NHS
Sandwell and
West Birmingham
NHS Trust

QUALITY ACCOUNT
2025/26

PATIENTS
PEOPLE
POPULATION

Foreword

I am pleased to introduce our Quality Account for 2025/26, which sets out how Sandwell and West Birmingham NHS Trust continues to improve the safety, quality and experience of care for the patients, families and communities we serve.

This year has been one of continued challenge for the NHS, with sustained operational pressures, workforce constraints and growing demand across all services. Against this backdrop, I am incredibly proud of the commitment and professionalism shown by our staff every day in delivering compassionate, high quality care. This Quality Account reflects both the progress we have made and the areas where we know we must go further and faster.

Throughout 2025/26, our work has remained firmly focused on our three strategic objectives for Patients, People and Population. We have seen stabilising performance across a number of key measures, including elective recovery and urgent and emergency care following our move into Midland Metropolitan University Hospital. At the same time, we recognise that performance has been mixed and that improvement is not yet consistent across all pathways. Where standards have not been met, we have been open about the challenges and have set out clear recovery actions.

Patient safety continues to be our highest priority. Over the year, we have strengthened our approach to recognising and responding to clinical deterioration, embedding Martha's Rule, improving digital observation systems, and reinforcing governance and learning through Patient Safety Incident Response Framework (PSIRF). While some safety indicators remain below our ambition, the systems and leadership in place to support improvement have developed significantly, providing a stronger foundation for the year ahead.

Listening to patients, families and carers remains central to how we improve. This year we have enhanced how feedback is gathered, shared and acted upon, with a renewed focus on communication, accessibility and personalised care. Initiatives such as "Getting to Know Me" boards, improved support for carers and the expansion of interpreting services reflect our commitment to ensuring people feel heard, understood and involved in their care.

Our staff are fundamental to delivering safe and effective services. The NHS Staff Survey results underline the very real impact that sustained pressure and organisational change have had on our workforce. While the findings highlight areas of concern, they also provide a clear mandate for action. During 2026/27, we will focus on restoring confidence, strengthening leadership, supporting wellbeing, and ensuring that staff feel listened to, valued and supported to do their best work.

This Quality Account also demonstrates our continued commitment to learning – from incidents, audits, reviews of care, and research activity – and to working in partnership across the system to improve population health and reduce inequalities. Through our Group working with Dudley Group NHS Foundation Trust and our wider system partners, we are laying important foundations for more integrated, sustainable services.

I would like to thank our staff, patients, carers and partners for their continued support, challenge and collaboration. While we are proud of the progress made during 2025/26, we are clear that there is more to do. The priorities set out in this Quality Account will guide our improvement work over the coming year as we continue to strive for consistently high quality, safe and compassionate care for everyone who relies on our services.

To the best of my knowledge, the information contained in this report is accurate.

Diane Wake, Chief Executive
Sandwell and West Birmingham NHS Trust

Front cover left to right: Rhia Desai, Principal Pharmacist, Dawn Love - Senior Learning Disability Liaison Nurse, Charlotte Horton - Learning Disability Acute Liaison Nurse and Becky - Senior Physiotherapist

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

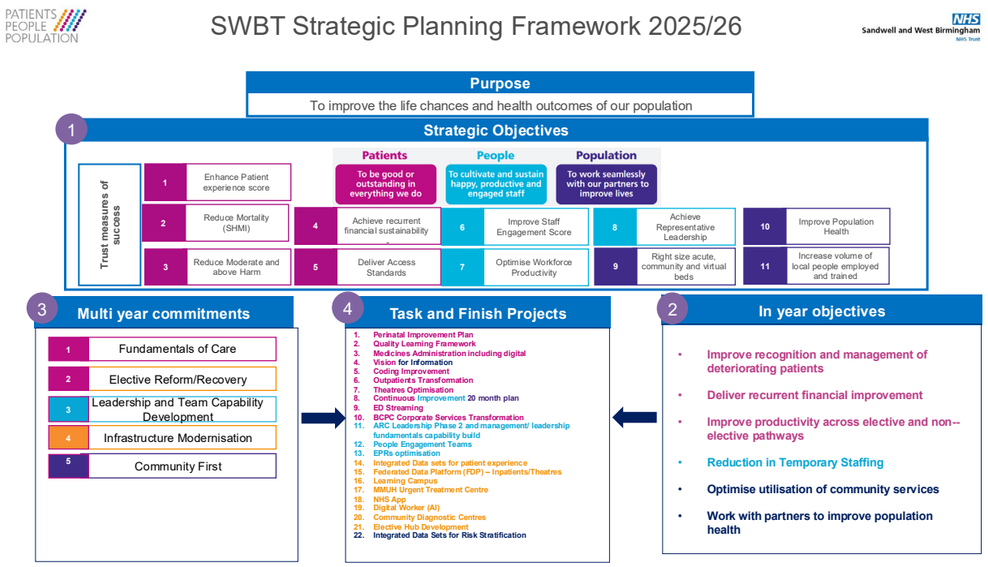
Our Trust Strategy 2022/27

Refreshed overview

In 2022, our Trust Board approved a five-year strategy, recognising that achieving our ambitions requires a clear focus on improving outcomes for our patients, supporting our workforce, and working with partners to improve population health.

Our purpose is to improve life chances and health outcomes, and our vision is to be one of the most integrated care organisations in the NHS, delivering high-quality services through strong partnership working and a commitment to continuous improvement.

Our values - Ambition, Respect and Compassion - remain at the heart of how we deliver care and will remain as we move to a Group Strategy in 2026/27 and beyond.



Our improvement system: Improving Together

Our improvement system, Improving Together, continues to underpin the way we deliver sustainable change. It supports teams to identify variation, reduce harm, improve productivity, and strengthen patient experience through consistent improvement methods and shared learning.

