Sandwell and West Birmingham Hospitals NHS
NHS Trust





Quality Account 2015/16

Where EVERYONE Matters

Quality and Performance Analysis

Incorporating our Quality Account 2015/16

This section details our performance and includes our Quality Account which is our annual report to the public about the quality of our services. In this section you can find:

- How we performed in 2015/16 in the eyes of our patients.
- How we performed for 2015/16 against our standards.
- How well we performed against external measures.
- How well we performed when compared to other Trusts.
- Our priorities for 2016/17.

Jasbir Hayer, on Priory 3 ward at Sandwell Hospital.

William Ricketts, Community Respiratory patient.

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

Signature

Richard Samuda

Chairman

Signature

Toby Lewis

Chief Executive

How we measure quality

We review our performance against external frameworks (primarily the NHS TDA Accountability framework 2015/16, CQC and the Well-led Framework) as well as internal targets on a broad range of indicators published in our Integrated Quality & Performance Report (IPR). The IPR is published monthly to a number of senior committees as well as the Trust Board. Performance is managed through our Groups through our group performance review programme.

Data quality improvements

We have implemented a performance indicator assessment process, the data quality kitemark which provides assurance on underlying data quality. Each indicator is assessed against seven data quality domains to provide an overall data quality assurance rating which is included in the IPR. Data Quality remained an on-going area for development during 2015/16. We have a data quality improvement plan in place to ensure that the quality of our performance information continues to improve. During the year we have improved data quality as reported in the IPR. Our audit plan is a rolling programme covering all performance and quality indicators. We are establishing a Data Quality Group whose scope will be to identify and implement data quality improvements and address data quality issues.

The Trust's SUS (Secondary Users System) data quality is benchmarked monthly against others via the HSCIC SUS Data Quality Dashboards which are used to monitor compliance with mandatory fields and commissioning sets.

During 2015/16 we provided data to secondary users for inclusion in Hospital Episode Statistics (HES) as follows:

	Percentage with valid NHS number	Percentage with valid GP practice
Inpatients	98.8%	100%
Outpatients	99.7%	100%
Emergency patients	96.7%	99.2%

Peer Group

The peer group we have used for benchmarking is a mix of Foundation Trusts, non-Foundation Trusts, local and inner City Trusts with a geographical spread and similar levels of activity to Sandwell and West Birmingham NHS Trust.

- Bradford Teaching Hospitals NHS Foundation Trust (BTH)
- Kings College Hospital NHS Foundation Trust (KCH)
- Royal Liverpool and Broadgreen University Hospitals NHS Foundation Trust (RLBUH)
- The Royal Wolverhampton Hospitals NHS Trust (RWH)
- University Hospitals Bristol NHS Foundation Trust (UHB)
- Worcester Acute Hospitals NHS Foundation Trust (WA)
- Northumbria Healthcare NHS Foundation Trust (NH)

Sandwell and West Birmingham Hospitals NHS Trust is registered with the Care Quality Commission and has no conditions attached to that registration.

Services provided / subcontracted

During 2015/16 we provided and/or subcontracted 44 NHS services. We have reviewed all the data available on the quality of the care in these services. Where we have subcontracted any activity, it would only be to a provider, who like us was registered with the CQC but has no conditions attached to that registration. Agreements between the Trust and the subcontracted providers require that the same high standards of care are given when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust. The Income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Trust.

How we performed in 2015/16: In the eyes of our patients

During the year we have actively encouraged concerns, complaints and feedback from patients and carers that has enabled us to make improvements in the care we provide.

Family and Friends Test

The Family and Friends Test (FFT) - would recommend scores give us important feedback from people who use our services. During 2015/16, the Trust expanded the FFT survey to other parts of the organisation including Outpatients, Day Surgery areas and Children's services. We use a blended methods approach comprising of electronic tablet PCs, mobile phone SMS and paper/card surveys to seek feedback from patients. This survey has helped us to identify both good and some not so good areas of our services. The Clinical Groups and Directorates use 'near real time' FFT data to make improvements in their areas. Making FFT inclusive for all and increasing response rates continues to be a challenge for the organisation.

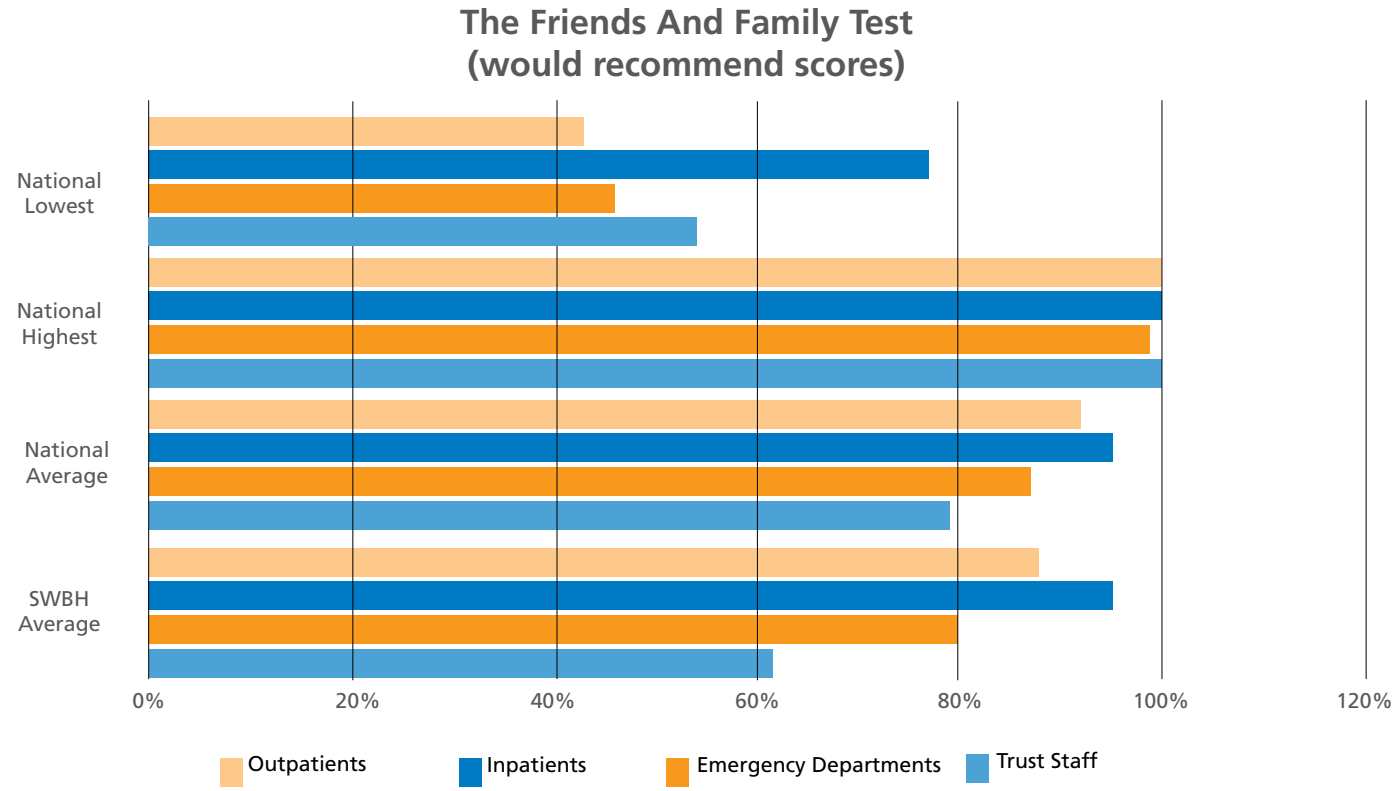
Some of the improvements that we made during the last year include the introduction of 'open visiting' to ward areas, a breakfast club for stroke rehab patients, launch of a 'snacks n papers' trolley service for ward-bound patients, a 'What makes you sad and What makes you glad' feedback board in the neonatal unit, introduction of volunteer breastfeeding helpers in the maternity unit and rolling out an innovative series of training workshops called 'Towards Service Excellence' for all patient facing staff members.

Family and Friends Test (FFT) - would recommend scores

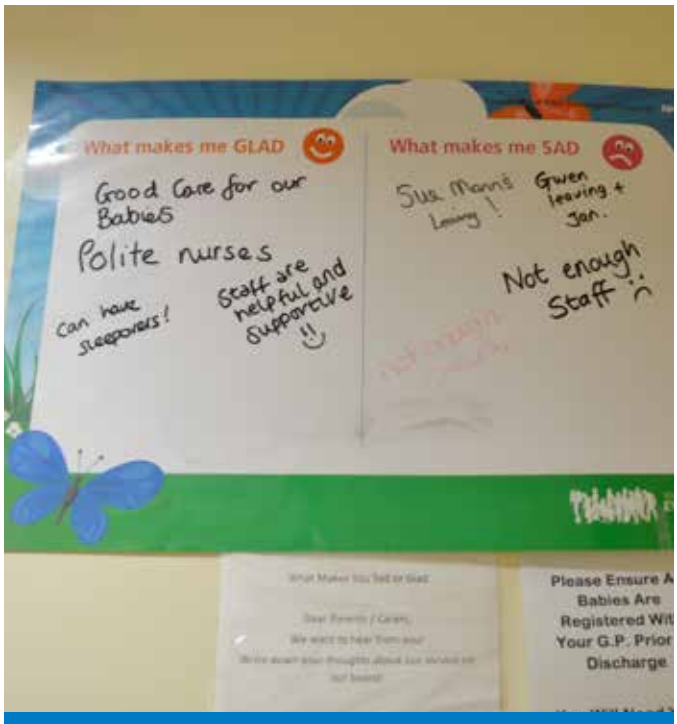
SWBH Inpatient score	National Average	National lowest	National Highest
95%	95%	77%	100%

SWBH ED score	National Average	National lowest	National Highest
80%	87%	46%	99%

ED: Emergency Departments

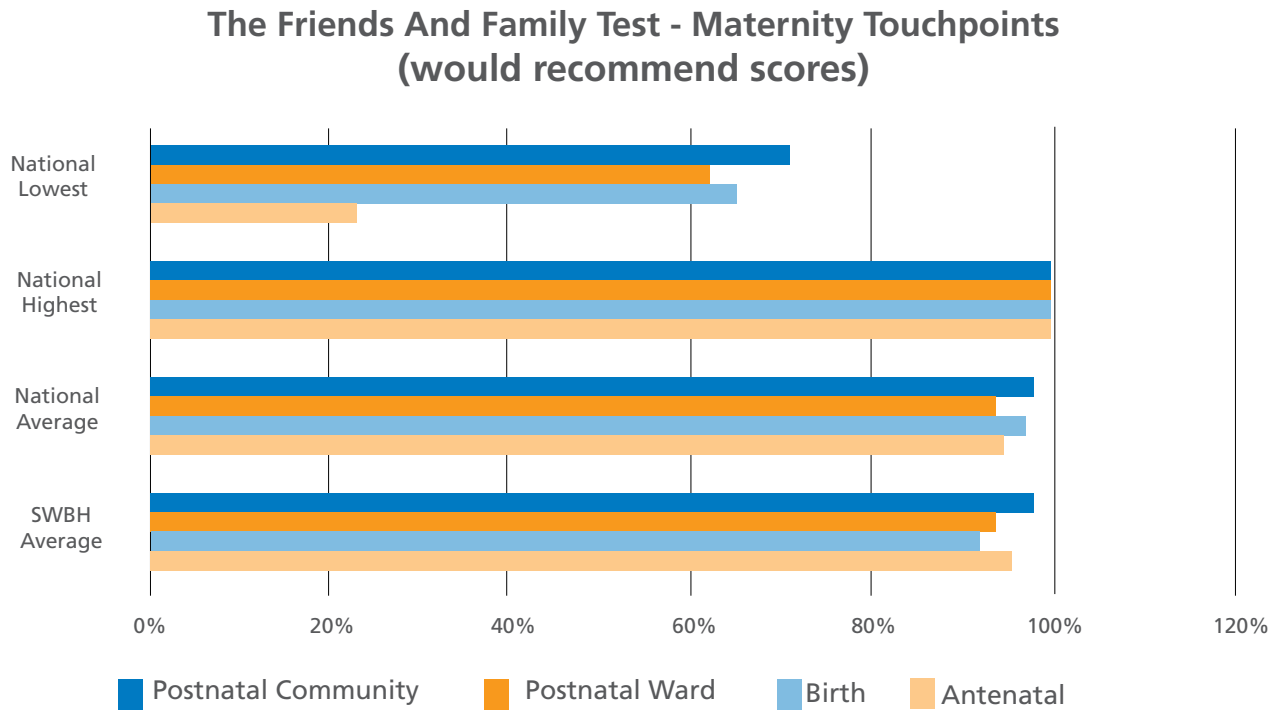


Members of Agewell, Pauline Withey and Deb Harrold launch a new trolley service at Sandwell Hospital.



The new 'what makes you sad, what makes you glad?' feedback board in our neonatal unit.

THE FRIENDS AND FAMILY TEST: MATERNITY (Would Recommend Scores)				
Areas	SWBH Average	National Average	National Highest	National Highest
Antenatal	96%	95%	100%	23%
Birth	92%	97%	100%	65%
Postnatal Ward	94%	94%	100%	62%
Postnatal Community	98%	98%	100%	71%



National Patient Surveys

The national survey programme is used to measure patient experience and perceptions across the NHS and this Trust.

We are continually striving to ensure that the quality of care provided meets expectation and we respond to the needs of service users, including the listening to patients, the need for privacy, information and involving patients in decisions about their care.

Eileen Keeble performs a 24 week scan on Habiba Sultana at Rookery Children's Centre.

Women's Experience of Maternity Services - 2015 Section Headings	SWBH 2013	SWBH 2015	Lowest Trust score achieved (National)	Highest Trust score achieved (National)
Start of care in pregnancy	*	4.9	3.6	7.3
Antenatal check-ups	*	7.0	6.0	7.9
During pregnancy	*	8.6	7.8	9.3
Labour and Birth	8.6	8.8	7.3	9.4
Staff	8.1	8.1	7.4	9.4
Care in hospital after birth	7.6	7.1	6.7	8.9
Feeding	*	8.4	7.1	8.5
Care at home after the birth	*	8.1	7.4	8.9

Scores out of ten, higher is better.
* Comparative data not available

Midwife Dominika Korsten with 28-weeks pregnant Emma Ingram.

Noel and Ryan Bradbury in the Maternity Special Care Ward at City Hospital

Patient Stories to the Trust Board

During 2015/16, patient stories have continued to form a key part of every SWBH NHS Trust Board meeting. The introduction of video patient stories has widened the reach of these stories so more teams and services are now able to learn from the themes that are raised and apply them to improvements in their own areas.

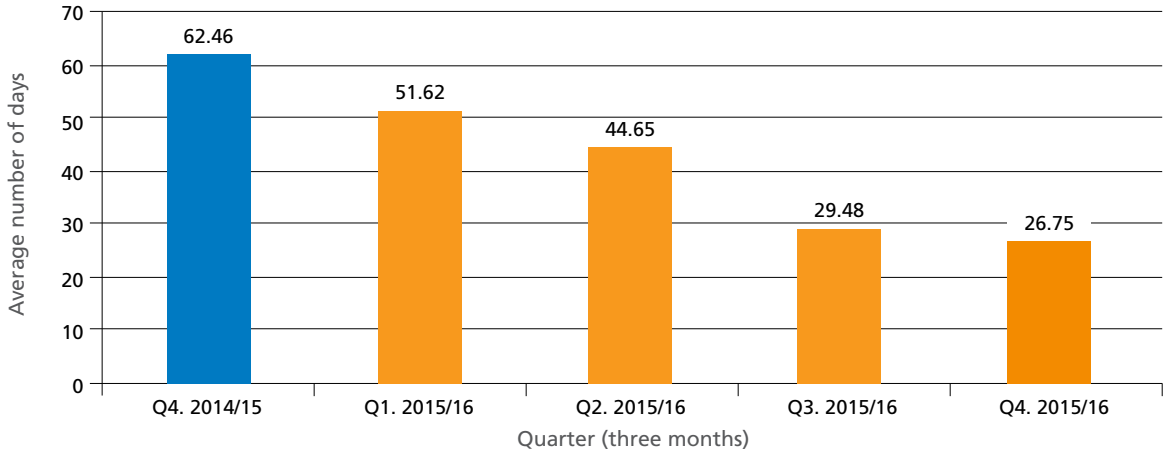
Complaints

The time taken to respond to complaints has improved dramatically as we have worked with patients to understand the outcomes that are important to them. This year we have changed the way that complaints are handled making sure that patients and families are able to have their complaints heard and resolved by people who are close to the situation. In many instances we have offered meetings as a first route to resolving a complaint and many patients and families have been pleased to take these meetings up. All complaints are taken seriously and handled sensitively. We have fast-tracked severe complaints to enabled speedier resolution where possible.

