Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account

2012/13

Where EVERYONE Matters

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Part 1: Chief Executive's statement

The fourth quality account issued by the Trust reflects performance last financial year. I joined the organization in April 2013 and have had the opportunity to reflect with the Trust Board on delivery in the year to which this report relates.

A great deal was achieved by clinical and managerial teams during 2012/13, in partnership with patients, visitors and other partners. We are especially proud of our improved performance in:

- Transforming stroke care for patients, by creating a single acute unit and a specialised rehabilitation facility. Both are located on our Sandwell site. While ambulance travel times for some patients are therefore increased, time to treatment times are not because we can concentrate diagnostic and other specialist resources into one place. A pathway exists to rapidly assess patients with suspected strokes and get them into our facility rapidly. We expect to see the time taken to do that to reduce further in the year ahead.
- Continuing to reduce pressure damage and to tackle avoidable infection. Though this winter saw considerable bed closure through managing norovirus in our predominantly open plan older wards, other forms of infection continued to reduce. In parallel, our nursing teams succeeded in reducing pressure damage and many higher risk wards saw many months without a pressure sore in their beds. We have work to do to extend these successes into how we maintain patients in their with our community services.
- We successfully focused on improvement in health visiting and midwifery services. The report relates awards and gains in performance through these teams. Each work increasingly closely with general practice, as well as integrating care into hospital services. There is more to do, and we have agreed with our CCG a programme to focus attention on community district nursing services in 2013/14.
- We delivered the majority of our CQUIN goals, two of which in particular stand out in that they reflect substantial improvement from prior years. Our mortality review programme is now well embedded in the Trust and allows us space to learn from error and to reflect on excellence. Moreover, our focus on every contact counts, particularly in respect of alcohol, will provide a good basis for the health promoting hospital work set out in our 2013/14 priorities.
- We sustained our successful trial recruitment programme for research. We know that organisations that undertake substantial research programmes not only provide benefit to future science, but also typically deliver better care to their patients. Our research profile remains strong and trial recruitment has grown over recent years. We are exploring what steps are necessary to substantially increase recruitment over the next five years in order to provide outstanding access to research medicine for local residents.

While noting these successes, I trust that you find this quality account candid about where we did not succeed or where we have quality indicators that give our Board and leaders cause for concern. The third section of this report details where delivery is been slower than intended or has not yet achieved the goals that we set. In our organisation that is particularly true of our emergency care pathways.

While improvements in stroke, changes in gynaecology and other developments provide an indication of some success, the largest number of patients still attend our two A&E departments. In particular, over the winter too many patients waited longer than the national minimum standard of four hours. While we have worked to ensure the safety of those departments, the experience of care in a long-wait environment is poorer and the pressure it places on our staff is significant. We intend to make changes to our system this summer to address this as we move towards next winter. Funding has been made available to make this happen, and we need to succeed in recruiting key clinicians to help us to succeed. We work collaboratively with local GPs, mental health service colleagues, the ambulance service and social service departments to provide high quality emergency care. All of those services, like us, are reflecting on how we change models of care to provide timely help to patients seven days of the week. You will see that both initial attendance at A&E and the possibility of readmission after discharge feature among our five top quality priorities for 2013/14.

Results matter however, but culture is crucial to the safety of patients and staff. A culture of openness and learning is important if we are to understand what we do when services succeed and what happened when things go wrong. This report outlines the initial steps that we have taken to begin to build that culture. Transparency about data and clarity about scrutiny and assurance are important and the Board has taken determined steps to alter those arrangements here. During 2013/14 we will work with patient representatives, through our patient surveys, and with our staff to make sure that the knowledge given to us through best practice evidence, incident reporting, complaints and compliments and professional expertise, are all brought to bear to set priorities for further improvement. When we report next year, I will assess how I believe that culture change programme has progressed. As a Board, we remain focused on the three goals that have underpinned our approach to quality over recent years:

1. To reduce adverse events that result in avoidable harm
2. To reduce avoidable mortality and morbidity
3. To increase the percentage of patients who would recommend us to their friends and family

That consistency of purpose will be important in ensuring that over coming years we improve care in our Trust, both in our community teams and in our hospital based services.

Toby Lewis
Chief Executive

Part 2: Priorities for improvement in 2013/14 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 2013/14 and explains the reasons 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 Sandewell and West Birmingham Hospitals NHT Trust (SWBH) is performing to essential standards, that we have appropriate systems in place 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 2012/13. In addition, we describe our performance against other measures of quality.

Where you see a red asterisk * this is an indication that the text and data is as specified by the Department of Health using the mandated wording and format.

2.1 Priorities for Quality Improvement in 2013/14

2.11 How we decided on the priorities for our Quality Account for 2013/14

Sandwell and West Birmingham Hospitals NHS Trust is always passionate about engaging with the people it serves.

During September 2012, staff were asked for their views to help influence the development of the Trust's priorities for 2013/14. In particular, they were asked to consider what had improved and got worse over the last 12 months, including where the Trust was and was not performing well, as part of the monthly hot topics discussion.

Feedback from the priorities event and hot topics, together with feedback from people attending the Trust's Annual General Meeting, was reviewed by the Trust Board in November, along with information from patient surveys and other patient and staff engagement.

At a Clinical Directors Away Day in December 2012, which was attended by most of the medical leaders in the Trust, we asked what they thought were the most pressing

quality priorities. All the responses were collated and brought together to feed into the development of this year's plan.

Birmingham and Sandwell Local Involvement Networks (LINks) carried out a joint 'enter and view' review into Dignity and Nutrition at our hospitals in 2012, making three recommendations. They also looked at maternity and A&E services and have recommended Sandwell Healthwatch pick up the following subjects in 2013/14:

- Review of discharge procedures (follows a Sandwell LINk enter and view report in 2011);
- Review of complaints procedures;
- On-going review of stroke / Transient Ischaemic Attack (TIA) services;
- Review of hospital meals;
- Review hospital appointment administration.

Before handing over to Healthwatch, Sandwell LINk also expressed a strong interest in understanding more about the supportive care pathway, particularly in the light of adverse media coverage, via an information request and through setting out potential priorities in their legacy document (published 27th March 2013). This information has been considered in putting together the Trust's quality priorities for 2013/14.

The Trust has continued to work on the development and implementation of its Quality and Safety Strategy. Our performance will continue to be reported in the Quality Report and to the Trust Board every month.

2.12 The Priorities for improvement in 2013/14

Our Quality& Safety Priorities sit within three domains described in our Quality and Safety Strategy, as our number 1 strategic objective and in our NHS Trust Development Authority (NTDA) Annual Plan. Our aim is firmly to deliver safe, high quality care and the 3 domains are:

Patient Safety	To reduce adverse events which result in avoidable harm	=	We do no harm to patients
Effectiveness of care	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

Table 1. The 2013/14 Quality and Safety Priorities.

Although all the areas in Table 1 are key priorities, in this Quality Account we have selected four focus areas for particular attention and more detailed description.

These focus areas are:

1. Continuing to improve the patient experience and safety in Emergency Departments (ED);
2. Reducing preventable deaths (mortality);
3. Being a Health Promoting Hospital;
4. Reducing emergency readmissions;
5. Patient Experience.

2.13 Focus Area 1- Continuing to improve the patient experience and safety in Emergency Departments (ED)

This is a theme which we have chosen to continue to work on as we still have much to be done to improve the service and experience we offer to our service users. Many patients first contact with our trust is when they attend ED so it is important for us to improve.

We plan to ensure that at least 95% of people who attend ED are seen and either treated and discharged or admitted within 4 hours of arrival. Our performance last year was 92.34%.

The quality of the experience in ED is not only determined by the service provided within the EDs themselves, but also on the bed flow and availability across a day for those requiring in-patient care. Our plans to improve our patient experience and the quality of our service for emergency care therefore include development in the Emergency Departments and across emergency care as a whole.

Key areas of work to improve include:

- Delivery of investment plans and recruitment in ED;
- Implementation of a new informatics system in ED;
- Development of our acute assessment and elderly care models in both hospitals; altering our surgical flow; changing our elderly care ward model, and introducing more step down capability for those patients requiring help to get home;
- Establishment of joint health and social care team to include both Birmingham and Sandwell Social Services;
- Improving the profile of discharges to precede admissions, building on the developments of the Transformation Plan with daily early senior ward reviews, transport and pharmacy projects to expedite early discharge;

- Establishment of a 7 day capacity team with an Operational Centre to determine a better predictive emergency care flow and planning.

How we plan to measure and monitor our progress:

The improvement programme will be chaired by the Chief Executive. These meetings will be held fortnightly and report to the Trust Board on a monthly basis. An integrated emergency flow score card will report progress and exceptions against planned improvement trajectories for key measures.

2.14 Focus Area 2 - Reducing preventable deaths (Mortality)

This was an area we worked on last year and, in the light of the Francis Report, feel we must continue to give it a very high profile in our priorities.

We aim to improve our death rate from lower half of the 2nd centile to upper half of 2nd centile. This means becoming a trust where death rates are lower (better) than half, if not more, hospital trusts in England.

We also aim to reduce the variation in the mortality between our 2 main hospital sites. Death rates are higher at Sandwell Hospital than City Hospital. It is important to us to understand why this is and to take action to improve the death rate at Sandwell.

What we plan to do and how we will measure and monitor our progress

- In 2012/13 we have increased the percentage of deaths that have been reviewed by senior doctors. However, we are committed to reviewing at least 80% of all deaths within 42 days of death;
- We will feedback to consultants regularly on deaths which have been identified as preventable so that lessons can be learnt by the organisation about how we can do things better;
- Ensure that 95% of admitted patients have a Venous Thromboembolism (VTE) risk assessment carried out;
- We will carry out root-cause analysis of confirmed cases of hospital associated thrombosis;
- We will set up a small, clinically-led group by the end of June 2013 who will be looking into deaths at Sandwell hospital and will identify themes which may need addressing to improve outcomes for patients;
- We will improve our mortality performance to be better than the England average by March 2014.

Reporting of progress against these goals will be reported to the Mortality, Quality Alerts Committee (MQuAC) which is chaired by the Medical Director. In addition, the Quality Report will be submitted to Quality & Safety Committee and will be reviewed by the Clinical Commissioning Group (CCG) at the Clinical Quality Review Meeting.

2.15 Focus Area 3 - Being a Health Promoting Hospital

A Health Promoting Hospital is one which recognises its duty to engage with patients, relatives, staff, the membership group and wider local population to encourage health improvement. It demonstrates this by explicitly stating that Health Improvement is part of its mission, and by taking practical steps to make it happen.

In December 2012 SWBH joined the World Health Organization (WHO) Health Promoting Hospital (HPH) network to build on the Health Improvement activities already taking place in the Trust.

What are the benefits of the WHO HPH network?

- Using the WHO and HPH logos on internal and external documents to act as reminders of the international importance of prevention, and to help raising awareness about these goals.
- Membership gives an opportunity to discuss and compare different health improvement projects from hospitals and health systems worldwide, in order to see what works elsewhere and might be tried locally.
- In addition, the HPN publishes a list of 40 standards for a member organisation. We can use them to assess how well we compare in health promotion activities.

In the first place, the WHO HPH requires a mission statement, strategy and coordinating group to deliver a programme of awareness amongst all staff.

They also are explicit around routine assessment of patients' need for health promotion, how information is given to patients and to staff to help them improve their health, and that health promotion is written into job plans, patient pathways and departmental policies.

Finally the standards encourage the hospital as an organisation to work to engage in health promotion throughout the local community.

What we plan to do & how we will measure and monitor our progress

We have already appointed a Clinical Champion for Prevention at SWBH and a Prevention Steering Group has been established with wide representation from across the health community. Links have been established with the Public Health Teams and Health and Wellbeing Boards in our locality, and with the Sandwell and West Birmingham Clinical Commissioning Group. Work has begun with our partners on a Health Improvement Strategy for SWBH.

We will:

- Submit a Health Improvement Strategy using the WHO HPH standards and local priorities from our partners by July 2013;
- Develop an action plan from the Strategy and implement new health improvement activities in SWBH using specialist staff by September 2013;
- Reinvigorate Health Improvement Training in the Trust including the Making Every Contact Count (MECC) programme, for all staff, focusing on stopping smoking, reducing alcohol consumption and making lifestyle preventive interventions for patients and employees by November 2013;
- Formally adopt the principles of the Health Promotion Hospital network into our mission statement, policies and procedures by December 2013.

Reporting of progress will be via the Prevention Steering Group, which reports to the Clinical Effectiveness Committee, and Trust Management Board. Progress will also be reported in the Quality Report, which is shared with the CCG.

2.16 Focus Area 4 - Reducing Emergency Readmissions

Readmission to the hospital once their treatment has been completed is not good for the patient, their families or the Trust. We want to improve our care, and support arrangements on discharge to keep patients at home so that we are at least as good as the top 50% of hospital trusts in England.

Over recent months The Trust Transformation Programme has completed a project that compares emergency readmission rates from the last three years by ward, by speciality, by diagnosis and by procedure. From this work, things have been identified which will help up to monitor performance on a month by month basis.

What we plan to do & how we will measure and monitor our progress

We will:

- Put in place action plans to ensure that emergency readmission will be avoided;
- By March 2014 we will aim to meet the national mean for 30 day non-elective & 28 day non-elective readmissions in 2013;
- By the end of June 2013, The Mortality & Quality Alerts Committee will develop and oversee an action plan to improve emergency readmission rates;
- The Trust is also planning to review readmission rates of babies within 30 days, and will review current maternity bed capacity in line with Birthrate plus recommendations. This will be completed by March 2014, but is subject to business case approval in Spring 2013.

How we plan to measure and monitor our progress

Reporting of progress against these goals will be reported to the Mortality & Quality Alerts Committee (MQuAC) which is chaired by the Medical Director. In addition, the Quality Report will be submitted to Quality & Safety Committee and will be reviewed by the CCG at the Clinical Quality Review Meeting.

2.17 Focus Area 5 - Patient Experience

Safe, high quality care remains the first priority of the Trust with a focus on improving the experience of patients being one element. We will listen and learn from patients, carers, staff and relatives as we develop and deliver leading hospital services to the people of Sandwell and West Birmingham.

We want our patients to be confident in us and recognise us as a listening and caring organisation.

We want our patients to experience:

- Excellent communication;
- Staff that listen to and act on feedback;
- That their care is planned (whatever their route of admission);
- That they feel safe in our care;
- That they are receiving the right information;
- No, or the minimum of delays;
- Always being treated with dignity and respect;
- That our staff work as a confident team;
- That we care about their environment;
- That they receive the food they have chosen and they get help if they need it;
- That they are cared for with kindness, respect and compassion.

We are particularly focusing on people's experiences in outpatients as this is where most people have contact with the Trust. We have developed 8 'outpatient standards' which are all about ensuring that patients find attending an outpatient appointment is a positive experience. These standards are what we aspire to and have set up a programme of work to drive them forward. The 8 outpatient standards are:

1. All patients will be seen within 6 weeks of the hospital receiving their referral. All referral letters will be scanned into CDA within 24hrs of receipt;
2. The patient's first visit will always be to the correct clinic;
3. No patient will wait more than 20 minutes later than their appointment time to be seen;

4. By March 2014, no patient will have their clinic appointment cancelled by the hospital;
5. All patients will have their first appointment for diagnostics within locally agreed targets;
6. All patients will be investigated and treated according to the Directorate's agreed clinical pathways;
7. A documented outcome of an outpatient visit will be available to the GP electronically within 2 working days. All communications will be easily accessible within the Electronic Patient Record. All patients will receive a copy letter within 5 working days;
8. All patients will be given an opportunity to comment on the outpatient service that they have received.

