NHS
Sandwell and
West Birmingham
NHS Trust

QUALITY ACCOUNT
2024/25

PATIENTS
PEOPLE
POPULATION

Front cover left to right: Mr Manoj Sikand, Consultant Surgeon in Trauma and Orthopaedics. The Cardiac Rehab team who are delivering preventative care to patients within the community. Harvest View patient Rosa has praised the facility for the compassionate care delivered to her in a modern setting.

Foreword

It is my pleasure to introduce the Quality Account for 2024/25 – a year in which our Trust not only met significant milestones, but also reaffirmed its commitment to delivering safe, high-quality, and compassionate care to the communities we serve across Sandwell and West Birmingham.

This year stands out as a defining moment in our history, with the successful opening of Midland Metropolitan University Hospital (MMUH) in October 2024. Years of careful planning and coordination came to fruition as we transitioned services, patients, and staff to this state-of-the-art facility. The move was delivered with precision, compassion, and an absolute focus on safety. Most importantly, it was delivered without patient harm. MMUH is already proving to be more than just a hospital – it is a symbol of regeneration, of ambition, and of our commitment to improving life chances and long-term health outcomes.

With modern infrastructure, digital advancements, and a model of care designed for the future, we are already seeing tangible benefits of MMUH – from improved infection control and enhanced patient privacy to increased Same Day Emergency Care capacity and improved ambulance turnaround times. But bricks and mortar are only part of the story. What brings it to life are the people within it – our incredible teams who deliver care with compassion, resilience, and professionalism every single day.

In this Quality Account, you will find both a reflection of our achievements and a candid recognition of where we must continue to improve. We have made encouraging strides in areas such as patient safety, reducing avoidable harm, enhancing the care of deteriorating patients, and improving access to planned and urgent care. Our mortality metrics and safety culture continue to evolve in the right direction, and we have embedded more rigorous learning from incidents through the implementation of the Patient Safety Incident Response Framework (PSIRF).

We are equally proud of the advances we've made in improving staff engagement, diversity in leadership, and workforce sustainability. Initiatives such as the ARC Leadership Programme, targeted retention efforts, and our new digital absence management tools are helping us create a culture in which every colleague feels supported, heard, and empowered to thrive.

We have continued to strengthen our integration with local partners, particularly in primary care and population health. Our work with GP colleagues on care pathways, early identification in end of life care, and the development of community-based interventions is helping to shift the focus from treatment to prevention. These partnerships are vital as we look to build a truly integrated care system across the Black Country.

As we look to 2025/26, our strategic priorities reflect the values and ambitions of our organisation. We will focus on improving perinatal services with equity and compassion at the core. We will enhance outpatient and planned care, delivering more timely, personalised, and digitally enabled services. We will build on our work to improve patient experience – embedding respectful, inclusive communication and co-producing improvements with patients and carers. And we will further strengthen our response to the deteriorating patient, a key factor in our ongoing efforts to reduce mortality and ensure timely, high-quality care.

None of this progress would be possible without the continued dedication of our colleagues, whose passion and commitment to our patients is evident in everything they do. I also want to thank our patients and local communities for their trust, engagement, and invaluable feedback – your voices are shaping the care we provide.

This Quality Account is more than a statutory requirement. It reflects our values in action – of our desire to be open about how we're doing, ambitious in what we aim to achieve, and committed to learning and improving together.

2024/25 was the year of delivering Midland Met – now it is time for us to maximise its benefits and create a health and care system that is not only fit for today but built for the future and has the needs of our local community at its heart.

Diane Wake, Chief Executive
Sandwell and West Birmingham NHS Trust

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.

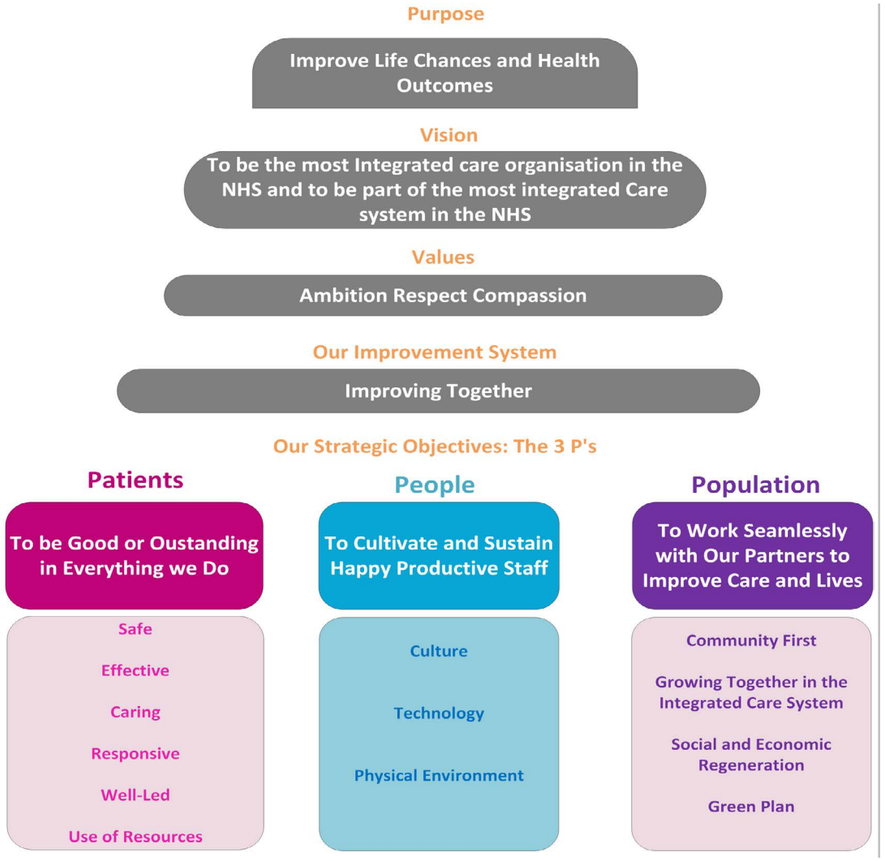
The Trust's directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Sir David Nicholson, Chair

Diane Wake, Chief Executive

Our Trust Strategy 2022/27

Overview 2024/25



In 2022, our Trust Board approved a five-year strategy, recognising that achieving our ambitions required a phased approach. A primary initial focus was the safe and effective opening of Midland Metropolitan University Hospital (MMUH), which required significant effort and resources.

We successfully moved into MMUH, transitioning patients and staff over three days in October and November 2024, while ensuring continuity of care. This state-of-the-art facility now provides maternity, children, and acute inpatient adult services to over 500,000 people. Beyond healthcare, MMUH is a catalyst for social and economic regeneration, improving life chances and long-term health outcomes.

Post MMUH focus will harness our new capabilities to make significant improvements to our most important measures. These 11 'Success Measures' underpin our three strategic objectives, our vision and our purpose. Our Improvement System 'Improving Together' will become the way that we improve, harnessing everyone to contribute towards our Trust's strategy and delivering its plans.

The translation from our strategy to our annual plan uses 11 Success Measures and Multi Year Commitments to ensure we are working on the delivery of in year and longer-term strategic objectives.

The way that we deliver improvement will be supported by three shifts set out in the NHS Long Term Plan:

1. Shifting from treatment to prevention to improve long-term health outcomes.
2. Moving care from hospital to community to provide more integrated, accessible services.
3. Accelerating the transition from analogue to digital to enhance efficiency and patient experience.

Performance summary 2024/25 and forward look

As we look back on the past year, it is essential to acknowledge both our achievements and the areas requiring further improvement. The summary below reflects our performance against key strategic objectives and outlines our future priorities. This year's starting strategic objective focused on population health, reinforcing our commitment to prevention, early intervention, and reducing health inequalities while aligning with national priorities and addressing local health challenges.

Population – Performance highlights

Right size acute, community, and virtual beds

Significant success has been achieved through new clinical models, such as Frailty at the Front Door and Virtual Wards (VWs). As a result, our Trust is the only hospital in the region to have successfully reduced its bed base while also reducing the need for a hospital stay for patients over 65 years old. This demonstrates the impact of innovative service delivery in improving patient flow and optimising acute care capacity.

However, not all of these new services are operating at full capacity. To build on this success, our focus for the forthcoming year will be on 'Community First' as we systematically challenge why a patient, who could be appropriately seen and treated in the community, has arrived at our acute hospital.

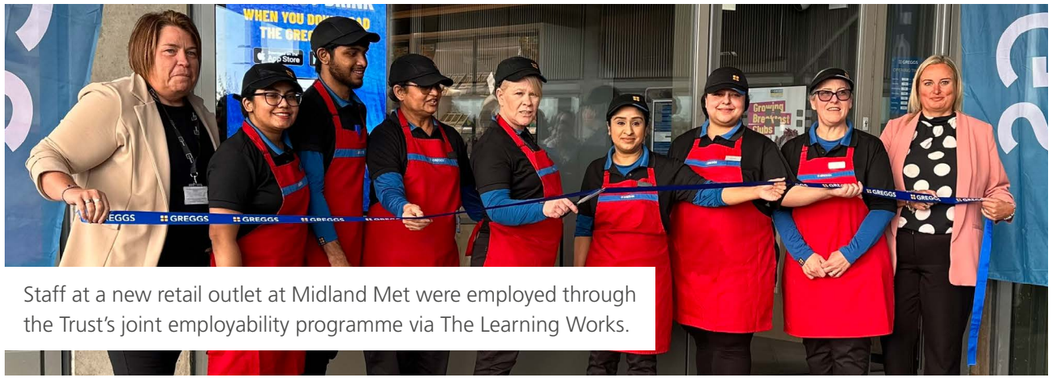
Increase volume of local people employed and trained

This year, we have strengthened recruitment and retention, with a high proportion of job offers leading to long-term employment. The launch of an externally funded employability programme has already helped individuals gain qualifications and secure roles within our Trust. To build on this progress, we are expanding targeted recruitment, apprenticeships, and training programmes while deepening partnerships with local educational institutions. Increasing the number of local people employed and trained remains one of our core 11 strategic goals, ensuring a sustainable and skilled workforce for the future.

Improve population health

We have recognised that investing in prevention and early intervention is essential for improving long-term health outcomes and reducing healthcare demand. By adopting a data-driven, evidence-based approach, we have begun identifying where preventative care can have the greatest impact, addressing wider determinants of health such as employment, housing, and economic stability. Prevention efforts have often been implemented too late in the care pathway and without a strong evidence base, limiting their effectiveness.

To address this, we will strengthen system-wide prevention strategies in alignment with our strategic objective to improve population health through Place-Based Partnerships. By enhancing multi-agency data sharing, integrating policies, and establishing clear intervention pathways, we will ensure a more targeted and effective approach. A task-and-finish model will focus on delivering a small number of evidence-based interventions in collaboration with local partners, enabling early identification of at-risk individuals, improving access to targeted education and resources, and enhancing coordination across services. This shift from reactive care to proactive prevention will improve population health outcomes and reduce long-term healthcare demand.



Staff at a new retail outlet at Midland Met were employed through the Trust's joint employability programme via The Learning Works.

Patients – Performance highlights

Deliver access standards

This year, we have improved Emergency Access Standards (EAS), with ambulance turnaround times reduced through the 45-minute offload standard. Temporary escalation space has been reduced and is only used in times of escalation, and diagnostic performance has improved, though some specialties require further recovery efforts. Cancer pathways have strengthened, with sustained improvements in the 28-Day Faster Diagnosis Standard (FDS), while work continues to meet the 31-Day Decision to Treat (DTT) standard. Elective and non-elective productivity has increased through theatre transformation, with the almost complete removal of 65-week waits, and outpatient enhancements such as virtual consultations and Patient-Initiated Follow-Ups (PIFU).

In the year ahead, the focus will remain on optimising theatre efficiency, reducing diagnostic and specialty delays, improving cancer pathway performance, and strengthening capacity planning to ensure sustained compliance with national standards. These efforts align with our long-term commitment to Elective Reform, ensuring timely and equitable patient access.

Reduce moderate and above harm

As the year has progressed, we have seen a reduction in moderate harm incidents, reflecting continued improvements in patient safety. Strengthened reporting mechanisms, increased case reviews, and enhancements to incident reporting systems have reinforced a proactive safety culture. Key initiatives, including the Quality Learning Framework and Medicines Administration Programme, will further embed safety improvements. Medication safety is being enhanced through automated dispensing, while the Patient Safety Incident Response Framework (PSIRF) drives targeted action on systemic risks.

Ongoing improvements in recognising and responding to deteriorating patients, alongside compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards, will reinforce early intervention and patient protection. By embedding these measures, we remain committed to reducing harm, improving outcomes, and upholding the highest standards of care.

Reduce mortality Summary Hospital-Level Mortality Indicator (SHMI)

Our SHMI remains above the peer average, highlighting the need for focused action. To strengthen escalation processes, we are relaunching the Deteriorating Patient Group as part of the strategic objective of improving the recognition and management of deteriorating patients, implementing a Standard Operating Procedure (SOP) for Early Escalation, and refining expected deaths assessments for improved reporting accuracy. Workforce development plans are underway supported by digital enhancements for early warning systems, ensuring early identification and intervention for at-risk patients.

To further drive sustained improvement, we are strengthening mortality reviews and learning frameworks, using insights to inform real-time service enhancements. The updated CURB (Confusion, Urea, Respiratory, Blood Pressure) Care Bundle will optimise pneumonia and sepsis pathways, helping to reduce preventable harm. Our commitment to continuous learning from clinical incidents ensures that best practices are embedded across all services, underpinned by the Quality Learning Framework task and finish project within our strategy.