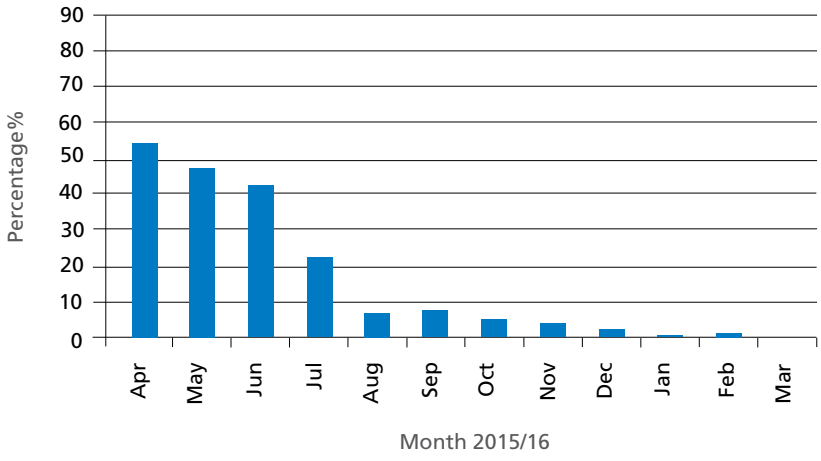
Lessons learned from complaints investigated are reported upon and shared to improve the care we provide. Ensuring that complaints are responded to in a timely manner means that these lessons, remedies, or changes in practice are implemented straight away.

	2014/15	2015/16
Formal complaints received	837	929

Average number of days to respond to complaints by quarter



Percentage of complaint responses where the time taken to respond has exceeded the original agreed response date



The most common themes of complaints

Theme	2014/15 %	2015/16 %
All aspects of clinical treatment	55	53
Appointment delay/cancellation (outpatient)	13	16
Attitude of staff	12	12
Communication/information for the patient	4	6
Personal Records	1	3
Appointment delay/cancellation (inpatient)	2	2
Admissions/ discharges, transfers	3	1
Transport services	2	1

We have embedded learning from complaints throughout our organisation. Some examples of changes we have put in place include:

- Making the self-check-in kiosks more user friendly for people with visual impairments.
- Ensuring that our rehabilitation wards are as focused on risks of developing pressure sores as our medical and surgical wards.
- Sharing clear information with patients on how to self-catheterise after a certain urology procedure so that patients can recover better at home.
- Implementing a pathway for patients who need bowel support but are admitted to hospital for other conditions, so that they can receive specialist support from our Faecal Incontinence Team.
- Ensuring that newborn babies transferred from other Trusts are given the same newborn screening and tests.

Patient Advice and Liaison Service

We encourage local resolution as much as possible, on the basis that clinical teams are well placed to deal with issues that arise on a day to day basis. Where this cannot be achieved, and where a formal complaint is not necessary, our Patient Advice and Liaison Service (PALS) provides an essential liaison service between the patient and organisation, clinician or team providing care. PALS also support patients who need clarification, additional information about our services or where they are concerned about an aspect of care, but not yet sure if a complaint is warranted.

The most common themes of PALS enquiries

Theme	2014/15 %	2015/16 %
Appointment issues	19	25
Clinical Issues	18	25
Complaints advice or referral	12	5

Kelly Stackhouse, Lead nurse FINCH service who won the Patient's Choice Award at the national RCNi Nurse Awards 2016.

Patient Roger Bowen was pleased with his care on Newton 4.

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 national PROMs 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 shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England.

Percentage reporting improvement

	Health Status Questionnaire - Percentage improving			
	Finalised data for April 13 – March 14 (Published August 15)		Provisional data for April 14 – March 15 (Published February 16)	
	SWBH	National	SWBH	National
Hernia repairs	50.5%	42.9%	50.7 %	43.7%
Hip replacement	89.4%	86.1%	89.6%	89.3%
Knee replacement	81.4%	74.1%	81.0%	78.0%
Varicose vein surgery	51.9%	46.5%	51.1%	46.7%

	Health Status Questionnaire - Average adjusted health gain							
	National	SWBH	Highest National	Lowest National	National	SWBH	Highest National	Lowest National
Hernia repairs	0.085	0.085	0.107	0.041	0.084	0.058	0.154	0.000
Hip replacement	0.436	0.417	0.495	0.348	0.437	0.414	0.493	0.347
Knee replacement	0.323	0.261	0.373	0.229	0.315	0.286	0.384	0.226
Varicose vein surgery	0.093	0.077	0.161	-0.021	0.095	0.087	0.154	0.040

The finalised data for 2013/14 and the provisional data for 2014/15 shows that there are areas where the reported outcome is below the average for England.

In response, the Trust has taken the following action:

Hip & Knee replacement	Pre-operative questionnaires and an information leaflet explaining the importance of completing the pre-operative PROMs booklets are posted to patients at home with their admission letter for completion and return on the day of surgery. Patients attend a 'joint club' where advice and information is imparted. This includes discussion with patients so they are fully aware of the risk and benefits, as well as expected outcome. Audits of listing of patients are in place to ensure that they meet the criteria consistently for replacement and meet the current CCG guidance. A contact point after discharge is provided if there are any problems and there is direct access to clinic if needed. A six month follow up and review of performance after surgery is also in place.
Varicose vein surgery	Most varicose veins are now done by radiofrequency ablation. Questionnaires are offered to patients at every opportunity. All patients have a discussion regarding risk and benefits and information leaflets are being updated to include more information on PROMS and on what symptoms to expect post operatively and in what time frame.
Groin hernia repair	Pre-operative questionnaires and an information leaflet explaining the importance of completing the pre-operative PROMs booklets are posted to patients at home with their admission letter for completion and return on the day of surgery. We will revise and reintroduce post operative expectations and further guidance information and literature to the patients. We will also introduce a PROMS lead within General Surgery.

How we performed in 2015/16: Against our standards

KPI (Key Performance Indicators) 2015/16

KPIs	Measure	2015/16	Standard	Achieved
Access metrics				
Cancer – 2 week GP referral to first out patient	%	94.0	=> 93	✓
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	96.3	=> 93	✓
Cancer – 31 day diagnosis to treatment all cancers	%	98.3	=> 96	✓
Emergency Care – 4 hour waits	%	92.54	=> 95	x
Referral to treatment time – incomplete pathway < 18 weeks	%	92.0	=> 92	✓
Acute Diagnostic waits < 6 weeks	%	0.55	< 1	✓
Cancelled elective operations	%	0.9	=< 0.8	x
Cancelled elective operations (breach of 28 day guarantee)	%	1	0	x
Delayed transfers of care	%	2%	=< 3.5	✓
Outcome metrics				
MRSA Bacteraemia	No.	3	0	x
C Diff	No.	29	<30	✓
Mortality reviews completed within 42 days	%	75	=> 90	x
Risk adjusted mortality index (RAMI)	RAMI	90	<100	✓
Summary hospital level mortality index (SHMI)	SHMI	97	<100	✓
Caesarean Section rate	%	25.2	=< 25	x
Patient safety thermometer – harm free care	%	93.8	=> 95	x
Never Events	No.	4	0	x
VTE risk assessment (adult IP)	%	95.1	=> 95	✓
WHO Safer Surgery Checklist (completion of all sections)	%	100	=> 98	✓
Quality governance metrics				
Mixed sex accommodation breaches	No.	2	0	x
FFT would recommend score - inpatient	%	95	95	✓
FFT would recommend score - emergency care	%	80	95	x
Staff sickness absence	%	4.9	=< 3.5	x
Staff Appraisal	%	85.8	=> 90	x
Medical Staff Appraisal and Revalidation	%	85.6	=> 90	x
Mandatory Training Compliance	%	97.4	=> 90	✓
Clinical quality and outcomes				
Stroke Care – patients who spend more than 90% stay on Stroke Unit	%	92.0	=> 90	✓
Stroke Care – Patients admitted to an Acute Stroke Unit within 4 hours	%	80.6	=> 80	✓
Stroke Care – patients receiving a CT scan within 1 hour of presentation	%	72.9	=> 50	✓
Stroke Care – Admission to Thrombolysis Time (% within 60 minutes)	%	83.9	=> 85	x
TIA (High Risk) Treatment within 24 hours of presentation	%	97.4	=> 70	✓
TIA (Low Risk) Treatment within 7 days of presentation	%	97.7	=> 75	✓
MRSA screening elective	%	93.6	=> 80	✓
MRSA screening non elective	%	93.1	=> 80	✓
Inpatient falls reduction – Acute	No.	599	< 660	✓
Inpatient falls reduction – Community	No.	345	< 144	x
Hip Fractures – Operation within 36 hours	%	71.4	=> 85	x
Patient experience				
Complaints received – Formal	No	929	N/A	
Patient average length of stay	Days	3.32	=< 4.3	✓
Coronary Heart Disease - Primary Angioplasty (<150 mins)	%	92.2	=> 80	✓
Coronary Heart Disease – Rapid Access Chest Pain (<2weeks)	%	95.1	=> 98	x

Children's Safeguarding

We continue to work closely with Sandwell and Birmingham Multi-agency Safeguarding Hubs (MASH) and frontline practitioners to improve the quality of inter-agency referrals so that children and families receive the most appropriate intervention and support at the right time in order to safeguard children.

We have developed a Safeguarding Children Training Strategy to ensure our staff are appropriately trained and skilled to respond to safeguarding children concerns. 70% of staff have received face to face training on how to recognise and refer safeguarding issues and 68% of key staff such as midwives, paediatric staff, ED practitioners and health visitors have received more in depth training. We have delivered specific training on Domestic Abuse Risk Assessment and Child Sexual Exploitation (CSE) to key groups so that they can recognise the risk factors/triggers and make appropriate referrals.

Following joint work with Sandwell's CSE Team we are now flagging the electronic patient records of children and young people who are assessed to be at medium/high risk of CSE in order to support staff in their risk assessment and response when these vulnerable children access our services.

We have updated a number of policies and protocols in response to the increasing agenda around CSE, Domestic Abuse, Female Genital Mutilation and the Savile report recommendations.

Priorities for 2016/17 will include the full implementation of the Child Protection Information Sharing Project across unscheduled care settings and to continue to meet the requirements of the two Local Safeguarding Children Boards. We will extend the IDVA Project into City ED in September 2016.

Jayne Clarke, Trust Child Safeguarding Lead.

Jacqui Ennis - Learning Disability Nurse Specialist.

Safeguarding Adults

During the year we have seen developments in how we implement the Care Act 2015. This has included a focus on raising awareness regarding domestic abuse, neglect, coercion and radicalisation. We have a Prevent policy in place with a referral form and information to support staff in understanding how and when a referral should be made.

Two new postholders to support safeguarding will begin work within the Trust in 2016. We are working closely with voluntary organisations who are supporting the Trust to carry out an audit on our transition and access to services for people with a learning disability. We are also appointing a second learning disability nurse specialist, thanks to investment from Sandwell and West Birmingham Clinical Commissioning Group.

The Trust charity funded a new Independent Domestic Violence Advocate (IDVA) Project that launched in the Sandwell Emergency Department (ED) in November 2015. The project is proving positive in increasing staff awareness, identification and onward referral into support services for domestic abuse victims. Since November – January 2016 there have been 50 referrals from ED.

Readmissions

Tackling readmissions remains a focus for the Trust as we strive to ensure we are in a position to provide good quality care and that means ensuring patients are cared for in an appropriate setting. We will reduce readmissions by a further 2% this year. This year we have trialled telephone calls to patients following discharge to give follow-up advice or link with appropriate community teams. Our intensive focussed week that we held this year brought together multi-disciplinary teams and different organisations to focus on how we work together better to reduce readmissions. We have continued with our frailty assessments at the front door to support our planned care pathways and better inform the support systems that patients will need to have in place that could avoid a readmission.

Outpatient Care

Outpatient care has continued to improve during the year to provide better, more efficient care for patients and to better support our primary care colleagues. In November 2015 we introduced partial booking for follow up appointments. Patients who need to be seen within six weeks are booked for their next appointment date before they leave the clinic. Patients who need an appointment further ahead are asked to contact the Trust nearer the time to agree a convenient date and time. Partial booking will be in all specialties in May 2016.

Our Consultant Assisted Triage Service (CATS) began this year where referrals are assessed and advice can be given to GPs where appropriate. This began in the vascular service and has been extended over a range of surgical and medical specialties throughout the year. We have further embedded e-Outcome which means that an electronic outcome for each patient is recorded at clinic or within the month. This gives assurance that each patient's care needs are being delivered and tracked. In the year ahead all our referrals will come in electronically and this year we will ensure that all first outpatient appointments are within six weeks of referral.

Community caseloads

Smarter scheduling is key for all community services to optimise the time available for face to face clinical care by reducing administration and travel. Currently this is largely done at practitioner level through both paper and electronic means so we are working hard to standardise our approach by accessing appropriate scheduling tools via mobile devices. A caseload management tool has been procured in adult community services to provide real time capacity information by combining staff availability with patient dependency to facilitate visualisation of current and future workload projection across the teams. Specifically the tool provides valuable information regarding dependency gaps, team and individual caseload. Children's services also plan to review how they can use the tool. We continue to investigate how we can access mobile, lightweight devices to allow us access to electronic patient records in patient homes and facilitate opportunities for telemedicine and virtual consultations. All community services are working with GP practices, children's centres, leisure centres and other community locations to streamline and increase clinic capacity.

Focused care

The Trust has spent the past year improving care in a number of ways, but our work in focused care is arguably one of the most exciting. As part of our Safety plan we have highlighted the importance of providing the best possible dementia care in our healthcare settings. We initiated a programme of work around focused care to increase quality, to reduce costs and reduce harm. We have adopted the principles of John's Campaign to promote partnership working with relatives and carers for patients with cognitive disorders to enable the carer to support patients whilst in hospital day or night. We have purchased fold away beds to enable relatives and carers to sleep next to patients with dementia to offer vital support when they need it most. The beds will be introduced in 2016. Four of our wards were part of our focused care programme where we tested new ways of working including personalised folders for each patient. These folders contain the patient's information and what the staff should expect from them, risk and monitoring charts and a process measurement activity. Focused Care and John's Campaign best practice will be implemented on all wards by the end of 2016. Staff and carer's surveys will help us evaluate the impact of our work and investment.

Ten out of ten (10 out of 10)

10/10 is our patient safety standards checklist completed on admission to prompt immediate action from members of the ward team (doctors, nurses and therapists) to put in place measures to reduce the risk of harm for all our patients. During 2016 we will see a focused initiative in our medical and surgical assessment units to integrate 10/10 into practice so that staff and patients are empowered to identify and reduce risks. A rapid improvement model will be used to assist the change and help with sustainability.

Quality Improvement Half Days

Last April, the Trust launched Quality Improvement Half Days (QIHDs) to provide dedicated time every month for teams to meet to consider how best to improve the quality of care or services provided to patients and staff. The four hour afternoon sessions were a big change for the Trust involving all non-emergency activity being paused to give whole multi-disciplinary teams the chance to get together. They offer staff a chance to take time out to learn and develop

They offer staff a chance to take time out to learn and develop new ideas. They also help to tackle the cross-organisational learning that we want to improve. With nearly 50 meetings taking place across the Trust at the same time, one of the challenges was to find sufficient space. Because there is no non-emergency activity, it gives an opportunity to use spaces which would normally be used for patient care. For example, nearly 50 staff from Outpatients, Medical Records and the Elective Access teams met in the patient waiting area of the fracture clinic at Sandwell. One of the largest sessions in April was held in the iBeds directorate, with 97 people meeting in the Physiotherapy Department at City. QIHDs have been going strong since it launched and continues to motivate and inspire staff across the Trust.

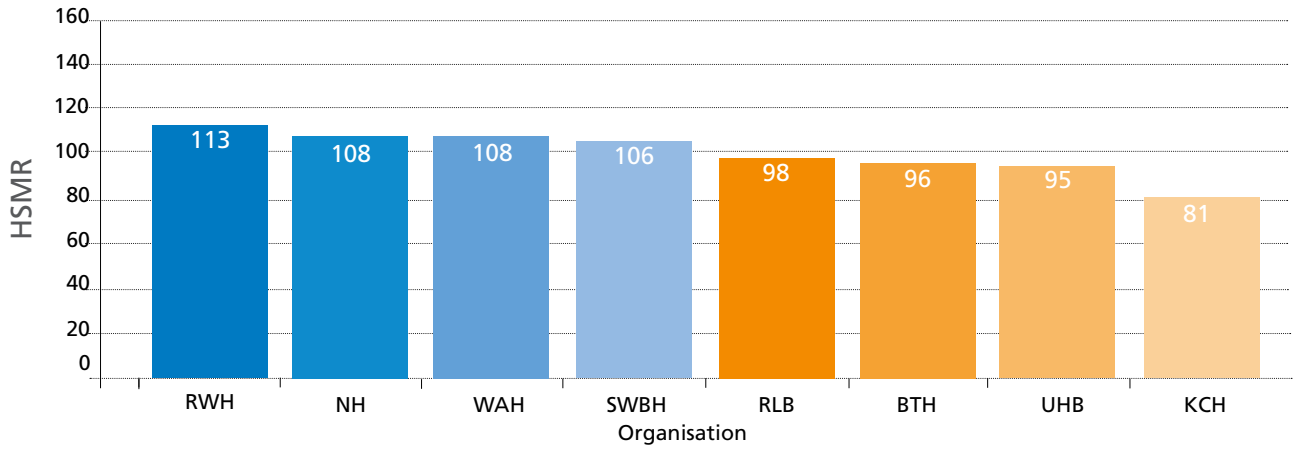
Mortality

Mortality data is now extracted from the CHKS system, which reports the Risk Adjusted Mortality Index (RAMI) as the principle measure of our organisation's mortality, and the HED system which reports the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI).

