NHS
Sandwell and
West Birmingham
NHS Trust

QUALITY ACCOUNT
2021/22

PATIENTS
PEOPLE
POPULATION

Foreword

Welcome to the Quality Account for 2021/22. This report provides an overview on the Trust's performance against our quality priorities for the year. During this year we focused on restoration and recovery after the first year of the COVID-19 global pandemic, partnership working with other Trusts and through our place based partnerships, together with improving mortality through our learning from deaths programme.

Patient safety has remained our priority as we have adapted our services to meet national and local infection prevention and control guidance.

We have learned and adapted during the year with new treatments for patients with COVID-19 and delivering services for different needs to maintain safety and improve convenience for patients.

Our staff deserve full credit for stepping up at every phase of this pandemic, following latest guidance with rapid changes and for many, working in different areas to go where the need has been greatest. We have continued to invest in colleague's health and wellbeing to support reflection and recovery.

We were pleased that our maternity services retained a "good" rating following a focused inspection from the Care Quality Commission (CQC) in May 2021. The service team continue to implement their improvement plan that is monitored at Trust Board and includes the actions from the Ockenden review.

Our Trust has continued to work towards CQC standards, preparing for future assessments with many services receiving unannounced in house inspections that have helped to identify areas for improvement.

We continue to work hard to develop a culture of learning within the organisation. Our quality improvement half day (QIHD) poster competition highlighted services who have demonstrated improvement in either patient care or service standards. There is much to learn from these beacons of excellence, both within the Trust and further afield.

This year we have developed a new five year strategy with three strategic objectives:

- **Patients:** To be good or outstanding at everything we do
- **People:** To cultivate and sustain happy, engaged and productive staff
- **Population:** To work seamlessly with partners to improve lives.

Our patient objective will support improved quality with an approach to establish fundamentals of care standards that all staff can understand and implement. Through this approach we are aiming to improve consistency in care provision so that all patients and family members can experience good quality of care whenever and wherever they access health care services.

We continue to work collaboratively with partners where we can improve outcomes for patients including our place based partnership work in Sandwell to improve care for population health and reviewing clinical services with partners in the Black Country to identify services that would benefit from integration and reconfiguration.

We expect partnerships to become even more developed in the coming year as the Integrated Care Boards become established along with the provider collaborative for the Black Country and our place based arrangements.

Richard Beeken, Chief Executive

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.

Sir David Nicholson, Chair

Richard Beeken, Chief Executive

Mum Bal who has praised the care her son Kavanveer has received at Sandwell Hospital.

Our Trust Strategy 2022/27

Our Trust has always aspired to be more than a hospital and a healthcare provider. Our purpose is to improve the life chances and health outcomes of our population by working seamlessly with our population, our people and our partners. Our vision is to be the most integrated care organisation in the NHS.

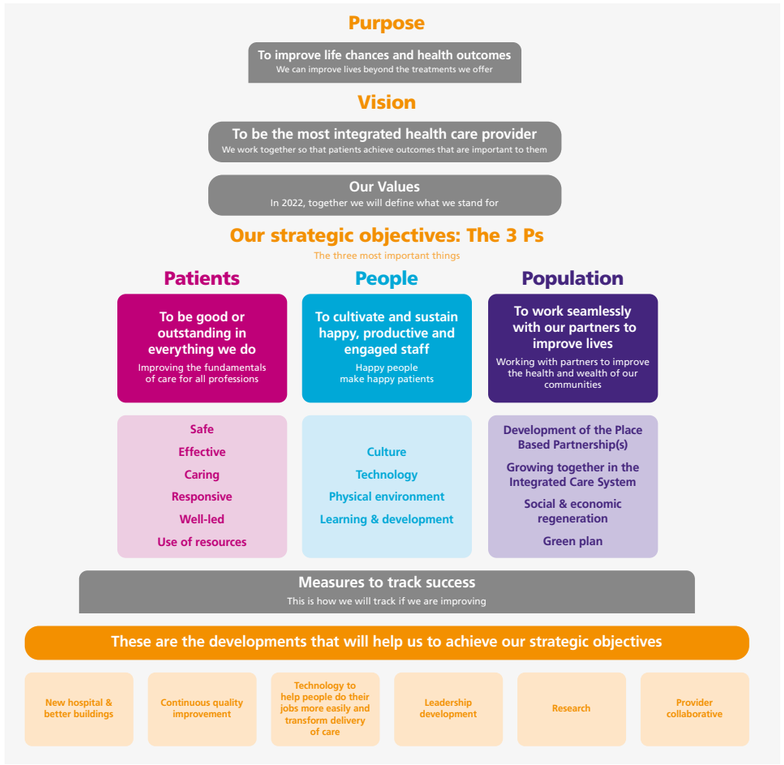
Since 2009 our Trust has lived by nine care standards, or promises, developed by frontline staff. In spring 2022, we started consultation with our people, patients, population and partners to agree a new set of values that reflect our inclusive, collaborative and compassionate community. When implemented these will be practiced through a new behavioural framework which will be fundamental to who we are, who we recruit, how we work and how we treat those that we work with and care for.

Our five year Trust strategy for 2022/27 has been set in the context of:

- Completing and opening a new hospital with both supply chain and workforce challenges
- Meeting the changing demands of COVID-19 including vaccination
- Recovery and restoration of our services, in particular our planned care waiting lists
- Worsening health in our population, exacerbated further through inequalities
- A workforce that is burnt-out and suffering physical and mental health impacts of COVID-19
- Integrating with other organisations in our region
- Finite resources in a health system that requires end to end transformation.

Strategic Framework

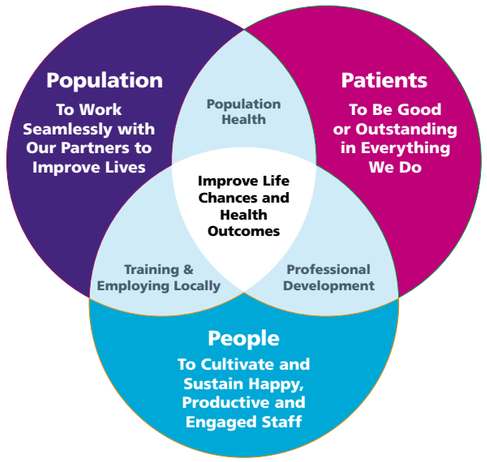
To deliver our strategy we need to be clear about five areas: purpose, vision, values, strategic objectives and board level metrics. These five fundamentals are underpinned by six 'enablers' that will support the achievement of our strategy: our new hospital and better buildings, continuous quality improvement, improved use of digital, leadership development, research, and our provider collaborative.



Over the next five years we will have three strategic objectives:

1. **Our People** – to cultivate and sustain happy, productive and engaged staff
2. **Our Patients** – to be good or outstanding in everything we do
3. **Our Population** – to work seamlessly with our partners to improve lives

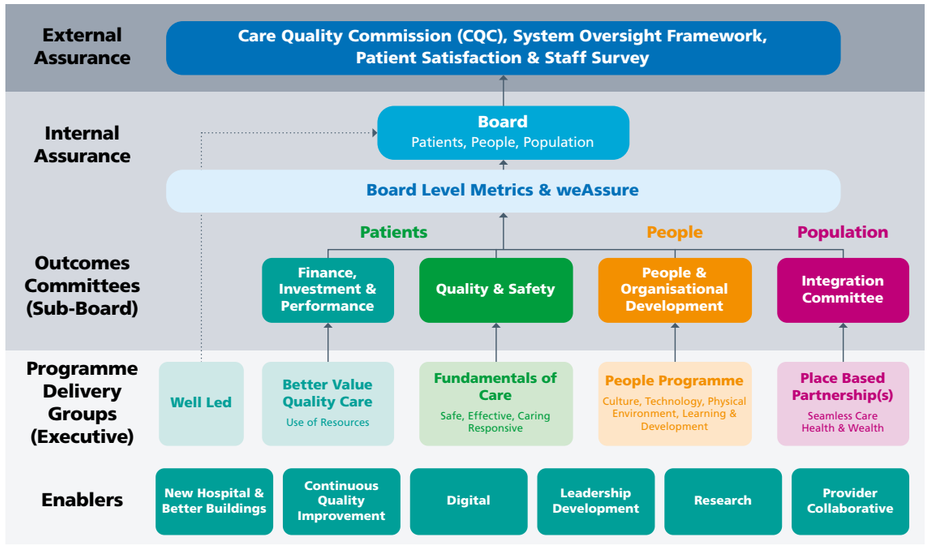
In setting our strategic objectives we have considered how they are linked together. We must deliver improvements in all three objectives if we are to be successful in delivering our purpose.



It is our governance that sets out and underpins 'how' we will deliver the strategy. Our governance flows from the external assurance mechanisms, such as the Care Quality Commission reviews and NHS England's System Oversight Framework, to our internal assurance mechanisms such as our Board, our committees, our board level metrics and through to our key programmes of work.

It is the role of our committees to scrutinise the journeys that the programmes are making. This structure will drive our improvement against our people, patient and population objectives with support from our strategic enablers.

In 2021/22, we started to change how we measure and manage our performance with the aim of simplifying and focussing what we monitor. The first step has seen us reduce the volume of targets we monitor at board level by 80% and we are focussing on the top 24 metrics known as our 'Board Level Metrics' (BLM). We have made sure to align these to national requirements such as the Care Quality Commission and national targets, as well as local targets that we need to improve. We have adopted Statistical Process Control (SPC) charts to monitor whether we are making a meaningful difference and we benchmark our performance against other NHS trusts. Details of our BLM can be seen on our Trust website here https://www.swbh.nhs.uk/about-us/trust-board/public-trust-board-papers/



We cannot do everything at once, so if we are to make meaningful progress on what is most important we must prioritise our key actions. We are therefore planning our strategy in actions before opening our new hospital and afterwards.

Priorities for Improvement in 2022/23

Priority 1

Acute care models for Midland Metropolitan University Hospital (MMUH)

As we prepare for the completion of the building work on MMUH, the models of care to deliver acute inpatient services are being reviewed. There have been many changes since the original business case for the new hospital was submitted that have required a close review of the work patterns when services come together on one site.

New clinical guidance from specialist societies, changes in acute care pathways reflecting the increased demand on front door services and an increased focus on admission avoidance and care within the community are some of the factors that have led to changes being required to the care models that will be followed in our new hospital.

These care pathways will need to link with the important out-patient and day-case services that will remain on the retained estate at our City and Sandwell sites.

Work is already underway to understand capacity requirements and specialty co-dependencies so that appropriate staffing levels and skill mixes will be in place for the services within MMUH. Given the specialised nature of some of the roles recruitment to these posts will require a carefully thought out approach. Close working with our education and research partners will be needed to maintain the quality of training we provide and academic reputation of the organisation.

Progress on this work will be monitored and reported through our MMUH Opening Committee.

Director of Research and Development Dr Derek Connolly at MMUH.

Priority 2

Fundamentals of Care

Improving the standards of care provided to our patients will always be a focus of our organisation. The interdisciplinary fundamentals of care approach, which is part of our Trust strategy, will focus on making sure that we maintain the focus on getting the basics right for our patients at all times. To do this consistently this requires close team working on our wards and clinical environments for all patient groups, to make sure that the standards that are set are understood, and met, by all those involved with patient care.

There will be nine objectives and a programme of training and support to make sure these objectives are delivered but we will also empower the clinical groups to deliver those aspects that are important to them and their patients. This puts the patient needs and voice at the centre of their care, not just their illness or treatment plan.

The standards of care will include personalised care, harm free care, promoting independence, nutrition and hydration, sleep and rest, maintaining healthy skin and continence and symptom management and communication. These standards will be fully developed with patient and relative representation.

The delivery programme for the standards is being developed along with an accreditation programme for all staff involved. Importantly these principles will overlap with those required from the GMC for good medical practice as well as those from the NMC for nursing and will be a collaborative programme between all professional groups, jointly led by our Chief Medical Officer and Chief Nurse.

Progress on this work will be monitored and reported through our Executive Quality Committee and Quality and Safety Committee.

Priority 3

Restoration and recovery of services while managing future COVID-19 peaks

There have been recurrent flares of COVID-19 infection with a change in severity (lessened) and infectivity (increased) over the last 12 months. We have to keep modifying our approach to patient care based on the rates and consequence of the infection. This has an impact not only on acute admissions but also on planned routine care.

Infection prevention and control policies and procedures are important in managing the flow of patients and the safe provision of care for those entering the Trust. As a consequence of COVID-19, delays in routine care have occurred and a process of prioritisation of cases has been followed as well as an assessment of potential harm from any delay in treatment.

The use of routine testing of admissions and appropriate placement of patients based on their risk profile is important to maintaining patient and staff safety within the Trust. Careful prioritisation of patients based on their clinical need will continue, while also being aware of those who have had long waits for treatment as a consequence of the impact of the pandemic on healthcare.

