the period

from April 11 – September 2011. Two of the PROMs relate to Orthopaedic procedures. Table 19 shows patients' views about how successful their procedure was.

The updated data for 2010/11 continues to show that the Trusts' performance with regard to the national average adjusted heath gain for the specified procedures is below the national figure for most of the measures.

The way the score is arrived at is by using the responses to patient questionnaires which ask about how the patient feels. The questionnaires are described in the following paragraphs and calculated to give a result.

EQ-5D Index – Questions that relate to the patients' quality of life which cover five dimensions – mobility, self-care, usual activities, pain/discomfort and anxiety/ depression.

EQ-VAS - A self-rating of health related quality of life measure. The respondent rates his or her health state by placing a line on a pre-drawn health status graph called 'Your health state today'

Procedure specific questions that relate directly to the condition itself e.g. Oxford Hip Score. No procedure specific score has been introduced for patients undergoing inguinal hernia repair.

The average adjusted patient reported heath gain versus the national figure is shown for the four index procedures in the table below. The average procedure specific scores are available to patients through NHS Choices website. The position relative to the previously published provisional data (November 11) for each indicator is indicated by the arrows.

Table 19. Updated provisional PROMs data - April 2010 – March 2011

	Health Status Questionnaire		Visual Analogue Scale		Procedure specific instrument (questionnaire)	
	National	SWBH	National	SWBH	National	SWBH
Hernia repairs	0.09 ⇔	0.09 ⇔	0.54 ⇩	0.28 ⇧	No measure	N/A
Knee replacement	0.30 ⇔	0.24 ⇧	3.09 ⇧	0.21 ⇧	14.88 ⇩	12.65 ⇩
Hip replacement	0.41 ⇔	0.37 ⇧	9.16 ⇧	4.21 ⇩	19.72 ⇩	18.01 ⇩
Varicose Vein surgery	0.09 ⇔	-0.01 ⇔	-0.08 ⇧	1.12 ⇔	-7.53 ⇧*	-7.05 (No data previously)

*The Aberdeen Varicose Vein questionnaire is scored from 0 to 100, where 0 represents a patient with no problems associated with varicose veins and 100 represents the most severe problems associated with varicose veins. A negative adjusted health gain and a lower average post-operative score than pre-operative score suggests an improved performance.

The trust has an action plan which includes a number of measures to improve patient outcomes for patients related to relating to joint operations, which will lead to improved outcomes in future.

3.2 CQUIN (Commissioning for Quality and Innovation)

This part of the 2011/12 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.

Last year the Trust agreed CQUIN goals with our commissioners. We successfully met or exceeded our targets. These are targets are specifically to do with quality of care as we know that they make a real difference to patient safety, patient experience, and clinical effectiveness (how well a treatment works). The 2011/12 goals are shown in the table below and shows our performance against each CQUIN target. Some of the CQUINs are included in the key priorities such as stroke, end of life care and basic nursing where a broader explanation of achievement can be found. Following table 20, there are a few highlights with short explanations of what has been achieved.

Table 20. CQUIN performance 2011/12

CQUIN SCHEMES			Actual 11/12	Data Period	11/12 Target
Acute	VTE Risk Assessment (Adult IP)	%	92.4	FY	90
	Pt. Experience (Acute) - Personal Needs	Score	70.8	FY	69.3
	Smoking Cessation (Acute) - Training	No.	94.0	FY	90
	Smoking Cessation (Acute) - Delivery	%	2890	FY	2000
	End of Life Care	%	80.0	M11	66
	Medicines Management - Missed Doses	%	-22.0	M11	-10
	Nutritional Assessment	%	89.0	M12	75
	Enhanced Recovery	%	Met	M10-12	Meet
	Stroke Discharge	%	90.5	M10-12	90
	Mortality Review	%	68.2	M11	60
	Alcohol Screening	%	88.5	M10-12	80
Community	Pt (Community) Exp'ce - Personal Needs	Score	92.9	FY	69.0
	End of Life Care	%	50.0	M12	36.7
	Health Visiting	%	72.4	M12	70
	Falls Prevention	%	62.6	M12	55.0
	Smoking Cessation (Comm) - Training	%	98.8	FY	80
	Smoking Cessation (Comm) - Delivery	%	94.7	M12	90
Specialised Commissioners	Chemotherapy Out of Hospital - Addit. Pt's receiving Herceptin at Home	No.	16	FY	16
	Chemotherapy Out of Hospital - Other Ambulatory Chemo/Oral Treatment	No.	500	FY	500
	Improving Access to Organs for T'plant	%	Met	M1-10	Meet
	Screening for Retinopathy or Prematurity	%	95.5	M7-11	92
	Auditing Neonatal Pathways		Compliant	M1-11	Comply