HSMR (Hospital Standardised Mortality Ratio)

The HSMR is a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in population structure. The ratio is of (observed) to (expected) deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. Our HSMR is currently (February 2016) 106 for SWBH. This information is derived from the HED system, which is rebased monthly to provide the most up to date data.

HSMR in comparison with our peers



Key
RWH - Royal Wolverhampton NHS Trust
NH - Northumbria Healthcare NHS Foundation Trust
WAH - Worcestershire Acute Hospitals NHS Trust
SWBH - Sandwell and West Birmingham Hospitals NHS Trust
RLB - Royal Liverpool and Broadgreen University Hospitals NHS Trust
BTH - Bradford Teaching Hospitals NHS Foundation Trust
UHB - University Hospitals Bristol NHS Foundation Trust
KCH - Kings College Hospital NHS Foundation Trust

RAMI (Risk Adjusted Mortality Index)

This is a methodology developed by Caspe Healthcare Knowledge Systems (CHKS) to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. It is a ratio of the observed number of deaths to the expected number of deaths that occur within a hospital. The Trust's RAMI for the most recent 12 month cumulative period (December 2015) is 90 and flagging marginally outside of statistical confidence limits which is above the National HES peer RAMI of 82. The aggregate RAMI for the City site is within statistical confidence limits with a RAMI of 82, and the Sandwell site with a RAMI of 96, which is outside of statistical confidence limits. Mortality rates for the weekday and weekend low risk diagnosis groups are within or beneath the statistical confidence limits. This data is derived from HED for the Summary Hospital Level Mortality Indicator (SHMI).

SHMI (Summary Hospital-level Mortality Indicator)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. Our SHMI score is currently 97 for the Trust.

Mortality comparisons against national data

	Lowest	Highest	SWBH
Observed	526	4672	2229
Expected	796.3	4555.0	2293.8
Score (SHMI)	0.66	1.02	0.97

The data above compares our mortality figures against all other Trusts nationally. A Trust would only get a SHMI value of one if the number of patients who died following treatment was exactly the same as the expected number using the SHMI methodology.

Trust Mortality Review System

For the year 2015/16 we set ourselves a target of reviewing 90% of all hospital deaths within 42 days and 100% of all hospital deaths within 60 days. By reviewing the care provided we can identify areas where learning can take place to improve outcomes for our patients. Although there has been an improvement in the number of deaths reviewed within 42 days we have not achieved our target and will keep this as a priority for 16/17.

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
Death	146	120	105	371	119	97	114	330	127	116	133	376	163	137	152	452	1529
Reviewed	132	105	98	335	104	88	98	290	100	54	62	216	122	94	92	308	1149
% Reviewed	90	87	93	90	87	90	85	87	78	46	46	57	74	68	60	68	75
% Cumulative Reviewed	90	89	90	90	89	89	89	89	87	82	78	78	77	76	75	75	75

November and December review rates were adversely affected by loss of electronic documentation relating to failure in our IT system.

Reducing avoidable deaths

We continue to focus on reducing avoidable deaths and during this year we will:

- Review 90% of deaths within 42 days and 100% of deaths within 60 days
- Ensure that we improve learning in three main areas which are improved sepsis management, management of acute kidney injury and end of life care.
- Streamline our mortality review system and reward reviews who complete 100% of their mortality reviews within our agreed timeframes.
- Participate in the National Retrospective Case Record Review (NRCRR) commissioned by HQUIP from Royal College of Physicians
- Participate in the National Learning Disability Mortality Review Programme (LeDeR) managed by the University of Bristol

End of life (palliative) care

In April 2016 we begin the Connected Palliative Care service which is a new service for patients in the last year of life. Sandwell & West Birmingham Hospitals NHS Trust is the lead provider for this new service and we are working with different partners to provide seamless care including Birmingham St Mary's Hospice, John Taylor Hospice, Age Concern and Crossroads. Our clinical staff will be leading the service development working closely with patients, carers and colleagues to join up services and support improvements in care.

Deaths of patients with involvement from specialist palliative care services

Diagnostic care coding= Z5.15. The table below provides information relating to the number of deaths at the Trust where there was a diagnosis of Palliative Care made.

Total number of deaths	Palliative Care	%
2229	471	21.13

Anita Chew from Birmingham Age Concern, Tammy Davis the End of Life Service Lead at SWBH, Sundip Gill from Birmingham St Mary's Hospice, Penny Venables from John Taylor Hospice, and Chris Christie from Sandwell Crossroads.

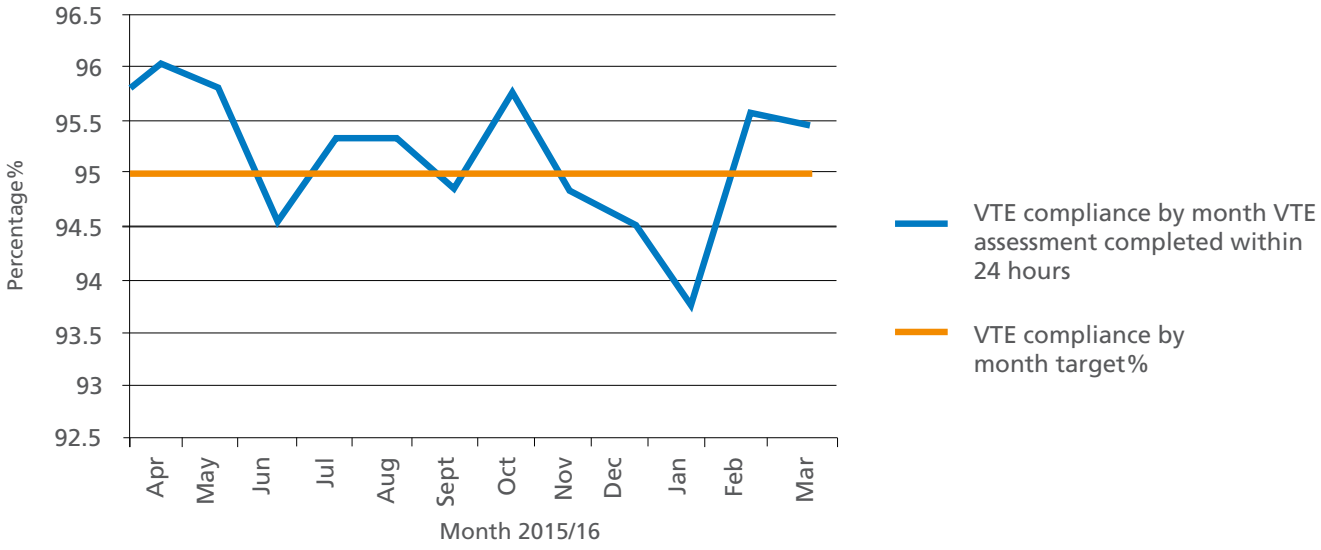
Venous thrombo-embolism (VTE)

A Venous thrombo-embolism (VTE) is a blood clot that forms in a vein. A calf vein is the most common site for this to occur but occasionally pieces of the clot can break away and flow towards the lungs and become a pulmonary embolism (PE). The Department of Health requires all Trusts to assess patients who are admitted for their risk of having a VTE. This is to try and reduce some of preventable deaths that occur following a VTE while in hospital.

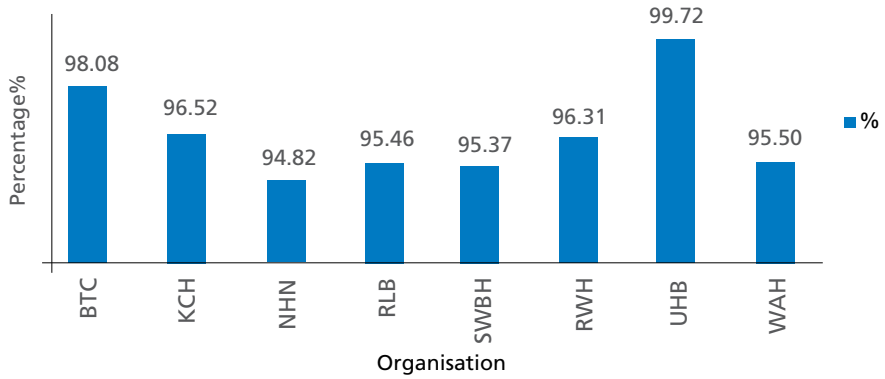
We report our achievements for VTE against the national target (95%) and report this as a percentage. The calculation is based on the number of adults admitted to hospital as an inpatient and of that number, how many had a VTE assessment within 24 hours. Following an audit of our VTE assessments last year we confirm that we are now reporting within the 24 hour period. Our year end position is 95.1%

Rachel Clarke, Deputy Manager of Anticoagulation and Joanne Malpass, Anticoagulant Services Manager.

VTE assessments completed within 24 hours 2015/16



VTE assessments compared to peers (higher is better)



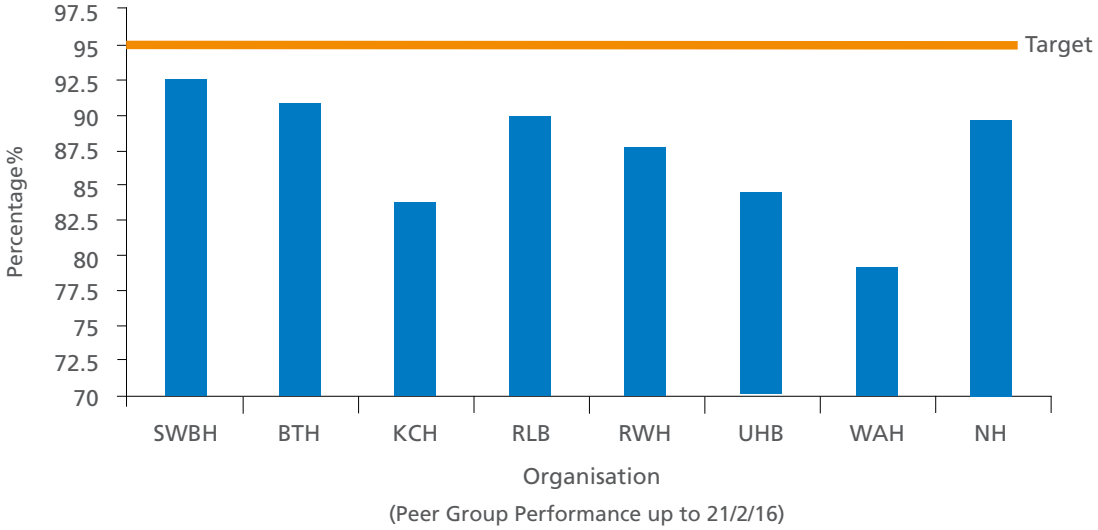
Data from NHS England – reporting period April 2015 – December 2015

Lowest	Highest	Average	SWBH
88.5%	100%	96.3%	95.1%

Emergency four hour waits

In line with the national standard we aim to ensure that 95% of patients will wait for no more than four hours within our Emergency Departments (ED). Although the majority of patients were seen within four hours on average we achieved 92.5%. Long waits for patients are now very rare and we have been able to reduce ambulance turnaround times meaning that ambulance crews can get back on the road more quickly. We remain committed to improving our performance and we are joining up work with community teams to improve our integrated care pathways.

Percentage of patients waiting 4 hours or less in Emergency Departments 2015/16 (Higher is better – target 95%)

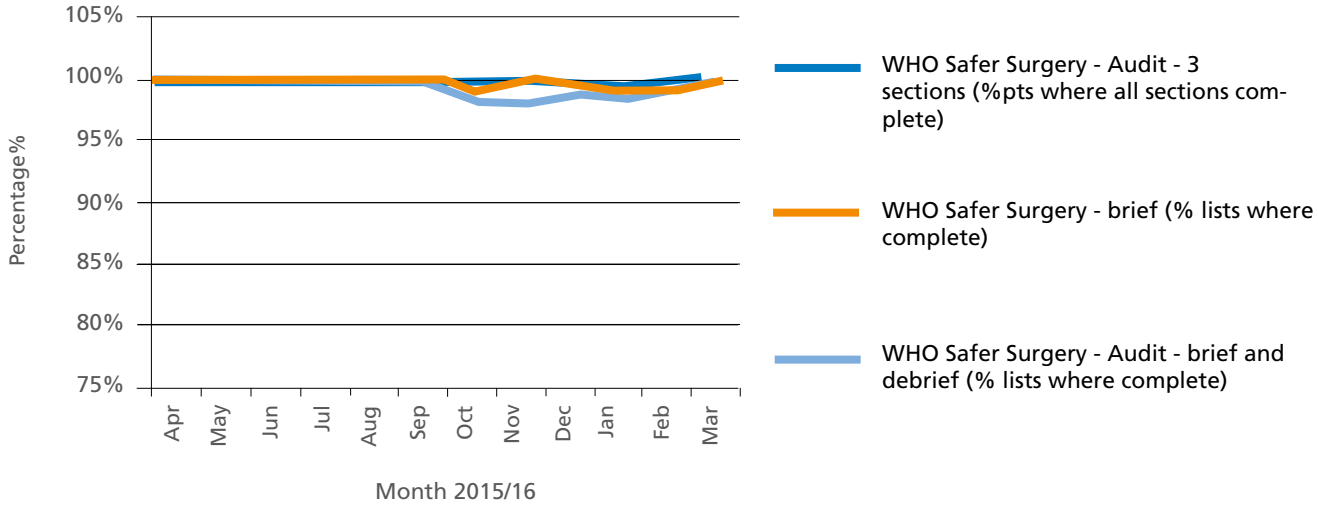


(Peer Group Performance up to 21/2/16)

WHO Safer Surgery Checklist

Compliance with the WHO safer surgery checklist is monitored through our monthly Theatre Management Board. Clinical directors are core members of the group. Surgery A have a monthly governance meeting where they discuss the audits on the WHO checklists. At the meetings they identify actions that will improve compliance.

Compliance with WHO Safer Surgery checklist 2015/16



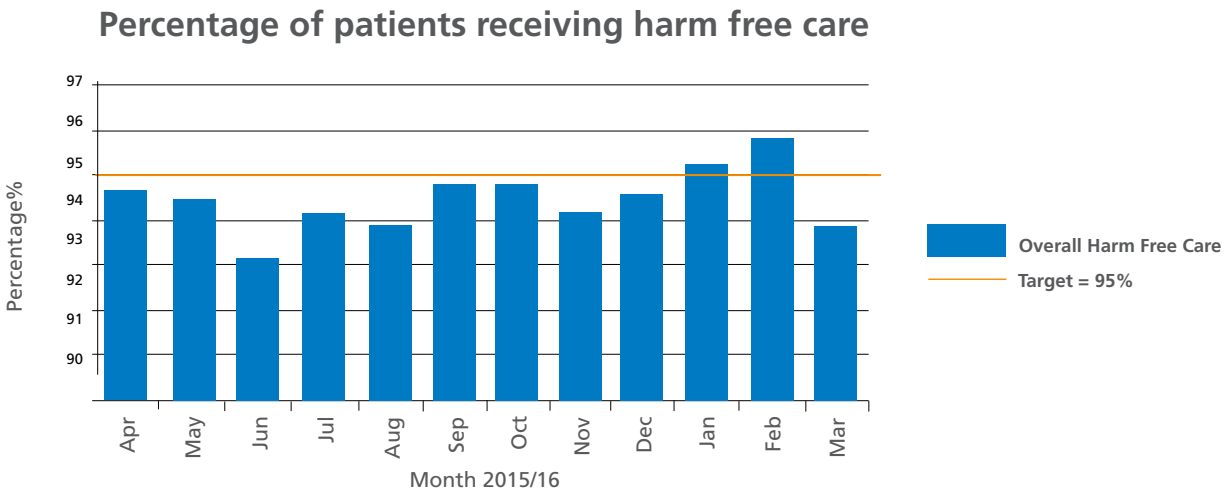
Harm free care

The Trust continues to undertake monthly prevalence audits looking at four harms – pressure ulcers, falls, catheter related UTIs and DVT. Results show that 94% of our patients suffer no harm whilst in our care. During the last 3 months of the year we have reached the national target of 95%. All harms are reviewed via the incident reporting framework with local and cross - Trust learning. For example, we are implementing a 'blue pillow' approach to heel elevation – an idea commenced by Newton 4 ward.

Patient Audrey Branwood on one of the new pressure relieving mattresses at City Hospital.

Harm free care by peer with national average

National Average	Sandwell & West Birmingham Hospitals NHS Trust	Bradford Teaching Hospitals NHS FT	Kings College Hospital NHS FT	Royal Liverpool & Broadgree University Hospitals NHS Trust	University Hospitals Bristol NHS FT	Worcester-shire Acute Hospitals NHS Trust	Northumbria Healthcare NHS FT
94%	94%	92%	95%	94%	93%	94%	97%



Pressure ulcers

Pressure ulcer prevention remains one of the key priorities within the Trust 10/10 safety standards with a clear focus on assessment of all patients to identify if someone is at risk of developing pressure damage and implementing preventative strategies to prevent pressure ulcers developing.