The Trust has identified equality, diversity and inclusiveness, in accordance with the Equality Act 2010, as core to its values and is committed to developing opportunities that are inclusive, appropriate and positive.

What we plan to do and how we will measure and monitor our progress

Patient Experience Strategy

A Trust Patient Experience Strategy was formally accepted by the Trust Quality and Safety Committee in April 2013, with an implementation plan to be rolled out during 2013.

Friends and Family Test

The national 'Friends and Family Test' was introduced on 1 April 2013 for inpatients who have spent at least one night in hospital and have attended an emergency department. The Trust will ensure that all patients falling into this group are offered the opportunity to complete a survey within 48 hours of discharge and that at least 15% respond. The Net Promoter Score is calculated using responses to the question "How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?" Responses range from 'extremely likely' to 'extremely unlikely' and 'don't know'.

Women using maternity services will be included in national reporting from October 2013. At present, this information is collected locally.

Patients under 16 years of age, outpatients and Community Services are not included in the national programme, but information is collected locally from participating services and reported to the Patient Experience Professional Advisory Group (PEPAG) and the Patient Experience Committee every month.

National reporting systems are in place and reported on a monthly basis.

Key milestones are:

- Increasing the response rate in the acute inpatients and A&E areas. Achieving a response rate within the top 50% of Trusts nationally, showing an improvement on our Quarter 1 response rate;
- Phased expansion of the friends and family test (FFT) to Maternity by end of Oct 2013 and additional services (yet to be defined nationally) by end of March 2014;
- Increase the FFT score within the 2013/14 staff survey compared to 2012/13.

National & Local Patient Surveys

The Trust is participating in the following national patient surveys during 2013 such as the Inpatient Survey, A&E Survey, Maternity Survey, Outpatient Survey, Cancer Patient Experience Survey, and Chemotherapy Patient Experience Survey. We also carry out local inpatient surveys every quarter.

Reports are received and we shape our services to improve based on the findings.

Patient Engagement Programme

The Trust has staged a number of interactive patient engagement/entertainment activities during January – April 2013 in a variety of ward environments to include paediatrics, elderly care, rehabilitation and surgery. This has been done by engaging with local entertainment providers, to include the charities 'Kissing it Better' and 'Music in Hospitals'. Activities include music, dance and drama events. An on-going programme of events is also being built to expand and increase the opportunities available for regular patient engagement.

Patient Stories

A programme of patient stories, which commenced in March 2013, has been devised to take to the Trust Board every month. These are supplied by each division, supported by the Patient Experience team. Plans are also being made to use these stories for staff training and awareness raising events. We want to provide an opportunity for divisions to share their care experiences with Board members on a 'ward-to-board' basis.

Volunteers

The Patient Experience team have been working closely with the WRVS to build up a team of reliable hospital volunteers to help and assist with various patient experience activities such as completion of patient surveys, directing people through the hospitals, ward-based volunteers and dementia buddies. The aim is to increase the overall number of volunteers and recruit from different age groups and ethnicities.

2.2 Statements of Assurance from the Board

2.21 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; and
- 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

27/06/13 ..... Date ..... Richard Samuda - Chair

27/06/13 ..... Date ..... Toby Lewis - Chief Executive

2.22 Annual Governance Statement

This Statement sets out for our staff and stakeholders of SWBH 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 at the end of this Quality Account.

2.23 Review of Services

During the period 2012/13 SWBH provided and/or subcontracted 46 NHS services.

The SWBH has reviewed all the data available to it on the quality of the care in 46 of these services. Where the trust has subcontracted any activity, it would only be to a provider which was registered with the Care Quality Commision (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 2012/ 13 represents 100% of the total income generated from the provision of NHS services by the SWBH for 2012/13.

2.24 Participation in Clinical Audits

During 2012/ 13, SWBH has participated in 31 national clinical audits and 2 national confidential enquiries covering NHS services which the Trust provides. The SWBH has reviewed all the data available to them on the quality of care in all of these services.

During that period, SWBH participated in 97% of national clinical audits and 100% national confidential enquiries in which was eligible to participate in.

The national clinical audits and national confidential enquiries that SWBH participated in and for which data collection was completed during 2012/ 13, are listed in the Appendix 2 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.

The reports of 14 national clinical audits were reviewed by the provider in 2012/13 and SWBH intends to take the following actions, of which a brief summary can be found in Appendix 3.

The reports of 17 local clinical audits were reviewed by the provider in 2012/ 13 and SWBH intends to take the following actions, of which a brief summary can be found in Appendix 4.

2.25 Participation in Clinical Research

More than 1700 patients receiving NHS services provided or subcontracted by SWBH in 2012/ 13 participated in research approved by a research ethics committee for The National Institute for Health Research (NIHR) Portfolio studies, and approximately 600 took part in non-NIHR Portfolio studies.

Participation in clinical research is really important for understanding and adding to treatments for health problems and 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.

SWBH was involved in conducting over 250 clinical research studies during 2012/ 13, of which around 200 were UK Clinical Research Network (UKCRN) portfolio studies. Research is undertaken across a wide range of disciplines including Cancer (breast, lung, colorectal, haematology, gynae-oncology, urology), Rheumatology, Ophthalmology, Stroke, Neurology, Cardiovascular, Diabetes, Gastroenterology, Surgery, Dermatology and Women and Children's Health. SWBH uses national systems to manage the studies in proportion to risk and implements the NIHR Research Support Service standard operating procedures.

2.26 Goals agreed with Commissioners for 2013/14

Use of the Commisioning for Quality and Innovation (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 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 newly established CCG. As we indicated earlier in the report, we are continuing with some of the CQUINs from last year as our highest priorities. We are doing this with the approval of our commissioners and we believe that patients will really benefit from this added attention and focus.

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 2013/14 it will be 2.5% of our total income.

You will note in the table below that many of last year's indicators are no longer there. This is because there has been a change to how the trust has contracts with the CCG. The 'old' CQUINs have now become part of the baseline contract and will continue to be performance managed as part of usual contract management discussions. The focus on quality remains and has been heightened.

Table 2. CQUINs 2013/14

Goal	CQUIN Pre Qualifiers	Criteria for providers	Quality Domain
1	Intra-operative fluid management (IOFM)	Providers will need to: • establish 2012/13 baseline use • put in place trajectories for 2013/14.	Innovation
2	Digital First	Establish a 2012/13 baseline and a trajectory for improvement to reduce inappropriate face-to-face contact.	Innovation
3	Carers for people with dementia	Demonstrate that plans have been put in place to ensure that for every person who is admitted to hospital where there is a diagnosis of dementia, their carer is sign-posted to relevant advice and receives relevant information to help and support them.	Innovation

Goal	CQUIN Goal Name	Description of Goal	Quality Domain
1	Friends and Family Test	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience. The 2011/12 national inpatient survey showed that only 13 per cent of patients in acute hospital inpatient wards and A&E departments were asked for feedback.	Patient Experience

2	NHS Safety Thermometer	To reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.	Patient Safety
3	Dementia	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers.	Clinical Effectiveness
4	VTE	To reduce avoidable death, disability and chronic ill health from (VTE).	Patient Safety
5	Safe Storage of Medicines	To improve compliance and safety of storage of all medicines and controlled drugs at ward level.	Patient Safety
6	Dementia patient stimulation	Programme of stimulating activities for patients whilst an inpatient.	Patient Experience
7	Use of pain care bundles	Use standard procedures to assess and manage a patient's pain throughout the course of care.	Clinical Effectiveness
8	Use of sepsis care bundles (Sepsis six)	Reducing mortality due to severe sepsis.	Patient Safety
9	Community Risk assessment and advice offered. (Falls and Pressure Ulcers)	Risk assessment at each patient review for falls and pressure ulcer – documented to care plan with additional documentation of advice provided to the patient/carer (System 1).	Patient Safety
10	(Recording do not attempt to resucitate (DNAR) Decisions) Do Not Attempt CPR - Improved patient communications and documented decisions	Improvement of communications about resuscitation with patients and clear recording of discussion and any DNAR decision.	Patient Experience

Specialised Services CQUINs

	Service	
1	Specialised cancer	Access to and impact of clinical nurse specialist support on patient experience.
2	HIV	Registration and communication with GPs about the care of HIV patients.
3	Neonatal Intensive care	Improved access to breast milk in preterm infants.
		Timely administration of total parenteral nutrition (TPN) in preterm infants.
		Timely simple discharge.
		Retinopathy of Prematurity (ROP) screening.

2.27 What others say about us

Statement from The Care Quality Commission -Registration and Compliance

SWBH is required to register with the CQC the independent regulator of health and social care in England.

- SWBH is registered without conditions with the CQC,
- The CQC has not taken enforcement action against the Trust during the period 1 April 2012 to 31 March 2013.
- The Trust has participated in the following reviews by the CQC:

Sandwell Hospital was inspected by the CQC in July 2012. The CQC carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services;

Outcome 04 - Care and welfare of people who use services;

Outcome 14 - Supporting staff.

The CQC team made the overall judgement that 'Sandwell General Hospital was meeting all the essential standards of quality and safety inspected'.

The CQC carried out unannounced inspections at City & Sandwell Hospitals on 27th, 28th September & 1st October 2012.

The CQC inspected the following standards as part of a routine inspection. This is what was found:

Consent to care and treatment	✗	Action needed
Care and welfare of people who use services	✓	Met this standard
Cooperating with other providers	✓	Met this standard
Safeguarding people who use services from abuse	✓	Met this standard
Supporting workers	✓	Met this standard
Assessing and monitoring the quality of service Provision	✗	Action needed
Complaints	✓	Met this standard

Table 3. CQC findings

The CQC did comment that both the areas for action to be taken would have minor impact on people who use the service. The CQC view was that the impact was not significant and the matter could be managed or resolved quickly. A summary of the actions the Trust has taken resolve these issues include:

Consent to Care and Treatment

- Improving staff awareness of consent and mental capacity issues through a range of media and training interventions;
- Developing a staff information leaflet regarding Mental Capacity, IMCA and advance directives;
- Carrying out a survey of staff regarding knowledge of Mental Capacity Act (MCA) including application to Consent and Deprivation of liberty safeguards to identify future training needs;
- Reviewing the MCA policy to ensure that it is up to date;
- Raising staff awareness of applying MCA to practice;
- Carrying out a review and update the Trust's Consent Policy;
- Undertaking monthly consent audits.

Assessing and monitoring the quality of service provision

- Providing timely feedback to staff about the outcomes of incidents reported;
- Monthly review of corporate wide action plans to monitor corporate trends;

- Maintaining safe staffing levels by developing the Trust's monitoring of staffing ratios across the wards and assessment units to identify issues at an early stage;
- Review the data inclusion and improvement of complaints / incident information within the Trust Quality Report;
- Develop an organisation-wide 'Lessons Learned' policy;
- Improve complaints handling ensuing timely and proportionate responses.

West Midlands Quality Review Service (WMQRS) Inspection

The WMQRS carried out a review of the care of adults with long term conditions and the care of children and young people with diabetes between 5-8 February 2013. The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services.

Many areas of good practice were identified, and recommendations for improvement were also made.

The final report has not yet been issued.

2.28 Limited Assurance Report

The External Auditors have provided the Trust's management with a signed limited assurance report. This report is attached as Appendix 5.

2.29 Data Quality & Information Governance

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

We need to know that we are counting, recording and storing information about people's care very carefully. We do not have concerns about inappropriate disclosure of data. We are however not yet assured about data quality in every domain of key quality performance. Given this concern, which arises principally from the discovery in 2012-13 of a potential backlog of patients needing expedited elective care, we have commissioned an external review of all our data reporting for key national indicators to take place in July-September 2013.

NHS Number and General Medical Practice Code Validity

Below is the National, Strategic Health Authority (SHA) and Trust performance on validity of these data items as published through the Health & Social Care Information Centre (IC) through Secondary User Service Data Quality Dashboard – Provider Based using 2012/13 financial month 12 data, which is the latest we have.

It shows we remain above the national benchmarks for all but 1 indicators in A&E (the conclusion time). We remain above all indicators for Outpatients except Patient Pathway

Identifier (which is optional). We remain above all indicators for inpatients except for ethnic origin 96.3%, compared to the national average performance of 98.2%, patient pathway identifier (optional) and we are slightly below NHS number coverage at 98.9% which which compared to a national average performance of 99.1%. However we will be resubmitting our data with another NHS Number trace before year end.

	National	SHA	SWBH
Inpatients	99.1%	99.4%	98.9%
Outpatients	99.3%	99.6%	99.6%
A&E	94.9%	96.9%	96.8%

Table 4. NHS Number

	National	SHA	SWBH
Inpatients	99.9%	99.4%	100%
Outpatients	99.9%	99.6%	100%
A&E	99.7%	100%	100%

Table 5. General Medical Practice Code

Clinical Coding Error Rate

The latest final Payment by Results external clinical coding audit shows the trust has a 2.0% Finished Consultant Episode HRG error rate against national error rate of 7.5%.

The overall error rate was 3.5% for clinical diagnosis coding, and 9.1% for clinical treatment coding.

Information Governance Toolkit (IGT) attainment levels

Last year we reported that we had work to carry out to achieve compliance with the IGT.

The standards which we failed to meet were:

- 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.
- Such progress has been made that SWBH Information Governance (IG) Assessment Report overall score for 2012/13 is now graded Satisfactory green according to the IGT Grading Scheme.

Part 3: Review of Quality Performance 2012/13

3.1 Report on Quality Priorities for 2012/13

In last year's Quality Account, we identified four focus areas for prioritisation. They sat within the 3 domains, patient safety, clinical effectiveness & positive patient experience which are identified in our Quality & Safety Strategy.

The focus areas were:

1. Continuing to Improve the Stroke & TIA Services (Patient Safety);
2. Essential Standards of Nursing Care (encompassing Patient Safety, Effectiveness of Care, and Patient Experience);
3. Mortality reporting and analysis (Clinical Effectiveness);
4. Improving Emergency Department Safety and Performance (Patient Safety).

For each of the focus areas, our achievements are summarised in the Table 6 below. For more detail, there is a section describing our activities later in this Quality Account.