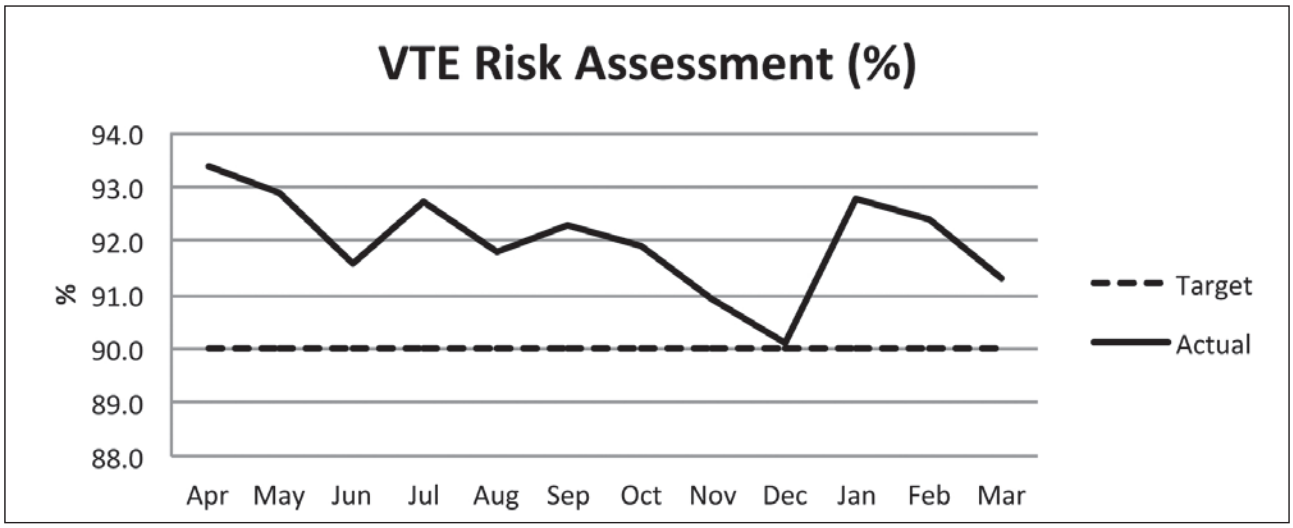
3.2.1 VTE (Venous thrombo-embolism)

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.

This CQUIN target has been carried on from 2010/11 into 2011/12 which has meant that every Trust had to achieve VTE assessment rates of 90% in admitted patients.

We have been very successful in meeting this target throughout the year, and exceeding it by more than 1% in all but 2 months.

Table 21. VTE Performance



3.2.2 Smoking Cessation

Evidence over the years has demonstrated that stopping smoking benefits your health. We have been focused on 2 areas: training our staff how to help people to give up smoking, and people being referred to smoking cessation services.

This was both a target for acute services and community services. Both community services and acute services have been successful in training the target number of staff identified to receive training. In addition, the trust has been successful in exceeding their target for referral to smoking cessation services.

