Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account 2013/14

Where EVERYONE Matters

Contents

01

Part 1: Chief Executive's Statement

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

Toby Lewis
Chief Executive

Our Quality Account is, for all of us at the Trust, an important document. It reports back to you, who pay for and use our services, on how we are doing. We aim to tell you honestly whether we believe our services are safe, and why we believe that. We also highlight improvements we have made, or want to make, and tell you what our priorities will be in the months ahead.

There is a great deal of good quality, compassionate care that is based on our team sustaining existing standards. For example, our infection rates have reduced again and remain low. We have significantly cut the impact of norovirus on our patients, and have seen a big jump in MRSA screening to reduce the risk of infection. We continue to deliver better than expected mortality rates on both our acute sites. Our review of four in five unexpected deaths helps us to find room for improvement. We know that the biggest gains we might make quickly are around sepsis risk identification. In 2014-15, we will deploy a computer system called VitalPacs, which has the potential to save lives by alerting us to those most at risk of deterioration.

For many patients, relatives and GP partners, our pursuit of quality also demands that we improve support systems. We need to cancel fewer operations, and towards the end of 2013-14 we made progress on that goal. We also need to re-organise fewer outpatient appointments: during 2014-15, we will introduce a system called partial booking into all our clinics so that appointments are booked with patient's agreement and nearer the time of confirmation. This reduces the waste and disruption of cancellation. It is really encouraging to find that we have now almost achieved our promise to make sure every clinical letter relating to outpatients is sent to, or copied to, both our patient and their GP.

For the year ahead, we want to try and move beyond safety commitments where we deliver excellence usually. The attempt to get things right every time will underpin our work on seven day services (we invested in expanding weekend radiology in 2013). It also explains our ten out of ten campaign, which is described in this Quality Account. Not only do we want to make sure that some core standards are met every time a patient is admitted, but we want to encourage patients and relatives to tell us when we make a mistake. By being very clear what our standards are, we hope to be able to step in when errors are made and resolve problems quickly, at the time they happen.

Feedback from people using our services is taken very seriously at the Trust. Every Board meeting hears form patients with their stories about our services. Websites like Patient Opinion, or those promoted by our local Healthwatch from a key part of our work to listen to what you tell us. Probably no service has gone further with this listening work than maternity care; We were pleased to see the recent national CQC audit work, which showed some encouraging results, especially for midwife led care - success in the eyes of mothers and fathers. We want to keep listening, which is why we continue to innovate in how we listen - there is a video "chair" in our maternity unit to capture the stories and opinions of those who want to talk with us.

Care is a partnership. It is a partnership most important with our patients, but also their loved ones. We are proud of improvements in palliative care at the Trust over recent years. But we know we can do better still, which is why this year we aim to review the last year of life of those who die in our care, so that we can understand what extra support we might provide sooner, to support patients in their choices about what care they receive and where. Both our Local Authority areas face longstanding and major challenges in safeguarding children. During 2013-14, both have introduced totally new systems to try and join up services better across agencies. We are proud of the part our staff have played in those changes and we are committed, from the Board down throughout our teams, to succeeding in protecting the most vulnerable, better. Safeguarding is a priority not just for our children's services, but for all who come into contact with families. As a Trust that strives to provide the very best integrated care, we are on a mission to get this right.

PATIENT STORY

Leanne Doveston and baby Sebastian

"I came into City Hospital, Birmingham, for an emergency C-section despite only being 26 weeks pregnant and so baby Sebastian arrived earlier than planned. I was really poorly which meant I was unable to actually see Sebastian until he was three days old. Unfortunately, at the same time Sebastian wasn't well either and had been put on ventilation. It was then discovered that he was having fits and had to be given fit medicine and then was also diagnosed with chronic lung disease…he may not have survived, but he did. I found it really hard, particularly as this is my first child, but Sebastian was a fighter from day one. He was around two-and-a-half months old when we started to try breastfeeding, which was really hard because he just didn't understand what he needed to do and neither did I. One of the nurses came and spent some time with me when they took the tube out of his mouth and tried it up his nose. Sebastian fussed about a lot and wasn't doing it properly and I was getting frustrated. I was on the verge of giving up but then Jenny (one of the nurses) spent some time with me when Sebastian wanted a feed and we did get it in the end. He still fussed and messed about but all of a sudden we have both become quite comfortable with each other, where I know where he is going to put his face and he knows where I'm going to put myself. We've just got to know each other a bit better now. I see why a lot of people miss the cues because if I didn't have people stood behind me who knew what to look for and offering their support, I would have missed the cues too. All the staff here have been superb - the whole unit has been really supportive."

Throughout the report you will find patients stories, scenarios and feedback that have been collated throughout the year. These provide us with some of the tools to monitor, assess and develop our services to be the best performing integrated Trust we can be. We encourage the voice of our patients and employees to help steer the Trust forward.

Within this section, we review our performance for last year with particular reference to the key focus areas we identified in our Quality Account 2012/13. Where we have not succeeded in meeting our objectives we have set out an improvement plan and goal for this year.

There are a number of successes we would like to draw attention to:

✓ Our maternity services are to be congratulated for achieving the risk management standards required for CNST (Clinical Negligence Scheme for Trusts) Level 3. This is the highest level of risk management standard that allows us to give our maternity patients the assurance that they are cared for in the safest possible environment.

✓ We continue to make progress in reducing our mortality rates. This has been through a relentless focus on examining the causes of death through the mortality review system, where we have exceeded our target of reviewing 80% of all deaths in hospital. In addition we have improved our performance in the prevention of hospital acquired venous thrombo-embolism (VTE) by exceeding our target of 95% of patients being risk assessed.

✓ Significant work has been done with our partners to improve the processes around children's safegaurding, particularly in Sandwell.

✓ Much work has gone into our role as a Health Promoting Hospital which has culminated in the public health plan for the Trust.

✓ There has been a very significant fall in the number of hospital acquired pressure ulcers. This is the result of a great deal of work by our nursing teams and tissue viability service.

There are also a number of areas where our performance is not where we would like it to be:

✗ We have had five never events, this is five too many. These are detailed in Section 3.2. We will be reporting further on this in future Quality Accounts.

✗ There are two CQUIN areas where we failed to meet the targets we set ourselves. These are:

- The Safe Storage of Medicines, where repeated audits have shown we are failing to reliably lock away unused medicines
- The Maternity Friends and Family Test response rate. We will continue to drive improvements in these areas even though they are not CQUINS again this year.

✗ A number of other key quality indicators are also below target - we have detailed these in section 2.3 above our plans to improve them this year.

Within Part 1 you will also find our future goals, what we aim to achieve in 2014/15 and the processes through which we aim to deliver these.

We hope you find this to be an open and honest appraisal of our performance last year with areas of focus on our patients at the centre of our thought process for our next year of care.

02

Part 2: Priorities for improvement and Statements of Assurance from the Board

2.1 Report on Quality Priorities for 2013/14

In last year's Quality Account, we identified five focus areas for prioritisation. They sat within three 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 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.

Summary of Key Quality Achievements 2013/14

Focus Area 1: Continuing to improve the patient experience and safety in Emergency Departments (ED)		
Aims	Actions	Did we do what we said we would do?
Delivery of investment plans and recruitment in ED	Structural change to ED in order to improve flow and patient experience. Fully recruited to middle grades and nursing staff	✓
Implementation of a new informatics system in ED	Implemented MSS Patient First IT 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 • 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		✓

Focus Area 2: Reducing preventable deaths (Mortality)		
Aims	Actions	Did we do what we said we would do?
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	Increased the number of doctors conducting mortality reviews	✓
Feedback to consultants regularly on deaths identified as preventable to aid lessons learnt	Held number of meetings and presentations of outcomes and Grand rounds	✓
Ensure that 95% of admitted patients have a VTE risk assessment carried out	Introduced mandatory use of electronic bed management system to carry out assessments before discharge	✓
Carry out root-cause analysis of confirmed cases of hospital associated thrombosis	Conducted detailed review of all cases of hospital acquired thrombosis by quarter	✓
Set up a small, clinically-led group by the end of June 2013 to look at mortality difference	Looking into deaths within the Trust 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	SWBH HSMR 2013/14 = 92.5 England average = 100.3	✓

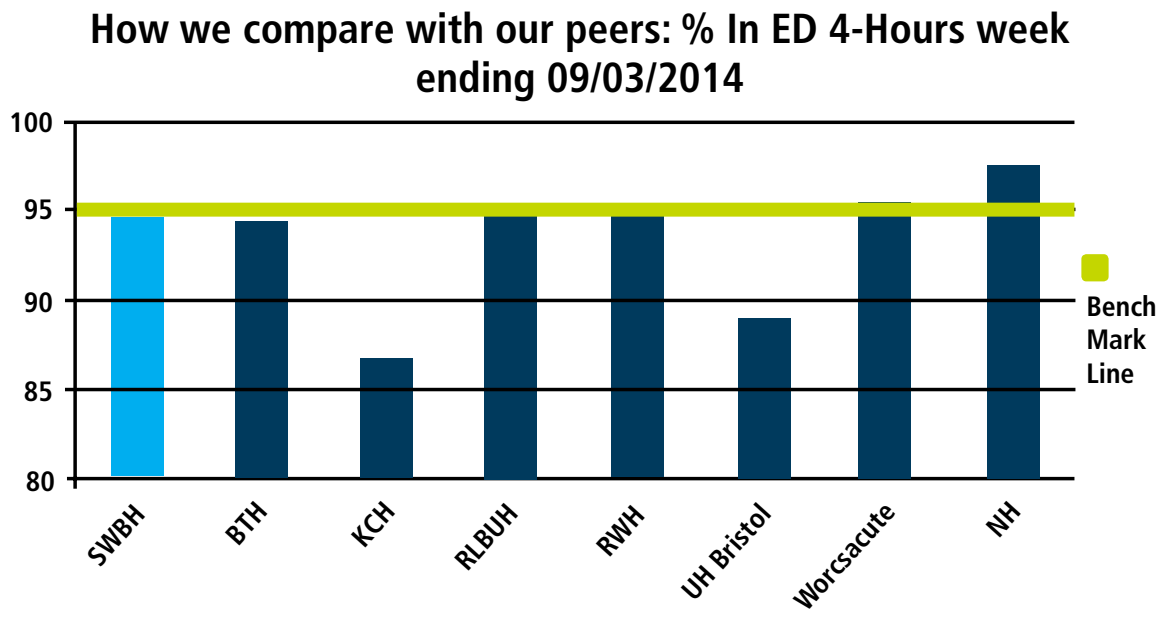
Focus Area 3: Being a Health Promoting Hospital		
Aims	Actions	Did we do what we said we would do?
Submit a Health Improvement Strategy using the WHO HPH standards and local priorities from our partners by July 2013	SWBH is a member of the World Health Organisation (WHO) Health Promoting Hospital network. Membership allows SWBH to adopt best practices and share experiences with other Trusts	✓
Develop an action plan from the Strategy and implement new health improvement activities in SWBH using specialist staff by September 2013	Develop an action plan in accordance with 40 HPH standards applied over five main domains - management policy, patient assessment, patient information, workforce health and community co-operation	✓
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	Clinical Champion for Prevention and a Health Promotion Facilitator alongside a Prevention Steering Group. Links established with Public Health teams and the Health and Wellbeing Board in our locality and region. Health Promotion strategy using HPH standards has been developed addressing health inequalities	✓

Formally adopt the principles of the Health Promotion Hospital network into our mission statement, policies and procedures by December 2013	We have fully achieved 30 and partly achieved 6 of the 40 HPH standards. We are still learning lessons on how to capture and evaluate health promotion interventions	✓

Focus Area 4: Reducing Emergency Readmissions		
Aims	Actions	Did we do what we said we would do?
Put in place action plans to ensure that emergency readmission will be avoided	Taskforce Group has been established to address issues related to emergency readmissions	Awaiting response from internal team
By March 2014 we will aim to meet the national mean for 30 day non-elective & 28 day non-elective readmissions in 2013	Scoring Tool adapted to identify patients who are likely to re-admit. Scores are based upon length of stay, acuity of admission, co-morbity and number of previous admissions	✓
By the end of June 2013, The Mortality & Quality Alerts Committee will develop and oversee an action plan to improve emergency readmission rates	Readmission Task Force has been established – collaboration between primary and secondary care in order to reduce the risk of readmission. This applies particularly in specialty areas such as cardiology, respiratory and elderly care	✓
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		✓

Focus Area 5: Patient Experience		
Aims	Actions	Did we do what we said we would do?
Implement the Patient Experience Strategy as detailed in the implementation plan	Completed	✓
Friends and Family Test milestone delivery	• Increased 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 • Phased expansion of the FFT to Maternity by the end of Oct 2013 and additional services by the end of March 2014 • Increased the FFT score within the 2013/14 staff survey compared to 2012/13	✓ ✗ ✓
National and local patient survey to improve services based on the findings	Completed the Inpatient Survey, A&E survey, Maternity Survey, Outpatient Survey, Cancer Patient Experience Survey and Chemotherapy Patient Experience Survey	✓
Patient Engagement Programme	An ongoing programme of events built to expand and increase the opportunities available for regular patient engagement	✓
Patient Stories	Patient stories collected as a learning tool for training and events as well as opportunity to share patient experience with the Trust Board	✓
Volunteers	Overall number of volunteer recruits from a wide age group	✓

Focus Area 1 - Continuing to improve the Patient Experience and Safety in Emergency Departments (ED)

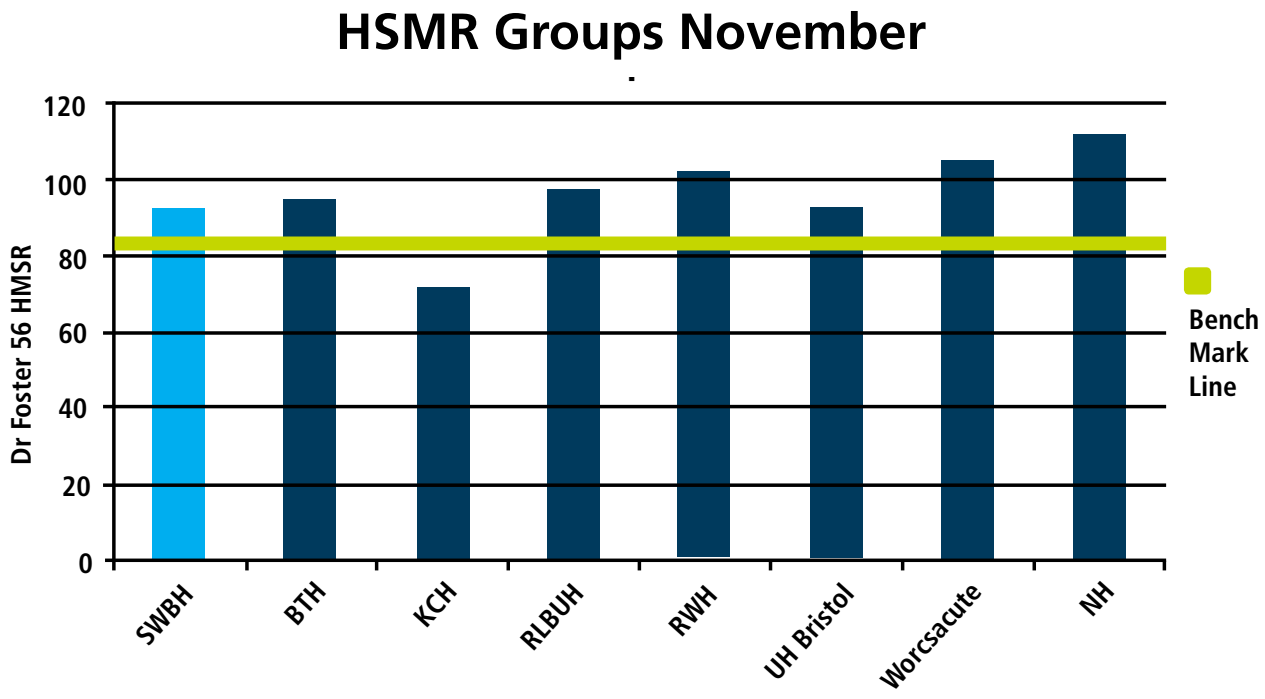


SWBH have a target of to ensure that 95% of our patients wait no more than four hours within Emergency Departments. We were able to achieve this target in six out of the 12 months and achieved an overall annual rate of 94.4%. The months where the target was achieved were June 13, August 13, November 13, December 13, January 14 and March 14.