Some of these patients will have decompensated fitness and require a more prolonged recovery period. How we work with partner organisations to limit the impact on individual patients will also become an increasing requirement. We will continue to respond to the changing status of COVID-19 infection rates, hopeful that the vaccination programme maintains immunity and reduces severity of infection, while closely reviewing and changing our approach where needed for those patients awaiting treatment or investigation within our Trust or wider health system.

Progress on this work will be monitored and reported through our Operational Management Committee and Quality and Safety Committee.

How we performed in 2021/22

Progress on 2021/22 Priorities

Priority one
Restoration and recovery of clinical services after COVID-19

Recurrent waves of COVID-19 infection within the community have impacted on hospital admissions of patients with COVID-19. This has affected our delivery of routine care, both acute admissions unrelated to COVID-19 infection and those on waiting lists for routine investigations or surgical treatment.

The change in COVID-19 variants and vaccination rates amongst patients and staff have altered the severity of COVID-19 infection but not necessarily the transmissibility of the virus. The latter point has meant that strict infection control procedures have been maintained in our organisation to protect the vulnerable from hospital acquired infection. Importantly, with the newer variants this has not led to severe respiratory infections so there has not been a need to increase capacity in our intensive care unit (ICU).

The consequence of this is that during successive waves of COVID-19 the requirement to redeploy staff to support medicine and ICU has been significantly less so cancellation of routine out patient, investigative and operative procedures has been less. We have therefore been able to establish normal pre COVID-19 waiting list times for procedures such as gastrointestinal endoscopy but cancer targets are not quite back to pre COVID-19 levels. This is due to a combination of factors, including accessibility of diagnostic imaging and the pressures on our histopathology service.

All surgical specialties have prioritised based on clinical need and those with the highest clinical need have been scheduled first. We have used external provider facilities for some specialty areas with the longest waiting lists (ophthalmology and orthopaedics).

Priority two
Identify opportunities for clinical collaboration with acute trust partners and primary care

The acute care collaboration between Integrated Care Systems (ICS) partner trusts has progressed with the appointment of a number of specialty clinical leads from within the partner trusts. Clinical areas for each of these specialties have been identified where closer working could help progress clinical service development in the Black Country.

Common themes from these discussions have been identified which are around waiting times for urgent referrals, staff recruitment and training and services that have a footprint outside of the Black Country such as ophthalmology and gynae-oncology services which have a regional referral footprint. Discussions continue with specialty clinical leads to prioritise areas for development.

Although West Birmingham is now part of the Birmingham and Solihull ICS, we still work closely on a place based basis with community and primary care colleagues. The appointment of a Chief Integration Officer is facilitating those working relationships and pathways between primary and secondary care in both West Birmingham and Sandwell, with both areas being key to the success of the clinical pathways in MMUH when it opens.

Priority three
Maintain work on all aspects of the Quality Plan with a focus on improving mortality through our Learning from Deaths Committee

There has been a continued focus on understanding the issues behind our mortality data which has been complicated by documentation and recording issues in relation to COVID-19 infection.

A review of our approach and outcomes from the different waves of COVID-19 has been analysed and submitted to board committees. Over time, as testing has become more timely and reliable, and our understanding of how methods of documentation influence data reporting, we have seen a fall in our mortality data. This has been assisted by additional clinical staff to support the ward based teams in documentation within our electronic patient record.

Quality improvement work has continued with a recent 'sepsis week' focused on understanding sepsis pathways at the front door to the hospital and how things could be improved both within our emergency departments and more widely across the Trust. Working groups continue to focus on the areas identified for change which continues to be the main focus of the Quality Plan, while we move to a refreshed Trust strategy focussing on three strategic objectives of patients, people and population.

These three areas will encompass improvement work from the previous Quality Plan and will also tie into the clinical pathways currently being developed for the acute care model at MMUH; improving end of life care, transitional care for young adults from children to adult services, improved mental health services for patients attending our emergency departments and reducing readmissions.

Staff raised awareness during Sepsis Rapid Action Week.

Safety Plan update / Perfect Ward

In Quarter 1 2021/22 we built on the work from the Safety Plan and introduced Tendable (Perfect Ward). The elements of the Safety Plan have been incorporated into the inspection types within Tendable. There are nine inspection types that cover the following fundamental elements of patient care; Infection prevention and control, medicines management, patient experience, nutrition and hydration, safeguarding, harm free care, ward management and 15 steps.

Tendable is a smart inspection app that makes quality inspections easy and efficient. It can be used across all clinical areas within the organisation including; inpatient wards, outpatient settings, theatres, community settings and teams, critical care areas, maternity and emergency assessment areas. Tendable drives quality and safety improvements providing real time audit results across the organisation. The app is easy to use and supports consistency of audit questions and guidance across the organisation. The data can be analysed by individual area, directorate, group or CQC regulatory theme. The app engages frontline staff in the quality assurance and improvement process and supports ownership of patient safety at a local level.

Tendable implementation commenced with a pilot in April 2021 with the wider roll out in July 2021. The majority of areas are now using the smart inspection app across all areas of the Trust. Tendable compliance is monitored monthly at Trust Board as one of the measures for the Board Level Metrics (BLM) under the caring domain. The data to support the BLM is taken from the Tendable Exec Level Dashboard which is web based. The clinical groups also have access to the Tendable dashboard and can review performance data by hospital site, clinical group, inspection type or clinical area.

We have developed a draft quality strategy which is called the Fundamentals of Care Approach. It is ambitious in what we want to achieve as an organisation over the next three to five years. We want to deliver better care to our patients. This means patients being seen in a timely and convenient way, feeling respected and listened to, and achieving the best clinical outcome possible for the best value. We want to take our focus back to basics and get the fundamentals of care right for every patient in a holistic way.

To achieve this, we are commencing a new care improvement approach across the Trust. The Fundamentals of Care Approach will bring together our doctors, our nurses, our allied health professionals and our operational leaders in a joint improvement approach for the first time. Fundamentals of Care is a Trust-wide initiative; it will empower our five clinical groups to work on what issues matter most to their patients and staff, supported by our corporate group. This is not additional work but will ensure that we are providing basic care for our patients and ensuring we move to providing the best care possible. Our patient fundamentals of care approach overlaps with both the people and population element of the Trusts overall strategy.

Quality Plan update

How the 10 priorities within the 2020 vision Quality Plan are now incorporated within our revised Trust strategy needs to be reviewed and clarified. The focus on management of COVID-19, restoration and recovery of services and more recently development of models for acute care within MMUH has been the focus of work across our organisation. These have naturally involved many of the clinical areas encompassed within the Quality Plan, with a strong focus on management of sepsis, improvement in mortality data, improved identification and management of end of life care and reduction of readmissions to hospital. Joint working with our community and primary care colleagues and a move to develop collaborative services with other providers across the Black Country ICS will support this work.

Mortality has been a focus for us and the review of outcomes from successive waves of COVID-19 in the local community showed how outcomes improved over time as we acquired better processes for identification of COVID-19 positive patients, understood the processes that lead to better infection control within the Trust and contributed to new research into patient treatments. This led to improved treatments for those with severe COVID-19, protective treatments for those who are most vulnerable and vaccination regimens to protect those within the community.

Our continued focus on sepsis and pneumonia management, as well understanding the importance of the way data is recorded in our electronic patient record, has also contributed to our improvement in Trust mortality.

Care Quality Commission

In May 2021, the CQC carried out an unannounced inspection of our Maternity service due to concerns raised, with the CQC, about the quality of the service. The service retained its rating of 'good' with the inspectors noting the challenges with staffing levels and staff feeling valued.

Engagement meetings have continued virtually with our GP practices and Heath Street Health Centre was inspected in December 2021. Following a comprehensive inspection, the practice was rated as 'good'.

The overall rating for the Trust remains the same at 'requires improvement' following the 2018 inspection, as the CQC put on hold all inspections during the pandemic, unless they had concerns about services or trusts. A programme of in-house inspections has been in place as part of our commitment to making continuous improvement to ensure that patients receive high quality care across all parts of the Trust. All wards have had an inspection, have developed plans for improvement and had notable practices highlighted.

Our goal remains, to attain an overall provider 'good' rating through the improvements we have made and continue to make. Prior to the pandemic we worked with the CQC through monthly engagement meetings, providing information on specific services from the services themselves, together with guided tours of departments of interest. Engagement meetings are set to recommence in 2022.

Sandwell and West Birmingham NHS Trust is registered with the Care Quality Commission and has no conditions attached to that registration. The Care Quality Commission has not taken enforcement action against Sandwell & West Birmingham NHS Trust during 2021/22 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

weAssure

The weAssure programme focusses on quality assurance against the five CQC domains. It aims to further strengthen and refine evidence summation to provide greater assurance of progress or risk on our journey to being good or outstanding in everything we do.

We have developed a robust set of standards for measuring and monitoring safety and quality across our organisation. These standards are based largely on the framework used by the Care Quality Commission – their Key Lines of Enquiry and adapted for use in our organisation.

As part of our business as usual approach to the continuous monitoring and improvement, and in readiness for our next CQC inspection, the weAssure programme has a number of key workstreams that aim to provide visibility and assurance on outputs and outcomes, not simply actions or processes.

We do this by:

- Undertaking regular unannounced safety and quality improvement visits to every service
- Requesting that services complete a regular self assessment
- Collecting documentary evidence from each service to demonstrate compliance against our safety and quality measures
- Triangulation of this information with that of other workstreams that measure quality and safety outputs, such as Perfect Ward, Fundamentals of Care, Safety Huddles, and Patient Experience data bringing together each of the elements so that an overall picture of each service may be understood.

In 2021/22 43 visits were carried out.. All clinical areas except Theatres, Critical Care and any areas that have remained red for COVID-19 risk, have had a first visit. Follow up visits are now underway across the Trust. The follow up visits also check that any actions have been addressed.

CareQuality Commission

Last rated
5 April 2019

Sandwell and West Birmingham Hospitals NHS Trust

	Inadequate	Requires improvement	Good	Outstanding
Overall rating		▼		
Are services Safe?		Requires improvement		
Are services Effective?		Requires improvement		
Are services Caring?				Outstanding ☆
Are services Responsive?		Requires improvement		
Are services Well led?		Requires improvement		
Use of resources		Requires improvement		
Combined rating for quality and use of resources		▼		

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/provider/RXK
We would like to hear about your experience of the care you have received, whether good or bad.
Call us on 03000 61 61 61, e-mail enquiries@cqc.org.uk, or go to www.cqc.org.uk/share-your-experience-finder

Find out what we have changed since we received this rating from CQC:

CareQuality Commission

Last rated
31 January 2020

Your Health Partnership

Your Health Partnership

	Inadequate	Requires improvement	Good	Outstanding
Overall rating		▼		

Are services

Safe?		Good
Effective?	Requires improvement	
Caring?		Good
Responsive?	Requires improvement	
Well led?		Good

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/location/1-565382741
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Find out what we have changed since we received this rating from CQC:

CareQuality Commission

Last rated
18 April 2017

Sandwell and West Birmingham Hospitals NHS Trust

Great Bridge Health Centre

⚠ The provider of this service changed

Rating from inspection with previous provider

	Inadequate	Requires improvement	Good	Outstanding
Overall rating			▼	

Are services

Safe?	Good
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/location/RXKH2
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CareQuality Commission

Last rated
17 December 2015

Sandwell and West Birmingham Hospitals NHS Trust

Lyndon Health Centre

⚠ The provider of this service changed

Rating from inspection with previous provider

	Inadequate	Requires improvement	Good	Outstanding
Overall rating			▼	

Are services

Safe?	Good
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/location/RXKH3
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Dr James Gwilt outside Lyndon Primary Care Centre.

How we measure data quality

Within SWB there are three sources of measurement for data quality

- The data quality kitemarks: these relate to all metrics forming part of our IQPR (Integrated Quality and Performance Report) which in turn feeds our Board Level Metrics.
- The SUS (secondary user service) benchmarking analysis for data quality: the Performance and Insight team compare data quality against other organisations at an overall level and against a number of sub criteria on a monthly basis.
- Feedback from our teams around data quality issues: these are raised in line with the data quality policy.

Data quality improvement approach

Our data quality improvement approach recognises a need to truly understand the purpose and make up (numerator and denominator) of each measure. Our data quality policy recognises that issues can be caused by incorrect inputs on the frontline, data transmission between systems and inaccurate reporting.

With this in mind our improvement approach (as set out in the Data Quality Policy) is as follows:

- The Associate Director of Performance and Strategic Insight takes the lead responsibility for data quality and compliance within the Trust. The key tool they use to manage this is the data quality log. The data quality log captures all known data quality issues and reports them to the Performance Management Committee for consideration, prioritisation and action.
- The NHS Secondary User Service provides benchmarking analysis for data quality indicators across a national, strategic and local benchmarking spectrum. These are available to the Trust Information Analysts via data quality dashboards. Outliers will be considered by the Associate Director of Performance and Strategic Insight and if required added to the data quality log.