In line with the Trust's vision to provide patients with the safest care possible the Trust promotes being open with the reporting of pressure damage incidences in order to learn from mistakes and improve future care for patients. Through ongoing monitoring and review of grade three pressure ulcers the Trust strives to keep our safety promises by learning from incidents, changing care when required and reducing harm to our patients.

During 2015 there was investment in new mattresses at City site which has meant patients have no delays in receiving pressure relief and do not need to be disturbed when they may be at a critical time in their illness. Traditional pressure relieving air mattresses remain available when clinically indicated. Benefits of the new mattresses also include improved patient comfort, mobility and reduced manual handling for our staff.

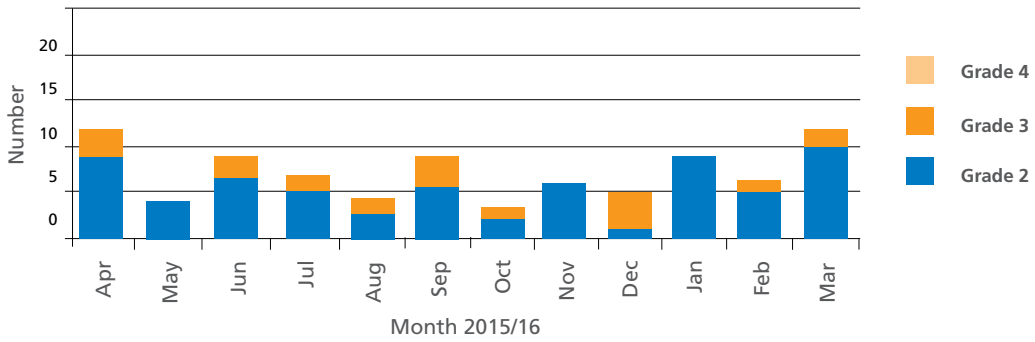
During the year the Tissue Viability team have had a focus of working with the Community nurses to promote the message of pressure ulcer prevention. This included a pressure ulcer awareness event and attending local resident meetings to talk about pressure ulcers and how to prevent them. This activity was welcomed by Agewell and gave an opportunity

for the public to ask advice on prevention within a social setting. The Tissue Viability team has also been working with Sandwell & West Birmingham Clinical Commissioning Group and have extended our training provision to include training for local practice nurses and nursing home nurses. These days provided a platform to raise awareness of pressure ulcer prevention as practice nurses are often the first health care professionals patients will have contact with.

More work is planned within the Sandwell community to reach out to the wider population, raising awareness of pressure damage and how to reduce the risk of pressure ulcers developing.

HCA Annette Reeves and Ward Manager Amanda Green celebrating 821 days pressure ulcer free on ward D21.

Avoidable Pressure Sores 2015/16

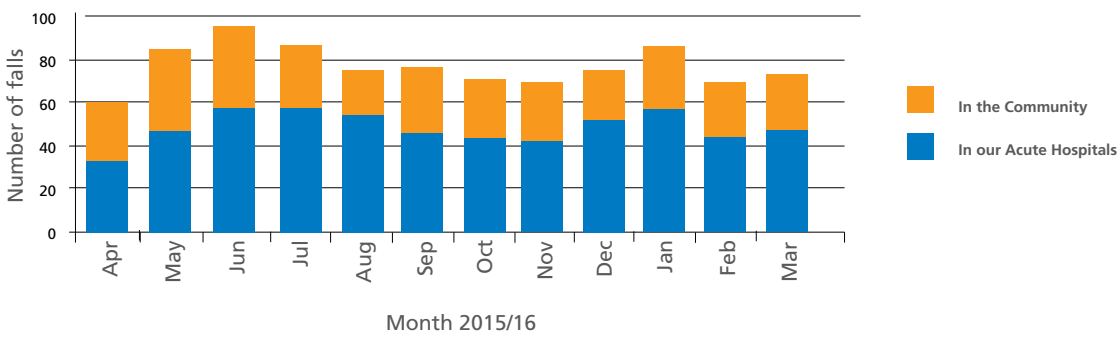


Falls

The number of falls in 2015/16 was 944 of which 21 resulted in serious harm.

We investigate and review each fall to ensure any learning points are shared with staff and that practice is reviewed to reduce the risk of repetition for that patient or others. All staff receive 'prevention of falls' training on induction and annual mandatory training. We are currently undertaking a project to review the medication of those patients that are at high risk of falling. Our newly appointed Dementia Lead will also have a focus on falls prevention and will be working closely with clinical teams to identify themes around falls, for example, a high proportion of our falls are patients with dementia /delirium. We are also working with the risk team to design a questionnaire for clinical staff to complete at the time of the fall to help us investigate why the fall happened, whether it could have been avoided, whether we care for the patient appropriately post fall, and whether there are any lessons to learn for the organisation. This will be launched with clinical staff in Spring 2016.

Falls In 2015/16



Infection Prevention and Control

We are committed to a zero tolerance goal to eliminate all avoidable health care acquired infections (HCAIs) and we are proactive in the identification, management and monitoring of infections. We have an infection prevention and control service (IPCS) who provide education and training, surveillance of infections, monitoring of our practices to ensure that we are in line with national standards such as National Institute for Health and Care Excellence (NICE) guidance, recommendations from professional bodies and the Infection Prevention Society [IPS] audit tools. We facilitate Patient Lead Assessment in the Clinical Environment (PLACE) audits. We work in partnership with the Clinical Commissioning Groups (CCGs), Trust Development Agency (TDA), Health Protection Unit (HPU) and Public Health England (PHE).

Marie Williams, Infection Prevention and Control Nurse Advisor raises hand hygiene awareness among staff and patients.

Target	Agreed target/rate [Year end]	Trust rate [End Mar 2016]	Compliant	Comments	
MRSA bacteraemia	0	3	No	**Pre 48hrs** 0	**Post 48hrs** 2 = Sandwell Site 1 = City Site
C.difficile acquisition toxin positive	30	29 (rate per 100,000 bed days = 14.14)	Yes	19 = Sandwell Site 10 = City site	
	• During this reporting period, SWBH introduced a more sensitive method of testing for C.difficile, enabling earlier detection of the organism in comparison to other tests. This has benefited our patients as early detection of C.difficile enables treatment to be commenced sooner, resulting in a better outcome. The introduction of the new method of testing was supported by SWB CCG. • As part of ongoing monitoring for C.difficile, a period of increased incidence [PII] was identified on one ward at Sandwell during February 2016, involving 3 patients [2 samples were identified with the same ribotype]. In line with Trust protocol the PII was escalated to an outbreak and a table top review was undertaken, resulting in the clinical group putting an action plan in place.				
MRSA Screening - Elective	85% (locally agreed)	93.6%	Yes		
MRSA Screening - Non Elective	85% (locally agreed)	93.1%	Yes		
Post 48hrs MSSA Bacteraemia (rate per 100,000 bed days)	N/A	5.73	N/A	All Post 48 hrs bacteraemia have a post infection review to identify issues and lesson learnt.	
Post 48hr E Coli Bacteraemia (rate per 100,000 bed days)	N/A	18.52	N/A	All Post 48 hrs bacteraemia – urinary catheter related have a post infection review to identify issues and lesson learnt.	

Blood culture contamination rates

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Blood culture contamination rates by site **(Target = 3%)**	**City**	2.4%	2.9%	1.7%	2.5%	3.2%	2.9%	2.9%	2.0%	1.7%	2.6%	3.7%	3.2%
	S.Well	3.5%	3.3%	3.9%	3.1%	4.1%	4.0%	1.5%	4.8%	4.1%	3.1%	6.0%	3.4%
	It needs to be recognised that due to the clinical condition of some patients there is a risk of obtaining an unavoidable blood contaminant. However, any Clinician identified as taking a contaminated blood culture is required to attend for further training to reiterate practices. In addition to this, since Aug 2014 the IPCS have introduced a training programme for all new doctors to the Trust.												

We monitor any periods of increase incident [PII] and outbreaks. During the period April 2015 – March 2016 there were a total of four wards closed on the Sandwell site due to symptoms of diarrhoea and/or vomiting: one ward in April 2015, one ward in February 2016 and one ward in March 2016 due to norovirus. One ward in January 2016 was closed as a precautionary measure with no organism identified. During the reporting period there were a total of three bay closures across the Trust, two of which were confirmed as norovirus but did not result in ward closure.

In addition to outbreaks of diarrhoea and/or vomiting, due to the emergence of multi resistant organisms, national guidance, increased surveillance and microbiological screening of patients, we identified more periods of increased incidence and outbreak attributed to a variety of micro-organisms including: - Clostridium difficile [CDI], Extended Spectrum ßeta lactamase organisms [ESBL], Carbapenamase resistant organisms [CRO] and Vancomycin resistant enterococci [VRE].

In all cases post infection reviews have been undertaken and multi-disciplinary and agency meetings held to identify lessons learnt and outcomes of lessons learnt.

Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by all staff. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

Information Governance Toolkit (IGT) attainment levels

The Trust is compliant across the Information Governance Toolkit requirements for 2015/16. We successfully achieved 86%, which is a "Satisfactory" (GREEN) level, according to the HSCIC IG Toolkit grading scheme and a minimum Level 2 achieved for all requirements. The Trust will continue to build on this to strengthen our IG practices and processes and work towards attaining Level 3 compliance.

Staff Nurses Nicola Hawthorne and Joanne McGugan at the sharps safety training session for community nurses.

Date	Trust rate of report-ing 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	11.67	12.46	1.72	24	0.2	16	0.1
	Average rate of reporting per 1000 bed days	Best reporter/ 1000 bed days	Worst reporter/ 1000 bed days	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
2014/15	56.19 per 1000 bed days	84 per 1000 bed days	7 per 1000 bed days	28	0.32	7	0.1
2015/16	54.86	74.67	18.07	18	0.3	2	0.03

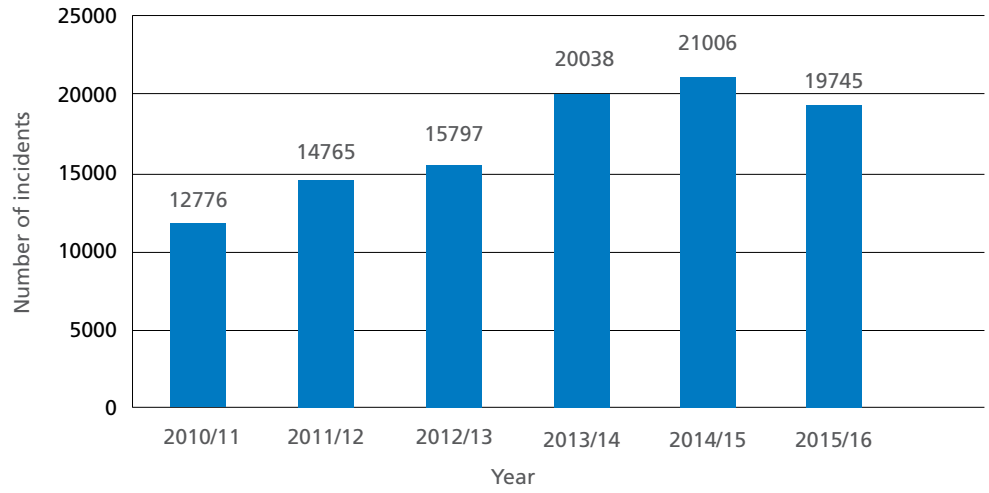
2015/16 data is up to 30 September 2015.

The data shows an overall position of reduced incidents resulting in severe harm or death.

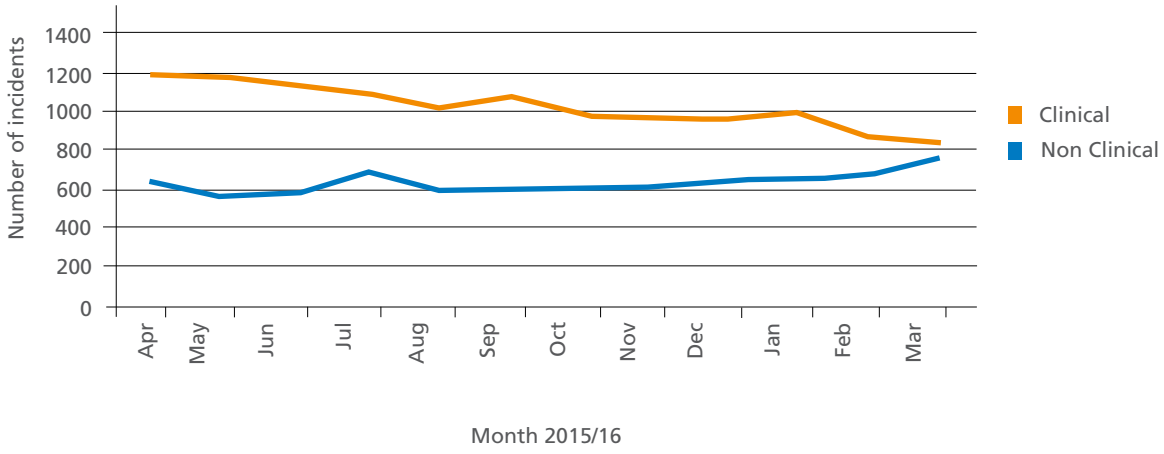
Incident reporting

A positive safety culture 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 is publically available and provides comparative data with like-sized Trusts. This data shows that as at the April 2016 report we remain in the highest 25% of Trusts with a reporting rate of 54.86 per 1000 bed days.

Total incidents reported by financial year



Incidents reported during 2015/16 (clinical and non clinical)



Incidents are generally categorised into clinical (patient safety) and non-clinical and then further categorised dependant 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. Patient safety incidents resulting in moderate harm or above that do not meet external reporting criteria are investigated at clinical group or corporate directorate level. The number of serious incidents reported in 2015/16 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, personal data or health and safety incidents.

2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs	4	1	3	1	1	4	0	2	2	6	4	0

Never Events

During 2015/16 four never events were reported. 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.

Never events reported in 2015/16

Incident	What Happened	Where it happened	What we learned
Wrong side lithotripsy **(April 2015)**	Identified that lithotripsy was being performed on the right instead of left side.	This incident occurred at the Adult Surgical Unit (BTC) at City Hospital in Urology.	The investigation identified a number of safety controls that were not in place or not adhered to. Safety controls and changes to working practices were implemented (eg WHO checklist changes, sedation policy updated, adherence to site marking and Sign In / Time Out procedure).
Wrong side anaesthetic block **(May 2015)**	The patient was listed for a left intermedullary femoral nail on the trauma list. A fascia iliaca block was performed on the right side.	This incident occurred at Sandwell Hospital Theatres under the care of Anaesthetics and T&O.	The investigation identified a number of issues that contributed to this incident including safety controls that were not adhered to, distractions within the anaesthetic room and overlap of cases which meant that the anaesthetist who did the Sign In did not perform the procedure. A combination of procedure changes and training to reinforce good practice and adherence to safety controls was implemented.
Retained swab **(June 2015)**	A maternity patient attended at 30+6 weeks and an intra-uterine death was confirmed by ultrasound scan. The patient had a semi elective c-section with a total abdominal hysterectomy performed. The patient remained unwell post operatively and was returned to theatre following an estimated blood loss of between 1500 and 2000mls. The patient was transferred to ITU with a pelvic pack in place (as planned) and was taken back to theatre for the removal of the pack. The patient remained unwell with abdominal distention and vomiting. An abdominal xray was taken which identified a retained swab. The patient returned to theatre for removal of the swab.	This incident occurred at City Hospital under the care of Maternity services.	The management and recording of swabs was not robust and the inability of staff to give or receive respectful challenge both contributed to this incident. Actions implemented included changes to policy and procedures in addition to learning events to promote effective team working as well as introduction of a recepticle for individual swabs to improve visibility and counts.

Incident	What Happened	Where it happened	What we learned
Wrong site surgery **(Feb 2016)**	The patient attended day surgery for removal of K-Wire right distal ulna, under general anaesthetic. The surgeon opened the radial side of the pateint's hand and realised the error. The radial side (thumb) was closed and the operation then proceeded on the ulna side (little finger).	This incident occurred at Sandwell Hospital Theatres under the care of T&O.	Although safety documentation was completed it was found that there was a lack of precise anatomical position (side (L or R) or top, middle, bottom) as a requirement of the documentation. These aspects are being addressed.

How we performed against external measures

Our Care Quality Commission improvement plan

In March 2015 we published our improvement plan as the Care Quality Commission published their inspection report following their visit to the Trust in October 2014.The Trust was overall rated as "requires improvement". Our improvement plan identified five key themes of improvement:

1. Improve how we learn across our organisation, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust.
In 2015 we introduced our quality improvement half days (QIHDs) that offer protected time for teams to learn, cancelling all non-emergency services.

2. Ensure that we consistently deliver the basics of great care, with disciplined implementation of policies on hand-washing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time.
Our "ok to ask" campaign enabled everyone in the Trust to feel comfortable questioning and challenging each other in our basic standards of care.