Enhance patient experience

This year, we have made progress in improving patient experience, with increased inpatient response rates for adults and children plus some marginal improvements in Friends and Family Test (FFT) scores. However, performance has not yet been consistently sustained, with inpatient experience slightly below national targets, outpatient satisfaction dipping earlier in the year before improving, and general response rates remaining low.

To address this, we are developing a patient experience dashboard and benchmarking progress through the CQC National Survey. Technology is being explored to enhance complaint resolution, while the 'Putting the Patient First' training programme is embedding a culture of compassionate care. Initiatives such as volunteer-led customer service sessions, student nurse training, and enhanced PALS support continue to strengthen patient interactions. The Quality Learning Framework will ensure learning from feedback informs service improvements, with a focus on increasing response rates, improving complaints resolution, and driving continuous improvement in patient experience.

Achieve recurrent financial sustainability

Our Trust forecasts an underlying deficit incorporating the full financial impact of MMUH. Key financial factors influencing this position include non-recurrent deficit funding, non-recurrent ICS income, and an efficiency target for recurrent savings.

To strengthen financial resilience, the Trust has prioritised the delivery of recurrent financial improvement as a strategic in year objective, with a focus on reduction in temporary staffing and improving productivity. Coding improvement has produced benefits to optimise income capture and financial accuracy. Ongoing monitoring of the underlying financial position into 2025/26 will ensure continued progress, with a firm commitment to delivering financial sustainability while maintaining patient care standards.

People – Performance highlights

Improve staff engagement score

Whilst the engagement score remains above previous levels and response rates have improved, maintaining participation remains a challenge. Over the past year, our People Engagement Teams and the ARC (Ambition, Respect and Compassion) Leadership Programme have strengthened staff morale through structured forums, leadership development, and wellbeing initiatives, fostering a culture of compassionate leadership. Aligned with our commitment to reducing reliance on temporary staffing, ongoing efforts focus on improving retention and workforce sustainability by enhancing staff experience. Phase 2 of the ARC Leadership Programme will further develop leadership capabilities, while the People Engagement Teams will deepen staff involvement in decision-making, ensuring feedback drives meaningful improvements.

Optimise workforce productivity

Workforce productivity has steadily improved throughout the year, with a significant reduction in staff turnover driven by targeted retention and staff engagement initiatives. Sickness absence rates have also declined, strengthening workforce resilience.

Building on this progress, the implementation of the 'GoodShape' absence management platform is expected to further reduce sickness-related absences, improving staffing stability and continuity of care. Programmes such as ARC Leadership Development, Team Effectiveness Interventions, and a Trust-wide retention strategy will continue to enhance workforce stability, while better access to training, career progression opportunities, and staff engagement through surveys will further reinforce these gains. In line with our commitment to reducing reliance on temporary staffing, efforts will continue to improve retention and workforce sustainability.

Achieve representative leadership

Over the past year, we have strengthened our leadership pipeline to better reflect the diverse communities we serve. Recognising its importance, our Trust has embedded this as a Measure of Success within its strategy. Key initiatives include targeted mentorship, structured leadership development, and inclusive recruitment practices, such as anonymised shortlisting and diverse interview panels. Moving forward, we will expand our talent management framework and provide enhanced leadership coaching to underrepresented groups, ensuring equitable access to senior roles.

Priorities for Improvement in 2025/26

Priority 1

Improving perinatal services

Our aim is to deliver a perinatal service, built on equity and equality, that meets the needs of our local population, supports our colleagues and ensures they develop and reach their potential. We will work in co-production to deliver services which

- place the needs of the mother, birthing person, baby and family at its centre so that pregnancy and childbirth is a safe and positive experience, with women, birthing people and babies treated with dignity, equity and respect through work with our Maternity and Neonatal Voices Partnership and perinatal experience group stakeholders.
- Promote healthy lifestyles for pregnant women and birthing people which have a positive impact on them and their family's health beyond the maternity and for future generations, working in partnership with Public Health to target smoking and provide smoking cessation support.
- provide onsite vaccination services.
- provide a range of high-quality choices of care as close to home as is safe and sustainable to do so, from midwife to consultant-led services and personalised to individual needs, ensuring appropriate risk assessments and providing aspirin at the point of care.
- provide family integrated care across our neonatal pathway.
- support a highly trained workforce able to deliver high quality, safe and effective services that are developed and reach their own potential, through our People Plan.
- work in collaboration across all stakeholders and through lived experience, to listen, hear and improve.
- are transparent, that we constantly review, learn and improve, providing a safe environment for care.

The Perinatal Improvement Plan will provide a focused framework to support the aim and monitor progress.

The program has four key priorities:

- Safe and Effective Care.
- To grow, retain and develop our workforce in line with the needs of the service.
- Work with service users, staff and community voices to shape our services.
- Create a collaborative culture of safety, learning and support through effective leadership.

Progress on the plan will be monitored through the Quality Committee, with associated metrics to monitor progress.

Priority 2

Improving outpatient and planned care services

Following the successful transition into MMUH, our focus now shifts towards improving outpatient and planned care services. This next phase of transformation aims to enhance efficiency, reduce waiting times, and improve patient experience, ensuring that services are accessible, responsive, and aligned with best practices.

One of the key priorities is reducing outpatient waiting lists by optimising referral management and consultation models. We will expand Advice & Guidance (A&G) Services, enabling primary care providers to seek specialist input without an automatic referral. The adoption of virtual consultations for appropriate cases will increase capacity for face-to-face appointments. Implementing patient-initiated follow-ups (PIFU) will further ensure that appointments are used effectively, reducing unnecessary clinic visits and empowering patients to manage their care.

To improve referral pathways and booking efficiency, we will introduce a digital triage system, ensuring that referrals are assessed and directed appropriately at the first point of contact. Standardising referral criteria across specialties will enhance clarity and consistency, reducing the need for re-referrals and unnecessary delays.

For planned care and elective procedures, increasing capacity is essential. We plan to maximise theatre utilisation through improved scheduling, introducing evening and weekend elective lists, and ensuring that surgical beds

are ringfenced to protect planned cases from emergency pressures. These measures will help clear the elective backlog and reduce long waits for routine procedures.

Improving diagnostic access is a crucial part of this transformation. We will expand current and introduce into new areas one-stop diagnostic clinics, allowing patients to receive tests and assessments in a single visit. Enhancing imaging capacity and turnaround times for MRI, CT, and ultrasound scans will ensure timely decision-making and reduce bottlenecks in treatment pathways.

Workforce development and digital innovation will underpin these improvements. Training and deploying Advanced Nurse Practitioners (ANPs) in outpatient clinics will help increase capacity, while enhanced patient portals will provide better access to appointment management, test results, and remote monitoring options.

By implementing these changes, we aim to create a more efficient, patient-centred outpatient and planned care model, ensuring that patients receive the right care, at the right time, in the right place. This transformation will lead to shorter waits, improved clinical outcomes, and a more sustainable healthcare system.

Progress on this priority will be monitored through the Finance and Performance Committee with updates provided for the Quality Committee.

Priority 3

Care of the deteriorating patient

A systematic investigation in SWB has identified a number of factors contributing to the high Summary Hospital-Level Mortality Indicator (SHMI) which our Trust has been reporting on since before the COVID-19 pandemic. One consistent theme for avoidable harm from the qualitative and thematic analysis of care provisions has remained the failure to, or delay in recognising, the deteriorating patient.

Developing on progress made over the last year, the aims are

1. To eliminate harm to patients from delayed recognition and ensure timely provision of pro-active nursing and medical interventions to deteriorating patients.
2. To improve Summary Hospital-level Mortality Indicator (SHMI) in line with peers.

Our work will focus on the following priority areas.

- A portfolio approach to ensure a sustainable workforce that meets the Resus Council UK Standards. This will be undertaken by the Resus Team who will carry out the training needs analysis and develop a suitable framework for ongoing training of all staff in line with national standards.
- Socialisation of the NEWS 2 dashboard metric within the adult wards and completing the work started for Paediatric and Maternity early warning scores will allow us to have a comprehensive Trust wide dashboard that informs performance at ward level.
- Optimisation of our electronic patient record system (EPR) to allow for easy visualisation of trends in patient physiology, developing a clinician friendly interface for recording of vital signs and interpretation of trends.
- Continuing with the 'Call for Concern' work already undertaken the wellness questionnaire will be rolled out in phases across wards in MMUH.
- Address coding, data flow and case mix standardisation as part of improvement work thus reducing SHMI.

The Deteriorating Patient Steering Group (DPSG) will provide steer and support to this programme of work and will work collaboratively across the system on the Deteriorating Patient national agenda. This work will be monitored through the Quality Committee.

Priority 4

Enhance patient experience

Our Patient Experience Group will oversee related themes and projects to improve experience of care and service. During 2025, we will work with our patients, our community and our staff to develop our forward plan in promoting positive patient experience.

We will provide more in-depth feedback to our teams. This will enable them to better understand the key drivers and factors influencing our patients' experience and inform their improvement plans to improve response rates.

The 'Getting to Know Me' boards devised during 2024 will be deployed across MMUH to support personalised care and communication in inpatient areas. In addition, the Essential Companions Access Card will be rolled out across SWB. This is to provide those carers who patients depend upon to perform activities of daily living, to be recognised as partners in care by our clinical teams. This will allow for their caring expertise to be embraced and valued within care provision. The Access Card also provides carers with routes to overnight stay and free parking.

Communications boxes, which have been created to support individual and diverse communication needs in clinical areas, will be made available across inpatient areas.

Communication is a consistent factor in how people experience services, and our work will encompass provision of consistently respectful, compassionate and professional communication. Our communication skills training work will continue and include

- Clinical communication skills
- Customer service
- Communication and the Equality, Diversion and Inclusion (EDI) agenda
- Consistency in clinical handover between teams
- Advanced communication training to those who often undertake difficult and complex conversations.

We will also widen our provisions and staff education regarding on-demand interpreting services and continue with provision of study days provided during 2024 on personalisation, vulnerabilities, end-of-life and mental health needs.

We will use our patient feedback and how we have performed nationally to improve our communication around discharge processes and expectations.

Progress on this priority will be monitored through the Quality Committee.

Progress on 2024/25 priorities

Priority one

Improve care of the deteriorating patient

The improvements to the care of deteriorating patients have continued with a lens on timely intervention and enhanced awareness. As part of our ongoing commitment to quality care, we are strengthening the management of our patients showing clinical deterioration, a priority area outlined in our annual plan and this year through collaborating and participating in the Black Country Deteriorating Patient Project. By focusing on early recognition and intervention, we have sustained impact across all areas we are measuring. Through the improvement work in time critical conditions like sepsis, we have seen a sustained improvement in sepsis treated within an hour.

The 'Sepsis Hour' report initially showed performance below 90%, but since transitioning to MMUH, we have been tracking monthly and have consistently achieved between 90% and 100% for time to treatment within one hour from October onwards.

Key to our success is the early detection of deterioration, the speed of our responses, and the competence of those responding. The application of the NEWS2 (National Early Warning Score), a Track and Trigger system endorsed by NHS England, is central to this progress. We now have a comprehensive data dashboard to monitor progress, drawing from key indicators in the national cardiac arrest audit. This will facilitate local improvements in the forthcoming year by providing ward areas with the ability to track their compliance.

An external and independent auditor visited our MMUH site and completed an audit over two days in February 2025. A formal report is awaited. The audit findings will provide insight in the Trust compliance with national standards with regards to our approach to timely recognition and response standards to deteriorating patients.

A notable achievement is the successful rollout of our 'Call for Concern' service, designed to enhance patient safety and outcomes for critically ill patients. This initiative is fully aligned with NHS England's Martha's Law, which ensures that all patients, families, carers, and advocates have access to 24/7 critical care outreach support. Through this service, patients and families can now seek immediate help if they feel their concerns about a patient's deteriorating condition have not been fully acknowledged. The Critical Care Outreach team, available around the clock, handles all referrals and provides guidance to both ward teams and concerned patients or families.

This initiative has been integral in addressing patient needs and has proven to be a vital step in improving patient care. Monitoring and reporting of these efforts are now managed through our Executive Quality Group and Quality Committee, ensuring that the work continues to meet high standards of care.

Priority two

Personalisation of care

The Communication Skills Working Group established four clear priorities regarding communication training needs for our people. These are:

- Clinical communication skills
- Customer service
- Communication related to the equality, diversity and inclusion agenda
- Handover processes.

All colleagues currently undertake communications skills training relevant to their role via mandatory training requirements.

In addition to this we have delivered two training sessions on advanced communication skills. These sessions are 2-day training sessions led by our Palliative Care team using actors for role play scenarios that help colleagues to develop their skills in complex communication skills. We plan to deliver additional sessions during 2025/26.

Sessions focusing on positive behaviours have been delivered across the organisation through Nursing Associate and Preceptorship training programmes. Two day-long sessions were provided to ED reception teams and similar sessions are being planned for the Acute Medical Unit and Audiology teams. Further customer-focussed education was provided through the harm-free study programme and the personalisation module on the nursing degree programme at Birmingham City University. Seven sessions entitled 'Putting the Patient First' have now been scheduled for 2025 which will accommodate 140 colleagues. These sessions will be evaluated for further roll out.

Study days, available to all colleagues, have taken place to support how staff can adjust practice to meet individual diverse needs. These have included a focus on vulnerable people, personalisation and end-of-life. These have been well attended and positively received. The vulnerabilities day was used to launch the Oliver McGowan training and included Paula McGowan as a keynote speaker. The end-of-life event included a focus on local cultural needs for end-of-life care for patients and their families. A recent mental health needs event discussed stigmatisation and how acute healthcare staff can best care for people with mental health needs.

Education around the wider use of video interpreting has commenced and includes British Sign Language (BSL) as an online and on-demand service to support the BSL community.

The senior nursing leadership team has worked across disciplines to implement standardisation of handover information in the clinical setting. This work will continue across areas in 2025/26 and become refined through the PDSA (Plan, Do, Study, Act) improvement cycle.