Table 6. Summary of Key Quality Achievements 2012/13

Aims	Actions	We did what we said we'd do
Focus Area 1 : Continuing to Improve the Stroke & TIA Services (Patient Safety)		
Continuously deliver safe, timely care for stroke and TIA & value for money		✓
Consultation and open reconfigured stroke & TIA services	We completed the consultation Opened 55 bedded stroke & neurology unit at Sandwell Hospital.	✓
Monitoring of our performance against agreed targets	We set targets for stroke performance achieving 4 out of the 5 main targets, and only slightly underperforming against the target we failed (CT scan within 24 hours arrival in hospital).	✓ ✗

Focus Area 2: Essential standards of Nursing Care		
To reduce avoidable hospital-acquired weight loss in elderly patients and vulnerable adults	• Introduced 'care rounds'. • Improved meal time experience. • Ensured patient hydration requirements are met. • Protected patients dignity at all times.	✓
To meet agreed Control of Infection Standards	• Met targets set for Clostridium difficile (C. Diff), methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, methicillin-sensitive Staphylococcus aureus (MSSA) and Escherichia coli (E. coli) cases • 30 day mortality for C. Diff. • Reduced the use of antibiotics. • Achieved hand hygiene standards, CQC standards & Patient Environment Action Team (PEAT) scores at excellent. • We did not achieve the MRSA screening targets for emergency patients by 8% below target.	✓ ✓ ✓ ✗
To increase Harm Free Care	Introduced the 'Safety Thermometer', reduced falls, assess 90% of admitted patients for VTE risk, reduce serious pressure sores, avoidable weight loss, and increasing the number of people on supported care pathways at the end of their lives.	✓
To increase dementia awareness and assessment	We carried out a trust wide campaign, increased the number over the age of 75yrs assessed, and improved referrals to support services.	✓

Focus Area 3: Mortality Reporting & Analysis		
Analyse and understand the causes of death in the Trust better and reduce mortality	Carried out reviews by consultants of more than 60% of deaths. Used Hospital Standardised Mortality Rate (HSMR) and Summary hOSPITAL Mortality Index (SHMI) to ensure that we are achieving less than average mortality rate. Carried out in depth investigations into any alerts raised though mortality alerts systems.	✓
Focus area 4: Improving Emergency Department Performance		
To increase the senior medical team	The trust has not been successful in increasing the senior medical team Although an ED clinical director has been appointed.	✗
To improve clinical systems and IT	Whilst work is well underway with the ED dashboard the installation of a new ED system is scheduled go live in May 2013.	✗
Meet to national 4 hour wait performance target	The achievement of national 4 hour waiting time was narrowly missed.	✗
Work more closely with our primary Care and Social Care partners	A rapid response team has provided additional social work support. GPs are providing services in the ED at City Work is in progress around transforming urgent care both in the trust and in the community.	✓

3.12 Focus Topic 1 - Continuing to deliver service improvement and outcomes in Stroke and TIA Services (Patient Safety)

Focus Area 1 : Continuing to Improve the Stroke & TIA Services (Patient Safety)		
Continuously deliver safe, timely care for stroke and TIA & value for money		✓
Consultation and open reconfigured stroke & TIA services	We completed the consultation Opened 55 bedded stroke & neurology unit at Sandwell Hospital	✓
Monitoring of our performance against agreed targets	We set targets for stroke performance achieving 4 out of the 5 main targets, and only slightly underperforming against the target we failed (CT scan within 24 hours arrival in hospital).	✓ ✗

Table 7. Summary of Focus Topic 1 achievements

Last year we said we were going to continue with improvements to Stroke & TIA services. We said we would:

- 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 in 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 said we would 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.

Over the past year significant progress has been made with Stroke and TIA services. The public consultation was completed. After the public consultation, the first part of a new 55-bed acute Stroke and Neurology Unit was opened at Sandwell Hospital on Monday, March 11th 2013. The new acute Stroke and Neurology Unit is part of the Trust's plans to concentrate all its services for Stroke patients and Neurology inpatients at one hospital. All rehabilitation and outpatient services for Stroke patients have also moved to Sandwell Hospital. This saw the opening of the hyper-acute and acute Stroke and Neurology ward where patients will spend the initial part of their hospital stay.

The ward has been designed to meet the specific needs of Stroke and Neurology patients including beds with additional monitoring facilities and a gym for therapy staff to work with patients from an early stage. There are also enhanced levels of nursing and therapy staff in line with nationally recommended standards.

By concentrating all stroke services at Sandwell Hospital, the Trust can provide a better service for Stroke patients and offer greater training and career development opportunities for staff.

The move saw doctors and nurses from City Hospital transferring to Sandwell Hospital to create a large, specialist Stroke Unit providing high quality care for stroke patients from Sandwell and West Birmingham. There is a hyper-acute stroke unit with supporting acute beds on one ward and rehabilitation beds on an adjacent ward.

In addition, the hospital team is working closely with community nursing and therapy teams, including specialist stroke community staff and early supported discharge teams, to ensure patients can be discharged home safely as soon as possible with the support they need. The Unit also provides acute and rehabilitation Neurology beds.

There is evidence that specialist hyper-acute stroke units with a larger number of skilled doctors, nurses and therapy staff give patients a better chance of making a full recovery after a stroke. Additional staff supporting the new unit includes specialist therapists, nurses and ward clerks. The new unit is expected to treat about 600 stroke patients every year.

The Ambulance Service now takes anyone suspected of having had a stroke directly to Sandwell Hospital. There are robust and safe procedures in place to care for anyone who self-presents at City Hospital with a suspected stroke.

The benefits of the new hyper-acute Stroke Unit include:

- Patients will continue to receive safe, timely care for stroke and TIAs resulting in a reduction in long-term complications including death;
- All stroke patients will be admitted directly to a stroke bed, with imaging en-route to the ward, within four hours of arriving in hospital;
- All stroke patients will be assessed daily by a specialist consultant clinician for stroke;
- At least 50% of stroke patients will have a CT scan within an hour of arrival and 100% will have a CT scan within 24 hours;
- Early supportive discharge teams will be in place for all patients living in Sandwell and there are plans to extend the service to Birmingham residents;
- All patients suspected of having a serious TIA will be seen on the unit within 24 hours.

As part of the plans for the new Stroke Unit a new £680,000 64-slice CT scanner has been installed at Sandwell Hospital. This scanner replaces the oldest 4-slice scanner currently at City Hospital. The second more modern CT scanner at City Hospital will remain on the City site for both in-patients and out-patients.

The new scanner will improve the service available for stroke. Outpatient services for Neurology patients will continue to be provided at City Hospital.

The Stroke Dashboard has been developed which gives clinicians access to performance information at their fingertips.

The table below summarises our performance against our main targets.

Main Stroke Targets	Target	Achievement YTD Feb 2013
Patients spending >90% stay on Acute Stroke Unit	80%	87.6%
Patients receiving CT Scan within 24 hrs of arrival	100%	92.1%
Patients receiving CT Scan within 1 hr of arrival	50%	52.2%
TIA (High Risk) Treatment <24 h from initial presentation	60%	69.5%
TIA (Low Risk) Treatment <7 days from initial presentation	60%	76.8%

Table 8. Stroke Target Performance.

In the table above you will see that we have not fully met all of our targets. What we can say is that despite our concerted efforts and a very high level of activity, we are confident with the reorganisation of our services to the Sandwell site. And, that by

bringing together nursing and medical stroke expertise into one place, we will be able to offer better care and achieve our objectives. Stroke & TIA services continue to be in our priorities for 2013/14.

3.13 Focus Topic 2-Essential Standards of Nursing Care (Patient Safety, Effectiveness of Care & Patient Experience)

To reduce avoidable hospital-acquired weight loss in elderly patients and vulnerable adults	• Introduced 'care rounds' • Improved meal time experience • Ensured patient hydration requirements are met • Protected patients dignity at all times	✓
To meet agreed Control of Infection Standards	• Met targets set for C. Diff, MRSA bacteraemia MSSA and Escherichia Coli (E. coli) cases • 30 day mortality for C. Diff • Reduced the use of antibiotics • Achieved hand hygiene standards, CQC standards & PEAT scores at excellent We did not achieve the MRSA screening targets for emergency patients by 8% below target.	✓ ✓ ✗
To increase Harm Free Care	Introduced the 'Safety Thermometer', reduced falls, assess 90% of admitted patients for VTE risk, reduce serious pressure sores, avoidable weight loss, and increasing the number of people on supported care pathways at the end of their lives.	✓
To increase dementia awareness and assessment	We carried out a trust wide campaign, increased the number over the age of 75yrs assessed, and improved referrals to support services.	✓

Table 9. Summary of Focus Topic 2 achievements

We said we would continue to improve the safety and experience of our in patients through specific attention to the reduction of events which harm our patients and through efforts to greatly improve the care we deliver.

We gave this priority the name of 'Essential Standards of Nursing Care' because it covered several of the quality priorities; reducing avoidable weight loss in elderly & vulnerable patients; 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.

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

Specifically we said we would:

- 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.

What we have achieved:

1 'Intentional Rounding' (Care Rounds)

'Care Rounds' were implemented in adult inpatient areas in 2012 for patients who do not require high levels of intervention, whereby a nurse visits the patient every two hours to attend to comfort needs (pain relief, positioning, toileting, food/ fluids) and follows prescribed standards of care. For those patients whose clinical condition dictates a higher level of intervention, the care standards are replaced with detailed care plans.

The results of this are shown in Table 10. The different factors which are included in this check are also included, and some of the interventions are described in more detail later on in this section.

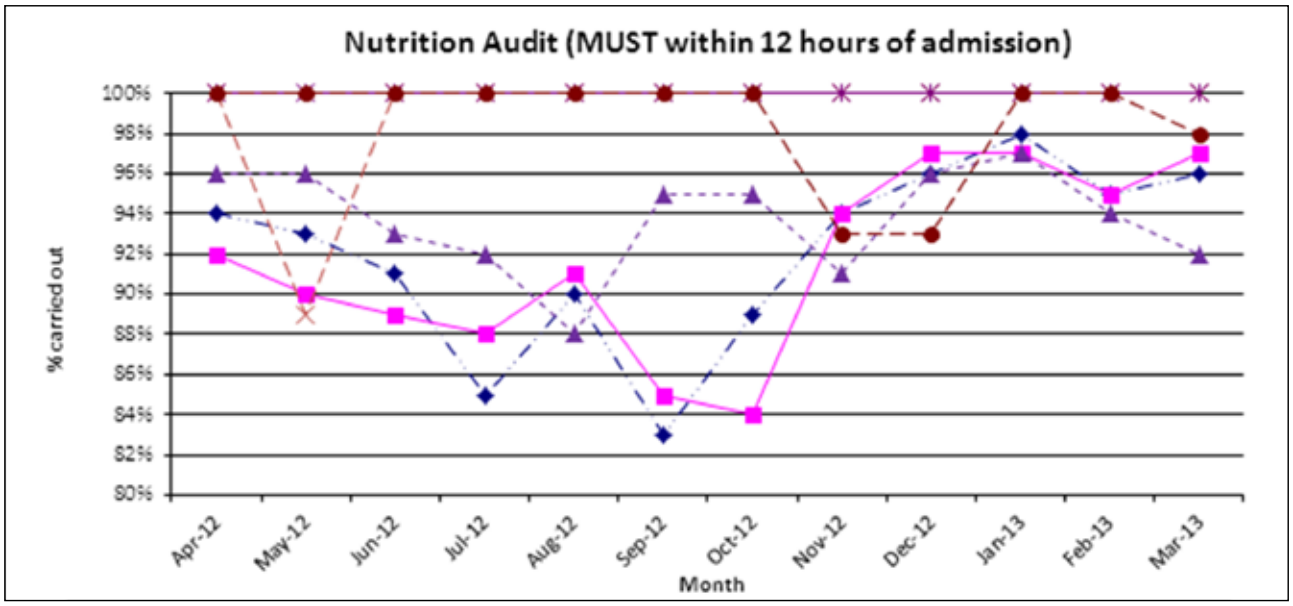
	Compliance with the 2 hourly patient checks	%
1	Allocated nurse	75
2	Active daily care standard/ Goal list	91
3	Mobility	87
4	Hygiene	87
5	Elimination	87
6	Eating and drinking	87
7	Cups target/ Dietary intake	58
8	Personal safety	69
9	Frequency of care	78
10	Events log	40
11	Carer involvement	24

Table 10. Compliance of 2 hourly patient checks (March 2013)

Nutritional Audits

Nutritional audits are carried out every month to check our performance. By paying a high level of attention to patients' food and fluid intake we can be confident that patients will not become malnourished during their stay with us, especially those who are identified as particularly vulnerable and at risk. We set a met or exceeded our target of 90% of patients being MUST (malnutrition universal screening tool) assessed within 12 hours admission in 9 months of the past 12 months. Nutrition continues to be high priority with the nursing staff.

Figure 1. Nutrition Audit



Protected mealtimes are in place which means that staff and visitors are discouraged from entering the wards so that patients can have peaceful, undisrupted time to eat and rest. It also means that the nursing staff can give those needing help with food and drink, their full attention and preserving privacy and dignity as much as possible.

Findings from the care round audits are reviewed at the Patient Experience Professional Advisory Group, which meets monthly. This is where ward managers are held to account for the findings and actions are agreed to improve patient experience and quality standards.

Standards and targets for infection control.

These standards included:

- Meeting targets set for C. Diff;
- Meeting targets for MRSA bacteraemia;
- Monitoring and recording MSSA and E. coli cases;

- Monitoring 30 day mortality for C. Diff;
- Reducing the use of antibiotic associated with C. Diff;
- Maintaining PEAT scores at good or excellent;
- Achieving hand hygiene standards;
- Achieving MRSA screening targets;
- Complying with CQC standards.

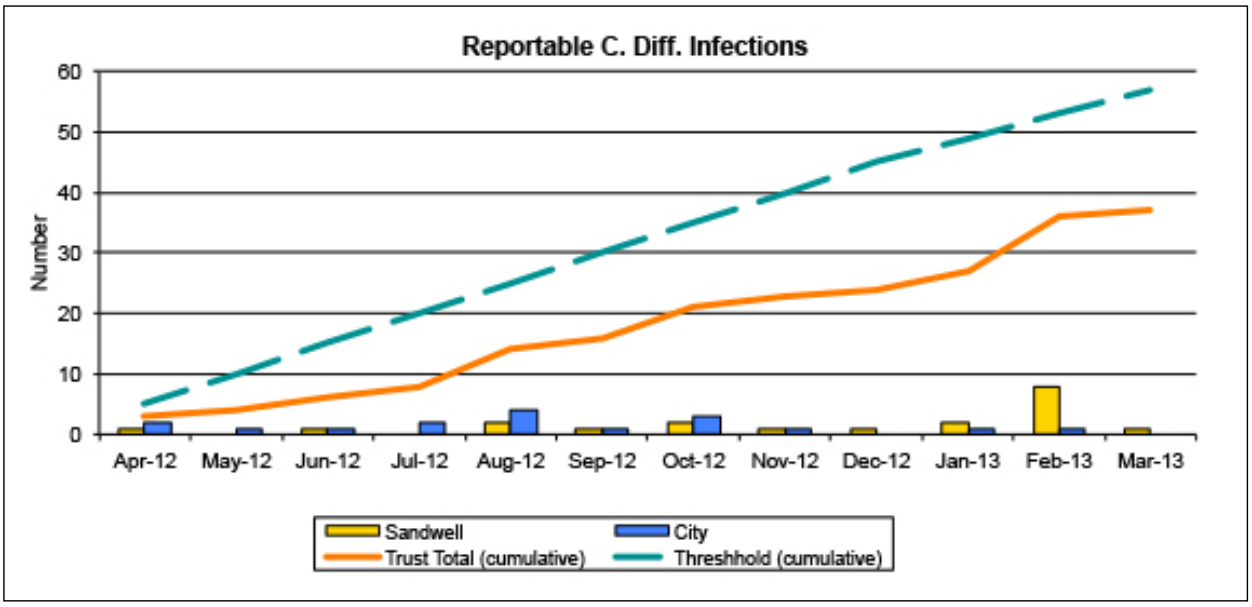
What we have achieved:

C. Diff Incidences.

In 2012/13 we have been very successful in keeping well below the number of occurrences agreed by the Department of Health, with only 37 occurrences of C. Diff. against a trajectory of 57 during the past year.