Each Data Quality Issue goes through a five stage process covering:

- Submit/Capture
- Assessment (with consideration to organisational risk)
- Prioritisation
- Action
- Close

The initial assessment is carried out by a combined team from the Strategy and Governance Directorate, the Performance and Insight team and the Governance team. This group also allocates a lead executive who will make a final decision about scoring, priority (and time before commencing resolution) and solution lead.

The data quality group meets monthly to monitor progress of data quality issue resolution. This group is made up from a core within the Strategy and Governance Directorate (Governance and P&I) and the solution leads allocated to the data quality issues prioritised by the lead executive.

The Executive Performance Management Committee oversees progress of the Data Quality Group and seeks appropriate action where required to resolve urgent/ important matters.

The Trust is audited to ensure that:

- Applicable legislative acts are complied with
- NHS and Trust policies and standards are complied with
- Suitable processes are used, and controls put in place, to ensure the completeness, relevance, correctness and security of data through the Data Quality Audit carried out by the Trust's auditors
- Data Security & Protection Toolkit annual assessment is an internal self-assessment used to monitor data quality standards

Hospital Episode Statistics

The Trust submitted records during April 2021 – October 2021 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data;

- which included the patient's valid NHS number was 95.8 per cent for admitted patient care; 99.9 per cent for out-patient care; and 94.8 per cent for accident and emergency care.
- which included the patient's valid General Medical Practice Code was 100.00 per cent for admitted patientcare; 99.8 per cent for outpatient care; and 99.1 per cent for accident and emergency care.

Services provided / subcontracted

During 2021/22 we provided and/or subcontracted 45 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 Care Quality Commission (CQC) but has no conditions attached to that registration. Contracts 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 2021/22 represents 100 per cent of the total income generated from the provision of NHS services by the Trust.

Commissioning for Quality and Innovation (CQUINs)

A proportion of income is normally conditional on achieving quality improvement and innovation goals agreed between SWB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. This was not a requirement for 2021/22 therefore no agreed goals were set for this period.

Seven day hospital services

The seven day hospital services programme was developed to support acute providers to deliver high quality care and improve patient outcomes on a seven day basis for patients admitted to hospital as an emergency admission.

Now that we are beginning to restore our services back to pre COVID-19 levels we will be revisiting our seven day services plans to ensure that where we were achieving 100% compliance we continue to do so and where we were not achieving full compliance we have plans in place to improve.

We have created our rotas and recruitment plan to reflect our acute care offering in MMUH, which truly delivers all services across seven days achieving all standards.

Speaking Up

During 2021/22 we continued to report to Board on our activities in relation to Speak Up, and were successful in recruiting a full time Speak Up Lead role who has now commenced in post. As part of National Speak Up Month in October a bespoke Speak Up communications campaign was delivered to improve awareness of the existing and new channels open to staff to highlight concerns relating to experience, safety and quality, along with promoting managerial access to support tools.

Our approach to Speak Up has been to focus on introducing mechanisms to build a restorative and just culture, as part of reinforcing the importance of creating a culture of openness, trust, learning and accountability. We have created a related decision making framework for all conduct related employee relations concerns to ensure that all relevant matters are dealt with in a fair and consistent manner, enabling swift and proportionate action to be taken to address identified concerns in line with just and learning principles. This is supported by a multi-disciplinary group, led by the medical Responsible Officer which is called the Responsible Officer Advisory Group. This group independently assesses concerns raised about medical staff and monitors progress against recommendations and actions. This includes identifying areas where wellbeing or professional support is needed.

Our Chief Executive, Chief Nurse and Chief People Officer have made concerted efforts to engage with staff offering regular drop in sessions for staff to raise concerns and share ideas for improvement. In addition to this feedback 400 leaders to date have participated in providing feedback on the new people plan (includes Speak Up commitments under psychological safety) and values which will help to drive and embed the cultural improvements required in this area. The plan will also reach a further 10% of the organisation over the coming months.

The outcome of this work will lead to a new behavioural compact and aligned leadership development framework to support the required change in emphasis. We are currently reviewing our whistleblowing policy as one of the priority policies for engagement with trade union colleagues through the Trust's negotiating and consultative mechanisms to support subsequent ratification. This will be followed by a relaunch of Trust communications and training.

There is a current gap in reporting of concerns and taking action on themes through the group management structure. These gaps can act as a barrier to learning and restrict the ability for local improvements to be made. Currently no central log is maintained of all whistleblowing concerns raised and investigated therefore the overall quantum of such issues is difficult to gauge. A central whistleblowing recording system will be established to document all issues raised of a whistleblowing nature and a template investigation document will be developed to ensure that an audit trail is maintained of cases to ensure consistency. This will allow lessons learnt to be disseminated trust-wide.

We will be reviewing the appropriateness of our current system used to record all whistleblowing concerns and reviewing other organisation's systems to ensure we record all speak up concerns in a secure, confidential and where necessary anonymous manner, to ensure all they are centrally logged and able to be reported on, and triangulated. This will also enable tracking against key performance indicator resolution targets.

A cultural barometer has been produced for our People and Organisational Development Committee which acts as a heat map identifying teams in difficulty by triangulating key performance indicators such as sickness absence, turnover levels, staff satisfaction scores etc across a range of people measures. Speak Up and incident numbers will now also be included in this tool moving forwards to ensure deeper dives and intervention work is appropriately targeted to tackle emerging trends and themes in this area.

Despite the tremendous efforts of existing Speak Up Guardians and the positive introduction of a new Lead for Freedom to Speak Up Guardian, the capacity of the existing guardians remains a challenge, as does Executive Director capacity to support the function fully. It is for this reason that during 2021/22 we have relaunched Speak Up in our Trust, recognising that it is critical that the function sits under executive leadership with the capacity required to ensure that real progress is made. The executive leadership for the function now sits with the Chief Finance Officer, who passionately believes in the importance of speaking up.

The shared vision is to lead the way nationally in relation to speaking up, bringing together the Freedom to Speak Up Guardians, staff side colleagues, cultural ambassadors, staff networks, chaplaincy, faith groups, and equality diversity and inclusion champions. A paper was submitted to our Public Board in April 2022, setting out a 30, 60 and 100 day action plan, and setting out our intention to lead the way nationally in relation to speaking up. This action plan fully covers all of the self-assessment carried out in 2020 against best practice standards, and an internal audit review of progress on the action plan is planned for early Quarter 2 of 2022/23.

Speak up concerns can be raised through a number of routes which include;

- Emailing an individual speak up guardian directly
- Emailing the speak up guardian email address which only the guardians can access
- Through the staff networks
- Through a trade union or staff side representative
- Contacting Safecall, a confidential external 'hotline'
- By contacting a member of the executive team
- By contacting the non-executive lead for Speak up.

The key priority for the year ahead is delivery of the action plan.

Rota gaps

In order to monitor our rota gaps we maintain a monthly record of current vacancies for both training and non-training grades. This is reviewed monthly and active measures are taken to try to recruit to all trainee vacancies. Junior Specialist Doctor (JSD) posts have been established since August 2017, and are used to replace gaps in our rotas and also create new posts where additional service needs have been identified. We currently have 112 of these posts of which 85 doctors are in post and the remaining posts have recruitment pending or awaiting clearance.

In addition to conventional routes, we have used alternative methods for recruitment including using external companies where needs were high and undertaking Microsoft Teams interviews. We have been successful in recruiting new doctors to the UK and trainees wishing to do interim years eg 'Foundation Year 3'. We have also increased the numbers of certificates of sponsorship through the Home Office.

NHS Staff Surveys - Encouraging advocacy

The annual NHS Staff Survey provides an opportunity for organisations to survey their staff in a consistent and systematic way. This makes it possible to build up a picture of staff experience to compare and monitor change over time and to identify variations between different staff groups. Obtaining feedback from staff, and taking account of their views and priorities, is vital for driving real service improvements in the NHS.

The results are primarily intended for use by organisations to help them review and improve their staff experience so that their staff can provide better patient care. The Care Quality Commission uses the results from the survey to monitor ongoing compliance with essential standards of quality and safety. The survey will also support accountability of the Secretary of State for Health to Parliament for delivery of the NHS Constitution.

The NHS staff survey poses nine mandatory questions to ascertain how engaged staff are. All NHS staff are given the opportunity to give their feedback on these questions every quarter in the national staff survey and the newly introduced quarterly pulse survey.

Below is a comparison of results between 2020 and 2021 in relation to advocacy. These results are based on staff who agreed or strongly agreed as part of the NHS Staff survey in 2020 and 2021.

NHS Staff Survey	Survey Results	
	SWB 2020	SWB 2021
Staff who would recommend the Trust as a provider of care to their family and friends	63%	58%
Staff who would recommend our organisation as a place to work	60%	54%

Data Source: National NHS Staff Survey Co-ordination Centre.
The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website

We recognise that these results are not where we want them to be and are talking to staff about what would make the most difference to how they feel about their jobs and working for our organisation.

Each clinical group and corporate directorate has committed to hold regular listening events where team members are invited to take part in a discussion about the feedback received and what improvement can be made. The events are attended by two executive directors and the group/directorate leads. Each session is recorded and published on the intranet.

An action plan template has been developed and shared with the clinical groups and corporate directorate leads to complete and return to the Director of Communications by the end of April 2022.

We are working with organisations who have made sustained improvements in staff survey results to identify learnings. We have also requested support from NHS England and Improvement for the development of a core operating model to respond to Pulse survey results.

Data Security and Protection Toolkit (DSPT) attainment levels

The Data Security and Protection Toolkit includes 10 mandatory data standards. The next submission evidencing compliance with the assertions in the Data Security and Protection Toolkit is 30 June 2022.

The Trust is currently not meeting all mandatory assertions in the Toolkit and an improvement plan was submitted to NHS Digital. In addition, the Trust has reconfigured its IG service with one of its primary objectives being to demonstrate DSPT compliance.

General Data Protection Regulation

Work continues to ensure that data protection obligations are implemented and monitored for all processing activities across our Trust. Over the past year, as a result of COVID-19, it has been necessary to find alternate ways of working and there has been continued focus on review of new and existing processing activities prior to implementation.

Complaints, PALS concerns and purple point calls

Complaints

Sandwell and West Birmingham NHS Trust received 1119 written complaints during this year compared to 1040 received during 2020/21.

The number of complainants who return, after their initial response, as they are not satisfied with our response is a measure of the effectiveness of our complaint process. In 2021/22, 28 complainants wrote to us again either because they felt we had not addressed all their concerns or there were unresolved issues (2021/22 = 2.3%). We work with the complainant to reach a resolution.

Themes of complaints during 2021/22

The top five themes arising from complaints during 2021/22 are the same as the previous year:

1. Clinical Treatment – The highest sub-categories being in relation to delay in treatment, inappropriate treatment and delay or failure to act on results
2. Communication – with patients and/or families
3. Patient Care – The highest sub-categories being in relation to care needs not adequately met, failure to provide adequate care and inadequate support
4. Values and behaviours of staff – attitude of staff
5. Appointments – The highest sub-categories being in relation to appointment cancellations, appointment delay and appointment error.

Two areas which have significantly increased are communications and loss of property. Both increases were mostly due to COVID-19 restrictions and our response to the challenges faced. Additional resources were provided to wards to enable patients to communicate with their families, such as mobile phones and iPads for voice and visual calls. Scheduled updates from clinical staff to families were also put in place.

The Trust's arrangements for managing patient complaints experienced challenges throughout the year and has resulted in a build-up of overdue responses. The delays are unacceptable, and we recognise that waiting for a response is not easy. Concerns are being investigated paying attention to the length of time a complaint has been with us together with the availability of the team to respond to the concerns raised. We have taken on additional staff to help us address the overdue complaints as quickly as possible and we are in contact with those who have raised concerns to update them on progress. We value the feedback received from our patients and the opportunity to improve our services.

PALS/ Purple Point

Sandwell and West Birmingham NHS Trust received 1863 PALS enquiries during this year compared to 1405 received during 2020/21. Purple Point is a designated service for inpatients who need immediate resolution to a concern and operates 12 hours per day, seven days a week. The Trust received 28 Purple Point calls during the year, compared to 57 received in 2020/21. Purple point activity has been severely impacted by COVID-19, not unexpectedly, as during 2019/20 we received 314 calls.

The themes for PALS and Purple Point are the same as those identified for written complaints.

Compliments

Wards and departments can log expressions of appreciation through the Ulysses Safeguard system and in 2021/22 a total of 478 were recorded; whilst it is likely this number is far higher. Work is in progress with the Patient Involvement and Insight Lead to see how we can best capture these.

Learning from complaints

The following have all occurred due to the feedback we have received via complaints:

- An information sheet, explaining the contact lens pricing policy is now sent to all new patients with their appointment letters to avoid misunderstandings during contact lens collections
- Some appointment letters have been revised as they did not contain correct information to direct patients to the correct clinic
- Weekly multidisciplinary meetings now take place between the Trust and St Mary's Hospice
- We have more than one policy for dealing with patient property, these are now being merged and an improved process is being implemented.