In the summer of 2013, we launched the 'Winter Must be Better' (WMMB) 2013 Transformation Programme which encompassed a re-design of Emergency Care Pathways. The Patient experience in Winter 2012 had been poor with many patients waiting longer than four hours in the Emergency departments (ED), ambulances frequently waited longer than 60 minutes to handover patients and those needing admission experienced long trolley waits due to a lack of beds on the Acute Medical Units. The WMBB 2013 Programme set out to establish a new service model which encompassed the establishment of dedicated Ambulance Assessment areas in ED and an increase in total funded medical beds from 452 to 494. The specialty allocation of the 494 beds changed from 60 to 120 Acute Medical Unit beds operating with a maximum length of stay of 48 hours and two dedicated nurse-led Medically Fit for Discharge wards comprising of 48 beds.

Alongside the 'structural' service model, changes to all departments involved in the delivery of Emergency care engaged in new ways of working; such as, the rapid assessment of frail elderly patients in ED by therapies staff to prevent unnecessary admissions; the rapid turnaround of diagnostic tests in ED and acute wards; seven day working in Pharmacy and Radiology and weekend consultant reviews on the Acute Medical Wards. The Trust also introduced a Community Intravenous Antibiotic Therapy Service which both prevented admissions and enabled earlier discharges of patients.

Focus Area 2 - Reducing Preventable Deaths



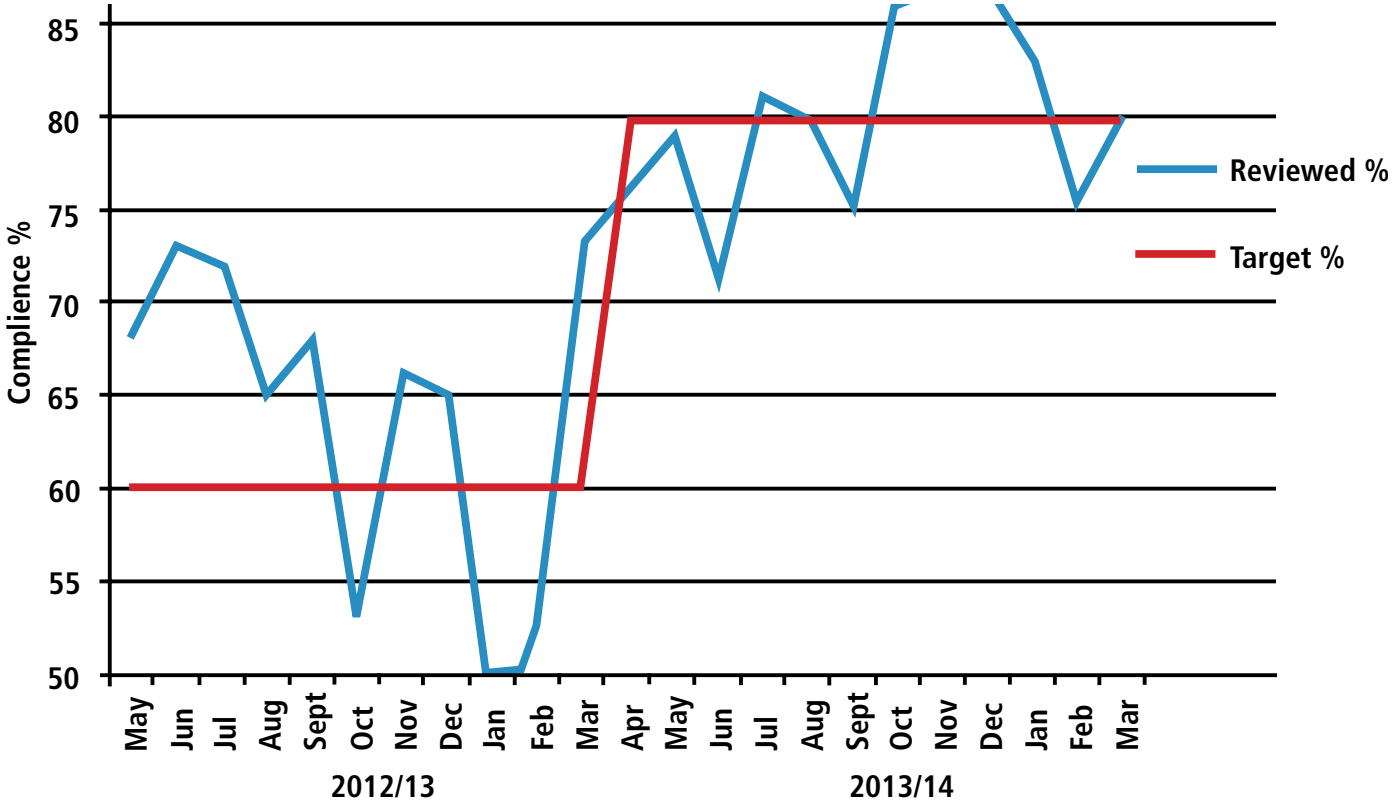
The improvements we said we would make were:

- Hospital Standardised Mortality Ratio (HSMR) - better than England's average.
  - SWBH – 92.5
  - West Midlands Average – 98.8
  - National Average – 100.3
- Over 80% of all deaths reviewed
- Feedback to Consultants – Lessons Learnt
- An investigation into differences in mortality between the two main hospital sites
- Improvement in risk assessment and prevention of hospital acquired venous thrombosis embolism (VTE)
- Conducted root cause analysis of all cases of hospital acquired VTE

Over 80% of all deaths reviewed

In 2012/13, we were successful in increasing the percentage of deaths that were reviewed by senior doctors to above 60%. However, we highlighted this as a continual high priority to improve further in 2013/14 and increased the target further to 80% of all patients reviewed within 42 days of death.

We have continued to apply great efforts to achieving our mortality goals and this has been demonstrated with our 82% annual compliance, further to that, quarter 3 alone saw a rise to 88.9% and Quarter 4 data awaited.



VTE Compliance Progression 2012/13 - 2013/14

Use of Hospital Standardised Mortality Ratio (HSMR) & Summary Hospital – Level Mortality Indicator (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 Mortality and Quality Alerts Committee (MQuAC). We also carry out in-depth reviews of any diagnostic code that has shown that our incidence of disease seems to be 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 Trust's 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.

Investigation into Differences in Mortality across the two Hospital sites

As a result of the difference in mortality ratios between the main hospital sites, the MQuAC commissioned a 'Task and Finish' Group to examine the data behind this difference in more detail. The interim report details the findings from the work undertaken to date and it makes a number of recommendations including those to further the investigation going forward.

The HSMR at Trust level has (over recent years) been below that expected. This is explained in part by City Hospital experiencing significantly less deaths than would be expected (according to Dr Foster's statistical methodology), whereas Sandwell Hospital has demonstrated a number of deaths in excess of that which could have been expected.

As a result of the difference in mortality ratios between the main hospital sites, the MQuAC commissioned a 'Task and Finish' Group to examine the data behind this difference in more detail. The interim report details the findings from the work undertaken to date and it makes a number of recommendations including those to further the investigation going forward. The below conclusions of the report indicates that the difference in ratio has many causal factors.

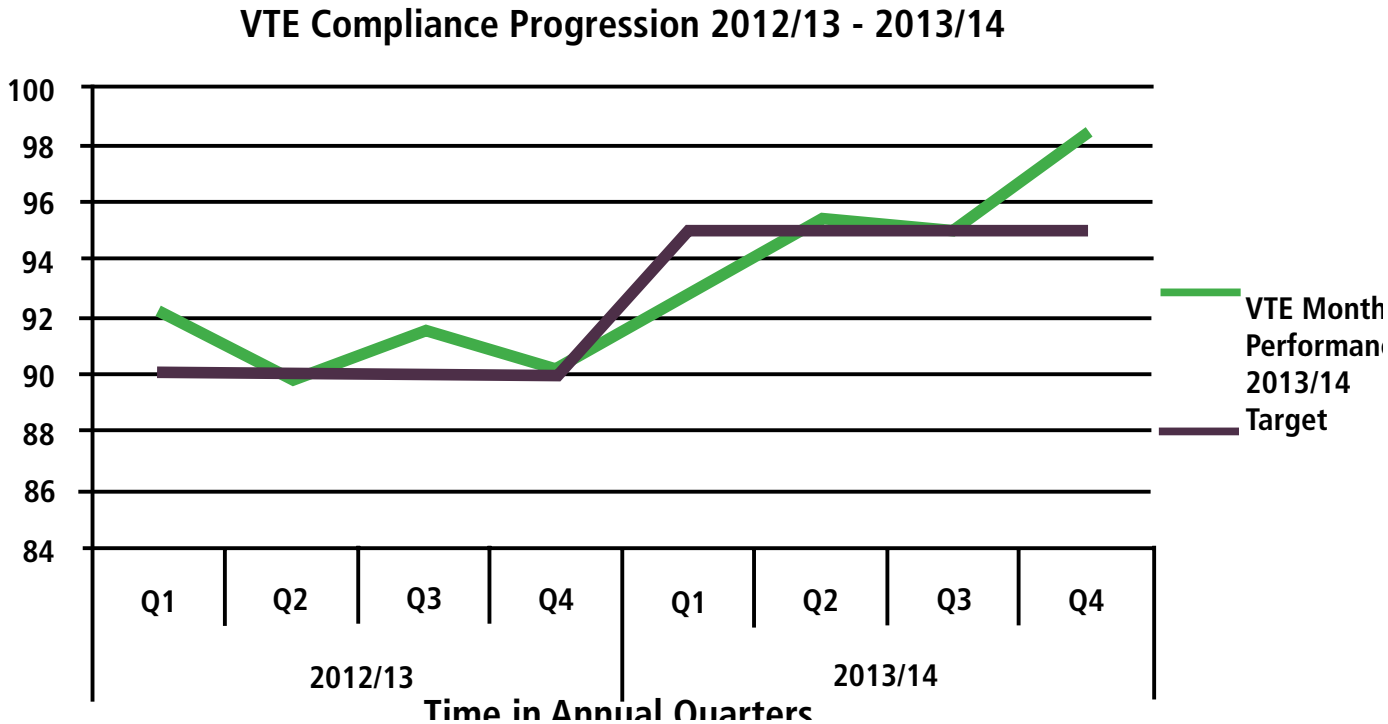
- Risk adjustment relies on accurate coding of reasons for admission and co-morbidities. Detailed analysis demonstrates that our coding practice is not consistent between the two hospitals. Work is underway to improve this
- Diagnosis on admission is not always the cause of death - we don't always have cause of death available at the time of review or coding
- There are differences in case mix between the two sites, with Sandwell having a more elderly population and in addition hosting Trauma and Stroke services and City having a younger population but with a higher deprivation index
- Coding for palliative care has increased in the last few years - this is due to the successful development of palliative care services. There are slight differences in the palliative care coding rates between the two hospitals - this impacts on HSMR but not on SHMI
- Our mortality review system has indicated a slightly higher number of adverse triggers for patients at Sandwell Hospital - this has not reached a statistically significant level, but could be suggestive of quality of care issues being a contributing factor. However, the vast majority of deaths on both sites do not have any adverse triggers.

The work on site differences in mortality continues to form part of the mortality programme this year.

Venous Thrombosis Embolism (VTE)

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 through to 2012/13 but with a more stringent target of an assessment rate of 95% in admitted patients. The Trust met the 95% VTE target in 8 out of the 12 months. However, the 95% of admitted patients did receive a VTE risk assessment across the year. Over 98% was met consistently after December 2013, with significantly improved performance.



Root cause analysis of Hospital Acquired Thrombosis (HAT)

Over the past year, we have identified the importance of identifying the root cause of patients with a Thrombosis to provide a scope for lessons learnt but also to identify how many patients' deaths, were preventable. By establishing the preventable deaths we can recognise service areas for improvement along with reassurance that we are continuing to develop patient safety and provide best practice.

In quarter three of 2013-14 (October to December 2013), 45 cases of HAT were reviewed with 12 being proved to be preventable if closer adherence was made to Trust policy. The remaining 33 cases were proved to be unpreventable.

We have made progress from a quarterly review of the root cause analysis as directed by Department of Health to a monthly consultant-led review as suggested by the All Party Parliamentary Thrombosis Group (APPTG).

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. We have been engaged in this area for two years.

In September 2012, SWBH appointed a Clinical Champion for Prevention and in December of that year, SWBH joined the World Health Organisation (WHO) Health Promoting Hospital (HPH) network to build on the activities already taking place in the Trust.

What are the benefits of the WHO HPH network?

- The 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
- The ability to use the WHO and HPH logos on internal and external documents to act as reminders of the international importance of prevention, and to help in raising awareness of these goals
- The HPN list of 40 standards, applied over five domains to management policy, standard patient assessment, patient information, workforce health and cooperation with the community. We can use them to assess how well we compare in health promotion activities.

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

The mission statement is expressed in our Public Health Plan: 'We want to become renowned as the best integrated care organisation in the NHS, embedded in our local communities, not just as somewhere to be treated, but someone to be trusted – with health'.

There is a Clinical Champion for Prevention and a Health Promotion Facilitator 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 SWB Clinical Commissioning Group. We have carried out engagement events with the Trust Leadership Meeting, Consultant Conference, with the Membership, and to the public at large at the Trust Board Annual General Meeting. A Health Promotion Strategy using the HPH standards and local priorities from the local health economy has been developed, with 13 major objectives covering clinical health promotion, addressing health inequalities and ensuring that we are mindful of our local community as we develop plans for a new hospital.

These standards 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. Over the last year, based on audits of our processes, we have improved the prevention components of our clinical pathways and patient record documentation for our doctors, nurses and therapists to encourage them to ask about, and give advice on, health promotion to patients, visitors and staff.

Finally, the standards require the Trust as an organisation to engage in health promotion throughout the local community. We have engaged with our Health and Wellbeing boards, set up community – based projects to increase local employment and improved the access of our local homeless population to healthcare and improvement in the social determinants of their health.

What we have done as a Health Promoting Organisation in 2013-2014?

We have fully achieved 30 and partly achieved 6 of these 40 standards.

We still need to improve how we capture and evaluate health promotion interventions; further extend the health promotion components of our clinical pathways and ensure reassessment for health promotion at discharge. We need to engage our staff more in health promotion through induction and training to ensure that the majority are confident in advising and signposting colleagues, patients and relatives for further advice if required.

Several of the action plans will be implemented by specialist health promotion meetings which are already in existence: the Making Every Contact Count Implementation Group, Tobacco Strategy Meeting, and Alcohol Pathways Meeting. Reporting of the progress of Action Plans will be to the Public Health Community Development and Equality Committee which in turn reports to the Trust Board. The Prevention Steering Group will continue to meet to discuss and coordinate Health Promotion programmes, making wider links and informing the Public Health, Community Development and Equality Committee. Progress will also be documented in the annual Quality Report, which is shared with the CCG.

PATIENT STORY

Margaret Jones

"I had my mastectomy years ago at another hospital and I wasn't offered a reconstruction, but was given a silicon pad to use in my bra and give me back my shape. It wasn't until this started leaking and I asked for a replacement that I heard that surgeons at City Hospital will do reconstructions. I was overjoyed when Mr Staiano offered one to me. At first my children were against the idea, because they thought I was too old, but I was determined and loved the idea of getting back into my bikinis and womanly lingerie. My treatment at City was first class and everything went so well. The nurses looked after me brilliantly on the ward, and Mr Staiano explained everything beforehand, giving me a realistic idea of what to expect after the surgery. I am overjoyed with the result, and just can't wait for my next foreign holiday which I booked after my operation."

Focus Area 4 - Reducing Emergency Readmissions

We have developed a programme of work to support a reduction in re-admissions. This follows the analysis of data reviewing the high number of emergency re-admissions within 30 days to the Trust over a three year period. A Taskforce Group has been established to monitor and drive this key piece of work forward.

Development of the "LACE" Tool to identify patient at high risk of re-admission

We have developed a scoring tool to help identify patients who are likely to re-admit in real time. The tool known as LACE uses a scoring system based on L (length of stay), A (acuity of admission), C (Comorbidity), E (number of previous emergency attendances). This score produces an electronic symbol on the Trust's bed management system. Once fully developed, the tool will consist of four components:

- An alert report showing patients with a high LACE score who are currently in-patients and those recently discharged
- A symbol on the bed management system
- A discharge checklist to support patients Care Plan
- An alert to GP/Community services that the patient has been discharged with a copy of the discharge checklist.