Actions to achieve this good performance included hand hygiene audits, a reduction in the use of antibiotics and maintaining a high level of environmental cleanliness.

Figure 2. Reportable C.Diff Infections



*SWBH considers that this data is as described for the following reasons:

During the reporting periods in the table below, the Trust was getting to grips with the C. Diff issue. We have implemented stringent infection control measures and have continued to maintain a high level of vigilance and activity of infection control, as described in this section of the Quality Account.

It can be observed in the table below that the rate of infection per 100,000 bed days has decreased from 87.5 in 2007/08 to 31.8 in 2011/12. Our performance has improved through 2012/13 as described on the previous page.

Year	Trust Apportionment	Total occurrences	Trust Rate	National Average	Lowest rate	Highest rate
2007/8	281	423	87.5	93.3	0	205
2008/9	158	237	49.5	54.9	0	133
2009/10	148	306	48.2	36.7	0	85.2
2010/11	116	240	39.7	29.6	0	71.8
2011/12	93	202	31.8	21.8	0	51.6

Table 11. C. Diff Performance

C.Diff performance is described in terms of rate per 100,000 bed days for specimens taken from patients aged 2 years and over, using the IC data.

MRSA Screening & Bacteraemia

The aim for us was to screen 85% of eligible patients for MRSA by March 2013. The target was exceeded for elective patients but we achieved 76.8% for non-elective (emergency) admissions which did not meet the required standard. We are not satisfied that we have not achieved this standard.

We are working with teams to improve their focus on carrying out screening on all patients, and we are striving to ensure that we capture the data in the most timely and complete way possible.

Across the whole of 2012/13 the total number of MRSA bacteraemias attributed to the Trust target to date was 1, which is below the set tolerance of 2.

PEAT Score

The PEAT score for national standards of cleanliness was an average of 96%.

Reduction of Antibiotic usage

The Trust met the Medicines Stewardship antibiotic related reduction target scoring 83 against a target of 70, which is better than the required standard.

Increase Harm-free care

We said we would increase harm-free care across Inpatient areas and District Nurse caseloads in 4 key areas.

We said we intended to continue to improve the safety and enhance patient experience

through specific attention to the reduction of harm events and through efforts to measurably improve care delivered.

Specifically, we said we intended 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 by patients in 4 specific areas:

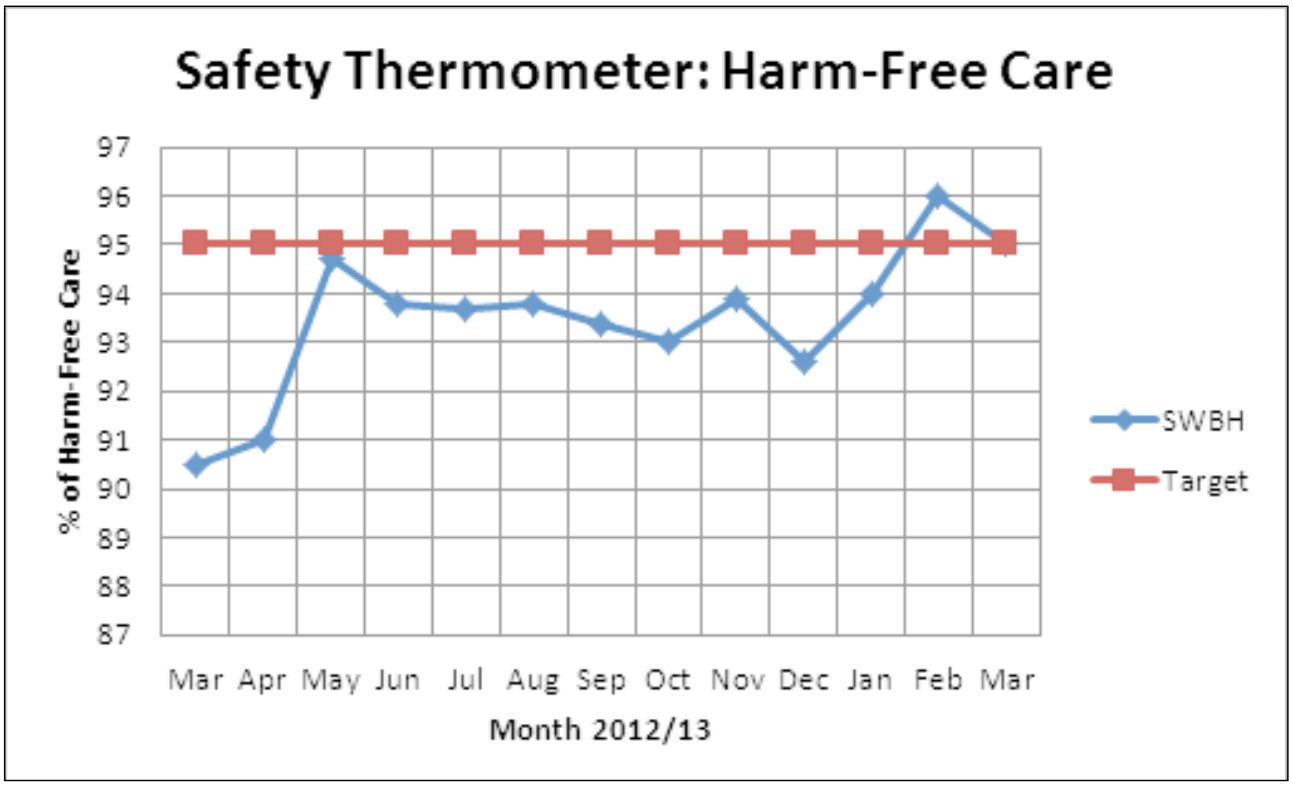
1. Pressure ulcers;
2. Falls;
3. Catheter-associated Urinary Tract Infections (CAUTI);
4. VTE.

What we have achieved:

The Safety Thermometer Audit is completed trust wide including the Community Services on a pre-prescribed day, once a month. The data is then submitted to the IC. This is then published nationally.

The monthly whole Trust audit of patients for 4 harm events (falls, pressure damage, CAUTI and VTE) has been accepted very positively with good engagement of nursing staff. Work has commenced to add other harm measures to the tool, e.g. avoidable weight loss.

Figure 3. Harm free care trend



Falls

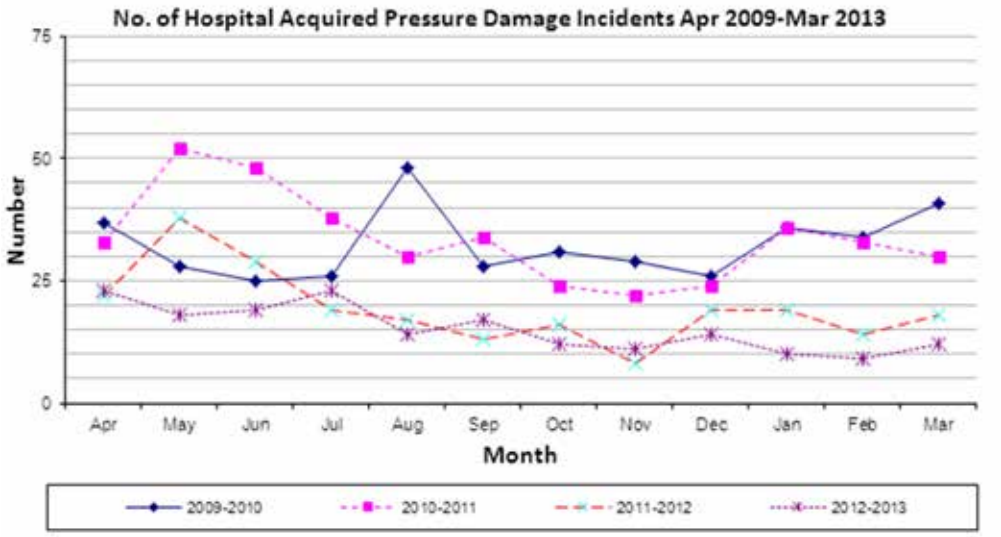
The internal target of reduction of 10% above the initial baseline assessment has been exceeded and the requirements of the Safety thermometer have been met but we have not become complacent and will continue to reduce all avoidable falls. Our audits have become part of our normal day to day work and we will continue to monitor risk assessment compliance, appropriate use of care bundles and numbers of falls. Falls with injury were reported as adverse incidents and internal reviews were conducted.

Pressure Damage

We are committed to reducing all avoidable pressure damage with the ultimate aim of eradicating them totally: a grade 4 pressure sore is worse than a grade 2 pressure sore. We have been assessing patients to check for the risk of developing pressure sores, introducing the appropriate care bundle and conducting internal reviews on all grade 3 and grade 4 sores to understand why they occurred. This is then fed back to staff so that lessons can be learnt.

As you can see from the following table, steady progress has been made and this year we have continued to reduce the occurrence of these serious sores.

Figure 4. Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 January 2013



VTE Risk Assessment

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 2010/11-2012/13 which has meant that

every Trust had to achieve VTE assessment rates of 90% in admitted patients. The Trust met the 90% VTE target in 10 out of the 12 months. However, the 90% of admitted patients did receive a VTE risk assessment across the year.

2011/12	Quarter1	Quarter2	Quarter3	Quarter4
SWBH	92.1%	89.6%	91.2%	89.58
England Highest	100	100	100	Not Available
England Lowest	80.8	80.9	84.6	Not Available
Average	93.7	93.8	94.3	Not Available

Table 12. 2011/12 VTE performance

Data source- Health & Social Care Information Centre (IC) (Q1, 2 & 3). Local data Q4

The 2012/13 performance against the 90% VTE assessment target is displayed below in table 11. Comparative data cannot be displayed as this is local data.

2012/13	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% VTE Assessed	92.44	92.87	90.95	91.28	87.41	90.97	91.8	91.96	90.66	91.83	91.14	87.44

Table 13. 2012/13 VTE performance

*SWBH considers that this data is as described for the following reasons:

During March 2013 there was a major technical problem which meant that we could not guarantee that the data was complete for VTE risk assessments.

The SWBH intends to take the following actions to improve this number by taking the steps described in Focus Area 2 in Part 2 of this Quality Account, as it acknowledges that it is a high priority for improving patients' safety.

A new electronic tool is being designed to make it easier for clinicians to record their VTE assessments. An indicator has been added to the electronic bed boards in every ward which show when VTE assessments are required.

In addition, the clinically led Thrombosis Group meet bi-monthly to address issues relating to VTE risk assessment management, amongst other clinical issues, and is reviewing hospital associated incidences of embolus. This group reports to the MQuAC.

Dementia awareness and assessment

We said we would raise dementia awareness and assessment by:

- Delivering a trust-wide awareness-raising campaign;
- Carrying out assessments of all people over the age of 75 who are admitted as emergencies who are 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 if dementia is suspected.

It is estimated that 25% of general hospital beds are occupied by people with dementia, rising to 40% or higher in certain groups such as elderly care wards. The presence of dementia is associated with longer lengths of stay, delayed discharges, readmissions and inter-ward transfers. This can result in patients not feeling as well cared for as they would have liked and distress for the carer.

By introducing the Dementia CQUIN, awareness has been raised across the trust. This has helped us identify patients with dementia and other causes of impaired cognition alongside their other medical conditions. This has also, this meant that patients were much more likely to get a prompt referral to appropriate services and follow up in the community after leaving hospital.

Of the 40% of people over 75years of age with dementia admitted to general hospitals, it is estimated that only half have been diagnosed before admission. The better we are at picking up dementia, the better care patients will get.

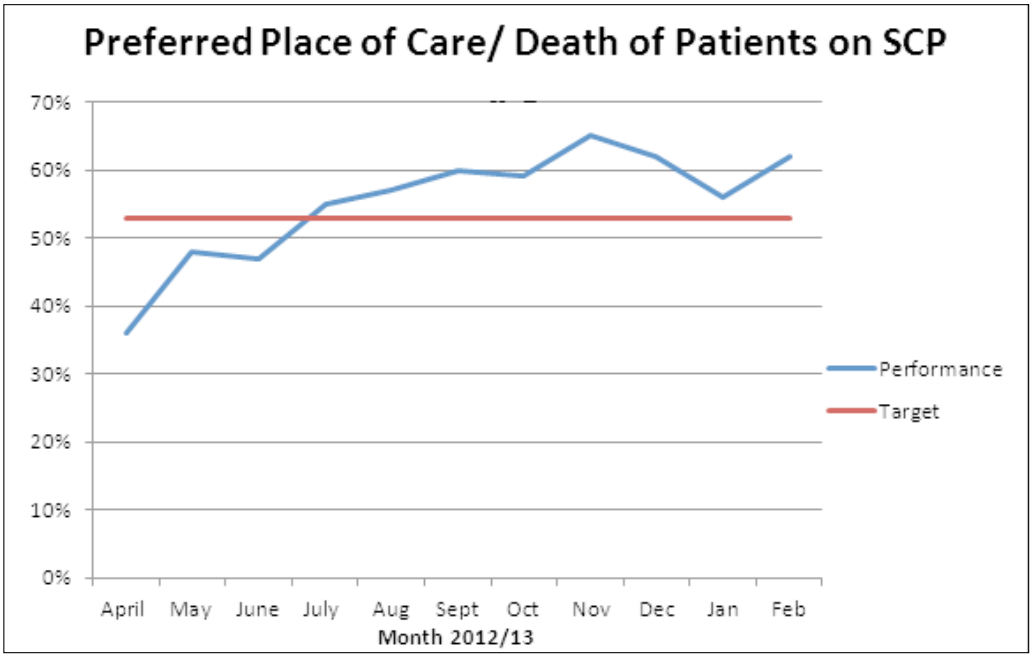
The target was met and it is we are confident that this will have improved how patients and carers are offered care and supported.

End of Life Care

We said we would increase, by 10%, the number of patients achieving death in their preferred place and who were on a supportive care pathway (SCP) in both the acute hospitals and in the community. This means that patients have services set up to have a dignified death in the place of their choice. This standard is very important in making sure that patients can have every dignity afforded to them at a time when they can be very vulnerable.

The 53% target has been exceeded every month since July 2012 and 60% has been achieved or exceeded for 3 out of the last 4 months of the year.

Figure 5. Preferred place of death/death of patients on SCP



3.14 Focus Topic 3 – Mortality Reporting & Analysis (Clinical Effectiveness)

Analyse and understand the causes of death in the Trust better and reduce mortality	• Carried out reviews by consultants of more than 60% of deaths. • Used HSMR and SHMI to ensure that we are achieving less than average mortality rate. • Carried out in depth investigations into any alerts raised though mortality alerts systems.	✓

Table 14. Summary of Focus Topic 2 achievements

We said we would 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 said we would use the HSMR) and SHMI, to monitor and improve the Trust's performance. These measures allowed us to measure our performance against other trusts' performance across the country. By adopting these systems, processes and practices at every level we said we would aim to reduce avoidable harm and death.

