NHS
Sandwell and
West Birmingham
NHS Trust

QUALITY ACCOUNT
2022/23

PATIENTS
PEOPLE
POPULATION

Foreword

Welcome to the Quality Account for 2022/23. This report provides an overview on our Trust's performance against our quality priorities for the year.

During this year we focused on preparations for the move into the Midland Metropolitan University Hospital, the launch of our Fundamentals of Care framework and continuous monitoring and improvement in readiness for our next CQC inspection. We also developed our integrated Place Based partnerships to ensure we can better meet the needs of our population and right size our services to ensure sustainable delivery.

The challenge on our services over the past year has been unprecedented. For the first time in a very long while we declared three critical incidents over the Christmas and New Year period due to the unrelenting demand on our services. Although we were largely unaffected by nurse industrial action, we certainly felt the pressure with the first industrial action by our non-consultant colleagues. However, our unique position as an integrated Trust, also delivering in partnership Primary Care services, afforded us the opportunity to respond to the challenges through coordinated activity. For example we deployed falls response teams, enhanced urgent community response care navigation services and virtual wards.

To help us achieve our patient objective of 'To be good or outstanding in everything we do', we co-produced and launched our Fundamentals of Care framework with our staff and local communities. As we started to put measures in place to live with COVID-19, Fundamentals of Care gave a perfect opportunity to get back to basics in terms of the care that we provide. We partnered with the International Learning Collaborative (ILC) and Flinders University who will help us deliver this crucial piece of work. We want to ensure the approach has a focus not just on nursing, but the involvement of all professions working in all clinical setting including primary and community care.

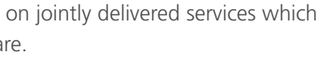
For the year ahead, we will focus on two priorities for Fundamentals of Care – communication and harm free care. These are now enshrined as objectives in our 2023/24 Annual Plan. We recognise that communication is the one thing that comes up as an issue in our complaints or when relationships break down between our patients and our clinical teams. If we communicate well, we can profoundly enhance the experience of our patients.

This year will see a notable change in how we report on patient safety with the introduction of the Patient Safety Incident Response Framework (PSIRF). Our focus on harm free care will ensure continuous learning, and quality improvement underpinned by openness and transparency. We are also anticipating the planned changes to regulation that will see a focus on systems of care delivery across wider partners. In preparation, we are working on strengthening our quality governance to include oversight on jointly delivered services which will include social care.

In March 2023, NHS England carried out an inspection of our infection control practices which saw us achieve the equivalent of 'green' status. This is the first sign of improvement in the Fundamentals of Care journey and a huge accomplishment after being rated 'red' only two years ago.

Medicines management is also a key area of safety with up to eight per cent of hospital admissions being medicines related. We are going to work to remove medication errors include prescribing, dispensing and administration issues through improved training, support and oversight. As part of this work, we have been strengthening our systems and processes to improve safe medicines management and recognition of deteriorating patients by our community teams. We are also looking to strengthen stewardship of antibiotic use to help guard against bacterial resistance.

We look forward to opening the Midland Metropolitan University Hospital in 2024. Activity has already increased as we prepare our clinical teams for the move. This means embedding new practices and pathways on which the new hospital will depend. We will standardise ward practices to achieve early decision making and optimise clinical care, staff efficiency and improve patient flow. As we prepare for MMUH the successful delivery of out of hospital services in partnership have never been so important.



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

Sir David Nicholson with maternity staff.

Our Trust Strategy 2022/27

Overview 2022/23

As an integrated NHS Trust, we span a range of services and structures that support the delivery of this strategy. Sandwell & West Birmingham NHS Trust:

- Is made up of five clinical groups and a number of corporate directorates;
- Employs over 7500 people and has a budget of over £700m;
- Is part of the Black Country Integrated Care System whilst being the main acute provider for the West Birmingham Place which forms part of the Birmingham and Solihull Integrated Care System.
- Is the host provider for the Sandwell Health and Care Partnership, our local placed based partnership.
- Is a key stakeholder in the Ladywood and Perry Barr Locality Partnership
- Has its main sites at City Hospital on Birmingham's Dudley Road and Sandwell General Hospital in West Bromwich along with Intermediate Care Hubs at Rowley Regis and Leasowes in Smethwick.
- Owns and runs the Birmingham and Midland Eye Centre (a supra-regional eye hospital), as well the regional Sickle Cell and Thalassaemia Centre, and the regional base for the National Poisons Information Service based at City Hospital.
- Has significant academic departments in cardiology, rheumatology, ophthalmology, and neurology.
- Is one of only a handful of NHS Trusts in the country that delivers substantial Primary Care in partnership with local GP's in both Sandwell and West Birmingham
- Has all age community teams that deliver care across Sandwell providing integrated services in GP practices, in community clinics and at home, offering both general and specialist care.
- Provides an integrated palliative care service working with the voluntary sector and hospices delivering urgent and planned care for people at the end of life.
- Is building the new Midland Metropolitan University Hospital on Grove Lane, on the Smethwick border with West Birmingham. This will see a consolidation of our acute services into a state-of-the art facility with outpatient and day case procedures being provided at City and Sandwell Hospital.

Our strategy

In 2021/22, we signed off our five-year Trust strategy, which set our long-term direction. The strategy set out:

- Our purpose: To improve life chances and health outcomes
- Our vision: To be the most integrated health care provider
- Our values: Ambition, Respect and Compassion
- Our strategic objectives:
  - **Patients:** To be good or outstanding at everything we do
  - **People:** To cultivate and sustain happy, productive, and engaged staff
  - **Population:** To work seamlessly with partners to improve lives

We also set our several priorities to be completed prior to the opening of MMUH. These are shown in the following diagram.

Our Trust Priorities

Before MMUH

- Launch our Strategy and co-develop the plans e.g. Fundamentals of Care
- Value and Behavioural Framework
- Prepare for and open MMUH
- Staff journey from recruit to retire
- Budget reset and cost control
- Place Base Partnership Development
- Agree a Continuous Quality Improvement approach

MIDLAND METROPOLITAN UNIVERSITY HOSPITAL

After MMUH

- Embed new ways of working and Continuous Quality Improvement
- Make significant improvement in our Board Level Metrics, Staff Survey and Patient Experience
- Develop a Learning Campus
- Work closer with partners in the Integrated Care System

Since launching our strategy in 2022, we have:

- Developed and launched the multi-year strategic changes including the Fundamentals of Care, People Plan and Digital Strategy;
- Developed and launched our new 'ARC' values and behavioural framework;
- Developed our hosting of 'Place' and made improvements in attendance avoidance, admission avoidance and acute hospital length of stay reduction;
- Delivered our nationally recognised integrated discharge hub;
- Considerably transformed our community services provision including the opening of an 80 bedded integrated intermediate care centre
- Created the 'Midland Metropolitan University Hospital' programme company, to focus the organisation on a safe and successful opening;
- Developed our understanding of improvement systems and gained approval from our Board to move to full business case for implementation

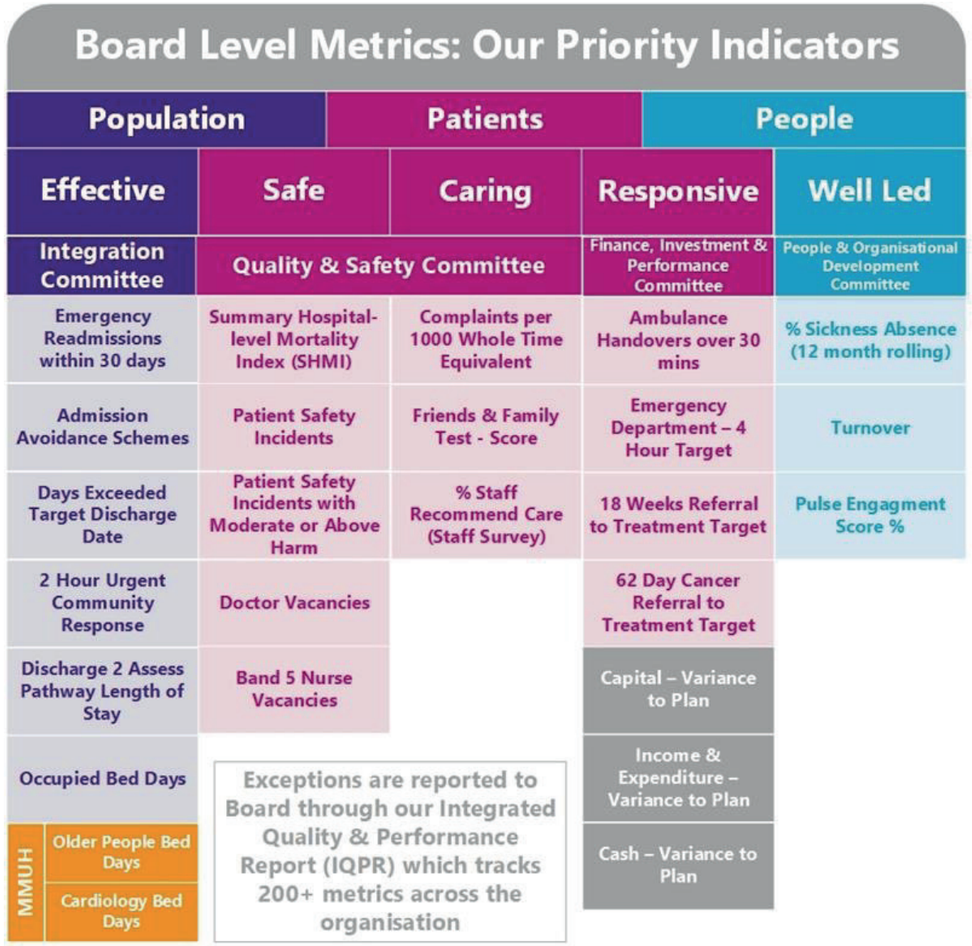
Whilst we are making progress we still have much work to do:

- Our patient and staff experience scores remain low;
- We remain rated as 'requires improvement' by the Care Quality Commission
- We are faced with an unprecedented financial challenge as the NHS works to restore productivity levels to and beyond pre-pandemic levels whilst dealing with high inflation;
- Our waiting lists are long;
- Our staff are tired and many are working extra shifts to sustain safe care;
- We need to deliver against our clinical transformation and workforce preparation to safely move into our new hospital;
- We need to deliver more services in a preventive manner if we are to change the future demands on our services and improve life chances for our population;
- We need to embed our quality governance within our Place Based Partnerships.

Dermot Reilly Emergency Department Charge Nurse at the Midland Metropolitan University Hospital.

Performance summary 2022/23

We have continued and further developed our approach to tracking performance. We have reviewed, rationalised and re-focused our 'Board Level Metrics' so that they align with our three strategic objectives. We have also developed the metrics scorecards in our Board committees to provide further assurance and detail to support out Board Level Metrics. The following diagram shows the metrics we track at Board.



Patients – Performance Highlights

- In the last year, we have made significant positive progress in reducing band 5 nursing vacancies, hitting our zero vacancies target.
- Performance has remained consistent in several areas including:
  - Patient safety including levels of harm
  - Complaints
  - Friends and Family test
  - Staff service recommender score
  - Emergency access standard, which consistently ranks in the top quartile nationally.
- Performance has declined in some areas. These include:
  - 18 week referral to treatment standard
  - 62 day cancer referral to treatment standard
  - Ambulance handovers within 30 minutes
  - Doctors in post.

People – Performance Highlights

Performance in our 'People' metrics has largely remained consistent. Sickness, turnover and our 'engagement' score on the quarterly 'pulse check' have neither improved nor declined and remain below their respective targets.

However, we have seen improvement in our scores from the annual national staff survey, particularly in how staff feel about their line manager. This is a substantial improvement the like of which has not previously been seen. They provide a positive indication that the work of the socialisation of the new strategy and values with leaders at all levels in the Trust may have had an early impact.

Population – Performance Highlights

In 2022/23 we have developed several new metrics in our Population strategic objective of our performance reporting. This looks at performance against schemes in our Sandwell Place Based Partnership and schemes supporting the delivery of MMUH.

- We have made positive progress in admission avoidance schemes, increasing the number of bed days saved per month
- We are achieving the 70% urgent community response target throughout the year whilst increasing the number of contacts
- Readmissions have remained stable at the target level.
- However, there are several areas where we have not achieved the targets set, particularly in relation to bed occupancy:
  - Our occupied bed days, older people bed days and cardiology bed days remain above target.
- Bed occupancy is a particular area of concern and focus as we plan the opening of our new hospital in 2024.