Following ongoing carer support work, a carer passport trial is under implementation, and this will be developed across the organisation and tailored to suit areas such as maternity and paediatrics. We will further support patients, carers and relatives with wayfinding and information with the implementation of digital signage across our Trust sites and will increase provision of video interpreting.

Carer support work has been refined. The 'Essential Companions Access Card' has been developed and is now available across SWB wards and clinics. 'Getting to Know Me' boards have been created to support personalised care and are ready for implementation across MMUH inpatient areas.

The '#CallMe' project provides a clear and easy way of patients indicating their preferred name to our staff. Initial development has taken place and delivery plans will continue in the year ahead.

We are recruiting to a SWB Patient and Public Voice Group, to facilitate ongoing dialogue with our local population. Patients can become further involved into the day-to-day workings of the organisation and continue to support ongoing work in personalised care, food, nutrition and hydration. We will continue to capture and utilise lived experiences of care through storytelling to be used in educational settings to improve the care we provide.

Priority three

Midland Metropolitan University Hospital (MMUH) – Safe move and opening

We are proud of the successful and safe move of our patients into MMUH. No patient harm was caused by the move. The moves took place over three days through October and November 2024 following 18 months of meticulous planning through the MMUH Move Group. We worked closely with our move partners, Health Care Relocations (HCR) as well as our neighbouring Trusts and transport teams including West Midlands Ambulance Service (WMAS), Kids Intensive Care and Decision Support (KIDS) and Adult Critical Care Transfer Service (ACCOTS). In preparation we simulated 'mock moves' and 'patient census' which prepared our teams involved in the move to the new hospital.

In addition, we carried out in-depth reviews of 41 critical life and limb patient flows and carried out in situ simulation for 15 of these scenarios to ensure the care pathways could be safely implemented when MMUH opened. No incidents have been reported from our 41 predetermined critical patients flows.

Our patient census work ensured we only moved patients that were acutely unwell from our hospital sites into MMUH with other patients moving into community beds and end of life patients being transferred to their place of choice. Virtual ward utilisation increased during this period and the census team played a key role, working with teams to discharge patients safely to their homes. We did not see any increase in readmission post move.

Our Emergency Department access target has improved, and we have recorded some of the best turnaround times in the region. Activity in Same Day Emergency Care has increased which has had a positive effect on the number of patients requiring emergency admission.

The impact of 50% side rooms during the flu season has prevented ward closures which we have seen in previous years.

Primary Care

General Practice

Our Trust Vision continues to be the most integrated healthcare provider in the country. With this in mind we have continued to build relationships with our local GP community to build sustainable solutions to shared problems and improve the health of our patients. This has included working together on the delivery of the NHSE Recovering Access to GP actions and setting up wider interface groups to identify areas to work on together in 2025/26 such as Wound Care, Diabetes and Frailty.

Throughout 2024/25 our own practices have delivered another year of high performance against the local commissioning and national quality frameworks (Quality and Outcomes Framework and Primary Care Commissioning Framework). This work is important to maintain the health of our patients but especially impactful at reducing admissions to our acute beds.

The work Your Health Partnership (YHP) undertook with their staff and patients has led to a change of Access system. This has really improved both staff and patient experience and has contributed to YHP receiving a CQC Good rating.

Heath Street Surgery has continued to enhance patient engagement and strengthen partnerships with third-sector organisations to provide more holistic care. In 2024/25, the surgery:

- implemented a dedicated programme focused on improving access, which resulted in a significant increase in online triage appointments and enhanced care navigation, ensuring patients were directed more efficiently to the most appropriate services.
- implemented a targeted cervical smear campaign successfully raised uptake from a regionally below-average level to above both the Integrated Care Board average and national targets.
- expanded its dedicated support area for social prescribing, enabling more patients to access non-medical assistance, including housing, employment, and financial support.
- successfully piloted a new proactive care model, integrating health coaching and peer support for patients with long-term conditions, leading to improved self-management and health outcomes.

The SWB GP footprint has allowed us to look at how we can work across the primary/secondary care interface to improve care pathways. Some of the initiatives we have implemented are below:

- Heath Street Surgery continue to work with a consultant diabetologist who has risk stratified all diabetic patients to target effective lipid interventions where they are most needed.
- YHP practice continues to provide medical and Advanced Clinical Practitioner support to the community beds at Rowley Hospital and at Harvest View.
- Linked GPs into our Trust's palliative care, rheumatology and dermatology teams, helping to manage demand in the most effective way. In the coming year we will add a second GP to focus on musculoskeletal issues.
- The three YHP GPs developing ultrasound skills in primary care continue their learning.
- The YHP Diabetic nurse team have supported the District Nursing team to better manage housebound patients with Diabetes.

The recent opening of MMUH has put a refreshed focus on the need to work together with all Primary Care colleagues, not just those where we are the contract holders. This work will continue into 2025/26, ensuring patients are seen at the most appropriate location and that colleagues understand all the community-based services that can help support our patients.

Over the past few years, relationships and processes between primary and secondary care teams (which includes acute secondary, maternity, mental health and community care) have become more fragmented. There are many reasons for this, including overall system delivery pressures and organisational structures that have not encouraged collaboration and problem-solving at a clinical level. To address this, we have set up an Interface Work Programme to improve processes, reduce bureaucracy for Primary Care at our service interface and take the opportunity to work together on specific pathways such as the current project on Improving Wound Care which is led by our Deputy Chief Medical Officer for Integration and Pathways and Primary Care leaders from both Sandwell and West Birmingham.

Pictured are members of the district nursing team who have been working collaborative on a diabetes improvement project with GPs at Your Health Partnership.

What we want to achieve for 2025/26

Service development

As part of long-term NHS planning there will be a renewed focus on Primary care and prevention, and we must be ready to respond to this. The work we have done in the Locality Hubs in West Birmingham puts us in a good position to move forward.

Improve interface between primary and secondary care

As we expand the number of patients we provide care for we will look for new opportunities to further improve the interface of primary and secondary care to enable us to work more effectively to deliver systematic change and build on the work that has already been implemented in diabetes, rheumatology and dermatology. Our aim is to improve the interaction of primary/secondary care clinicians to share responsibility for a patient in a collaborative rather than a transactional way as we are doing with the MDT discussions at City Hospital to expedite discharges.

Happier patients, happier staff and improved access

Heath Street aims to further develop its social prescribing offer by embedding a dedicated care navigator within the team to streamline patient access to community-based support. Additionally, Heath Street plans to build on its existing digital initiatives, improving remote access for vulnerable patient groups while maintaining continuity of care.

YHP will continue to roll out their new access model, aiming to make continual improvements. The next focus is on improving telephone response times, whilst continuing to promote the digital points of access.

Primary Care (Palliative and end of life care)

We are working with partner organisations within the Sandwell Health and Care Partnership to improve the quality of experience of patients living and dying with a palliative diagnosis across Sandwell. Work has been ongoing to deliver the actions identified by the partnership quality improvement project.

Key achievements over the last 12 months include:

- Working with Primary Care colleagues to improve communication between services and early identification of patients who are in their last 12 months of life to ensure they receive appropriate support.
- Delivering a comprehensive teaching webinar programme for Primary Care.
- Securing funding for representatives from all partner organisations to attend Compassionate Communities training with the aim of achieving the standards for Sandwell.
- Development of Palliative and End of Life Care Champions within Community Nursing teams who work to share best practice and improve skills and confidence of the community nursing workforce.
- Delivering a training plan to the whole workforce that includes Syringe driver training and verification of death training.
- Continued conversations with our patients, families and members of the public to gain feedback on their experience of end-of-life care and bereavement.
- Bereavement information available to support people who are bereaved.

Areas for continued focus for improvement:

- Consistency in approach to end-of-life care across Partners.
- Earlier recognition of dying.
- Utilisation of care planning in community services.
- Shared care records / sharing of information.
- Access to end-of-life data.

Over the next 12 months the project group will prioritise the delivery of the following actions:

- Continue with the delivery of a comprehensive programme of education and training for community staff to improve workforce skills and confidence to identify and communicate with patients in their last year of life.
- Ensuring bereavement resources are accessible and readily available at the time of need.
- Working towards achieving Compassionate Community status.
- Working with Primary Care to ensure continued improvement in the early identification of individuals at end of life.
- Working with colleagues across the Black Country system to implement Shared Care Records.

Positive progress has been made, but a number of challenges remain which includes improving the end-of-life pathway for children and young people, data sharing across organisations and consolidating data into one dashboard, so it is easy to access to evidence project progress. We will continue to work on this project with partner organisations through 2025/26.

Fundamentals of Care (FoC)

We have successfully completed 16 projects with positive outcomes following the launch of the Fundamentals of Care (FoC) Year One MMUH Readiness, aligned with our vision of 'To be good or outstanding in everything we do.' The projects were successfully delivered to ensure we were ready to move safely into the Midland Metropolitan University Hospital (MMUH).

These projects focused directly on relevant standards, with each project being delivered under executive oversight through a rigorous reporting governance for assurance against delivery and impact. Several workshops and engagement events with staff and patients informed new ways of working at MMUH such as Medicine Management, the patients Rhythm of The Day (RoTD) and Personalisation of Patient Care.

Of the 16 MMUH FoC projects two were significant Transformational Projects.

- End to end digital medication administration known as Omnicell to reduce the number of patient drug administration incidents and to reduce medication wastage.
- Scan4Safety: How we manage 'stock' in our clinical areas so that we can reduce wastage and importantly to ensure we have the right products for our patients at the right time through timely electronic stock management.

Both these largescale projects will have a significant impact on overall Patient Quality.

Our focus has been on standardisation at MMUH whilst ensuring personalised care is maintained. This is achieved through the Multidisciplinary Team (MDT) and other key stakeholders working together to establish a 'Rhythm of the Day' (RoTD) for patients. This has created a structured approach that promotes patient wellbeing, supports effective care delivery, ensures smooth ward operations and address the physical, mental, and emotional needs of patients without conflicting with personalisation.

We are now in a better position to track and monitor quality of care through our Digital FoC Dashboard which maps daily touchpoints of care and interventions. Through the next year we can develop and utilise as a quality dashboard to enhance the focus on patient-centred care, operational efficiency, and continuous improvement, ultimately enhancing overall healthcare experience and outcomes. This is motivating staff by providing clear feedback on performance. It enables teams to track improvements over time and fosters a culture of continuous improvement.

Care Quality Commission

There have been five focused inspections by the CQC in the 2024/25 period;

- Emergency Department at Sandwell General Hospital
- Mental Health focused visit for Emergency Department
- Maternity at City Hospital
- Your Health Partnership GP Practice
- Great Bridge GP Practice.

Regular meetings have been held throughout the year to ensure that a constructive relationship is maintained and any concerns or queries from either organisation may be addressed in a timely manner. We are also part of a CQC Engagement pilot which commenced January 2025.

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 specific trusts.

As part of our business-as-usual approach to continuous monitoring and improvement, and in readiness for CQC inspections, we continue to undertake regular unannounced safety and quality improvement visits to every service. A programme of unannounced in-house inspections has been in place for four and a half years as part of our commitment to making continuous improvement to ensure that patients receive high quality care across all parts of our 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.

We are in the process of re-visiting our self-assessment exercise in line with the three other provider organisations within the Black Country system. This is to enable learning to be shared across the system and this will be repeated twice yearly in March and September. The process involves the gathering of evidence which will be triangulated with other data sources to support compliance and self-rating against each of the CQC's Quality Statements and contains an Improvement Plan for each Core Service. This is being monitored at the Black Country Acute Provider Collaborative Executive Board.

We have successfully registered Midland Metropolitan University Hospital as our new location prior to opening in November 2024 and deregistered some activities at the City & Sandwell Health Campuses to reflect the care and services we now provide on those sites.

Our 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. As part of a Maternity Inspection, we were served with a Section 29a and ratings for Maternity changed from Good to Requires Improvement. The actions from the Section 29a have been completed and a rating re-inspection is awaited.

Sandwell and West Birmingham Hospitals NHS Trust

Inspection report

City Hospital
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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**

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 Integrated Quality and Performance Report (IQPR) which in turn feeds our Board Level Metrics.
- The Secondary User Service (SUS) 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 Group 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 auditor
- Data Security & Protection Toolkit annual assessment is an internal self-assessment used to monitor data quality standards.

Hospital Episode Statistics

Our Trust submitted inpatient and outpatient records during April 2024 – December 2024 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data below.

	Admitted Patient Care			Outpatient		
	Invalid	**Total**	**%**	**Invalid**	**Total**	**%**
NHS Number	301	85435	**99.65%**	1022	997156	**99.90%**
GP Practice	0	85435	**100.00%**	1678	997156	**99.83%**

Source: CDS DQ Dashboard (APC, OP) Link: Microsoft Power BI

The Trust submitted Emergency Care Dataset (ECDS) records during April 2024 – February 2024 which are included in the latest published data below.

	Emergency Department - NHS Number			Emergency Department - GP Practice		
Dept Type	**Invalid**	**Total**	**%**	**Invalid**	**Total**	**%**
Type 01 – City/Sandwell ED	2442	155357	98.43%	148	155346	99.90%
Type 02 – BMEC Eye Centre	134	16777	99.20%	7	16777	99.96%
Type 03 – Urgent Treatment Centres	9039	83612	89.19%	4454	83612	94.67%
Total	11615	255746	**99.80%**	4609	255735	**99.80%**

Source: ECDS DQ Dashboard Link: Microsoft Power BI

Services provided / subcontracted

During 2024/25 we provided and/or subcontracted 46 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 2024/25 represents 100 per cent of the total income generated from the provision of NHS services by the Trust.

Some of the maternity staff inside the new department at the Midland Met.