The improvements we said we would make were:

1. Reducing mortality in the Trust;
2. Understanding the causes of deaths in our hospitals better, including in Emergency Departments;
3. Continue to review the agreed percentage 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.

What we have achieved:

Over the past year, we have continued to monitor the mortality rates in the Trust. Consultants have continued to review deaths of patients and have exceeded 60%. There have been a lot of very ill, often frail and elderly patients, admitted to our hospitals over the winter which has meant that there has been a high level of activity. Our staff have been spending time with patients rather than carrying out reviews. This has meant that we have not been able to carry out quite as many reviews as we intended.

Where reviews have been carried out, and a death has been identified by the reviewer as preventable, a deeper review is carried out to explore what can be learned from this and what we can do better in future. However, this is an area we want to improve on and have included it in something we want to do this year.

Use of HSMR & SHMI

We said we would use a range of tools to analyse mortality. We use HSMR and SHMI. It is reported every month to the Quality & Safety Committee, the Commissioners, and is discussed in detail at the MQuAC. We also carry out in-depth reviews of any diagnostic code that has shown that our incidence of disease seems to higher than expected.

HSMR is a standardised measure of hospital mortality and is an expression of the relative risk of mortality. It is the observed number of in- hospital spells resulting in death divided by an expected figure.

The Trusts 12-month cumulative HSMR (87.8) at the Trust remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (96.7). The in-month (January 13) HSMR for the Trust has decreased to 81.4

The 12 month cumulative site specific HSMRs are 76.2 and 99.7 for City and Sandwell respectively, neither of which are currently in excess of upper statistical confidence limits. We are looking at the differences between the 2 sites to identify if there are any significant reasons for this.

The SHMI is a national mortality indicator launched at the end of October 2011. The intention is that it will complement the HSMR in the monitoring and assessment of Hospital Mortality. One SHMI value is calculated for each trust. The baseline value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment was exactly the same as the number expected using the SHMI methodology. SHMI values have also been categorised into the following bandings.

1	where the Trust's mortality rate is 'higher than expected'
2	where the trust's mortality rate is 'as expected'
3	where the trust's mortality rate is 'lower than expected'

The last SHMI data was published on 24/01/13 for the period July 11 – June 12. For this period the Trust has a SHMI value of 0.97 and was categorised in band 2.

- 11 trusts had a SHMI value categorised as 'higher than expected'
- 16 trusts had a SHMI value categorised as 'lower than expected'
- 115 trusts had a SHMI value categorised as 'as expected'

Further SHMI data for the period October 2011 – September 2012 is due to be published this month. In addition, the UHB Healthcare Evaluation Data (HED) tool provides data in month based on the SHMI criteria. The SHMI includes all deaths up to 30 days after hospital discharge. The Trust SHMI for the most recent period for which data is available is 94.4.

Internal Data:	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
Hospital Deaths	133	146	126	121	132	121	139	106	140	157
Dr Foster 56 HSMR Groups:										
Deaths	110	129	111	100	113	101	124	89	126	132
HSMR (Month)	84.6	89.2	89.7	85.5	83.9	84.8	91.1	64.2	83.3	81.4
HSMR (12 month cumulative)	89.7	88.3	96.4	95.5	94.2	93.1	92.5	90.4	89.1	87.8
HSMR (Peer SHA 12 month cumulative)	94.9	93.3	101.3	100.2	98.7	97.8	96.7	96.4	96.8	96.7
Healthcare Evaluation Data (HED) SHMI (12 month cumulative)	96.2	96.0	96.3	96.3	94.2	95.6	94.9	94.4	.	.

Table 15. Mortality Performance Statistics 2012/13

SWBH	Observed deaths	Expected deaths	Rate	Band
April 11 - March 12	2171	2243	0.96	2
July 11 - June 12	2196	2256	0.97	2

Table 16. SHMI performance - Data source –IC, 8/4/13*mandatory entry

Palliative care

Over the past couple of years the palliative care service has been developing. This service focuses on ensuring that people end their lives with a dignified death in the place of their choice and without pain.

SWBH	Denominator	Numerator	Rate of palliative care coding	National average	National Lowest	National Highest
April 11 - March 12	2171	440	20.3	18	0	44.2
July 11 - June 12	2196	494	22.5	18.6	0.3	46.3

Table 17. Palliative Care Coding

* SWBH considers that this data is as described for the following reasons:

Actions have been in place over the past few years which is to do with the scrutiny of the HSMR, SHMI and reviews by the senior medical staff. SWBH remains in Band 2 and the HSMR and SHMI is below 100 using both indicators.

That the focus on developing the palliative care service has increased which has led to more patients being coded as on a palliative care pathway.

The SWBH has taken the following actions to improve this percentage and so the quality of its services by employing palliative care medical consultants and strengthen work across the acute and community services to develop better end of life care for patients.

Palliative care consultants and nurses are actively involved in the MQuAC which reviews a broad range of aspects of mortality including HSMR, SHMI, CQC alerts, incidents and internally identified concerns.

The Trust intends to take the actions described in Part 2, Section 2.14- Focus Area 2.

3.15 Focus Topic 4 - Improving Emergency Department (ED) Performance (Patient Safety & Patient Experience)

To increase the senior medical team	Recruitment continues but a key risk to us remains senior medical presence. Recruitment in other professional groups in ED is substantially improved.	✗
To improve clinical systems and IT	Whilst work is well underway with the ED dashboard the installation of a new ED system went live in May 2013.	✗
Meet to national 4 hour wait performance target	The achievement of national 4 hour waiting time was narrowly missed.	✗
Work more closely with our primary Care and Social Care partners	A rapid response team has provided additional social work support. GPs are providing services in the ED at City Work is in progress around transforming urgent care both in the trust and in the community.	✓

Table 18. Summary of Focus Topic 4 achievements

The ED is the place many local people, many of them very unwell, frail and elderly, first come into contact with our hospitals. It is an area which has been under a lot of pressure during the past year. We have not succeeded to achieve all that we wanted to in the EDs.

Last year we said we would:

- Continue to recruit more middle and consultant grade doctors to the EDs;
- 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 ED to be reviewed by senior doctors;
- Support the delivery of the Integrated Development Plan for our Emergency Departments, working in partnership with the commissioners;
- Improve the IT 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 Emergency Department are appropriately redirected;
- Continue to meet national standards in respect of 4 hour waits, and perform better against the other national standards for Emergency Departments;
- Ensure protocols/guidelines are being followed to provide a consistent level of high quality care.

ED Performance against the national 4 hour wait standard

Performance in the ED has not achieved the standards which we wanted. This is due to particularly to there being high levels of winter illnesses which have had a knock on effect of beds being unavailable when patients require admission. The Trust has experienced a significant and prolonged norovirus outbreak over the winter months. Several wards were closed due to infection control precautions, further impacting on capacity.

The performance across the year was that 92.34% of patients were waiting in ED for less than 4 hours, which does not meet the 95% standard.

The reasons behind this were to do with patients not being seen and treated within 4 hours in the ED or because when it was decided to admit them to hospital, a bed was not available immediately.

Our aim remains for patients to get the appropriate care within as short a time as possible and that no one should wait more than 4 hours to get the care they need. We know we need to work more effectively on achieving this and that is why we are taking this forward into 2013/14 as a top priority.

ED Staff Recruitment

We have tried to recruit more senior doctors for the EDs. This has not been as successful as we would have hoped.

The Trust Board approved a workforce investment business case in November 2012 to increase medical and nursing establishment for ED. The £2.186 million investment case was based on a workforce model to strengthen clinical leadership providing an increase in 7 day consultant coverage of the department and expansion of nursing staff.

We are continuing to work on our staff plans and developing training opportunities for leadership team.

High Standard of Care

Much of what leads to a high standard of care and a positive experience for patients is by having a well trained workforce. We have begun work on a raft of training to help raise standards.

We are adopting the West Mercia Guidelines for Emergency Care which is a collection of pathways which offer the proven best ways of caring for people in our emergency medicine areas. This will also mean that there will be standardised care across our hospitals.

We are pleased to report that we have seen a reduction in the number of serious incidents reported in the EDs, which is very positive for service users.

Improvements of the ED IT systems

The ED has worked closely to develop electronic tools to help managers and clinicians understand the patients' progress in the ED.

Work is in progress on installing a new ED electronic system. It is planned to go live in May 2013. This will help doctors and nurses look after patients better by freeing up time and keeping the information they need in one place.

Working with our Commissioners, Primary Care and Social Care

We have been working closely with our commissioners, primary care and social care services. The Trust continues to work with external partners to reduce delayed transfers of care and appropriate admission avoidance schemes.

Additional social work capacity has been provided Monday to Friday by Birmingham Social Services to work with the Rapid Response Team based in ED and the assessment units.

A recent improvement is that GP services are being provided in the City ED, as they are at Sandwell where appropriately identified patients are seen. This is helping reduce waits for patients and also means that patients are seen by the right health professional.

Work has commenced between the CCG, Social Services and the Trust to develop a joint social and health care team and determine a priority plan to reduce delays in the acute sector. The initial scoping phase of urgent care transformation has been completed with a multi-agency team presenting an outline conceptual model for urgent care provision across the system. This will now be formally commissioned as a project hosted by the CCG to be progressed over the first half of 2013/14.

3.16 Strengthening Governance Arrangements at SWBH

The decision was taken to review and strengthen Clinical Quality Governance arrangements in the Trust. The move to divide the Governance Committee into 4 areas of scrutiny was taken replacing it with 4 committees:

1. Patient Safety Committee;
2. Clinical Effectiveness Committee;
3. Compliance & Assurance Committee;
4. Patient Experience Committee.

The purpose is to be able to focus attention on really making sure we are giving patients the best experience and safest care possible. These 4 committees report into the Quality & Safety Committee which is a sub-committee of the Board.

The Committees' key agenda items focus on all aspects of quality and making sure that a good level of assurance is provided to the Board that clinical services are appropriately delivered in terms of patient experience, quality, effectiveness and safety. They also aim to ensure that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance. Where quality and performance falls below acceptable standards, they ensure that action is taken to bring it back in line with expectations, and to promote improvement and excellence. In addition, the committees ensure that service user and carer perspectives on quality are at the heart of the Trust's quality assurance framework.

Led by Clinical Directorates, 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 and Senior Manager. In turn, they are responsible to the Board.

3.17 Patient Safety & Incident Reporting

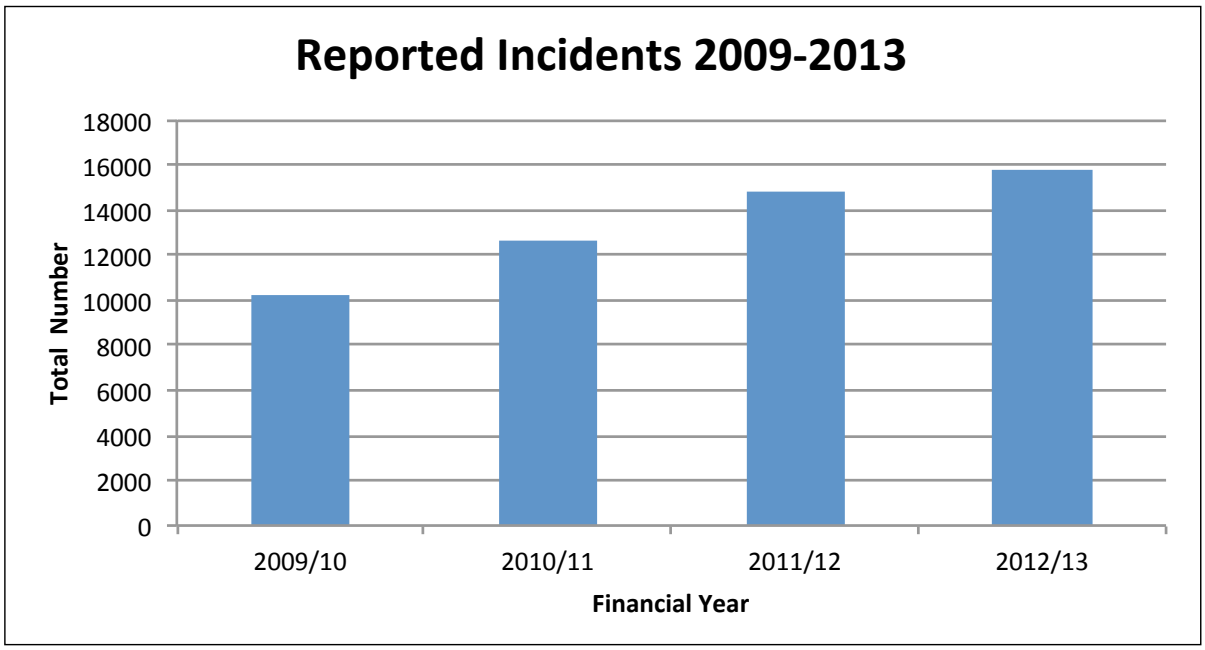
An effective safety culture is often evidenced by high levels of incident reporting. The Trust submits patient safety incidents to the National Reporting & Learning System (NRLS) which provides comparative data with like sized Trusts. The next comparative report was due in March 2013 although this was not available at the time of writing this Quality Account.

The Trust has a system for investigating incidents of all grades and learning from our mistakes. Staff are actively encouraged to report incidents and near misses, whether the incident directly affects patient safety or they relate to the health and safety of staff and members of the public.

Electronic incident reporting has improved reporting rates across clinical staff. However, at a Listening into Action (LiA) staff engagement event in April 2012, staff identified that feedback was often not provided following submission of an incident being reported. Following the LiA, feedback to staff was made compulsory on the electronic system. Quality of data and information has become more robust since moving to an electronic system.

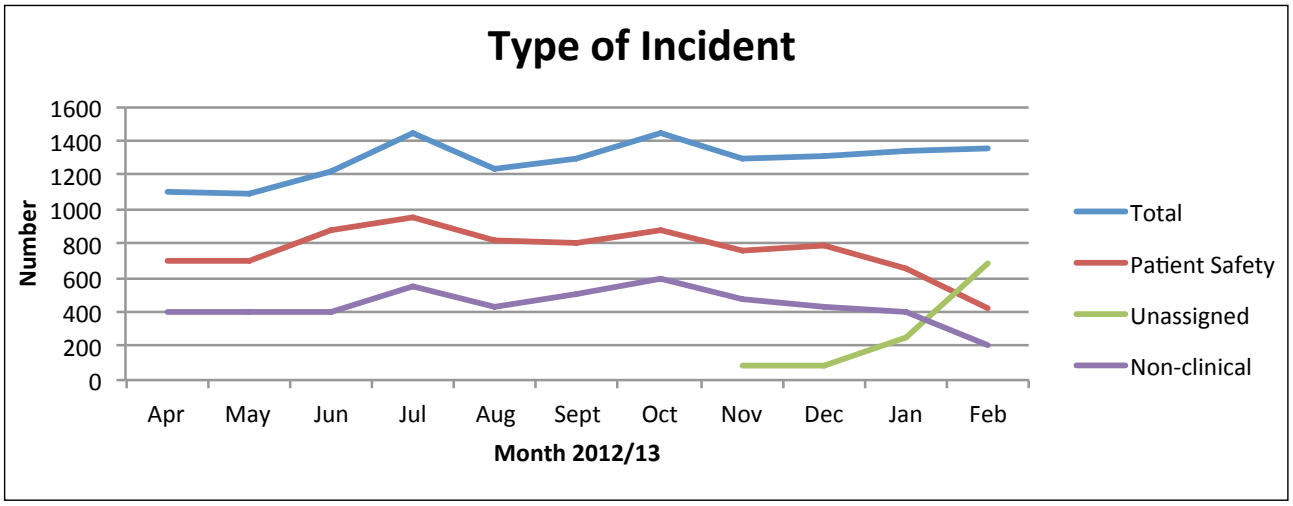
We see the increase in reporting of incidents as a positive step as it means that our staff are better at identifying risks and then, as an organisation we are able to learn from them and take action to prevent these incidents happening again in the future.