Our strategic objectives: **Patients**, **People**, **Population**

Our strategy is structured around our Trust's three strategic objectives:

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

Progress is measured through our Trust Success Measures and Multi-Year Commitments, aligned with the NHS Long Term Plan's three shifts:

1. Treatment to prevention
2. Hospital to community
3. Analogue to digital.

District Nurse Team Leader - Beverley Callaghan

Performance summary 2025/26 and forward look

We have continued to make progress against our strategic objectives for Patients, People and Population, while recognising the significant operational pressures experienced across the NHS.

Performance across the year has been mixed but stabilising, with early progress evident across several Trust Success Measures. Delivery in 2026/27 will build on this foundation, with continued emphasis on improving access standards, reducing avoidable harm, strengthening community pathways, and supporting our staff.

Patients – Performance highlights

Deliver access standards

We have maintained focus on improving timely access to care across elective, diagnostic, cancer and urgent pathways.

Elective recovery has continued, with Referral to Treatment Time (RTT) performance improving and now close to the year-end trajectory. However, demand pressures and specialty variation remain material, and further improvement will require sustained grip into next year.

Emergency care performance remains below the national standard, reflecting ongoing challenges in flow, discharge and system demand. Recovery actions are in place to strengthen performance through Q4 and beyond. We are also focusing on cancer pathways to improve our position.

Patient experience is key, young and old

Reduce mortality (SHMI)

Hospital-level mortality remains broadly as expected, with continued focus on strengthening recognition and response to deterioration.

A key priority this year has been improving early escalation through:

- Martha's Rule implementation
- Digital enhancement of e-Observations
- Strengthened governance via the Deteriorating Patient Safety Group.

While National Early Warning Score 2 (NEWS2) compliance remains below the required safety threshold, the underlying system to support safe escalation has strengthened significantly during the year.

Reduce moderate and above harm

Patient safety remains a core priority, supported through sustained reporting, learning and improvement. We have continued to embed the Patient Safety Incident Response Framework (PSIRF), strengthening:

- Medicines safety
- Digital safety systems
- Quality learning and governance
- Targeted harm reduction programmes.

Moderate and above harm incidents remain stable, with continued focus on prevention and improvement.

Enhance patient experience

Patient experience measures have remained broadly stable despite sustained operational pressure. Satisfaction remains close to target, while Friends and Family Test (FFT) response rates remain below ambition, highlighting the need to strengthen patient voice and engagement further. We continue to embed improvement through:

- Learning from complaints and feedback
- Service responsiveness initiatives
- Patient experience benchmarking and improvement work.

Population – performance highlights

Optimise utilisation of community services

A major focus this year has been shifting care closer to home through strengthened community pathways and virtual capacity. Virtual wards have remained consistently above the occupancy threshold, demonstrating sustained demand and effective use of community-based alternatives to admission.

As utilisation increases, our focus is shifting from establishing services to optimising:

- Flow and resilience
- Admissions avoidance pathways
- Integration with locality hubs and partners.

Improve population health

Improving population health requires prevention, partnership working, and addressing health inequalities. SWB continues to develop targeted approaches using:

- Risk stratification
- Public health insight
- Community partnership delivery.

Work is progressing to strengthen data-sharing and system collaboration to enable earlier intervention and improved outcomes for deprived and frail populations.

People – Performance highlights

Improve staff engagement score

Supporting our staff remains essential to delivering high-quality care. The 2025 survey findings reflect an intensely challenging operational and financial context and has highlighted some key areas for improvement that we need to make for our people during 2026/27. Further information on this can be found in the NHS Staff Surveys section of the account.

Optimise workforce productivity

Workforce productivity has stabilised across the year, supported by:

- Reductions in agency usage
- Improved grip on temporary staffing
- Strengthened divisional oversight.

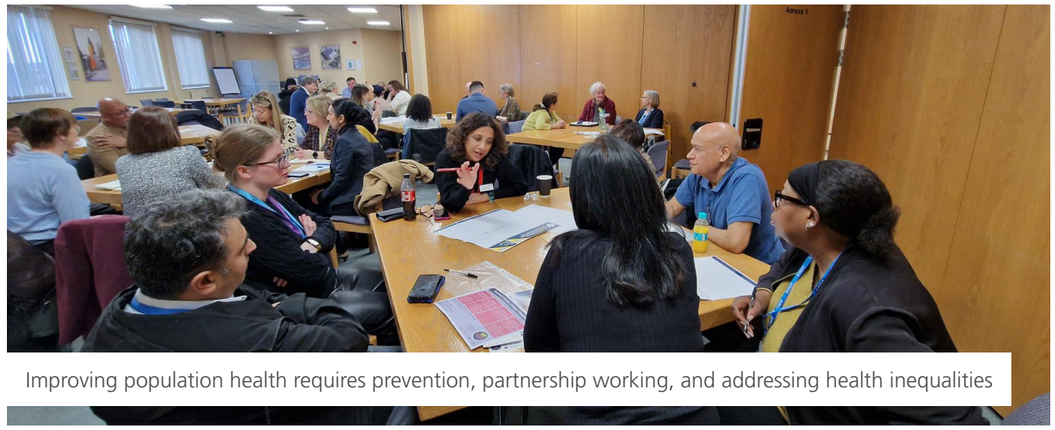
Bank staffing remains the principal driver of workforce variance, particularly in high-pressure services. Further work is underway to strengthen rostering, deployment and specialty-level productivity improvement into next year.

Achieve representative leadership

We remain committed to inclusive and representative leadership.

Key actions include:

- Targeted mentoring and development
- Talent management frameworks
- Strengthening equitable access to senior roles
- Embedding inclusion within leadership culture.



Improving population health requires prevention, partnership working, and addressing health inequalities

Priorities for Improvement in 2026/27

Priority 1

Primary / Secondary Care Interface

In 2026/27 we will build on the progress made through the co-produced Primary and Secondary Care Interface Principles to deliver a more consistent, reliable, and patient-centred interface across our system. The refreshed governance model, including our Clinical Oversight Group and strengthened Steering Group, provides the framework to accelerate this work and ensure greater shared accountability across primary and secondary care.