Commissioning for Quality and Innovation (CQUINs)

A proportion of income is normally conditional on achieving quality improvement and innovation goals agreed between SWB and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. This was not a requirement for 2024/25 due to CQUIN schemes being paused nationally therefore no agreed goals were set for this period.

7 day hospital service

Following the completion of the transfer of acute services into MMUH we now operate 7-day, consultant-led acute care cover. This change has supported the continuation of improved length of stay and bed occupancy across our medical wards and provides increased consistency of senior clinical decision making whenever services are accessed.

Speaking Up

We have continued to show commitment to the Freedom to Speak Up (FTSU) agenda throughout 2024/25. The FTSU mechanisms have continued to remain aligned to our Trust strategy, People Plan and our Equality, Diversity and Inclusion (EDI) Plan, to support all colleagues to have equitable access to raising concerns. There has been change in the core leadership of FTSU, with a substantive FTSU Lead and new Executive FTSU Lead, bringing stability to the FTSU agenda.

The FTSU mechanisms continue to be unique and innovative, with having over 20 guardians supporting colleagues from a variety of backgrounds. This has been a conscious effort to support colleagues being able to have access to individuals they feel they can relate to, in turn supporting all voices to be heard.

The FTSU team led the 'Working with Our Partner Organisations' within the Black Country System to host the first collaborative Freedom to Speak Up conference. This was attended by colleagues from acute provider trusts, primary care organisations and colleagues working for the system, showing a demonstrable commitment to the FTSU agenda throughout the Black Country System.

We have reviewed our FTSU mechanisms in 2024/25 to identify gaps in our processes and actively engaged with key stakeholders throughout the organisation to gain feedback. This has led to the development of the FTSU strategy which is to be implemented over three years.

The FTSU team are sharing concerns with the five clinical directorates in addition to data being triangulated through internal multidisciplinary working groups, in doing so leading on wider organisational learning.

Our focus for 2025/26 will be

- Completing recruitment to FTSU champions roles to promote FTSU throughout the organisation.
- With colleagues in the Black Country, host a regional senior leadership event to discuss barriers to Speaking Up and how to overcome them.
- Monitoring of compliance for FTSU training module that have been included in online learning.

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 94 of these posts of which 34 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 2023 and 2024 in relation to advocacy. These results are based on staff who agreed or strongly agreed as part of the NHS Staff survey in 2023 and 2024.

NHS Staff Survey	2023	2024
Staff who would recommend the Trust as a provider of care to their family and friends	54.9%	58.6%
Staff who would recommend our organisation as a place to work	54.7%	59.2%

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

The survey measures progress and improvement against the seven elements of the NHS People Promise. This year, the results are promising, showing a rise in positive responses across most areas compared to 2023. The table below shows the scale of the improvement.

People Promise elements	2023 score	2024 score	Statistically significant change
We are compassionate and inclusive	7.03	7.13	Significantly higher
We recognised and rewarded	5.8	5.93	Significantly higher
We each have a voice that counts	6.58	6.61	Significant
We are safe and healthy	6.08	6.2	Significantly higher
We are always learning	5.31	5.44	Significant
We work flexibly	6.11	6.27	Significantly higher
We are a team	6.58	6.7	Significantly higher

Themes	2023 score	2024 score	Statistically significant change
Staff engagement	6.7	6.75	Significant
Morale	5.79	5.97	Significantly higher

As a result of these improvements, we scored above the national peer average in four of the People Promises, including 'We work Flexibly' and 'Morale.'

The results are encouraging and have been driven by the implementation and delivery of the programmes aligned to the SWB People Plan. This is in addition to the early benefits from the opening of MMUH and local improvements implemented through our People Engagement Teams. The survey has also highlighted some important improvements that we need to make for our people during 2025/26, these include:

- Ensure that all our staff have a meaningful PDR which supports them in their day-to-day work, as well as with career development, health, and wellbeing.
- Continuing to support team development by prioritising the roll out of the ARC (Ambition, Respect and Compassion) Team Effectiveness programme to those who require it the most.
- Rolling out Module 2 of the ARC leadership programme to support leadership development.
- Strengthen the provision of core people management skills for line managers through a collaborative approach with Dudley Group NHS Foundation Trust.
- Continue to develop our health and wellbeing support through implementation of our health and wellbeing plan priority workstreams.
- Recognise the major service contribution of our staff. We will celebrate the service and contributions of our colleagues by relaunching our long service awards programme.
- Strengthen the support, coverage and impact of the Staff Inclusion Network Leads to identify actions required to improve the diversity and equality elements of the survey aligned to our Equality, Diversity, and Inclusion priorities.

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 27th June 2025.

The Trust overall risk assurance rating is 'Moderate' for all 10 data standards.

In September 2024, the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and Information Governance assurance.

- There 47 Questions split into 5 chapters
- Achieved 18 = 38%, Partially achieved 23 = 49% and Not achieved 6 = 13%
- As there is an expectation that some Trusts will not achieve all requirements, this means that this version of the DSPT requires two years to complete.

The deadline for publishing the 2024/25 DSPT is 30th June 2025.

Staff working at Midland Met within the Maternity Department.

General Data Protection Regulation (GDPR)

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 leads on actions to make improvements.

Complaints and PALS (Patient Advisory Liaison Service)

During the financial year 2024/25, our Trust received 680 complaints, compared to 769 in 2023/24. A key improvement this year has been the continued decrease in complaints as more concerns were effectively resolved through PALS, following its transfer to the complaints portfolio. This proactive approach has enabled earlier intervention and better resolution at the first point of contact.

Themes of Complaints

The top four complaint themes in 2024/25 differed from previous years, focusing on:

- Clinical treatment (e.g., delays, misdiagnoses, treatment concerns)
- Communication (e.g., lack of updates, unclear explanations, discharge concerns)
- Values and behaviours (e.g., attitude of staff, breach of confidentiality)
- Patient care (e.g., concerns about dignity, pain management, personal care)

Theme	2024/25	2023/24
Clinical Treatment	226 (33%)	211 (27%)
Communication	97 (14%)	141 (18%)
Values and Behaviours	82 (12%)	113 (15%)
Patient Care	110 (16%)	67 (9%)

Patient Advice and Liaison Service (PALS)

The PALS service handled 2605 concerns in 2024/25, compared to 2,115 in 2023/24. The integration of PALS into the complaint's portfolio has allowed for better coordination in managing patient concerns, leading to quicker resolutions and a reduction in the escalation of issues to formal complaints.

With the move to MMUH, the introduction of a patient-facing office has significantly improved accessibility to PALS, making it easier for patients and families to seek support in person. This change has contributed to an increase in early resolution of concerns.

Compliments

Throughout the year, 652 compliments were recorded by ward and clinic staff and the Patient Experience team. This reflects the ongoing commitment of teams across the Trust to delivering positive patient experiences.

Management of Change and Team Structure

Integration of Teams: A key development in 2024/25 has been the merging of the PALS function with the Complaints team under the umbrella of the Patient Experience team. This integration has created a more cohesive and patient-focused approach, enabling:

- A single, streamlined service for patient feedback, concerns, and complaints.
- Better collaboration with clinical teams to implement improvements based on patient feedback.
- A stronger focus on learning from complaints and concerns to drive service enhancements.

We also continued to refine our complaints management processes, ensuring timely responses and improved communication with complainants. However, challenges remain, particularly in addressing complaint themes related to clinical treatment and staff behaviours, which require ongoing training and service improvements.

Move to the Midlands Metropolitan University Hospital

The transition to the new hospital has provided an improved environment for patient engagement, particularly through the establishment of the patient-facing Patient Experience office. This has:

- Increased visibility and accessibility of the team.
- Enabled more direct, face-to-face interactions with patients and families.
- Helped resolve concerns more quickly and efficiently.

These changes have been positively received, with feedback indicating that patients and relatives value the opportunity for in-person discussions about their concerns.

To enhance our services, we have implemented several key changes:

- Policy Enhancement: We have revised our PALS and Complaints Policy to align with the Parliamentary and Health Service Ombudsman NHS Complaints Standards, NHS Complaints Policy, CQC Regulation 16.1 Acting and receiving Complaints and Legislation 2009 aiming to improve patient experience when contacting our services.
- Enhanced Accessibility: We have rolled out a web-based platform for tracking complaints, providing more detailed departmental information for easier tracking by groups and staff across our Trust.
- Reporting Systems: New reporting systems have been developed to closely monitor PALS and Complaints themes, facilitating proactive interventions and improvements.
- Learning and Improvement: We have implemented a 'Learning on One Page' initiative, detailing actions to improve services Trust-wide for all formal complaints, ensuring continuous learning and service enhancements.

Future Developments

We are committed to the following future developments:

Strengthening early resolution and reducing complaints

- Enhancing PALS responsiveness to resolve concerns at an early stage, further reducing the escalation of issues into formal complaints.
- Introducing a real-time patient feedback mechanism via digital platforms to enable faster intervention before concerns escalate.
- Expanding the Patient Experience Team's accessibility.

Improving complaints handling and response times

- Streamlining complaints triage processes to ensure urgent cases are prioritised more effectively.
- Implementing a complaints response dashboard to monitor case progress in real-time, reducing delays and ensuring timely updates for patients.

Embedding learning from complaints and PALS concerns

- Strengthening the 'Learning on One Page' initiative, ensuring every complaint results in clear and measurable service improvements.
- Enhancing feedback loops between PALS/Complaints and clinical teams to ensure learning is embedded in day-to-day practice.
- Developing a thematic learning framework, focusing on high-volume complaint areas (eg clinical treatment, staff communication).
- Ensuring PALS and complaints training includes real-life complaint case studies, with frontline staff participating in reflective learning sessions.

Expanding the use of digital and data-driven solutions

- Enhancing automated reporting tools to identify trends in complaints and concerns more efficiently, allowing for proactive interventions.
- Integrating complaints and PALS data into Trust-wide dashboards to ensure senior leaders have visibility of key issues.

Enhancing staff training and culture change

- Embedding customer service and communication training for all frontline staff.
- Ensuring senior leadership engagement by embedding complaints learning in divisional governance meetings and executive briefings.

Policy and structural developments

- Conducting an annual review of the Complaints and PALS Policy, ensuring alignment with best practices and national standards.
- Strengthening collaboration with external partners (e.g., Healthwatch, local advocacy services) to support independent resolution and patient voice initiatives.
- Exploring further integration opportunities between PALS, Complaints, and patient experience team to ensure a seamless patient support structure.

By continuing to focus on learning, accessibility, and early resolution, we aim to further enhance patient experience and confidence in our services.

Incident reporting

A positive safety culture remains essential for the delivery of high-quality care. As part of the NHS Patient Safety Strategy, the NHS transitioned to the Learning from Patient Safety Events (LFPSE) system in December 2023. This replaced the previous National Reporting and Learning System (NRLS) and is a central system for collating incident data and identifying national trends. There has continued to be development of this portal over the last 12 months and national reporting will resume in 2025/26.

SWB had the challenge of launching the new Patient Safety Incident Response Framework (PSIRF) from 1st April 2024, alongside the preparation activities required to successfully and safely open MMUH. The patient safety team worked tirelessly to promote the new framework and ways of reporting and reviewing incidents to frontline staff who have all been receptive and enthusiastic about the changing methodology. The team visited physical SWB sites and put on virtual sessions to support staff during the transition to PSIRF. The team also gave substantial support to the MMUH teams, proactively identifying potential Patient Safety concerns, including the review of clinical pathways and physical environments.

The move to PSIRF has seen a shift in how incidents are investigated, and trends of incidents are identified and reviewed. Serious Incident investigations are no longer completed, having been replaced by Patient Safety Incident Investigations (PSII's). However, there has been a change in the criteria to categorise the level of investigation, with more flexibility being afforded to deciding what level is required. This means that incidents that may have been a lower level of harm, but a greater amount of potential learning points identified in initial debriefs can be investigated in closer detail than the previous framework. If a trend of a particular type of incident or a particular environment is identified, this can also have a thematic review undertaken to reduce the likelihood of further harm being caused. This approach is already being shown to be beneficial for our clinical teams.

The below table includes those incidents reported as a PSII, including those cases reported to the MNSI which were accepted for investigation.

2024/25	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of PSII's (by date reported as PSII)	0	1	1	1	3	2	0	3	0	6	1	0

Never events

Never events are incidents that are considered 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 2024/25 two never events were reported. One case was due to a mis-selection of high dose midazolam for procedural sedation. The other case was due to a wrong site nerve block for pain relief of a neck of femur fracture. Both cases were reported as Patient Safety Incident Investigations and investigated as part of standard procedures.

Safety Alerts highlighting the learning to staff were disseminated Trust Wide via the SWB communications bulletin, the monthly Patient Safety Newsletter and discussed at the monthly Patient Safety Oversight Meeting.

Emergency access standards

In line with the national standard, we aim to ensure that 78% of patients will wait for no more than four hours within our Emergency Departments (ED).

2024/25 Emergency Access Standards

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
70.7	69.9	70.2	70.1	71.0	69.7	72.3	72.0	71.6	74.4	73.5	75.0

In 2024/25 on average, we achieved 71.6%. This is an increase from 2023/24 (69.4%) and has benefitted from improved length of stay and bed occupancy prior to and after moving to the Midland Metropolitan University Hospital. We have positively improved flow through the hospital and therefore improved access times in the Emergency Department.

Community and acute services are vital to our on-going improvement, and we are focused on optimising interventions such as Virtual Wards, Medical Same Day Emergency Care (MSDEC) and our Frailty pathways. We continue to deliver on our Urgent and Emergency Care Improvement Plan, which focuses on care closer to home, care navigation, Quality Standards and outflow.

Urgent and Emergency Care performance is an organisational priority for the year ahead to improve access and quality of care for our patients which will be demonstrated in our delivery for 2025/26.