Figure 6. Year-on-year increase in incident reporting



Incidents are divided into clinical (patient safety), non-clinical and, others which are categorised dependent upon their causative factor groups. This enables trends and themes to be reviewed and direct action to be taken.

Figure 7. Type of Incidents



The chart above shows the numbers of clinical and health & safety incidents by type month through 2012/13.

Within the electronic incident reporting system incidents are held outside of the "live" system until they have been managed and closed. These remain unassigned until completion and are shown in the graph above seperately in yellow.

Serious incidents are reported to the CCG and investigated corporately. The Trust also assigns the designation "corporate amber" to some incidents either because they require reporting to other external stakeholders or to raise awareness. Examples are: pressure sores, selected sharps injuries, selected violent incidents and selected medication errors.

During 2012/13 the total number of patient safety incidents of all grades reported to the National Reporting & Learning Service was 9846. The number of serious incidents reported, classified as severe (resulting in permanent or long term harm), was 14, and the number reported classified as resulting in death (death caused by the incident) was 12: a total of 26. The percentage of patient safety incidents resulting in severe harm or death during 2012/13 was 0.26%. This was local data and was extracted from the Trust's reporting system. The numbers may be changed following investigation and change to the grading of the incident. The national reporting period of October 2012-March 2013 and the final position will not be released until September 2013. For this reason, there is no comparative information about performance against other trusts and the rate has not been calculated.

The number of serious incidents (not exclusively patient safety incidents) reported internally was 66 in 2011/12 and reduced to 42 in 2012/13, excluding pressure sores, fractures resulting from falls, ward closures, some infection control issues or health and safety incidents.

Month 2012/13	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
No. Serious Incidents reported	7	7	8	2	3	6	2	1	2	0	3	1

Table 19. Number of Serious Incidents reported during 2012/13*

*The serious incidents reported in the table above do not include pressure sores, fractures resulting from falls, ward closures, some infection control issues or health and safety incidents.

The SWBH considers that this data (below) is as described for the following reasons:

The Trust has improved its reporting culture which has led to more incidents being reported. From the first period reported above to the second period we have moved from being in the middle 50% of reports to the highest 25% of reporters, which is very positive.

Rate of incidents per 100 admissions	October 2011 - March 2012	April 2012 - September 2012
SWBH	6.7	9.4
England Median	5.9 (of 41 large acute trusts)	6.2 (of 39 large acute trusts)

Table 20. Incident rate

Degree of Harm	Number Oct - March12	Number April - Sept 12
None	2207	3138
low	1159	1668
Moderate	471	347
Severe	40	30
Death	6	12

Tables 21. Incidents-Degree of Harm Source: (IC)

The percentage of severe incidents between October and March 12 was 1.0% at SWBH, compared to 0.6% in all large acute organisations. The percent of severe incidents between April and September 12 was 0.6% at SWBH, compared to 0.6% in all large acute organisations which is an improvement.

The percentage of incidents resulting in death between October and March 12 was 0.2% at SWBH, compared to 0.1% in all large acute organisations. The percent of incidents resulting in death between April and September 12 was 0.2% at SWBH, compared to 0.1% in all large acute organisations.

As described in our Quality & Safety Strategy, SWBH intends to continue the actions to improve safety by taking the steps described in Section 2 of this Quality Account, as it acknowledges that it is a high priority for improving patients' safety & experience. Crucial to this success is complying with governance arrangements which are conducive to openness and honesty. Learning from incidents also ranks highly at the top of our agenda and sharing lessons learnt.

'Never Events'

'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. However, we have reported 2 never events since 1 April 2012. One related to the retention of a guide wire following the insertion of a central venous line and the second was the removal of the wrong tooth, which is classed as wrong site surgery. Both were fully investigated and actions taken to avoid these incidents occurring again.

The use of the WHO Surgical Safety Checklist at all our hospital sites for all surgical procedures and many interventional procedures has significantly improved patient safety over the past two years and work continues to ensure that this safety mechanism is embedded.

NHS Litigation Authority Risk Management Standards

The NHS Litigation Authority (NHSLA) through their claims data, develop risk management standards which Trusts are assessed against. There are three levels, 1, 2 and 3 (1 being the lowest). The Acute Trust attained Level 2 compliance in February 2011

and with the transfer of Sandwell Community services were required to be reassessed in February 2013. Due to changes within the NHSLA, we requested a postponement of this assessment, which was granted until 2014/15.

Maternity services undertook a separate assessment called Clinical Negligence Scheme for Trusts (CNST), as well as being part of the Acute assessment. Maternity undertook a Level 2 assessment in February 2013 and were deemed compliant with a compliance of 44/50. This is an extremely good achievement as many maternity services struggle to achieve this level of attainment. However, the maternity services wish to progress to an even higher level and a Level 3 assessment is provisionally booked for February 2014.

What this means is that the risk of harm to patients has been assessed as lower because the Trust has systems and processes in place, which are being followed, to protect patients, or in the case of maternity, to protect women and their babies.

3.18 Safeguarding Adults and Children

The safeguarding of children, young people and vulnerable adults is a key responsibility of the Trust. Safeguarding level 1, 2 and 3 training is delivered across in accordance with the intercollegiate document (2010). Training is delivered across the Trust, covering Community, Acute, Adult and Children's Services staff together.

Safeguarding Adults Training continued as planned throughout 2012/13. Increasing awareness across the trust was targeted by attaching updated Safeguarding information leaflets to all wage slips in June 2012. We also have scheduled Mental Capacity and Deprivation of Liberty Safeguard leaflets to be attached to all wage slips in May 2013.

The Learning Disability Liaison Nurse continues to work across the Trust with patients from Sandwell, and with the Birmingham Community Services Health Facilitation Service assisting patients living in Birmingham. The 'Good Healthcare for All' group continues to meet supported by the 'Changing our Lives' group from Sandwell.

The Trust has a comprehensive plan to improve the care of patients with dementia, as referred to earlier in section 3.13. This work is very important and the Chief Nurse personally oversees these activities.

Safeguarding Children

We have embraced a new commitment to developing a safeguarding children's service that is focused around the journey of the child. This pathway may consist of a child visiting the Emergency Department, being admitted to a children's ward and then being discharged back home and to the community services. By training and working together across acute and community boundaries, we feel this approach strengthens our approach to safeguarding our most vulnerable children.

In addition to training, staff need to know where to go for support to be able to safeguard the vulnerable. We have a key contacts identified named safeguarding professionals for advice and support. We focus closely on the child travelling through our services and providing early support and interventions where possible. We offer support to staff through supervision, increasing staff knowledge, skills and experience and moving away from criticism and fear of getting it wrong.

Safeguarding Children is everyone's responsibility and all children have a right to be safe and protected from harm.

Compliance with Safeguarding training at the end of March 2013 is illustrated in the table below.

Training	% staff compliant
Safeguarding Adults Level 1	99.36
Safeguarding Adults Level 2	80.11
Safeguarding Children Level 1	99.37
Safeguarding Children Level 2	63.07
Safeguarding Children Level 3	79.97

Table 22. Compliance with safeguarding training at the end of March 2013.

Health Visiting

We have developed a Directorate Integrated Development Plan that brings together the activities required to deliver The Health Visiting National Strategy 2011 - 2015, 'A Call to Action'.

We are on track to meet the workforce plan of recruiting 41 additional health visitors (HVs) for Sandwell by 2015. Seventeen student HVs are in training and will qualify in September 2013, who add to the previous eight we supported through training last year. We are continuing to offer good opportunities to attract qualified health visitors to work in the Sandwell area.

We are working on reducing the caseload of our HVs down to between 250-350: some had between 700-900 on their books. We are making good progress with the average case load of 540.

To our credit, we were identified by the Strategic Health Authority (SHA now dissolved) and the Department of Health (DH) as an early adopter site for the 'A Call to Action' Health Visiting Strategy. This was in recognition of our current journey in developing, delivering and transforming our HV service. By working with the DH we were able to share our leadership, commitment and resilience in taking forward this challenge in number of key areas. We presented a joint project between HV and midwifery on

domestic abuse in pregnancy at the National Leadership Event for the DH. We had the opportunity to meet the Minister for Children and showcase our work.

We were also nominated for best practice by the SHA for our programme that supports our large numbers of newly qualified health visitors. This has also been recognised by the Sandwell Safeguarding Children's Board.

We will continue to improve the health outcomes, giving our children the best start in life.

Midwifery Staffing

Nationally the Royal College of Midwives has stated that there is an overall deficit of up to 5,000 midwives across the country and SWBHT mirrors the concerns that investment is required into training and retention programmes.

The current state of play for staffing at the Trust according to the workforce planning services for midwifery, Birthrate+, is that we are adequately staffed in each midwifery area apart from the ward areas. Community Midwifery caseloads have been redressed with investment from the commissioners and with the final investment equivalent to 10 whole time equivalent posts. This brings community midwifery caseloads to 1:98 which is better than the national average of 1:100. We are working on improving the staffing levels in the postnatal ward areas.

Supervision of Midwives

The Trust currently has 16 supervisors of midwives who report to the Local Supervisory Authority Midwifery Officer. Those supervisors oversee approximately 16-18 midwives each which is an average number compared to other Trusts. The supervision process is vital in maintaining robust governance.

Puerperal Sepsis

Over the last decade, there has been a rise in the number of women becoming ill with puerperal sepsis. Puerperal sepsis is a severe infection affecting women following childbirth and is associated with a rise in maternal morbidity and mortality. There have been several factors linked to this such as hospital acquired infections, reduced midwifery postnatal visiting and failure to recognise the early signs of sepsis onset. Sepsis can overwhelm women in a relatively short period of time and due to pregnancy immune suppression staff are expected to recognise and act with speed.

At SWBH, the population we serve is particularly at risk as many of our patients are physically, medically or socially compromised and are more likely to be at risk of sepsis. As a result the department has implemented a Sepsis Pathway for any woman which helps us identify those with one or more positive symptoms. Women who present in the postnatal period are referred back to the Midwifery Triage so they can be prioritised and receive care without loss of time and expertise. All women who are readmitted are treated as a priority.

3.19 Emergency Readmissions to hospital within 28 days of discharge from hospital

Emergency readmissions to hospital following discharge are a useful measure about of hospital care.

The tables below demonstrate that SWBH, based on the IC's most up to date data for adults of 16 years and over, had a higher than England average score for emergency readmissions to hospital within 28 days. For children, 0-15 years of age, the SWBH performance demonstrated a lower than England average readmission rate during the 4 year period illustrated. Over the 4 year period an increase rate of 28 day emergency readmissions was indicated in both groups. It is the most recent data available from the IC which gives us information about how we compare to others.

Indicator	% Emergency readmissions to hospital within 28 days of discharge from hospital				
Age 0-15	10/11	09/10	08/09	07/08	06/07
England	10.08	10.18	10.09	9.14	9.61
SWBH	9.54	9.04	8.67	8.54	8.5
SHA	11.02	10.7	10.32	9.72	10
Highest*	14.34	16.5	15.85	16.03	12.97
Lowest*	6.49	6.12	5.85	6.16	5.97

Table 23. Emergency Readmissions 0-15years within 28 days of discharge from hospital

Indicator	% Emergency readmissions to hospital within 28 days of discharge from hospital				
Age 16+	10/11	09/10	08/09	07/08	06/07
England	11.42	11.16	10.9	10.57	10.43
SWBH	13.25	12.22	11.79	10.93	10.63
SHA	11.64	11.28	10.94	10.44	10.18
Highest*	14.09	13.18	13.94	12.79	12.24
Lowest*	9.18	8.92	8.64	8.71	8.61

Table 24. Emergency Readmissions 16+ years within 28 days of discharge from hospital

* Compared to other Large Acute Hospitals as defined in the IC data.

Tables 23 & 24 demonstrate the performance at SWBH, based on IC data. It is not possible to make direct comparisons to more recent years as the ways that the results were calculated are based on different definitions, and different age bands of people which were required for this report. 2011/12 and 2012/13 data was not available from the IC at the time of writing this Quality Account.

In Table 25, the data suggest that the 28 day rate of readmission of children aged 14 years and under had increased from 2011/12 compared to 2012/13. These results were

generated using criteria which were specified in the Quality Account guidance and we were not able to measure the performance against other trusts as they may have been using different definitions to produce their results.

Indicator	% Emergency readmissions to hospital within 28 days of discharge from hospital	
Age 0-14	12/13	11/12
SWBH	15.65%	15.43%
England	Not Available	Not Available
Highest*	Not Available	Not Available
Lowest*	Not Available	Not Available

Table 25. Emergency Readmissions 0-14 years within 28 days of discharge from hospital (local data).

Indicator	% Emergency readmissions to hospital within 28 days of discharge from hospital	
Age 15 years+	12/13	11/12
SWBH	14.81%	13.79%
England	Not Available	Not Available
Highest*	Not Available	Not Available
Lowest*	Not Available	Not Available

Table 26. Emergency Readmissions 15+ years within 28 days of discharge from hospital (local data).

In table 26, the data suggests that the percentage of 28 day emergency readmission in the 15 years and over increased between 2011/12 and 2012/13. These results were generated using criteria which were specified in the Quality Account guidance and we are not able to make comparisons against other trusts as they may have used different definitions to produce their results.

However, we are working to reduce emergency readmissions of all patients as a priority as described in section 2.16.

The IC's most up to date data, which we are required to report, uses different definitions and age groups to generate their results. It does also not relate to the required reporting period which this Quality Account covers and has, therefore, not been included.

* The SWBH considers that this data is as described for the following reasons:

The percentage of readmissions has increased, as shown in Table 25, as defined in patients between 0 and 14 years. The percentage of readmissions has increased, as shown in Table 26, in patients over 15 years during the defined period. We do intend to improve the position.

The SWBH intends to take the following actions to improve this number by taking the

steps described in Section 2, 2.16 Focus Area 4- Reducing Emergency Readmissions, of this Quality Account, as we acknowledge that it is a high priority for improving patients' experience and the service we provide.

3.20 Improving Patient Experience

Involving our patients, relatives, carers and community in improving patient experience is central to our success as an organisation. It is at the heart of the NHS Constitution (DH, 2009) and increasingly is also a key indicator of a performing NHS.