3. Tackle our sickness and vacancy rates if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.
We have not achieved our ambitions on cutting absence due to sickness this year although some teams have sustained low levels and others have dramatically improved. We have changed many of our recruitment processes to fill vacancies with the right people more quickly including open days where recruitment checks and job offers can be made within a day, and guaranteed jobs for our student nurses who have passed their relevant competencies and assessments.

4. We need to build on our best practice around local management and leadership, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way.
We have continued the second year of investment in our leadership programme supporting the top leaders in the Trust to be able to successfully lead and deliver our 2020 vision. Our monthly Your Voice survey engages every employee in feedback that is acted on by directorate and group leaders.

5. We need to do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – we know where our issues are, and need to address them more quickly when they are identified.
We have published all of our risk registers on our intranet site so that they are readily available to all staff. Anyone can view anyone's risk register. This has helped to facilitate greater understanding among groups of staff.

The majority of actions within our improvement plan have been completed successfully. During the first half of 2015/16 we will complete all of our actions and in the later part of the year we will seek assurance that our actions have achieved the desired outcome to improve the quality of care for our patients.

Despite clear and evidenced progress having been made against the majority of recommendations there remain eight areas where further work or a different approach may be required to succeed. These include embedding the Ten out of Ten (10/10) safety checklist, improving mandatory training compliance, and further strengthening discharge processes to meet the patient's preferred place of care / death.

In November 2015 the CQC published their report into our community services for children and young people. These services received an "outstanding" rating.

Service area	Plans delivered	Outstanding actions
Accident and Emergency	11 out of 12	• Complete roll-out of secure drug storage
Medicine and Emergency care	1 out of 5	• Further embed 10/10 • Improve mandatory training compliance • Ensure patient/carer agreement with their treatment plan is always obtained • Introduce new patient-centred care plans
Surgery	7 out of 8	• Update our electronic theatre management system
Children and Young People	5 out of 5	
Maternity	11 out of 12	• Complete roll-out of secure drug storage
End of Life care	2 out of 4	• Improve discharge processes to meet patient's preferred place of death • Further improvements required to achieve 100% completion of DNA CPR forms by doctors
Outpatients and diagnostic imaging	8 out of 11	• Resolve perception and communication issues • Improve outpatient experience for people with dementia and learning disabilities • Improve privacy of patients in the Sandwell eye clinic through relocation
Community	9 out of 10	• Complete roll-out of secure drug storage

CQUINs (Commissioning for Quality and Innovation)

The Trust is contracted to deliver a total of 20 CQUIN schemes during 2015/16. Seven schemes are nationally mandated, a further five have been agreed locally, five identified by the West Midlands Specialised Commissioners and three by Public Health. Out of a maximum £8.8m available we received £8.7m based on our achievements. Sandwell and West Birmingham CCG have declared that we have achieved to their satisfaction against the principal CQUIN objectives for 2015/16.

We agree, although we were unable to demonstrate achievement in a secondary objective in the following: Acute Kidney Injury - due to delays in the implementation of a new electronic discharge letter we were unable to demonstrate an improvement in informing GPs of patients with AKI. Similarly in Sepsis we demonstrated improvement through intermittent audit - however IT delays again hampered our ambition to capture every case of sepsis in A&E electronically.

CQUINs for 2015/16			
1	National	Acute Kidney Injury	x
2	National	Sepsis Screening	x
3	National	Sepsis Antibiotic Administration	✓
4	National	Dementia - Find, Assess, Investigate, Refer & Inform	✓
5	National	Dementia - Staff Training	✓
6	National	Dementia - Supporting Carers	✓
7	National	Improvement in diagnosis recording in HES Data Set of Mental Health presentations	✓
8	Local	Community Therapies - Dietetics Community Communication with GPs	✓
9	Local	Reduce Number of Ward Transfers experienced by patients with Dementia	✓
10	Local	Reduce Number of Out Of Hours Patient Transfers	✓
11	Local	Safeguarding	✓
12	Local	Falls Medication	✓
13	Spec.	Reduce Number of Consultant-Led Follow Up OP Attendances	x
14	Spec.	HIV - Reducing Unnecessary CD4 Monitoring	✓
15	Spec.	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	✓
16	Spec.	Breast Cancer - help patients make more informed choices regarding treatment	✓
17	Spec.	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	✓
18	Public Health	Breast Screening - improvement in uptake	✓
19	Public Health	Bowel Screening - improvement in uptake	✓
20	Public Health	Maternity and Health Visiting Services - Integrated working	✓

External Visits

Care Quality Commission inspection of community children's services

In June 2015 the Care Quality Commission sent a team of inspectors to our community children's services. The inspection was as a result of the CQC being unable to determine a rating for these services following the inspection of the Trust in October 2014. The CQC rated the services overall as being "outstanding", the highest possible rating. Every part of the service provided achieved a rating of either good or outstanding. The Trust achieved an outstanding rating for both caring and for leadership.

Overall Rating	Outstanding
Domain	Rating
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Outstanding

The CQC highlighted several areas of good practice:
"Staff were made aware of trust wide incidents in various forms, for example, through weekly team meetings, monthly governance meetings and emails from line managers to share lessons learned."

"All CYP teams had infection control champions who attended infection control meetings. The champions shared any actions to local teams to improve infection control practices"

"There was a multi-disciplinary approach to care and treatment and a proactive engagement with other health and social care providers to achieve best outcomes."

"We saw the transition of children moving from infant to junior and secondary school was seamless, however staff told us the transition for young adults when leaving education needed to be improved."

"Staff demonstrated determination and creativity to overcome obstacles to delivering care. Children/young person's individual preferences and needs were always reflected in how care was planned and delivered.

Staff were proactive about seeking the views of people who used services and to ensure children and their parents were fully involved in their care."

"The service was responsive to the diverse community and difficult to reach groups. Staff worked with other health professionals to provide an integrated and seamless service in a timely manner."

"We attended home visits with the children's nurse service and saw care delivery was individualised to meet the complex needs of children and support for the parents. For example, one parent told us the nurse looked at the needs of their child and planned care to support the family as a whole."

Children's Therapy Team Leaders Una Peplow, Kay Baker, Heather Bennett, Joanna Hall, Petrina Marsh, Jackie Williams, Jane Mills, and Harminder Bahia. The CQC rated our community and young peaple's service as outstanding.

"Local and senior leaders had an inspiring shared purpose, strive to deliver and motivated staff to succeed. Staff felt supported and nurtured by local and senior leaders with comprehensive and successful leadership strategies in place to ensure delivery and to develop the desired culture."

"Staff from all disciplines spoke with passion about their work and conveyed how happy they were within their respective teams, staff were self-motivated and energised to continually improve."

Inspection by the Human Tissue Authority

Mortuaries operate under the Human Tissue Act 2004 Licence and are inspected by the Human Tissue Authority (HTA) every three years. The mortuaries on both the Sandwell and City sites were visited on 30 September - 1 October 2015 as part of a routine inspection to assess whether the facility continues to meet the HTA's standards. It included a visual inspection of the mortuary, Post Mortem (PM) suite, body store and viewing room at the hub site (Sandwell) and a visual inspection of the body store, viewing room and storage of tissue, blocks and slides in Histology at the satellite site (City). Interviews with members of staff and a review of documentation were undertaken.

SWBH Mortuary services are licensed under the Human Tissue Act 2004 for the:

Making of a post mortem examination;

1. Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation; and storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose. Storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose

The HTA found that:

- the Designated Individual and the Licence Holder were suitable in accordance with the requirements of the legislation the premises and all practices were suitable in accordance with the requirements of the legislation. All applicable HTA standards were assessed as "all fully met".

Many areas of strengths and good practice were observed throughout the inspection including:

- Detailed and comprehensive standard operating procedures covering all areas of activity in the mortuary;
- Inclusion of the mortuary in end of life care training for nurses and junior doctors, to give them a better understanding of mortuary work;
- A clear visual system to track any cases that have gone elsewhere for PM examination ensuring that the rotating staff can see at a glance in the current status of each case;
- The use of markers on fridge doors to alert staff when bodies need to be handled with care due to irregular body shape; and efficient and prompt traceability of tissues.

The HTA assessed the establishment as suitable to be licensed for the activities specified and there were no non-compliances.

The mortuary at Sandwell, where many areas of good practice were found by the Human Tissue Authority when they inspected it last autumn.

Participation in clinical audits

During 2015/16 we participated in 37 national clinical audits and three national confidential enquiries covering NHS services which the Trust provides. SWBH has reviewed all the data available to them on the quality of care in all of these services. During that period Sandwell and West Birmingham NHS Trust participated in 97% of national clinical audits and 100% national confidential enquiries of 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 2015/16, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Women's & Child Health		
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Vital signs in children (Care in Emergency Departments)	Yes	100%
Diabetes (National Paediatric Diabetes Audit)	Yes	100%
Paediatric Asthma (British Thoracic Society Audit)	Yes	99%
National Pregnancy in Diabetes Audit	Yes	97%
Cystic Fibrosis Registry	Yes	100%
Acute care		
Emergency use of oxygen(British Thoracic Society Audit)	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	98%
Severe trauma (Trauma Audit & Research Network)	Yes	60%
Adult Critical Care (Case Mix Programme)	Yes	100%
National COPD Audit (Secondary Care)	Yes	100%
National Complicated Diverticulitis Audit	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	67%
Procedural sedation in adults (Care in the Emergency Department)	Yes	100%
VTE in lower limb immobilization	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit) Adult	Yes	100%
Diabetes (National Foot care Audit)	Yes	100%
Inflammatory Bowel Disease (IBD)	No	NA
Rheumatoid and early inflammatory arthritis	Yes	Ongoing
National COPD Audit (Pulmonary Rehabilitation)	Yes	100%
UK Parkinson's Disease Audit	Yes	75%
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	93%
Heart Failure (Heart Failure Audit)	Yes	50%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SSSNAP)	Yes	90%+
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
National Prostate Cancer Audit	Yes	100%
Oesophago- gastric Cancer (National O-G Cancer Audit)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion (Audit of patient blood management in scheduled surgery)	Yes	100%
National Comparative Audit of Blood Transfusion (Use of blood in haematology)	Yes	100%
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP) – National Hip Fracture Database	Yes	100%
FFFAP- Inpatient falls	Yes	100%
FFFAP- Fracture Liaison Service Database	Yes	0ngoing

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Other		
Elective Surgery (National PROMs Programme)	Yes	78%
National Ophthalmology Audit	Yes	100%
National Confidential Enquiries (Clinical Outcome Review Programmes)		
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following studies in 2015/16: Acute pancreatitis Physical and mental health patient in acute hospital Non invasive ventilation	Yes Yes Yes	92% Ongoing Ongoing
Maternal, infant and newborn clinical outcome review programme	Yes	100%
Child Health Clinical Outcome Review Programme - Chronic neurodisability - Young people's mental health.	Yes	 Ongoing Ongoing

The team who carried out mock CQC inspections across all areas of the Trust in January 2016.

Karen Blackford, Sarah Potter, Antony Lynch, Claire Phillips, Anne Rutland and Rohima Khatun are all part of the Research & Development team.

Karim Raza, Director of Research and Development.

Participation in clinical research

In 2015/16 we recruited 2450 patients from our Trust to participate in research studies adopted onto the National Institute for Health Research (NIHR) Portfolio. This was the largest number of new research patients recruited by our Trust in any single year. In addition, a further 500 patients were recruited for non- NIHR Portfolio studies. Participation in clinical research demonstrates our ongoing commitment to improving the quality of care offered to patients and to making a contribution to wider health improvement. Furthermore, it ensures that clinical staff stay abreast of the latest treatment possibilities. Research is undertaken across a wide range of disciplines including Cancer (Breast, Lung, Colorectal, and Haematological, Gynaecological, and Urological malignancies), Cardiovascular disease, Dermatology, Diabetes, Gastroenterology, Neurology, Ophthalmology, Rheumatology, Stroke, Surgery and Women and Children's Health. We use national systems to manage the studies in proportion to risk and implement the NIHR Research Support Service standard operating procedures. Examples of excellence in the last year include:

- The award of major research grants to clinicians at the Trust. Prof Karim Raza (Rheumatology) is a co-investigator on the Arthritis Research UK Strategic Programme Award 'The microbiome as a therapeutic target in inflammatory arthritis' (£2 million) and Miss Si Rauz (Ophthalmology) is a co-investigator on a Direct Pathway Finding Scheme MRC Major Award to develop a sight-saving synthetic, optically-transparent, patient-delivered, biologically-smart dressing for the prevention of corneal scarring during acute microbial keratitis (£2.36 million).
- Continued excellence in publishing research in the highest impact factor journals.
- Increasing the breadth of our research to areas with historically limited research activity, for example Clinical Immunology and Respiratory medicine.
- Increasing the number of Allied Health Professionals delivering clinical research, in particular with important contributions from Physiotherapy.
- Integrating patient representation into the Trust's Research & Development (R&D) committee allowing the patient voice to influence the Trust's R&D programme.

Strategic Objective	Priorities for 2016-17	How will we achieve it?
 **Safe, High Quality Care**	Reducing readmissions.	Continue to identify patients at risk. Outcomes will be a 2% fall in re-admission rates at Sandwell compared to the 2014/15 baseline.
	Improving the experience of outpatients	Improve care so that patients experience a maximum wait of six weeks, elimination of clinic rescheduling and 98% patient satisfaction rate. We expect to reduce did not attend (DNA) rates by 2%.
	Achieving the gains promised within our 10/10 programme.	We will focus on a 100-day roll out in our assessment units during the first quarter of the year and invest in ward managers to support delivery.
	Meeting the improvement requirements agreed with the Care Quality Commission.	In the first half of the year we will ensure we complete the remaining outstanding tasks in the Improvement Plan and in quarter three we need to ensure benefits have been gained from that work.
	Tackling caseload management in community teams.	We will make sure that nursing caseloads at team level are reduced to the median in the Black Country. Patient contact time will be increased by 10% among district nurses, health visitors and midwives.
 **Accessible and Responsive**	Meet national wait time standards, and deliver from a guaranteed maximum six week outpatient wait.	Achieve 93% or better for four hour waits in our emergency departments from Q2. Achieve the 18 week referral to treatment standard consistently. Eliminate open pathway referral issues seen in prior years. Deliver the 62-day standard in specific tumour groups.
	Double the number of safe discharges each morning, and reduce by at least a half the number of delayed transfers of care in Trust beds.	Have fewer than 15 delayed transfers of care in Trust bed base with 40% of discharges taking place before midday.
	Deliver our plans for significant improvements in our universal Health Visiting offer, so 0-5 age group residents receive high standards of professional support at home.	Deliver our contractual standards and establish our new partnership model with Sandwell Metropolitan Borough Council so that it delivers effective health visiting care for families.
	Work within our agreed capacity plan for the year ahead, thereby cutting did not attend (DNA) rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure, and accommodating patients declined NHS care elsewhere.	Cut did not attend (DNA) rates by 2%. Ensure all specialties by October 2016 achieve a recurrent balance between demand and capacity.
 **Care Closer to Home**	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home.	Make sure there is an increase in the proportion of patients identified as being on the planned pathway >72 hours before passing and Increase the proportion of patients able to die in place of their choosing.
	Respiratory medicine service sees material transfer into community setting, in support of GPs.	Establish the community respiratory service so that we see a reduction in unplanned readmissions for respiratory patients at Sandwell.

Strategic Objective	Priorities for 2016-17	How will we achieve it?
 **Good use of resources**	Create balanced financial plans for all directorates, and deliver Group level I&E balance on a full year basis.	Demonstrate group level balance for income and expenditure for the full year.
	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board.	Establish a reporting tool at frontline service level with clearly visible monthly reports on standards to support the performance improvement cycle.
	Reform how corporate services operate to create efficient transactional services that benchmark well against peers within the Black Country Alliance.	Conclude benchmarking work across the alliance and report to the programme board, with a rationalisation plan. Meet the KPIs for each corporate service.
 **21st Century Infastructure**	Get NHSI approval for EPR full business case, award contract and begin implementation, whilst completing infrastructure investment programme.	Approve the preferred bidder and put capability in place for effective implementation next year.
	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre.	Ensure that all departments relocating from City site know their future location at Sandwell and agree the investment trajectory as part of the 2016-2019 capital plan.
	Finalise and begin to implement our RCRH plan for the current Sheldon block, as an intermediate care and rehabilitation centre for Ladywood and Perry Barr.	Establish the West Birmingham intermediate care facility under the Better Care Fund.
 **An engaged and effective organisation**	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness.	The overall Trust sickness aim is 2.5%, comprising a fall from 2% to 1% in short term sickness and a fall of 100 people in long term sickness at any one time.
	Finalise our long term workforce plan, explaining how we will safely remove the pay-bill equivalent of 1000 posts between 2016 and 2019.	Make sure that the 2017/18 pay and whole time equivalent start point and proposed change plans reflect the Trust's long term workforce model.
	Create time to talk within our Trust, so that engagement is improved. This will include implementing Quality Improvement Half Days, revamping Your Voice, Connect and Hot Topics, and committing more energy to First Fridays	Make sure that we see an improvement on employee engagement score by at least 5%, with Your Voice response rates of at least 25% and understanding of actions being over 50%. We will have at least 100 senior leaders at our monthly team briefing system with high visibility of senior leaders and improved feedback on organisation communications.