Communication flows between teams and board review meetings will be essential to ensure triggers alert appropriate specialities to initiate an MDT review. The tool is in the pilot phase and following analysis, we plan to roll it out to all wards across the Trust over the course of the next couple of months.

In support of this piece of work, teams in AMU are working on processes to improve care planning for patients with speciality teams at the beginning of their journey. By identifying patients likely to re-admit early on in the admission process, this will assist clinical teams to plan discharge, educate patients and carers to gain a better understanding of patients' medical condition and to aid patients in the self- management of their condition. This will also facilitate an early discharge where appropriate, back into a community setting without admission onto a main hospital ward. The discharge checklist will be signed off by a senior decision maker and include planning with appropriate community teams to support patients in their "home" environment. More intensive follow up will be required in community with follow-up phone calls and reviews in hot clinics as required.

PATIENT SCENARIO

Barbara, a 74 year old lady was re-admitted 10 times in 11 months with all visits to A&E resulting in a stay overnight or admittance onto a medical ward. The lady lives alone, has a number of co-morbidities and social problems. She has two daughters, one having just been diagnosed with breast cancer and the other moved to another part of the country - her son assists her with shopping etc. To help support her situation, the patient has recently moved into sheltered accommodation but has (to date) refused any kind of care at home although she would benefit from this. She is known to the community team and has had contact with community services on and off for the last couple of years, but still has multiple re-admissions. She has a history of psychoactive substance abuse and will use 999 as first point of call, especially if family are not around to support her.

This lady's case is being reviewed by the MDT team which oversees her care together with her family to help facilitate better support outside of the hospital environment.

Although the LACE tool will identify patients who are likely to re-admit, it will not facilitate a reduction in re-admissions on its own and there will need to be a re-design of processes, robust discharge plans and joint working with colleagues across the community including the voluntary sector and other groups such as West Midlands Ambulance Service to help support some of this work.

The speciality audits have started to inform some of the change that needs to take place, and has also highlighted other areas where changes in practice could improve quality of the Trust's data collection.

Supporting Work

In addition to the LACE tool, a number of other key pieces of work will support the work programme:

- Work has begun to review of a number of ambulatory care pathways to reduce both the number of admissions and re-admissions and to facilitate a better patient experience
- Acute consultants and GPs are working together to create a new discharge summary. This will provide a greater in-depth summary and care plan to aid community teams with greater knowledge of the patient's admission so support can be offered to keep patients at home
- A Virtual Ward model is being developed by the Trust Community Admissions Avoidance Team who are working with colleagues in primary care to identify patients who would benefit from care within their own home instead of repeat admission to hospital
- A planned review of job plans to maximise consultant-led 'front door' early specialist input
- Expansion of antibiotic services and establishment of diuretic heart failure services
- Use of community teams to in-reach to support early discharge
- Working with Clinical Teams to review completion of coding data and ensure patient episode are recorded against correct consultant, to improve quality of data on transfer of care following "on-take"
- Pilot of an alert system to Care Home Teams when patients are admitted from care homes. This will help reduce numbers of re-admissions by facilitation of shared patient information and assist in either immediate discharge back to care home or early supported discharge
- Working with West Midlands Ambulance Service to reduce numbers of admissions for respiratory patients
- Development of information to raise awareness to staff in the Trust of community services available to support patients in home setting and potentially reduce re-admissions
- Review of patients discharged at the end of the week with social care packages who were subsequently re-admitted revealed the need to develop referral into Palliative Care Pathways.

Conclusion and next steps

The reduction of re-admissions is a complex and challenging area of work and involves all partner agencies in health and social care working together. The work will not only facilitate a reduction in re-admission rates, but offer a better quality experience for patients and carers.

The work programme will expand over the next 12 months and will be supported by the development of another work programme looking at Long Term Conditions.

Focus Area 5 - Improving Patient Experience

We are committed to delivering the best possible experience of the services used by patients, their families and their carers being mindful that this can only be achieved by ensuring this commitment is shared by everyone employed at the Trust.

To this end, we have developed a strategy that brings together these simple truths based on an important belief: That our patients know best ie. they have knowledge that we do not, because they know themselves better than we can.

We know that across the Trust there are areas where we achieve the best and others where we could do better. We want the best of SWBH now to be what we do consistently across SWBH. We know that we don't always get it right, but it is our intention to implement a culture where we continually listen and learn from patients, staff and carer feedback so that we work together to achieve sustainable service improvement and thereby deliver the best care possible.

We recognise that staff are our biggest asset and in order to deliver a good patient experience, we need to ensure a good staff experience. All staff have a responsibility to work within a way that ensures that 'the patients voice is heard at every level of the organisation.' We expect staff to let us know when they feel unable to do this, either due to personal circumstances, lack of resources or inadequate systems and processes.

When a patient, resident, relative, carer, friend or visitor leaves a service we need only simply, humbly and sincerely ask; 'Are you happy with the way you've been treated today?' and when we go home, ask ourselves; 'Is everything I've done today what I'd do for my family? ' To achieve this service, delivery will focus upon the following key themes:

- Give patients, carers and colleagues the same respect that we would want for ourselves or a member of our family
- Patients, their families and carers feeling informed, being involved and given options
- Staff who listen and spend time with their patient
- Being treated as a person and not a number
- The value of support services
- Consistent efficient processes.

2.2 CQUIN (Commissioning for Quality and Innovation)

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.

CQUIN performance 2013/14

The 2013/14 CQUINs agreed were as follows. The CQUIN contract value was £8.970m. As a result of not achieving and delivering Medicine Management, FFT roll out in Maternity and Sepsis bundle use, the total of withheld funding was £0.9105m. These non-achieving areas are explained in the below table.

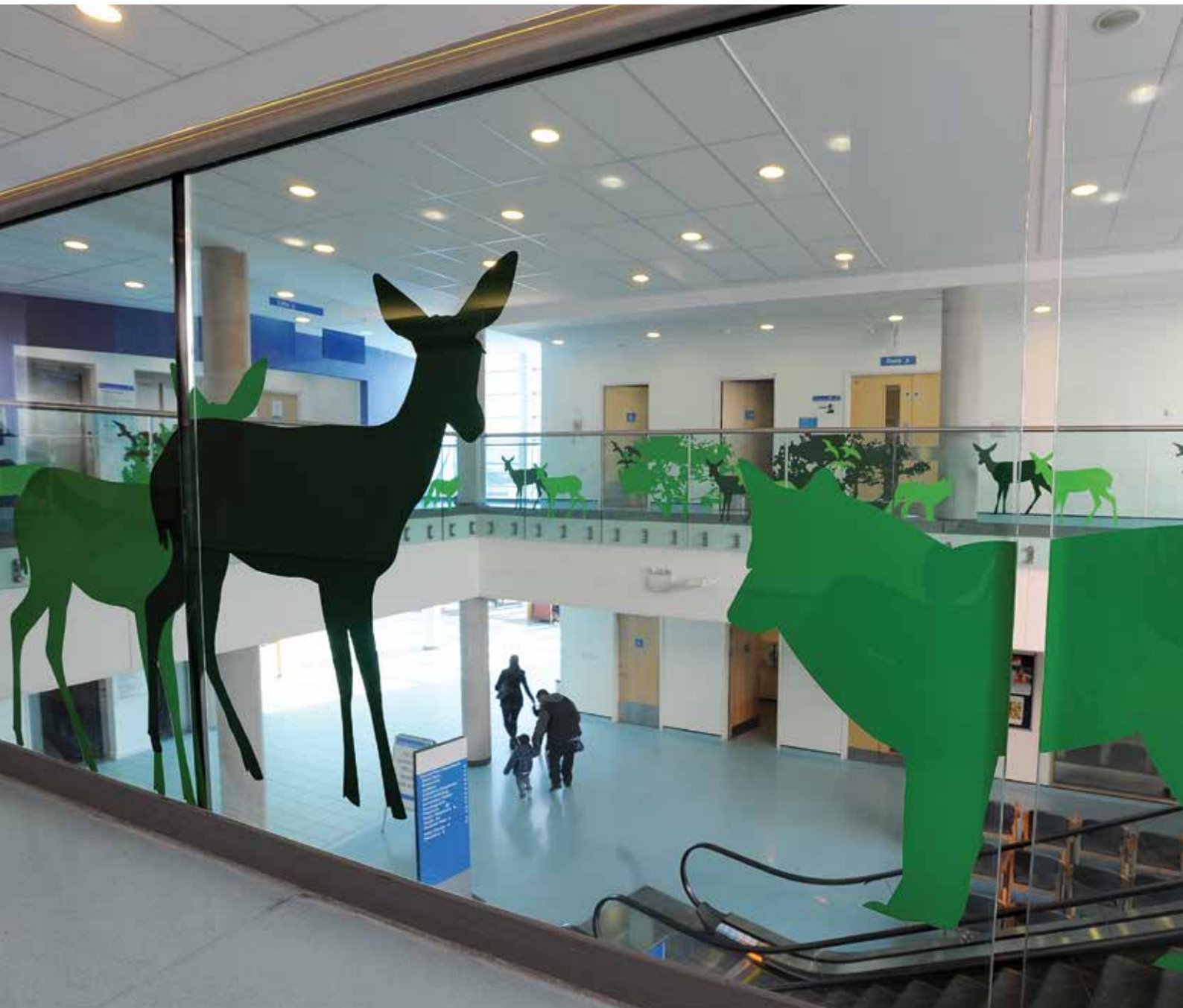
	Commissioning for Quality & Innovation (CQUIN)	Measure	2013/14
National	VTE Risk Assessment (Adult IP)	%	98.7
National	VTE Root Cause Analysis	%	100
National	NHS Safety Thermometer - Reduction in Pressure Sores	No	On Track
National	Dementia - Find, Investigate and Refer	No	Met
National	Dementia - Clinical Leadership		In Place
National	Dementia - Supporting Carers of People with Dementia		Monthly Surveys in Place
National	Friends and Family Test - Phased Data Collection Expansion	%	16.4
National	Friends and Family Test - Increase Response Rate (Emergency Care and Wards)	%	20.3
National	Friends and Family Test - Improve Performance on Staff FFT		
Local	Safe Storage of Medicines	%	81
Local	Dementia Patient Stimulation	%	In Place
Local	Use of Pain Care Bundles	%	Met
Local	Use of Sepsis Care Bundles	%	Met
Local	Community Risk Assessment & Advice		Met
Local	Recording DNAR Decisions		On Track
Specialised	Clinical Quality Dashboards		Fully Compliant
Specialised	Bechets Highly Specialised Service		Fully Compliant
Specialised	HIV - Communication with GPs		Fully Compliant
Specialised	Neonatal - Retinopathy of Prematurity Screening	%	Met

Key Performance Indicators 2013-14

These are a list of areas we have set ourselves to improve upon, these are reported at the beginning of the year and monitored throughout the year. They have no financial implication attached to them however hold great importance to achieve.

Access Metrics	Measure	2013/14
Cancer - 2 week GP Referral to First Outpatient	%	95.0
Cancer - 2 week GP Referral to First Outpatient (Breast Symptoms)	%	96.7
Cancer - 31 day Diagnosis to Treatment for All Cancers	%	99.2
Cancer 62 day Urgent GP Referral to Treatment for All Cancers	%	87.0
Emergency Care 4-hour waits	%	94.5
Referral to Treatment Time - Admitted <18 weeks	%	91.5
Referral to Treatment Time - Non Admitted <18 weeks	%	96.8
Referral to Treatment Time - Incomplete Pathway<18 weeks	%	93.4
Acute Diagnostic Waits >6weeks	%	0.81
Cancelled Operations	%	1.1
Cancelled Operations (breach of 28 day guarantee)	%	0.020
Delayed Transfers of Care	%	3.1
Outcome Metrics		
MRSA Bacteraemia	No	1
C Diff	No	39
Mortality Reviews	%	80.0
Hospital Standardised Mortality Rate	HSMR	92.1
Summary Hospital-level Mortality Index	SHMI	100.1
Caesarean Section Rate	%	24.9
Patient Safety Thermometer - Harm Free Care	%	94.4
Never Events	No	5
VTE Risk Assessment (Adult IP)	%	98.7
WHO Safer Surgery Checklist	%	99.9
Quality Governance Metrics		
Mixed Sex Accommodation Breaches	No	124
Patient Satisfaction (FFT) - Response Rate (IP Wards and Em. Care)	%	20.3
Patient Satisfaction (FFT) - Score (IP Wards and Em. Care)	No	60
Staff Sickness Absence	%	4.33
Staff Appraisal	%	96.7
Medical Staff Appraisal and Revalidation	%	97.0
Mandatory Training Compliance	%	86.6
Clinical Quality & Outcomes		
Stroke Care - Patients who spend more than 90% stay on Stroke Unit	%	91.3
Stroke Care - Patients admitted to an Acute Stroke Unit within 4 hours	%	76.4
Stroke Care - Patients receiving a CT Scan within 1 hour of presentation	%	71.9
Stroke Care - Admission to Thrombolysis Time (% within 60 minutes)	%	51.2
Stroke Care - Swallowing Assessments within 24 hours of admission	%	98.6
TIA (High Risk) Treatment within 24 hours of presentation	%	70.9

TIA (Low Risk) Treatment within 7 days of presentation	%	84.5
MRSA Screening Elective	%	92
MRSA Screening Non Elective	%	94
Inpatient Falls Reduction – Acute	No	607
Inpatient Falls Reduction – Community	No	119
Hip Fractures - Operation within 24 hours	%	70.3
Patient Experience		
Complaints Received - Formal and Link	No	948
Patient Average Length of Stay	Days	3.7
Coronary Heart Disease - Primary Angioplasty (<150 minutes)	%	92.5
Coronary Heart Disease - Rapid Access Chest Pain (<2 weeks)	%	95.7
GU Medicine - Patients Offered Appointment <48 hours	%	100



It is important for us to share with the public our failures, as well as our accomplishments to give an honest overview of our hospital, but also to show you where we need to put our focus for the next year. Below are the non-achieved CQUINS and Key Performance indicators explaining how the failure has occurred and what plan we have actioned to improve throughout the next year.

Non-achieved CQUIN

Medicine management

In 2013/14 we saw the protocols were not followed by all employees resulting in the performance being 9% lower than the 90% needed.

Although this will not continue forward into 2014/15 as a CQUIN, we hold this as having great importance in the professional Nursing role and will continue to monitor with spot checks on a weekly basis. Where required, we will hold staff to account, going through the disciplinary process as a consequence of not following our policies on medicines management and in particular to the safe storage of medicines.

FFT roll out in Maternity

Friends and Family Test (FFT) is dependent on new mothers completing and returning a postcard with their views once discharged and at home with their new born baby. We are aware that the new parents are unlikely to fill this postcard in therefore we have looked into new ways of getting this data fed back.

We are currently in the process of trying to get the FFT installed on iPads for community midwives to have instant information on midwife visits. We are currently working through a number of information Governance issues before this can take place.

Non-achieved Key Performance Indicators (KPI's)

Emergency Care 4-hour waits

The trend of underperformance that emerged in 2012/13 continued into 2013/14. During the year, a significant pathway reengineering programme (initially entitled Winter Must Be Better) was implemented, which led to the creation of a new model of emergency care (ED pathways and revised principles for assessment units), as well as new areas dedicated to the care of patients who were medically fit for discharge but remain within the acute trust.

Supporting this was the development of an operations centre allowing for greater coordination of patient moves across the Trust. Performance trajectories were agreed with the CCG and the LAT and this was intensively monitored on a weekly basis by the chief officers of the groups concerned.

Cancelled Operations

Cancelled operations remain an area of concern. During 2013/14, we instituted tighter controls around theatre utilisation, whereby session utilisation and throughput are reviewed on a weekly basis and list sizes amended to ensure sessions run to time, however regrettably, cancellations have still occurred. In addition, better control over bed flows via the Capacity Management team has meant that late notice cancellations due to 'no bed' should be reducing. For this financial year, the Clinical Groups are focused upon improving theatre utilisation and reducing cancellations as part of their efficiency improvements.

Cancelled Operations (breach of 28 day guarantee)

The process for checking the potential 28 day breaches and ensuring that they are booking within the agreed time, was revised during the year following the (retrospective) emergence of some breaches. This has been revised again in 2014/15 following a further breach of this guarantee, in response to the root cause analysis and the identification of a further system weakness.

MRSA Bacteraemia

The majority of the attributable MRSA bacteraemias for 2013/14 were due to skin contaminants from blood cultures taken in Emergency Departments (ED). We aim to reduce these numbers by organising urgent training of ED nurses to enable them to take blood cultures effectively.