The Trust seeks patient views in a variety of ways including the national patient inpatient and outpatient surveys, and a trust-generated internal inpatient survey. The internal survey generates around 1000 replies every month which is in excess of 10% of inpatient admissions. This survey is given out to patients when they are discharged and is available in easy read format and other languages. What we find out from these surveys really does help us to shape the services we deliver.

Everyone can contribute, everyone matters and it is everyone's business to improve help us care for our patients, carers and relatives better. More and more there is evidence that a patients having a positive experience results in patient feeling better sooner feeling like they have had a good quality service. Patients often remember the little things – a smile, a kind tone of voice, kind words and someone there to hold a hand. This is what matters to us all.

Patient experience will improve if Trust staff are motivated to do everything they can to make patients feel cared for. Paying attention to equality and diversity is also an essential requirement to be able to achieve good patient experience and good outcomes.

The Trust is fully committed to developing and supporting patients, carers and relatives to play an active role in all aspects of the planning, delivery and evaluation of its acute and community health care services.

In early 2013 the Trust produced its first Patient Experience Strategy in which the key challenge is that all staff constantly question "How does this practice, information or change affect patients, carers and relatives? Does it improve the experience?" The only way to know the answer is to ask and to listen.

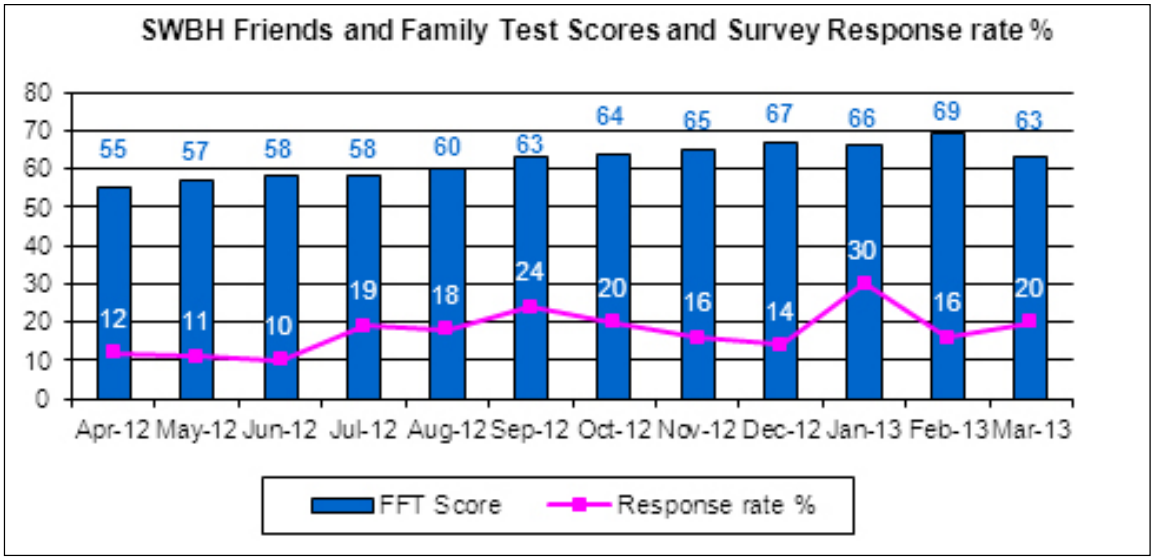
The strategy describes the Trust's plans and details how patients, carers, relatives and the general public will be involved. It is hoped that all staff will welcome the strategy, so that all patients can fully benefit from improved care and services as a result.

Friends and family test (FFT) Survey

The friends and family test asks service users, 'How likely is it that you would recommend this service to friends and family?'. It is based on a Department of Health Net Promoter

Score (NPS) methodology. It measures patients' perceptions of the quality of the health services they recently received. This assists the hospital in identifying both successes and problem areas. The Trust implemented the FFT survey programme in April 2012. There has been a steady improvement of about 2 points every month and an average 17% response rate of inpatient admissions was achieved.

Figure 8. Friends & Family response rate.



The table below represents the IC data with regard to the percentage of staff employed by or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. This is summarised below:

	SWBH	England Average	England lowest	England Highest
2011-12	76.1	75.6	67.4	87.7
2010-11	76.1	75.7	68.2	87.3
2009-10	74.7	75.6	68.6	86
2008-09	77.3	76	68.1	87.6

Table 27. Friends and family test scores

The score allocated is based on a calculation of the aggregation of the responses to various questions from the annual, and is scored out of 100.

* The SWBH considers that this data is as described for the following reasons:

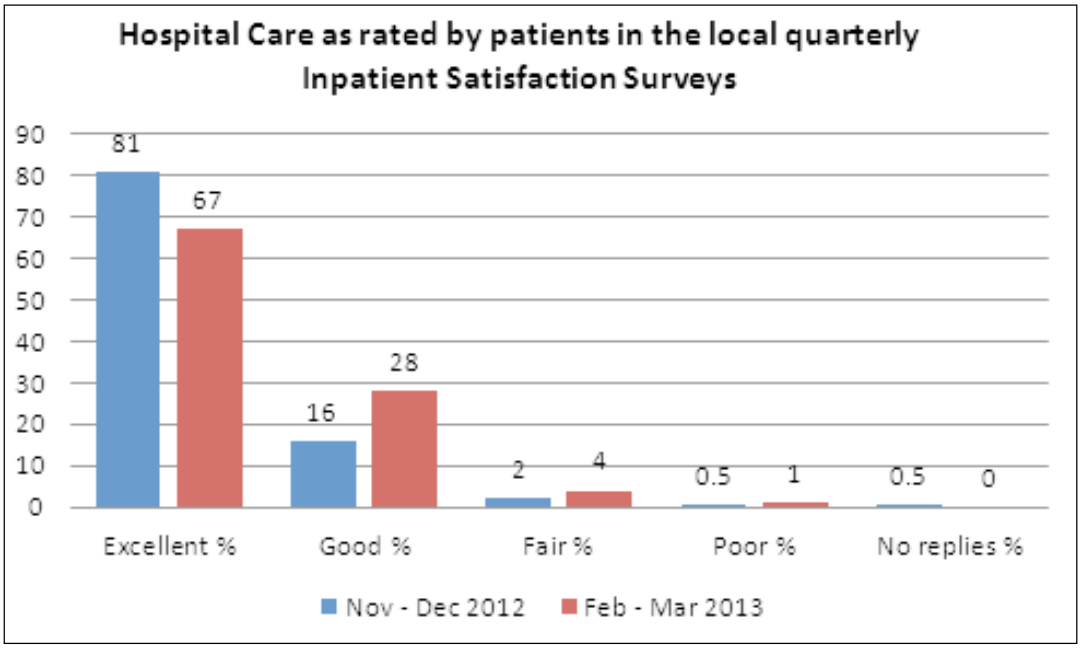
The data shows that between 2008/09 and 2011/12, compared to the England average, patients rating of having a positive experience of care better than average.

The SWBH trust intends to take the following actions to improve this number by taking the steps described in Section 2 of this Quality Account, as it acknowledges that it is a high priority for improving patients' experience. As you will note, patient experience is in Part 2, 2.17, Focus Area 5 in this year's Quality Account priorities.

Local Inpatient Experience Survey

These surveys collect detailed feedback from patients regarding various aspects of their care. The results are used by the wards as part of ward performance reviews to improve patient care and experience. Of those patients who responded during November and December 2012, 97% rated the satisfaction with the hospital care as good or excellent. There was a slight drop in February and March 2013 with only 95% rating their satisfaction with the hospital care as good or excellent. This is something we want to improve on, which is why we are investing even more time and energy into making patient experience better.

Figure 9. Local inpatient survey



Composite Indicator on Responsiveness to Personal Needs

As was mentioned earlier in this Quality Account, we have specific targets which are all about quality measures: these are CQUINs. One of these is measuring our response to patients' personal needs.

The CQUIN questions are as follows and the scores are in table 28:

- Q32 Were you involved as much as you wanted to be in decisions about your care and treatment?
- Q34 Did you find someone on the hospital staff to talk to about your worries and fears?
- Q36 Were you given enough privacy when discussing your condition or treatment?
- Q56 Did a member of staff tell you about medication side effects to watch for when you went home?
- Q62 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Year	Q32	Q34	Q36	Q56	Q62	CQUIN
2012/13	72.1	53.6	83.4	51.4	74.1	66.9
2011/12	71.4	63.7	81.4	54.4	82.9	70.8
2010/11	69.9	60	81.4	44.5	80.8	67.3

Table 28. Results for each responsiveness to personal need questions

In addition, the IC provided average score from a selection of questions from the National Inpatient Survey measuring patient experience (Score out of 100).

* The SWBH considers that this data is as described for the following reasons:

1. SWBH has made progress since 07 - 08 with the experience patients have when in our care, which is represented by the increase in the score through the years.
2. The Trust has a good history of engagement with the people we serve and plans to continue doing so with a schedule of engagement and patient representative involvement interventions.

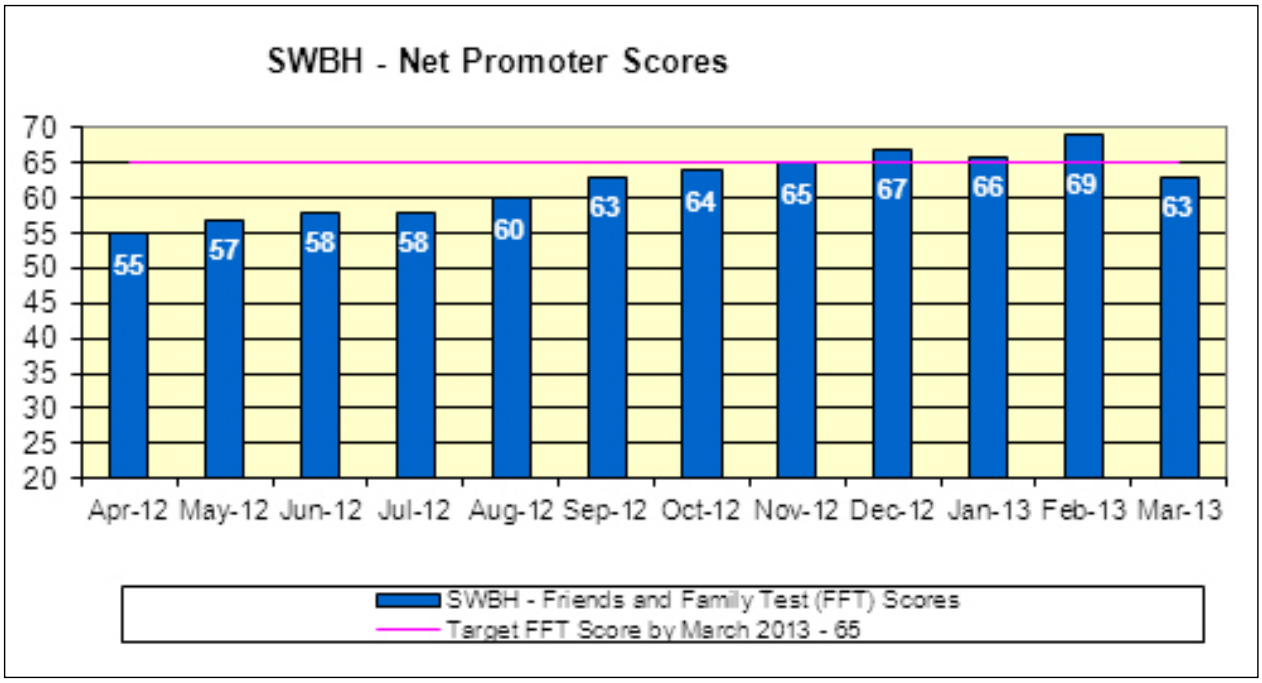
The SWBH NHS Trust has identified Patient Experience as one of its top priorities as described in Part 2, 2.17, Focus Area 5 in of this Quality Account and aims to achieve the described metrics by March 2014.

	SWBH	National Average	National Highest	National Lowest
11-12	76.1	75.6	87.8	67.4
10-11	76.1	75.7	87.3	68.2
09-10	74.7	75.6	86.0	68.6
08-09	77.3	76.0	87.6	68.1
07-08	74.0	75.3	86.5	66.8

Table 29. Patient Experience Performance - Data Source - IC

The Trust does not just use one measure of patient experience and satisfaction, but is using the 'Net Promoter'. The Net Promoter Score (NPS) is a series of questions which are prescribed. Our performance had increased to 69 at the end of February 13 which exceeded the local SHA target of 65.

Figure 10. Net Promoter performance



The Trust has expanded the Patient Experience Team which means we can make a better approach to bringing in improvements which will being benefits to patients.

3.21 Patient Reported Outcome Measures

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently, covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are:

1. hip replacements;
2. knee replacements;
3. hernia;
4. varicose veins.

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

The IC publishes PROMs national-level headline data every month with additional organisation and record-level data made available each quarter. Data is provisional until a final annual publication is released each year.

Table 30 below shows the performance of the Trust against national data for the two finalised data periods (2009/10 & 2010/11) for the measures as described below. The finalized data for 2011/12 has not yet been finalised by the IC. The arrows indicate whether there has been an improvement when compared to the previous data period. This data has not been adjusted for case-mix.

Health Status Questionnaire (EQ-5D–Index)

The percentage of respondents who recorded an increase in their general health following their operation, based on a combination of five key criteria concerning their general health (EQ-5D Index score) for each procedure.

Visual Analogue Scale (EQ-VAS)

The percentage of respondents who recorded an increase in their EQ-VAS score (current state of the patients general health marked on a visual analogue scale) for each procedure.

Condition Specific

The percentage of people who responded who recorded an increase in a condition specific measure (Oxford Hip Score, Oxford Knee Score or Aberdeen Varicose Vein Score) following their operation for each procedure is shown below.

Procedure	Health Status Questionnaire Percentage improving*				Visual Analogue Scale Percentage improving*				Procedure specific instrument Percentage improving*			
	Finalised data for April 09 – March 10 (Published 17/08/11		Finalised data for April 10– March 11 (Published 15/08/12		Finalised data for April 09 – March 10 (Published 17/08/11		Finalised data for April 10– March 11 (Published 15/08/12		Finalised data for April 09 – March 10 (Published 17/08/11		Finalised data for April 10– March 11 (Published 15/08/12	
	National	SWBH	National	SWBH	National	SWBH	National	SWBH	National	SWBH	National	SWBH
Hernia repairs	49.3%	39%	50.5%↑	46.3%↑	38.2%	31.8%	39.1%↑	31.8%↔	None	None	None	None
Hip replacement	87.2%	79.2%	86.7%↓	83.3%↑	61.4%	54.5%	61.4↔	51.3%↓	97.7%	92.2%	95.8%↓	95.0%↑
Knee replacement	77.6%	69.1%	77.9%↑	69.3%↑	50.2%	41.7%	50.8%↑	44.6%↑	91.4%	87.5%	91.4%↔	86.0%↓
VV surgery	52.4%	50.7%	51.6%↓	29.2%↓	40.4%	47.5%	39.8%↓	40.9%↓	83.4%	80.8%	82.5%↓	68.6%↓

*The percentage of complete questionnaire pairs for the procedure and measures where an improvement was recorded

	Trust below national percentage		Trust above national percentage

Table 30. Summary of PROMs

The data for 2009/10 and 2010/11 (above) shows that the percentage of patients reporting improvements is below the national average percentage for most of the measures in the two finalised data periods concerned.