The table below outlines the 14 objectives to be delivered in 2023/24 against our three strategic objectives. These draw from and align with the national operational planning guidance 2023/24.

Patient Objectives
To increase patients rating their experience as good or very good for all touchpoints including Friends & Family Test (FFT) by area
Reduce patient safety incidents with moderate or above harm *Balancing metric: no reduction in reporting of no harm / low harm incidents*
To reduce the length of our waiting list in all specialities so that no patients have to wait 65 weeks or more for Referral to Treatment standard
To see and treat at least 76% of our emergency patients within 4 hours
To see and treat at least 85% of cancer patients within 62 days of being referred to our services
To provide at least 85% of our patients with access to diagnostic services with 6 weeks of referral
To deliver income and expenditure plan and improve our underlying deficit position
To deliver 104% or more of our 2019/20 elective activity levels
To reduce our bank and agency spend
People Objectives
To improve staff experience as measured in the national NHS staff survey
To develop leaders in compassionate and inclusive leadership, restorative people management, and in safety and service innovation
Population Objectives
To reduce the acute care occupied bed days in line with our plans to fit into the new Midland Metropolitan Hospital
To deliver a 2-hour response to 70% or more of our patients in the community whilst increasing the volume of our population that use this service
To reduce health inequalities through targeted improvements for patients with type 1 diabetes and for patients with respiratory conditions

Priorities for Improvement in 2023/24

Priority 1

Improving communication and the user journey

A key part of the quality of our services is the experience our patients (or users) have along their clinical pathways as in-patients but also as out-patients and in the community. This encompasses both the timeliness of their journey and the communication they receive.

Communication has been a consistent theme within complaints and is one of our 'Fundamentals of Care'. We believe some of our lost activity and 'did not attend' (DNA) rates may be affected by poor communication around appointments.

Our patient experience group will work as a multidisciplinary body that includes patient partner representation to develop and improve on our patients' experiences. The group will move beyond just the 'friends and family test', and will monitor the feedback received from patients, relatives and carers via trends and qualitative and quantitative data to systematically understand the patient, carer and relatives' experience. This group will determine the strategies and measures required to improve and maintain consistently high patient experience across all sites and locations.

Our Elective Access Team will review how we communicate about appointments and changes to time or location, ensuring that our patients receive accurate information. This will help improve patient experience as well as reduce DNA rates and wasted appointment slots.

Access in a timely manner is a key enabler of a quality service and remains a key focus to ensure patients can expect us to meet the national targets which we are required to meet by April 2024. This will ensure that no existing patient is waiting more than 65 weeks as part of the 'Referral to Treatment' standard. New referrals should meet the expected standards for example the '6 week diagnostic' standard and the '62 day cancer' standard.

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

Priority 2

Achieving harm free care

Harm free care is a priority for our Trust and one of our seven 'Fundamentals of Care'.

Our new Patient Safety Incident Response Framework (PSIRF) will be implemented across 2023 and integrates four key aims:

1. Compassionate engagement and involvement for those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement. This will replace the current Serious Incident Framework and heralds a new era for the management of incidents. This change will be key to establishing effective and compassionate patient safety reporting with systems in place for continuous learning and quality improvement, underpinned by openness and transparency of a just culture. To that end we will ensure a 'human factors' approach to safety and will strengthen our 'speak up' culture through our freedom to speak up guardians.

Medicines management is a key area of safety. Around 5-8% of hospital admissions are medicines related. Medication errors include prescribing, dispensing and administration issues. Antibiotic use needs good stewardship to help guard against bacterial resistance, secondary infections such as c.difficile, and harm from intravenous access beyond the time that oral antibiotics would be appropriate. We will work with our medicines management team to improve on training, support and oversight of these issues.

Prompt recognition of the deteriorating patient is an important factor to improving hospital outcomes and avoidable harm. We will work with our deteriorating patient and I.T. teams to improve the digital alerts to enhance this and support our ward clinical teams to improve the recognition of early warning signs.

Preventing functional decline and dependence in our patients is an important part of avoiding harm. Our place-based partnerships will help us to address admission avoidance, reduce length of stay and address inequalities in access to support.

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

Priority 3

Midland Metropolitan University Hospital (MMUH) readiness

As the opening of MMUH draws closer over the coming year we will see an escalation in the process of preparing clinical teams for the move to MMUH and in embedding new practices and pathways on which the new hospital will depend.

During this time we will be standardising ward practices to achieve early decision making and optimising clinical care and staff efficiency. A rhythm of the day will help incorporate board rounds and safety huddles and improve patient flow.

We need to achieve target bed occupancy levels by speciality to safely open the new hospital. To achieve this we will build on our pathways for same day care, such as the 'Frailty Same-Day Emergency Care Unit' that will have a front door team of consultants, therapists and advanced clinical practitioners (ACP). This pathway will avoid unnecessary admissions through our emergency department. Our heart failure pathway improvement will be modelled on national best practice moving the patient from acute to community pathways.

We will grow our use of virtual ward services that enable patients to remain in their own home whilst still receiving daily treatment and monitoring by our multi-disciplinary teams.

As we move towards opening a new acute site, it will become increasingly important that our teams are digitally enabled and that we maximise the opportunities in our IT systems. Equally it will help our patients to have a single digital front door by which to access our services and information. To that end our digital proficiency group will work with our staff to improve digital literacy, improve automation of our processes, optimise our key electronic patient record (EPR) systems and develop the digital support offered to our patients.

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

The frailty team is a growing multi-disciplinary team.

How we performed in 2022/23

Progress on 2022/23 Priorities

Priority one
Acute care models for Midland Metropolitan University Hospital (MMUH)

With the ongoing urgent and emergency care demands and challenges, our Trust has worked hard to create and deliver pathways for admission avoidance. This includes virtual wards that cover the specialties of respiratory medicine and frailty and soon to include cardiology and paediatrics. Epicentre which is the acute medicine Hospital at Home Model with point of care diagnostics has been running since late 2020 and gaining momentum; showing it is safe to keep patients at home whilst still delivering acute care. Many patients, particularly the elderly, who have multiple co-morbidities would prefer to receive care within their own home.

Areas such as same day emergency care (SDEC) and frailty are key in reducing admission to hospital. A new SDEC unit at Sandwell Hospital has recently opened and the configuration of this unit is MMUH ready. We are currently working towards a 7-day frailty service that will provide our patients with access to a multi-disciplinary team of professionals which will reduce unnecessary admissions and bed occupancy.

Focused MMUH recruitment is under way to provide a 7-day consultant led service to enable senior decision making consistently across the week. A focused open day and recruitment for MMUH has been arranged to concentrate on the most challenging specialties to recruit to. The recruitment strategy not only focuses on consultants but also allied health professionals such advanced clinical practitioners.

Priority two
Fundamentals of Care

Through Spring and Summer 2022 our Trust engaged with patients, staff and population to co-produce the Fundamentals of Care framework to help us achieve our patient objective of 'To be good or outstanding in everything we do'. We engaged with over 2000 patients and staff.

The Fundamentals of Care framework was approved by our Trust Board in September 2022 and formally launched on 22nd September 2022 where over 260 patients and staff attended. It was a fantastic launch, and this was followed up with four further sessions to capture as many staff and patients as we were able to. The framework also includes all clinical work that we are implementing within MMUH.

The framework has seven standards, Nutrition & Hydration, Communication, Harm Free Care, Sleep and Rest, Personalisation, Promoting Independence and Symptom Management. This year's priorities are Communication and Harm Free Care to improve the patient journey. Each standard has leads who are medical colleagues, nurses, midwives, allied health professionals or operational colleagues. There are also six workstreams, three of which will be delivered via the People Plan and three within Fundamentals of Care as below.

An accreditation programme under the banner of Pathway to Excellence continues to be developed and it will be implemented during 2023/24. Progress metrics have been developed for the Quality & Safety Committee and clinical groups are also developing metrics to show their journey.

Progress on Fundamentals of Care is currently reported through to the Executive Quality Committee and group reviews. A Fundamentals of Care steering group is to be created to monitor the work more closely in 2023/24.

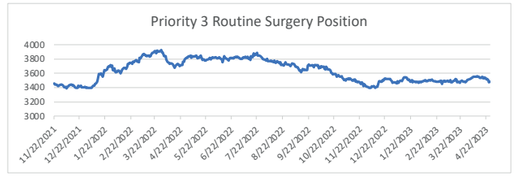
The first signs of improvement within this journey is our Trust being awarded the equivalent to green status by NHS England for infection control which means we move to routine monitoring. This is a huge accomplishment as we were rated red two years ago before moving to amber and now the equivalent of green.

Work has also commenced regarding triangulation of evidence of the weAssure approach, Chief Nursing Officer Quality & Safety reviews, Fundamentals of Care projects and our service/ward metrics.

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

Throughout the phases of the pandemic we focussed on caring for patients with COVID-19 and other urgent and emergency conditions. This means some patients have waited longer than expected for planned care, including treatments, surgery and diagnostic procedures.

We have resumed treating patients on our waiting list for planned care as quickly as possible and in order of clinical need – based on assessments managed by our clinical teams.



The chart above shows waiting list of patients categorised under priority 3 routine surgery covering the period November 2021 to April 2023 and illustrates that our backlog of patients has reduced to approximately the same levels as in late 2021.

We continue to see patients on an urgent pathway for a possible cancer diagnosis as quickly as possible, almost all within two weeks for their first appointment.

We are reducing waiting times by;

- **Increasing capacity:** We have created extra operating lists and clinics where possible, including some weekends and evenings. We are also looking to external organisations via outsourcing and insourcing to help with provision of additional capacity.
- **Virtual appointment:** When appropriate we use virtual appointments which reduces the need for patients to attend on site. Virtual appointments provide greater flexibility in how we provide advice and care, enabling more convenient and appropriate care for our patients and making the best possible use of clinical time and expertise.
- **Triage:** As part of our triage processes, we have improved prioritisation and alternative treatment options and pathway management. This supports best of use of resources with the right care and right treatment.
- **Clinical validation of waiting lists**: We are validating our waiting lists to ensure the situation for patients on our waiting lists is still the same. Some patient's conditions may have improved, they may have received treatment elsewhere and some might feel that they don't need surgery any longer and may wish to cancel or postpone.
- **Workforce gaps:** We are pro-actively identifying and addressing workforce gaps across key staff groups and sectors so that we can maintain our capacity for service delivery.
- **Utilisation:** We review our resources so that we are making the best use of our outpatient and theatre capacity.

The Emergency Department team at a recruitment event held to recruit into hard to fill roles.

Fundamentals of Care (Perfect Ward)

We introduced Tendable as a pilot in 2021/22. Tendable is a smart quality inspection app that can be used across all clinical areas. It provides real time audit results via the easy-to-use app which supports ownership of patient safety at a local level.

The inspection types within Tendable 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 now fully implemented as part of our Fundamentals of Care framework and we are now working on a service accreditation programme. The Fundamentals of Care framework was a priority for our Trust for 2022/23. Further information on this programme can be found in the 'Progress on 2022/23 priorities' section of our Quality Account.

Care Quality Commission

In October 2022, the Your Health Partnership (YHP) Primary Care Network, who joined the Trust in April 2020, were visited by the Care Quality Commission (CQC) and underwent an announced inspection. While their overall rating remained 'requires improvement' the inspection noted positive patient experiences and rated caring as 'good'. Another practice, The Great Bridge Health Centre, in West Bromwich, was also inspected and rated as 'requires improvement' and 'good' for caring. Two regulatory breaches were identified by the inspectors relating to control of infection oversight and monitoring of patients on long term medication or treatment. Action has been taken to address both areas of concern.

The overall rating for the Trust remains '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 unannounced in-house inspections has been in place for two years 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 been inspected, some more than once, and have developed plans for improvement with notable practices highlighted and shared across the organisation.

The Trust's patient-related strategic objective is 'to be good or outstanding in everything we do', which is supported by our plans to attain an overall provider 'good' rating through delivery of our Fundamentals of Care framework.