Never Events

Last year we reported five never events, including one from the previous year; as a trust this has caused grave concern and a patient safety conference was called for all senior clinical leads and managers to attend. Section 3.2 goes into detail of the individual never events, the learning and actions to go with these and our focus to improve on this for 2014/15.

Mixed Sex Accommodation Breaches (MSABs)

Under-reporting of MSABs was identified during 2013/14 with regards to the nature of the exceptions that had been built into the reporting system. In particular around declaring patients who had stepped down from level 2 or 3 to level 1 but remained on a mixed sex unit. The policy was amended and we have recently implemented a new electronic tracking system to track gender bed allocation.

In parallel we have tightened our processes on the stroke unit to ensure that patients are reviewed and stepped down from level 2 to level 1 much quicker in their pathway. This transition has led to an unanticipated increase in mixed sex breaches as these patients remained in level 2 areas when they were downgraded to level 1 care, on our stroke unit. The Trust has this performance area as a significant focus. We are reviewing bed flows and capacity on the stroke units to accommodate this and auditing the new procedures.

Staff Sickness Absence

We have not met the local goal set of 3.15% sickness however we have achieved our trust goal, we have identified key areas of improvement and areas of further audit.

Mandatory Training Compliance

NHSLA standards for level 3 state that where an audit is conducted and risk management (mandatory) training compliance is more than 75% but less than 95%, then an action plan should be in place to improve the level of compliance with an aim of achieving 95%. We are a level 2 organisation but we wanted to stretch the compliance target to achieve level 3 standard.

In 2012/13 we conducted such an audit and found compliance to be around 78%. Over the last 12 months we have managed to increase compliance to 87% which is very positive.

The target of 95% is idealistic and unlikely to be achieved due to sickness absence, staff turnover, maternity leave and other operational factors. However, in 2014/15 we will review the risk management TNA and try to reduce the mandatory training liability thus potentially increasing the likelihood of improved compliance.

Stroke care – admissions to acute stroke unit within four hours

In some months of 2013/14 we have not been able to meet this target which relates to the increased number of stroke admissions, together with difficult discharge of some of the complex stroke patients. Despite this, our overall performance of 76.4% has been one of the best in the country, compared to the overall of 51.2% nationally.

We plan to address this to streamline the Stroke Pathway and remove all bottle necks with the following measures:

- Two beds to be kept free at any time – one of these beds to be a side-room to ensure timely admission of stroke patients from ED to the stroke unit
- Continue Board rounds every morning and invite the ESD (Early Supported Discharge) team to attend once weekly. This should help identify plans to ensure two beds are free and also identify patients who could be discharged early with rehabilitation at home
- When there is no identified plan and/or when only one bed available, the Ward Co-ordinator will now alert Consultants and Matron
- To improve earlier recognition of stroke and quicker transfer, we are currently exploring the possibility of the routine stroke being scanned and clerked and transferred directly to the stroke unit
- Group establishing in June 2014 to address the complex discharge for the cohort of patient with increased length of stay.

Stroke Care – Admission to Thrombolysis Time (% within 60 minutes)

In November 2013, we established a negative impact of the target with Emergancy Departments. Meeting were held throughout December and the Stroke Pathway was changed to visualise a better incorporation of all services to be more efficient and timely for the patient, including colleagues in ED and Imaging. This has had great impact on the patient care in our Emergency Department and we have increased our thrombolysis rate to more than 13% of our stroke patients. We achieved more than 95% in less than 60 minutes and in fact, most of our patients were thrombolysed in less than 45 minutes. We hope that in 2013/14 we can share a 95% achievement across the year.

Hip Fractures – operation within 24 hours

The national guideline for Fractured Neck of Femur (#NOF) best practice tariff is 36 hours. We try our best to take the patients to the theatre as soon as possible as #NOFs are our priority. The target of 24 hours is a locally agreed target with CCG 3. This target is 80% to allow for patients coming before 9am which have a high risk of 24 hour breach unless we can take them to theatre the same day, which is not always possible. In addition, some patients may not be immediately fit for surgery within 6-8 hours of admission. Our bar has been set much higher compared to national guidelines.

This has been further complicated by the fact that in 2013/14 we have also seen a substantial rise in the volume and complexity of patients coming through our Emergency Department with hip and other types of fractures. Some of these also need priority surgery.

Actions undertaken:

- We have now extended our trauma clinic from 9am-5pm, every day, including weekends
- NOF is always a priority (open fractures - children - #NOF - then any other fracture)
- We have a live NOF database & BPT dashboard to analyse every breached patient. Trying to identify trends, if possible to pre-empt
- We have dedicated Anesthetists for the whole week now, who assess #NOFs as they are admitted to bring them to theatre ASAP

- Ortho-geriatrician assesses every NOF as soon as admitted to make them fit as soon as possible.

Possible options:

- Dedicated #NOF lists every day, which will need additional trauma theatres to accommodate all other fractures
- Extend trauma list in the evening till 8pm
- Creating extra trauma theatres at short notice when volume is high.

Coronary Heart Disease – Rapid Access Chest Pain (<2 weeks)

A shortfall of three consultants resulted in an overwhelming capacity on the remaining service providers. Although Rapid Access Chest Pain (RACP) clinics were maintained during this period, the demand for these was not met in a timely way by the capacity which was available.

To rectify this, the three vacant posts have now been appointed and from April 2014 are all within the Trust providing care. We will be able to offer an additional RCAP Clinic to improve the throughput of cases.

Although the process by which we monitor and escalate RACP cases which are of potential long waits has been assessed and improved. Further work has been outlined to analyse the type of cases which are referred to us, ensuring our patients are being seen through the optimal pathway.

2.4 How we decided on the priorities for our Quality Account for 2014/15

Our priorities for 2014/15 are informed not only by our long term quality goals, but also through extensive consultation with our patients, staff, local commissioners, health and wellbeing boards and also national priorities.

We have sought the views of patients through our member's events throughout the year – including the sharing of the draft public health strategy, consultation on our quality priorities and gaining feedback on the success of the reconfiguration of stroke services.

We have engaged with staff through regular staff forums such as our monthly Hot Topics meetings, feedback from our annual general meeting, leadership conference and consultant conference.

We work in close collaboration with our principle commissioner – Sandwell and West Birmingham CCG – with whom we agree our CQUIN (Commissioning for Quality and Innovation) targets for the year and service development improvement plans.

In March this year we met with the Birmingham Overview and Scrutiny Committee and shared with them our quality priorities for the next three years.

We have collated information and feedback from all of the above and selected the following areas for focus in 2014/15:

1. Reducing emergency re-admissions
2. Reducing preventable deaths
3. The patient Experience in Outpatient departments
4. Publication and implementation of the first year of our three year public health plan
5. Improving the safety of patients in hospital through our 10/10 campaign.

Focus Area 1- Reducing Emergency Readmissions

We have selected this area for focus again this year because our emergency readmission rates remain high compared to the national average. A great deal of work has been done in this area over the last year – mainly in advancing our understanding of reasons for readmission.

This year we intend to implement the learning from this in particular we will be:

- Embedding the use of the electronic LACE tool and other predictors of readmission to target interventions aimed at reducing the risk of readmission
- Improving the quality and timeliness of information provided to GPs following discharge from hospital by improving our discharge letter process
- Implementating evidence based discharge bundles for patients with respiratory disease and Heart Failure
- Improving rapid access to specialist advice in respiratory and cardiac disease through the increase in rapid access clinics and emergency ambulatory care pathways
- Improving specialist advice at the front door through initiatives such as 'Cardiologist in AMU' and the 'Front Door Geriatrician'
- Improving integration of hospital, ambulance, primary care and community teams – with a system of alerts for patients at high risk of readmission
- Conducting an audit into the 'Last year of Life' looking into reasons for multiple admissions to hospital towards the end of life.

Through this programme of interventions we intend to reduce the emergency re-admission rate by 1% - which will bring us in line with other acute trusts.

PATIENT STORY

Donald Bayley (as told by his wife Pam)

"Don was making a pot of tea when he suddenly stopped and grabbed hold of the worktop. I knew there was something really wrong when I couldn't get a response from him. When I managed to sit him down, he just slumped off the chair. Our local hospital doesn't have an out of hour's emergency service, so the paramedics bought us to Sandwell Hospital where Don received the treatment which saved his life."
Donald is now up and about and has moved to the stroke rehabilitation ward where his is receiving treatment from occupational and speech and language therapists.

Focus Area 2- Reducing preventable deaths (Mortality)

The importance of our mortality rates as an indicator of quality of care means that we have to continue to keep this as one of our top priorities. We are amongst the best Trusts in the West Midlands for our mortality rates – however there is much we can do to get closer to the best in the country.

In 2013/14 our cumulative HSMR was 92.5% – this puts us above average, however we want to be in the top quartile (the best 25%) in the country. We will do this by the following:

1. Improving our mortality review system with the aim of reviewing 100% of deaths within 42 days by the end of the year.
2. Improving the lessons learnt by taking part in and incorporating some of the methods from the PRISM2 study into the mortality review system.
3. Investigating differences in mortality between the weekend and week days and improving seven day services.
4. Improving the process of death certification and referral to the coroner. An electronic system for referral and recording of death.
5. Introducing VitalPAC – the electronic recording and monitoring of patients' vital signs. All adult acute wards will have VitalPAC by September 2014.
6. Continuing with the work to improve the recognition and response to the patient with sepsis. Increasing the percentage of patients screened positive for sepsis receiving sepsis six bundle to 50%.
7. Improving the prevention of hospital acquired venous thromboembolism (HAVTE) – improving risk assessment, prophylaxis and conducting root cause analysis on all cases of HAVTE. More than 98% of inpatients will be risk assessed.

Focus Area 3 - Year of Outpatients

The purpose of the Year of Outpatients is patient care; we want at least 98% of our patients to tell us that their outpatient experience was outstanding. We have set ourselves a programme to design a better experience for patients, staff and carers. We are trying to create an expectation from our patients for an experience which gives timely and well informed care. In particular we aim to achieve:

- Letters sent to patients within 5 days
- Hospital led cancellation of appointments will be a rarity
- Patients will be informed that we have received their referral.

We will have a personalised way of undertaking outpatient care, the eight standards need to be met and patients are seen to be happy with the services we provided. The standards will become compulsory by March 2015. The programme, which will commence in May 2014 will be chaired by the Chief Executive with a fortnightly board meeting to measure progress. A weekly Chief Operating Officer delivery group meeting will take place on a weekly basis the directorate will be reporting on a quarterly basis against the standards set from June 2014.

Focus Area 4 - Public Health Implementation

Our Trust is a very large employer, and many of our employees and patients live locally. We spend more than £80m a year on resources and services, and many of those are bought locally and sustain local employment. We know that one of the top roles that we can play in local health is by helping with employment as we know the next few years could see turbulence in public service jobs. Our Public Health Implementation Plan commits us to working with our employees to ensure that they too have access to the best health advice, and are supported by their peers and employers to achieve the difficult jobs we do.

Public Health Objectives

	Definition
Objective 1:	80% of Trust staff to be trained in Making Every Contact Count and confident in making very brief interventions
Objective 2:	For all pregnant women to receive carbon monoxide monitoring and, as required, intensive smoking cessation support
Objective 3:	All of our community nurses, and nurses working for others in the community, to be delivering audited asthma advice to prevent acute admissions and to improve self-management habits
Objective 4:	All Trust sites to be smoke-free by 2018, supported by an extensive and effective programme of cessation advice and Nicotine Replacement Therapy for both staff and patients
Objective 5:	Reduce alcohol related admissions by at least a fifth against 2013-14 baseline, with a 50% increase in referrals from the Trust to partner alcohol support agencies by the end of 2015
Objective 6:	The Trust can evidence that the food we serve and others serve on our sites actively and successfully promotes healthy choices, appropriate portions, and is consistent with nutritional advice
Objective 7:	All new employees joining our Trust, and existing staff who choose to do so, will provide health data to us, which we will use to offer tailored support with risk issues including weight management, smoking, and alcohol consumption
Objective 8:	We will deliver our 'strand one' health promotion priorities, including extensive Nicotine Replacement Therapy for staff, gym facilities on our Sandwell site, and out of hours access for night-workers to healthy food options
Objective 9:	We will be recognised as a leader in workplace mental health provision and support for our teams. This will support our drive to cut sickness absence below 3%
Objective 10:	Our Trust is recognised as the youth employer of choice in our region, because we have doubled the number of apprenticeships we offer and have a work experience programme embedded in all local schools
Objective 11:	The Trust tackles the number one priority of local Health and Wellbeing Boards by delivering outstanding services for homeless people in partnership with the third sector and others - both as a care provider and as an employer
Objective 12:	We will select our new hospital partner in accordance with our regeneration obligations, and will shift by at least 10% the proportion of type B goods and services purchased locally
Objective 13:	We will deliver our sustainability action plan, which will cut landfill use by 5% and stabilise our energy usage at current levels, and therefore improve our NHS good corporate citizen assessment score by 10% or better

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

- Formally launch the Strategy as 'Our Public Health Plan' by June 2014; and continue high-profile information campaigns around Health Improvement in our communities
- Develop and implement action plans for each of the 13 objectives in the Plan and implement new health improvement activities in SWBH across all the domains of the Health Promoting Hospital Standards
- Promote Health Improvement Training in the Trust including the Making Every Contact Count (MECC) programme, focusing on giving staff the skills in very brief interventions for stopping smoking, reducing alcohol consumption and making lifestyle preventive interventions for patients and employees. We intend for all staff to be aware of the programme and 80% of public-facing staff to be confident in advising, signposting and making these very brief interventions
- With our partners in Public Health Departments, implement an integrated information technology support system across the Trust's computers to assist in staff training in Health Promotion and referral of patients and relatives for formal smoking, alcohol, and lifestyle counselling
- Offer and support lifestyle services to our patients, staff and the wider local community in partnership with other agencies and organisations
- Formally adopt the principles of the Health Promoting Hospital network into our Trust's mission statement, policies and procedures by December 2014
- Make contacts with other organisations locally, nationally and internationally to further develop our reputation and capability in Public Health.

Focus Area 5 – Safety 10/10 Implementation

Ten out of Ten Safety Standards

During 2014/15, we will implement a programme aimed at ensuring that we do everything possible to prevent harm being experienced by any patient. The 'ten out of ten' approach is focused on the ten things we should do for every admitted patient, if these are completed we improve the individual patient's experience throughout their stay with us. We want patients to know about these standards and will be placing a copy beside every bed in our hospitals and inform patients about them in our communications with them.