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 and Learning System (NRLS) which is publicly available and provides comparative data with like-sized trusts. This will transfer to Learning from Patient Safety Incidents (LFPSE). We will continue to report incidents into the national benchmarking scheme.

Date		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
2018/19	**Apr 18 to Sept 18**	34.3	107.4	13.1	7	0.2	1	0.0
	Oct 18 to Mar 19	53.8	95.9	16.9	13	0.22	3	0.05
2019/20	**Apr 19 to Sep 19**	51.2	103.8	26.3	8	0.1	0	-
	Oct 19 to Mar 20	50.1	110.2	15.7	2	0.0	2	0.0
2020/21	**Apr 20 to Mar 21**	60.1	118.7	27.2	18	0.2	49*	0.4

** The increase in incidents resulting in deaths refers to COVID-19 deaths.*

The Trust considers that this data is as described for the following reasons: It is consistent with incident data submitted to the National Reporting and Learning System (NRLS). Note NRLS comparative data is now released annually.

Incidents are generally categorised into clinical (patient safety) and non-clinical and then further categorised dependent upon their causative factor. Serious incidents continue to be reported to the ICS.

Patient safety incidents resulting in moderate harm or above are being discussed at the weekly Incident Assessment Meeting which is a multi-professional forum. This provides an environment of openness and transparency to discuss level of investigation and actions already taken.

The number of serious incidents reported in 2021/22 is shown in the following table. This does not include pressure ulcers, fractures from falls, ward closures, some infection control issues including hospital acquired COVID-19 infections, personal data breaches, IT or health and safety incidents.

2021/22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs (by date reported as SI)	5	6	3	5	5	7	3	6	6	6	2	1

Never Events

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 robust controls are in place to prevent them from happening.

During 2021/22 10 never events were reported, these are detailed below.

Never events reported in 2021/22

Speciality	Type of Never Event	Cause	Changes Made
Ophthalmology	Wrong site surgery	Squint surgery, procedures of the same level of intervention would be put on the same list. Lapse in concentration lead to wrong muscles being shortened/ lengthened	Surgeons to complete the task of transcribing the surgical information from the pre-operation ward round onto the surgical whiteboard. Operating surgeon to lead the pre-op pause. Shared learning sessions organised to support wider learning from the incident.
Emergency Department - City	Unintentional connection of a patient requiring oxygen to an air flowmeter	The engineered safety precaution (air guard) was bypassed by a member of staff due to a gap in knowledge.	All air guards to be audited to ensure they are functioning as intended.
Critical Care - City		Patient incorrectly attached to air flow despite air guard in place.	Removed all air flow meters.
Elderly Care - Sandwell		Patient was attached to a cylinder of air not oxygen.	Air cylinders removed from wards.
Respiratory medicine - City		Airflow meter not removed and returned to medical engineering.	All flow meters removed, returned and air outlets capped off.
AMU - Sandwell	Incorrect procedure - Patient received a lumbar puncture rather than pleural tap	There was a lack of confirmation of the clinical plan between the consultant and the junior doctor who documented it.	Weekend board round reviews implemented to identify similar errors in clinical plans. I.T. working group established to resolve electronic record issues identified. LocSSIP to be implemented and assurance given. Work stream commissioned to identify any other areas where LocSSIP's have not been implemented.
Surgery Services	Wrong route medication – medication for inhalation was given intravenously	Distraction leading to human error.	Exploring whether adrenaline can be sourced in plastic containers.
Theatres	Wrong site surgery	Lapse in concentration.	The incident is still under investigation.
Critical Care - Sandwell	Misplaced NG tube.	The incident is still under investigation.	The incident is still under investigation.
Elderly care - Sandwell	Wrong route medication – oral medication given intravenously	The incident is still under investigation.	The incident is still under investigation.

All never events undergo an internal investigation to identify route case and lessons learned. Never events are reported to the Quality and Safety Committee and through to Trust Board. They are also reported externally through the serious incident framework.

During the year, four never events were associated with the incorrect administration of air rather than oxygen. As a result air cylinders and air flow meters were removed to avoid future such incidents.

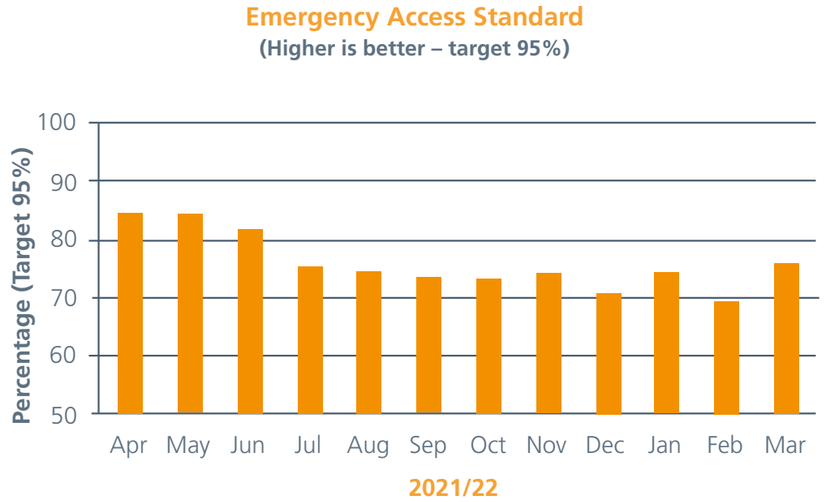
Emergency access standard

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). In 2021/22 on average, we achieved 75.5%. this is a reduction from 21/22, linked to an increase in attendances and admissions across the organisation. In context this still moved us from middle to upper quartile nationally, indicating a national drop off in ED performance.

You can see that the four-hour performance aligns to the fluctuations we saw with the numbers of COVID-19 admissions; with recovery in April and May from the third wave and subsequent drop in performance as another wave hit at the end of September, recovering again in March.

We have embedded the Urgent Care Centre at Sandwell and will do the same at City, which will continue to support our emergency care offering. We aim to continually improve our urgent care to ensure patients are seen in the right area and in a timely manner.

Our ED departments have worked hard to provide a safe and effective environment for patients both with and without COVID-19, therefore should be commended on their efforts and achievements. ED performance is a trust wide issue and this focus will be evident in the delivery for 2022/23. We are focusing our efforts on driving improvement in same day emergency care (SDEC) utilisation, timely discharges and ensuring timely movement of patients out of the ED department and into our bed base.



Patient Reported Outcome Measures (PROMs)

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

The following table 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.

Procedure	Organisation	Average Pre-op Q Score	Average Post-op Q score	Health Gain	Improved	Adjusted Average post-op Q Score	Adjusted average Health Gain
April 2020 – March 2021							
Total Hip replacement	SWB	0.190	0.686	0.496	12 (85.7%)	Not available as less than 30 questionnaires	Not available as less than 30 questionnaires
	National	0.327	0.792	0.465	6,863 (90%)	0.792	0.465
Total Knee replacement	SWB	0.415	0.554	0.14	14 (63.6%)	Not available as less than 30 questionnaires	Not available as less than 30 questionnaires
	National	0.434	0.749	0.315	6,251 (82%)	0.749	0.315
April 2019 – March 2020							
Total Hip replacement	SWB	0.264	0.722	0.458	79 (85.9%)	0.782	0.440
	National	0.342	0.802	0.460	17,757 (90.1%)	0.802	0.460
Total Knee replacement	SWB	0.331	0.681	0.350	138 (85.7%)	0.742	0.330
	National	0.412	0.753	0.341	18,556 (83.2%)	0.753	0.341

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and SWBH data is consistent with trust reported data. Nationally a number of Trusts did not achieve more than 30 completed questionnaires and therefore we are not an outlier.

The data for 2020/2021 shows that the reported outcome for the average health gain for hip replacements is above the national average and the health gain for knee replacements is below the national average.

In April 2020 the trust set out an improvement plan to address the marginally lower average health gain scores. However, some progress against the improvement plan has been slow in light of further waves of the pandemic. With hip and knee joint replacement surgery suspended at Sandwell between April and June 2020 and January and March 2021 there has been lower PROMS data collection/submission. It is worth noting that the uptake of the questionnaires and return rate has been lower than previous years with an average of 70% which means our data is not a true reflection of the whole population that received hip and knee surgery.

In response to the above the responsible multidisciplinary team are progressing a reset and recovery plan to reinstate the PROMs improvement plan from April 2020. The focus of the plan will be to address the lower reported health gain of knee replacements, the low participation rate (56.6%), and the response rate for the PROMs booklets post-surgery (70% total, 65.79% knee replacements).

Despite the pressures of a pandemic the PROMS project team has still made changes to improve the quality of care our patients receive post hip and knee surgery. This includes:

- Pre surgery, administration teams have set up a process to ensure all patients have completed their PROMs booklets.
- Post-surgery, ward staff ensure that all total knee replacements are booked in for their first physiotherapy appointment prior to discharge from the ward.
- Producing a video to demonstrate what patients can expect post-surgery and how to ensure optimum recovery and mobility in the six months following their surgery: supported with a recovery information booklet that reiterates the information in the video.
- Information booklet that provides details of how to identify wound infection once home and contact details for any concerns for early identification of surgical site infections. This is a collaborative quality improvement project with the clinical effectiveness team to improve the surgical site infection surveillance processes we currently have in place at the Trust.
- The physio teams have visited two high performing hospitals for improvement ideas. One trip was to observe the PROMs process in place during the COVID-19 pandemic and the other was to observe a community care clinic which aims to ensure all patients receive good quality post-operative care by visiting patients in their own homes.

A great example of how innovation is informing the improvements in the quality of care at our Trust is a project entitled 'MSK Equity: Evaluating quality using information technology'. The project aims were to increase the percentage of patients completing PROM and PREM scores, as well as other post-operative quality of care measures including whether patients felt they received sufficient information post-surgery.

The outcome of this project has highlighted opportunities to further improve and sustain changes; developing a digital application to help inform patient recovery and improve the quality of care post-surgery.

Julie a Sister on Priory 3 with patient Andrea Kerr.

How we performed in 2021/22 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2020/21 position	2021/22 position	Comments
Cancer – 2 week GP referral to first out patient	%	=>93	88.8	86.6	Up to end Feb 2022
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	=>93.0	72.3	71.3	Up to end Feb 2022
Cancer – 31 day diagnosis to treatment all cancers	%	=>96	91.9	90.9	Up to end Feb 2022
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Excluding Rare Cancer)	%	=>85	70.8	61.6	Up to end Jan 2022
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Including Rare Cancer)	%	=>85	71.4	59.2	Up to end Jan 2022
Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral	%	=>90	86.1	93.4	Up to end Jan 2022
Emergency Care – 4 hour waits	%	=>95	81.9	75.5	March 22
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92	70.1	70.5	Up to end Feb 2022
Acute Diagnostic waits < 6 weeks	%	<1.0	37.2	25.7	Up to end Feb 2022
Outcome Metrics					
C Diff (post 48 hours)	No	<41	22	25	Full Year
MRSA Bacteraemia	No	0	1	0	Full Year
Never Events	No	0	4	10	Full Year
WHO Safer Surgery Checklist 3 sections (% patients where all sections complete. Main theatres only)	%	=>100	99.8	100	Full Year
VTE Risk assessments (adult IP)	%	=>95	95.6	96.2	Full Year
Clinical Quality and Outcomes					
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	85.7	88.3	Full Year
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	64.8	58.2	Full Year
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50	86.0	85.4	Full Year
Stroke care – Admission to Thrombolysis Time (% within 60 minutes)	%	=>85	75.4	69.8	Full Year
TIA Treatment within 24 hours from receipt of referral	%		86.2	96.4	Full Year
MRSA screening elective	%	=>85	77.0	62.1	Full Year
MRSA screening non elective	%	=>85	89.9	80.4	Full Year
Hip Fractures – operation within 36 hours	%	=>85	78.7	85.0	Full Year
Patient Experience					
Coronary heart disease - primary angioplasty (<150 mins)	%	=>80	85.2	78.0	Full Year
Coronary heart disease – rapid access chest pain (<2weeks)	%	=>98	100.0	100.0	Full Year

All data in the table above is subject to final validations and year end results when available

Infection prevention and control

The Health and Social Care Act 2008 requires all Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection (HCAI). Our Trust's nominated Director of Infection Prevention and Control (DIPC) is currently the Chief Nurse who has Board level responsibility and chairs the Infection Control Committee.

The pandemic has continued to be challenging over the past year. Staff, patients, visitors and carers have all been impacted by COVID-19. We have had to respond quickly to ever changing situations and guidance. At the heart of this have been the principles of good infection control standards which are monitored and improved where required. Universal mask wearing has been a mitigating requirement for staff, patients and visitors. This is not without challenge and continues to be a COVID-19 control measure.

What we said we would do in 2021/22

- Aim to have zero avoidable HCAI
- Focus on MMUH and innovative ways of delivering the IPC agenda
- Be prepared in the event of another pandemic, drawing on lessons learnt following this difficult year.