Table 22. Smoking Cessation Training Performance

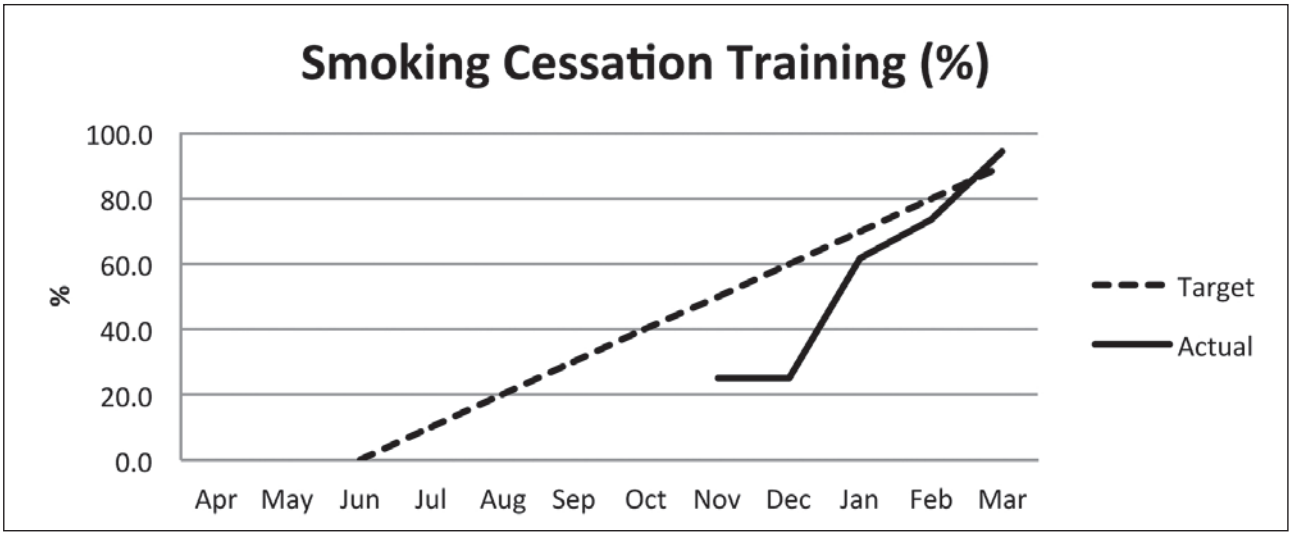
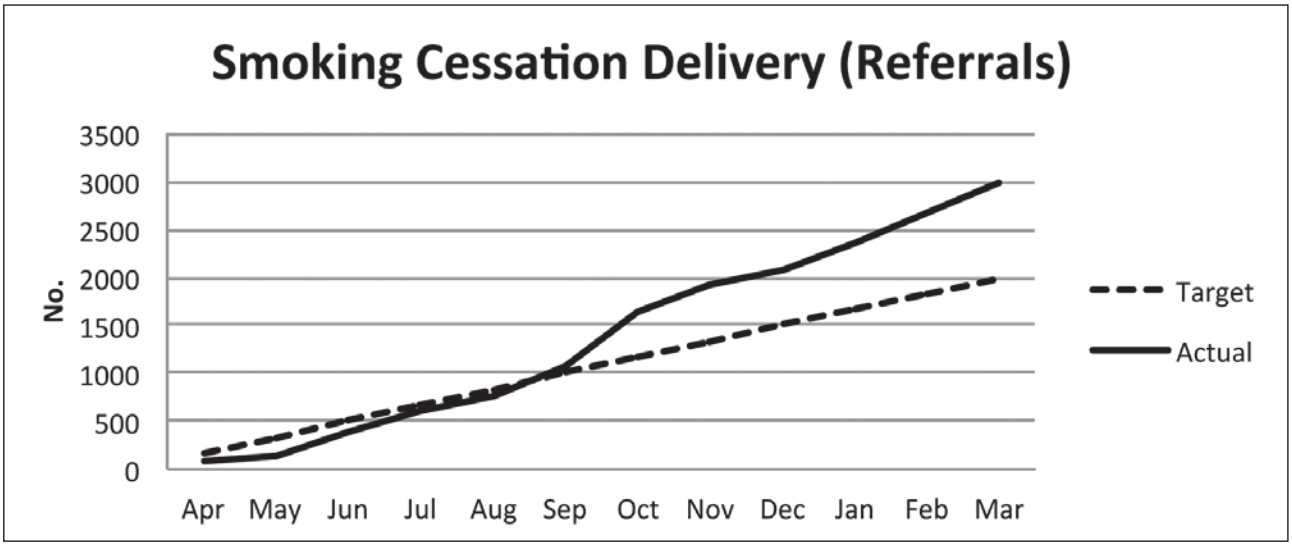