Our priorities for 2026/27

1. Embed the interface principles across all services

We will ensure all clinical teams understand and adopt the agreed principles covering referrals, communication, follow-up, onward referrals, discharge, patient initiated follow up (PIFU) and fit-note responsibilities. This includes incorporating the principles into induction materials, education, and routine clinical governance processes.

2. Improve the quality and timeliness of communication

We will reduce unwarranted variation in the quality of discharge summaries and clinic letters, ensuring clear accountability for actions, timely information flow, and reliable points of contact for primary care colleagues. This reflects one of the key areas of improvement highlighted through the self-assessment and Steering Group feedback.

3. Strengthen Advice & Guidance (A&G)

Working with the Integrated Care Board (ICB) and specialties, we will improve turnaround times, ensure responses are outcome-focused, and reduce administrative use of A&G, in line with national expectations. We will track quality and utilisation through our interface governance structures and contribute to system-wide maturity improvement.

4. Deliver our audit and learning programme

We will implement a proportionate audit programme across the Emergency Department, Medicine, Surgery and Outpatients to understand current practice, identify gaps, and drive improvement. This work is designed as quality improvement rather than performance management and will inform updates to the Interface Principles where needed.

5. Reduce avoidable workload transfer and improve flow - Outpatient transformation

By clarifying ownership of results, onward referrals, fit notes, and follow-up, we will aim to reduce unnecessary re-direction to primary care and improve the patient journey. This includes strengthening PIFU implementation to avoid inappropriate GP re-referral and ensuring specialists arrange investigations and referrals directly (where clinically indicated).

6. Enhance joint culture and education

We will expand our cross-sector education sessions and communication channels, ensuring clinicians have easy access to updates, points of contact and shared learning. This builds on positive engagement trends reported through the Steering Group and Primary Care Liaison function.

What success will look like

- Patients experience fewer delays, clearer instructions, and smoother transitions between care settings.
- Primary and secondary care colleagues report improved clarity, reduced duplication, and easier communication.
- A reduction in avoidable queries, inappropriate re-referrals, and administrative burden at the interface.
- Improved compliance with agreed standards for discharge summaries, clinic letters, onward referrals and PIFU.
- Clear evidence of learning and improvement from the audit programme.

Progress on the plan will be monitored through the Integration Committee.

Priority 2

Perinatal plan

In 2026/27, we will build on the progress achieved during 2025/26 to further improve perinatal outcomes, with a continued focus on safety, equity and quality of care and experience. This plan is informed by national guidance and local data, including MBRRACE-UK 2024 findings.

Nationally published data for 2024 births demonstrates a clear year-on-year improvement in key perinatal outcomes:

- The stillbirth rate (stabilised and adjusted) reduced from 3.34 per 1,000 births in 2023 to 2.95 in 2024
- Neonatal mortality reduced from 1.59 to 1.15 per 1,000 live births
- Extended perinatal mortality reduced from 4.98 to 4.10 per 1,000 births.

Whilst this demonstrates sustained progress, we are committed to going further - reducing perinatal mortality rates at pace, improving safety and experience, and addressing unwarranted variation and inequalities in outcomes.

Key Priorities for 2026/27

1. Reducing stillbirth (SB) rates

We will take a systematic approach to further reducing stillbirth rates, with the aim of achieving sustained improvement in outcomes for all women and babies. Building on the Improving Together workstream, we will:

- Deliver timely, responsive and consistent triage, ensuring that women presenting with concerns are assessed and escalated without delay
- Strengthen fetal growth surveillance and risk assessment, reducing variation in practice
- Enhance community pathways and continuity of care, supporting earlier identification and management of risk
- Improve equitable access to services, including translation and interpretation, to ensure all women receive safe and personalised care
- Ensure rapid translation of learning from reviews, including Perinatal Mortality Review Tool (PMRT), into clinical practice.

This work will be underpinned by a clear ambition to further reduce stillbirth rates year-on-year, with a particular focus on narrowing inequalities in outcomes.

2. Improving safety and quality of care and experience

We will continue to strengthen our safety culture, with a clear focus on delivering consistently high-quality care and improving clinical outcomes and experience. This will be achieved through:

- Strengthening multidisciplinary learning and accountability, ensuring that learning from incidents and reviews leads to demonstrable change
- Using data more proactively to identify variation, monitor outcomes and drive improvement
- Continuing the organisational development programme, building strong, effective teams and confident, compassionate leaders
- Involving women and families in our improvement journey.

This approach will support a culture where safety is continuously improved, and high standards of care are consistently delivered across all settings.

3. Reducing term admissions to neonatal care

We will take a proactive and system-wide approach to reducing avoidable term admissions, with the aim of keeping mothers and babies together wherever it is safe to do so. Key actions will include:

- Further developing transitional care pathways to safely manage babies without separation
- Strengthening early identification and management of risk factors across the perinatal pathway
- Improving multidisciplinary decision-making, ensuring timely and appropriate escalation
- Embedding consistent, evidence-based practice across maternity and neonatal services.

This work will support improved clinical outcomes and family experience, with a clear ambition to reduce unnecessary separation and improve neonatal outcomes.

4. Optimising induction of labour (IOL)

We will deliver a redesigned approach to induction of labour, focused on improving safety, experience and flow. This will include:

- Streamlining IOL pathways, including triage, booking and escalation processes
- Reducing delays and improving the timeliness and predictability of care
- Ensuring clear communication and personalised care planning, improving women's experience
- Using data to identify variation and drive continuous improvement.

This work will support a more efficient, responsive and woman-centred service, improving both clinical outcomes and experience.

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

Priority 3

Communication

We remain committed to delivering compassionate, inclusive and person-centred care by strengthening how we respond to the individual needs of our patients, families and carers in all care settings. Recognising that a positive healthcare experience is shaped not only by clinical outcomes but also by how safe, understood and supported individuals feel throughout their care journey. Our approach will introduce a series of targeted initiatives aimed at improving communication, accessibility and emotional wellbeing.