	Ten out of Ten Safety Standards
1	We will use positive patient identification using three unique identifiers
2	We will assess every patient for their risk of developing a pressure ulcer and put in place the appropriate preventative measures
3	We will assess every patient for their risk of falling and ensure that the correct preventive measures are in place
4	We will assess every patient for the risk of developing venous thrombo-embolism and ensure the correct prophylaxis is prescribed where appropriate
5	We will ensure every patient has a base line set of observations carried out by a registered nurse including at least one record of height and weight
6	Every patient will have their medicines checked and reconciled against a definitive list and have any allergies clearly documented on their prescription chart
7	Every patient will have their mental capacity assessed and where required referral for further assessment
8	Every patient will have their pain assessed against a visual analogue scale and offered analgesia if required
9	Every patient will be screened for MRSA and give decolonisation treatment if required
10	Every patient will have their nutrition and fluid needs assessed and given access to appropriate nutritional advice

Use of the CQUIN payment Framework

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

CQUINs 2014/15

Goal	CQUIN Goal Name	Description of Goal	Quality Domain
1	Friends and Family Test	Implementation of staff FFT and early implementation to patients. Increase the response rate within the Trust and reduce the negative responses received from both patients and staff	Patient Experience
2	NHS Safety Thermometer	The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey	Patient Safety
3	Dementia	Improve early assessment, referral and treatment of dementia with a viable support system for carers of people with dementia. Clinical leadership in dementia to be further development	Clinical Effectiveness
4	Learning from Safeguarding Concerns	To ensure safeguarding practices support the needs of vulnerable children and adults. To ensure that providers continue to embed safeguarding into practice, implement lessons learnt following a safeguarding event, reflect on practice and ensure voice of adult/ child is heard	Patient Safety
5	Outpatient and Discharge Letters	Assess the quality of outpatient and discharge letters to ensure high care quality is maintained when in communication between health care providers. Reducing the likelihood of omissions of vital importance such as new or altered medical treatments	Patient Experience
6	Sepsis	Reducing mortality due to sepsis	Patient Safety
7	Pain Care Bundles	Decide what the pain review process will be at ward specific or clinical pathway level. Write down and agree it across the team (using the method of asking patients to describe their pain level on a scale of 0 to 10 at agreed pathway intervals) Measure how many patients receive it. Objective: Eliminate pain review process that leads to variation in patient experience of pain relief	Clinical Effectiveness
8	Medication & Falls	The cause of a fall can be complex; however the association between drugs and falls has been widely studied, with increasingly robust evidence of a causal link. Both specific classes of drugs and the total number of drugs taken are associated with falls. This CQUIN aims to raise awareness of, and examine what actions, can be taken to prevented falls through multifactorial interventions - focusing on the impact of medications	Patient Safety
9	SUI assurance (including Never Events)	Through clinical audits - assurance that low compliance and poor audit result areas are being actioned by the Trust. Evidence of improving the approach to share learning across departments	Patient Safety

10	Community Therapies referral to treatment	Effective referral management across community services	Patient Safety
11	Implementing unified assessment criteria to support equitable access and informed choice for place of birth	Evidence that women deemed low risk are having low risk births at time of delivery	Patient Experience

Specialised Services CQUINs

	Service	
1	Behcets clinical outcomes collaborative audit meeting	Providers of highly specialised services will hold a clinical outcome collaborative audit workshop and produce a single provider report
2	HIV home delivery	Establish the national baseline for home delivery of HIV medicines and to expand this to a minimum of 70%
3	Neonatal retinopathy of prematurity screening	To achieve an increase in screening to a target of 95% of babies with a birth weight of <1501g or a gestation of <32+0 weeks who undergo first Retinopathy of Prematurity (ROP) screening whilst still an in-patient and screened 'on time'
	Neonatal parenteral nutrition	During early postnatal life, the nutritional needs of preterm infants are usually met through parenteral nutrition. This indicator aims to improve the proportion of preterm babies who start TPN by day two of life. It excludes babies who undergo surgery on day one or two of life.
	Existing specialised services dashboards	This indicator is aimed at ensuring that providers embed and routinely use the required clinical dashboards developed during 2013/14 for specialised services. The Area Team is responsible for agreeing the relevant dashboards with the providers

Statement of Directors' responsibilities in respect of the Quality Account

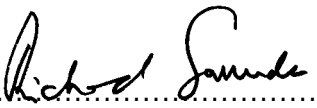
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service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

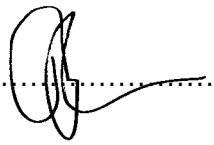
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- 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 they have complied with the above requirements in preparing the Quality Account.

By order of the Board:

16th June 2014 ..... Date  ..... Chair

16th June 2014 ..... Date  ..... Chief Executive

PATIENT STORY

Donald Berry

For over 30 years, paraplegic Donald Berry has suffered with incontinence, but thanks to a new treatment his life has improved drastically with the help of the FINCH team at Sandwell Hospital.

"I had always been treated with suppositories or enemas, which were what was traditionally given to treat the symptoms of faecal incontinence. I used to have to get up in the morning and have to insert the suppositories and have to sit for an hour to empty my bowels. Irrigation is cleaner and makes me less paranoid about bowel care. When I was using suppositories I would occasionally have accidents, but I don't with this system. This treatment totally revolutionises your life. Now I can do it at any time during the day, if I am busy in the morning, I can do it whenever I want to. It is cleaner and quicker. Liz (from the FINCH team) is absolutely fantastic. She didn't ask me to do anything she wouldn't be confident doing. Liz came up to the ward, showed me how to do it and helped the nurses become used to it. She even showed the nurses how to do it. Their help and support has been first class. The irrigation system has totally freed up my whole life and it is so much more comfortable than using suppositories. The team's help and understanding have been excellent and they have helped make things better for me."

Review of Services

During the period 2013/14, the Sandwell and West Birmingham Hospitals NHS Trust provided and/or subcontracted 46 NHS services.

The Sandwell and West Birmingham Hospitals NHS Trust has reviewed all the data available to it on the quality of the care in 46 of these services. Where the Trust has subcontracted any activity, it would only be to a provider which was registered with the CQC. Agreements between the Trust and the subcontracted providers require that the same high standards of care given by SWBH are maintained when giving care on its 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 2013/ 14 represents 100% per cent of the total income generated from the provision of NHS services by the Sandwell and West Birmingham Hospitals NHS Trust for 2013/14.

Participation in Clinical Audits

During 2013-14, our Trust has participated in 31 national clinical audits and three national confidential enquiries covering NHS services which the Trust provides. We reviewed all the data available to them on the quality of care in all of these services.

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

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust participated in and for which data collection was completed during 2013-14, are listed in attached Appendix 3 along with key findings and learning areas.

We reviewed, along with the providers, 18 local clinical audit reports in 2013-14, these are listed in Appendix 4, with key learning areas and findings.

Participation in Clinical Research

During 2013/14, we recruited in excess of 2'000 patients, all of which are receiving NHS service care from our Trust, to participate in research approved by a research ethics committee for National Institute for Health Research (NIHR) Portfolio studies. With a further 800 for non-NIHR Portfolio studies.

Participation in clinical research demonstrates our ongoing 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. It further ensures that clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

We were involved in conducting over 250 clinical research studies during the 2013-14 period, 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. We use national systems to manage the studies in proportion to risk and implements the NIHR Research Support Service standard operating procedures.

Health Education West Midlands Visits

The Health Education West Midlands (HEWM) Visits are vitally important in the ongoing development of the good training practice we provide at Sandwell and West Birmingham Hospitals. Training undergraduate and post graduate staff plays a big part in developing staff to be kind and compassionate as well as efficient and effective within their role.

HEWM visited the trust seven times within the last year, looking into areas such as the medical training provided Plastic Surgery, Emergency Medicine and Obstetrics and Gynecology. Below is a selection of the positive feedback we received during these visits.

The Clinical Tutor involvement in exploring issues/identifying possible areas of concern from the GMC NTS and JEST is commended.

Following previous concerns raised with regard to the collaborative working with nursing staff, the overall opinion of Trainees is that once trust is gained by the nursing staff, the interaction and team work is good.

Trainees commend the support provided by the middle grade, with the exception of locum cover. In particular, one consultant was clearly identified by Trainees as enthusiastic and passionate about education and training within the Emergency Medicine department.

Care Quality Commission (CQC) Registration

The Care Quality Commission is an independent regulator of all health and social care services in England. The Commission checks all hospitals in England to ensure they are meeting national standards and they share their findings with the public.

What are the national standards?

The national standards cover all aspects of care, including:

- Treating people with dignity and respect
- Making sure food and drink meets people's needs
- Making sure that the environment is clean and safe
- Managing and staffing services.

All health and social care services in England have to be registered with the Care Quality Commission (CQC). Our hospital is registered with no conditions, meaning we are safe to practice and our patients are in good care.

The CQC regularly inspects Trusts with very little warning, or sometimes withought warning to ensure the standards listed above are met. The table opposite details our 2013 inspection and the findings.

Date	Site	Inspection Details	Rate	Outcome
June 2013	Sandwell General Hospital	Respecting and involving people who use services	✓	Met this standard
		Consent to care and treatment	✓	Met this standard
		Care and welfare of people who use services	✓	Met this standard
		Assessing and monitoring the quality of service provision	✓	Met this standard
June 2013	City Hospital	Respecting and involving people who use services	✓	Met this standard
		Consent to care and treatment	✓	Met this standard
		Care and welfare of people who use services	✓	Met this standard
		Assessing and monitoring the quality of service provision	✓	Met this standard

FEEDBACK

The overwhelming majority of people that we spoke with during the inspection, told us that they were happy with the quality of service they received. One person said "I don't think that anything could be done better."

During this inspection we found that there had been significant improvements in this area. Whilst we acknowledge that there were on-going areas for improvements, such as staffing and completing the reorganisation of the complaints process, the Trust had plans in place to support this. We therefore found that there was an effective system to regularly assess and monitor the quality of service that people received.

All the people who were in-patients and their relatives that we spoke with told us that their medical and nursing needs were being met. One person told us, "They really look after you, more than fit for purpose." On all the wards that we visited, we saw that staff were generally caring and committed to their work. We found that people experienced care, treatment and support that met their needs and protected their rights.

West Midlands Quality Review Service

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

WMQRS audited in February 2013, the purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of People with Long-term Conditions, Version 1.1, August 2012
- Care of Children and Young People with Diabetes, Version 1.2, June 2012

Service	Number of Applicable QS	Number of QS Met	% Met
Care of Children and Young People with Diabetes			
Primary Care	3	3	100
Specialist Care of Children & Young People with Diabetes	29	25	86
Trust-Wide: Sandwell & West Birmingham NHS Trust	4	4	100
Commissioning	7	7	100
Health Economy	**43**	**39**	**91**
Care of Adults with Long-Term Conditions			
Primary Care	8	1	13
Community Long-term Conditions Services	52	35	67
Specialist Care of Adults with Diabetes	59	44	75
Specialist Care of People with COPD	56	25	45
Specialist Care of People with Heart Failure	57	20	35
Specialist Care of People with Chronic Neurological Conditions	58	24	41
Trust-Wide: Sandwell & West Birmingham NHS Trust	7	3	43
Commissioning	12	4	33
Health Economy	**309**	**156**	**50**

FEEDBACK

This review found many individual teams who were caring for their patients and very committed to providing good services. Reviewers were impressed that the 'SystmOne' IT system was used by community staff and 60% of GP practices. This meant that information about patients could be easily shared between community staff and GPs.

Good care for children and young people with diabetes was provided by a committed team who had worked hard with commissioners to develop a quality service. The requirements of Best Practice Tariff were already being achieved due to robust service organisation. There was also good collection of data to support management of the service. The service had strong leadership and a forward-looking approach was apparent throughout the service, including in education programmes. The service was appreciated and highly praised by the parents and patients who met the visiting team.

Risk Review of Theatres

Sandwell and West Birmingham Hospitals NHS Trust Board commissioned an independent review of risks in the Trust's theatres. This was in response to a number of Never Events within the theatre environment in City, Sandwell and Birmingham Midland Eye Centre (BMEC) hospitals, between June 2013 and January 2014. The focus of the visit was to review the processes and safety culture within the operating theatres, to identify areas of good practice, and also to highlight areas for improvement. The project scope was to:

- Review the Trust's corporate governance and risk systems specifically in relation to theatres
- Identify the level of safety culture and perceived risk that exists in the Trust's theatres based on corporate risk appetite, gaps in resources and weaknesses in process.

Key Strengths	Areas for Improvement
• Loyal workforce • Staff able and willing to raise concerns • Incident reporting culture embedded • Patient safety high on the agenda • Friendly, welcoming staff culture • Learning environment • Patients satisfied by level of care.	• Informality leading to relaxed approaches to some safety processes • Some disengagement of medical staff in safety checks • Working / shift patterns for theatre staff which are compromising safety • Need to integrate BMEC into the organisation as a whole • Tighter control of document development • Cross site learning from near miss and actual events.

Healthcare Associated Infection review by the Trust Development Agency

The NHS Trust Development Authority was set up to provide support, oversight and governance for all NHS Trusts on their journey to delivering what patients deserve.

The review conducted during February 2014 explored the infection prevention and control arrangements against the following ten criteria.

1.	Systems to manage and monitor HCAI.	✓
2.	Clean and appropriate environment.	✓
3.	Information to service users and visitors.	✓
4.	Suitable accurate information on infections.	✓
5.	Prompt identification/appropriate treatment and care of patients with infection.	✓
6.	Staff engagement in the process of preventing infection.	✓
7.	Secure adequate isolation facilities.	✓
8.	Secure adequate access to laboratory support.	✓
9.	Have appropriate policies and assurance.	✓
10.	Assurance (as far as possible) those healthcare workers are free from and protected from infection and are suitably educated.	✓

The report was overall very positive against each criteria with a small number of operational matters highlighted, many of which were able to be corrected with immediate impact. There were no organisational risks identified that would pose a threat to the safety of care for patients or to the safety of the environment for staff.

Joint Advisory Group (JAG) Accreditation Revisit Report

The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.

The JAG revisited on 8 April 2014 following concerns that arose at the previous visit. We are pleased to confirm that the endoscopy units at City Hospital, Birmingham, and Sandwell Hospital have now met all of the required JAG Accreditation standards.

Overall Visit Feedback

This is an effective and well-led endoscopy service, supporting an excellent patient centered experience. The organisation should be congratulated on having made such substantial changes and investment into endoscopy, and its clinical team. The safety and clinical governance processes are of a high standard. The workforce is well trained and competent, and involved in the management and development of services across the country. There are key elements of good clinical services in place, and we congratulate the endoscopy team and Trust.

The unit should be congratulated on:

- The organisation has invested into a modern, flexible endoscopy decontamination unit, supported by the decontamination manager. To utilise its potential fully, the organisation should consider moving to dedicated decontamination technicians, managed under the auspices of sterile and decontamination services
- The service has invested in review of the booking processes and a new e-diary and electronic scheduling system. This will allow greater capacity for fully booking patients, and data collection. This responsiveness to productivity and performance will support increasing demand over the next five years.

The External Auditors are reviewing the Quality Account in May 2014 and will provide assurance following this.

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of Sandwell and West Birmingham Hospitals NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for veneous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

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 Regulations).

In preparing the Quality Account, the 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, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated 11/06/2014;
- feedback from Local Healthwatch dated 11/06/2014;
- the latest national patient survey dated May 2014;
- the latest national staff survey dated May 2014;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 24 April 2014;
- the annual governance statement dated 06/06/2014;
- Care Quality Commission quality and risk profiles/intelligent monitoring dated April 2013- May 2014; and
- the results of the Payment by Results coding review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Sandwell and West Birmingham Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of our appointment under the Audit Commission Act 1998 and in accordance with the Commission's Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sandwell and West Birmingham Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP, Statutory *Auditor*

One Snowhill,

Snow Hill Queensway

Birmingham, B4 6GH

27 June 2014

We need to know that we are counting, recording and storing information about people's care very carefully. We have commissioned an external review of all our data reporting for key national indicators to take place to assure the organisation of the appropriateness of our national information reporting. We do not have concerns about inappropriate disclosure of data.

NHS Number and General Medical Practice Code Validity

Below is the National and Trust performance on validity of these data items as published through the Health & Social Care Information Centre (HSCIC) through Secondary User Service Data Quality Dashboard – Provider Based using 2013/14 financial month 10 data, which is the latest we have.

It shows we remain above the national benchmarks for all indicators in A&E apart from NHS number which is 95.2% against a national picture of 95.7%. We remain above all indicators for outpatients except Patient Pathway Identifier (which is optional). We remain above all indicators for in-patients except for ethnic origin 95.0% nationally 97.9%, commissioner at 96.7%,nationally at 99.0%, patient pathway identifier (optional) and we are slightly below NHS number coverage at 98.9% which is nationaly 99.1%, however we will be resubmitting our data with another NHS Number trace before year end.

NHS Number Compliance

Data Set	Nationally	SWBH
Inpatients	99.1%	98.9%
Outpatients	99.3%	99.6%
A&E	95.7%	95.2%

General Medical Practice Code

Data Set	Nationally	SWBH
Inpatients	99.9%	100.0%
Outpatients	99.9%	100.0%
A&E	99.1%	100.0%

Clinical Coding Error Rate

The Payment by Results external clinical coding audit shows the trust has a 1.2% error rate of patient spells that where audited that affected payment, the previous year was 2.0%.