Table 23. Smoking Cessation Referrals Performance



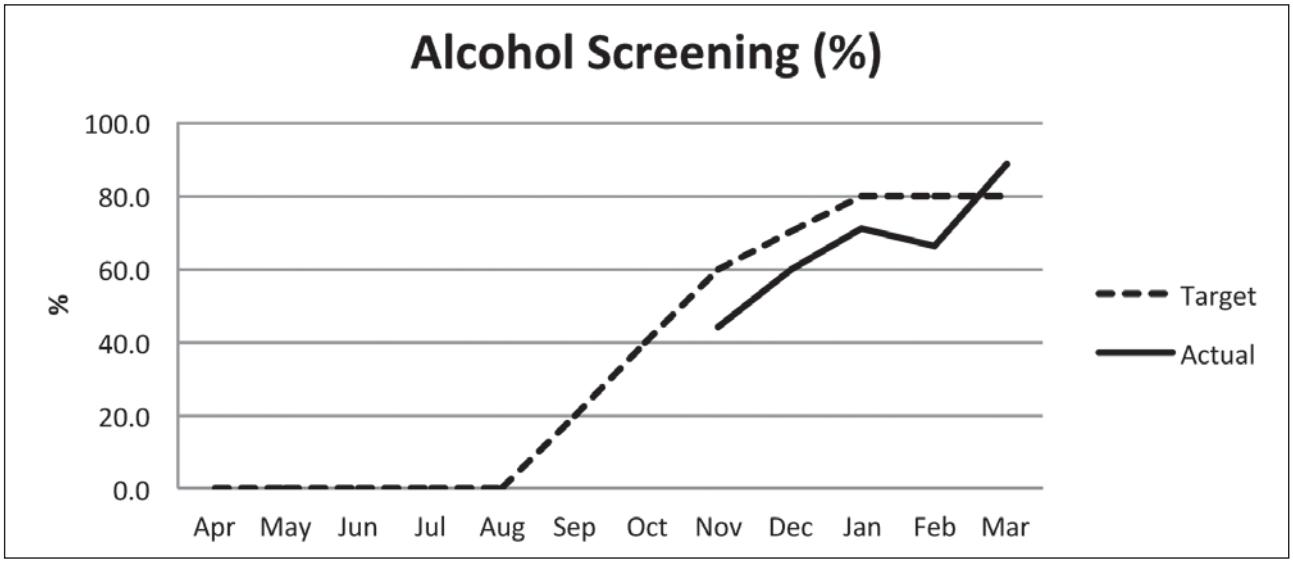
The table above demonstrates that we hit the referrals target for the year 3 months before we were required to do so.

3.2.3 Alcohol Screening Programme

We agreed with the commissioners to measure people being admitted into our hospitals against our alcohol screening form. It is very important to assess alcohol risk to ensure that patients are treated appropriately and also to be able to advise them on health issues if appropriate.

Although there was a slow start early in the year we have successfully achieved the target in March through very focused efforts.

Table 24. Alcohol Screening Performance



3.3 Other Indicators of Quality

3.3.1 Privacy and Dignity

Over the past year, the Trust has continued to promote the importance of privacy & dignity to ensure patients feel valued, listened to, and respected. This cumulated in a Dignity Campaign in December 2011 launching the role of the Dignity Champions on each ward. This has been followed up with regular workshops preparing the Champions to promote privacy and dignity in their area by checking that patients are called by their preferred name, assisted to use toilet facilities, encouraged to wear their own clothes to help protect patients' modesty, given choice in their care needs etc. (gowns have been removed from wards and over the next few months we will be supplying our own brand of pyjamas which means that patients are covered and comfortable).

Each patient's stay commences with a 'meet and greet' pack and welcome to the ward. Each bedside cabinet contains an information folder regarding access to advocacy, access to chaplains and other spiritual needs, ward routine, key staff and other messages. Individualised admissions allow the patient and carer to be involved in planning care. We have provided 'communication folders' to assist patients who do not speak English, are deaf/dumb or have Learning Disabilities to communicate their needs. Access to interpreters and telephone interpreting is also used wherever possible and the service has been advertised and training undertaken.

We want our staff to be as well trained as possible. Staff also receive training

regarding: equality and diversity, customer care and safeguarding vulnerable adults (including the Mental Capacity Act, dementia, self -harm). Policies guide this training and provide reference information to staff.

We evaluate and monitor how patients have found their hospital stay using patient surveys which we review monthly and follow this with actions every month. Senior nurses (matrons, charge nurses) directly observe care and evidence of care giving quarterly. These results are evaluated as part of ward reviews and help determine the standard of care provided and identify any actions required to improve.

We plan to continue the above strategies and further develop our user feedback systems to include more 'patient stories' to the Trust Board.

We know that dementia is increasing in the population. We plan to increase awareness and will be further developing staff knowledge regarding care of patients with dementia.

3.3.2 Same Sex Accommodation

We understand that as part of privacy and dignity, how we accommodate people in our hospitals is very important. Same Sex accommodation issues are very important to us.

Same sex accommodation means that the room where your bed is will only have patients of the same sex as you in it and that the toilet and bathroom will just be used by your gender and will be close to your bed area.

It is possible that there will be both male and female patients on the ward but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom but you will not have to walk through the opposite sex areas.

You may share some communal space such as day rooms or dining rooms and it is very likely that you will see both men and women patients as you move round the hospital, for example, on your way to the X-ray department or operating theatre.