Provisional data for the 2011/12 financial year published on 03/05/13 is shown below.

Procedure	Health Status Questionnaire Percentage improving*		Visual Analogue Scale Percentage improving*		Procedure specific instrument Percentage improving*	
	National	SWBH	National	SWBH	National	SWBH
Hernia repairs	49.8%	40.4%	38.8%	35.6%	N/A	N/A
Hip replacement	87.3%	89.1%	63.6%	52.4%	95.8%	95.1%
Knee replacement	78.4%	73.7%	53.7%	45.5%	91.6%	86.1%
VV surgery	53.2%	61.0%	42.0%	36.0%	83.1%	85.7%

*The percentage of complete questionnaire pairs for the procedure and measures where an improvement was recorded

	Trust below national percentage		Trust above national percentage

Table 31. Percentage of patients reporting an improvement 2011/12 (provisional data)

An adjusted measure (adjusted health gain) takes account of the fact that organisations deal with patients with a different case mix. The provisional adjusted health gain data for April 2011 – March 2012 is shown in the Table 32 below.

	Health Status Questionnaire		Visual Analogue Scale		Procedure specific instrument	
	National	SWBH	National	SWBH	National	SWBH
Hernia repairs	0.087	0.047	-0.440	-2.453	N/A	N/A
Knee replacement	0.302	0.250	4.480	2.088	15.148	13.676
Hip replacement	0.416	0.405	10.000	8.753	20.091	18.876
VV surgery	0.094	0.098	0.079	-1.241	-7.893	-7.612

*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.

	Trust below national percentage		Trust above national percentage

Table 32. Average adjusted health gain 2011/12 (provisional data)

* The SWBH considers that this data is as described for the following reasons in that since it was published progress has been made.

In response the Trust has taken action taken to improve the percentage of patients reporting improvements and the quality of its services which included the following:

Hip & Knee

- It has been made a requirement that all patients undergoing hip and knee surgery attend pre-operatively the Hip & Knee Club, where full information on the care and recovery pathway can be explained.
- Patient information booklets have been reviewed to include raising the awareness of PROMs.
- A poster campaign has been run to improve referral information.

Varicose veins

The focus has been on increasing the participation rate in the PROMs for this condition.

Provisional data for 2012/13 shows that the Trust is now demonstrating above the national average percentage improvements for the health status questionnaire (EQ-5D Index) and for the procedure specific instrument (Aberdeen Score).

The Trust intends to take the following action to improve the scores in relation to hernia repairs:

- To take measures to increase the percentage of patients participating in the PROMs programme .This to include informing patients that PROMs is a way of monitoring the effectiveness of services and that their feedback is important to this process.
- To consider establishing a single source dedicated hernia clinic, where full information on the care and recovery pathway can be explained.

3.22 Alcohol Screening Programme

We agreed with the commissioners to carry out screening of patients to check if they are at risk of harm from alcohol. 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.

We have carried out audits every 3 months to test if we meet this standard of 80%: we have been successful in exceeding it.

We have spread this intervention to include more services, so we can screen even more patients. These services include inpatients in the medical assessment units, and to new patients attending Gastroenterology, Cardiology, and Endocrinology outpatient clinics.

Our findings are summarised in Table 33.

Attendance Type	Number of Attendances	Number of Think Alcohol Assessments	Target	% Compliance
Inpatient - MAU / EAU	411	356	80%	86.62
New Gastroenterology Appointment	102	96	80%	94.12
New Cardiology Appointment	61	55	80%	90.16
New Endocrinology Appointment	9	9	80%	100
Total	583	516	80%	88.51

Table 33. Think Alcohol Audit (March 2013)

3.23 WHO Surgical Safety Checklist

Last year we identified that we needed to improve our use of the WHO Surgical Safety Checklist. We wanted to go even further than just using the Checklist and ensure that the NPSA "Five Steps to Safer Surgery" were adopted across the trust and recorded for every patient undergoing a surgical intervention or operation. Patients are very vulnerable during operations and safety is very important.

The work was led by a project team and the contribution of the theatre and ward staff was vital. Whilst we have been able to collect how many checklists were completed and how many pre-operating list briefings and debriefings were done, we also started doing reviews to focus on how well the checklists were being used to test that communication was working well.

The Trust has agreed checklists and a 'Safer Surgery' Policy in place, so staff are clear about what is expected of them.

The reported compliance with the 3 sections in the checklist over the past year is shown in Table 34.

2012/13	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
WHO Checklist Safer Surgery Audit - 3 Sections (All areas)	99.45 %■	99.65% ▲	99.83 %▲	99.46% ▼	99.82 %▲	99.80 %▼	99.72 %▼	99.83 %▲	99.38 %▼
WHO Checklist Safer Surgery Audit - 3 Sections and Brief	92.89 %■	93.90% ▲	93.50 %▼	93.55% ▲	94.17 %▲	96.75 % ▲	95.27 %▼	95.81 %▲	95.29 %▼
WHO Checklist Safer Surgery Audit - 3 Sections, Brief and Debrief	80.61 %■	80.67% ▲	76.33 %▼	81.71% ▲	81.61 %▼	89.19 %▲	84.32 %▼	83.71 %▼	82.07 %▼

Table 34. WHO checklist compliance (data source CDA SHA submission and CQUIN Compliance Report 9/4/13)

3.24 CQUIN

This part of the 2012/13 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 in the Quality report presented to our Quality & Safety Committee and at our Trust Board throughout the year. The detail behind many of the figures has been reviewed 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 all but a few of 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 2012/13 goals are shown in table 35, 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.

CQUIN SCHEMES 12/13			Actual 12/13	Data Period	12/13 Target
Acute	VTE Risk Assessment (Adult IP)	%	90.7	M1 - 12	90
	Pt. Experience (Acute) - Personal Needs	Score	66.9	M1 - 12	71.6
	Appropriate Use of Warfarin	Comply	✓	M1 - 11	Comply with audit
	Safety Thermometer	Submit	✓	M1 - 12	Submit data
	Antibiotic Use	Score	83	M1 - 12	70
	Reducing avoidable Pressure Ulcers	Comply	✓	M1 - 12	Comply with audit
	Nutrition and weight Management	Comply	✓	M1 - 12	Comply with audit
	Safe Surgery Operating Theatres	%	100	M12	100
	Safe Surgery Other Areas	%	99.7	M12	98
	Stroke Care	Comply	✓	M1 - 9	Comply with requirements
	Dementia	%	✓	M1 - 12	Comply with requirements
	Mortality Review	%	63.0	Ytd M10	Year end 80%
	Net promoter	No.	69.0	M1 - 11	65
	End Of Life care	%	62.0	M1 - 11	53
	Every Contact Counts - Alcohol	%	89.0	M1 - 12	80
	Every Contact Counts - Smoking	%	✓	M1 - 11	
Community	Safety Thermometer	Submit	✓	M1 - 11	Submit Data
	Reducing avoidable Pressure Ulcers	Comply	✓	M1 - 11	Comply with audit
	Nutrition and weight Management	Comply	✓	M1 - 11	Comply with audit
	Dementia	%	✓	M1 - 11	Comply with requirements
	Pt. Experience (Community) - Personal Needs	Score	92.0	M1 - 11	90
	Net promoter	Number	50.0	M11	75
	Every Contact Counts	Meet	✓	M1 - 11	Comply with requirements
	Smoking Cessation	Meet	✓	M1 - 11	Comply with requirements
Specialised Commissioners	Clinical Quality Dashboards		✓	M1 - 12	Comply with requirements
	Neonatal - Hypothermia Treatment	%	✓	M1 - 12	Comply with requirements
	Neonatal - Discharge Planning / family Experience	%	✓	M1 - 12	Comply with requirements
	HIV Optimum Therapy	%	✓	M1 - 12	Comply with requirements

Table 35. CQUIN performance 2012/13

3.25 Complaints

The Trust remains committed to providing timely and fair responses to formal complaints which it receives about its services. Complaints provide us with vital information about how patients and their families have felt about their experience whilst using our services and we can use this information to improve.

The table below shows the top themes of complaints received over the last 3 years, which we use with other patient experience sources to set our priorities.

Category Type	2010/11	2011/12	2012/13
All Aspects Of Clinical Treatment	553	573	578
Attitude Of Staff	161	127	142
Appointment Delay/cancellation outpatient appointment	126	84	94
Appointments Delay/cancelled inpatient	26	28	33
Communication/Information To Patient	92	55	66
Admissions/discharges, Transfers	44	42	59
Transport Services	12	17	7
Totals	**1014**	**926**	**979**

Table 36. Complaints by category

3.26 Staff Indicators

As we mentioned earlier in the report, we regard staff training as key to delivering good, compassionate patient care. Our workforce ambition is to become the 'employer of choice' and for our staff to consistently highly recommend our Trust as a place to work or receive treatment.

Workforce Development

Our new appraisal policy strengthens the Trust's approach to succession planning and career development by ensuring that future leaders are identified and developed and staff are supported to reach their full potential. A variety of staff education and training programmes have been introduced and run throughout the year including 'Action-Centred Leadership' programmes and leadership development training for clinical teams.

Widening Participation

We are a major employer in the area. We are well aware of the long-term economic wellbeing of our local population. We are dedicated to helping tackle unemployment and social deprivation in the area by employing people from the local community, with

the right attitudes and behaviours. We also aim to support them through learning to reach their full potential.

At the end of March our 'Learning Works' opened in conjunction with our high profile partners including Sandwell Council, Birmingham City Council, Job Centre Plus, other major employers and charities. Together we are providing:

- Work experience schemes through schools for 15 to 16 year olds;
- Work placement schemes for the long-term unemployed;
- Apprenticeships for young people aged 16-21;
- Staff support for developing the Trust's own staff.

Staff Experience

We value insight and ideas from our staff about their experience of working at the Trust and view this as a good barometer of the quality of leadership and management of the Trust, our approach to risk management and the standards of care we provide:

NHS Staff Survey

Following significant year on year improvement across the whole range of key findings since 2008, our results in 2012 include a mixture of some positive shifts and some worsening trends. The overall position is one of no significant changes overall, indicating that there is still much more to achieve to move towards the top quartile. Our key achievements and areas for improvement are set out below:

Key achievements	Areas for improvement
5% more staff than last year said they were appraised in the last 12 months (better than England average)	Staff agreeing that their role makes a difference to patients (worse than England average)
6% more staff than last year said that their appraisal was well-structured (best 20% of Trusts nationally)	Staff feeling pressure in last 3 months to attend work when feeling unwell (worse than England average)
12% more staff than last year said that they are informed about errors, near misses and incidents that happen in the organisation (around the national average)	Staff satisfaction at work (worse than England average)
10% more staff than last year said that their immediate manager takes a positive interest in their health and well- being (around the national average)	Staff motivation at work (average)
5% more staff than last year said that they are satisfied with the recognition they get for good work (better than the national average)	Staff believing that the trust provides equal opportunities for career progression or promotion (worse than average)

Table 37. Staff indicators

Staff Engagement

We are very proud that our last five years of success in this area is recognised nationally and that this is further endorsed by our most recent success as the winner of the 2012 prestigious Health Service Journal Award in Staff Engagement. Our pioneering approach to staff engagement, called 'Listening into Action', continues to be instrumental in engaging staff at all levels from across the Trust to drive improvements to deliver better outcomes for patients and making our Trust a good place to work. This way of working has been used to drive our service transformation plan, enhance our patient safety culture and redesign and reconfigure how care is delivered, such as stroke services.

We recognise that there is still more to do to ensure that engaging and involving staff in driving improvements becomes well embedded and sustainable. Our overall score for staff engagement, as determined by the NHS staff survey in 2012, has not significantly changed since the previous year and is average when compared to acute Trust's nationally.

Key Staff Performance Indicators (KPIs)

A range of workforce KPIs are included in the Trust's Performance Management Framework and we are in the process of implementing the NHS Workforce Assurance Tool to further enhance the management of workforce risks. An overview of our performance against the key indicators is set out below.

Staff Turnover

Staff turnover (excluding junior medical staff) has fallen steadily year on year since 2008/09 when it was 11% and is currently running at around 10%. This represents a reasonably healthy level of staff leavers, notwithstanding that this will have been influenced, to some degree, by our workforce reduction programme.

Mandatory Training

Our compliance in this area shows a continuing improving trend across a comprehensive range of training topics. The trust compliance at the end of March 2013 was 87.74%. There is more work to do to consistently achieve the higher standards and we continue to look at this at directorate and divisional level. A radical review of access to training and methods of delivery has resulted in the introduction of more e-learning modules and a new 'mandatory training day', both of which aim to deliver high quality training whilst minimising, as far as possible, time spent away from the work place.

Appraisal

87% of staff participating in the 2012 NHS staff survey said that they had received an appraisal in the last 12 months (5% higher than in 2011), ranking the Trust as better than the national average for acute trusts. 42% of staff reported that their appraisal had been well-structured (6% higher than the previous year), placing the Trust in the best 20% of all acute trusts for this finding.

Sickness Absence

Our sickness rate demonstrated a steady improvement from April to June 2012. Since that time this has gradually worsened, with only February 2013 showing an improvement. The sickness absence rate for 2012/13 was 4.5%, compared to 4.04% in 2011/12 and 4.11% in 2010/11 (Source-CDA Workforce local information). This is above the target of 3.5%.

We have an ambitious improvement plan in place to address this.

Our plan includes the following key actions:

- Improving levels of staff engagement;
- Effective management of change;
- Regular sickness absence case management review;
- Development of focused action plans in response to 'hot spot' areas.

We continue to deliver a wide range of staff initiatives, including physical exercise, weight management classes, and a programme of healthy lifestyle topics that link to the national health promotion programme and are aligned to our internal work about the key reasons for absence from work due to sickness. The Trust also has an occupational health and well-being service, an on–site gymnasium and a dedicated counselling service for staff.

3.27 What others think about our Quality Account

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

Our Commissioners, made the following statement:

On behalf of the Cross City CCG, the Black Country Cluster commented:

- Good explanation of priorities and intention to achieve these;
- Great Patient Experience section overall;
- All relevant elements are included and discussed clearly for easy reading for the public;
- The document is open and honest in content and reflects accurate data;
- The only omission noticed is there is nothing on Safeguarding - amended by the Trust following feedback;
- Overall, a good Quality Account.

The Birmingham Overview and Scrutiny Committee issued the following statement:

'Thank you for providing the Birmingham Health & Overview Scrutiny Committee with a copy of your Quality accounts. The committee appreciated the opportunity to read the accounts and the information contained therein.

At a recent meeting the members decided not to provide statements to any of the Quality Account providers and requested that a letter be drafted to the Secretary of State about the Quality Account process and the issue this gives rise to for the Birmingham Scrutiny Committee on an annual basis.'

3.28 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 Toby Lewis,
Chief Executive,
D29 Corporate Management Suite,
Sandwell & West Birmingham NHS Hospitals Trust,
City Hospital,
Dudley Road,
Birmingham,
B18 7QH

We will value your feedback.