We are committed to using patient feedback as a key driver for continuous service improvement, gathered through conversations, surveys, compliments and complaints. We use this information to identify themes, inform staff training, adapt care delivery and improve communication.

In 2026/27, we will strengthen communication with patients, families and carers by introducing a range of targeted, inclusive initiatives designed to improve understanding, accessibility and engagement.

- Personalised and accessible communication tools will be expanded through the introduction of Communication Boxes across clinical areas, providing easy read information, visual aids and cue cards to support patients with communication needs, cognitive impairment or limited English proficiency.
- Virtual interpreting services will be implemented to improve timely access to language support, reduce delays in care and ensure patients can communicate effectively with healthcare professionals across planned and unplanned care settings.
- "Getting to Know Me" boards will be embedded across wards to support meaningful conversations, improve staff understanding of individual preferences and promote consistent, person centred communication across multidisciplinary teams. Targeted communication support for vulnerable patients will be enhanced through the introduction of Calm Bags for individuals with learning disabilities, autism or mental health conditions, helping staff communicate more effectively during periods of distress or sensory overwhelm.
- Improved communication with carers will be supported through the establishment of a dedicated Carers Hub, providing clear information, signposting and support, and reinforcing the use of the Essential Companion Access Card.
- Organisational learning and engagement will be promoted through You Matter Wednesdays, a monthly initiative that shares patient feedback, learning and improvements, reinforcing the importance of listening to and acting on the patient voice.

This work will be monitored through the Quality Committee.

Priority 4

Medicines safety

A thematic analysis of medication related incidents has identified several medicines safety themes that will be a focus of work to reduce the risk of medicines related harm to patients. Our overarching aim is to ensure that medicines related errors are reduced and safer use of medicines occurs throughout our Trust, by ensuring:

- Collaborative working with all health professionals and associated services (e.g. logistics, informatics) to ensure shared responsibility of provision of robust and sustainable systems and processes for safe and secure handling of medicines across the organisation.
- Better compliance with basic legislative standards, decreasing the risk of prescribing and administration errors caused by poor or ineffective storage and handling of all medicines, including Controlled Drugs (CD).
- Communication of up-to-date guidelines and policies to support all staff involved in medicines management across our Trust.
- Optimisation of digital medicine storage solutions to better leverage the patient safety features available.
- Adequately trained staff who are aware of the required standards of practice in relation to medicines and adopt best practice at all times to meet these standards.
- Better monitoring and display of key metrics relating to medicines safety, allowing clinical areas to review and identify issues and trends before actual harm to patients occurs.

From themes identified, there are three main areas of focus for the programme:

Optimisation of digital medicines management

- Work with Performance and Insight (P&I) to develop and produce a dashboard with appropriate Key Performance Indicators (KPIs).
- Improve Scan for Safety percentage compliance.
- Work with nursing/midwifery colleagues, Omnicell/Alphatron and Trust Informatics to optimise medicines administration workflows.
- Increase superuser numbers and knowledge to deliver local training in clinical areas.
- Work with nursing/midwifery Practice Development Nurse (PDN) colleagues to develop a more robust training process and increase percentage compliance of completion of training for all clinical staff using Omnicell/SMART carts.

Increase statutory medicines management compliance

- Work with P&I and Patient Safety to develop reporting of safety metrics and related KPIs.
- Work with all clinical colleagues to improve statutory audit results in all clinical areas for SSHM audits ensuring a robust, detailed action plan is in place with deliverable outcomes.
- Work with all clinical colleagues to improve statutory audit results in all clinical areas for CD audits ensuring a robust, detailed action plan is in place with deliverable outcomes.
- Ensure increased compliance with "red flag" statutory regulations for all CD (Schedule 1 – 5).

Increase availability of time critical medications and decrease missed doses

- Work with P&I to develop and deliver reporting metrics for delayed and missed doses of time critical medicines.
- Ensure availability of time critical medicines across all clinical areas by working with clinical and logistics teams to improve timely access across all SWB sites.
- Develop and embed clinical pharmacy support to our ED to ensure that patients on time critical medications have their medication needs addressed.
- Work with medical/prescribing colleagues in Acute and Emergency Medicine to develop training and processes to support timely prescribing of time critical medications.

Progress with this programme of work will be monitored by the Medicines Safety & Quality Group, working with the Fundamentals of Care Group. Regular updates will be sent to Quality & Safety Group, which will report to Quality Committee for overall assurance.

Progress on 2025/26 priorities

Priority 1

Improving perinatal services

During 2025/26, we have made measurable progress in delivering our priority to improve perinatal services, with focused action across the four key areas of the Perinatal Improvement Plan.

Safe and effective care

Improvements in safety and effectiveness have been driven through strengthened governance processes, enhanced risk management, and a continued focus on learning from incidents. Risks are clearly identified and managed, with the risk register reflecting current service challenges and informing mitigating actions.

A key development during the year has been the commencement of the Improving Together programme, which provides a structured approach to reducing perinatal mortality. This workstream has focused on:

- Improving triage processes to support timely assessment and escalation
- Strengthening transitional care and induction of labour pathways
- Ensuring robust processes for allocating a named community midwife to each pregnant person
- Improving access to translation and interpretation services.

Whilst elements of this work were already underway, the formalisation of this programme has enabled a more coordinated approach.

Learning from reviews and incidents has been embedded through governance forums, safety huddles and team-based discussions, supporting continuous improvement in care delivery. A CQC inspection in 2025 has noted the progress of improvement and our Safe rating has been adjusted to 'Requires Improvement'.

Workforce: Growing, retaining and developing our people

We have made clear progress in strengthening our maternity workforce. Midwifery staffing has increased by over 26 Whole Time Equivalent (WTE) during 2025/26, improving workforce capacity across the service. The current midwifery vacancy gap is 14 WTE.

An organisational development programme has been commenced across perinatal services to support team development and strengthen leadership capability at all levels.

Mandatory training compliance, including maternity-specific requirements, remains strong, supporting the delivery of safe care. Workforce support has also included a focus on staff wellbeing and retention.