It is probable that visitors of the opposite sex will come into your room where your bed is and this may include patients visiting each other. It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

The NHS will not turn away patients just because a 'right sex' bed is not available immediately.

If an occasion arises when a person of the opposite sex has to be located in a gender-specific area, the Executives are informed immediately. We also strive to ensure this happens as rarely as possible and arrange for patients to be moved at the first opportunity.

Over the past year there have been 109 breaches reported in the trust. This figure is deceptive. If a man was placed in a room where 10 women were sleeping, for example, that would count as 10 breaches. However, we have improved from 2010/11 when 1064 breaches were reported. We will continue to work to totally eliminate all same sex accommodation breaches.

3.3.3 Complaints

The Trust is committed to providing both comprehensive and timely responses to formal complaints about its services. Complaints give us a good picture of what has not worked very well for patients and their families, just as compliments tell us what people have found good.

The table below shows us the top themes of complaints over the past 3 years. Good progress has been made although we continue to monitor the complaints and use the themes to help us set our priorities.

Table 25. Complaints, by theme

Complaint Theme	2008/9	2009/10	2010/11
Clinical Treatment	386	350	377
Attitude of Staff	95	100	83
Appointment delay/ Cancellation Outpatient Appointment	178	105	71
Communication/ information to patient	56	53	36
Appointment delay/ Cancelled Inpatient	27	11	16
Long wait in Clinic	61	33	20
Transport Services	17	10	12
Cancelled appointment/ operation / treatment	48	17	12
Totals	868	679	627

Complaints Handling Process

In response to the NHS Complaints Regulations introduced in April 2009, the Trust changed to a system of formally investigating each complaint and providing a detailed and analytical investigation report with the response.

In light of the complaints backlog and the intervention of the CQC in March 2011, the Trust prescribed an Action Plan to maintain and improve compliance with the CQC's Essential Standards of Quality and Safety Outcome 17: Complaints.

The Action Plan's prescribed actions included review of the complaints handling policy; review and increase in complaints staffing capacity; staff training, introduction and implementation of a strategy for the reduction of the complaints backlog by the end of December 2011 and increased performance monitoring and reporting at Trust Board and Board Committee level.

In March 2012, the CQC issued its draft report which suggests that the Trust is regarded as being compliant with Outcome 17 and recognised the recent improvements made in the handling of complaints.

3.3.4 Staff Indicators

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.

Staff Survey

Every year, a Staff Survey is carried out nationally. The 2011 survey results show that there are some significant improvements from previous years and compare favorably with other trusts. This is summarized in the table below and gives a good indication how we have been doing over time across a range of measures.

Table 26. Staff Survey Findings

Key Findings	Sandwell and West Birmingham Hospitals NHS Trust					National Average				
	2007	2008	2009	2010	2011	2007	2008	2009	2010	2011
Percentage feeling satisfied with the quality of care and patient care they are able to deliver	-	63%	78%	77%	79%	-	62%	74%	74%	74%
Percentage agreeing that their role makes a difference to patients	-	90%	92%	91%	92%	-	89%	90%	90%	90%

Percentage of staff reporting errors, near misses or incidents witnessed in the last month	92%	96%	35%	38%	36%	95%	95%	37%	37%	34%
Staff recommendation of the trust as a place to work or receive treatment	-	-	3.56	3.53	3.59	-	-	3.50	3.52	3.50
Appraisal/KSF in the last 12 months	60%	86%	83%	80%	82%	61%	86%	70%	78%	81%
Good communication between senior management and staff	-	30%	33%	36%	40%	-	25%	26%	26%	26%
Care of Patients is my Trust's top priority	46%	58%	63%	64%	68%	46%	54%	59%	58%	58%
Percentage of staff feeling valued by their work colleagues	-	71%	72%	75%	74%	-	75%	77%	76%	76%
Staff Job Satisfaction	3.35	3.41	3.40	3.45	3.52	3.38	3.45	3.48	3.48	3.47
Satisfied with support from immediate manager	3.50	3.61	3.53	3.56	3.67	3.56	3.57	3.60	3.61	3.61
Trust commitment to work life balance	3.26	3.29	3.27	3.35	3.40	3.31	3.39	3.40	3.38	3.36
Overall Staff Engagement	-	-	-	3.62	3.67	-	-	-	3.62	3.62

The trust has been keen to respond to feedback it received from staff as the senior team knows that if you have staff who feel safe, don't feel too stressed and feel valued, they will do their jobs well in caring for patients.