During the year we agreed 10 goals for our Quality Plan and 10 safety commitments for our three year Safety Plan. Both of these plans are published in 2016.

Our Quality Plan Goals

Our health outcomes will be among the best in the NHS.

1. We will reduce deaths in hospital that could be avoided so that we are among the top 20% of comparable NHS Trusts in the UK. We will take action to cut avoidable deaths from Sepsis, Hospital Acquired Venous Thromboembolism, Stroke, Acute Myocardial Infarction (Heart Attack), Fractured Neck of Femur and High Risk Abdominal Surgery.
2. Cancer patients that we treat will have some of the best health outcomes in the UK, with SWBH being among the top 20% of comparable NHS Trusts.
3. We will coordinate care well across different services so that patients who are discharged are cared for safely at home and don't need to come back for an unplanned further hospital stay.
4. We will deliver outstanding quality of outcomes in our work to save people's eye-sight, with results among the top 20% of comparable NHS Trusts in the UK.
5. More Sandwell and West Birmingham residents will take up the health screening services that we provide than in other parts of the West Midlands.
6. We will reduce the number of stillbirths and deaths in the first week of life so that we are providing a better service than others in the West Midlands.
7. Patients at the end of their lives will die in the place they choose, receiving compassionate end of life care.
8. Children we care for will have convenient appointment times and those who need to stay in hospital will be treated quickly so that they are not missing out on valuable time at school.
9. Patients will report that their health is better following treatment with us than elsewhere in England, ranking SWBH in the top 20% of NHS Trusts for patient-reported outcomes.
10. We will work in close partnership with mental health care partners to ensure that our children's, young people's, adult and older people's crisis and ongoing care services are among the best in the West Midlands.

Our Safety Plan Commitments

We will keep our promises to provide safe and compassionate care.

1. Because we complete our Ten out of Ten safety checklist for every patient within 24 hours, all patients will receive expert care.
2. Because we assess and monitor every patient, and learn from every incident, we will protect patients from harm so that they do not experience pressure ulcers or falls that could be avoided
3. Because we have outstanding infection control practices, we will prevent avoidable infections in our care
4. Because we always monitor patients' Vital Signs at the right time we can and will quickly take action if their condition worsens.
5. Because we involve patients in their care plans, and sign personalised plans, our patients and their carers will be best placed to understand their condition and have an agreed care plan.
6. Because we are committed to providing dementia care in the best possible manner, we will work with carers to meet always meet the commitments in our Focused Care plan and John's Campaign
7. Because we review all patients with antibiotics every 72 hours, patients will only be given antibiotics when they are needed.
8. Because we always give patients their medication at the right time, no patient will miss out on a dose medication.
9. Because we give patients clear information about any invasive procedures, patients are able to give informed consent that we will always record.
10. Because we involve patients in their discharge planning, we will usually deliver the expected date of discharge and will always make sure we follow up home care packages to make sure they are in place

Stroke Alert Nurse Priscilla Javillo. Our quality plan aims to cut avoidable deaths due to stroke even futher.

CQUINs (Commissioning for Quality and Innovation) 2016/17

The following CQUIN (commissioning for quality innovation) targets are agreed with our NHS commissioners. We publish data on how we are doing on each target every month within our intergrated performance report, which is dicussed in our public board meetings.

	Goal Name	Description of Goal
Goal Number	Staff Health and Well Being	OPTION B: Introduction of Health and Well Being Initiatives.
	Staff Health and Well Being	Healthy food for NHS Staff, visitors and patients.
	Staff Health and Well Being	Improving Uptake of Flu Vaccination.
	Sepsis	A&E screening and treatment.
	Sepsis	Inpatient screening and treatment.
	Antimicrobial Resistance and Antimicrobial Stewardship	Reduction of Antibiotic consumption.
	Antimicrobial Resistance and Antimicrobial Stewardship	Review of Antibiotic prescribing.
Local	Cancer	Audit of 2 week wait cancellations.
	Cancer	Cancer Treatment Summary record in discharge care plans.
	Cancer	Cancer VTE Advice.
	Safeguarding - CSE	Production of a child sexual explotation awareness video that is used in staff training sessions.
	Mortality	Achieve an improvement in the % of avoidable and un-avoidable death reviews within 42 days.
	Discharges	Implementation of Transfer of Care Plans.
	Discharges	Reduction in readmission rate.
Specialised Services	Materninty	Local QIPP scheme Preventing Term Admissions to neo-natal intesive care.
	Blood and Infection	Haemoglobinopathy Improving pathways.
	Trauma	Activation system for patients with long term conditions – GE2.
Public Heath and Dental	Improving access and uptake through patient and public engagement	Breast Cancer Screening.
	Improving access and uptake through patient and public engagement	Bowel Cancer.
	Secondary Care Dental	Sugar Free Medicines Audit.

Partner statements

Healthwatch Sandwell

"In general this is an impressive report with good evidence of the Trust using information from audits and complaints to improve the service.

The handling of complaints with an emphasis on resolution by staff in the area involved has speeded up resolution and probably improved quality. The Trust has aimed to learn from complaints and gives valuable examples of this. Table top reviews following incidents are a process which has been used as a benchmark for other health and social care organisations and the ability to tackle such delicate issues as the giving and receiving of respectful challenge shows their value.

The use of Patient Reported Outcome Measures places the patients' perspective at the centre of evaluation of the service. The resultant improvement of information packs and guidelines to make expectations more realistic and pre-operative assessment more thorough shows their value. The development of the Ten out of Ten tool shows an appreciation of the importance of close attention to details of care in improving safety.

The Trust has taken part in a large number of national and local audits and following these has developed achievable action plans for improvement. A good example is increasing Consultant review of patients where emergency laparotomy is being considered and early plans for a General Surgeon/Elderly Physician appointment for patients over 70 years. There has been a significant increase in the participation of patients in clinical research, which tends to improve the quality of care as a result of more successful staff recruitment.

Other improvements include the provision of folding beds to allow carers of patients suffering from dementia to remain with them.

Inevitably, some problems persist. Staff sickness rates remain high but deeper analysis of this has shown improvements in some areas. The audit of the use of the Trauma Team shows a problem which is unlikely to be resolved merely by appointment of a scribe and re-auditing may lead to a more radical solution. Falls while under care in the community are much higher than the target. Friends and Family test scores at the start of care in pregnancy are low. Breastfeeding rates at the time of discharge are extremely low, this being a big social and medical issue.

The Trust appreciates that their biggest problem is the rising readmission rate of over 7%, which cannot be simply regarded as a product of an "efficient" reduced length of stay. It is gratifying that this is regarded as a high priority for the future and we suspect that considerable analysis of the causes of this have already been undertaken, even if not reported on."

Lyndon 2 patient Elsie Williams celebrating her 100th Birthday with a card from HM The Queen.

Jenny Simpson, a patient on D16, happy to be discharged after successful treatment

Healthwatch Birmingham

"At Healthwatch Birmingham we are passionate about putting patients, public, service users and carers (PPSuC) at the heart of service improvement in health and social care in the City of Birmingham. In line with our new strategy, we are focused on helping drive continuous improvement in patient and public involvement (PPI) and patient experience. We also seek to champion health equity so that PPSuC consistently receive care that meets their individual and collective needs. We have therefore focused our comments on aspects of the Quality Account which are particularly relevant to these issues.

We are pleased to see details of the Trust's Friends and Family Test (FFT) performance included within the Quality Account. We note the Trust has achieved a 95 per cent 'would recommend' FFT score for the Inpatients Department (in line with the national average), and that the Trust has achieved on or above the national average in three out of its four 'maternity touchpoints' (based on month 11 data). However, we are disappointed that the Emergency Department and Outpatients Department FFT scores are below the national average. We would value more detail on whether the Trust has identified the reasons why performance is relatively low in these areas, and whether it has any plans for improvements.

We appreciate the inclusion of the results from the National Women's Experience of Maternity in the Quality Account. However, there are no national averages or comparisons with previous years provided. This makes it difficult for us to comment on the Trusts performance, and we would therefore ask for these data to be provided in the Quality Account (if available).

As mentioned previously, one of Healthwatch Birmingham's focuses is on promoting health equity in the City. We note that the draft provided to us states that making FFT inclusive for all remains a challenge for the Trust, and we would appreciate more information on how the Trust will seek to address this challenge. We would also value any additional information on how the Trust has monitored and improved the experience of 'hard to reach groups' (e.g. people with learning disabilities, people with mental health problems, minority ethnic groups etc.). If this is not available, we would ask for this to be considered for next year's Quality Account.

It is positive that the Trust has changed the way complaints are handled this year to make sure patients and families are able to have their complaints heard and resolved by people who are close to the situation. We are happy to see the Trust has significantly improved its response times to complaints, from an average of 62.46 days in Q4 2014/15 to 26.75 days in Q4 2015/16. It is also excellent to see that the percentage of responses exceeding the original agreed response date have decreased markedly over the year. In addition to this, we value the information provided on the learning that has been taken from complaints.

We note that appointment issues are a prominent theme in both complaints and PALS enquiries. This corresponds with some of the feedback we have received this year about SWBH. Several patients and carers have commented on issues they have had with appointments via our feedback centre. These issues have included: poor communication around appointment cancellation and rearrangement, long waiting times in clinic, and comments on the disorganisation of the appointment system. Given these issues, we are encouraged to see that the priorities for 2016/17 include a commitment to improve the outpatient experience and cut cancelled clinic and operation numbers. We request clear evidence to be provided of progress against these priorities in next year's Quality Account. We also note that 12 per cent of all complaints received by the Trust in 2015/16 have been about the attitude of staff. This year we have received mixed feedback about staff at SWBH. We have had several positive comments about the care patients have received from staff at the Trust. However, we have also received a significant number of negative comments about staff, particularly around attitude and communication. We would therefore appreciate information on whether there are any initiatives planned to improve in this area.

We would like to congratulate the Trust on achieving an 'outstanding' rating for its community children's services following a CQC inspection. It is particularly heartening that staff were assessed as being proactive about seeking the views of people who used services, and as always reflecting individual preferences in how care is planned and delivered. It is also excellent that the CQC commented on the service's responsiveness to difficult to reach groups.

Whilst the draft Quality Account provided to us provides detail on how patient feedback is gathered at the Trust, there is limited information on how the Trust engages and involves PPSuC when developing or redesigning services. We would therefore value more detail on this in the Quality Account.

It is concerning that there have been four Never Events at the Trust in 2015/16, and that the Trust did not attain the 95 per cent standard set for harm free care during this time (averaging 93.5 per cent for the year). It is also concerning that the Trust was not compliant with its MRSA bacteraemia target. We hope to see improvements in these areas in next year's Quality Account."

Sandwell and West Birmingham Clinical Commissioning Group

"Overall Sandwell and West Birmingham CCG believe this to be a well put together report, that is clear, concise and easy to read, and well structured. In addition to this, we would also like to make the following points:

In terms of Quality, the CCG has been involved in the development of quality measures through the Chief Officer for Quality and the Trust has continued to develop throughout the year.

Regarding Complaints, there has been a significant improvement during 2015/16 in the Trust's complaint response times and its ability to identify lessons to improve the quality of the service.

In terms of Harm Free Care, the CCG Governing Body has kept aware that the Harm Free Care score of 94% is just below the 95% target and target will continue to be monitored. It is encouraging however to note that the Trust are continuing to the reduce the number of serious pressure ulcer incidents, with zero being reported in Q4. Regarding External Visits, the CCG recognises the excellent achievement of the Trust in receiving an 'Outstanding' rating for Community Childrens services by the CQC.

In terms of Never Events, there were four never events reported by the Trust this year. Although these are events that should never happen, the CCG was fully informed and involved in the investigative process and acknowledge the actions taken by the Trust to help prevent these incidents happening again in future."

Trust response

We thank our partners for their supportive comments on our Quality Account. We have included benchmark data on the National Women's Experience of Maternity Care Survey as requested by Healthwatch Birmingham.

Alesha McIntosh, one of our Sickle Cell and Thalassaemia Centre (SCAT) patients at City Hospital.

Community patient Wesley Thompson attending our pain management clinic at the Lyng.

KPMG

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

We are required 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 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. 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 2016 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infection;
- Percentage of patient safety incidents resulting in severe harm or death.

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

Respective responsibilities of the Directors and the auditor

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 ("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 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated June 2016;
- feedback from Local Healthwatch dated June 2016;
- the 2015 national patient survey dated January 2016;
- the 2015 national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016;
- the annual governance statement dated 31/05/2016; and
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015.

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.

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 the 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 2016:

- 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.

KPMG LLP
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

30 June 2016

Apendices

National and local audits and actions taken

The reports of 16 national clinical audits were reviewed by the provider in 2015-16 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare we provide:

Report	Findings, Our Learning, & OurActions
Provisional Patient Reported Outcome Measures (PROMs) **Audit description** An audit of outcomes reported by patients undergoing hip replacement, knee replacement, varicose vein surgery and surgery for inguinal hernia repair The Health & Social Care Information Centre publishes data on a quarterly basis	**Key findings/learning** The provisional data for April 14- March 15 in showed that the Trust is no longer a statistical outlier for the Average Adjusted Health Gain (AAHG) following primary knee replacement based on the health status questionnaire and for the Visual Analogue Scale, but it can be considered to be a statistical outlier for the AAHG for hernia repair for the general health status questionnaire. **Action** A number of steps have been taken to ensure that patients undergoing these procedures receive appropriate information and support. The actions have included the updating of information on risks and benefits and the implementation of guidelines for the listing of patients for surgery.
National Comparative Audit of Blood Transfusion: Audit of patient information and consent **Audit description** An audit to assess to what extent hospitals document the provision of information on blood transfusion to patients and to what extent and by what means the patients consent to be transfused is captured in the medical record.	**Key findings/learning** The local findings of the clinical case note audit highlighted that in only 60% of cases was the reason for transfusion documented. No cases had the consent for transfusion been documented, or if the patient information had been supplied with an information leaflet. In addition, there was no documentation of the risks of transfusion or that alternatives to transfusion had been discussed. The national report highlights documentation of the indication for transfusion should be a minimum requirement, with the explicit need to communicate the indication to patients supported by discussion of the risks, benefits and alternatives. **Action taken** The above elements are recommended as part of the Trusts Blood Transfusion Policy and forms part of teaching on the mandatory training module. In addition, an information leaflet is available. In order to improve practice, it was recommended to consider the re-design of the standard consent form the consent form to include transfusion and also to evaluate whether blood transfusion could form part of the electronic prescribing (e-prescribing).
National Diabetes Audit- Reducing harm in hospital – Mortality and Morbidity Project – Event Report **Audit description** The project aimed to identify the root causes of serious diabetes harms which occur in hospitals, specifically the harms identified in the National Diabetes Inpatient Audit (NaDIA).	**Key findings/learning** Key findings from the root cause analysis of a small number of cases indicated that:- • Guidelines were not always followed. • There was a low uptake of the training of staff which could be contributing to errors. • There were delays in commencing active treatment, particularly on the transfer of a patient. • The wrong or incorrect type insulin was prescribed. **Action** New clinical guidelines have been launched and a review undertaken of the uptake of training in key areas and with closer monitoring of this going forward. In addition, a new prescription chart has also been implemented to improve the prescription of insulin.

Report	Findings, Our Learning, & OurActions
National Bowel Cancer Audit (NBOCAP) **Audit definition** The Audit's overall aim is to measure the quality of care and survival of patients with bowel cancer in England and Wales.	**Key Findings/learning** Locally, the findings indicated that the Trust had been an outlier for 2 year adjusted mortality rate. It had been determined that this was largely due to incomplete capture and review of data important to measuring a patients pre-operative health status (ASA Grade), **Action** Action has been taken to ensure that all relevant data is checked at MDT meetings. Separately, surgeons check data that has been uploaded onto NBOCAP data platform prior to deadlines for the year. In order to assess the quality of care provided further, an additional action was to audit of a random sample of 50 cases from the cohort of deaths that had occurred within 2 years of surgery.
National Inflammatory Bowel Disease (IBD) Audit **Audit definition** The UK IBD programme aims to improve the quality and safety of care for people with inflammatory bowel disease throughout the UK by assessing individual patient care and the provision and organisation of IBD service resources.	**Key Findings/learning** The audit findings indicated that locally the IBD Specialist Nurse provision was below the recommended ratio. In addition, in order to ensure the highest quality pre–discharge information, there was a lack of a disease specific discharge information bundle or documented pathway. **Action** To review the IBD Specialist Nurse establishment and the provision of pre – discharge information and to ensure that a disease specific pathway is created in the new Electronic Patient Record in 2017.
Sentinel Stroke and Stroke Improvement National Audit Programme (SSNAP) **Audit description** The Sentinel Stroke National Audit Programme (SSNAP) is led by the RCP and commissioned by HQIP as part of the National Clinical Audit Programme. Updated reports are published every three months. This allows each hospital to be compared to other local hospitals and to the national average for a range of 10 categories of care.	**Key findings/learning** The results have shown that the Trust has attained a high level of performance compared to other Trusts. The data released in year shows that the Trust has maintained an overall SSNAP level B. Level B was achieved by 20% of Trusts with only 7% achieving a Level A. The main areas that showed the lowest domain level scores in time period related to the:- - provision of Speech & Language Therapy - percentage of patients who had a continence plan drawn up within 3 weeks. - proportion of applicable patients screened for nutrition and seen by a dietician by discharge **Action** To review staffing levels in Speech and Language Therapy and to reinforce the need of clear documentation regarding continence, mood and cognitive screening especially for patients that are discharged within in a short time frame. This to be addressed through the ongoing education and training of staff.