Patient Reported Outcome Measures (PROMs)

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

The following table shows the percentage of patients reporting an improvement in their health status following the procedure and the average adjusted health gain achieved compared against the average for England. This data covers the financial year 2023/24.

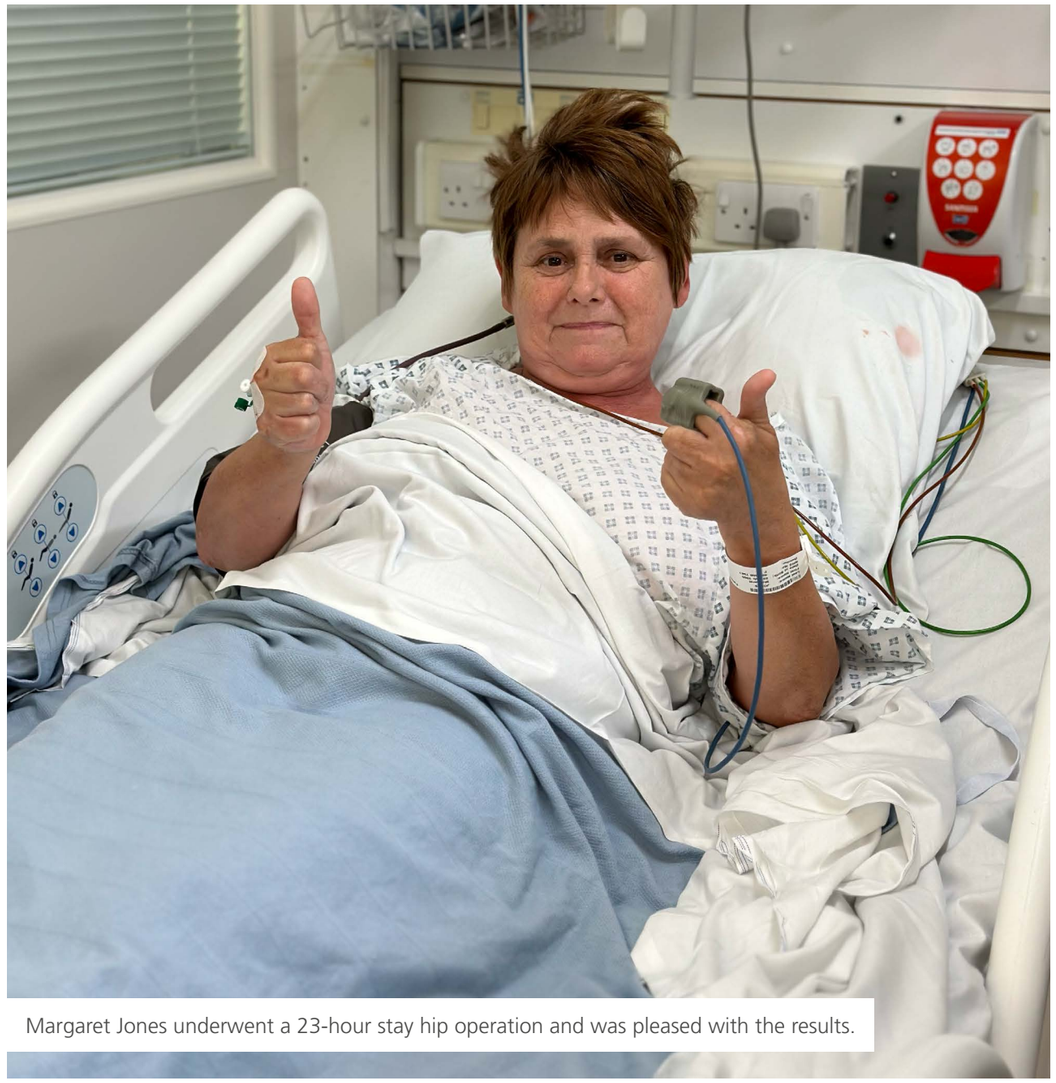
April 2023 - March 2024

Procedure	Organisation	Average Pre-op Q Score	Average Post-op Q score	Health Gain	Improved	Adjusted Average post-op Q Score	Adjusted average Health Gain
Total Hip replacement	SWB	0.26	0.736	0.47	47 92.2%	0.78	0.469
	National	0.318	0.77	0.453	12,491 88.8%	0.77	0.453
Total Hip replacement	SWB	0.3483	0.58	0.24	65 72.3%	0.65	0.241
	National	0.411	0.734	0.323	13,777 80.9%	0.734	0.323

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

The data for 2023/2024 shows that the reported outcome for the average health gain for hip and knee replacements are below national average. However, when adjusted, the health gain for hip replacements is above national average, but the knee replacements still remain below. This is in line with previous years. Data shows that only 72.3% of our knee replacement patients saw an improvement in their PROMs Q score between pre and post operation. However, 92.2% of patients improved with total hip replacements, this is an increase on last year's data. It is also worth noting that the uptake of the questionnaires and return rate has been low (n=111) meaning our data is not a true reflection of the whole population that received hip and knee surgery.

The PROMS working group for SWB has been looking into the implementation of a new PROMS collection and monitoring system across the trust. A clinician backed software programme (Open Outcomes) has been sourced and has been implemented in the Trauma and Orthopaedics and Pain Management teams with the intention to rollout wider across the Trust. Our aim is to digitalise communication methods to replace the traditional paper return forms. This we believe will increase response rates to provide a more accurate representation of our adjusted health gain scores.



Margaret Jones underwent a 23-hour stay hip operation and was pleased with the results.

How we performed in 2024/25 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2013/24	2024/25	Comments
Cancer – 2 week GP referral to first outpatient	%	=>93	94.2	93.2	Full Year
Cancer – 2 week GP referral to first outpatient (breast symptoms)	%	=>93	99.5	97.7	Full Year
Cancer – 31 day diagnosis to treatment all cancers	%	=>96	94.2	89.1	Full Year
Cancer – 62 day wait for first treatment from NHS Cancer Screening Service referral	%	=>90	90.4	88.7	Full Year
Emergency Care – 4 hour waits	%	=>95	69.4	71.6	Full Year
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92	52.0	53.5	Full Year

Outcome Metrics	Measure	Target	2013/24	2024/25	Comments
MRSA Bacteraemia	No	0	1	5	Full Year
Never Events	No	0	0	2	Up to end Jan 2025
WHO Safer Surgery Checklist 3 sections (% patients where all sections complete. Main theatres only)	%	=>100	99.9	100.0	Full Year
VTE Risk assessments (adult IP)	%	=>95	96.1	96.9	Full Year

Clinical Quality and Outcome	Measure	Target	2013/24	2024/25	Comments
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	89.2	84.3	Up to end Dec 2024
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	64.4	59.5	Up to end Dec 2024
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50	85.5	88.3	Up to end Dec 2024
Stroke care – Admission to Thrombolysis Time (% within 60 minutes)	%	=>85	65.9	75.5	Up to end Dec 2024
TIA Treatment within 24 hours from receipt of referral	%		98.7	96.7	Up to end Dec 2024
MRSA screening elective	%	=>95	72.4	66.3	Full Year
MRSA screening non elective	%	=>95	80.8	77.3	Full Year

Patient Experience	Measure	Target	2013/24	2024/25	Comments
Primary angioplasty (Call to balloon time 150 mins)	%	=>80	86.1	90.8	Full Year
Primary angioplasty (Door to balloon time 90 mins)	%	=>80	91.4	88.0	Full Year

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 the Chief Nursing Officer, who has Board level responsibility for IPC and chairs the Infection Control Committee. Our Trust declares compliance with all 10 sections of the Hygiene Code. Compliance with the Hygiene Code continues to be monitored at the Infection Control Committee.

What we said we would do in 2024/25

- Ensure IPC is at the forefront of final works at MMUH prior to the opening and for the safe transfer of patients to the new site, minimising risk of healthcare associated infection
- Ensure that MMUH has infection prevention and control enshrined into clinical practice and business as usual from the outset
- Continue to participate in local workstreams including with the Black Country Integrated Care Board to tackle healthcare associated infections including C. difficile
- Continue to implement the revised process for the identification and investigation of surgical site infections and expand on the types of surgery investigated
- Further improve the screening process for Carbapenemase producing Enterobacteriaceae including revised screening questions
- Continue with a planned programme of peer review audit using Tendable®

What we achieved

- The Trust successfully opened the new Midland Metropolitan University Hospital in late 2024. The provision of 50% side rooms has meant that any patient with a suspected or known infection can be placed in a single room with ensuite, thus minimising any risk of spread of infection. The new hospital has a mechanical ventilation system that is compliant with current building standards. This means that for any ward area, there are a minimum of six air changes per hour, and any airborne infection is therefore quickly dissipated and removed. In open bays of four patients, the bed spaces are also compliant with current healthcare building guidance meaning the increased space between patients also reduces infection transmission risk. The fabric of the new building is also easier to clean effectively compared to our older estate. Experience during early 2025 has indicated that outbreaks of infection such as influenza have reduced compared to previous years
- Part of the opening of MMUH has seen the introduction of new IPC posters on all side room doors. This enables our staff to quickly identify the correct Personal Protective Equipment required to enter the room and care for the patient depending on the nature of infection. These posters also indicate which waste stream is required to ensure that healthcare waste generated is disposed of correctly.
- We have invested in new environmental decontamination facilities using UVC light which can be used in single rooms once a patient with a known infection has left. This ensures the room is thoroughly clean and is decontaminated prior to use by another patient
- We have improved screening for Carbapenemase producing Enterobacteriaceae (CPE) for Neonates that transfer in from another Neonatal Unit. This helps to control any spread of CPE which are highly antibiotic-resistant bacteria
- We have continued to work on improving the process for identification of surgical site infection and have refined the process of data collection to identify surgical site infection in elective hip and knee replacement surgery
- The Infection Prevention & Control section of the Trust Tendable® audit system has been updated to reflect the NHS England standard infection control precautions monitoring tool. A particular focus has been added in relation to segregation and management of waste in clinical areas

NHS England Infection Prevention & Control inspection

Our Trust underwent NHS IPC inspections on 5th March and 12th August 2024. Principal actions related to Emergency Pathways which required replacement of damaged trolley mattresses and a process to ensure that trolley mattresses are regularly checked and replaced where necessary. Our Trust retained its 'green' status on the NHS England IPC matrix.

Mandatory reportable organisms (figures April 24 - Jan 25)

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. Cases have been near trajectory for these organisms with the exception of Clostridioides difficile which was significantly above trajectory. This is a similar position when compared to other Black Country acute trusts and reflects an increase in cases nationally.

Organism	NHSE set target	Reported cases
MRSA bacteraemia (post 48 hours admission)	0	5
C. difficile toxin	52	85
E. coli bacteraemia	70	70
Klebsiella bacteraemia	19	20
Pseudomonas aeruginosa bacteraemia	10	10

Clostridioides difficile

We have undertaken a deep dive exercise looking at Clostridioides difficile. It would appear most cases are an unfortunate consequence of necessary antibiotic therapy and are not due to cross infection. We have an action plan to reduce the consumption of antibiotics known to trigger the infection and replace them with lower risk antibiotics where antibiotic therapy is required. We are also working with other Black Country partners looking at the prescribing of antibiotics both in hospital and community to ascertain if there are further actions that could be put in place to help reduce the incidence of Clostridioides difficile.

What we want to achieve for 2025/26

- Work with Black Country partners to address the increased incidence of Clostridioides difficile to ascertain what additional actions could be taken to reduce numbers of cases, with a particular focus on antimicrobial stewardship.
- Further refine the process for the surveillance of surgical site infection to improve accuracy of data collection and learning from cases of surgical site infection.
- Focus on waste management and improve the segregation of waste at the point of disposal in clinical areas.
- Focus on the infection prevention basics of hand hygiene and dress code, ensuring that staff perform hand hygiene in accordance with the established '5 moments of hand hygiene' and are compliant with local uniform and dress code standards expected.

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.

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 2024/25 is 96.9%

2024/25 VTE Compliance %

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.5	96.4	96.0	96.8	97.1	96.8	97.2	96.7	95.9	97.0	95.5	95.1

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

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

- Standardise VTE prophylaxis practices for Arthroplasty.
- Review of VTE guidelines.
- Ensure Hospital acquired thrombosis are reported appropriately.

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 Readmissions	Percentage of Readmissions
4 - 15			
2024/25 (Apr-Feb)	4341	247	5.60%
2023/24	4038	274	6.79%
16+			
2024/25 (Apr-Feb)	63011	4091	6.49%
2023/24	65610	4484	6.83%
All ages			
2024/25 (Apr-Feb)	67352	4338	6.44%
2023/24	69648	4758	6.83%

The data in the table shows a reduction in our adult and paediatric readmission rates. There has been positive improvement particularly for paediatric patients.

We continue to focus on reducing readmissions and through the pathway redesign work for MMUH we have improved our Urgent and Emergency Care patient journeys. For both paediatrics and adults, we are continuing to optimise our community admission avoidance initiatives, Virtual Wards, Same Day Emergency Care services, hospital length of stay, and facilitated discharge.

We expect to continue the trend of improving our readmission rates and remain below the national average. To support this, we have extensive services we are continuing to develop that provide support to patients when they are discharged from hospital and provide on-going care where required.

Safeguarding and vulnerable adults

The Safeguarding and Vulnerable Adult Service has undergone a service review. The outcome of this review has introduced a new structure and leadership model. This is a response to identified learning from statutory reviews, serious incidents and complaints. The introduction of an Associate Director of Safeguarding to oversee the team has seen a more robust governance approach.

The team consists of a Head of Adult Safeguarding, Head of Mental Health and Learning Disabilities, Senior Adult Safeguarding Nurse, Senior Learning Disability Nurse with funded full time substantive posts for a Safeguarding Nurse, Mental health registered Dementia Nurse, Learning Disability Nurse and a full-time administrative support post.