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 2022/23 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Sandwell and West Birmingham Hospitals NHS Trust

Inspection report

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Date of inspection visit: 4 and 5 September, 11 and 12 September, 18 and 19 September, 19 and 20 September, 9, 10 and 11 October
Date of publication: 05/04/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
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**
Are resources used productively?	**Requires improvement**

weAssure

The weAssure approach 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 and adapted for use in our organisation.

As part of our business as usual approach to continuous monitoring and improvement, and in readiness for our next CQC inspection, weAssure 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 Tendable, 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 2022/23 63 visits were carried out. All of our base wards have had an initial visit, as well as some of our community teams and other clinical services (eg outpatient areas and clinics). In addition to this, 18 areas have had a second follow up visit, three areas have now had three visits, and one area has had a fourth visit. The follow up visits also check that any actions have been addressed. Of our areas that have had more than one visit, six areas have maintained the rating they were given at their initial visit, eight areas have achieved an improvement in rating, and four areas have a reduced rating.

Future plans include visits to our imaging teams and our GP Practices. We are also re-mapping our toolkits to mirror the CQC's new assessment framework due to be launched in Spring 2023 but now delayed until later this year. This will remain centred around the existing five domains (safe, effective, caring, responsive and well-led) but is moving away from the key lines of enquiry and will be made up of 34 new quality statements.

Our Fundamentals of Care have been aligned to the weAssure programme so that they are now integrated and embedded within the workstreams of the programme.

Quality and improvement outcomes framework (QIOF)

The Quality and Improvement Outcomes Framework (QIOF) ensures that there is a proactive, high-quality knowledge and library service available to all staff and learners (NHS Education Contract 2021-24). It concentrates on assessing quality improvement, development, and delivery of service outcomes.

The six outcomes of a quality and high performing service are:

1	All NHS organisations enable their workforce to freely access proactive library and knowledge services that meet organisational priorities within the framework of Knowledge for Healthcare.
2	All NHS decision making is underpinned by high quality evidence and knowledge mobilised by skilled library and knowledge specialists.
3	Library and knowledge specialists identify the knowledge and evidence needs of the workforce to deliver effective and proactive services.
4	All NHS organisations receive library and knowledge services provided by teams with the right skill mix to deliver on organisational and Knowledge for Healthcare priorities.
5	Library and knowledge specialists improve the quality of library and knowledge services using evidence from research, innovation and good practice.
6	Library and knowledge specialists demonstrate that their services make a positive impact on healthcare.

The SWB Library and Knowledge Services submitted their portfolio for 2021/2022. The baseline scores for this service improvement journey are below:

Not developed → **Highly developed**

	Level 0	Level 1			Level 2			Level 3			Level 4		
	0	low	medium	high	low	medium	high	low	medium	high	low	medium	high
Outcome no.													
1													
2													
3													
4													
5													
6													

Figure 1. Validated outcomes for SWB NHS Trust – levels achieved are shown in blue

The national validated picture (Figure 2) shows that most library services were at Level 1 or Level 2 for each of the outcomes.

Not developed → **Highly developed**

	Level 0	Level 1			Level 2			Level 3			Level 4		
	0	low	medium	high	low	medium	high	low	medium	high	low	medium	high
Outcome no.													
1	10.71%	25.00%	**44.21%**	4.46%	4.91%	7.59%	0.89%	1.34%	0.89%				
2	6.70%	20.98%	**22.78%**	8.48%	11.16%	12.05%	13.39%	2.23%	2.23%				
3	6.25%	16.96%	**32.15%**	13.84%	17.41%	9.82%	1.34%	1.34%	0.89%				
4	10.27%	19.20%	**35.71%**	6.70%	7.14%	10.27%	4.46%	3.57%	2.23%	0.45%			
5	12.95%	22.32%	**29.01%**	10.71%	6.25%	11.16%	1.79%	3.13%	2.68%				
6	12.95%	17.41%	11.16%	12.50%	**18.30%**	11.16%	4.46%	5.80%	3.13%	2.68%	0.45%		

Figure 2. National baseline shows % of services at each level with modal average in bold

The Midlands validated picture (Figure 3) shows how knowledge and library services were scored. SWB Library and Knowledge Services performed far above modal average in the region.

Not developed → **Highly developed**

	Level 0	Level 1			Level 2			Level 3			Level 4		
	0	low	medium	high	low	medium	high	low	medium	high	low	medium	high
Outcome no.													
1	17.50%	17.50%	**37.50%**	5.00%	7.50%	15.00%							
2	5.00%	**22.50%**	15.00%	15.00%	15.00%	17.50%	10.00%						
3	2.50%	**30.00%**	20.00%	15.00%	22.50%	10.00%							
4	15.00%	20.00%	**30.00%**	10.00%	5.00%	10.00%	5.00%		5.00%				
5	10.00%	22.50%	**27.50%**	10.71%	6.25%	11.16%							
6	10.00%	20.00%	7.50%	10.00%	**25.00%**	7.50%	12.50%	5.00%			2.50%		

Figure 3. The Midlands baseline shows % of services at each level with modal average in bold

The QIOF validation identified the following areas of good or innovative practice for SWB Library and Knowledge Services:

- Proactive engagement with weLearn and weConnect initiatives to support organisational priorities
- Use of the Knowledge Mobilisation Self-Assessment Tool
- Use of impact statements and stakeholder endorsements in a business case

The report also credited the SWB Library and Knowledge Services for maintaining access to evidence and services throughout the pandemic year.

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 2022 – December 2022 to the Secondary Users 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 99.6 per cent for admitted patient care; 99.9 per cent for out-patient care; and 90.4 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 97.6 per cent for accident and emergency care.

Services provided / subcontracted

During 2022/23 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 2022/23 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 core contractual 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 2022/23 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.

As a Trust we are undertaking a management of change programme that will incrementally change the working patterns of several clinical and non-clinical staff to ensure our non-elective patients receive the care they need on the day they access our services. In particular this means we are investing in services that improve access to diagnostics, senior clinical decision and discharge pathways.

Our seven day plans are picking up pace, as are our rotas and recruitment plan, to reflect our acute care model that will be implemented when we open MMUH.

Speaking Up

During 2022/23 we began the year with a renewed focus on Freedom to Speak Up. This included an articulation of the Trust's vision, which is to lead the way nationally in relation to Speak Up. In order to achieve this, we have worked on ensuring commitment from all colleagues to support the agenda and prioritise the work of the Freedom to Speak Up Guardians (FTSUG) and Speaking Up, and promote a culture that supports its growth and profile in the organisation. "It is the behaviour of executives and non-executives (NED), which is then reinforced by managers, that has the biggest impact on organisational culture. How an executive director (or a manager) handles a matter raised by a worker is a strong indicator of a trust's speaking up culture and how well led it is". As lead executive director for Speak Up our Chief Finance Officer (CFO) has focused on ensuring all speak up matters raised are handled as swiftly as possible and for the individual who raised the concern, they do so without fear of detriment.

During the year, a full time Speak up Lead Guardian role commenced in post. This was a key signal in relation to our Trust's commitment to Speak Up as a function. She has focused on delivery of the April 2022 Board approved action plan which aimed to set the tone for the above vision and identified specific actions from the previous in depth review of the Trust's performance against National Guardian's Office standards.

The main areas of progress during the year have been;

- To establish the Lead Speak Up role
- To establish a regular meeting timetable with the CEO, Chair, CFO and Lead NED – in place
- To begin recruitment of more FTSUG – During the year we received 21 expressions of interest from colleagues across the Trust keen to become a FTSUG. We started the year with 6 in post, 3 left in year, so we have operated with 3 for most of the year. This level of interest is really exciting for the Trust and much more than we have seen before.
- To refresh content at Trust induction
- FTSUG job descriptions updated and aligned with the National Guardian's Office

- Templates for FTSUG to use to record concerns have been produced
- We have visited other organisations and networked with trusts where the approach to Speak Up is deemed excellent
- Beginning to link FTSU activity to patient safety and incident reporting
- Planning of regular communication and promotion of awareness
- Review of the FTSU policy to a new national template, currently working in partnership with our staff side colleagues
- Internal audit review of action plan against best practice completed with recommendations in progress.

Next steps;

- Alignment of the vision with the wider Trust and stakeholder groups
- Establish regular Board reporting (currently annual)
- Recruiting to FTSU Champion vacancies
- Consider administrative support to the team to ensure good management of data and information
- Establish a stakeholder group including network chairs, staff side, equality diversity and Inclusion, HR, cultural ambassadors, faith groups and chaplaincy
- FTSUG and lead to develop plan to host regional events and meetings
- Input into a Board development session
- Qualitative reporting
- Confirm relationships of policies and pathways – Just and learning culture, whistleblowing, grievance and disciplinary
- Confirm training plans for all staff – including consideration of the NHS FTSU training for all managers
- FTSUG and lead to attend Board meeting
- Completion of strategy and plan to evaluate and measure progress and results
- Review of HR processes in line with strategy
- Development of a dedicated intranet page for Speak Up.

Our approach to Speak Up has been to continue 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 Nursing Officer 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 and regularly go on "walkabout" in the Trust. In addition to this feedback hundreds of leaders participated in providing feedback on the new People Plan which 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 was launched in year. 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 and maintained by the lead FTSUG 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 and ensure all 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 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.

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 one guardian and the executive lead for speak up 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 continued delivery of the action plan, and further development.

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 are used to replace gaps in our rotas and also create new posts where additional service needs have been identified. We currently have 119 of these posts of which 102 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 2021 and 2022 in relation to advocacy. These results are based on staff who agreed or strongly agreed as part of the NHS Staff survey in 2021 and 2022.

NHS Staff Survey	2021 %	2022 %
Staff who would recommend the Trust as a provider of care to their family and friends	58%	52.3%
Staff who would recommend our organisation as a place to work	54%	52.1%

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.

Clinical groups continue to be encouraged to adjust their action plans in view of the staff survey results and ensure their managers discuss the survey results with their teams and review or identify new actions.

One of our three strategic objectives is to cultivate and sustain happy, productive and engaged staff. Our new People Plan supports that strategic objective by focusing on improving staff satisfaction and experience and developing a positive organisational culture.

Within the plan we are also focusing on developing leaders as an annual objective for the year ahead. Our new leadership framework has been developed using best practice from Professor Michael West and the Institute of Healthcare Improvement, and will see 200 leaders developed in 2023/24 over three modules. We know from our staff survey results that line managers have a significant impact on staff experience and retention. Developing highly skilled, empowered and compassionate leaders at all levels of the organisation is one of the most powerful things we can do to help staff and in turn, our patients and population.

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 2023.

The Trust overall risk assurance rating is 'Substantial' for all 10 data standards. The Information Governance service continues to strive for improvement over the next year and maintain the 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. The Trust recognises the importance of robust information governance and the Information Governance Group oversees and is leading actions to make improvements.

Complaints, PALS Concerns and Purple Point Calls

Complaints

Sandwell and West Birmingham NHS Trust received 1102 written complaints during 2022/23 compared to 1119 received during 2021/22.

The number of complainants who returned to the Trust to express dissatisfaction with the initial response, is a measure of the effectiveness of our complaint process. In 2022/23, 29 complaints were reopened because complainants felt we had not addressed all of their concerns, or there were unresolved issues (2022/23 = 2.6%). We work with each complainant on a case-by-case basis to reach a resolution.

Themes of Complaints During 2022/23

The top five themes arising from complaints during 2022/23 are the same as the previous year.

Clinical Treatment	290
Communications	235
Values And Behaviours (Staff)	164
Appointments	161
Patient Care	96

The highest sub-categories are in relation to:

- Clinical Treatment: delays in treatment, inappropriate treatment and incorrect diagnosis.
- Communications: communication with patient and communication with families.
- Values and Behaviours (Staff): attitude of staff.
- Appointments: appointment availability, appointment cancellations and appointment delays.
- Patient Care: failure to provide adequate care.

Our Trust's arrangements for managing patient complaints have continued to experience challenges throughout the year, however despite this, there has been a reduction in the number of overdue responses. We recognise that waiting for a response is not easy, and we are working with our teams to ensure timely responses are sent to complainants. We value the feedback received from our patients and the opportunity to improve our services.

We have successfully recruited to all vacant posts within the team which has assisted in the reduction of overdue responses at the start of the year.

PALS/ Purple Point

Sandwell and West Birmingham NHS Trust received 1767 PALS enquiries during 2022/23 compared to 1863 received during 2021/22.