Report	Findings, Our Learning, & OurActions
National Emergency Laparotomy Audit (NELA) **Audit description** The National Emergency Laparotomy Audit (NELA) is part of the National Clinical Audit and Patient Outcomes Programme. The audit was commissioned by HQIP following evidence of a high incidence of death, and a wide variation in the provision of care and mortality for patients undergoing emergency laparotomy in hospitals across England, Wales and Scotland.	**Key findings/learning** Nationally, the audit found that less than half of patients undergoing emergency laparotomy were seen by a consultant within 12 hours of admission. This reflected the local position. Local findings also showed that the documentation of the mortality risk pre surgery was much higher than the national average. In addition, although the input from an elderly medicine specialist locally was in excess of the national average, this was below the recommended level and far from being routine. **Action** In order to improve the percentage of patients reviewed by a consultant with 12 hours, to implement a consultant review between 4-6 pm as regular event. A further action was to consider the appointment of a new general surgeon/elderly care physician to carry out the assessments of in patients >70 years of age.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report- "Just say Sepsis" **Audit description** The aim of the study was to identify and explore remediable factors in the process of care for patients with sepsis	**Key findings/learning** Overall, it was considered that there was good compliance with the key recommendations contained in the national report. For example, the Trust has had a formal protocol in place for the management of sepsis for some time. The audit found that approximately a third of participating hospitals did not have a protocol in place. Further areas identified for improvement concerned enhancing the clinical coding of sepsis and in providing an information booklet for patients. In addition, to continue work with Primary Care to ensure that there is continuity of care though promoting the use of a similar proforma or systems. It was also identified that locally the recording of sepsis on discharge letter to GP's is not being achieved systematically at present. **Action** The action identified to help address the above included working on a regional approach to ensure that there is consistency across the health economy and to share and promote good practice. Specific actions included ensuing that an information leaflet is available for those patients diagnosed with sepsis and in ensuring that the Trust's new Electronic Patient Record facilitates the informing of GP's on discharge that their patient has experienced a diagnosis of sepsis during their admission.
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report -'Time to get control?' **Audit description** The study examined the process of care for patients aged 16 years or older that were coded for a diagnosis of Gastro-Intestinal (GI) bleed.	**Key findings/learning** The national report identified remediable factors in the clinical and organisational care of patients experiencing a GI bleed. Locally, it was identified that Network arrangements were required to be clarified in order to ensure that patients have access to 24/7 endoscopy .In addition, further work was required to ensure that the traditional separation of care between physicians and surgeons for upper and lower GI bleeding in acute hospitals needed to change. It was also recommended that care pathways for all GI bleeds should include a minimum content. **Action** The main action to address the above was to continue with the development and then to introduce a GI Bleed Care Bundle. This would also incorporate risk assessments and the arrangements for the escalation of care.

Report	Findings, Our Learning, & OurActions
National Neonatal Audit Programme (NNAP) – Annual Report 2015 **Audit description** The key aims of the audit are: • To assess whether babies requiring neonatal care received consistent care across England; • To identify areas for improvement in neonatal units in relation to delivery and outcomes of care; • To provide a mechanism for ensuring consistent high quality care in neonatal services	**Key findings/learning** The audit results showed that the reported compliance for the Trust was below the national average for some indicators. This included rates for the administration of antenatal steroids .Although there had been a slight improvement in this from the previous year, a further audit was required to confirm whether this was due to mothers presenting late for delivery. The local audit findings also identified that locally the number of babies being breastfed when discharged from hospital was below the national average. . The capture of data on 2 year survival still required to be improved as this remained below the national average. **Action** For the Neonatal Unit to continue to work closely with the Infant Feeding Team on breast feeding initiation. In addition, to work with community paediatric team (consultant and Health Visitor) to improve data capture for 2 year survival rates. Also, to consider using an electronic system (BadgerNet) for clinical notes to help in the capture of key audit data e.g. on the consultations with parents and carers.
The Trauma Audit and Research Network (TARN) **Audit description** The Trauma Audit and Research Network (TARN) is an established national clinical audit for trauma care and has been supporting trauma receiving trusts for over twenty years by providing each hospital with case mix adjusted outcome analysis, performance on key process measures and comparisons of trauma care.	**Key finding/learning.** TARN audit reports highlighted that data submission rates continued to be below those expected by the national audit. In addition, more meaningful analysis could be provided if the depth of data collected by the Trust was increased. The data also showed that there was lower than expected activation of the Trauma Team according to the severity of injury scores that were subsequently determined by TARN. **Action** A number of actions have been taken to address the above including:- • A trauma booklet has been developed and is available in the Emergency Departments (EDs). Also, proformas used within EDs has been altered to facilitate better documentation. • A Major Trauma Policy has been implemented which adds the role of a scribe to the Trauma Team improve the recording of real-time data. The policy also incorporates a clearer process for the activation of the Trauma Team. • Nurse training has been implemented. • Data is regularly shared at Trauma Group meetings, and specific trauma scenarios are explored at the Trusts Quality Improvement Half Day sessions.
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Report	Findings, Our Learning, & OurActions
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report -'Time to get control?' **Audit description** The study examined the process of care for patients aged 16 years or older that were coded for a diagnosis of Gastro-Intestinal (GI) bleed.	• A Major Trauma Policy has been implemented which adds the role of a scribe to the Trauma Team improve the recording of real-time data. The policy also incorporates a clearer process for the activation of the Trauma Team. • Nurse training has been implemented. • Data is regularly shared at Trauma Group meetings, and specific trauma scenarios are explored at the Trusts Quality Improvement Half Day sessions.
National Pregnancy in Diabetes Audit (NPID) **Audit description** The National Pregnancy in Diabetes (NPID) Audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant. The audit measures the quality of pre-gestational diabetes care against NICE guideline based criteria and the outcomes of pre-gestational diabetic pregnancy. It aims to answer the following three key questions: • Are women with diabetes adequately prepared for pregnancy? • Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother? • Did any adverse outcomes occur?	**Key learning/finding** Nationally, the NPID audit showed that pre-conception care is not achieving the standards set out in NICE guidance and improvements are required. The potential impact of these findings on patient care includes miscarriage, uncontrolled blood glucose, pre-term deliveries and stillbirths **Action** The action plan to deliver improvement includes the following aspects:- • Developing programmes in primary care for pre-conception care by Diabetes Specialist Nurse (DSN) and General Practitioners (GP). • Earlier referrals in to hospital for viability ultrasound scan (USS) and appointments arranged early into the joint Endocrine and Obstetric Ante Natal Clinic. • Weekly telephone consultations with the DSN and Diabetes Specialist Midwife (DSM). • The importance of pre-conception care, early referrals into hospital are learned and communicated to staff via team meetings with joint endocrine and obstetric team.
National Paediatric Diabetes Audit – Patient & Carers Experience. **Audit description** The National Paediatric Diabetes Audit (NPDA) collects data on the quality of care for children and young people with diabetes mellitus in England and Wales	**Key findings/learning** Overall, the data presented in the first report of PROMs outcomes data from the National Paediatric Diabetes Audit showed that there was a positive experience of care, and for many data items the results were ahead of the national average and particularly for Sandwell Hospital. One area for improvement that was highlighted concerned waiting times for patients. The proportion of patients being seen within 15 minutes of their appointment time, were worse than peers. **Action** To amend clinic scheduling to improve waiting times and to ensure that patients are seen within 15 minutes of their appointment time.
Adult Critical Care (Case Mix Programme) (ICNARC) – Summary Reports 2015 **Audit description** The audit aims to promote local audit of critical care through the provision of comparative data, and to promote the use of evidence in critical care practice and policy.	**Key findings/learning** ICNARC reports had indicated that the overall demand broadly matches funded capacity, but there is significant variation between summer and winter. 24/7 Critical Care Services (CCS) Outreach has made a clinical impact, but there will be a formal analysis of this until after 12 months. All CCS deaths have a mortality review by a CCS consultant. All post CCS discharge death mortality reviews are verified / completed by the CCS ICNARC lead. No death was rated as "preventable". The CQC rated CCS as 'Good' and the team are aiming for that to be 'Outstanding' by the next inspection.

Report	Findings, Our Learning, & OurActions
Adult Critical Care (Case Mix Programme) (ICNARC) – Summary Reports 2015 **Audit description** The audit aims to promote local audit of critical care through the provision of comparative data, and to promote the use of evidence in critical care practice and policy.	**Action** To audit the clinical impact of 24/7 outreach after 12 months. All action points from 2014 report were completed. Re-audit is planned to take place in 12 months.
Falls and Fragility Fracture Audit Programme (FFFAP). National Hip Fracture Database (NHFD) Annual Report 2015 **Audit description** The National Hip Fracture Database (NHFD) is a clinically led, web-based audit of hip fracture care and secondary prevention.	**Key findings/learning** Results for Sandwell General Hospital showed that the hospital was in the top quartile for the following indicators:- • Admitted to an orthopaedic ward within 4 hrs. • Perioperative medical input. • Proportion of patients receiving spinal anaesthetic with nerve block • Return to usual residence within 30 days. The results showed that the Trust was in the lowest quartile for:- • Subtrochanteric fractures treated with IM nail • Recording the presence or absence of pressure sores **Action** To conduct an audit into the management of Sub trochanteric fractures treated with an IM nail. There is now ongoing review of any patient developing a Grade 2+ pressure sore during their admission by the Surgical Care Practitioners.
National COPD Audit - Pulmonary Rehabilitation – 'Time to breathe better' – Organisational element	**Key findings/learning** The national report recommended that commissioners and provider work together to review and enhance referral pathways for pulmonary rehabilitation (PR) and on education and training for referring healthcare professionals. Locally, a DVD has been developed on the benefits of PR and this needs to be edited for use with and by GP's. The report also recommended that PR should be offered to all patients with respiratory disease. Locally, it was identified that there was need to ensure that that the number of patients referred from secondary care is increased. It was also identified that approximately only 60% of patients complete pulmonary rehabilitation and that this need to be improved. **Action** To help to ensure that PR is offered to every patient prior to discharge, a new discharge care bundle is to be introduced which includes referral for PR. In addition, to conduct a further audit to determine why 40% of patients don't complete PR. The impact of the lack of transport needs to be quantified through this audit.

The reports of 32 local clinical audits were reviewed by the provider in 2015-16 and Sandwell and West Birmingham NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Report	Findings, Our Learning, & OurActions
Audit of results acknowledgement **Audit description** A snapshot audit of medical inpatients to determine the compliance with the standard that all imaging should be acknowledged with 72 hours of being performed (ideally within 24 hours).	**Key findings/learning** The audit found that the levels of acknowledgment were poor generally, with only 20% acknowledged within 24 hours regardless of modality. In addition, there was a lack of awareness of the need to acknowledge results amongst junior doctors. **Action** To emphasise the need to acknowledge results to junior doctors at departmental inductions and to encourage the acknowledgment of results on consultant ward rounds. It was recommended that teams need to take steps to ensure that their junior doctors know how to acknowledge results in the Clinical Data Archive (CDA) system.
NICE Quality Standard 68 – Acute Coronary Syndromes **Audit description** An audit to review the compliance with quality statements contained in NICE Quality Standard 68 using data collected for the Myocardial Ischaemia National Audit Project (MINAP).	**Key findings/learning** The audit results demonstrated that door to reperfusion times have improved on both sites since the introduction of a new activation pathway in conjunction with the West Midlands Ambulance Service (WMAS). The audit also found that the percentage of NSTEMI patients receiving an angiogram within 96hrs remained below the national average. The findings also showed that the deployment of secondary prevention medication in line with NICE recommendations continues to be excellent across both sites. **Action** Further work is required to ensure that processes are as efficient as possible, including a revision of the acute chest pain algorithm. Cardiology services were reconfigured in August 2015. This included the deployment of new scheduling software and extended Catheter Lab opening hours to improve access.
An audit of the initiation of staging investigations in ovarian cancer. **Audit description** An audit to measure compliance with NICE quality statement 5 contained in NICE Quality Standards 18 that all women who are offered staging for ovarian cancer, following ultrasound, are offered computed tomography (CT) of the abdomen and pelvis as the initial staging investigation.	**Key findings/learning** The audit found good compliance was achieved. Out of the 55 patients reviewed, 54 complied with the standard. 1 patient had an MRI due to the presence of a small tumour. No further action was required to be taken.
Management of hypertension in pregnancy **Audit description** A re-audit of the management of hypertension in pregnancy related to NICE Quality Standards 35.	**Key findings/learning** The audit found that although there was high compliance with the documentation of assessments and management plans, the requirements were not strictly adhered to in all cases. **Actions** To make minor amendments to the current protocols and to examine how records are coded, as in the small sample audited, 30% were not found to have a diagnosis of severe eclampsia or eclampsia.

Report	Findings, Our Learning, & OurActions
Re- audit of new referrals to the Rapid Access Breast Service (RABC) **Audit description** A re-audit of new breast referrals to the Rapid Access Breast Clinic (RABC) to identify the quantity and the quality of referrals.	**Key findings/learning** Key findings/learning The main finding was that many referrals do not map directly to clinical guidelines i.e. for breast pain. The conclusion was that the percentage of breast pain referrals is high (18.5%). There is a wide variance in breast pain referral rates between practices (5-42%). There are different pathways in GP practices so support, education and training are needed to modify practice. **Action** To work closer with primary care and offer support and education to help improve referral practice. In addition, to consider whether patients can be triaged before referral to urgent clinics.
An audit of the use of a "Surgical Pause" before opening implants in joint replacement surgery. **Audit description** An audit to assess compliance with the operational policy for theatres that in all cases the theatre team is expected to "pause" at the important juncture when the implants are being opened and delivered to the scrub nurse to check that the correct implants are opened.	**Key findings/learning** The audit found that in the cases reviewed the surgical pause occurred and so the standard was met **Action** To consider adding the 'surgical pause' to the WHO Checklist poster in theatres.
Management of Delirium Audit **Audit description** Audit of samples of patients to assess whether if there was evidence of acute confusion the patient was managed in accordance to NICE guidance.	**Key findings /learning** The audit found that there was good recognition of behavioral change in newly admitted patients, but the achievement of different management standards according to the documentation varied. For example, in only 46% of the sample audited was a cognition/orientation assessment documented. **Action** .As a result of the audit, a Delirium pathway and delirium card for staff have been developed and piloted. Teaching sessions have also been held to provide education on delirium. Following embedding of the pathway a re-audit will be conducted to review the effect on the length of stay, morbidity and mortality.
Global Rating Scale Audits **Audit description** Annual audit programme mandated by the National Joint Advisory Group (JAG) for endoscopy for service accreditation.	**Key findings/learning** Findings were reported for a series of 8 mandated audits for the endoscopy Global Rating Score (GRS) audits. Improvements were reported compared to previous rounds and no patient came to specific harm. Although some improvements were reported there some recurring themes were identified. These included higher than the recommended sedation and also unmet criteria for diagnosis, sampling and follow up that can be improved. Action To monitor the outcomes as part of the revalidation criteria for procedurists. In addition, to review the data on a regular basis with the gastroenterology multidisciplinary team (MDT) in clinical governance meetings.

Report	Findings, Our Learning, & OurActions
WHO Checklist Compliance Audit **Audit description** To assess the compliance with the "Five Steps to Safer Surgery" in the Trust. This includes use of the Surgical Safety Checklist. All patients undergoing interventions, surgical procedures or treatments (defined as the intervention provided by a team in an operating theatre or procedure room) should have the 3 sections in the Safer Surgery Checklist completed (Sign in, Time out, Sign out). A brief and debrief should also conducted for relevant lists.	**Key findings/learning** Results have shown a high compliance with the completion of the three sections on the Surgical Safety Checklist. This figure was 99.7% in the period examined. Data also had shown that for elective lists the brief & debrief elements had been completed in 99.2% of cases in the period examined. **Action** To undertake some spot check audits to ensure that all the relevant documentation has been fully completed.
Healthcare Records Audit **Audit description** An audit to assess whether entries in the case notes comply with the basics of record keeping in that they are:- • written in black ink • legible • dated • timed • signed • name of author clearly printed • designation of author recorded	**Key findings/learning** In the period examined, the audit found areas of good practice and also areas where practiced needed to be improved. For example, a daily entry made in 96% of cases where deemed relevant, but only 51% of last entries complied with all the 7 elements of the basics of record keeping. The main area for improvement in the composite indicator was in the timing of entries, with 29% of entries not being timed. **Action** To continue to raise awareness of the need to improve the timing of entries through learning alerts.
Audit of Patient Consent **Audit description** An audit to assess compliance with Trust policy, in particular, in that consent is taken by clinicians who are capable of performing the procedure or have received specific training to do so and that risk and benefits are fully explained.	**Key findings/learning** In the period examined the audit found that in 82 % of cases the consent was taken by a clinician who was capable of performing the procedure or who had training to do so. In addition, although there had been a reduction in the percentage of patients consented on the day of surgery; there were still some examples of missed opportunities to gain consent prior to admission. The audit also found that it was not recorded on the consent form in half of elective cases whether the patient had been supplied with an information leaflet. **Action** For Directorates to determine the types of procedure where it is not being recorded whether the patient is being supplied with an information leaflet on the consent form and the procedures where consent is being taken on the day of surgery, so that targeted action can be taken.
Thromboprophylaxis Audit **Audit description** An audit to assess compliance with the Trusts guidelines on thromboprophylaxis, in particular, that all patients assessed to be at high risk of developing a VTE are prescribed thrombopro-phylaxis.	**Key findings/learning** In the period examined the audit found that 94% of patients who were at high risk of venous thromboembolism (VTE) and who were eligible to receive thromboprophylaxis were prescribed it. In addition, the data highlighted that Directorates within Medicine were now contributing cases to the audit. **Action** To ensure that the Thrombosis Committee reviews all cases where high risk patients are indicated not to have received thromboprophylaxis and to take steps to identify the root causes. In addition, to review the audit criteria in line with the revised clinical guidelines that is under development.