What we achieved

Following the pandemic ventilation has been highlighted as a high level control measure. We have completed a ventilation risk assessment and this identified improvement for ventilation at Sandwell site where we have now purchased units that filter the air. The impact of this implementation is currently under review.

There is continued overview of MMUH by the IPC and we have been involved in the sign off process for the demonstration rooms.

Below are the alert organisms that are mandatory. We have not breached any of the set trajectories for our Trust. However we were at the upper limit for clostridioides difficile (Cdiff). All cases were scrutinised and lessons learnt disseminated.

Alert Organism	Number of accountable cases
MRSA	0
Clostridioides difficile (Cdiff) - Pre 48 or Community - 4 week rule	8
Clostridioides difficile (Cdiff) - Post 48 hours	25
E.coli – Case threshold for 2021/22 = 80 post 48 hour	23
Klebsiella spp. - Case threshold for 2021/22 = 29 post 48 hour	11
P.aeruginosa - Case threshold for 2021/22 = 10 post 48 hour	6

The Trust considers that this data is as described for the following reasons: It is the latest available on the NHS Digital website and is consistent with Trust reported data.

What we want to achieve for 2022/23

- Learning from healthcare associated infection – to increase engagement and disseminate learning across the groups.
- Integration of IPC team members into Groups to enable IPC to be a fundamental part of group governance to improve patient outcomes.
- Continued involvement in MMUH development.
- Management of indwelling devices.

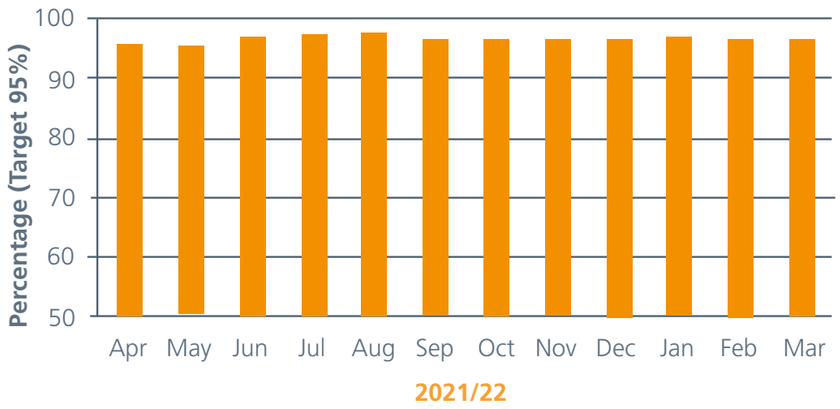
Venous thromboembolism (VTE)

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. Our compliance for 2021/22 is 96.2%

In previous years we have published our compliance for each quarter and indicated the national average and highest and lowest NHS trust percentages. In order to release capacity across the NHS to support the COVID-19 response the Office for Statistics Regulation has paused the collection and publication of some official statistics. VTE is included in the paused data sets therefore we are only able to publish SWB data for the quality account for 2021/22. Further clarification on this can be found here https://www.england.nhs.uk/statistics/statistical-work-areas/vte/

VTE Compliance



The Trust considers that this data is as described for the following reasons: The data is consistent with trust reported data.

The Trust intends to take the following actions to improve the quality of its services

- Continuing to monitor compliance of VTE assessments on admission.
- Use data on prescribing for VTE prophylaxis and our review of any hospital acquired VTE to improve all aspects of care around VTE prevention with a focus on delayed and missed doses of medication.

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).

The results of an external audit on this measure recommended we change the counting method to fall in line with the Secondary Uses Service (SUS) readmission definitions which excludes some activity. The SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. We applied this recommendation to our reporting from July 2019 and as a result of this the numbers are lower particularly in the age 4-15 age group as the SUS definition excludes aged under four. This group was previously reported as 0-15 years.

Age 4 – 15 years

SWB	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2021/22 (Apr-Feb)	4070	216	5.31%
2020/21	2658	132	4.97%
2019/20	7447	375	5.04%
2018/19	15917	968	6.08%

Age 16 and over

SWB	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2021/22 (Apr-Feb)	66716	5136	7.70%
2020/21	55648	5497	9.88%
2019/20	80379	6706	8.34%
2018/19	86051	7113	8.27%

All Ages

SWB	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
2021/22 (Apr-Feb)	70786	5352	7.56%
2020/21	58306	5629	9.65%
2019/20	87826	7081	8.06%
2018/19	101968	8081	7.93%

The data in the table above shows a return to expected admission levels but we have seen a decrease in our re-admission rates. This is despite a reduction in elective activity which usually shows a low re-admission rate.

Going forward the Trust along with all other NHS trusts will restore its elective programmes of care which will naturally result in an increase in patients admitted to hospital. A return to more usual levels of activity is expected with an anticipated increase in confidence within our community to attend our emergency departments when they need to access care. We expect to continue to improve our re-admission rates and are proud to be continually below the national average.

Readmission reduction remains a priority for our Trust. To support this, we have in place plans that will support patients when they are discharged from hospital and to support patients when they are at home. These include:

- Use of population health data to identify patients at risk of deterioration, linking to case management, integrated pathways, community multi-disciplinary teams (MDTs) and ensuring that patient preferences matter.
- Admission avoidance services will be enhanced using EPICENTRE and AA Hot clinics.
- High intensity user MDTs have been established.

Safeguarding children

The commitment to children's safeguarding is a number one priority for our Trust which is embedded in practice across all disciplines and roles; from our Chief Nurse, as the Executive Lead for Safeguarding through to our frontline staff. We have a dedicated team of specialist safeguarding professionals led by our Safeguarding Children Lead Nurse, who supports the workforce through a programme of targeted training, advice, support and supervision.

As an organisation we are clear that safeguarding is integral to everything we do; we have a robust assurance and quality framework to ensure we are compliant with statutory requirements to safeguard and promote the wellbeing of children and young people who may access the wide range of services we provide across both acute and community settings at all hospital sites.

This past year has held significant challenges for all of us, not least the impact of COVID-19 and subsequent lockdowns which removed vulnerable children from the protective gaze and attention of agencies and placed an enormous strain on families. Our corporate safeguarding team and paediatric services continued to work closely with both Sandwell and Birmingham Children's Trusts establishing positive relationships and attending strategic meetings with our multi-agency partners to ensure that vulnerable children were still seen and supported during this difficult time. This meant ensuring we had robust risk assessments in place and contingency plans developed to mitigate risk given the enforced change to service provision considering COVID-19 restrictions.

We have continued developing partnership priorities, procedures and working arrangements to safeguard and protect vulnerable children, young people and families, at both an operational and strategic level. This has included contributing to both Local Safeguarding Children Partnership's quality audit programmes and completion of the Section 11 Audit (Children Act 2004) for Sandwell Children's Partnership to not only provide assurance to the partnership but also to demonstrate that SWB as an organisation is meeting their corporate responsibilities in relation to safeguarding children.

Our maternity, health visiting, school nursing, looked after children, community paediatric nursing and allied health professional teams have continued to visit and support those most vulnerable children and families, providing care innovatively in a virtual world where appropriate. This has remained an overriding priority to safeguard our most vulnerable groups against the adverse effect the pandemic has had on our communities.

Our safeguarding team have continued to provide advice and support to our staff, and we have continued to deliver specialist safeguarding children training to our workforce in line with the RCPCH Intercollegiate Document (2019) guidance which includes recommendations from serious case reviews, child safeguarding practice reviews and domestic homicide reviews to embed learning and changes in clinical practice. At the outset of the pandemic in 2020 we moved quickly to a virtual training platform. This has evaluated well, improved accessibility and provided a level of flexibility for our busy frontline staff.

Throughout 2021/22 assurance, quality and accountability has been demonstrated by the inclusion of quarterly and exception reporting from our Safeguarding Children Operational Group to the Vulnerable People's Executive Committee, chaired by the Chief Nurse where safeguarding concerns and risk are discussed and reviewed with Black Country and West Birmingham Clinical Commissioning Group (Sandwell place). Designated professionals are in attendance to offer a level of scrutiny regarding our safeguarding arrangements. In addition to this, quarterly joint adult children safeguarding reports are produced by our safeguarding leads and presented to our Quality and Safety Committee and Clinical Leadership Executive to ensure senior executives are fully sighted on key safeguarding developments and challenges faced during the year.

SWB has demonstrated further assurance by having clear escalation processes, whistleblowing procedures and Speak Up Guardians to support staff where they may have concerns. In line with this we have provided a consistent response to local and national priorities in accordance with statutory guidance working collaboratively with partners to deliver strategic priorities to safeguard children and young people.

We have continued to work with developers for our electronic patient record system (Unity) to ensure that the national NHS digital Child Protection Information Sharing (CP-IS) Project is embedded within the system for our emergency departments (ED) and maternity services to access safeguarding information in relation to child protection, unborn child protection plans and looked after child status for those children and women accessing unscheduled/planned care. This continues to be a focus given the challenge Unity presents in integrating this into the record and as such remains on our corporate nursing risk register.

Our Looked after Children Team continue to support the statutory requirement of assessing the health needs of Sandwell's looked after children; Sandwell has continued to have the highest number of children in local authority care across the Black Country and neighbouring health providers. We have worked with Black Country and West Birmingham Clinical Commissioning Group (Sandwell place) to agree and support an increase in the clinical nursing resource to support this vulnerable cohort of children.

Our ED Domestic Abuse Advocacy Service continues to be a positive venture and has increased accessibility for victims to access specialist domestic violence and abuse support. NHS England have released a four-year plan for domestic abuse which supports the roll out of IDVA's across all NHS services and highlights how innovative and trailblazing SWB were in supporting the introduction of the project in 2015. We continue to receive part funding from Safer Sandwell Partnership with our Chief Executive and Chief Nurse supporting SWB funding for the remaining cost of the project. In July 2021 we successfully transferred the service to SWB which further endorsed our commitment to being recognised as a domestic abuse aware hospital.

Due to the impact of COVID-19 and 'hidden harm' we have seen across all safeguarding systems, it has been noted that domestic abuse incidents have increased by approximately 30% with referrals into Sandwell Multi-agency Safeguarding Hub (MASH) also rising significantly. This has had a direct impact on the capacity of the nursing resource in MASH to meet the increased demand. In addition, in both Sandwell and West Birmingham, we have seen an increase in child neglect cases, levels of violent crime amongst our youths, gang activity, exploitation and parental mental health needs which has impacted on parental capacity to parent competently. We have also seen an increase in complex mental health presentations of children requiring specialist therapeutic input. We have been involved in several safeguarding children practice reviews throughout the year as a result of injury and death to children which may be attributed to some of these factors and particularly the level of gang related activity being seen in the community in both Sandwell and Birmingham. The team have also been involved in two Sandwell domestic homicide reviews, one which involved child on parent violence and abuse.

We have undertaken a scoping exercise jointly with Sandwell partners given the increased youth violence, gang and exploitation levels being exhibited across Sandwell place. This has led to a review of specialist services available to support young people who have been affected by youth violence, Ganga and exploitation. There is sufficient empirical evidence which supports that young people affected by an adversity related injury, substance misuse or mental health crisis who present to ED can be supported innovatively by hospital based case workers who have the lived experience of an adverse lifestyle offering a 'teachable moment'; the ethos being to help young people establish healthy lifestyles which move them away from gang, violence, crime and victimisation activity. As a result, a decision has been made to work with St Giles Charity 'Turning a past into a Future' as an established provider of services to young people exposed to this level of violence and crime for a one year fixed term project with joint funding secured from Sandwell Place and Sandwell Safer Partnership.

Key themes to continue for 2022- 2023 include:

- Continue to liaise with Black Country and West Birmingham Clinical Commissioning Group (Sandwell place) to receive the full clinical resource required for our Looked after Children Service in line with statutory guidance to ensure the health needs of this vulnerable group are met.
- Undertake a review of Sandwell MASH clinical nursing resource with our CCG (Sandwell place) to ensure there is sufficient resource to meet the increased demand and activity seen across both safeguarding children and domestic abuse.
- Progress the service plan for St Giles to have case workers in ED to deliver this specialist service to our young people accessing our ED/hospital departments.
- Integration with our safeguarding adult team and wider place collaboration to support victims of domestic abuse.
- Focus and develop an implementation plan required in preparation for the introduction of Liberty protection standards.

- Continue to review and ensure that our Safeguarding Children Level 3 training meets organisational requirements and includes lessons learnt from child safeguarding practice review/serious case reviews and domestic homicide reviews.
- Continue to report and comply with data collection required for the Black Country and West Birmingham CCG STP Provider Safeguarding Performance Framework 2022/23.

Safeguarding adults

The Vulnerable Adult Team consists of a Vulnerable Adult and Safeguarding Service Lead Nurse, Vulnerable Adult Lead and a newly appointed Adult Safeguarding Lead with funded full time substantive posts for a Safeguarding Nurse, mental health registered Dementia Nurse and a full time administrative support post. The service has recently been reviewed, in particular learning disabilities, following bench marking against learning disability standards with the expectation of a better resourced service with two full time learning disability posts in comparison to the last financial year of one.