During the past year the team have continued to focus on assessment of mental capacity, deprivation of liberty, best interest process and patient advocacy. The Dementia Liaison Nurse has focused on improving practise in our elderly care wards raising awareness of associated screening, working with digital teams to integrate fields in electronic patient care.

The Learning Disabilities Nurses have reviewed and updated Trust pathways and policies, with a focus on patients that did not attend or were consistently not brought to appointments. Strengthened community relations with Learning Disability Services contributed to structured judgement reviews and shared learning from Learning Disability and Mortality (LeDeR) reviews. We have participated in the National Learning Disability Standards audit. All safeguarding and vulnerable adult activity have work plans to continue to close identified gaps and improve patient experience.

The team are working closely with the Patient Experience Team to improve vulnerable adult pathways and improve personalised care planning. This includes 'Getting to Know Me' and 'All About Me' posters, providing detailed information about our service users with cognitive impairments, allowing staff to deliver better quality care.

The team have provided input into several work streams and training in Dementia, Learning Disabilities, Mental Capacity and Safeguarding and are visible and provide operational support to frontline colleagues.

We continue to work closely with Sandwell and Birmingham multi agency safeguarding boards, ICB and partners and are building relations with charities in the third sector. We are 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.

Safeguarding children

Keeping children safe remains an important priority for the Trust and 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 children professionals who offer safeguarding training, advice, support, and supervision to Trust employees to enable them to fulfil their safeguarding responsibilities and duties on a wide range of safeguarding issues affecting the unborn, babies, children and young people and their families and carers.

This team incorporates the Children We Care For service (previously known as Children in Care) consisting of a specialist nursing team to meet the health needs of the Sandwell children we care for.

A Named Midwife for Safeguarding Children commenced in post in Autumn 2024. The role provides focused oversight of safeguarding arrangements within maternity services and will offer support, supervision and practice development for the maternity workforce.

The workstream of Domestic Abuse has evolved with priorities led by Independent Domestic Violence Advocates who offer support to identified affected patients who present through emergency department and the wider Trust, with safety planning and sign posting to community support services.

Progress towards achieving a Trust wide approach of All Age Safeguarding has commenced with an integrated and co- located Safeguarding Children and Vulnerable Adults 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.

During the year 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 its corporate responsibilities in relation to safeguarding children. This, combined with our learning from serious incidents and child safeguarding practice reviews has led to a focus on childhood neglect, serious youth violence and exploitation as recognised themes and sought to ensure that the voices of children are sought, heard and responded to.

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 compliance against statutory safeguarding standards. The past year has seen the development of a revised safeguarding governance structure and an embedded process of self-assessment of safeguarding standards.

Throughout 2024/25 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 Group, chaired by the Chief Nursing Officer, where safeguarding concerns and risks are discussed and reviewed. Membership includes Designated Nurses from Black Country Integrated Care Board (BCICB) 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 the Trust Executive Quality Group to ensure senior executives are fully sighted on key safeguarding developments, priorities and any challenges faced during the year.

A refreshed workplan for 2025/26 has been approved and the team look forward to building on last year's work to further embed quality assurance and innovation around safeguarding practices within the Trust.

Learning from deaths (LfD)

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 2024/25, 1253 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: 316 deaths in Q1, 272 deaths in Q2, 333 deaths in Q3 and 332 in Q4.

Of the 1253 deaths reported during 2024/25, 1253 (100%) underwent a tier one mortality review by medical examiners. This equated to 316 reviews in Q1, 272 in Q2, 333 in Q3 and 332 in Q4. Of these, 132 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, 36 cases in Q2, 30 in Q3 and 32 in Q4.

Of the cases which received further scrutiny, 7 cases (representing 0.6 per cent of all patient deaths during 2024/25) were 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: 4 patient deaths representing 1.27 per cent of the patient deaths for Q1, 1 patient death representing 0.37 per cent of the patient deaths for Q2, 1 patient deaths representing 0.3 per cent of the patient deaths for Q3 and 1 patient death representing 0.3 per cent of the patient deaths for Q4.

2024-25

	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
Total Inpatient spells	24,271	24,417	24,268	24,630
Total deaths	316	272	333	332
Avoidable deaths	4	1	1	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, to an average of 90% in 2024/25. All comments are analysed and fed back to the caring team for review/action.

Next of Kin Contact 2024/25

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
89%	91%	89%	90%	92%	87%	89%	95%	90%	88%	93%	96%

Statutory System September 2024/Community roll out

Since September 2024, the Medical Examiner service across the NHS in England and Wales has become a statutory process supported by legislation. It is now mandatory to review all non-coronial deaths in both primary and secondary care. Alongside our aim to review 100% of inpatient deaths within our Trust, we are now working with 47 GP Practices/Groups in our area and reviewing all non-coronial deaths in Sandwell before the MCCD is completed and sent to the Registrar.

Mortality Indices - Standardised Hospital-Level Mortality Indices (SHMI)

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 12-month cumulative SHMI figure based of Hospital Episode Statistics (HES) data that is linked to the Office of National Statistics (ONS) (Figure 1). The SHMI reported in February 2025 (reporting period up to October 2024) is 103.05.

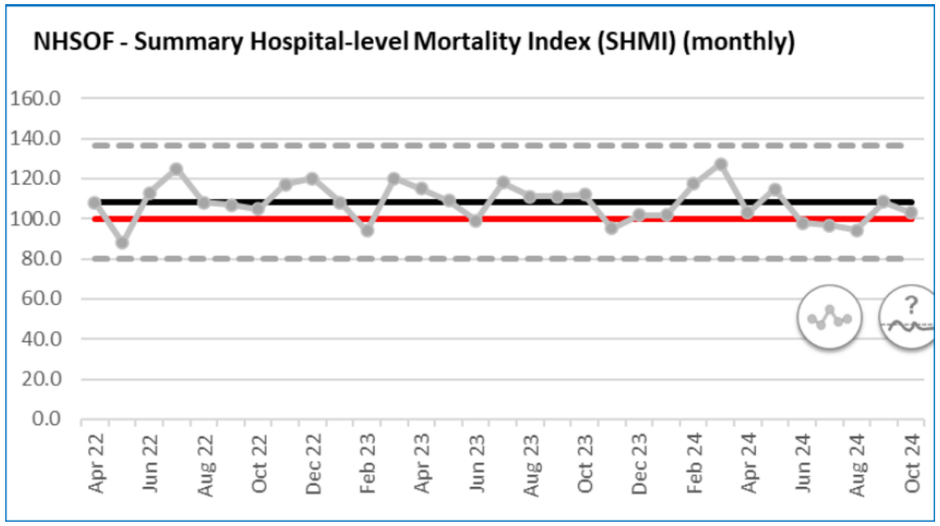


Figure 1: 12-month cumulative SHMI (HES-ONS linked dataset)

Strategies to improve SMHI include:

- **Dissemination of information:** in 2024/25 the Learning from Deaths Team have reviewed their mechanisms of sharing information to ensure findings from LfD are reaching the right audiences to further trust wide learning and improvement. This has involved: reviewing attendance lists to ensure involvement of relevant stakeholders, what data and narrative is included in monthly reports to the Governance Groups, newly established regular report into the PSIRF Oversight Group meeting and continuing to look at methods for sharing findings from completed SJRs and mortality meetings.
- **Factors influencing SHMI for SWB and Peers:** This year, the SWB LfD team have reached out to peer trusts to gain a better understanding from other trusts at different stages of their SHMI journey, what have been the biggest contributing factors to poor SHMI and what changes have been most successful in improving SHMI. These conversations have provided helpful intelligence about the different resources available across the trusts, and how this influences LfD functions and SHMI. It has also provided inspiration for potential change ideas to enable us to improve our SHMI in 2025/26.
- **Policy review:** In 2024 we welcomed a new Deputy Chief Medical Officer for Quality & Safety who is also our Trust Lead for Mortality, as well as a new Learning from Deaths Facilitator. This timing has worked well with the upcoming review date for the SWB Learning from Deaths Policy (end of March 2025) and has presented an opportunity to review our processes within the LfD service. Potential opportunities have been identified, particularly when reflecting on conversations with peer trusts, to create more effective service delivery that strengthens learning, ownership of improvement and confirmation of assurance. Conversations with key stakeholders have been ongoing to establish which of the proposals for change are feasible. Long term more effective and efficient LfD functions will enable us to better understand and improve our SHMI.
- **Thematic analysis of SJRs:** This year we have reviewed our methodology for thematic reviews to make it possible to complete more of these with the limited resources available. The annual thematic review was completed in Q3 and in Q4 there has been a spotlight thematic analysis on deaths of patients with Learning Disability. Enabling our team to complete more thematic reviews makes the information within SJRs more accessible and provides a new lens to scrutinising our data to identify specific areas that require improvement.

Sue Edwards is our bereavement lead nurse at the Trust who supports relatives of patients.

Specialty Reviews

To provide clinical assurance, the Learning from Deaths Group asks each specialty to review their deaths routinely and report into the Group to share key learnings and actions taken. In 2024/25 the following specialties presented an overview of their SJRs, key learning points and what action they have taken in response.

Specialty	Month of presentation
Acute Medicine	June 2024 & March 2025
Toxicology	July 2024 & January 2025
Cardiology	October 2024
Elderly Care	September 2024
Haematology	November 2024
Respiratory Care	November 2024
Stroke	September 2024
Trauma and Orthopaedic	March 2025
Vulnerable Adults/Learning Disability	September 2024 & January 2025
Gynaecology and Gynae-Oncology	April 2024
Neonates	September 2024
Paediatrics	December 2024
Palliative Care	July 2024

Trust wide Quality improvement projects developed as a result of mortality reviews include

- **Coding and Pneumonia:** The impact of clinical documentation and subsequent coding on SWB SHMI has been acknowledged frequently over the years. This year, it has also been recognised that we consistently have more "observed" than "expected" deaths of patients with a Pneumonia coding, therefore creating a consistently high SHMI for Pneumonia. Based on the Pareto Principle, it has been agreed that focusing resources to tackle these two most frequently occurring areas of concern, is a logical approach to making a significant impact on our SHMI using the limited resources available.

  a. The Trust Lead for pneumonia is completing an investigation of our pneumonia deaths contributing to the high SHMI to identify any gaps in clinical management. A "pneumonia bundle" has been developed within our electronic patient record system to standardise clinical management of pneumonia. This bundle will enable SWB to bring care in line with ICB standards and can serve as an audit tool to identify areas for further improvements.

  b. The Trust Lead for Pneumonia has worked closely with the SWB Coding Manager as part of completing a deep dive into the data behind our high pneumonia SHMI. As a result, a hypothesis has been developed that a significant contributory factor to our high pneumonia SHMI, and trust wide high SHMI, is the impact of "first consultant episodes" (FCEs) on the SHMI calculation. There are ongoing discussions to explore ways of standardising data submission and opportunities to resubmit data.

- **Deteriorating patient:** The Deteriorating Patient Steering Group has been established. There are three main focuses at this point; Infrastructure (staffing, resources, policy and SOPs), Dashboard of local data and Unity Optimisation (documentation and visibility of deterioration indicators). It has been clarified that these things alone will not "move the dial" for deteriorating patient but they will provide a solid foundation for further improvement. The aim of the Deteriorating Patient Group is to provide steer and accountability for all key stakeholders that empowers smaller working groups to progress improvement across the trust. Going forward Learning from Deaths is a key stakeholder in this monthly meeting and supports the collation of information from governance sources, as well as continuing to monitor mortality data. Early recognition of and appropriate action in response to deterioration is expected to have a positive impact on SHMI in the long term (fewer deaths from treatable conditions) as well as improving overall patient care and experience.

- **End of Life Quality Improvement Project:** The National Audit of Care at End of Life has relaunched this year. The End of Life Care team are aiming to improve compliance with NACEL standards through their Continuous Quality Improvement Project. Following the launch of their trust wide mandatory e-learning package on end of life care, one area the team are now focused on is encouraging conversations about preferred place of death, as our local data indicates significant opportunities to reduce the number of inpatient deaths by supporting patients to pass away in their preferred location outside of hospital. The team are also working to improve the number of Support Care Plans and Treatment Escalation Plans developed for patients early on in their journey, so patients have adequate support and management in the dying phase. This is likely to result in improved clinical care of patients in the dying phase and improved patient and family experience.

SHMI Alerts:

In 2024/25 we have changed our approach to managing and investigating SHMI Alerts to better optimise learning opportunities and ownership of actions. The Trust receives a pre-warning of diagnostic groups where we may have more deaths than expected. Further investigation is undertaken to identify reasons for the alerts, and learning and actions that can be taken:

Diagnostic group reviewed	Review Period	Investigations
Hepatitis, Viral infection, other infections including parasitic, sexually transmitted infections (not HIV or hepatitis) and immunizations and screening for infectious diseases	January 23 – Sept 2024 (Recurrent Alerts)	Following investigation of the cases triggering this alert, it's been identified that there is a high number of "B99X" codes, ("unspecified infection"). This significantly increases the number of "observed" deaths in this category compared to the "expected" deaths, therefore resulting in high SHMI. The cases with "B99X" codes are sent to the Coding team for learning and to explore if there are options to update and resubmit the coding.
Urinary tract infections	March 23 – July 2024 (Recurrent alerts)	Initial analysis of the data behind this alert was able to rule out that documentation and coding were not significant factors influencing SHMI. It was agreed to continue to monitor, if further recurrent alerts were issued, specific cases would be selected for a deep dive into the clinical data. However, further alerts were not issued after the analysis was completed.
Skin and subcutaneous tissue infections	June 23 – Sept 2024 (Recurrent alerts)	Following a review of cases triggering recurrent alerts in 2023/24, findings were presented to Learning form Deaths in 2024/25. This review was completed through a community care lens and identified multiple areas of learning for community partners. Since this presentation there have been more recurrent alerts, which are being investigated through an Acute Medicine lens to identify if there is any further learning directly applicable to SWB.