Report	Findings, Our Learning, & OurActions
Parkinson's Disease (PD) Audit **Audit description** An audit to assess compliance with NICE Parkinson's Disease Guidelines (CG35).	**Key findings/learning** The audit reviewed 40 cases which were randomly selected from a sample of 200 admissions. The audit found problems with delays in referral to speech and language therapy; issues with lack of familiarity with drugs and lack of staff awareness; coding of PD cases. **Action** As a result of the audit, teaching sessions have been undertaken on medicine wards. In addition, a Parkinson's Disease pathway has been developed and an alert system for Parkinson's patients has been put into operation. Most patients are now coded internally in PD clinics. A further action was to review the Patient Self-administration Policy in order to facilitate the self-administration by patients with PD through the possible use of timer devices.
Re-audit of compliance with the Society for Acute Medicine standards. **Audit description** An audit to assess compliance with the standards based on those from the Society for Acute Medicine (SAM).	**Key finding/learning** The standard that all patients should have an Early Warning Score measured upon arrival and within 4 hours was met in 84% of cases. In 55% of cases referred from ED were clerked within 4 hours of arrival (national average 88%). 87% of these were reviewed by a consultant within 14 hours which was above the national average. **Action** To take steps to improve the recording of the EWS with ongoing education. To consider the development of an integrated clerking proforma that commences in ED and continues in AMU. The aim would to be to reduce duplication.
Injection Therapy Patient Group Direction Compliance **Audit description** An audit to assess whether all electronic notes audited for patients who received injection therapy contain fully completed consent and drug forms.	**Key findings/learning** The audit found that 10% of Electronic Patient Records (EPRs) audited contained consent / drug forms that were not fully completed. 4% of EPR audited had no consent form / drug form attached. **Action** To ensure that each injector audits their practice to check that they have fully completed the drug and consent forms and attached these to the EPR In addition, to set up a database to collect the data. A further action was to investigate the options around the use of digital signatures to avoid the need for printing and scanning the consent / drug forms.
Audit of Heavy Menstrual Bleeding (HMB). **Audit description** A re-audit to review the management of women with heavy menstrual bleeding who have been referred to secondary care, looking specifically at demographics and the investigations and treatment offered as indicated in the relevant NICE Quality Standards.	**Key findings/learning** Although the re-audit had shown some improvements in pre referral investigations, it highlighted the need to reinforce with GP's the need for a recent full blood count and out-patient ultrasound scan if indicated, to aid diagnosis. In addition, pharmaceutical treatment should be started before referral to secondary care and this had only occurred in 32%.of cases audited. **Action** To consider the introduction of an electronic referral and/or a triage system, with re-referral once tests have been carried out
Audit of late (under 8 days) Theatre cancellations **Audit description** This was a baseline audit to determine the most common reasons for late cancellations, with a view to look for solutions and to achieve a reduction.	**Key findings/ learning** The audit found that there was a cancellation rate of <3.7% within 7 days of surgery, but that only 21.9% of patients were re placed and so potentially wasting theatre resources.

Report	Findings, Our Learning, & OurActions
Audit of late (under 8 days) Theatre cancellations **Audit description** This was a baseline audit to determine the most common reasons for late cancellations, with a view to look for solutions and to achieve a reduction.	**Actions** It was concluded that the cancellation rates in ENT were already low, but it that if there was a larger pool of patients who have had pre-op assessment, this would allow for more of these slots to be filled going forward. This was the key recommendation to address arising from the audit.
Audit of the management of Post-Partum Haemorrhage (PPH) **Audit description** A retrospective audit to measure practice against the departmental guidelines for the management of massive obstetric haemorrhage.	**Key findings/learning** There audit identified 45 patients with obstetric haemorrhage in the one year timeframe examined. This accounted for 0.78% of deliveries. In addition, it was recorded that the consultant obstetrician was informed in 43/45 cases of these cases and was present in 24 of these. The audit also found that a third of the patients audited had pre-existing anaemia. It was felt there was a need to improve management of anaemic women in the antenatal period. **Action** For the Antenatal Development Group to develop guidelines for screening and treatment of anaemia (to include timing of iron tablet prescription). In addition, for Junior doctors to be informed of the need to involve consultant obstetricians when there is a massive obstetric haemorrhage.
Audit of swab counts in maternity **Audit description** An audit to determine compliance with local clinical guidelines to ensure that swab and instrument checks are correctly documented.	**Key findings/learning** Overall, assurance was gained that safe practice exists for cases of caesarean section involving the completion of swab counts on Surgical Checklists and Maternity Care Plans. The audit found that there were some instances where there was a lack of a second signature on some Instrumental Delivery proformas to confirm that the swab count was complete. **Action** To continue to raise awareness of safe checking procedures within maternity and to continue to ensure that this is included as part of Skills Drills training. In addition, to re-audit compliance when the practice of recording this information electronically on BadgerNet has become embedded.
Born Before Arrival (BBA) at Hospital Audit **Audit description** A re-audit of babies born before arrival (BBA) following an earlier audit conducted in 2013.	**Key findings/learning** The audit concluded that the underlying reasons for BBA are multifactorial. They are associated with language barriers, late presentations during pregnancy, navigating the maternity services and a high number of social concerns that may have influenced women when choosing to come into hospital. **Action** • To hold a meeting with the Ambulance Service to discuss the management of BBA and to include the 3rd stage protocol. • If there is a language barrier when discussing planning and signs of labour, to ensure that an interpreter is available at each contact visit. • To continue to review in detail all cases of BBA.
A clinical audit of physiotherapy and occupational therapy interventions in acute hospital delirium **Audit description** The audit was conducted a clinical audit against NICE Clinical Guideline 103 – Delirium: prevention, diagnosis and management.	**Key findings/learning** Previous clinical audits focusing on delirium undertaken by medical staff, found that awareness and application of best evidence by the multidisciplinary team required to be improved. This therapy based audit found that just over half of patients at risk of delirium were assessed for reduced mobility within first 24 hours of admission and that only 39% had a therapy-derived mobility treatment plan in place.

Report	Findings, Our Learning, & OurActions
A clinical audit of physiotherapy and occupational therapy interventions in acute hospital delirium **Audit description** The audit was conducted a clinical audit against NICE Clinical Guideline 103 – Delirium: prevention, diagnosis and management.	**Action** To establish a rolling education programme delivered to multi-professional teams which aims to a) raise awareness of the condition, b) instil competence and capability using delirium assessment tools, and c) outline the importance of application of the evidence base
Caesarean Section Audit **Audit description** An audit conducted against NICE Quality Standards 32 (Caesarean Section). These focus on improving the decision-making process and the information available to women who may need, request or have had a caesarean section. The standards also focus on reducing potential risks or complications for the woman and the baby. This re-audit aimed to measure current practice against the quality standards.	**Key findings/learning** The previous audit conducted in 2014 found that there was poor documentation about the mode of communication. NICE standards require documentation of how the consultant was informed for emergency sections. Following this audit changes were made. The re-audit assessed whether there was improvement in documentation. Overall, the findings showed that there was good compliance with the NICE guidance. The area of documentation that needed further work concerned recording that a de-briefing with the mother has occurred. **Action** To address the debriefing requirement, consideration would be given to adding check boxes to the proforma for caesarean section (operation note) so that staff are reminded to discuss and to document the discussion of the operation and future concerns with the patient. It was also recommended that these fields could be made mandatory before the electronic record/page can be closed.
Clinical audit of physiotherapy in the assessment and prevention of falls in older people Audit description The audit was conducted against selected standards contained in NICE Clinical Guideline 161- Falls in Older People: Assessing risk and prevention.	**Key findings/learning.** The key finding from the audit was that documentation required to be improved and that no standards were fully met and in almost all areas compliance was below 50%. It was also identified was an overreliance on walking as a means of assessment and treatment. The audit highlighted the need to commence falls rehabilitation whilst the patient remained on the acute site and to then ensure that follow up services are utilised so as to minimise risk and to prevent readmissions. **Action** As a result of the audit new documentation has been introduced to standardise assessments and a re-audit would be conducted once this has been embedded to measure the expected improvement.
Comparing gynaecology outpatient clinics with the 8 outpatient quality standards set by SWBH. **Audit background** An audit to compare gynaecology services with the proposed Trust outpatient standards.	**Key findings/ learning** The audit found that the standards were being met apart from the standard that a documented outcome of an outpatient visit will be available to the GP electronically within 2 working days. **Action** It was recommended that data is collected on by how many days the target was missed, and to consider setting up a template letter to be printed out for the patient to take to their GP if the only change was to their medication. This would help to reduce the quantity of letters required to be processed.
Verification of death audit **Audit description** A re-audit to measure adherence to the code of Practice for the Diagnosis and Confirmation of Death; Academy of Medical Royal Colleges; October 2008 Also to compare the findings from a previous audit completed in Acute Medicine in 2014.	**Key findings/learning** The audit found that documentary evidence of compliance with all of the ten requirements was poor. All the requirements were met in only 6% of cases. The least well completed aspect was the duration of assessment (29% completed)

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Verification of death audit **Audit description** A re-audit to measure adherence to the code of Practice for the Diagnosis and Confirmation of Death; Academy of Medical Royal Colleges; October 2008 Also to compare the findings from a previous audit completed in Acute Medicine in 2014.	**Action** To raise awareness of the findings of the audit and to develop a standard proforma for verification of death to be used throughout the Trust. This could be based on the checklist used by appropriately trained registered nurses when verifying a death.
Audit of outcomes from a diabetes renal clinic. **Audit description** To evaluate the impact of doctor and nurse led diabetes & renal clinic on specific outcomes including HbA1c & blood pressure.	**Key findings/learning.** Although the audit found that there were significant improvements in HbA1c, both systolic and diastolic blood pressure, creatinine and eGFR in the diabetic renal combined clinic over 12 months, disappointingly, Urine ACR results did not improve. This was considered to possibly be due to poor patient compliance in arranging for a urine sample to be tested. . **Action** To reinforce patient education needs to ensure that even better clinical outcomes arise from the Diabetic Renal Clinic. To further this by introducing additional Chronic Kidney Disease and Diabetes education leaflets for patients.
A local audit against standards from the National Neonatal Audit Programme (NNAP). Audit description A local audit to assess whether babies requiring neonatal care received consistent care according to standards set by the National Neonatal Audit Programme (NNAP).	**Key findings/learning** The results from the national audit had indicated that breast feeding rates were below those expected, and that documentation required to be improved in a number of areas. The local audit found that the temperature was recorded in 85% eligible babies within one hour of birth. The national average was 94%. .In addition, when examining feeding at discharge, the audit found that 24% were discharged on some form of their mother's milk. This was less than the national average of 60%. **Action** To encourage vigilance in preventing admission hypothermia by using accepted techniques such as the use of occlusive wraps, radiant warmers, hats and adjusting the temperature of delivery rooms, to ensure that babies are warm on admission. Also, to conduct a review of feeding practices, and to undertake a quality improvement intervention involving the relevant clinical teams and parents so as to encourage higher rates of breast feeding.
An audit of the completeness of basal cell carcinoma (BCC) surgical excisions **Audit description** The aim of the audit was to provide a snapshot of non-Mohs excision practice for patients with NMSC receiving treatment in the Dermatology Department at City Hospital. The department follows British Association of Dermatologists (BAD) clinical guidelines for excision margins for Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC)	**Key findings /learning** The audit provided an assessment of the completeness of excisions at a non-Mohs centre in secondary care. In the sample audited, although the numbers were small, there was a higher than the national rate of cases with no clear excision margin. It was reported that this was not due to surgical technique as the department doesn't have Mohs In a center that conducts Mohs surgery, during the procedure, after each removal of tissue and while the patient waits, the tissue is examined for cancer cells. That examination informs the decision for additional tissue removal. Mohs surgery is one of the many methods of obtaining complete margin control during removal of a skin cancer) **Action** To undertake a review of the cases of incomplete excision to establish whether incomplete excision could have been anticipated and to determine if any changes to pathways are required as a result.

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Compliance with Enhanced Recovery Protocol post colorectal surgery. **Audit description** An audit to assess whether the enhanced recovery protocol was utilised in appropriate cases following colorectal surgery.	**Key findings /learning** The audit found that there was no formal documentation in the patient records examined to support the use of the Enhanced Recovery Protocol. Delivery of certain elements was also suboptimal. For example, 30% of the sample were not mobilised on day 1. **Action** To redevelop and re-launch the protocol through the Early Recovery After Surgery (ERAS) Implementation Group.
Meeting Outpatient Standards in a multidisciplinary pain clinic **Audit description** An audit conducted to assess compliance with the Trust "Standards for Out Patients Clinics and Letters"	**Key findings /learning** The audit found that a low percentage of patients were seen within 6 weeks of referral, and under half were seen within 20 minutes of their appointment time. 62% of letters were typed and available electronically within 2 days of the appointment. **Action** The actions identified included reviewing the administrative support for the Pain Clinic and also to consider the introduction of virtual or extended clinics.
Bowel Cancer Mortality Audit **Audit description** The Trust had been notified of being an outlier for 3 year adjusted mortality based data submitted on patients to the National Bowel Cancer Audit (NBOCAP) for the period 2008-11. Previous investigations found that this was mainly due to the inaccurate recording of ASA grades leading to incorrect risk profiling. Steps were taken to correct this from 2012 onwards. An audit of sample of major resections from this period was requested to ensure that there were no other underlying reasons	**Key findings/learning** The audit found that there were no outliers for individual surgeon mortality and that all patients with an indication for radiotherapy received radiotherapy. There was an indication for chemotherapy in 38 patients (adjuvant 20, palliative 15, both 3). However only 14 (37%) received chemotherapy. Of the 24(63%) who did not receive chemotherapy despite an indication, 14 were unfit on clinical assessment, 5 declined and 5 died prior to the commencement of treatment. There were some delays in radiotherapy and 16% of patients had a delay in surgery >31 days. In summary, the audit did not show any systemic failures in surgical, medical and clinical oncology care. Patients were also referred appropriately for liver resection. Following the outlier alert, robust checking of data submitted to NBOCAP was implemented. ASA grades are now specifically recorded in MDT meetings. Surgeons also check their data before it is submitted prior to annual reports. The latest report for patients who had undergone major resections in 2011/12 showed that the Trust is no longer an outlier for 2 year adjusted mortality. **Action** In order to build upon the findings of the audit, it was recommended that General Surgery regularly report on the monitoring of key complications in a local dashboard.
An audit of compliance with Paediatric High Dependency Unit (HDU) care standards. **Audit description** An audit to assess the compliance with locally and regionally agreed standards of care for the critically ill children.	**Key finding/learning** It is recommended that all HDU patients should be reviewed by a registrar within 4 hours of admission and subsequently have 8 hourly medical reviews. Previous audits also highlighted a need to improve the documentation of HDU care on the ward rounds. The latest audit found that there had been a significant improvement in the frequency of medical review of patients on HDU. The audit also found that there was a slight improvement in the documentation of HDU care on the ward round, this still needed to be improved further. A further audit was also identified as being required on the escalation and de-escalation of care against locally agreed protocols. **Action** To consider developing a ward round proforma for HDU patients. This would remind the team to perform 8 hourly reviews and could also prompt the team as to when to de-escalate from HDU.

Readmission rates

The table below details our readmission rates. The information is collected during a financial year period and we now measure readmission within 30 days (previously 28 days). Our readmission rates continue to rise and readmission reduction remains a priority for the Trust.

Age 0 – 15 years

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
15/16	15,867	1,100	6.9%
14/15	15819	1360	8.6%
13/14	15331	1350	8.8%
12/13	15679	1463	9.3%
11/12	14533	1257	8.6%
10/11	15077	1219	8.1%

Age 16 and over

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
15/16	92,650	7738	8.4%
14/15	94349	7707	8.2%
13/14	96981	7530	7.8%
12/13	101647	7693	7.6%
11/12	102660	7235	7.0%
10/11	110729	7734	7.0%

All Ages

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
15/16	108517	8838	8.1%
14/15	110168	9067	8.2%
13/14	112312	8880	7.9%
12/13	117326	9156	7.8%
11/12	117193	8492	7.2%
10/11	125806	8953	7.1%