Co-production and engagement with service users and communities

Co-production has been strengthened through ongoing engagement with service users and community stakeholders. A key area of progress has been partnership working with faith and local community organisations to promote public health messages, supported by the Consultant Midwife.

This has supported improved engagement with local communities and contributed to efforts to address inequalities in access to care. Feedback from service users has informed improvements, including the prioritisation of translation and interpretation services within the Improving Together workstream.

Leadership, culture and a learning organisation

Progress has been made in strengthening leadership and embedding a culture of safety and continuous improvement. The organisational development programme has supported the development of leadership capability and team effectiveness across perinatal services. Learning is shared through governance structures, team discussions and huddles, supporting a more open and responsive culture.

Priority 2

Improving outpatient and planned care services

At the start of the financial year, and following the successful transition into MMUH, we committed to improving outpatient and planned care services, improving patient experience, ensuring that services are accessible, responsive, and aligned with best practices.

This commitment requires a multiyear approach and over the last 12 months we have been laying a solid foundation on which we can build. In quarter one we set up a revised governance structure which introduced an Outpatients, Elective and Diagnostics Improvement programme, each led by senior operational directors. Each programme clearly set out its priorities and its work programme for the year and a dashboard to monitor Key Performance Indicators (KPIs) and outcomes.

Within the Outpatients Improvement Programme, the focus has been on improving the ability for patients to communicate and manage outpatient appointments digitally. We were successfully awarded £394,000 to improve our Patient Engagement Portal and increase interoperability with the NHS App. This is a priority for implementation in early 2026/27.

Within the Diagnostic Improvement Programme, work has been undertaken to develop plans for a Community Diagnostic Centre, and in Q4 we were awarded funding to develop a feasibility study and a business case for 2026/27. Operationally, the group have improved efficiencies in ultrasound capacity, supported pathway improvement in cancer by redeveloping their CT prep processes and reduced the backlog of plain film reports.

Finally, within the Elective Improvement Programme, the focus has been on improving theatre utilisation and efficiency. During 2025/26 we have increased the average cases per theatre session by 4.59% compared to 2024/25. The percentage of session time lost to late start has decreased in 2025/26 by 29.25% when compared to 2024/25.

Throughout 2025/26 we have been developing plans for an Elective Hub at Sandwell General Hospital and in Q4 were awarded £9.75m of capital. A significant proportion of this funding will enable estate improvement in the currently unutilised level 1 theatres and two wards on level 3, whilst the remaining investment has been used to purchase equipment and surgical instrumentation. Development of the Elective Hub will continue into 2026/27.

Priority 3

Care of the deteriorating patient

Throughout 2025/26 we have continued to focus on the care of the deteriorating patient. Early recognition and timely response to clinical deterioration are key to preventing avoidable harm. During the year we have made progress in a number of areas to strengthen this pathway and to support improvements in patient safety and the Trust's Summary Hospital-level Mortality Indicator (SHMI).

We have successfully recruited to our resuscitation team workforce with two new team members; this additional support will mean that we are now able to focus on completing the learning needs analysis and creating an educational framework to ensure that all colleagues working across SWB have the knowledge, skills and capability to care for those patients who experience a deterioration in their health.

The NEWS2 dashboard is now embedded within the organisation and forms part of the Fundamentals of Care dashboard. This is providing a reliable data source for wards and clinicians to understand and interrogate NEWS 2 compliance. The statistical process charts are automatically generated within the dashboard which allows for easy interpretation of the data and tracking of compliance to facilitate early identification of any deterioration in compliance and improvement, following quality improvement projects and interventions. Engagement with the dashboard can be seen as the data is often referenced within Trust level reports and discussed at ward level when reviewing metrics and performance.

During 2025/26 we pledged to optimise our electronic patient record system (EPR) to enable easier monitoring and visualisation of vital signs and trends. As we needed to implement the National Paediatric Early Warning Score (nPEWS) the decision was taken to focus on this element.

We are currently replacing our PEWS scoring system with nPEWS. This is a national standardised approach of tracking deterioration of children in hospital and will allow for consistency in how this is recognised. Within nPEWS we will reintroduce the visual traffic light system, with graphical display of observations. This will provide a clinician friendly interface for recording of vital signs and interpretation of trends.

We have seen some delays in the implementation, however this work is now progressing and once complete will enable replication of the graphical display of observations across our adult national early warning score (NEWS2) system meaning that trend monitoring and colour coded visual prompts will be seen when digitally recording observations.

We have been recognised regionally for the work that has been completed within Martha's Rule and have implemented all three components within SWB, in line with the national programme requirements.

Building on the successful implementation of "Call for Concern" for patients, relatives and staff we have now rolled out the patient wellness questionnaire across our adult inpatient wards at MMUH. In January 2026 we held a promotional stand to support the launch of the Patient Wellness Questionnaire (PWQ) and continue to raise awareness of all components of Martha's Rule.

The PWQ mandates that all patients are asked daily, how they are feeling, how this compares to yesterday and whether they are aware of the ongoing plan for their hospital stay. Patients that either aren't able to answer the questions, or who trigger for escalation on the PWQ are then assessed for early 'soft' signs of deterioration. Families, carers and loved ones are actively encouraged to participate in the PWQ as the people who know the person best, supporting our aim for improvement in personalised care.

To ensure that the PWQ is accessible we translated the questions into our top 10 languages, and it will also be available in Makaton to support those accessing our care with a learning disability or communication difficulties. To promote awareness of Martha's Rule to our patients and visitors there are promotional displays across the organisation, and all patient lockers have a sticker with the Martha's Rule contact number and our escalation processes.

Compliance is monitored via the newly created Martha's Rule dashboard, and monthly ward audits. During the launch of the PWQ colleagues from the National Patient Safety team visited MMUH and were impressed with our dashboard and the digital recording of the soft signs of deterioration and have asked that we share this work as an exemplar. The next phase of this will be to build on this success within our community services.