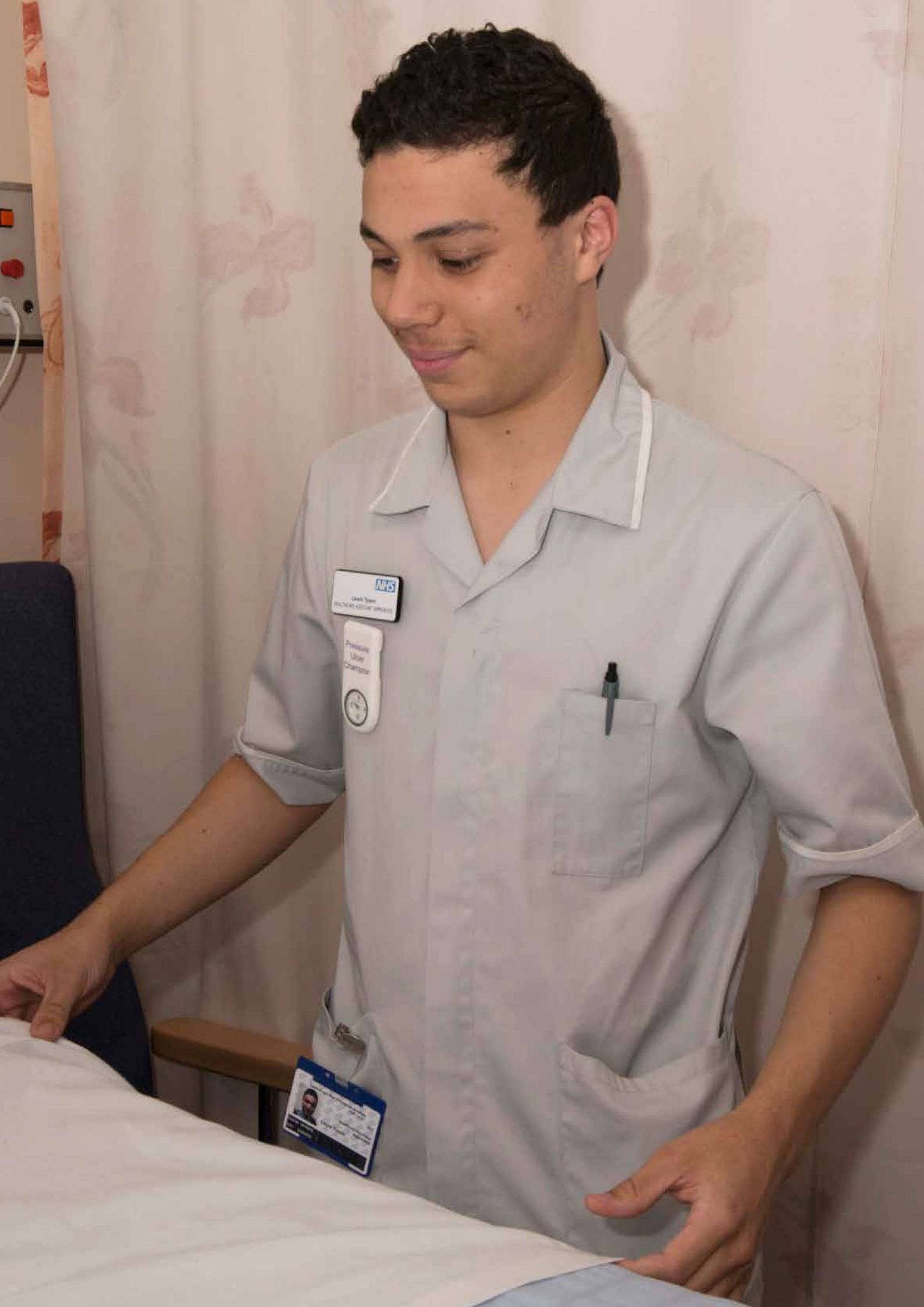
The overall error rate is 5.9% for clinical coding in general with 2.0% for primary diagnosis coding and 13.3% for primary procedure coding.

Information Governance Toolkit (IGT) Attainment Levels

The Trust is compliant across the Information Governance Toolkit requirements for 2013/14.

We successfully achieved 74%, which is a "Satisfactory" (GREEN) level, according to the HSCIC IG Toolkit grading scheme and a minimum Level 2 achieved for all requirements.

Over the coming year, the Trust will build upon its current performance and further strengthen its position, aiming towards Level 3 compliance.


NHS
Pressure
Ulcer
Champion

03

Part 3: Review of Quality Performance 2013/14

3.1 Peer Group comparisons

We strongly believe in comparisons to Trusts of similar size and type as ours to ensure we perform to our best ability, along with striving to perform alongside the best performing Trusts. This is used as a benchmark throughout our performance targets.

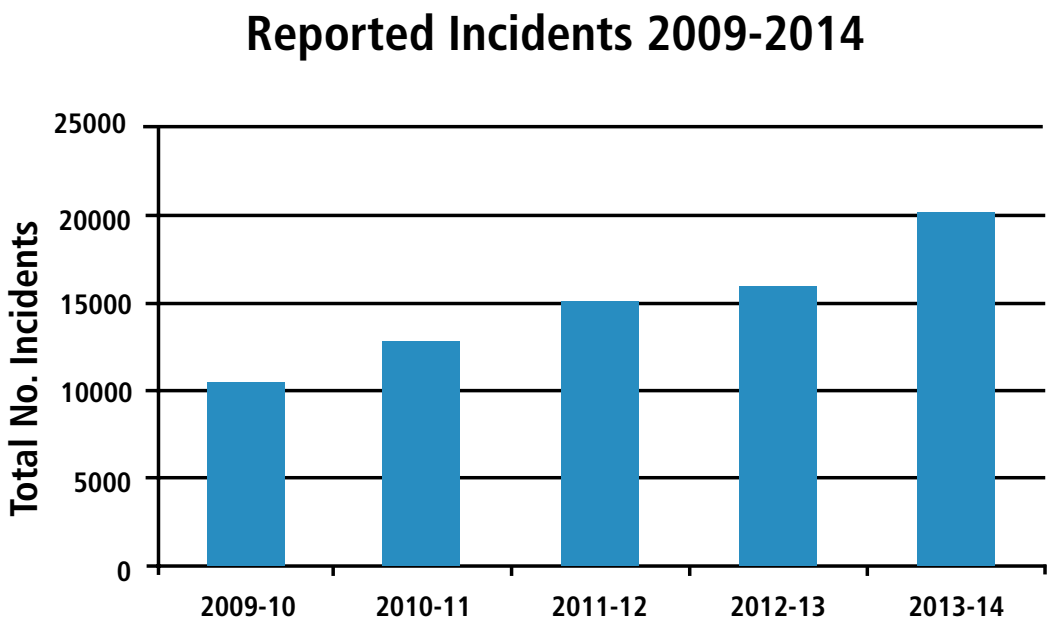
Identifying our peer group was completed by the Performance team who identified a mix of Foundation Trusts, non-Foundation Trusts, Local and Inner City Trusts with a geographical spread in which there are similar levels of activity, and which access to data to Key Performance Indicators (KPIs) could be identified. These are:

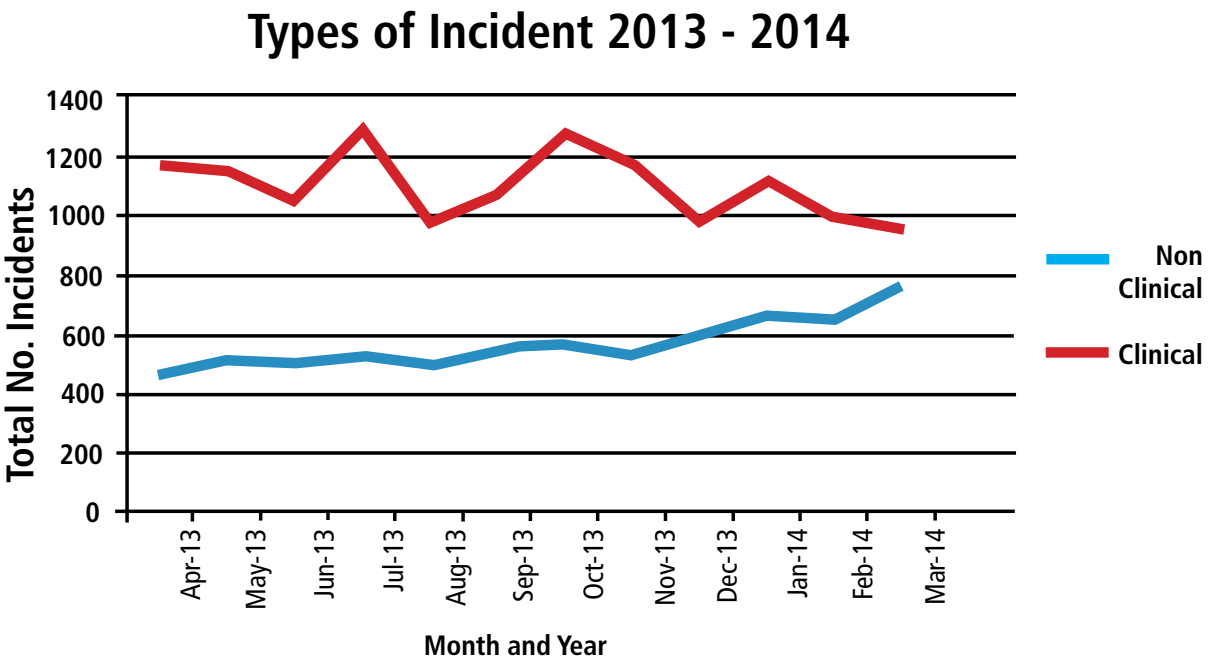
- Bradford Teaching NHS Foundation Trust (BTH)
- Kings College Hospital NHS Foundation Trust (KCH)
- Royal Liverpool & Broadgreen University NHS Foundation Trust (RLBUH)
- The Royal Wolverhampton NHS Trust (RWH)
- University Hospital Bristol NHS Foundation Trust (UH Bristol)
- Worcestershire Acute Hospital NHS Foundation Trust (Worcs Acute)
- Northumbria Healthcare NHS Foundation Trust.

Throughout part 3 of this document we have compared ourselves with our peer group in as many areas as possible. These tables show our six peers and the top achieving against which we benchmark.

Safety culture or climate remains essential for the delivery of high quality care. The Trust continues to submit its incident data to the National Reporting & Learning System (NRLS) which provides comparative data with like sized Trusts. The comparative data shows that as at the September 2013 report, we remain in the highest 25% of Trusts with a reporting rate of 6.7 per 100 admissions.

To further promote patient safety, a Patient Safety Summit was held in February 2014. The focus of the summit was to launch the use of MaPSaF, (The Manchester Patient Safety Framework). Those who attended used the tool to define where they thought both the organisation and their team were on the safety maturity matrix. The Trust Board underwent a similar exercise in March 2014. Our Clinical Teams have been asked to undertake "culture checks" within their areas of responsibility.





Incidents are generally categorised into clinical (patient safety) and non clinical and then further categorised dependent upon their causative factor.

The chart above shows the data for the main types of incidents throughout the year, month on month.

Serious incidents continue to be reported to the CCG and investigations for these are facilitated by the corporate Risk team. Those incidents designated as 'amber' are investigated at clinical group or corporate directorate level.

The number of serious incidents reported in 2013/14 is shown in the following table. This does not include pressure sores, fractures or serious injuries resulting from falls, ward closures, some infection control issues or health and safety incidents.

Month 2013/14	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
No. serious incidents reported	9	3	4	6	4	3	3	3	7	3	1	2

Never Events

Unfortunately, last year we reported five never events, including one never event that occurred in the year before but was reported late. A never event is a serious, untoward incident that has either caused or has the potential to cause serious harm that should never happen if the proper procedures are carried out to prevent them from happening. There is a list published by NHS England of 26 possible never events which include incidents such as 'Wrong Site Surgery', 'Retained Instruments or Swabs' and 'Wrong Implant'. The following table gives an overview of the never events that we reported with the key actions and learning points from each:

Incident	What Happened	Where it happened	What we learned
Wrong Site Surgery December 2012 (reported July 2013)	A patient received an operation on their wrist instead of their elbow. This error was only detected when the patient returned for their outpatient follow up appointment	Plastic surgery service at Sandwell Hospital	The process for obtaining consent from patients should start in clinic at the time of decision to operate. In this case, consent was obtained on the day of surgery and a failure to check the notes resulted in the wrong operation being done
Wrong Implant June 2013	A patient having an intraocular lens implant for the treatment of cataract received the wrong strength lens	Operating theatres in the Birmingham Midland Eye Centre	Strengthening of the final step of the implant checking procedure. A change and reinforcement of the theatre visitor policy
Wrong Implant November 2013	During a total hip replacement operation, the wrong size femoral head implant was selected for the acetabular cup size that had been implanted	Orthopaedic theatres Sandwell Hospital	A rationalisation and reorganisation of implants available in orthopaedic theatres. Reinforcement of the responsibility of the consultant in charge of the operation. A written implant selection procedure

Wrong Site Surgery November 2013	A patient received the wrong laser procedure to their eye due to an error in identifying the patient	Outpatients department Birmingham Midland Eye Centre	A Trust wide learning alert on positive identification of patients in all settings. A review of never event risks in outpatient procedure areas
Wrong Implant January 2014	A patient received the wrong strength intra-ocular lens due to a same name error resulting in the wrong electronic record being accessed	Theatres Birmingham Midland Eye centre	Operating in BMEC was suspended for three days whilst an investigation was undertaken. Reinforcement of the importance of team brief for catching unforeseen changes to the operating list. Locking down of operating lists 24 hours before. Video reflexivity exercise to reinforce safety behaviours. Identification of risks of partial EPR implementation

Following this final never event, we launched a major safety review of operating theatres across the Trust. We invited in external reviewers from the NHSLA to examine in detail our safety procedures, policies and culture. The recommendations from this review have been turned into a comprehensive plan of action for this year. This includes:

- Strengthening of our WHO Checklist steering group to look at all potential never events and gain assurance on control measures to prevent them
- A programme of safety culture assessment using the MaPSAF tool
- A review and update of policies and procedures in theatres
- Incorporation of never events assurance audit as a CQUIN.

We will report back our progress in all these areas in next year's Quality Account.

Clinical Negligence Scheme for Trusts

The Clinical Negligence Scheme for Trusts is the maternity risk management standards of the NHSLA (NHS Litigation Authority) which utilises data from clinical claims to set standards. Following on from their successful Level 2 assessment in February 2013, the Maternity service was assessed at Level 3 in February 2014. They were successful in attaining Level 3.

This shows that as well as having the systems and processes in place to protect patients from harm, they can show this across all aspects of their service and consistently throughout the year.

Complaints

The Trust remains committed to providing timely and proportionate responses to formal complaints which it receives about its services. Complaints provide us with information about how patients and their families have felt about their experience, giving us information which we can use to improve. Equally compliments let us know what people have found has been good.

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

Category Type	2010-11	2011-12	2012-13	2013-14
All Aspects Of Clinical Treatment	553	573	578	406
Attitude Of Staff	161	127	142	115
Appointment Delay/cancellation outpatient appointment	126	84	94	45
Appointments Delay/cancelled in-patient	26	28	33	16
Communication/Information To Patient	92	55	66	53
Admissions/discharges, Transfers	44	42	59	21
Transport Services	12	17	7	6
Totals	**1014**	**926**	**979**	**856**

Complaints Handling process

In November 2013, the system for complaint handling changed to a largely devolved model. Complaint co-ordinators now assist staff within our services to address the complaints themselves and make any necessary amendments to services directly.

We have also set ourselves a target of 30 working days to resolve complaints and early indications are that complainants are being responded to in a more timely manner. However, there is further work to do to ensure we can meet these requirements consistently.

As part of the renewed process for handling complaints, we are offering more meetings to try and resolve issues directly. These meetings are recorded so that no delays occur in transcribing and the complainant receives an accurate record of the conversation.

Date	Average rate of reporting per 100 admissions	Best reporter/ 100 admissions	Worst reporter/ 100 admissions	Number of incidents resulting in severe harm	Percentage of incidents resulting in severe harm	Number of incidents resulting in death	Percentage of incidents resulting in death
2011/12	6.29	9.82	2.34	86	1.15	14	0.2
2012/13	9.58	12.65	2.49	32	0.32	19	0.15
2013/14*	10.59	11.06	3.85	6	0.1	10	0.2

The Trust submits data to the National Reporting and Learning system which is nationally and publicly available. The latest data (April - September 2013) shows the Trust has improved its position in the rate of reporting, resulting in it remaining within the top 25% of large acute Trusts. The data shows an improving position for incidents which result in severe harm but a fairly static picture for those which result in death. The table shows the Trusts position per 100 admissions as compared with the best and worst reporters and the previous financial year's position on reporting of degree of harm.