Purple Point is the designated service for inpatients who need an immediate resolution to a concern and operates 12 hours per day, seven days a week. The Trust received 17 Purple Point calls during the year, compared to 57 received in 2021/22. Purple point activity was severely impacted by COVID-19 as during 2019/20 we received 314 calls. Looking forward, the Trust recognises the value of Purple Point in providing an accessible resolution service for inpatients, and there is evidence from patient and staff feedback that the service is needed. Therefore, the Trust is planning a relaunch of Purple Point over the course of the next year.

The themes for PALS and Purple Point reflect those as identified for written complaints.

Compliments

Wards and departments can log expressions of appreciation through the Ulysses Safeguard system and in 2022/23 368 compliments were recorded directly by our services such as staff on the ward or clinics. A further 100 compliments were logged by the Governance Support Unit.

Learning from complaints and future developments

- This year our Trust launched the Fundamentals of Care framework which encompasses all professional groups and support teams working together, to ensure essential aspects of care are maintained at all times for all patients.
- Over the next year, we will work towards integration of the NHS Complaint Standards framework into the Trust's complaints policy and procedures to ensure good practice and a consistent approach to complaints handling.
- In order to enable directorates to closely monitor complaint themes within their own teams, we aim to improve oversight of complaints, including any learning outcomes and actions taken in order to close the feedback loop at a local level.
- An example of a change in clinical practice following complaints received, is a Trust wide programme of improvement for the management of medicines including administration practices and digital improvements to the recording of administration.
- Learning has been taken by the Pain Management team regarding the recording of communication preferences in individual records to ensure that the most appropriate method of contact is used for the patient.
- There has been learning for staff around the process of gaining and re-checking for informed consent throughout procedures.

The student nurses learn more about the Fundamentals of Care programme.

Incident reporting

A positive safety culture remains essential for the delivery of high-quality care. We continue to submit incident data to the National Reporting and Learning System (NRLS) which is publicly available and provides comparative data with like-sized trusts. NRLS will transfer to a new system called Learning from Patient Safety Incidents (LFPSE) within the 2023/24 period.

The Learning from Patient Safety Events (LFPSE) system is a new patient safety database that supports real time reporting and uploading of incidents to identify risks and issues more effectively. Providers of NHS services are expected to transition across from NRLS to LFPSE by the end of September 2023. We will continue to report incidents into the national benchmarking scheme from September 2023, following transfer to LFPSE to meet our national incident reporting requirements.

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
2019/20	**Apr 19 - Sep 19**	51.2	103.8	26.3	8	0.1	0	-
	Oct 19 - Mar 20	50.1	110.2	15.7	2	0.0	2	0.0
2020/21	**Apr 20 - Mar 21**	60.1	118.7	27.2	18	0.2	49	0.4
2021/22	**Apr 21 - Mar 22**	77.3	205.5	23.7	22	0.1	17	0.1

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 Integrated Care Board.

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 the level of investigation required and ensure all moderate harm or above incidents are screened appropriately. In addition, reducing patient safety incidents with moderate or above harm (whilst maintaining or increasing no or low harm incident reporting) is an annual objective for the Trust with additional oversight.

The number of serious incidents reported in 2022/23 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.

2022/23	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of SIs (by date reported as SI)	4	3	4	4	1	1	2	0	3	2	3	3

Never Events

Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. (NHS Improvement, 2018). During 2022/23 four never events were reported, these are detailed below.

Never events reported in 2022/23

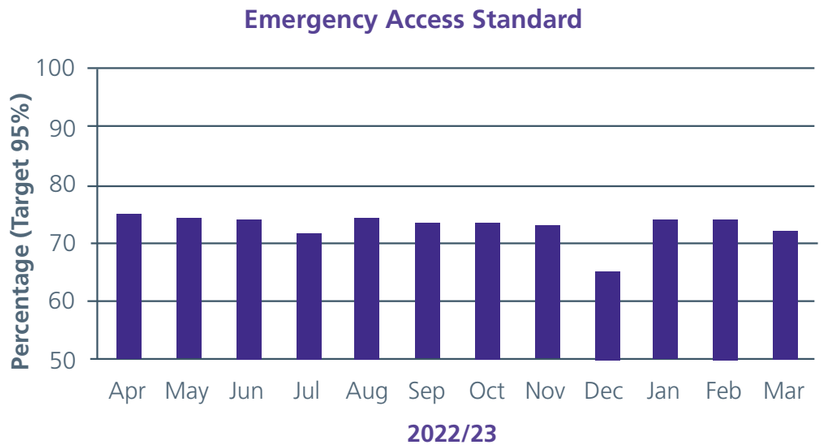
Speciality	Type of Never Event	Cause	Changes Made
Emergency Department – City	Medication Error – Wrong Route	Administration of patient medication via wrong route ie intravenous instead of nebulised. Lapse of care regarding documenting the correct route via prescription.	A rolling training programme implemented ensuring there are sufficient numbers of level 1 care trained staff within group to support the level 1 areas.
General Surgery		Administration process did not observe the patient physically take the medication via the correct route and left the patient bedside once the enteral syringe had been given to the patient.	Medicines management training for all staff. In addition, continuous competency assessment is required to ensure that all staff understand they are undertaking the correct procedure.
Gastroenterology	Endoscopy Wrong Route	Patient attended for biopsies of rectal stump. The camera was inserted into the wrong place and biopsies taken from the wrong anatomical area.	The WHO checklist will be modified to include a STOP moment for all procedures to ensure all staff ready for procedure to take place, patient fully prepared and correct entry site identified.
Dermatology	Wrong Site	Failure to review and confirm the correct surgical anatomical site; which led to wrong site incision Non-review of available body mapping/ medical photography prior to the clinical procedure in conjunctions with absent skin marking.	Review of theatre operational policy – to ensure all pre procedure safety checks revisited and affirmed with staff, inclusive of full Unity documentation review pre procedure. Application and assurance that all patients attending dermatology clinic will have the pre procedure checklists/ WHO checklist completed prior to any invasive procedure – in both theatre and clinical treatment room settings. Implement invasive procedure LocSSIP within Dermatology theatres, in conjunction with WHO checklist, theatre operational policy and safer surgery.

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

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 2023/24 the operational planning guidance amends this target to 76%.

In 2022/23 on average, we achieved 72.7%. This is a reduction from 2021/22 (75.5%) and due to increase in attendances and admissions across the organisation, increased length of stay from winter conditions being seen earlier and for longer than anticipated and a higher acuity of patients across the medical bed base. We have maintained an upper quartile position nationally for EAS, indicating a national decrease in performance.



We have embedded the Urgent Treatment Centre at Sandwell Hospital and extended the hours of operation to improve access for patients. We have also introduced virtual wards to improve care in the community and established a Frailty Same Day Emergency Care (FSDEC) service to provide specialist care in a dedicated unit. These interventions continue to support improving our emergency care offering and we aim to continually increase our performance to ensure patients are seen in the right place at the right time.

ED performance is an organisational priority to improve access and quality of care for our patients which will be demonstrated in our delivery for 2023/24. We are focusing our efforts on improving SDEC utilisation with extended hours on both sites and a new modular unit at Sandwell Hospital to increase physical capacity and enable increased activity to be seen for medical presentations.

Frailty services will be enhanced with the development of our acute and community team. Timely discharges will be targeted with a focus on ward standardisation and coordination of wrap around care. In addition, streaming will improve care navigation and ensure timely movement of patients out of ED to an appropriate place of care.

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.

This year we are unable to produce data for PROMs as the data is not available from the NHS Digital website. There is a current pause in PROMs reporting due to significant changes that were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. The updated linkage process is not complete and currently does not have a definitive date for completion. A full statement is available on NHS Digital website https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

If available, we will include any missing data with next year's published data.

Abbie Bates a HCA with a young patient on the children's ward at Sandwell Hospital.

How we performed in 2022/23 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2021/22 position	2022/23 position	Comments
Cancer – 2 week GP referral to first out patient	%	=>93	87.7	94.9	Full year
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	=>93.0	73.4	98.2	Full year
Cancer – 31 day diagnosis to treatment all cancers	%	=>96	90.9	91.9	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Excluding Rare Cancer)	%	=>85	61.7	57.5	Full year
Cancer – 62 day wait for first treatment from urgent GP referral for suspected cancer (Including Rare Cancer)	%	=>85	59.5	58.5	Full year
Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral	%	=>90	93.2	93.5	Full year
Emergency Care – 4 hour waits	%	=>95	75.5	72.7	Full year
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92	70.1	59.2	Full year
Acute Diagnostic waits in excess of 6 weeks	%	<1.0	27.3	48.2	Full year
Outcome Metrics					
C Diff (post 48 hours)	No	<41	25	47	Full year
MRSA Bacteraemia	No	0	0	3	Full year
Never Events	No	0	10	4	Full year
WHO Safer Surgery Checklist 3 sections (% patients where all sections complete. Main theatres only)	%	=>100	100	100	Full year
VTE Risk assessments (adult IP)	%	=>95	96.2	95.0	Full year
Clinical Quality and Outcomes					
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	89.6	88.5	Full year
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	58.5	54.1	Full year
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50	85.2	85.4	Full year
Stroke care – Admission to Thrombolysis Time (% within 60 minutes)	%	=>85	69.8	76.6	Full year
TIA Treatment within 24 hours from receipt of referral	%	=>70	96.4	97.4	Full year
MRSA screening elective	%	=>85	62.1	76.9	Full year
MRSA screening non elective	%	=>85	80.4	69.7	Full year
Hip Fractures – operation within 36 hours	%	=>85	85.0	77.7	Full year
Patient Experience					
Coronary heart disease - primary angioplasty (<150 mins)	%	=>80	78.0	82.6	Full year
Coronary heart disease – rapid access chest pain (<2weeks)	%	=>98	100.0	96.0	Up to end Feb 2023

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

Infection prevention and control (IPC)

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 Nursing Officer who has Board level responsibility for IPC and chairs the Infection Control Committee. The Trust declares compliance with all 10 sections of the hygiene code. However, the Trust also acknowledges some challenges, principally the backlog of estate maintenance due to old estate at both City and Sandwell sites.

Our Trust continued to be challenged by the ongoing COVID-19 pandemic, though the principles of good IPC were maintained. Patients who tested positive on admission were housed away from other patients and any patient who became symptomatic with respiratory symptoms whilst they were an inpatient were also routinely tested in line with national guidance.

What we said we would do in 2022/23

- Continue to protect patients, staff and visitors from hospital acquired COVID-19 infection.
- Work with the Midland Metropolitan Programme Company to ensure good Infection Prevention & Control is integral to the ongoing building works.
- Ensure our Trust is prepared for other Infection Prevention & Control risks such as outbreaks of Norovirus.
- Ensure all areas of our Trust meet or be above the national minimum standards for cleanliness.
- Expand the Infection Prevention & Control Team and increase engagement with Groups to ensure IPC issues maintain a high profile and that learning from hospital associated infections is disseminated and embedded.

What we achieved

Cases of infection with SARS-CoV-2, the virus that causes COVID-19 were broadly in line with national trends. We continued to follow national guidance regarding management of cases and IPC measures were in place such as use of single rooms and use of air filtration machines.

The IPC Team has continued to work closely with the MMUH Programme Company with regular walk rounds and discussions to ensure that good IPC is intuitively built into the developing Hospital. The IPC Team have attended monthly walk rounds of areas of MMUH as they have been fitted out, and any IPC issues addressed.

The Support Services Team have embedded the new 2021 National Standards of Healthcare. Cleanliness and star ratings are now displayed across all Trust sites.

NHS England infection prevention & control inspection

The Trust underwent an Infection Prevention & Control (IPC) inspection by NHS England in March 2023. We are pleased to report a positive outcome from the visit. The inspector witnessed a strong infection prevention culture with good leadership and staff demonstrating their responsibilities regarding effective Infection Prevention & Control.

The NHSE inspector also noted the increase in the IPC Team workforce including the appointment of a new Deputy Director Infection Prevention & Control and substantive appointment of an IPC Matron and additional IPC nurse team members.

Mandatory reportable organisms

The following are organisms required to be reported as part of mandatory reporting to the UK Health Security Agency (UKHSA) against NHS England set trajectories.