Diagnostic group reviewed	Review Period	Investigations
Other inflammatory condition of skin, Chronic ulcer of skin, other skin disorders	Jan 23 – Dec 23 and Oct 23 – Sept 24 (2 alerts)	The cases triggering this alert will be investigated by the Lead Nurse for Tissue Viability.
Short gestation; low birth weight; and fetal growth retardation	Jan 23 – Dec 23, March 23 – Feb 24 and June 23 – July 2024 (recurrent alerts)	The Patient Safety Team have been working with the service following the identification of concerns relating to this mortality alert through incidents reported. The data from these mortality alerts have been fed into that work, so that patient safety, learning form deaths and the clinical service can work collaboratively going forward to identify opportunities for learning and improvement.
Gout and other crystal arthropathies, Rheumatoid arthritis and related disease, Osteoarthritis, Acquired foot deformities, Other acquired deformities, Systemic lupus erythematosus and connective tissue disorders.	July 2023 – June 24	The cases triggering this alert will be investigated by the Acute Medical and Rheumatology Teams. Lessons learnt to be shared with Quality Committee in Q1.
Cancer of pancreas	July 2023 – June 24	The cases triggering this alert will be investigated by the Upper Gastrointestinal Team and lessons learnt to be shared with Quality Committee in Q1.
Intestinal obstruction without hernia	Sept 23 – Sept 24 (2 alerts)	The cases triggering this alert will be investigated by the general surgery team and lessons learnt will be share with the Quality Committee in Q2.
Nutritional deficiencies, disorders of lipid metabolism, other nutritional endocrine and metabolic disorders	Nov 23 – Oct 24	The cases triggering this alert will be sent to an Endocrinologist for investigation and identification of learning.
Phlebitis, thrombophlebitis and thromboembolism, varicose veins, haemorrhoids, other diseases of veins and lymphatics	Dec 23 – Nov 24	As this condition does not typically cause death, the Learning from deaths facilitator has reached out to HED and the SWB Coding team to gain insight into why this category is triggering an alert. A provisional look at the data indicates that only 2 cases related to patients who had a cause of death relating to this category, indicating that a greater understanding of the Coding is needed, rather than highlighting genuine concerns about clinical practice.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2024/25 that were recruited to participate in research approved by a research ethics committee was 4806. 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 90 studies were open for participation across 19 specialties at SWB. Of these seven are commercially sponsored/funded and 2% percent of recruits are from the commercial portfolio. This is a 58% increase on last year. This year has also seen an increase in the areas of research in which we are active including: Trauma & orthopaedics, surgery, Musculoskeletal (MSK) and Critical Care.

We have delivered on numerous deliverables that were set out in Year one of our Research Strategy 'Improving Lives Through Research'. Such deliverables included: hosting more training events, submission of more grant applications, developing and embedding interactive reporting mechanisms, and analysing community and people information to ensure services and projects are tailored to our population's needs.

A Research Exemplar Framework for departments has been developed providing an internal accreditation system with awards in three tiers bronze, silver and gold. This is on track to be launched in the new financial year.

This year has seen the launch of our Community of Practice events. These events are hosted virtually and consist of an expert talk and sharing of practice, experiences and a Q&A element. These are open across the organisation and have been well attended with positive feedback. Staff of all levels and experience have attended with attendees proposing topics for future events.

This year we have invested a further £350,000 in research fellowships with more applications being submitted for nationally competitive funding. One fellowship in collaboration with University of South Wales, and the National Poisons team has resulted in grant submissions in excess of £2m, and three awards (internal, regional and national), as well as several publications.

A suite of interactive reports has been developed to cover all key aspects of R&D service delivery including: set up, delivery, finances, and quality assurance. This has resulted in regional and national recognition and further investment from the West Midlands Clinical Research Network (WM CRN) to develop the reports across the Black Country Provider Collaborative. It is anticipated that this will be further disseminated and utilised across the West Midlands Research Delivery Network providers.

This year saw the department host its first undergraduate physiotherapy student formative placement with the University of Wolverhampton, specifically for research. The students undertook their own research project with supervision to enable review and development of validated tools to assess research skills. This will be submitted for publication and will form the basis of Trust wide research skills assessment as part of the wider Research Strategy.

Numerous patient events have been undertaken successfully including a 'Thank you' event for those who had participated in research at SWB. Current participants have spoken at regional celebration events, sharing their experiences of research at the Trust, and are actively seeking opportunities to promote and celebrate the opportunities in research, within their own communities. Posts for members of the public have been developed on a voluntary basis to ensure better engagement and input from our communities into the services and projects offered.

Multiple joint events have been held including a staff research poster event and awards. This saw more than 50 submissions from SWB and Dudley Group Hospitals, further strengthening the partnerships and collaborations across the organisations. A Black Country Provider celebration event was successful with more events planned in the next financial year.

Participation in clinical audits

During 2024/25, 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 that were paused by the provider) we participated in 94 per cent national clinical audits and 100 per cent national confidential enquiries.

The following table outlines:

- Column 1: The national clinical audits and national confidential enquiries that Sandwell and West Birmingham NHS Trust were eligible to participate in during 2024/25.

- Column 2: The national clinical audits and national confidential enquiries that we participated in during 2024/25.
- Column 3: The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2024/25, 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.

Provider and Title	Are we participating in this?	Case ascertainment (1% cases submitted)
British Hernia Society Registry	TBC	N/A
British Society for Rheumatology - National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100%
Healthcare Quality Improvement Partnership (HQIP) - National Joint Registry (NJR)	Yes	78%
Intensive Care National Audit & Research Centre (ICNARC) - Case Mix Programme (CMP)	Yes	100%
Intensive Care National Audit & Research Centre (ICNARC) - National Cardiac Arrest Audit (NCAA)	Yes	<33%
King's College London - Sentinel Stroke National Audit Programme (SSNAP)	Yes	>90%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Managing acute illness people with learning disability	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Child Health Clinical Outcome Review Programme – End of Life Care	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Blood sodium	Yes	20%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Emergency Paediatric Surgery	Yes	29%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Juvenile Idiopathic Arthritis	Yes	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Rehabilitation following critical illness	Yes	100%
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	>90%
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	>90%
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	90% >90%
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	>90%
NHS Benchmarking Network - National Audit of Cardiovascular Disease Prevention in Primary Care	Yes	100%
NHS Benchmarking Network - National Audit of Care at the End of Life (NACEL)	Yes	100%
NHS Blood and Transplant - National Comparative Audit of Blood Transfusion: Audit of Blood Transfusion against NICE Quality Standard 138	No	0%
NHS Blood and Transplant - National Comparative Audit of Blood Transfusion: Bedside Transfusion Audit	No	0%
NHS Digital - Breast and Cosmetic Implant Registry	Yes	100%
NHS Digital - National Diabetes Audit (NDA) – Diabetes Prevention Programme (DPP) Audit	Yes	100%
NHS Digital - National Diabetes Audit (NDA) - National Diabetes Core Audit Partial return from Secondary care	Yes Yes	100% from Primary care 100%
NHS Digital - National Diabetes Audit (NDA) - National diabetes Footcare Audit (NDFA)	Yes	100%
NHS Digital - National Diabetes Audit (NDA) - National Diabetes Inpatient Safety Audit (NDISA)	Yes	100%
NHS Digital - National Diabetes Audit (NDA) - National Pregnancy in Diabetes Audit (NPID)	Yes	100%
NHS Digital - National Diabetes Audit (NDA) – Transition (adolescents and young adults) and young type 1	Yes	100%
NHS England - Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	100%
NHS England – National Major Trauma Registry (NMTR)	No	0%
Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA)	Yes	>90%
Royal College of Anaesthetists - Perioperative Quality Improvement Programme (PQIP)	Yes	16 cases
Royal College of Emergency Medicine (RCEM) - Emergency Medicine QIPs: Care of Older People	Yes	100% (92 cases)
Royal College of Emergency Medicine (RCEM) - Emergency Medicine QIPs: Time critical medications	Yes	96 cases
Royal College of Emergency Medicine (RCEM) – Emergency Medicine QIPs: Adolescent mental health	Data collection postponed by provider	Data collection postponed by provider
Royal College of Obstetrics and Gynaecologists - National Maternity and Perinatal Audit (NMPA)	Yes	100%
Royal College of Ophthalmologists (RCOphth) - National Ophthalmology Database (NOD) Audit - National Cataract Audit	Yes	100%
Royal College of Paediatrics and Child Health - Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Royal College of Paediatrics and Child Health - National Neonatal Audit Programme (NNAP)	Yes	100%
Royal College of Paediatrics and Child Health - National Paediatric Diabetes Audit (NPDA)	Yes	100%
Royal College of Physicians - Falls and Fragility Fracture audit Programme (FFFAP): Fracture liaison Service Database (FLS-DB)	No	0%
Royal College of Physicians - Falls and Fragility Fracture audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Yes	100%
Royal College of Physicians - Falls and Fragility Fracture audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	76%
Royal College of Physicians - National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	>90%
Royal College of Physicians - National Asthma and COPD Audit Programme (NACAP): Children and Young people's Asthma Secondary Care	Yes	>90%

Provider and Title	Are we participating in this?	Case ascertainment (1% cases submitted)
Royal College of Physicians - National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	>90%
Royal College of Physicians - National Asthma and COPD Audit Programme (NACAP): Pulmonary Rehabilitation	Yes	100%
Royal College of Psychiatrists - National Audit of Dementia: Care in general hospitals	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre (NATCAN) – National Kidney Cancer Audit	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre (NATCAN) – National Ovarian Cancer Audit	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre (NATCAN) - National Bowel Cancer Audit (NBOCA)	Yes	100%
Royal College of Surgeons of England (RCS) - National Lung Cancer Audit (NLCA)	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre (NATCAN) - National Audit of Metastatic Breast Cancer	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre (NATCAN) - National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre (NATCAN) - National Prostate Cancer Audit (NPCA)	Yes	100%
Serious Hazard of Transfusion (SHOT) - Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine - Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	50%
The British Association of Urological Surgeons (BAUS) - ELLA	Yes	66%
The British Association of Urological Surgeons (BAUS) – Penile Fracture Audit	Yes	100%
Univeristy of Bristol - National Child Mortality Database (NCMD)	Yes	100%
University of Oxford / MBRACEUK collaborative - Maternal, Newborn and Infant Clinical Outcome Review Programme: - Annual topic based serious maternal morbidity	Yes	100%
University of Oxford / MBRACEUK collaborative - Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality confidential enquiries	Yes	100%
University of Oxford / MBRACEUK collaborative - Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance	Yes	100%
University of Oxford / MBRACEUK collaborative - Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality and serious morbidity confidential enquiry	Yes	100%
University of Oxford / MBRACEUK collaborative - Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	Yes	100%
University of Oxford / MBRACEUK collaborative - Perinatal Mortality Review Tool (PMRT)	Yes	100%
University of York - National Audit of Cardiac Rehabilitation	Yes	>95%

Of the 6 percent of National Audits with no participation in 2024/25:

National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standard QS138 and National Comparative Audit of Blood Transfusion - Bedside Transfusion Audit: The blood transfusion nurses were unable to participate in this national audit due to the time intensive methodology. The team have agreed that a more effective use of time is to focus resources on supporting other national audits (i.e. SHOT), embedding the new SWBH Transfusion policy and delivering local training and support to improve practice trust wide.

National Major Trauma Registry (NMTR) (previously TARN): Following a cyber-attack in 2023, TARN stopped running nationally. In 2024, NHS England relaunched the audit as the National Major Trauma Registry, however, it has been recognised nationally that, due to the length of time TARN wasn't running, many trusts are now seeing reduced resources to participate, as the previous resources were reallocated during the TARN down time. This is the situation that has prevented SWB participation in NMTR in 2024/25 – The Governance Support Unit (GSU) used to provide the bulk of data collection for TARN, however during the period of TARN not running, they have seen a significant increase in subject access requests (SARs), therefore resources had to be reallocated. We are working to getting participation re-established for 2025/26, by reviewing resources available in GSU, Clinical Effectiveness and the Emergency Department team.

Falls and Fragility Fracture Audit Programme (FFFAP) - FLS-DB: The service was recovering from the pandemic in 2022/23 which impacted data collection for 2022/23. An electronic template has been developed to support data collection going forward, however, due to clinical capacity, the clinics were not processing patients that fit into the cohort for financial year 2023/24. In 2024/25 we have seen ongoing barriers to reinstating participation as the final developments on the electronic patient record have not yet been completed, therefore the capacity issues within the clinical team have meant they have been unable to submit data.

The Frailty team.

Local Quality Improvements in response to Local Clinical Audit Findings

The reports of 49 national clinical audits and confidential enquiries were reviewed in 2024/25 and Sandwell and West Birmingham NHS Trust intends to take several improvements forward to improve across various domains some of which are described in the following table.