Children's Safeguarding

13/14 was a particularly challenging year with recruitment of new team members, change in leadership , local Ofsted reviews and the development of new models of working with our partner agencies. The latter part of 2013/14 saw the development of Multi Agency Safeguarding Hubs (MASH) in the Sandwell side of our community, where key agencies (health, police, social services) meet together. The aim being that organisations work closely to identify the level of potential risk to the child and put actions/support in place to reduce the risk and protect the child. Other areas of priority this year have been staff training -99% of all staff (7,500) have received Children's Safeguarding information leaflets , 68% of staff identified have received face to face training regarding recognising and referring concerns regarding potential child abuse and 84% of staff identified (community children's services, A&E nurses and doctors, health visitors etc) have received higher level training regarding children's safeguarding. We have employed four more team members to meet the demands of growing pressures and this includes a nurse to support victims of domestic abuse. We have set key targets to increase the number of Health Visitors who receive supervision regarding their role in child protection cases and we aim to undertake some analysis of key themes and gain feedback from children and families involved in this process. This will influence how we shape our service in the future to protect children.

PATIENT SCENARIO

Following assessment in baby clinic, concerns were raised regarding a child's development and Mum's ability to provide essential care. This concern was discussed with the Safeguarding Team which prompted a multi-disciplinary meeting (with social workers, doctor etc). This resulted in a plan of care being developed which directed ward staff to observe Mum's interaction with the child. Reports from ward staff, health visitors, doctors and social workers resulted in the recommendation of the transfer of main carer role to Dad, who was supported by the social worker and discharge planner to make arrangements for discharge.

This illustrates how a concern is identified, referred on, investigated and results in a plan of care (multi professional) which supports the family and protects the child. It illustrates that training and policies support front line staff to protect children.

Adult's Safeguarding

The Safeguarding Vulnerable Adults Team supports staff in the organisation to protection the most vulnerable and frail in our society. Some of this work consists of identifying when a vulnerable adult may be at risk and reducing that risk by putting nationally defined actions in place. We aim to increase harm free care from 2013/14 to 94%(falls, pressure damage) . In 2013/14 the team received 727 referrals where staff needed advice/support or where harm needed to be investigated. Investigations illustrate the need for continual staff training.

Staff are trained according to their role/grade. 99% of our 7,500 staff received leaflets outlining forms of harm/abuse and who to contact for support . 65% of senior staff (nurses, doctors etc) received classroom training on actions to take to protect patients and investigate harm incidents.

We undertake audits to review how we support vulnerable patients who may not be able to make decisions unaided (mental capacity) and these illustrate more patients/families are being involved in some difficult /complex decisions. There is still work to do.

We have undertaken a major project to improve the environment for patients with dementia and their carers following a successful bid to the DoH – bathrooms have been up-graded, rooms decorated, furniture purchased, conservatory built, lighting improved etc. We have invested money in University training for staff and employed activity co-ordinators to provide patients with dementia therapeutic activity. Next year we will be evaluating whether these improvements have had a positive effect on the experience of patients with dementia (length of stay, carers survey).

Safeguarding Vulnerable Adults Training continues as planned throughout 2013/14. The Trust continues to raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards and all staff received leaflets attached to their wage slip in 2013. The Trust continues to work with the police on training for staff regarding vulnerable people who may be converted to terrorism.

The Learning Disability Liaison Nurse continues to work across the Trust with patients from Sandwell. This has seen a reduction in complaints and improved care for patients especially at the end of life. The Trust has a comprehensive plan to improve the care of patients with dementia which has seen a number of changes to ward environments. The Trust has employed three activity coordinators to work with patients with dementia, ensuring they remain active and involved in their care during their hospital stay.

PATIENT SCENARIO

A lady was admitted who had a moderate learning disability who had a left sided weakness, and was diagnosed with a stroke. The left sided weakness improved but her swallow remained affected and she had a feeding tube fitted. The lady was diagnosed with pneumonia whilst a patient. Multi-disciplinary team discussions were held around end of life care including support from her psychiatrist and the home manager and an advocate service due to the lady having no friends or family to help doctors make decisions. Decisions included if the patient should be resuscitated and if a chest drain to remove fluid from her lungs should be considered. It was agreed that if this procedure would be considered for patients without a learning disability, then the procedure should be considered for this lady. This procedure was then completed and with a course of antibiotics her condition improved and she was discharged back to the home where she had lived for a number of years. Community Services were put in place to support her discharge.

Safety Thermometer

This tool, which was introduced by the Department of Health, enhances the understanding of harm free care experience by our patients in four specific areas:

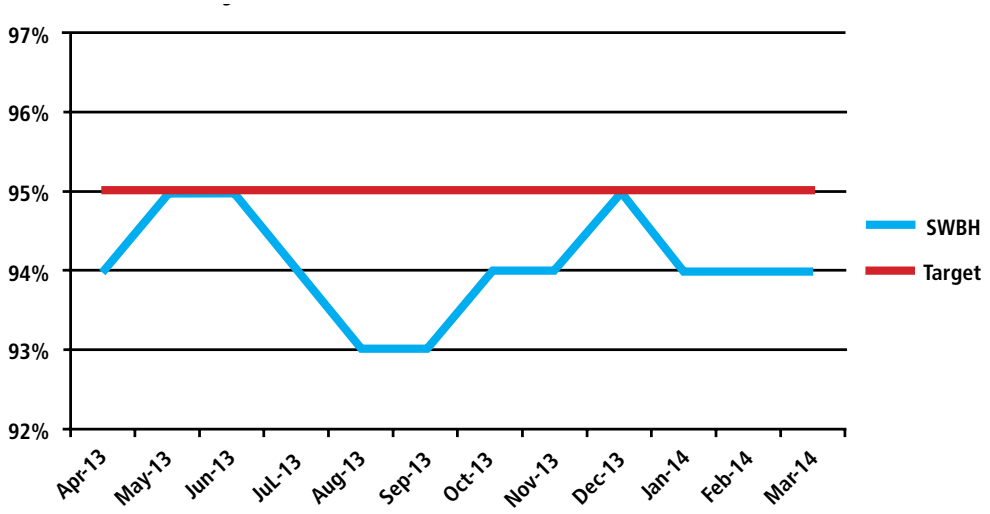
1. Pressure Ulcers
2. Falls
3. Catheter-associated Urinary Tract Infections
4. VTE

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.

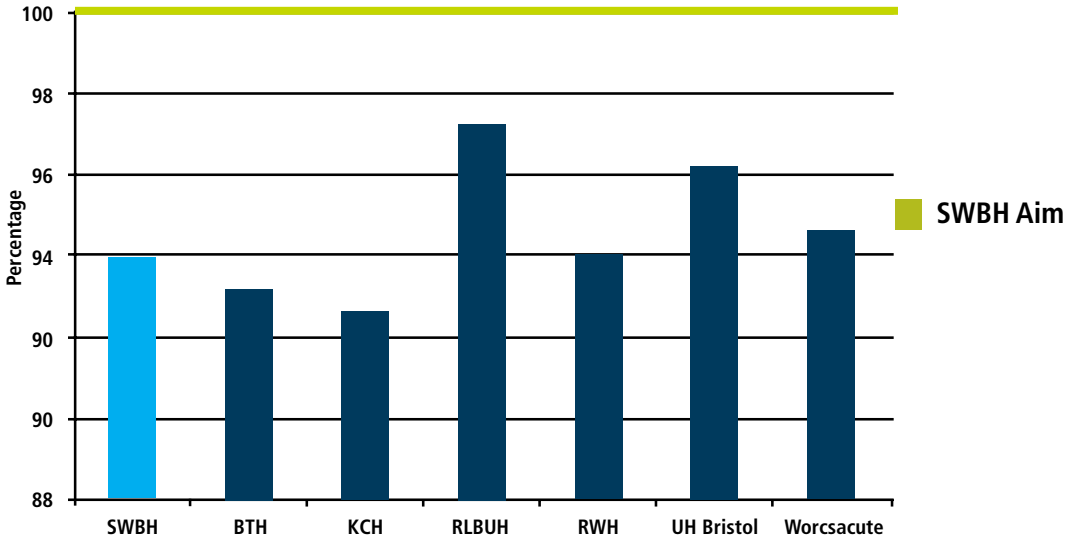
The Safety Thermometer audit is completed Trust-wide including Community Services on a pre-prescribed day, once a month. The data is then submitted to the NHS Information Centre which is then published nationally.

The monthly whole Trust audit of patients for three harm free events has been accepted very positively with good engagement of nursing staff.

The Trust harm-free percentage for 2013-/2014 dipped mid-year, but it has improved to 94% which is just below the target.



How we compare with our peers: Safety Thermometer - Overal Harm Free Care Feb-14

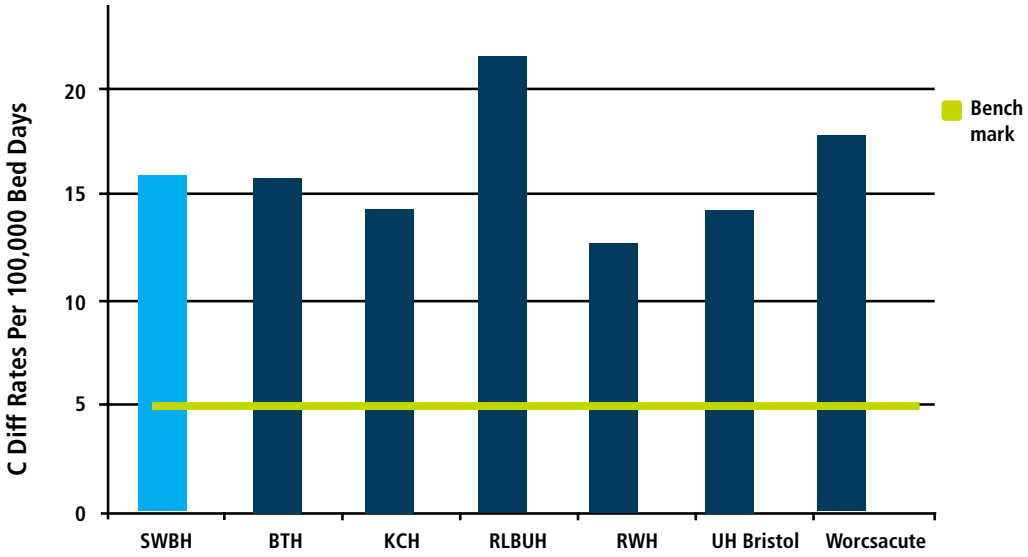


Infection Prevention and Control

C. Difficile (C. Diff) Incidences

In 2013/14 we have been very successful in keeping well below the number of occurrences agreed by the Department of Health, with only 39 occurrences of C. Diff. against a trajectory of 46 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.



Element	Performance and Action
C Diff.	39 cases for the year against a target of no more than 46 cases.
MRSA blood stream infections	2 cases for the year against a zero tolerance target.
MRSA Screening	Elective - 78% against target of 80%. Non Elective - 78% against target of 80%.
Antibiotic Stewardship Programme	Improved access to antibiotics guidelines ('Microguide' application accessible on mobile phone devices). Achievements this year include allergy status above 97% and prescribing compliance above 90%. Redesign of hospital drug-charts in progress to improve documentation targets.

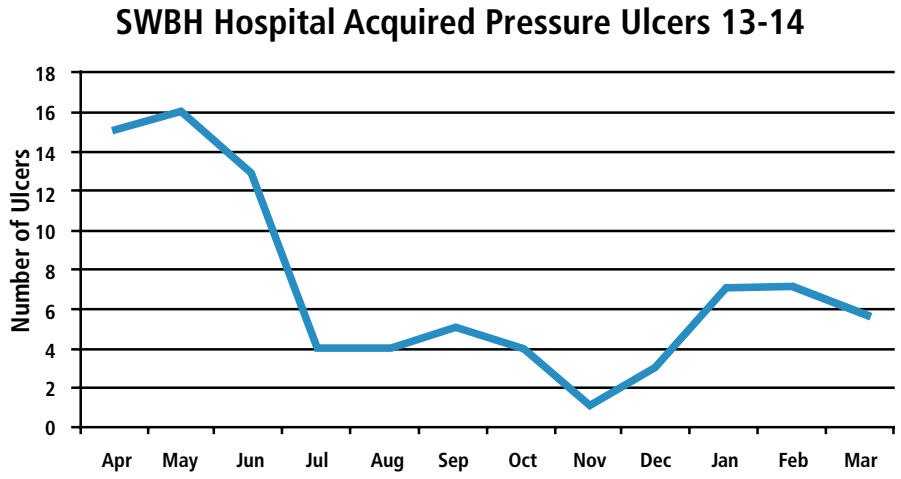
Pressure Damage

Reducing avoidable pressure ulcers

Following the implementation of a focussed pressure ulcer reduction campaign, the incidence of avoidable hospital acquired pressure ulcer has been reduced by 54% during the last twelve months. Many of our wards have achieved sustained elimination of pressure ulcers with the highest celebrating 600 days pressure ulcer free.

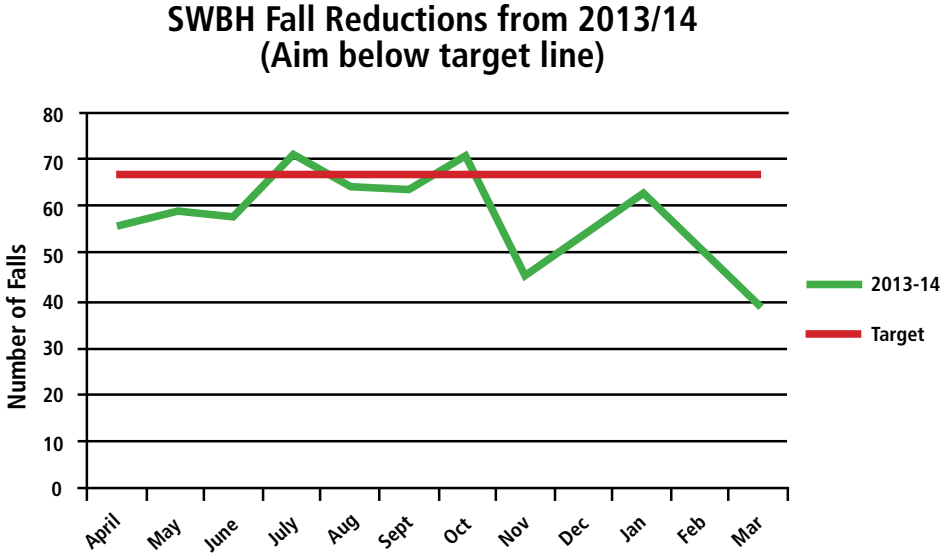
All severe pressure damage is reviewed to identify the cause and implement local actions reflecting the lessons learnt.

Following the success in reducing pressure ulcer incidences within the Hospital setting, the focus of the pressure ulcer reduction campaign will now be placed on reducing incidences within Sandwell Community and patients under the care of our District Nursing teams.



Patient Falls

We continued to reduce the overall number of falls in 2012/13 by over 10%, however there has been an increase in the number of falls resulting in harm to our patients (for example a hip fracture /head injury) from 17 in 2012/13 to 30 in 2013/14 . We investigate and review each one of these serious incidents and determine whether different actions could have reduced the risk of the fall happening. Out of the 27 reviewed to date, it was determined that in 13 incidents the organisation believes we could have reduced the risk of the patient falling. For example, we have determined that on some occasions the patient required a higher level of supervision by nursing staff or that greater accuracy of transferring information from one department to another was required. We continue to invest in equipment and training – all staff receive prevention of falls on induction and annual mandatory training. A new initiative recommended nationally - Fallsafe - will be implemented this year to co-ordinate the best practice in reducing the risk of falls - this includes a detailed review of medication and the use of specific care bundles (plans of care).



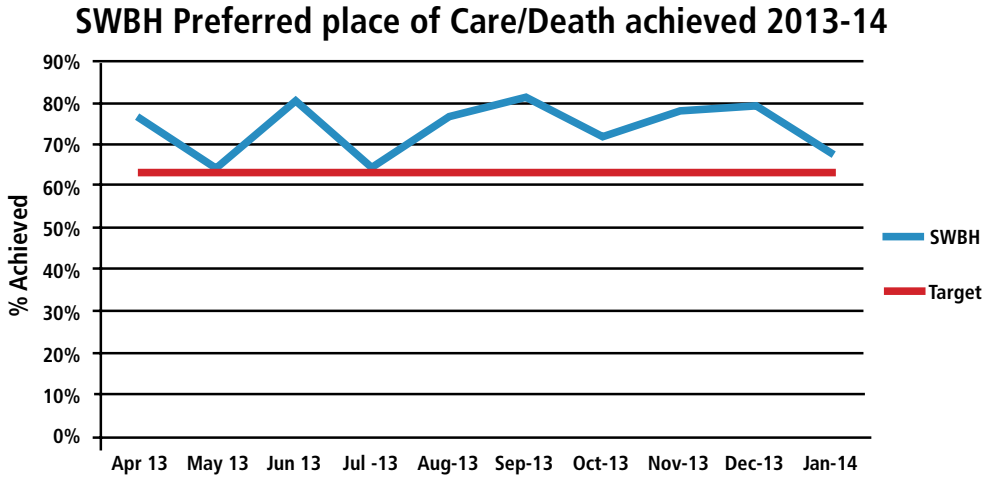
Dementia

2013/14 has seen many developments to improve the care of patients with dementia and their relatives. The organisation was successful in bidding for funding from the Department of Health to 'enhance the healing environment' and this had led to structural and visual improvements in wards to support the care of patients with dementia. We screen patients to determine risk of dementia which may lead the patient to undergo a further assessment. We have supported the training of staff at University to increase knowledge of the signs and symptoms, treatment and care of patients with dementia and the needs of their carers. We have recently employed three staff to provide activities and therapy to this group of patients. The above strategies aim to improve patient and carer experience and reduce harm to patients.