Organism	NHSE set target	Reported cases
MRSA bacteraemia	0	3
C. difficile toxin	41	47
E. coli bacteraemia	51	63
Klebsiella bacteraemia	19	27
Pseudomonas aeruginosa bacteraemia	9	10

What we want to achieve for 2023/24

- Develop the process for identification and investigation of surgical site infections.
- Improve the screening process for carbapenemase producing enterobacteriaceae.
- Improve the infection prevention audit programme using the Tendable platform with clinical areas undertaking their own audits and the IPC team undertaking periodic validation audits using the same process.

- Continue to ensure that IPC considerations are at the forefront of the continuing development of the Midland Metropolitan University Hospital and that best IPC practice is in place from the outset of the hospital opening.
- Develop workstreams to tackle mandatory reportable organisms to achieve a within trajectory position.

Venous thromboembolism (VTE)

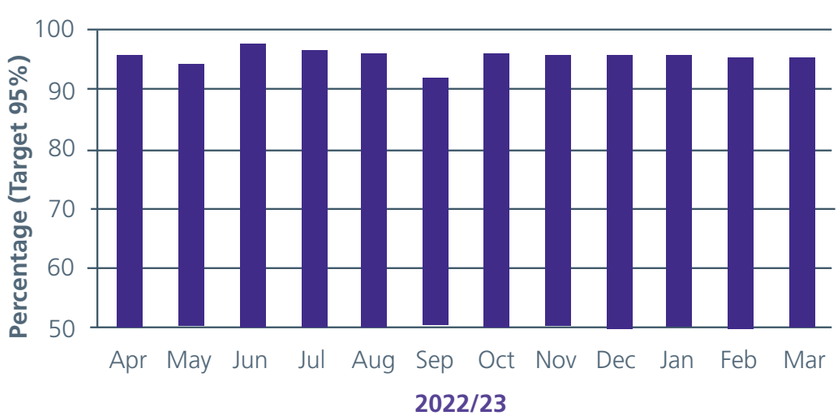
A venous Thrombo-embolism (VTE) is a blood clot that forms in a vein. A calf vein is the most common site for this to occur but occasionally pieces of the clot can break away and flow towards the lungs and become a pulmonary embolism (PE). The Department of Health requires all Trusts to assess patients 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 2022/23 is 95%.

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 2022/23. 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.

We have developed new guidelines for;

- Patients attending with trauma and orthopaedics conditions
- Ambulatory care of patients with venous thromboembolism in our Medical Assessment Unit
- Management of venous thromboembolism among patients with COVID-19 infection.

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

- Improvement in accuracy of data in safety huddles dashboard to make information more relevant and accessible.
- Improve the visibility of medication doses in our electronic patient record to aid detection of missed or delayed doses.
- Improvement in patients' care plan to include the option for mechanical thromboprophylaxis.

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).

SWBH	Number of Patients	Total Number of Re-admissions	Percentage of Re-admissions
4 – 15			
2022/23 (Apr-Feb)	4229	237	5.60%
2021/22	4230	226	5.34%
2020/21	2658	132	4.97%
16+			
2022/23 (Apr-Feb)	66778	4696	7.03%
2021/22	68370	5119	7.49%
2020/21	55648	5497	9.88%
All Ages			
2022/23 (Apr-Feb)	71007	4933	6.95%
2021/22	72600	5345	7.36%
2020/21	58306	5629	9.65%

The data in the table shows a continuation in our admission levels as expected and an improvement in our adult readmission rate. A slight increase has been seen in our paediatric readmissions which following an audit has been driven by a rise in readmissions with respiratory related illnesses.

Going forward we will continue to focus on reducing readmissions with efforts centred around the national urgent and emergency care recovery plan along with preparation for our move to MMUH. For both paediatrics and adults this will see a continued implementation and establishment of our virtual ward and same day emergency care services along with continued development and investment into our community admission avoidance services. 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 and early discharge schemes including Epicentre, same day emergency care and virtual wards for services including paediatrics, frailty and heart failure.

Safeguarding children

Keeping children safe is truly everyone's responsibility and remains a number one priority for our Trust. This principle is embedded into practice across all disciplines and roles; from our Chief Nursing Officer, as the Executive Lead for Safeguarding through to our frontline staff. We have a dedicated team of specialist safeguarding professionals which is made up of a diverse and multi-professional team who provide specialist and expert safeguarding training, advice, support, and supervision to all Trust employees to enable them to fulfil their safeguarding responsibilities and duties on a wide range of safeguarding issues affecting the unborn, children and young people and their families and carers. The safeguarding team strive to ensure all safeguarding processes are robust and effective and are responsive to emerging local and national needs. This enables us to achieve full compliance against all our safeguarding standards. More importantly we ensure that the person at risk or suffering, neglect, harm or abuse always remains in our 'line of sight', we 'hear their voice' and they remain at the centre of all we do.

As an organisation we are clear that safeguarding is integral to everything we do. We have a vigorous assurance and quality framework to ensure we are compliant with the statutory requirements of Section 11 Children Act (2004), Working Together to Safeguard Children (2018, updated 2020) to promote the well-being 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 reflects a period when we, along with the rest of the world, were emerging from the COVID-19 pandemic. Ensuring the safety of children during the pandemic became more complicated and complex and held significant challenge for us all, highlighting how difficult life had been for many young people and placing enormous strain on families, which has been compounded further by the impact of the cost-of-living crisis we are experiencing.

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 to demonstrate that SWB as an organisation is meeting our corporate responsibilities in relation to safeguarding children. This, combined with our learning from tragic national child safeguarding reviews has ensured that the voices of children are heard, listened to, and responded to.

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.

We have continued to deliver specialist safeguarding children training to our workforce in line with the Royal College of Paediatric Child Health Intercollegiate Document (2019) guidance which includes recommendations from child safeguarding practice reviews and domestic homicide reviews to embed learning and changes in clinical practice.

Throughout 2022/23 assurance, quality and accountability has been demonstrated by the inclusion of quarterly and exception reporting from our Safeguarding Children Operational Group to the Safeguarding Vulnerable People's Committee, chaired by the Chief Nursing Officer where safeguarding concerns and risks are discussed and reviewed. Membership includes Black Country Integrated Care Board (BCICB), Sandwell Place designated professionals who 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 Trust Management Committee to ensure senior executives are fully sighted on key safeguarding developments and challenges faced during the year.

During the year both the Safeguarding Children and Adult team have been involved in a safeguarding review with a view to moving towards a fully integrated Children and Adult Team. This is a positive move and will support a seamless transition for vulnerable children moving through to adult services to ensure their needs are met and responded to.

We continue to work with Unity developers (electronic patient record system) 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 both unscheduled and unplanned 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 Children in Care health team continue to support the statutory requirement of assessing the health needs of Sandwell's children in care. 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 BCICB (Sandwell Place) to successfully increase the clinical nursing resource to support this vulnerable cohort of children. Another development has been the co-location of the team with the local authority children in care team which has enhanced joint working and communication with our partners in responding to the needs of this group of children.

Our Emergency Department Domestic Abuse Advocacy Service continues to be a positive venture and has demonstrated this by having the ED Independent Domestic Violence Advocacy (IDVA) service increase accessibility for victims to access specialist domestic violence and abuse support via either our ED departments or in-patient episodes. We continue to receive part funding from Safer Sandwell Partnership and in December 2022 transferred the service fully onto NHS Terms and Conditions which endorsed the service being part of our SWB NHS 'family'.

During Q4, 84 evaluation questionnaires were completed, and demonstrated that following the ED IDVA intervention:

- 100% said that they now know where to go for support
- 93.9% felt less scared
- 93.05% felt better about their overall situation.

Comments included:

- "Thank you made me feel better your positivity has made me feel so much better about myself"
- "You have been unbelievable I can't believe as a professional I am in this position you have been truly amazing"
- "I feel very, very happy thank you I am safe".

Due to the impact of COVID and 'hidden harm' we have seen across all safeguarding systems, we have seen an increased number of domestic abuse incidents through Sandwell Multi-agency Safeguarding Hub (MASH) and cases of high risk being discussed at Multi Agency Risk Assessment Conference. This increased activity has had a direct impact on the MASH nursing resource to meet demand.

Across the partnerships we have seen an increase in cases of child neglect, level of violent crime, exploitation and gang activity amongst our youths and increased parental mental health needs which has impacted on parental capacity to parent competently.

Due to the difficulties vulnerable young people have faced during the pandemic which, in many cases, removed them from the protective gaze and attention of universal services and education, has resulted in an increase in complex mental health presentations of children onto our wards requiring specialist therapeutic input.

Throughout the year we have been involved in several safeguarding children practice reviews as a result of injury and death to children which may be attributed to some of these factors, particularly the level of gang related activity being seen in the community in both Sandwell and Birmingham. Another theme to emerge has highlighted the need for increased visibility and focus on males involved in children's lives, and on our cultural competence when working with our diverse communities. The team have also been involved in two Sandwell domestic homicide reviews; one which involved child on parent violence and abuse.

In 2021 we undertook a scoping exercise jointly with Sandwell partners given the increased youth violence, gang and exploitation levels being exhibited across Sandwell Place and particularly in response to a young person's death due to gang affiliated activity. Empirical evidence demonstrated that young people affected by either an adversity related injury or substance misuse 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 of this SWB were successful in working with St Giles Charity 'Turning a past into a Future', an established provider of services to young people exposed to this level of violence and crime for a one-year fixed term project after securing joint funding with Sandwell Place and Sandwell Safer Partnership. During the year we have seen a significant improvement in the response and support offered to our young people presenting to ED in these circumstances.

Since the start of the project in July 2022 the case workers based in ED have received 158 referrals and feedback has been positive:

(Client) - *'it has done me good to get out of the house and you have helped me a lot with my anger issues, since you came, I don't really get angry anymore and I just want to say thanks for helping me out with my boxing training, you are someone that I can also talk to about my problems'*

(Client's Mom) - *'We feel that your input so far has been useful to help with CC's mental health, knowing you are coming and putting things in place is good as we are always tied up in the moment as life takes over. We are so grateful for this. CC has found your input and the security of knowing that you will be around, offering support, very assuring. It's been important for CC to have a good male role model who is also able to be on his level to help him develop into a young person. We feel your reliability, professionalism and punctuality is second to none, thank you'*

Despite seeing positive outcomes and evaluation from both young people and families we have been unable to secure further funding and the service will cease in March 2023, however, we are working actively with BCICB to determine a way in which children presenting to our EDs can access the St Giles service which has been commissioned from a neighbouring trust. This is particularly pertinent given the Serious Violence Prevention Duty which came into effect in January 2023.

Key themes to continue for 2023/24 include:

- Undertake a review of Sandwell MASH clinical nursing resource with our BCICB to ensure there is sufficient resource to meet the increased demand and activity across both safeguarding children and domestic abuse being seen.
- Continue to seek funding to re-instate St Giles case workers in ED to deliver a specialist service to our young people accessing our ED/hospital departments who are victims of assault, exploitation, and gang affiliation.
- Work collaboratively with BCICB and serious violence duty requirements.
- 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 in 2024.
- Continue to review and ensure that our safeguarding children level 3 training meets organisational requirements and includes lessons learnt from child safeguarding practice reviews and domestic homicide reviews.
- Continue to report and comply with data collection required for the BCICB Provider Safeguarding Performance Framework 2023/24.
- Continue to work in partnership with both Birmingham and Solihull ICB and BCICB to ensure SWB are equal partners at board and strategic level in relation to the safeguarding agenda.

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 Nurse, with funded full time substantive posts for a Safeguarding Nurse, mental health registered Dementia Nurse, Learning Disability (LD) Nurse and a full-time administrative support post. Following a review of services it was determined that learning disability services should be part of a service level agreement and provided by a specialist LD Trust (Black Country Health Care). Contracts for this post are being agreed.

During the past year the team have improved assessment of mental capacity and 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 an ambition to increase referrals to memory services and improve dementia pathways and the team have had input into several work streams and provided 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 and also working closely with partners.

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

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 de-escalation techniques. 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, ICB and statute partners and are building relations with charities in the third sector. Our Trust 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.

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 out Trust 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 2022/23, 1539 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: 351 deaths in Q1, 382 deaths in Q2, 416 deaths in Q3 and 390 in Q4.

Of the 1539 deaths reported during 2022/23, 1523 (99%) underwent a tier one mortality review by medical examiners. This equated to 347 reviews in Q1, 375 in Q2, 413 in Q3 and 388 in Q4.