Together these initiatives strengthen our ability to recognise deterioration early, empower patients and families to raise concerns and ensure timely clinical response. This work will continue to be a priority for our Trust as we strive to reduce avoidable harm and improve outcomes for patients.

Priority 4

Enhance patient experience

Over the past year, significant progress has been made in strengthening how patient experience insight is identified, shared and translated into meaningful action across our organisation. These achievements reflect our continued commitment to embedding personalised, inclusive and responsive care.

We have strengthened our approach to identifying key themes from patient feedback, complaints, compliments and engagement activity. These themes are now routinely analysed and shared with clinical and operational teams in a structured and timely way. Teams are taking ownership of the themes relevant to their services and developing targeted action plans to address areas for improvement. This has supported a culture shift from feedback collection to feedback-driven improvement, ensuring the patient voice directly informs service development and quality improvement work.

The "Getting to Know Me" boards have undergone design alterations following feedback from patients, carers and staff. The redesign has improved clarity, accessibility and relevance, ensuring the boards better meet the needs of patients and carers and support meaningful conversations about what matters most to individuals. As a result of this collaborative approach, the boards are now in place on most adult wards, and we will work to embed this during 2026/27. Their implementation is supporting more personalised care, enhancing communication and strengthening staff understanding of individual preferences and needs.

The Essential Companion Card has been successfully rolled out across the organisation and is now embedded into routine practice. Awareness and understanding among staff has increased significantly, supporting consistent recognition of patients who require additional support from a carer or essential companion. Through close collaboration with carer groups, awareness of the card has also increased within the community, reinforcing partnership working and recognising carers as key partners in care delivery.

Customer care training has been widely delivered across the organisation, reinforcing expectations around compassion, communication and patient-centred interactions. Regular sessions are also being delivered in partnership with the University of Birmingham to pre-registration healthcare students. This proactive approach ensures that patient experience principles are embedded early in professional development, strengthening the future workforce's understanding of compassionate, personalised care.

Education has commenced across services to prepare for a transition to a new model of interpreting, moving from predominantly face-to-face provision to an enhanced virtual interpreting offer. This change aims to improve timeliness, accessibility and efficiency while maintaining high standards of communication support. A pilot of the virtual interpreting model has commenced at Birmingham and Midland Eye Centre, enabling evaluation of patient and staff experience prior to wider organisational roll out.

Collectively, these developments demonstrate sustained progress in embedding patient experience into everyday practice - ensuring that the patient and carer voice is heard and reflected into practice.

Continuing professional development

Primary Care - General Practice (GP)

Our vision to be one of the most integrated healthcare providers in the country remains central to all that we do. We continue to build our relationships with our local GP communities as well as developing our own GP services.

Our practices have had another good year of high performance, delivering well against the local and national quality frameworks.

In 2025/26 we have:

- Successfully embedded Summerfield practice into our Primary Care delivery unit and continue to align the Heath Street and Summerfield teams to our Your Health Partnership practices.
- Heath Street have assumed responsibility to deliver the Urgent Primary Care Centre that works alongside the Emergency Department at MMUH. This has been of benefit to our Trust and the local population.
- The West Locality Hub has launched which helps target and manage patients with multiple needs in West Birmingham, improving their health and reducing hospital utilisation.
- Continued to develop our locality Frailty Hub model and our shared approach to Wound Management, in both cases linking acute and primary care services together.
- Continued to develop our interface work between Primary and Secondary care, working together to reduce administrative issues and to smooth pathways.
- Integrated practices have continued to expand specialist roles for GPs such as support for stroke beds and point of care ultrasound.
- The primary care nursing workforce continue to be leaders in service development. Their work supporting housebound patients with long term conditions has been excellent, and their work with care homes on improved diabetes management has been recognised.
- The reception and telephony teams have been developing better services for patients across our sites, improving ease of access leading to better patient survey scores.

In 2026/27 the focus for our practices will be to deliver the new requirements in the updated GP contract as well as preparing for the new Neighbourhood Health models. Building services around neighbourhoods is a key NHS priority to support the 10 Year vision of Acute to Community shift.

- We will continue to deliver education for our local GPs in partnership with our consultant teams. We are also aiming to develop some GPs to work alongside our cardiology consultants, helping to manage our patients promptly.
- As SWB continues its journey of Group working with Dudley Group Foundation Trust (DGFT) we will ensure that we build relationships and learn from those practices that are integrated in Dudley.

Fundamentals of Care (FoC)

2025/26 has been an important period for introducing, embedding, and allowing time for new ways of working to settle following moving into MMUH. This has helped create a stronger foundation for continued improvement. Further progress will focus on building confidence, consistency, and sustainability as these ways of working become routine.

Good progress has been made in the Fundamentals of Care work. We have consistently been below the national falls rate and following improvements to support the reduction in patients falling, there have been improvements in the way that we support patients that require enhanced care. We have also achieved 24 months of no recorded Grade 4 pressure ulcers.

There is a growing focus on seeing the whole person, not just their medical needs, and on working well as a team to provide safe and effective care. Learning has been supported through practice, reflection, and feedback, utilising ward level data to help staff understand how these fundamentals improve patient experience and outcomes.

To drive organisational change around FoC, the key is consistent messaging and embedding in everyday processes that are:

- Clear: "FoC is central to safe, effective, compassionate care." I/We will do this by…….
- Actionable: "Every staff member has a role in embedding FoC daily." I/We will do this by….
- Aligned to Outcomes: "FoC improves patient outcomes, safety, and experience." I/We will do this by…

Care Quality Commission (CQC)

SWB has undergone four CQC Core Service inspections since September 2026. This is due to the requirement of all hospitals to have inspections within the first 12 months of opening. The four Core Service areas inspected included:

- Maternity Services
- Surgical Services at MMUH
- Surgical Services at BMEC
- Emergency Department at MMUH

We also had an IRMER (Ionising Radiation (Medical Exposure) Regulations) Inspection to Radiology and Cardiology at MMUH in June 2025, and a CQC Well Led Assessment which took place on the 11th – 13th November 2025.