Palliative and End of Life Care

We said we would increase, by a further 10%, the number of patients known to the specialist palliative care team achieving their preferred place of care/death in both the acute hospitals and the community. This means that patients and their families have been involved in discussions about their condition and have talked about what is important to them including where they want to be cared for and where they want to die.

The 63% target has been exceeded every month since April 2013 with an overall achievement of 74%.



The specialist palliative care service has been developing over the past few years and is now delivering a seven day visiting service and advice out of hours in both the acute hospitals and the community. This service focuses on ensuring that people who have an advanced life limiting illness are supported to improve or maintain their quality of life.

Just a note to say thank you for all you did for my Dad through such a difficult, painful period at the end of his life. You got to know he was a proud, independent man but he trusted you completely and took real comfort and reassurance from your kind, practical care. Personally, I would also like to say just how much your professionalism, combined with genuine compassion helped me care for Dad and grant his final wish to be at home.

I would like to take this opportunity to thank you for the support and compassion which your team afforded my late husband and I. Throughout the last days of his life, the care was exemplary. I thank you for your openness when conveying difficult information regarding my husband's health. Your professionalism and respect will never be forgotten.

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 in-patient and outpatient surveys, and a Trust-generated internal in-patient survey. The internal survey generates around 1'000 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 help us care for our patients, carers and relatives better. We are seeing more and more evidence that our patients are having a positive experience, resulting in patients feeling better sooner, and 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 their 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.

2013/14 was the first full year of the Patient Experience Strategy in use. All staff have welcomed the strategy, allowing all patients to fully benefit from improved care and services as a result.

Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to NHS patients from the patient perspective. Currently these cover four clinical procedures where the health gains following surgical treatment is measured using pre- and post-operative surveys. The Health & Social Care Information Centre publish PROMs national-level headline data every month with additional organisation-level data made available each quarter. Data is provisional until a final annual publication is released each year.

The tables below show the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared with the average for England.

Percentage reporting improvement

	Health Status Questionnaire Percentage improving			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	SWBH	National	SWBH
Hernia repairs	51.0%	40.2%	50.2 %	50.0%
Hip replacement	87,5%	88.4%	89.7%	88.2%
Knee replacement	78.8%	71.8%	80.7%	72.7%
Varicose vein surgery	53.6%	61.0%	52.7%	43.8%

Average adjusted heath gain

	Health Status Questionnaire Average adjusted health gain			
	Finalised data for April 11 – March 12 (Published October 13)		Provisional data for April 12- March 13 (Published February 14)	
	National	**SWBH**	**National**	**SWBH**
Hernia repairs	**0.087**	**0.047**	**0.085**	**0.088**
Hip replacement	**0.416**	**0.405**	**0.438**	**0.369**
Knee replacement	**0.302**	**0.247**	**0.319**	**0.271**
Varicose vein surgery	**0.095**	**0.100**	**0.093**	**0.053**

	SWBH below England average
	SWBH above England average

The finalised data for 2011/12 and the provisional data for 2012/13 show that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken the following action:

	Action taken
Hernia repairs	Work to ensure 80% of questionnaires are handed out. All patients seen and listed have been audited to ensure: Patients' cases are symptomatic and have copies of letters, consented appropriately and all risks and benefits explained. Introduction of Hernia clinic has been piloted and gradual roll-out will commence from Feb 2014.
Hip & knee replacement	Our streamline questionnaires hand out process ensures >80% uptake. A joint club is in place and has information leaflets given out. Discussion with patients so they are fully aware of the risk and benefit as good outcome. Audit of listing of cases to ensure we meet criteria consistently for replacement and meet the current CCG guidance. We offer our patients a contact point after discharge if there are any problems and a six month follow up and review of performance after surgery.
Varicose vein surgery	Most varicose veins are now presented to us by treated radiofrequency ablation. Questionnaires are given on the day they are seen. Current wait times mean many of these are invalid and the process has to be repeated. Work is being undertaken to reduce wait time to ensure consistency. All patients have a discussion with a consultant regarding risk and benefits.

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. This is now one of our key objectives in our Public Health Plan.

WHO Surgical Safety Checklist

During the year, we have continued to have regular WHO checklist committee meetings to monitor compliance with the checklist. Monthly compliance of completion of all five components of the checklist in all areas is monitored.

There remains a high standard of completion in all areas, with debrief being marginally lower than other sections.

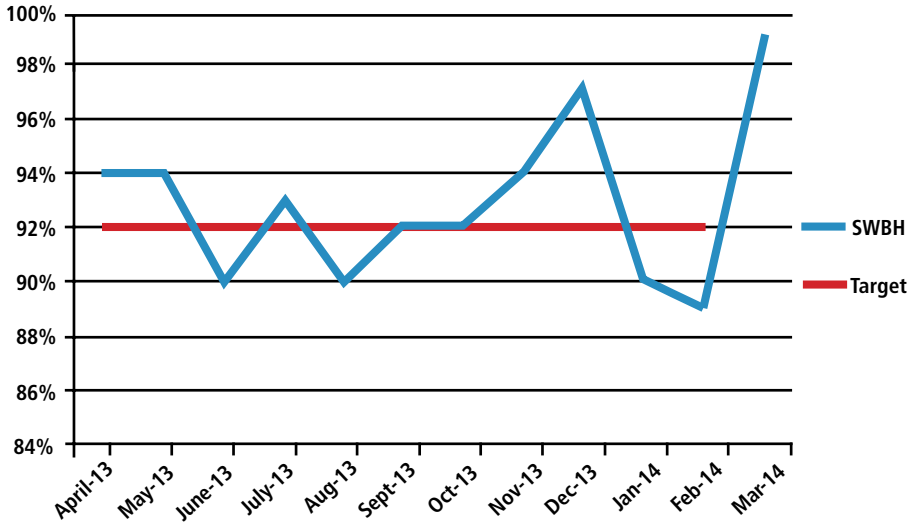
There are intermittent notes-based audit cross checks against this data to ensure recording accuracy.

We have focused on quality of completion, ensuring it does not become a tick box exercise, with regular qualitative reviews by observers of the checklist process. Instant feedback is given to teams at intervals.

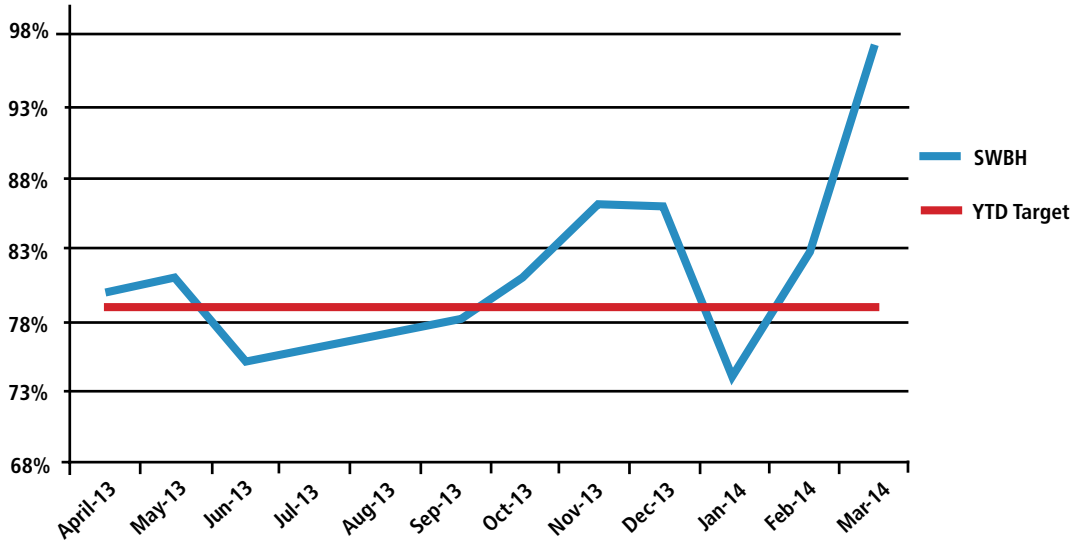
We have approved several updated versions of the checklist for specific areas, following on from review of incidents or locally differing requirements.

In February, we introduced a compulsory check on ORMIS (operating theatre computer system) to highlight the completion of three areas of the checklist. This will make the collection/entering of audit data less onerous for staff. However, during the changeover period there will be difficulty in data collection as the team brief/debrief components are recorded separately per list, leading to some short term data inaccuracy.

WHO Checklist Safer Audit - 3 Sections and Brief 2013-14



WHO Checklist Safer Surgery Audit - 3 sections, Brief and Debrief 2013-14



Staff Engagement

In September 2013 we introduced 'Your Voice'. This is an online staff survey which is sent out via NHS mail accounts to a third of our staff every month, so that every three months we get results back for the whole Trust. The survey uses the same nine questions which are used in the national NHS Staff Survey to measure levels of staff engagement. This gives us a staff engagement score for each group, team and directorate in the Trust. The overall response rate to date is 21%, which is good for an online survey. The survey also uses five free text questions:

- What top two things could we introduce or improve to make you more positive about working at the Trust?
- What are the two most significant things that you would like to pursue within your area of work to make your service even better for patients?
- How do you feel about working for the Trust?
- Do you know the Your Voice results for your area of work?
- Are you aware of any changes that have happened as a result of Your Voice?

These questions enable local management teams to respond on a 'You said, we did' basis and for us to be able to monitor our progress. To date, each area of the Trust has completed the survey twice and we have seen that where teams have responded positively to the issues raised by staff, their engagement score has improved considerably. Our pioneering approach to staff engagement 'Listening into Action' continues to be widely used and is now being used to help address issues raised through the Your Voice survey. Our overall score for staff engagement, as determined by the NHS staff survey, improved in 2013 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 which include specific targets against which all Groups/Directorates are performance managed.

Staff Turnover

Employee turnover rate has averaged 11% over the year 2013/14. This level of turnover is slightly higher than is considered ideal but will, in part, be a result of our on-going workforce transformation programme and the age profile of our workforce. We are closely monitoring turnover at Group/Directorate and staff group level and focusing on improving our retention rates in specific areas. Our approach to retention includes improved leadership skills, employee engagement and personal/professional development to ensure we are creating an environment whereby our employees are motivated, engaged and empowered to maximise their potential.

Appraisal

We are committed to ensuring that all of our employees receive an annual appraisal. It is anticipated that our compliance rate will be close to 100% by the end of the 2013/14 financial year. The plan moving forward will be to build on that platform and improve the quality of the appraisals undertaken. We take close note of the feedback from our national staff survey results which currently confirm that of those who were appraised, 60% said it had helped them to improve how they did their job; 83% said it had helped them agree clear objectives for their work; and 66% said their appraisal left them feeling that their work was valued by their organisation.

Sickness Absence

Our sickness absence rate is currently above the Trust's target with the current year to date figure at 4.33%. Our approach to reducing sickness absence is integrated within our newly developed Public Health Plan as set out below:

Current position:

- There is a high level of musculoskeletal and mental health issues among the long term sick in particular
- In 2013 the Trust's sickness absence rates are still over 4%
- There is significant sickness associated with Trust investigatory and disciplinary procedures
- There is no mental health training regularly available to managers when undergoing an investigation
- Health and Wellbeing training will be mandatory for employees.

Aim by 2017:

- We will have no higher than 3% sickness absence (2% long term and 1% short term)
- We will have a rate of work related illness that has fallen year on year
- Will have mental health training within the Trust for managers
- We will have developed a range of short interventions to support particular groups of employees at difficult times – e.g. when undergoing an investigation
- Health and Wellbeing training will be mandatory for employees.

Recruitment – Time to Fill Posts

The time it takes the Trust to replace vacant posts (thereby ensuring we maintain a full establishment and reduce our reliance on temporary staffing) is critical in supporting the organisation to provide a high quality and effective service.

We now routinely report our 'time to fill', identifying the time it takes to fill a vacancy from the point an existing employee tenders their notice to the date of commencement of the new employee. Our aim is to achieve an average 'time to fill' of 14 weeks. Our current median 'time to fill' is 15.8 weeks. We currently have some Groups that are already achieving this, and are working closely with all our recruiting managers to implement improvements where necessary.

3.7 What others think of our Quality Account

We invited our commissioners, the Overview and Scrutiny Committees in both Sandwell and Birmingham and Healthwatch groups in Birmingham to tell us what they thought of our Quality Account.

On behalf of the Cross City CCG, the Black Bountry CCG commented:

- Much of the data in the review sections is well presented; supporting the assertions and claims made in the introduction
- It is interesting that the achievements section is not balanced by a review of shortfalls! This is supposed to be a Quality Account and not a 'management report' and it should present objective findings with a balanced commentary – ***amended by Trust following feedback***
- The Introduction would be better if the achievements were set against targets and previous year information.
- Report is incomplete. A number of important sections are missing including the Chairman's Statement – ***this was reviewed when in progress, Trust has completed report following feedback***
- Many important actions are identified but there is no confirmation that they have been completed or when they will be completed
- Many Audit Actions are described as intents with general goals rather than objectives or targets
- Overall, fair and balanced in content
- Very good use of patient stories, and report statements from visits
- Good explanations of outcomes to CQUINs and priorities specific to patients
- Would expect the Quality Account to have visual aids/pictures to make account easy reading - ***the Trust has inserted visual aids following completion of the report.***

Message sent on behalf of Cllr Susan Barnett, Chair Birmingham Health and Social Care Overview & Scrutiny Committee

The Birmingham Health & Social Care Overview & Scrutiny Committee ("the HOSC") recognises that healthcare providers publishing Quality Accounts have a legal duty to send their Quality Accounts to the HOSC in the local authority where the provider has its registered office, giving the HOSC an opportunity to comment on the Quality Accounts before publication.

The members of the Birmingham HOSC wrote to the Secretary of State for Health in May 2013 and again in November 2013 raising a number of practical issues including the number of Quality Accounts and volume of information, timing of receipt, time constraints within committee meetings, the degree of knowledge and expertise required to make informed comments, the fact that the Quality Accounts are reviewed by both internal and external auditors and the Clinical Commissioning Groups, all of which impact on the ability and capacity of the HOSC to provide a statement on Quality Accounts.

On Wednesday 30th April 2014 there will be an opportunity for Healthcare Provider Trusts to update the HOSC members about their response to the Francis Report, many of which actions will impact on quality and may be reflected in aspects of the Quality Accounts.

However, in the interests of avoiding any potential conflicts of interest and of not fettering its discretion to scrutinise matters which may arise in the course of the year, the Birmingham HOSC will not be supplying an audit statement on the 2013/14 draft Quality Accounts. The HOSC is circulating this statement so as not to hold up publication of the accounts.

Healthwatch Group Birmingham

Healthwatch Birmingham recognise that Quality Accounts are a useful contribution to ensuring NHS providers are accountable to patients and the wider public about the quality of the services they provide. Below are some of the comments provided in their report.

- The openness in reflecting on areas for improving performance alongside success is appreciated, and has helped us focus our comments
- The summary of actions completed against the five focus areas for prioritisation is positive
- We are pleased to see the focus on reducing emergency readmissions. The importance of integrating discharge with community support has been recognised
- The commitment to improving patient experience is welcome, including the recognition of the experiences of relatives, carers, friends and visitors being part of the patient experience. Healthwatch Birmingham is keen to work with the Trust to provide independently-gathered patient experience
- We are pleased to see the focus on the 'year of outpatients' and the ambition to have at least 98% of patients having an outstanding outpatient experience.

3.8 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.grainger-lloyd@nhs.net

Or send 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.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account 2013/14

Where EVERYONE Matters

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