Of these, 182 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 37 cases in Q1, 48 cases in Q2, 44 in Q3 and 53 in Q4.

Of the cases which received further scrutiny, 8 cases (representing 0.5 per cent of all patient deaths during 2022/23) 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: 0 patient deaths representing 0 per cent of the patient deaths for Q1, 4 patient deaths representing 1 per cent of the patient deaths for Q2 and 3 patient deaths representing 0.7 per cent of the patient deaths for Q3. There was 1 patient in Q4 representing 0.25 per cent of the patient deaths.

	2022/23			
	Q1 Apr-Jun	**Q2 Jul-Sep**	**Q3 Oct-Dec**	**Q4 Jan-Mar**
Total Inpatient spells	24,503	25,514	25,890	25,799
Total deaths	351	382	416	390
Avoidable deaths	0	4	3	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 an average of 90% in 2022/23. All comments are analysed and fed back to the caring team for further actions.

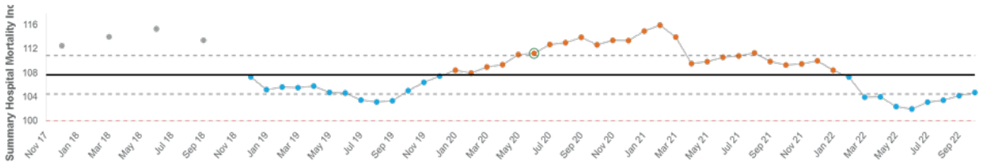
Next of Kin Contact 2022/23											
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
84%	85%	89%	90%	92%	91%	89%	89%	90%	93%	93%	94%

Mortality Indices (HSMR)

The Standardised Hospital-Level Mortality Indices is the ratio between the actual number of patients who die following hospitalisation at the trust over the number that would be expected to die based on average England figures, given the characteristics of the patients treated. This acts as a "smoke alarm" and a prompt to investigate the cause of an elevated SHMI. Contributing factors such as data coding, severity of illnesses, admission pathway, end of life care provision and local population characteristics are all taken into consideration when reviewing the quality of care and treatment of patients. This ensures that care and quality has not been compromised and potentially predisposing to avoidable harm. It includes death up to 30 days post discharge and does not adjust for palliative care. SHMI above 1 is higher than benchmark.

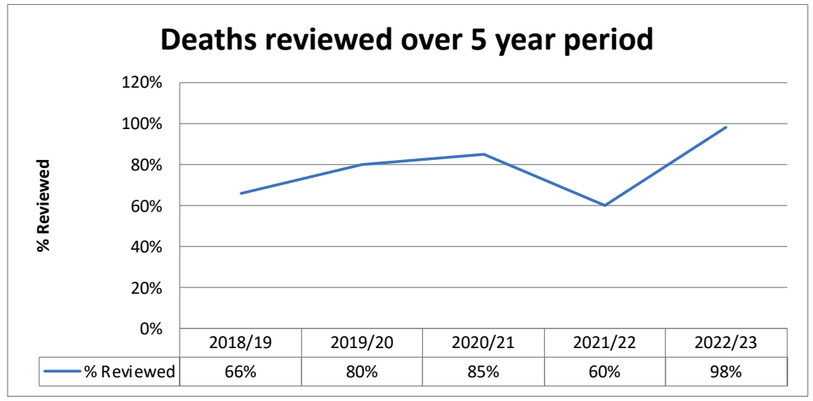
Trust Board level reporting of mortality activity uses the SHMI figure based of NHS Digital Monthly data (Figure 1). The NHS Digital SHMI reported in March 2023 (reporting period up to October 2022) is 104.76.

Figure 1: SHMI: NHS Digital Monthly (October 2022)



Strategies to improve SMHI include:

1. Robust medical examiner process: The percentage of deaths scrutinised by medical examiners has improved significantly over the last 5 years. Currently we routinely scrutinise 96-100% of all deaths. We are introducing a peer review system as a quality assurance process to the medical examiner case note reviews. The number of medical certificate of cause of death (MCCD) discussed with Medical Examiners (to ensure accuracy) prior to issuing it to next of Kin has also improved and is on average about 76%. Quality improvement initiative to support bereaved relatives and improving the process and timeliness of issuing death certificates is ongoing. In 2022/23 the Medical Examiners Service launched the roll out of scrutiny of community deaths with MEO support. To date we have rolled out to 20 GP practices.



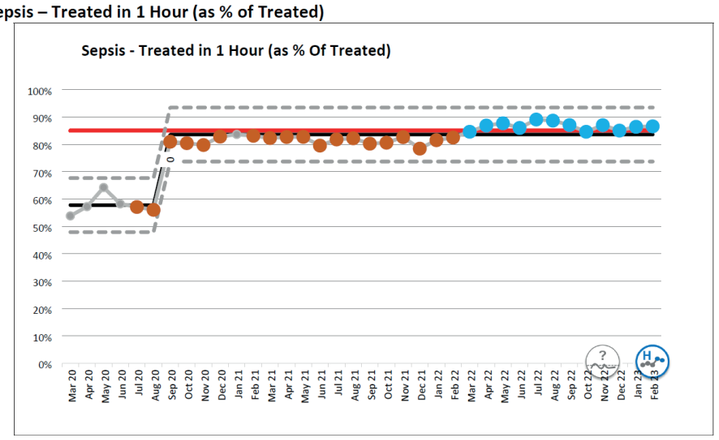
2. Improved process of disseminating learning from death:
   - Thematic analysis of structured judgement reviews (SJRs) which are fed back to groups and directorates at governance meetings for action.
   - Production of learning documents/bulletins which are widely circulated to highlight key learning points.
   - Development of an open intranet site where key documents and presentations can be easily accessed by staff.
   - Thematic analysis of feedback from next of kin as well as complaints.

3. Specialty Reviews

   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.

4. Quality improvement projects developed as a result of mortality reviews include;
   - Reinstating the Pneumonia Task Force with the aim to improve the percentage of patients with CURB65 score completed. A pneumonia care bundle is being developed for integration into our digital electronic patient record (EPR) system UNITY.
   - End of Life Quality Improvement Project: Report improvement in % of patients identified as in their last year of life who are on a Supportive Care pathway (SCP pathway) Work is on-going to improve Trust compliance with the National Audit of Care at the End of Life (NAECL) National audit.
   - Further improvement of Safety Huddles, including updating safety huddle dashboard to make information more relevant and accessible.
   - Sepsis Quality Improvement: This has led to further improvement in the percentage of patients receiving antibiotics within one hour.

7.2 Sepsis – Treated in 1 Hour (as % of Treated)



5. Efficient coding and documentation process
   - A key focus for changing practice has been the education of junior doctors who are usually responsible for completing documentation. A digital clinical fellow led lunchtime teaching sessions on the topic of 'Coding for Clinicians'. The aim was to educate doctors on the coding process, thus highlighting the importance of high-quality clinical coding and the impact clinicians have upon this. The teaching was also shared more briefly at the Trust registrar forum.
   - We have introduced a short module on Clinical Coding and Documentation in the induction pack for junior doctors.
   - Awareness Campaign: The Communications Team has been involved in helping to raise awareness of the on-going work in the mortality project. We have published communication within our Trust explaining mortality indices and explaining the impact of clinical coding on this. This promoted the aims of the project and focussed on documentation issues. A new poster and computer sticker has also been designed detailing the national coding guidelines and providing key guidance for documentation. These have been distributed across all hospital wards, particularly AMU and SAU. This is also being shared as a screensaver across all hospital computers.

6. 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, learning where identified and actions required. The diagnostic groups reviewed are detailed in the table below.

Diagnostic group reviewed	Review Period	Presented to Committee
Sepsis (Septicaemia except in labour)	March 2022	April 2022
Acute Myocardial infarction	April 21 – March 22	September 2022
Cancer of the Anus and Rectum	September 2021-22	September 2022
Pneumonia		August 2022

Review of the deaths due to Myocardial Infarction as well as cancer of the rectum and anus did not highlight any systematic issues in care. Quality improvements in sepsis continue.

Positive alerts: Conditions where the Trust has significantly less deaths than expected in the diagnostic groups listed below.

Diagnostic group reviewed	Review Period
Congestive Heart Failure and Other Nervous System Disorders	April 2022
Other Nervous System Disorders	June and July 2022
Gastrointestinal haemorrhage, 'Other nervous system disorders', Acute cerebrovascular disease, Congestive heart failure; COPD and bronchiectasis	August 2022
Acute Cerebrovascular disease, Congestive Cardiac Failure, COPD and Bronchiectasis and Fracture Neck of femur	November 2022
Congestive heart failure; non hypertensive and Acute cerebrovascular disease	January 2023

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2022/23 that were recruited to participate in research approved by a research ethics committee was 2067. This includes all studies eligible for inclusion onto the National Institute for Heath & Care Research Portfolio as well as non-portfolio studies. A total of 28 studies were open for participation across the organisation.

Our Trust has commenced a bench-marking exercise for assessing the research activity and engagement of its nurses, midwives, allied health professionals, pharmacists, psychologists, and scientists (NMAHPPS). A group has been formed to develop and implement strategies to increase the uptake and engagement in research across the organisation amongst these groups. The development of engagement initiatives across our Trust and the development of a Knowledge Hub means that there is a single point of information provision for all interested in research across the organisation.

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. Specialty research leaders are engaged and actively promote research within their areas, prioritising projects according to patient need.

Participation in clinical audits

During 2022/23, a total of 67 national clinical audits and national confidential enquiries were relevant to the services that are provided at our Trust: Sandwell and West Birmingham.

During this period, of those that we were eligible to participate in (excluding those which were paused by the provider) we participated in 93 per cent national clinical audits* and 100 per cent national confidential enquiries.

**60 National Clinical Audits on the SWB working list: 2 paused by provider in the time frame; 54 National audits participated in; 4 not participated in (PQIP, FLDBS, MITRE, and NDA-inpatient safety)*

Table 1 below outlines:

- Column 1: The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust were eligible to participate in during 2022/23.
- Column 2: The national clinical audits and national confidential enquiries that we participated in during 2022/23.
- Column 3: The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2022/23, identifying 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.

Title	Are we participating in this?	% of eligible cases submitted
Barts Health NHS Trust - National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	>90%
Barts Health NHS Trust - National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
Barts Health NHS Trust - National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	99%
Barts Health NHS Trust - National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	100%
British Association of Urological Surgeons: Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	No	0% See note
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	Yes	28 cases
British Society for Rheumatology: National Early Inflammatory Arthritis Audit	Yes	127 cases
British Thoracic Society: Respiratory Audits - Smoking Cessation Audit- Maternity and Mental Health Services	Paused by provider	N/A
Clinical Effectiveness Unit of the Royal College of Surgeons of England: National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
Healthcare Quality Improvement Partnership (HQIP): National Joint Registry	Yes	97.46%
IBD Registry: Inflammatory Bowel Disease Audit	Yes	>50%
Intensive Care National Audit & Research Centre (ICNARC): Case Mix Programme (CMP)	Yes	948 cases
Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK (RCUK): National Cardiac Arrest Audit (NCAA)	Yes	77 cases
King's College London: Sentinel Stroke National Audit Programme (SSNAP)	Yes	>90%