Table 27. Staff suggestions and the organisations responses

You said we needed to improve ……	We did ……
Staff experiencing discrimination at work in the last 12 months Staff believing that the Trust provides equal opportunities for career progression or promotion Staff experiencing harassment, bullying or abuse from staff in the last 12 months Staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	A review of the findings against the HR dashboard (that is monitored quarterly across the diversity strands) Put in place a process to record and monitor any concerns about discrimination, equality of opportunity and harassment that are made outside of the formal processes Reviewed and revised the Trust's Dignity at Work Policy Raised the profile of the Trust's 'harassment advisors'
Staff experiencing physical violence from staff in the last 12 months Staff experiencing physical violence from patients, relatives, or the public in the last 12 months	Strengthened the Trust's approach towards dealing with violence and aggression by revising the Trust's procedure for 'managing aggressors' Reviewed Customer Care training content
% of staff suffered work-related stress in the last 12 months	Launched a comprehensive programme of health and well-being aimed at reducing stress, including an emphasis on the importance of taking regular exercise and healthy eating

3.3.5 What others think about our Quality Account

We invited our Commissioners, the Overview and Scrutiny Committees (OSC) in both Sandwell and Birmingham and both LINks groups in Sandwell and Birmingham what they thought about our Quality Account.

Our Commissioners, made the following statement:

Clinical Commissioning Group (CCG) Supportive Statement

'Sandwell and West Birmingham Clinical Commissioning Group (CCG), with Sandwell Primary Care Trust, is the lead commissioner for Sandwell and West Birmingham Hospitals NHS Trust and has the responsibility of seeking assurance that the services delivered by this Trust are of a consistently high standard. The CCG takes this task very seriously and works closely with the Trust throughout the year to ensure that services are of high quality. The Trust takes a proactive approach putting quality at the heart of their organisation. The CCG has undertaken a number of announced and unannounced visits to the Trust to see at first hand the quality of services provided, and that the experience patients have is as we would expect. The Trust has been open

and responsive to these visits. Good practice is acknowledged and a collaborative approach ensures that actions to address any problems identified are put in place at the earliest opportunity.

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

Sandwell LINk made the following comments:

'The following constitute Sandwell LINk's comments on Sandwell and West Birmingham NHS Hospital Trust's Quality Accounts.

LINk members felt that the report reflects a lot of the good work done by the Trust over the past year, but that it is concerning that there remains a lack of clarity about the future of the new hospital. They also queried how the collection of data will be kept to a minimum with the vast number of audits being undertaken, and how improvements will be implemented and monitored as a result of the audits.

They felt that the Trust could be more proactive in its approach to consulting with patients and the public, particularly around changes such as the diabetic clinic and with LINk (or Healthwatch in future) on the Quality Accounts. Whilst understanding that the Trust has tight timescales for producing the data, the LINk members felt it would be highly beneficial for the Trust to look to arrange a meeting to present the report to the LINk ahead of time, thereby enabling a dialogue to occur around the contents and a more substantial commentary to be offered.'

Birmingham Overview and Scrutiny Committee made the following comment:

We recognise that Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the Overview & Scrutiny Committee (OSC) in the local authority area where the provider has its registered office, inviting comments from the OSC by the end of May. However the role of the OSC in providing assurance over a provider's Quality Account is a voluntary one. Birmingham City Council's Health & Social Care OSC (HOSC) will not be supplying a statement on any of the ten sets of 2011/2012 Quality Accounts it will be sent from nine different providers. In the local elections held on 3 May a third of the Council's members (councillors), including the Chairman of the HOSC, stood for re-election. It wasn't decided until 22 May whom the members of the new HOSC would be, and their first meeting will not be until June, so there is no opportunity for HOSC to provide a statement during May or even early June. HOSC is also reluctant to provide an assurance statement on quality Accounts which could compromise the HOSC's ability to scrutinise matters independently afterwards.

Birmingham LINk made no comment.
Sandwell OSC declined to make comment.

3.3.6 How to provide feedback on this Quality Account.

As an organisation, we would like to know what you thought of our Quality Account. After all, this document is for the public and we would like to know what you think. As a result of reading this document, do you think you have a better understanding of how committed we are to providing high quality care.

You can e-mail the Trust Board Secretary on *simon.graingerpayne@nhs.net*

Or send us a letter to Mr John Adler,
Chief Executive,
Management Centre
Sandwell & West Birmingham NHS Hospitals Trust
City Hospital
Dudley Road
Birmingham
B18 7QH

We will value your feedback.