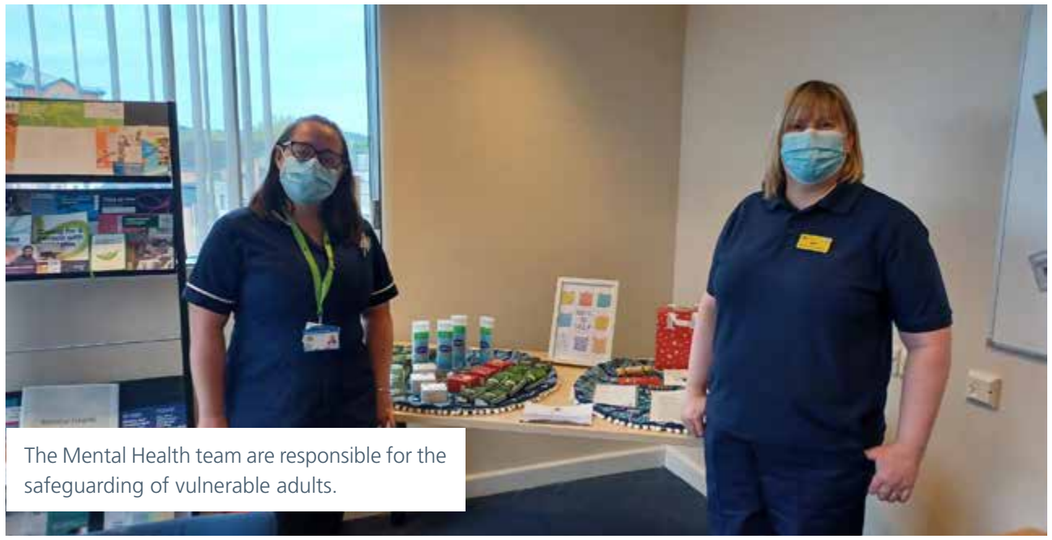
During the past year the team have improved assessment of mental capacity, recognition of self-neglect and have continued to focus on best interest process, patient advocacy, relevant screening for confusion and diagnosis/ recognition of cognitive impairment and personalised care planning. The team have had input into several work streams and provide training, visibility and operational support to frontline colleagues. The team are supporting the organisation with preparation of legislation change from deprivation of liberty safeguards to liberty protection safeguards.

The vulnerable adult team have developed a new focus with ambitions for a fuller development of dementia and learning disability services within the Trust in line with the national Dementia Friendly Hospital Charter initiative.

Bespoke training is provided twice monthly to promote least restrictive care, risk enablement and patient empowerment and includes mental capacity, deprivation of liberty and safeguarding, dementia awareness and learning disability awareness. The sessions have included therapeutic intervention for people living with cognitive impairment who have complex health care needs.

We continue to work closely with Sandwell and Birmingham multi agency safeguarding boards. SWB is compliant with all cases meeting the threshold for statute public enquiries and participate and contribute to several work streams that include improving learning disability and vulnerable adult services. The team are committed to the national PREVENT strategy and agenda, attending NHS England forums and local steering groups.

During COVID-19 restrictions the teams have delivered bespoke training sessions virtually, promoted John's Campaign and supported relatives and carers with reasonable adjustments which included visiting for those service users that live with cognitive impairments inclusive of dementia, learning disabilities and new onset confusion.



The Mental Health team are responsible for the safeguarding of vulnerable adults.

Learning from Deaths

The mortality review pathway is a multi-step process, which has been designed to provide assurance that deaths receive adequate independent review. The first step is the medical examiner service which has been in place at SWBH since 2019. The role of the medical examiner is not only to scrutinise the case notes to identify any issues in care but also to ensure accuracy of the death certificate and speak to the next of kin about the care their loved ones received. Following scrutiny of notes, the medical examiner can request a structured judgement review of cases that either meets a nationally set criteria or cases where they have identified issues in care.

During 2021/22, 1476 of Sandwell and West Birmingham NHS Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 320 deaths in Q1, 379 deaths in Q2, 393 deaths in Q3 and 384 in Q4.

Of the 1476 deaths reported during 2021/22, 1406 (95%) underwent a tier one mortality review by medical examiners. This equated to 319 reviews in Q1, 370 in Q2, 362 in Q3 and 354 in Q4.

Of these, 197 were referred for further review in the form of a Structured Judgement Review (SJR) or for panel discussion at the Clinical and Professional Review of Mortality Group (CAPROM) to determine if they were avoidable. This consisted of 40 cases in Q1, 60 cases in Q2, 59 in Q3 and 42 in Q4.

Of the cases which received further scrutiny, 1 case representing 0.06% per cent of all patient deaths during 2021/22 was judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter this consisted of: zero patient deaths representing 0 per cent of the patient deaths for Q1, zero patient deaths representing 0 per cent of the patient deaths for Q2 and zero patient deaths representing 0 per cent of the patient deaths for Q3. There was 1 patient in Q4 representing 0.3% of the patient deaths.

	2021/22			
	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
Total Inpatient spells	21,964	24,286	24,788	24,020 (TBC)
Total deaths	320	379	393	384
Avoidable deaths	0	0	0	1

Engagement with Next of Kin (NOK)

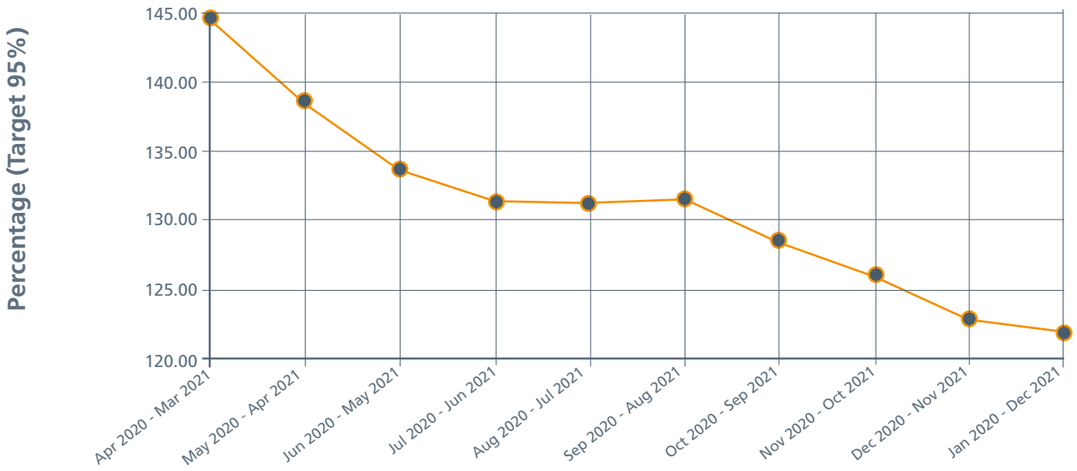
With the expansion of the number of medical examiner officers, we have increased the percentage of next of kin contacted, to seek their views on the care their relative received whilst in our care, from 60% in April 2021 to over 80% in February 2022. All comments positive or negative are analysed and fed back to the caring team for further actions.

Next of Kin Contact 2021/22											
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
60%	65%	69%	60%	55%	71%	65%	71%	72%	73%	85%	80% (TBC)

Mortality Indices (HSMR)

Definition: The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

Prior to the COVID-19 pandemic the Trust's HSMR was elevated above national standard, and increased demonstrably by special cause variation aligned to COVID-19 peaks. In the last year, the HSMR has continued to improve such that September 21 saw the first score below the target of 100 in over 18 months. The latest 12 months cumulative (Jan 2021-Dec 2021) HSMR is 121.



Strategies to improve HSMR include

1. Improved process of disseminating learning from death:
   a. Thematic analysis of SJRs which are fed back to groups and directorates at governance meetings.
   b. Production of learning documents/bulletins which are widely circulated to highlight key learning points.
   c. Development of an open intranet site where key documents and presentations can be easily accessed by staff.
   d. Thematic analysis of feedback from next of kin as well as complaints.
2. Specialty Reviews
   a. To provide clinical assurance, the Learning from Deaths committee asks each specialty to review their deaths routinely and report into the committee at a set frequency on key learnings and actions taken. Overleaf is a list of specialty presentations during the last year.

Area Reviewed	Review Period	Presented to Committee
Emergency Department	Jan 21 – Jul 21	Aug 21
Acute Medicine	Jul 21 – Jan 22	Jan 22
Cardiology	Mar 21 - Mar 22	Mar 22
Respiratory	Feb 20- Mar 21	Jun 21
Stroke Unit	Nov 20 - May 21	Jun 21
Surgery	Aug 21 – Oct 21	Nov 21
Critical Care	Jan 21 – Dec 21	Dec 21
Neonates	Jan 20 – Dec 20	Jun 21
Toxicology	Aug 19 –Mar 21	May 21
Paediatrics	Sep 20 – Jun 21	July 21
Elderly care	Aug 21 – Feb 22	Feb 22
Haematology/Oncology	Feb 20 - Jan 21 (Leukaemia red alert)	Jul 21
Trauma and Orthopaedic	Jul 21 – Jan 22	Jan 22
Cardiac Arrest Reviews	Apr 20 - Mar 21	Nov 21

3. Quality improvement projects developed as a result of mortality reviews include
   a. Sepsis rapid improvement week
   b. Blood transfusion pathway review
   c. Development of Trust wide falls group
   d. End of life pathways quality improvement with development of a dashboard, increased training for clinical staff and improved process of the supportive care pathway (SCP)
   e. Non clinical pathways that affect mortality indices (including the accuracy of documentation, number of finished consultant episodes within a hospital spell and coding practices). In the last year, we appointed a Clinical Digital fellow to lead on this work.
   f. Introduction of safety huddles and development of safety huddles dashboard.
4. Alerts: The Trust receives a pre-warning of diagnostic groups where we may have more deaths than expected. These are then reviewed to identify reasons, any learning and actions required. Overleaf is a list of diagnostic groups reviewed

Diagnostic group reviewed	Review Period	Presented to Committee
Chronic obstructive pulmonary disease (COPD)	Aug 21	Jan 22
Short gestation age	Mar - May 21	Jan 22
Sepsis		Dec 21
Skin and subcutaneous infection	Dec 20 – Jul 21	Mar 22

COVID-19 Mortality

The mortality rate for COVID-19 infection has continued to improve: 7.5% for wave 3 (May 21 to December 21) compared to 16.1% for wave 2 (March 20 to May 20) and 31.8% for wave 1 (September 20 to April 21 (See table below).

The reason is multifactorial. Vaccination rates are much higher in wave 3 than previous waves. In the majority of hospitalised patients, COVID-19 positivity was an incidental finding rather than the main diagnosis, therefore the proportion of patients being treated for COVID-19 pneumonia was lower. In addition, there have been many advances in therapeutics and the way we manage patients with COVID-19. In December 2021, we started offering neutralising monoclonal antibody therapy and antiviral medications to COVID-19 positive high-risk patients. Waves 2 and 3 were mainly due to the Delta variant.

	Wave 1 Mar 20 - May 20	Wave 2 Sep 20 - Apr 21	Wave 3 May 21 - Dec 21
Total number of COVID admissions	1009	4,744	2437
Total number RIP	321	767	184
% RIP	31.8%	16.1%	7.5%

Comparison between waves 1, 2 & 3 n mortality rate

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2021/22 that were recruited (via a consent process) during that period to participate in research approved by a research ethics committee was 1636. Of these, 1605 were recruited into National Institute for Health Research (NIHR) portfolio studies whilst 31 were recruited into non-NIHR portfolio studies. This information includes recruitment figures up to March 2022. Anonymised research data was submitted for a further 5881 participants for whom no consent process was required.

Research has continued to play an important role throughout the COVID-19 pandemic and our Trust recruited significant numbers of patients to the highest priority COVID-19 studies, including those with the highest impact on changing patient outcomes, REMAP-CAP in Critical Care, RECOVERY and CCP-ISARIC in admitted and emergency care. The portfolio of research has expanded again to include research participation across more than 15 specialties.

A number of awareness raising activities have taken place over the year to enable research to be embedded into all clinical services to ensure that our patients are able to participate in practice changing research.

Participation in clinical audits

During 2021/22, a total of 62 national clinical audits and national confidential enquiries covered relevant health services that Sandwell and West Birmingham NHS Trust provide.

During that period Sandwell and West Birmingham NHS Trust participated in 95 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in (excluding those which were paused by the provider).

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust were eligible to participate in during 2021/22 are as follows (see column 1).

The national clinical audits and national confidential enquiries that we participated in during 2021/22 are as follows (see column 2).

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 2021/22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see column 3 of the below table).