Title	Are we participating in this?	% of eligible cases submitted
MBRRACE-UK led from the University of Oxford - Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance and confidential enquiry	Yes	*100%*
MBRRACE-UK led from the University of Oxford - Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal confidential enquiries	Yes	*100%*
MBRRACE-UK led from the University of Oxford - Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality surveillance	Yes	*100%*
MBRRACE-UK led from the University of Oxford: National Perinatal Mortality Review Tool	Yes	*100%*
National Comparative Audit of Blood Transfusion(NCABT), NHS Blood and Transplant - National Comparative Audit of Blood Transfusion((NCABT): 2022 Audit of Acute Upper Gastrointestinal Bleeding (AUGIB)	Yes	*100%*
National Comparative Audit of Blood Transfusion(NCABT), NHS Blood and Transplant - National Comparative Audit of Blood Transfusion((NCABT): 2022 National Comparative Audit of Blood Sample Collection and Labelling	Yes	*100%*
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Child Health Clinical Outcome Review Programme: Testicular torsion	Yes	80%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Child Health Clinical Outcome Review Programme: Transition from child to adult health services	Yes	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcome Review Programme: Community acquired pneumonia	Yes	40%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcome Review Programme: Crohn's disease	Yes	80%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcome Review Programme: End of Life Care	Paused by provider	N/A
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcome Review Programme: Endometriosis	Paused by provider	N/A
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcome Review Programme: Epilepsy Study	Yes	100%
NHS Benchmarking Network: National Audit of Care at the End of Life (NACEL) (Round 4)	Yes	100%
NHS Digital - National Adult Diabetes Audit (NDA): National Core Diabetes Audit	Yes	Ongoing data collection
NHS Digital - National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit	Yes	35 cases submitted
NHS Digital - National Adult Diabetes Audit (NDA): National Diabetes in Pregnancy Audit	Yes	*100%*
NHS Digital - National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	No	0% (See note)
NHS Digital - National Adult Diabetes Audit (NDA): NDA Integrated Specialist Survey	Yes	100%
NHS Digital: Breast and Cosmetic Implant Registry	Yes	100%
NHS Digital: Elective Surgery (National PROMs Programme)	Yes	551 cases submitted (Apr 22- Feb 23)
NHS England: LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Yes	100%
Parkinson's UK: UK Parkinson's Audit	Yes	100%
Royal College of Anaesthetists: Perioperative Quality Improvement Programme (PQIP)	No	0% (See note)
Royal College of Anaesthetists: National Emergency Laparotomy Audit (NELA)	Yes	*90%*

Title	Are we participating in this?	% of eligible cases submitted
Royal College of Emergency Medicine - Emergency Medicine QIPs: Assessing cognitive impairment in older People (July 2022 Renamed to 'Care of Older People (COP))'	Postponed by provider	N/A
Royal College of Emergency Medicine - Emergency Medicine QIPs: Consultant Sign Off	Yes	95%
Royal College of Emergency Medicine - Emergency Medicine QIPs: Infection Prevention and Control 1819	Yes	100%
Royal College of Emergency Medicine - Emergency Medicine QIPs: Mental Health self harm	Yes	Data collection ongoing
Royal College of Emergency Medicine - Emergency Medicine QIPs: Pain in Children	Yes	100%
Royal College of Obstetricians and Gynaecologists (RCOG): National Maternity and Perinatal Audit (NMPA)	Yes	100%
Royal College of Obstetricians and Gynaecologists (RCOG): National Neonatal Audit Programme (NNAP)	Yes	100%
Royal College of Opthamologists: National Ophthalmology Database Audit (NOD) Adult cataract Surgery Audit	Yes	100%
Royal College of Paediatrics and Child Health (RCPCH): Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Yes	66% (See note)
Royal College of Paediatrics and Child Health (RCPCH): National Paediatric Diabetes Audit	Yes	100%
Royal College of Physicians (RCP) - Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	No	0% (See note)
Royal College of Physicians (RCP) - Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls	Yes	100%
Royal College of Physicians (RCP) - Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database	Yes	77.3%
Royal College of Physicians (RCP) - National Asthma and COPD Audit Programme (NACAP): Adult Asthma Secondary Care	Yes	37%
Royal College of Physicians (RCP) - National Asthma and COPD Audit Programme (NACAP): Chronic Obstructive Pulmonary Disease Secondary Care	Yes	73%
Royal College of Physicians (RCP) - National Asthma and COPD Audit Programme (NACAP): Paediatric Asthma Secondary Care	Yes	100%
Royal College of Physicians (RCP) - National Asthma and COPD Audit Programme (NACAP): Pulmonary Rehabilitation Organisational and Clinical Audit	Yes	27 cases
Royal College of Psychiatrists - National Audit of Dementia: Care in general hospitals	Yes	100%
Royal College of Surgeons (with project management subcontracted to NHS Digital) - Gastro-intestinal Cancer Audit Programme (GICAP): National Bowel Cancer Audit	Yes	>80%
Royal College of Surgeons (with project management subcontracted to NHS Digital) - Gastro-intestinal Cancer Audit Programme (GICAP): National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
Royal College of Surgeons of England: National Lung Cancer Audit	Yes	100%
Royal College of Surgeons of England: National Prostate Cancer Audit (NPCA)	Yes	100%
Serious Hazards of Transfusion (SHOT): Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%
Society for Acute Medicine: Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
The Trauma Audit & Research Network (TARN)/University of Manchester: Trauma Audit & Research Network (TARN)	Yes	40%
University of Bristol: National Child Mortality Database (NCMD)	Yes	100%
University of York: National Audit of Cardiac Rehabilitation	Yes	100%

The Clinical Effectiveness team will continue to further strengthen local processes around supporting national audits going into 2023/24. This will be achieved through greater governance of the assurance element of Group participation in national audits through diarised check-ins with clinical audit leads. The Team will also introduce mapping the process of each national audit to identify if there are any opportunities to monitor case ascertainment more robustly.

Of the seven percent of National Audits with no participation in 2022/23:

- Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE) - SWB did not submit any data throughout 2022/23 as the data submission was not completed. In 2022/23 there were missed participants. To mitigate missed opportunities to benchmark the Urology Governance Lead has led on a local audit using the resources from the BAUS national audit, so that local practice can still be mapped against best practice standards.
- Peri-operative Quality Improvement Project – Surgery and Research departments have experienced challenges with the data collection. Progress has been made to improve the uptake of participating in this study in readiness for 2023/24.
- Fracture Liaison Service Database – Post pandemic the Fracture Liaison Service required an evaluation, impacting on data collection for 2022/23. Progress has been made with the service (reset) thereby participation in this study will occur in 2023/24.
- National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit (NDISA). – Unexpected staffing changes impacted on the data submission. Progress has been made with the service to improve participation in 2023/24 in light of a new workforce.

Having identified the issues for compromised participation in these four national audits, the Clinical Effectiveness team have been working with relevant services to develop recovery plans and escalation arrangements to ensure participation in 2023/24 national audits.

Local Quality Improvements in response to national clinical audit findings:

The reports of 39 national clinical audits and confidential enquiries were reviewed in 2022/23 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 Paediatric Diabetes Audit	• To improve compliance with national standards face to face clinics have been re-established, with a pre-clinic checklist to ensure clinicians are aware of each patient's level of compliance with the necessary standards. • To improve the number of children having four HBA1c tests done, all patients are offered four appointments, with ongoing monitoring and nurse led clinics offered where appropriate.
National Audit of Breast Cancer in Older People	• Breast cancer surgical teams will evaluate their re-operation rates after breast conservation surgery, to inform quality improvement projects with an aim to reduce rates.
National Ophthalmology Audit Adult Cataract	• The ophthalmology team will work with the Clinical Effectiveness team to test a process for setting up a local audit that would provide insight into SWB specific compliance with national standards, therefore identify clear opportunities to share good practice and make improvement.
National Audit of Care at the End of Life (NACEL), 2021 Round 3	• Embed a rolling program of saturation weeks on wards with Shared Care Plan as the focus. • The team has submitted a bid for a bereavement support service and is awaiting feedback. • Comfort care packs have been developed and will soon be available on all wards. • Over the next year there will be increased education and development around the awareness of death. Staff training on talking to families will continue to be provided.
National Diabetes Inpatient Safety Audit in England (NaDIA)	• Policy development will progress in 2023/24. • A process has been agreed between the Diabetes team and Clinical Effectiveness team to have regular review meetings about the data to submit to this audit, to ensure participation in 2022/23.
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	• Improving education resources across the clinical pathway (GPs, physiotherapists, first contact practitioners) to set up Early Inflammatory Arthritis referral pathways. • Removing barriers to audit participation. The quality improvement aim is to have a standardised proforma on Unity, our electronic patient record. In the interim, consultants have worked with Clinical Effectiveness to create a free text template and establish a process that supports data collection and submission to this national audit. • Improve documentation of items of disease activity. • Rheumatology departmental cards have been introduced with contact details of the support available out of hours.
Epilepsy study - Medical and Surgical Clinical	• Create a patient information leaflet to be available in ED.
Outcome Review Programme	• To review our current pathway to identify improvement opportunities end to end of the pathway.
National Prostate Cancer Audit (NPCA)	• Introduction of monthly pathway meetings to reinforce the pathways we use, to improve our service.
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme - Pulmonary Rehabilitation	• Service improvement to our pulmonary rehabilitation (PR) being offered within 90 days of receipt of referral for all people referred with stable Chronic Obstructive Pulmonary Disease. • Outcome measures to be established for PR and evaluated. • The service will provide people completing pulmonary rehabilitation with an individualised, structured, written plan for ongoing exercise maintenance.
RCEM: 2021/22 Infection Prevention and Control	• Newly employed Deputy Director of IPC leading a number of quality improvement initiatives, including a Unity solution to enable effective screening and flagging of patients.
RCEM: 2021/22 RCEM: Pain in Children	• For the team to develop the use of flashcard, stickers or an identifier at door or bed to identify patient requiring review. • To use Display Board to seek attention of medics which helps to identify patients, when analgesia given, review in one hour, and review documentation. • A Unity popup window for reviewing redocumentation of pain score in moderate to severe pain solution is required with the support of Unity and IT lead to see if it is workable.
National Diabetes Footcare Audit	• Improving education and awareness across the pathway (G.P. practice nurses and HCA's). • Service enhanced with podiatry clinics accessible daily with Saturday clinics and domiciliary visits if required.
Trauma Audit Research Network	• Action to improve the Trauma booklet. • Improve the TARN Coding – to improve the identification of samples to audit and improve the number of cases captured to audit. • HES data validation exercise – to review data to address the ascertainment figure discrepancies.

Local Quality Improvements in response to National Clinical Audit Findings

Reports of 375 local clinical audits were reviewed in 2022/23 performed by our people at Sandwell and West Birmingham NHS Trust with some of the quality improvements implemented or to be progressed as identified in the table below taking a Model for Improvement approach implementing Plan Do Study Act Cycles (see table 2).