National Audit	Quality Improvement Activity
FFFAP - Fracture Liaison Service Database 2024 State of the Nation report (891)	We are still working to reinstate the service. During COVID osteoporosis clinics moved to iCares which uses SystemOne The IT team have understood the requirements and are working on implementing a system to allow identification of eligible cases and submit to NA platform. IT to implement a system to allow identification of eligible cases and submit to NA platform. The proforma was utilised to produce templates and they have been discussed with IT. In the meantime the IT team will create templates on System One to capture the required information.
MBRRACE Saving Lives, Improving Mothers Care Report: Data for 2020-22	The use of the Pregnancy Unique Quantification of Emesis (PUQE) is being written into the local clinical guideline to support pregnant people presenting with nausea and vomiting. Local clinical guidelines are also being reviewed to promote consultation with the medical team on appropriate imaging and interventions in pregnancy and include the national guidance on recognising pregnancy (Human Chorionic Gonadotropin) as a cause of sudden cardiac arrest. Patient information leaflets are being reviewed to provide more information to pregnant people about the signs of ectopic pregnancy. The Multidisciplinary training will also include specific reference to the use of closed-loop communication.
National Hip Fracture Database	As the service had received outlier notifications for the 30-day case-mix adjusted mortality score at various points in the data collection period, the team had already put actions in place to improve future compliance by the time the annual report was published. The team have reviewed their processes for ring-fencing theatre lists and fractured neck of femur beds, to improve patient outcomes and flow. They also engaged with an external review by British Orthopaedic Association to review their clinical pathways and data collection processes to identify further opportunities for improvement.
National confidential Enquiry into Patient outcomes and Death (NCEPOS) study on Endometriosis	As part of becoming a specialist centre for Endometriosis, this national audit confirmed that the majority of our practice meets national standards. The team continue to review and improve patient information leaflets and the consent process.
Epilepsy12 State of the nation report 2021-2023	While the recommendations from this publication were not directly relevant to SWB, the Epilepsy team at SWB are continuing to work on their non-participation outlier notification action plan. As part of this the team regularly discuss cases in their multidisciplinary team meeting to identified opportunities to improve patient identification and data collection processes. The team have also developed a template for clinic letters to improve data standardisation.
National Emergency Laparotomy Audit (NELA)	The team are in the process of implementing an EMLAP pathway and care bundle onto unity, which triggers alerts in ED to speed up referrals to General Surgery specifically for EMLAP patients. The team have implemented a CT specific scan code and protocol for EMLAP patients following a change in national guidance. The team are currently taking a multidisciplinary approach to identify and improve standards around access to ICU care, including increased incident reporting.
National Child Mortality Database – Asthma and Anaphylaxis Thematic report	Although the majority of recommendations are not aimed at NHS providers, we have identified multiple things we can take forward to improve care and patient outcomes. The Allergy team will inquire as to housing situations and provide appropriate letters of support where damp or mould is identified as an issue. The team have developed a standardised template for this letter than can be used by the whole team. Regular reviews of practice against our "Was Not Brought" policy will be completed to identify improvement opportunities in the process for escalating to the safeguarding team. The team continue to complete regular inhaler reviews as well as training for patients and families on recognition and management of anaphylaxis.
Sentinel Stroke National Audit Programme:	SWB has seen an increase in compliance for this national audit, which is largely due to ongoing improved collaboration with therapy and physiotherapy teams, and improved documentation. The team have reviewed several processes to further improve the stroke pathway. There are daily meetings to review patients and ongoing efforts with the Emergency Department and the bed management team to improve flow. There have been improvements in IT out of hours, as it was identified that most thrombolytic breeches occurred out of hours due to various technical issues. The team has also changed their process to ensure that senior medical staff are present to review thrombolysis decisions.
National Ovarian Cancer Audit	The team ran a targeted educational event and created a vlog/educational video to improve education in Primary care. March is the Ovarian Cancer Awareness Month in which GP surgeries focused on patient education. A Grand Round focused on Ovarian cancer was completed in April 2025 to improve education in Secondary care. The team continue to review their fast-track pathways for patients with ascites and blue-light pathology assessment to establish an expedited pathway as per national recommendations.

Local Quality Improvements in response to Local Clinical Audit Findings

At the time of writing, a total of 139 local clinical audits have been completed by our People at Sandwell and West Birmingham NHS Trust in 2024/25 with a further 207 local clinical audits still ongoing. The following table lists some of the Quality Improvements implemented or to be progressed following these audits, in line with the 'Model for Improvement' approach of implementing Plan Do Study Act Cycles.

Patient education and Management of Post Stroke Fatigue	This audit, conducted by the Stroke team, looked at the assessment of and communication with patients about post stroke fatigue (PSF) prior to discharge following a stroke. Poor compliance with all standards identified multiple areas for improvement. The team increased awareness of PSF in the department to promote discussions with patients. The Fatigue Severity Scale (FSS) has been introduced to standardise the assessment of PSF. Assessment of PSF has been included in the process for discharging stroke patients.
Assessing Adherence to NICE Guidelines in the Prescribing of Dupilumab for Moderate to Severe Atopic Dermatitis	An audit completed by the Dermatology team, identified opportunities to improve our compliance with NICE standards for Prescribing Dupilumab for atopic dermatitis. The team developed and implemented a prescribing tool, as well as completing an awareness programme about NICE guidance as the proper documentation for atopic dermatitis using standardised tools.
Assessing use of SPICT, SCP and Anticipatory Medication in End of Life Care on Elderly Care wards	The Elderly Care team measured their activity against NICE QS144 and standards from the National Audit for Care at End of Life and Getting It Right First Time. Following the results they launched an awareness campaign, also identifying "EOLC champions" from the next Resident Doctor Cohort. They established dedicated teaching sessions for Elderly care Staff about the completion of SPICT/SPC and now have regular multidisciplinary meetings to identify patients who require an SPC, something which has been supported by the development of a Unity report to identify eligible patients.

Trauma QIP	Following an audit of the trauma alert protocol and its effectiveness at ensuring attendance of relevant specialty teams, the Emergency Medicine team agreed to update the Major Trauma SOP to allow for a more standardised approach to collecting trauma data and resulting in effective referrals.
EAC referrals	This audit and QIP resulted in the action to improve the EAC referral form, therefore making the start of the pathway more effective. The team also agreed an action to collaborate with Primary care to improve the communication that supports the pathway.
Are fracture clinics aligned with BOAST guidance that patient information leaflets are provided for common injuries	This audit identified that there was a gap in providing sufficient information to patients. The action from this was to develop an appropriate patient information leaflet for use going forward.
How can we optimise our recall rate for the Very High Risk NHS Breast Screening cohort?	The team found that they are over-recalling very high risk patients, so to tackle this they will be using kinetic curves regularly to aid interpretation of MRI breast scans and taking a consensus approach involving 2-3 peers to confirm the need to recall patient.
Evaluation of Head and Neck Cancer waiting times for Diagnosis and treatment	The team found poor compliance with the number of people being diagnosed within the 28th day target so implemented "one stop clinics" which increased compliance with this target by 32%. The team will continue to hold one-stop clinics and compare pre and post clinic data to further evidence positive outcomes.
Discharge Summary Quality Improvement Audit for neck of femur fracture patients	The audit completed at the start of this quality improvement project identified poor compliance with selection of anaesthesia, cognitive function, physiotherapy and rehabilitation plans and discharge facility inclusion in the discharge summaries for NOF fracture. The team have now developed a standardised template that has been circulated to improve quality of orthopaedic-specific discharge documentation, therefore having a positive impact on subsequent treatment plans.
An evaluation of Rheumatology nurse run clinic at SWBH	Following this project, the team are changing their model to clearly cohort their clinics into people requiring clinical review, people requiring education and initiation, and people requiring switching medication to enable clinics to run more effectively and provide a better patient experience.
Assessment of compliance with BTS NIV guidelines in patients with Acute Type 2 Respiratory Failure (T2RF)	This audit identified opportunities to improve knowledge and awareness. The clinical team are updating the SWB clinical guidelines as well as providing training sessions to senior medical leads in the Emergency Department and Paediatrics.
Identifying reasons for non attendance of Cardiac Rehab exercise appointments	Following this audit the team have implemented a new system of rapidly up titrating exercise programmes in response to patient feedback that the sessions did not feel challenging. They are also running evening classes and female-only classes to make the sessions more accessible. The team continue to work on improving the length of time between discharge and the first cardiac rehabilitation session as this is likely to positively impact DNA rates and improve patient outcomes.
Knowledge, Attitudes, and Practices of Junior Doctors in Sandwell Emergency Department regarding Support for Adult Carers - NG150 - NICE guideline on supporting adult carers among junior doctors in the Emergency department.	This audit identified a limited familiarity with NCG 150 and failure to differentiate between adult carers and paid support workers among Resident Doctors. In response to this the team plan to include awareness of this NICE guidance in Resident Doctors training going forward, as well as developing easy-to-access resources for Resident Doctors to support the implementation of this national guidance.

Stakeholder Comments

Lead Commissioner Comments – NHS Black Country Integrated Care Board - Quality Account Statement 2024/2025

The NHS Black Country Integrated Care Board (BC ICB) states that, to the best of its knowledge, the Quality Account prepared by Sandwell and West Birmingham Hospitals Trust (SWBH) accurately reflects the work carried out by the Trust during the 2024/2025 contractual year.

The Quality Account is an annual report that provides detailed insight into the quality of services provided by SWBH, including patient safety, clinical effectiveness, and patient experience measures. The preparation of this account involves rigorous data collection, analysis, and review processes to ensure accuracy and transparency. By affirming the accuracy of this document, BC ICB supports the Trust's commitment to maintaining high standards of healthcare delivery and continuous improvement. This endorsement also highlights the collaborative efforts between healthcare entities within the Black Country region to uphold trust and accountability in public health services.

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.

The Quality Account highlights the challenges and pressures faced by the Trust during 2024/2025, including the opening of the new Midland Metropolitan University Hospital (MMUH). The significant task of planning for the new hospital and transferring clinical teams and services was managed effectively and professionally, with minimal disruption to patients and service provision. The ICB pledges its continuing support to the Trust in 2025/2026, building on the initial successes and improvements observed with the new hospital. The modern facilities and dedicated workforce will continue to enable SWBH to deliver high-quality services for the population it serves.

The Patient Safety Incident Response Framework (PSIRF) marks a change from the Serious Incident Framework (SIF) 2015, with PSIRF emphasising Learning Responses and Outcomes. During 2024/2025, the ICB has continued to support local Trusts and Independent providers with maintaining compliance with PSIRF National Guidance. The ICB continues to support PSIRF within Trusts through quarterly PSIRF workshops and will keep monitoring the progress of local PSIRF implementation via the ICB PSIRF Quality Framework. While adverse incidents should not occur, SWBH has successfully identified several learning responses and areas for improvement from such incidents. Implementing actions to address the identified areas for improvement will enhance patient safety and improve clinical effectiveness and outcomes.

During 2024/2025, we have continued to work in partnership through our Clinical Quality Review Meetings (CQRM's) with the Trust, 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 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 supportive, candid, and receptive to any areas of improvement and feedback provided.

SWBH has been working hard to strengthen its relationship with the Local Authority and local partners. BC ICB have been impressed and supportive with the work undertaken by the Trust with Primary Care, acknowledging the need to fully understand and follow in the footsteps of the patients and look at the wider health needs of our diverse community to allow faster diagnosis, better prevention and truly integrated care.

The MMUH site has a reduced bed base, compared to the combined number of beds previously available at the City Hospital and Sandwell General Hospital sites. This has meant the Trust has had to introduce new pathways, embrace technology and utilise the Trust's Community Services and Single Point of Access to maximum effect. During a recent Quality Assurance Visit, BC ICB reviewed the integrated approach of the community hub, and witnessed the passion of the staff to ensure patients receive effective care at home where possible and where clinically appropriate, prevents hospital admissions.

The ICB recognises the work undertaken regarding personalisation of care and improved communication. Frequently, incidents and complaints unfortunately refer

to miss or poor communication which have contributed to a negative patient experience or outcome. The need to ensure clear communication in handover processes and during clinical procedures is evident and the ability for patients to feel supported and to be able to communicate concerns to an effective customer service team is crucial to maximise learning opportunities. We are pleased to note the training and focus that staff have received by the programme of work and the innovative delivery of these sessions that will help staff feel engaged and enthusiastic about such a crucial part of their role.

Looking forward, BC ICB welcomes and supports the Trust's ambitions and service priorities for 2025/2026. We are particularly impressed with the Trust commitment to service development pertaining to improved primary care interface and prevention strategies. We feel confident that the Trust will continue to innovate in this area and will build on the work already undertaken in areas such as diabetes, rheumatology and dermatology. The aim for shared care delivered in a collaborative manner, meaning the patient received the right care by the right person at the right time is very much in line with the national ambitions and BCICB will fully support the Trust in this important area of work

In conclusion the BC ICB recognise that SWBH has demonstrated their commitment to quality, experience, and safety in their continual improvement journey. We thank The Trust for their hard work. We look forward to seeing the impact of the identified 2025/2026 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 City Council Health and Adult Social Care Overview and Scrutiny Committee Comments for SWB Quality Report

The SWB NHS Trust representatives provided regular updates throughout year 24/25 on progress made on getting MMUH ready for a successful opening, providing a useful timeline leading to opening of site.

The Committee received a post-opening update in February 2025 and reported that patient feedback was positive in terms of quality of care and the Children Emergency Dept, although there were concerns on noise and poor communication in the main Emergency Department.

The Transformation models were working well and the merger of the two hospitals into one acute site has been a success so far. The committee learnt that future opportunities had been identified such as the development of elective hub for delivery of surgical services in the Black Country due to begin by the end of the year.

In terms of Patient Experience at SWB, the Patient Experience Ambassadors initiative has now been established to drive forward and undertake development activities and promote positive experience. Key priority going forward were understanding data better and developing training and learning objectives to help continuous improvement towards delivering excellent patient experience.

There was also acknowledgement that efforts would be made to value carers and better support them. The Committee was keen to receive key performance indicators in a consistent basis to help measure and understand 'what good looks like', in fulfilling its statutory role on behalf of citizens within the SWB NHS Trust area.

Cllr. Fred Grindrod
Chair of the Birmingham City Council Health and Adult Social Care Overview and Scrutiny Committee

Trust response

We would like to thank our stakeholders for their valuable comments on our Quality Account for 2024/25.

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