On the 18th of June 2025 CQC warranted IR(ME)R inspectors conducted an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of MMUH. The service provided evidence and assurance of compliance with IR(ME)R for most of the regulations, with only a few discrepancies identified. Inspectors noted there to be good governance and incident management arrangements in place. In response to the recommendations outlined in the Inspection report, we submitted an action plan to the CQC on 4th September 2025 which detailed how each recommendation will be addressed and the expected timescales for completion. The CQC formally closed the inspection following satisfactory response on 24th September 2025.

Following a previous unannounced Inspection of Maternity Services at City Hospital being undertaken in June 2024, a Section 29a Warning Notice was issued requiring immediate improvements. Those improvements were acted upon immediately. The overall rating from the June 2024 inspection moved from 'Good' to 'Requires Improvement', with 'Inadequate' for Safe. A further inspection visit took place in September 2025 at MMUH. The final report has been shared and shows that the rating overall remains as 'Requires Improvement', however the improvement undertaken has been recognised and the rating for Safe has moved from 'Inadequate' to 'Requires Improvement'.

A first inspection visit to Surgery at MMUH took place in September 2025. The final report has now been published and the rating for Surgery overall remains as 'Good', with 'Good' also being achieved across each of the five domains.

An inspection was carried out at BMEC surgical services, City Hospital in October 2025. The final report has now been published and shows the service being rated as 'Good' for the domains of Effective, Responsive Well Led and Caring. Safe remains as 'Requires Improvement' mainly due to the backlog of appointments which is an improving picture. This gives an overall rating for the service of 'Good'.

A first inspection visit was carried out in the Emergency Department at MMUH in October 2025. The final report has now been published and shows an overall rating of 'Good'. Safe was rated as 'Requires Improvement' due to wait times and overcrowding within the waiting rooms. This is a challenge for many organisations nationally and there is an action plan in place to address these concerns.

SWB also underwent a 'Well Led' inspection in November 2025 where the CQC assessed leadership across our trust and have awarded SWB a rating of 'Good'. A helpful letter was also received with the report with several suggested improvements to assist our Trust in continuing to improve and move to outstanding in the future.

There were several actions attached to all four core inspection reports, in addition to the Well Led letter. An action plan is being developed to incorporate and address these and will be managed via the Quality Committee with updates to Trust Board.

Our internal self-assessments continue 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 is being repeated twice yearly in March and September. The process involves gathering of evidence which is 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 are reviewing our own CQC in-house inspections with Dudley Group Foundation Trust to ensure sharing and consistency across the Group.

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 in June 2024 in six regulations, and ratings for Maternity changed from 'Good' to 'Requires Improvement.' A further inspection has now been conducted as above with the overall rating remaining as 'Requires Improvement', but with the improvement work undertaken being recognised and the rating for Safe improving from 'Inadequate' to 'Requires Improvement'. The Section 29a remains in place in 3 regulations and the actions that remain are being addressed as part of the Improving Together work.

Care Quality Commission

Last rated
12 February 2026

Sandwell and West Birmingham Hospitals NHS Trust

Overall rating	Inadequate	**Requires improvement**	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community Services	Requires improvement	Requires improvement	Outstanding ☆	Good	Outstanding ☆	Good
Primary Care	Good	Good	Good	Requires improvement	Good	Good
Well-led						Good
Overall Trust	Requires improvement	Requires improvement	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement

How we measure data quality

We measure data quality using nationally mandated NHS data standards and benchmarking tools, ensuring our performance is assessed consistently against peer organisations.

A key indicator within this framework is the Data Quality Maturity Index (DQMI), which highlights areas where we perform strongly and where improvement is required.

Over the past year, we have strengthened our internal assurance processes by re launching our Kitemarked metrics for Trust Board reporting. These metrics, aligned to the NHS Medium Term Plan, are evaluated across seven dimensions: Timeliness, Monitoring, Completeness, Validation, Relevance, Reliability and Audit—providing a structured assessment ranging from 'Not Assessed' to 'Sufficient'.

Alongside this, we have refreshed our Data Quality Group, which oversees our Trust's central Data Quality Log and supports directorates in resolving issues and driving improvement.

To embed good practice across the organisation, we have also increased data quality awareness through ongoing staff communications, encouraging colleagues to recognise the importance of robust data and to report issues promptly so that they can be addressed.

Data quality improvement approach

Data quality at SWB is overseen by the Associate Director of Data & Development, who holds organisational responsibility for the process.

The Data Quality Group acts as the central mechanism for reviewing and progressing issues logged across our organisation. Membership includes representatives from clinical divisions, corporate services and Information Governance, ensuring a broad oversight of data quality risks and operational challenges. All newly reported issues follow a structured lifecycle: submission and capture, assessment (including consideration of organisational risk), prioritisation, action and closure, with prioritisation guided by senior leadership to ensure alignment with organisational need.

The Group provides quarterly updates to the Audit & Risk and Quality Committees, reinforcing governance oversight and transparency.

Continuous improvement is supported through both internal audit processes and access to national data quality indexes and benchmarking tools, which help us identify areas requiring focus. Regular audits provide assurance that our Trust complies with legislative requirements, NHS and internal policy standards, and that appropriate processes and controls are in place to maintain the completeness, relevance, accuracy and security of data. This is further strengthened by the annual Data Security & Protection Toolkit self assessment, which provides an additional mechanism for monitoring and improving data quality and data governance standards across our Trust.