Table 2: Improvement activities against clinical audit

Speciality Audit	Improvement Activity
Assessment of the SWB Alcohol Withdrawal Pathway Guidelines	• The Alcohol Care Team used improvement methodology to gain a better understanding of how they could improve the care of alcohol withdrawal patients. • Education sessions have been introduced for the MDT. • The team will work with the Information Technology team to develop Unity to support standardisation of the pathway.
Fast Track Discharge process and Discharge-Enablement Team	• Clinical audit performed identifying the importance of patients' preferred place of death during the fast-track discharge planning. • It has been agreed to adopt a continuous data collection approach to this project going forward so the service can effectively monitor where positive change is needed and quickly assess the impact of interventions on service delivery.
Minor Surgery in Primary Care	• The Primary Care team reviewed their minor surgery practice compared to the Primary Care Network guidelines. Following these findings, an improvement action is to introduce the TENDABLE monthly audit platform to ensure any auditable issues are identified early and escalated appropriately.
Heart Failure in Elderly Patients, Quality Improvement Project	• This audit has resulted in actions to improve the IT systems in use: IT are investigating if the consolidation of information can be automated as part of medicine reconciliation and an addition to the discharge letter format will see a distinct Pharmacy comment box so medication changes and rationale can be documented clearly.
Photodynamic Therapy	• The Birmingham Skin Centre completed an audit of their Photodynamic Therapy, resulting in the Dermatology team creating standard operation procedures (SOPs) for referrals and nurse-led clinics, also building a new standardised digital referral and documentation template to be used on Unity.
Sepsis	• Following on from a Rapid Improvement Week, several opportunities were identified to improve the care of our patients on the Sepsis 6 pathway. A clear process will be agreed and implemented to provide standardisation across both hospital sites. A sepsis faculty will be established and sepsis training will be a requirement for all clinical colleagues. Investigations are ongoing about how a clinical decision point can be implemented and clearly documented on Unity to avoid over-confirming Sepsis.
Effective use of ROTEM equipment	• Following a quality improvement project looking at effective use of ROTEM in labour wards, equipment training videos will be circulated to staff and a quick reference guide (including algorithm for interpretation of results) will be created and placed on or near the ROTEM equipment to improve timeless of analysis and application of results.
Clinical use of Dexmedetomidine for ICU sedation, 2022 Re-audit	• The ICU team have agreed to use one concentration of 8mcg/ml instead of 2, which reduces the risk of human error in the process. The policy will be improved to provide our People with clarity around expectation when utilising Dexmedetomidine. Going forward the plan is improve Unity to allow for more effective documentation and monitoring.
6-month follow-up for patients in the Stroke pathway	• Following collaboration between the SWB Stroke team and the Stroke Association, the Stroke team will amend the local SSNAP (national audit) database to include a question on whether patients are suitable for 6-month referral, therefore making identification more accessible. I.T. will then create an electronic report that pulls together all additional details needed for referral.
Use of the Prescription line service in Rheumatology	• Rheumatology used audit to investigate the nature of patient calls to the prescription line service. To improve the use of this prescription line, a triaging process has been agreed to enable the admin team to filter out calls pertaining to other topics. A piece of awareness work will be done directly with patients to promote effective use of this service.
Surgical Site Infections in Dermatology	• The Dermatology team will not use hair removal routinely and only use electric clippers with a single-use head on the day of surgery, if needed. Movements IN and OUT of the operating room will be reduced (for those staff wearing theatre outfits) to reduce infection risk. Improved awareness and education on the requirement to complete skin assessment charts and swabbing prior to prescription of antibiotics.
Radiology Surveillance following cancerous kidney removal	• The Radiology Team will create a booklet for patients to keep, containing details of their kidney cancer risk and frequency of follow-up scans so they are empowered to monitor the progress of their own follow-up.
Radiology review of cancer coded patients resulting in cancer diagnosis	• The Radiology team have agreed to review processes to identify where they can improve compliance with national standards. There will also be a discussion with the Cancer board to review cancer flagging codes for increased accuracy going forward.
Assessing the analgesic response to IV Lignocaine Infusions and its effect on other prescribed analgesics in Chronic Pain patients	• The Team have agreed to test methods to improve treatment response such as procuring iPads to display a digital motivational video at Lignocaine infusion sessions and collaborating with Medical Illustration to create a poster for patients.
Zoledronic Acid Prescribing in Haematology Patients	• Haematology will develop guidelines or standard operating procedures for Zoledronate to improve effective use of this drug. A standardised biochemistry form has been introduced to support documentation and application of patient biochemistry results. A training regime for staff administering zoledronate will identify and remove barriers to pre-infusion biochemical testing.
CURB-65 score regular review for disease severity in Community Acquired Pneumonia (CAP)	• The AMU team have agreed to place visual aids at both City and Sandwell sites to promote use of the CURB-65 assessment tool. There will also be an improvement made to Unity to streamline the prescribing process, thereby enabling effective antibiotic prescribing.
Appropriateness of wireless pH study referrals in line with BSG guidelines	• The GI Physiology team will establish a process where internal referrals are now made via UNITY which ensures all correct clinical information is available on the referral. Local guidance has also been amended to offer repeat tests if failed or inconclusive.
Investigating causes for same-day ENT surgeries cancellations- Re-audit	• The ENT team have agreed to update their local process to include regular review and updating of operating lists, in order to reduce Did Not Attend rates and enable surgery lists to run efficiently.

The use of abbreviations recorded in the SMART4Hearing database	• The Neonatal team have updated existing performance checks to include monitoring of correct abbreviations so that colleagues can be supported where needed and promote effective communication.
Audit of Inclusion Health in City Hospital Emergency Department	• ED have created resources for homeless patients that are readily available to patients and staff. Introduction of a brief 4pm staff handover teaching session will emphasise the importance of good documentation and the severe weather protocol. The team are also working on Unity developments to build a flagging system for identifying homeless or at risk patients, and seeing if changes to address on discharge letters can be automated.
Review of declined CT and MRI requests	• The Imaging team have agreed to create guidance for CT and MRI vetting within the department, to more effectively use their current IT systems.
Time to Consultant Review in Paediatric Admissions	• The Paediatric team have agreed to record the time of patient admission on the doctors' handover sheet and raise the awareness throughout the team to improve accuracy of data. This will indicate where further improvement efforts are needed
Quality and accuracy of clinical referral letters for the specialist adult audiology services	• The Audiology team plan to improve the quality and accuracy of their letters by editing through the AuditBase software and encouraging wider discussion of issues to enable collaboration on further improvements
Accuracy of diagnoses populated on discharge summaries for clinical coding of adult patients discharged from acute medicine	• The Acute Medicine team have started work developing a tutorial to support the process of updating patient discharge diagnosis. Another system improvement within Unity will see a mandatory field that prompt review of the diagnosis on completion of discharge paperwork.
CT use in Pancreatitis.	• An improvement to the existing CT process will see the dedication of specific slots for surgical inpatients to improve compliance with timely ultrasound completion
Review and improvement of local Dermatology Surgical Referral forms	• The booking form is being reviewed and amended to improve data capture. Education on effective completion of booking forms is being provided to trainees and added to the local induction programme.
Effective use of trust guidelines in the diagnosis & treatment of hospital-acquired pneumonia (HAP) in patients receiving ward-based care	• Action is being taken to increase promotion of the available trust guidelines amongst ward-based clinicians including consultants via an organized teaching presentation. The current guidelines will also be reviewed and changes made to make the information more accessible.
Determining compliance of Acute asthma management in adults admitting through ED or Resus depending on PEFR	• Action has been taken to raise awareness of the requirement to record PEFR and severity of asthma on admission and pre- and post- nebulizer/inhaler. Going forward all patients will be referred to the asthma Clinical Nurse Specialist if admitted with to ED acute asthma exacerbation
Assessing the health needs of Unaccompanied Asylum-Seeking Children	• An information pack is being created for staff to serve as a reminder to record journey details as part of the Initial health assessments and provide blood forms at the time of assessment.
Compliance with CT Head injury NICE guidance in ED	• To improve timeliness of this process an ex- triage nurse will be in place to enable early escalation of patients with head injuries so they are seen within 15 minutes of arrival. The whole of our local head injury pathway is being reviewed to reflect the latest nationally recognised best practice (e.g. NICE guidance) and an awareness campaign will launched to improve practice across both ED settings.
Intimate examinations and chaperone use (An Assessment of documentation of consent and use of chaperon during Scrotal examination)	• A voluntary teaching session, emphasising the need for discussing chaperones, is planned for urology trainees as they are also most likely to encounter patients needing a intimate examinations. Relevant SWB guidelines will be reviewed to ensure that chaperone use, and correct documentation, is considered when needed.

POCUS (Point of Care Ultrasound) delivers ultrasound care at the bedside of a patient or in their home.

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.

NHS Black Country Integrated Care Board

NHS Black Country Integrated Care Board (BC ICB) 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 2022/2023 contractual year.

The BC ICB 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.

As detailed within this Quality Account, the challenges, and pressures that the Trust has faced during 2022/2023 have been unprecedented, with unrelenting demand on all services, industrial action, recruitment challenges and wider system pressures all significantly impacting on the organisation. The requirement to support out of area patients accessing SWBH care, has placed additional strain on the Trust, but the staff have responded professionally and the desire to provide high quality care to all patients is evidenced in the information contained within this Quality Account, such as the 368 compliments that were received.

Despite the intensive pressures experienced across the whole of the Black Country Integrated Care System during this time period, the BC ICB and SWBH Trust have continued to work tirelessly and collaboratively to improve the quality and effectiveness of care provided, enhancing the close working relationships between the ICB 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 2022/2023 quality and patient safety priorities which are outlined in this account.

We are immensely proud of the effective working relationships that continue to exist between the Trust and the BC ICB and in the improvements that have been made across the quality and safety agenda. During 2022/2023 we have continued to work in partnership through our Clinical Quality Review Meetings (CQRM's) with the Trust, which are well attended, and which provide positive engagement for the monitoring, reviewing, and mitigation of any safety and quality issues. We would like to thank the Trust for their support in this matter, and for their engagement openness and transparency in the establishment of these key meetings. We have also undertaken a series of Quality Assurance Visits and Quality Spot Check Visits within different areas of the Trust, and we have found the Trust to be extremely supportive, candid, and receptive to any areas of improvement and feedback provided.

SWBH has demonstrated its commitment to quality by the introduction of several quality improvement schemes during the year, including the provision of a new Same Day Emergency Care Unit (SDEC) which will provide same day multi professional care to patients, reducing unnecessary hospital admissions. The Trust also produced its Fundamentals of Care framework that enhances the Trust commitment to providing outstanding care to its patients. The award of "Green Status" from NHS England in relation to infection prevention and control demonstrates the merits of this framework.

Looking forward, BC ICB welcomes and supports the Trust's Quality Plan Objectives for 2023/2024 particularly its plans to ensure the Trust's readiness for the move to the new Midland Metropolitan Hospital, which will be essential in the trust embedding practices and making the move as successful and least disruptive to patient care as possible. The BC ICB also welcome and supports the Trust ambition to focus on improving communication to improve the patient journey, particularly as communication issues are often an identified factor/area for improvement highlighted within serious incident investigation reports.

The BC ICB is also fully committed to supporting SWBH with its transition from the Serious Incident Framework (2015) to the Patient Safety Incident Response Framework and the move from the National Reporting Learning System (NRLS) to the Learning from Patient Safety Events Service (LFPSE) in Autumn 2023.

In conclusion the BC ICB are confident that SWBH has demonstrated their commitment to quality, experience, and safety in their continual improvement journey. We thank The Trust for their hard work 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 2023/2024 priorities and the continuation of system wide collaboration within the Black Country Integrated Care System.

Sally Roberts
Chief Nursing Officer/Deputy Chief Executive Officer
Black Country Integrated Care Board

Birmingham and Solihull Integrated Care Board

We have worked collaboratively with Sandwell and West Birmingham NHS Trust over the course of 2022/23 to review the organisations' progress in implementing its quality improvement initiatives. Birmingham and Solihull Integrated Care Board are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2023/24.

Lisa Stalley-Green
Deputy Chief Executive and Chief Nursing Officer

Healthwatch Sandwell

This is well drafted and structurally, I think the report's content and style is good. It is very comprehensive and detailed, and certainly gives me a good sense of the actions the Trust has taken to improve and maintain quality - with improvements made in the year in question and what is planned in the year ahead. The impression created by the words and the content is that the Trust is well Governed with its focus on monitoring quality though using a range of performance metrics.

Although the overall CQC rating for the Trust is Requires improvement it is reassuring that "The Trust's patient-related strategic objective is 'to be good or outstanding in everything we do', which is supported by our plans to attain an overall provider 'good' rating through delivery of our Fundamentals of Care framework.".

However, while I am very positive, Sandwell is a collection of 6 Towns and expectations and experience of their interaction with integrated care services including hospital and primary care, has to be in a timely/accessible way, equitable, appropriate, effective and in a socially and demographically sensitive way. I am confident the integrated Trust will continue to work to achieve these dimensions of quality across the Borough, despite working in a very challenging economic, organisational, and demographic environment.

Phil Griffin
Chair

Birmingham Health and Adult Care Overview and Scrutiny Committee

The Birmingham Health and Social Care Overview and Scrutiny Committee recognises the challenges faced by the Sandwell and West Birmingham NHS Trust over the past 12 months to maintain services whilst coping with the additional demands including those created by the Covid-19 pandemic; and wishes to recognise the way the staff team have worked tirelessly to meet the needs of the people of Sandwell and West Birmingham.

The commitment to the "Speak Up" initiative to give employees the confidence to raise concerns is to be welcomed, especially given the exceptional work pressures staff will have experienced in recent times, and the importance of learning from the Trust's overall response to the pandemic. Of particular importance will be the restoration of clinical services and the closer collaborative working which will be critical in tackling waiting times for elective surgery.

We recognise the progress made to increase capacity over and above the pre-Covid baseline in order that progress can be made to catch up on delayed elective surgery in all priority categories; and we are pleased with the way the "Tendable "app has been rolled out across all clinical areas to help achieve the aims of Fundamentals of Care Framework. While some areas such as patient safety and complaints performance has remained consistent, other areas such as the 62-day cancer referral treatment standard and ambulance handovers within 30 minutes performance have unfortunately declined; and these remain areas which will deserve ongoing monitoring.

As part of the Sandwell / Birmingham Joint Health Overview and Scrutiny Committee (JHOSC), we look forward to working with the Trust over the coming year and look forward to receiving evidence of their further progress.

Councillor Mick Brown
Chair, Health & Adult Social Care Overview and Scrutiny Committee
Birmingham City Council

Trust response

We would like to thank our stakeholders for their valuable comments on our Quality Account for 2022/23.

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 2022/23. We therefore have no limited assurance opinion on our quality account to publish.

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