Title	Are we participating in this?	% of eligible cases submitted
Barts Health NHS Trust: National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM) Devices and Ablation	Yes	100%
Barts Health NHS Trust: National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	100%
Barts Health NHS Trust: National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	100%
N.B. All the NCAP reports are two years "behind", so we use the report published date as the time period, i.e., the 2019/20 data is published in 2020/21. We were made aware of data entry issue for 2019/20 data during 2020 (pandemic pause). Barts Health NHS Trust: National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	64%
British Society for Rheumatology: National Early Inflammatory Arthritis Audit (NEIAA)	Yes	58%
British Thoracic Society: National Outpatient Management of Pulmonary Embolisms Audit	Yes	100%
British Thoracic Society: National Pleural Services Organisational Audit	Yes	100%
British Thoracic Society: National Smoking Cessation Audit	Yes	100%
British Urology Researchers in Surgical Training (BURST): Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	No	TBC (CL)
Healthcare Quality Improvement Partnership (HQIP): National Joint Registry (NJR)	Yes	100%
IBD Registry: Inflammatory Bowel Disease (IBD) Audit	Yes	100%
Intensive Care National Audit & Research Centre (ICNARC)/Resuscitation Council UK (RCUK): National Cardiac Arrest Audit (NCAA)	Yes	100%
Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (CMP)	Yes	100%
King's College London: Sentinel Stroke National Audit programme (SSNAP)	Yes	99%
MBRACE-UK: Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiries	Yes	100%

Title	Are we participating in this?	% of eligible cases submitted
MBRACE-UK: Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality surveillance and mortality confidential enquiries	Yes	100%
MBRACE-UK: Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal morbidity and mortality confidential enquiries	Yes	100%
MBRACE-UK: Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	Yes	100%
MBRRACE-UK: National Perinatal Mortality Review Tool	Yes	100%
National Comparative Audit of Blood Transfusion programme: 2021 Audit of Blood Transfusion against NICE Guidelines & PBM survey	Yes	100%
National Comparative Audit of Blood Transfusion programme: 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	Paused by provider	N/A
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Child Health Clinical Outcome Review Programme: Transition from child to adult health services	Yes	TBC (Ongoing)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Medical and Surgical Clinical Outcome Review Programme: Community acquired pneumonia	Paused by provider	N/A
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Medical and Surgical Clinical Outcome Review Programme: Crohn's Disease	Yes	TBC (Ongoing)
National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Medical and Surgical Clinical Outcome Review Programme: Epilepsy	Yes	11 Patients
NHS Benchmarking Network: National Audit of Care at the End of Life (NACEL)	Yes	100%
NHS Digital: Elective Surgery (National PROMs Programme)	Yes	56.6%
NHS Digital: National Diabetes Audit - Adults: NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	100%
NHS Digital: National Diabetes Audit - Adults: National Core Diabetes Audit	Yes	TBC (Ongoing)
NHS Digital: National Diabetes Audit - Adults: National Diabetes Foot Care Audit	Yes	*TBC (CL)
NHS Digital: National Diabetes Audit - Adults: National Pregnancy in Diabetes Audit	Yes	*TBC (CL)
NHS England and NHS Improvement: Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
Public Health England: Surgical Site Infection Surveillance Service (SSI)	Yes	100%
Royal College of Anaesthetists: National Emergency Laparotomy Audit (NELA)	Yes	100%
Royal College of Anaesthetists: Perioperative Quality Improvement Programme (PQIP)	No	0%
Royal College of Emergency Medicine: Emergency Medicine QIPs: Consultant Sign Off	Paused by provider	N/A
Royal College of Emergency Medicine: Emergency Medicine QIPs: Infection Control	Yes	100%
Royal College of Emergency Medicine: Emergency Medicine QIPs: Pain in Children (care in emergency departments)	Yes	100%
Royal College of Emergency Medicine: Emergency Medicine QIPs: Fractured Neck of Femur	Yes	100%
Royal College of Obstetricians and Gynaecologists: National Maternity and Perinatal Audit (NMPA)	Yes	100%
Royal College of Paediatrics and Child Health (RCPCH): National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Partial submission
Royal College of Paediatrics and Child Health: National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%
Royal College of Paediatrics and Child Health: National Paediatric Diabetes Audit (NPDA)	Yes	100%
Royal College of Physicians: Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database	Yes	85.8%
Royal College of Physicians: Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database	No	0%
Royal College of Physicians: Falls and Fragility Fractures Audit programme (FFFAP): National Audit of Inpatient Falls	Yes	100%
N.B. RCP registry no obligation to input, therefore, 2020/21 no data inputted during Apr 20 - Mar 2021 Royal College of Physicians: National Asthma and COPD Audit Programme (NACAP): Adult asthma secondary care	Yes	2%
Royal College of Physicians: National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease	Yes	46%
Royal College of Physicians: National Asthma and COPD Audit Programme (NACAP): Paediatric - Children and young people asthma secondary care	Yes	*TBC (CL)
Royal College of Physicians: National Asthma and COPD Audit Programme (NACAP): Pulmonary Rehabilitation	Yes	6%
Royal College of Physicians: National Lung Cancer Audit (NLCA)	Yes	100%
Royal College of Surgeons: National Audit of Breast Cancer in Older People (NABCOP)	Yes	342 patients
Royal College of Surgeons: National Gastro-intestinal Cancer Audit Programme (GICAP): National Bowel Cancer Audit (NBOCA)	Yes	>80%
Royal College of Surgeons: National Gastro-intestinal Cancer Audit Programme (GICAP): National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
Royal College of Surgeons: National Prostate Cancer Audit (NPCA)	Yes	*TBC (CE)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA): Acute Internal Medicine / General Internal Medicine	Yes	100%
The British Association of Urological Surgeons: Management of the Lower Ureter in Nephroureterectomy Audit	Yes	100%
N.B. TARN are currently using old 2017-18 HES data figures to produce their reports. We need to undertake a new HES data exercise to re-adjust our total figures/ denominators for reporting purposes. Also, data collection will continue up to 8th July 22 for the 2021/22 audit. The Trauma Audit and Research Network (TARN): Emergency Medicine	Yes	31%
The Trauma Audit and Research Network (TARN): Emergency Medicine: NHS England Tackling Serious Violence sprint audit	Yes	100%
University of Bristol: National Child Mortality Database (NCMD)	Yes	100%
University of York: National Audit of Cardiac Rehabilitation (NACR)	Yes	95%

**TBC (CL): Case ascertainment not yet confirmed due to clinical delays in collating information.*
**TBC (CE): Case ascertainment not yet confirmed due to administrative delays in collating information*

Moving forward, to improve oversight of all clinical audits, the clinical effectiveness team, with the informatics team are collaborating to identify an approach to build a data query that will enable the clinical effectiveness team to pull hospital episode statistics from our electronic patient record system to monitor ascertainment rates throughout the year. This will ease the administrative burden for clinicians.

For 5% of our national audits there was limited participation:

- Peri-operative Quality Improvement Project – In light of the challenges with resources within Surgery or Research departments to complete the necessary data collection
- Fracture Liaison Service Database – As with other Trusts SWB opted out of entering data during the COVID-19 pandemic, in order to divert staff resources to patient care.
- Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery – The study isn't due to finish until some point later this year, however there are eligible cases with the data yet to be uploaded.

Having identified the issues for non/delayed participation in these three national audits, the clinical effectiveness team will support relevant services to develop recovery plans to ensure participation in 2022/23 with new escalation arrangements agreed to support participation.

The reports of 34 national clinical audits were reviewed in 2021/22 and Sandwell and West Birmingham NHS Trust intends to take several improvements forward to improve across various domains some of which are described in Table 1.

Table 1: Improvement activities against national clinical audits

Speciality Audit	Improvement Activity
National Asthma and COPD Programme (NACAP)	• An Asthma Lead Nurse has now been employed and will progress an education programme with cascade training via the ward link nurses with an aim to improve performance against key indicators. • The team are testing a discharge checklist proforma to be added to the patient electronic record system. • Improvement in overall care from diagnosis to outcomes through use of novel medical technology to be implemented: FeNO devices to be rolled out through outpatients.
Society for Acute Medicine's Benchmarking Audit (SAMBA	• Recruitment of a 9am-5pm consultant on Acute Medical Assessment Unit A • Improvements in the frailty care pathway with the frailty intervention team.
NCEPOD Dysphagia	• Parkinson's Disease Lead Nurse role in place to improve communication, support and referral pathways for patients living with Parkinson's disease. 'Closing the Gap' with Community Services. • Improvement in consideration of swallow status as part of social history, and development of a checklist to support clinicians gathering social history from families and carers. • A local audit to be commissioned looking into compliance with associated Parkinson medication administration times.
National Emergency Laparotomy Audit (NELA):	• Improvements will be made to our local electronic patient record system to include the EMLAP pathway. • Clinical Effectiveness Team will collaborate with the local NELA lead to develop and implement a dashboard for improved monitoring of related emergency laparotomy data. • To improve the care provided to emergency laparotomy patients a crash call protocol to be written, ratified and implemented within ED, also improving compliance against the NELA audit.
Surgical Site Infection Surveillance (SSI)	• A quality improvement project is underway with an aim of improving compliance with the Surgical Site Infection Surveillance Service (SSI) audit, the objective being an improved return rate within 30 days post operation. Key Drivers included use of local electronic patient record system, new database and new text message service. The process measures will be compliance of patient's returns, number of electronic/text reminders. This will provide SWB with a more thorough picture of wound care post op.
PROMS – Hip and Knee:	• A great example of how innovation is informing the improvements in the quality of care at our trust is a project entitled: 'MSK equity: Evaluating quality using information technology'. The project aims were to increase the percentage of patients completing PROM and PREM scores, as well as other post-operative quality of care measures including whether patients felt they received sufficient information post-surgery. The outcome of this project has highlighted opportunities to further improve and sustain changes; developing a digital application to help inform patient recovery and improve the quality of care post surgery.
Royal College of Emergency Medicine - Infection control	• Improvements are being made for a standard process across our sites: to ensure patients are completing the same prior to assessment forms. Create a screening proforma as an interim measure, to be completed by triage team with ED team to update the infection control form in the electronic care record to ensure all infection options are addressed.
National Cardiac Arrest Audit (NCAA)	• Improvements come from collaborating as a key stakeholder at the Learning from Deaths workstream to disseminate learning from the National Cardiac Arrest Audit. This is where the group review each interim report as part of team practice into understand any anomalous results that may indicate alterations and/or improvements in practice.

The reports of 211 local clinical audits were reviewed in 2021/22 and Sandwell and West Birmingham NHS Trust with some of the improvements implemented or to be progressed identified in the table below (see table 2).

Table 2: Improvement activities against clinical audit

Speciality Audit	Improvement Activity
Skin Cancer	• To improve compliance with standards for monitoring compliance of skin cancer patients in multi-disciplinary meetings. (MDT) staff will document the 'time limit' for planned procedures as an MDT outcome. Staff will also ensure documentation of any deviation from the MDT outcome to prompt a repeat MDT discussion.
Paediatrics and hearing loss against meningitis	• For continuous improvement to protect and assess hearing in children with meningitis, the general paediatrics department will continue to assess the use the referral proforma and email process to refer to audiology department. The team will improve coding knowledge to ensure patient diagnoses are correctly coded. Audiology staff will also continue to use inpatient assessment where resources allow prior to the discharge of patients from ward.
Vulva Biopsies	• A Quality Improvement Project to be implemented with objectives to include origins of referrals and accuracy of details of vulva biopsies for non-malignant disease.
Occupational Health	• An improvement project will aim to improve compliance of the splash/sharps occupational health questionnaire. To then enable wider sharing of injury data by collaborating with Health & Safety.

Atopic Dermatitis	• Improvements to be made with the aim of greater effective use of Dupilumab for treating atopic dermatitis. This will include design and implementation of a checklist tool that will flag up missing pieces of data from a patient's electronic care record, as this information will help to inform treatment. • To improve follow up rates there will be improvements to electronic systems for alerts for patients who have not been booked in for a blood test or follow-up appointment.
Frailty	• An improvement project aims to increase the identification and improve management of frail elderly patients admitted to acute medicine with a key driver that the frailty intervention team will implement a front door comprehensive geriatric assessment.
Delirium	• A quality improvement project will aim to improve identification and management of delirium, considering low compliance with care standards for delirium in older people admitted with COVID-19.
ICU readmissions	• To improve the number of unplanned patient readmissions within 48 hours. Change ideas will include information on handing over to parent teams into the doctors' handbook. Critical care team is developing a new discharge proforma which includes handover guidance. Educational key driver will be addressed with educational and learning resources to increase awareness of the ICU discharge checklist and the importance of completing it for every patient.
Urinary Retention	• The emergency department team will improve care with a quality improvement project to introduce a new urinary retention pathway and provide education sessions to promote timely catheterisation. • A Urinary catheter trolley with relevant equipment will also be established and restocked on a regular basis. • An online clinic referral form will be made available on the Trust intranet page.
Cardiac Resynchronization Therapy	• Project aim of providing greater valid comparison with post-op scores and indication of improvement. Achieved by reviewed and revised documentation of New York Heart Association (NYHA) functional scores prior to implantation of cardiac resynchronization therapy (CRT) devices in order that the NYHA score will be incorporated into the multidisciplinary team form. • The team will implement and evaluate the impact of booking a 12 lead ECG automatically at every clinic appointment and three month echo to be added to the electronic system at the point of implantation.
Staff Health and wellbeing	• A collaborative approach with key stakeholders will aim to improve the welfare of junior doctors when completing medical on calls. Achieved through the design and development of mentorship and wellbeing schemes targeted at general medical registrars.
Patient Flow – Surgery	• Improvement project with an aim of improving patient flow within surgery. This will be monitored and evaluated for impact including measuring emergency department breaches for patients referred to Trauma & Orthopaedics (Internal Professional Standards) utilising the "who's who" document and "right patient first time" document. • Application of SAFER Bundle whereby, senior clinicians will review patients to help expedite patients' discharge when safe and TTOs should be prepared on the day of surgery by junior doctors.
Deep Vein Thrombosis	• An improvement project with the aim of improving compliance for all patients at high risk for Deep Vein Thrombosis (following first scan being negative). Implementing changes to pathways and reporting for first scan report to repeat the DVT scan in one week as per NICE recommendations.
CAMHS	• A Children and Adolescent Mental Health Service Steering Group will be established with an aim to collaboratively reduce the number of delays when accessing inpatient CAMHS. The objectives are to deliver several actions including developing a CAMHS policy, identify any training needs for SWB staff and review of national and regional guidance to be adapted for local use at SWB.

The Health and Wellbeing team.

PARTNER STATEMENTS

In line with our obligations we sent our draft Quality Account to our stakeholder partners for their comments. The partner comments we have received are detailed below.

Healthwatch Birmingham on Sandwell and West Birmingham NHS Trust Quality Account 2021/22

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Sandwell and West Birmingham NHS Trust 2021/2022. We are pleased to see that there is an open evaluation of the Trusts performance between 2021 and 2022. There is a clear identification of areas where the Trust has done well and areas where further improvements are needed. We acknowledge that Covid-19 continues to have a significant impact on the Trusts activities. In particular, we note the challenges the Trust is experiencing in restoring normal pre-covid 19 waiting list times in some areas, especially cancer targets. We agree that addressing waiting times and reducing waiting lists should be a priority as delayed care has an impact on patients' wellbeing and outcomes. Indeed, the experiences we have heard from the Trusts patients point to concerns with long waiting times for care.

> *Waited long for the appointment but the consultation with the doctor was very good.*
>
> *I have waited over 15 months for an eye hospital appointment. My optician has sent 2 letters and my GP has also written. Still not had any response.*
>
> *I had been waiting six months for an appointment and the day before I was due to attend, they phoned and cancelled my appointment.*

We agree that resolving waiting lists will take time and note the actions the Trust is taking to resolve this. We are pleased to read that a process of prioritisation of cases has been followed by the Trust and an assessment of potential harm from any delay in treatment has been made. We, however, seek more clarity on the actions the Trust will be taking to ensure that there is support for people as they wait. How is the Trust making sure that people have the right information as they wait or are signposted to other organisations?

We welcome the work that the Trust has carried out over the past year to meet the priorities set. In particular, we are pleased to see the following developments:

- restoration of waiting times in gastrointestinal endoscopy and prioritising surgeries based on clinical need.
- identification of opportunities for clinical collaboration with acute trust partners and primary care on areas such as waiting times for urgent referrals, staff recruitment and training, ophthalmology and gynae-oncology
- development of clinical pathways for the acute care model at MMUH
- the introduction of Tendable to enable improvement in safety and quality.

We note the development of the Trusts draft quality strategy (Fundamentals of Care Approach) and its focus on improving standards of care for patients. We agree that to be successful, the implementation of this approach requires all staff, wards and departments to have a shared understanding of the standards the Trust wants to achieve. We are pleased to see that this approach includes ensuring that patients' needs, and voice are at the centre of their care. We note that standards of care will be developed alongside patients, and we look forward to reading in the 2022/23 Quality Account the impact this has had on the focus of the Fundamentals of Care Approach.

The Trust has set itself a commendable target in its strategy under the patient objective that aims to ensure there is consistency in the care provided to all patients. We are pleased that the Trust has committed to be good or outstanding at everything it does concerning patients. We believe that understanding patients experiences, views and insights into the care they receive from the Trust, their suggestions on changes and improvements will become even more important as a measure of the quality of care. Crucial to success will also be understanding the needs that are specific to particular individuals or groups, especially people more at risk of health inequalities. We would like to see the Trust ensure the following as it develops and implements actions around the fundamentals of care priority.

- That the key objective of engagement with patients, families and the public is 'to use patient and public insight, experience, and involvement to identify, understand and address the potential consequences of service improvement, design and development on health inequalities and barriers to improvements in health outcomes (including increasing independence and preventing worsening ill-health).'
- Public health data should inform engagement plans to ensure that the Trust is hearing from all sections of the community particularly those impacted negatively by changes or improvements to services. Also use this to understand wider impact on health inequalities that have an impact on how the trust delivers its services.
- That the Trust is using varied ways of engaging with services users and members of the public that go beyond the use of online methods to ensure that the communication needs of diverse groups are met.

We note that there has been a decrease in the percentage of staff who would recommend the Trust as a provider of care to their family and friends (a drop from 63 to 58%), and staff who would recommend the Trust as a place to work (a drop from 60 to 54%). We are pleased to see that one of the Trusts strategic objective is to cultivate and sustain happy, engaged and productive staff. We would like to read the impact of the actions implemented under this objective on staff in the 2022-23 Quality Accounts.

We note that improvements are needed across the KPI standards set for the Trust, especially under the Access metrics. With the exception of Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral, performance in all other areas has been below the target required.

- Cancer – 2-week GP referral to first outpatient – 86% (against a target of 93%)
- Cancer – 2-week GP referral to first outpatient (breast symptoms)- 71.3% (against a target of 93%)
- Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Excluding Rare Cancer) – 61.6% (against a target of 85%)
- Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Including Rare Cancer)- 59% (against a target of 85%)
- Emergency Care – 4 hour waits – 75.5% (against a target of 95%)
- Referral to treatment time – incomplete pathway <18 weeks – 70.5% (against a target of 92%)

Whilst we appreciate the impact that the COVID-19 pandemic has had on these numbers, it is worrying that the performance indicators are quite low for some of these access metrics. Considering the impact delayed care has on outcomes and the quality of life of patients. We will continue to work with the Trust and monitor the Trust's action plans implemented to make improvements. We will continue to share with the Trust feedback we receive from service users, carers, and the public on the Trust's services to inform improvements.

The feedback we receive at Healthwatch Birmingham from the Trusts patients is similar to the themes identified for complaints, PALS and Purple Point Calls. We note in particular communication which the Trust has identified as being focused around enabling patient contact with family and updates from clinical staff to families. We welcome that actions have been implemented to address these areas. Including the learning from complaints that has resulted in changes that will positively impact patient experience.

However, based on the feedback that we receive, we believe that the Trust needs to do more work to understand what other key underlying concerns are with communication. This would enable the Trust to develop varied interventions to address this. The feedback we have received indicates that in addition to updates to families, people want communication that meets their needs and communication in a way that they understand. Including communication that is compassionate and communication whilst people wait for care.

> *The individual is waiting for surgery to remove silicon oil from her eye after retina surgery in April last year. "The wait is awful. No contact from Birmingham eye hospital. Can't speak to anyone on the phone. I've now written them a letter. I'm worried I've been lost in the system."*
>
> *Communication could have been better, did not listen seem to be in a hurry didn't answer my question fully not very professional*
>
> *A few months ago, my mum was in hospital, and she does not speak English and staff at the hospital don't talk to the family to update and my mother didn't know what was happening.*

I am working as a part time interpreter, but when I experienced service provided there in AMU and afterwards at ward 26, I was overly disappointed regarding care in the ward. It needs a lot more effort, staffing and compassionate communication levels to deal with sick people.

Very poor communication with me and my family when I was there for treatment.

Lack of communication at every level, nobody knows what they are doing.

Healthwatch Birmingham agree with the strategic objectives covering the next five years and priorities for the Trust for 2022/23. We recognise many of the issues from our own engagement with the public and we will continue to work with the Trust to support this focus.

Andy Cave, CEO
Healthwatch Birmingham

NHS Birmingham and Solihull Clinical Commissioning Group

Birmingham and Solihull CCG appreciated the opportunity to read and comment on the Quality Account. The Medicines Management and Optimisation Team have commented that is positive to see that medicines management is included as one of the inspection categories for audit to drive safety improvements across the organisation. The use of technology to provide real time data is innovative and it will be good to see how this improves patient care.

It was positive to see the number of clinical audits that were undertaken in 2020-21, especially given the demands on the service at this time. It is encouraging to see that a national audit has prompted some local work to improve care of patients with Parkinson Disease by looking at the impact of timing of doses of medication. We would be interested to see if improvements in patient care and safety resulted from implementation of the action plans described. We would encourage sharing the results of other work done to review and promote safe, clinically appropriate prescribing, including the planned work around prophylaxis of venous thromboembolism.

In relation to the trust's use of antimicrobials, we would encourage sharing of the work carried out towards supporting the national antimicrobial stewardship agenda

Lead Commissioner Comments – BCWB CCG - Quality Account Statement 2021/22

The Black Country and West Birmingham CCG (The CCG) confirms that to the best of their knowledge, the Quality Account, prepared by Sandwell and West Birmingham Hospitals Trust (SWBH), is a true and accurate reflection of the work undertaken by the Trust during the 2021/22 contractual year.

The CCG welcomes the opportunity to comment on the quality of services provided by Sandwell and West Birmingham Hospitals NHS Trust (The Trust). Quality accounts enhance public accountability and engage the leaders of an organisation and the organisations that commission them in engaging and understanding the continuous quality improvement and patient safety agenda. They allow formative challenge and celebration of good practice.

In 2021/22, the Covid-19 Pandemic continued to place enormous pressures on the whole of the NHS and the CCG would like to take this opportunity to once again formally recognise the efforts that the Trust has made to maintain Quality whilst acknowledging the uncertainties and the challenges faced during 2020/2021. The CCG would like to thank all the staff and volunteers at SWBH for their outstanding continued commitment in responding to the pandemic and transforming services to deliver new ways of working that has ensured that in most cases, high quality patient care has been consistently delivered, despite the enormous challenges faced.

The pandemic has meant that to meet the unprecedented levels of demand, the whole of Black Country and West Birmingham System has been required to work collaboratively and in support of each other's needs. We commend the Trust for their exceptional contributions to this collaborative working approach and recognise the Trust as a key system partner in the collective response to the COVID-19 requirements.

Even with the extensive pressures experienced during the last year, the CCG and the Trust have continued to work tirelessly and collaboratively to improve the quality and effectiveness of care provided, enhancing the close working relationships between the CCG and the Trust to support the delivery of high quality, safe services provided to our population. We recognise and commend the Trust's achievements against their quality and patient safety priorities which are outlined in this account.

We are immensely proud of the effective working relationships that exist between the Trust and the CCG and in the improvements that have continued to be made across the quality and safety agenda. During 2021/ 22 we have worked together to address infection prevention and control, implementing new national guidance to combat the new variants of Covid-19 and sharing good practice and innovation across the whole of the Black Country and West Birmingham Care system. We would like to thank the Trust for their ongoing support in this matter, and for their engagement openness shown in the multi-agency infection prevention outbreak meetings.

The Trust have worked extremely hard to ensure that maternity services provision is delivered in line with the recommendations from the recently published Ockenden review and are safe for the community they serve. The CCG are grateful for the ongoing Trust commitment in implementing the Ockenden recommendations and for the recent benchmarking and self-assessment activity it has undertaken to identify areas for further improvement.

The Trust will also need to continue to demonstrate that they have learnt lessons from serious incidents. The CCG is encouraged by the work of the Trust to embed learning and positive change and in its early preparations for the new Patient Safety Incident Response Framework (PSIRF).

The work of the Infection Prevention and Control Team (IPC) has continued to be significant and impressive during the Covid-19 Pandemic and the Trust should be commended for all the measures put in place to keep both staff patients and the environment safe, in such challenging times.

The Trust have also outlined the introduction of the Wellbeing Team, who will provide support to staff. The CCG recognises the valuable work that colleagues have contributed to maintaining emotional and psychological wellbeing during difficult times of crisis.

In conclusion the BCWB CCG are confident that the Trust has demonstrated their commitment to quality, experience, and safety in their continual improvement journey. We thank The Trust for their hard work and outstanding response to the continuing Covid-19 pandemic and for the honest and open culture fostered within the organisation and their continued focus on putting patients first. We look forward to seeing the impact of the identified 2022/23 priorities and the continuation of system wide collaboration as we work in partnership as part of the Black Country Integrated Care System.

Trust response

We would like to thank our stakeholders for their valuable comments on our Quality Account for 2021/22.

Independent Practitioner's Limited Assurance Report to the Board of Directors of Sandwell and West Birmingham Hospitals NHS Trust on the Quality Account

Assurance work on quality accounts is not required for 2021/22. We therefore have no limited assurance opinion on our quality account to publish.

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