Continuous improvement involves all

Hospital episode statistics

Our Trust submitted inpatient and outpatient records during April 2025 – November 2025 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	326	79170	99.59	1559	901790	99.83
GP Practice	0	79170	100.00	1457	901790	99.84

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

We submitted Emergency Care Dataset (ECDS) records during April 2025 – January 2026 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 – Emergency Department	1950	125050	98.44	108	125036	99.91
Type 02 – BMEC Eye Centre	75	14857	99.50	11	14856	99.93
Type 03 – Urgent Treatment Centres	2608	78766	96.69	3351	78766	95.75
Total	4633	218673	97.88	3470	218658	98.41

Source: ECDS DQ Dashboard Link: Microsoft Power BI

Services provided / subcontracted

During 2025/26 we provided and/or subcontracted 77 NHS services. We have reviewed all the data available on the quality of the care in these services. Where we have subcontracted any activity, it would only be to a provider who, like us, was registered with the CQC but has no conditions attached to that registration. Contracts between our 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 our Trust. The income generated by the NHS services reviewed in 2025/26 represents 100 per cent of the total income generated from the provision of NHS services by our Trust.

Midland Met is helping to deliver the highest standards of care

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 2025/26 due to CQUIN schemes being paused nationally therefore no agreed goals were set for this period.

7-day hospital service

2025/26 marked the first full year of operating with a 7-day consultant led acute service following the transfer of acute services into MMUH at the end of 2024. Length of stay for acute non elective patients was at or below 6 days from May to November and is currently at 6.6 days.

Speaking Up

In 2025/26, we continued to promote an open and transparent culture where staff feel able to speak up. The Freedom to Speak Up (FTSU) work supports our strategic goals and People Plan, helping to create a workplace where people feel psychologically safe.

There has been a change in FTSU leadership, with a new executive lead appointed to better align this work with our organisation's strategy.

The FTSU team have focused on supporting colleagues to understand, and have awareness of the FTSU role, through the implementation of core speaking up e-learning module for all staff. In addition to this, FTSU continue to proactively engage with colleagues across our organisation to support an accessible and visible FTSU service.

During 2025/26, FTSU played an important role in the "With You All The Way" programme. They helped SWB learn from concerns raised by staff and ensured the work being undertaken addressed the issues raised.

SWB also continued to lead on learning across the wider system. This included hosting a system-wide FTSU conference focused on key themes raised through concerns. In addition, a workshop was held for leaders to help them understand the role of FTSU, how it links to CQC assessments, and the barriers staff face when raising concerns, as well as how leaders can help address these challenges.

The FTSU team, have continued work in addressing barriers to "speaking up" with the implementation of our Disadvantageous and Demeaning Treatment (detriment) standard operating procedure. In doing so, clear expectations were provided to colleagues regarding actions that will be taken when raising such concerns. The process enables greater assurance to be provided to our Trust Board on the number of such concerns and the organisational learning being undertaken.

Our focus for 2026/27 will be:

- Incorporating the "listen up" training as part of our leadership development offer
- Implementing a manager's guide, to support meaningful feedback being provided
- Continue to work with partner organisations to support system wide learning.

Medical rota gaps

In order to monitor our rota gaps, we maintain a 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 create new posts where additional service needs have been identified. We currently have 63 of these posts, of which 24 are filled, 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 CQC 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 annual staff survey poses 101 questions to build a detailed picture of staff experience, and all NHS staff are given the opportunity to give their feedback. In addition, there is a shorter quarterly Pulse survey comprising of 9 key questions to ascertain how engaged staff are. Below is a comparison of results between 2024 and 2025 in relation to advocacy. These results are based on staff who agreed or strongly agreed as part of the NHS Staff survey in 2024 and 2025.

NHS Staff Survey	2024	2025
Staff who would recommend the Trust as a provider of care to their family and friends	58.8%	51.7%
Staff who would recommend our organisation as a place to work	59.4%	51.5%

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 have deteriorated across all People Promises, reflecting the challenging financial climate and impact on staff morale. This pattern is consistent across the wider Black Country Provider Collaborative. The table below shows the change in scores.

People Promise elements	2024 score	2025 score	% Movement
We are compassionate and inclusive	7.2	7.1	-1.9%
We are recognised and rewarded	6.0	5.8	-3.0%
We each have a voice that counts	6.6	6.4	-3.0%
We are safe and healthy	6.3	6.1	-2.8%
We are always learning	5.5	5.4	-1.6%
We work flexibly	6.3	6.1	-3.1%
We are a team	6.7	6.7	-0.9%

Themes	2024 score	2025 score	% Movement
Staff engagement	6.8	6.5	-4.3%
Morale	6.0	5.8	-3.7%

The 2025 survey scores, along with free text comments, evidences a material decline in staff experience across the organisation. The findings reflect an intensely challenging operational and financial context, organisational change and sustained workforce pressure.

There are, however, credible strengths to build on: inclusion indicators remain comparatively strong; line manager domains are relatively resilient; and reporting behaviours have improved. A disciplined combination of targeted local support and organisation level action is being taken to restore confidence, improve experience and protect service quality.

The survey has highlighted some key areas for improvement that we need to make for our people during 2026/27, these include:

We are always learning

- Improve the quality and impact of Professional Development Reviews/appraisal conversations through strengthened manager training and guidance.
- Expand leadership development across the Group (ARC values/ Managers Essentials programmes; NHS Leadership & Management Framework; Inclusive Succession Planning and Talent Management Approach).
- Increase visibility of learning and development opportunities, especially for staff groups with lower survey scores.
- Establish a Group wide Coaching Academy to support compassionate, inclusive development.

We are recognised and rewarded

- Align and optimise organisational recognition schemes, with staff input, to ensure synergy and value.
- Support managers to embed everyday recognition habits through a simple, local recognition format.

We are safe and healthy

- Strengthen psychological wellbeing support through a new, aligned Employee Assistance Programme.
- Expand access to MHFAiders (Mental Health First Aiders) and introduce practical tools for supporting colleagues in distress.
- Implement post-incident and trauma support frameworks.
- Create resources to help staff recognise burnout, signpost to support, emphasise breaks to manage and reduce fatigue.
- Embed the six High Impact Disability Actions to improve reasonable adjustments and the experience of disabled staff.
- Progress anti racism work- including actions on antisemitism and Islamophobia- through a joint SWB/DGFT task group focusing on education, accountability, improved data and competency based development.
- Full implementation of Sexual Safety Charter and promote FTSU.

Advocacy

- Strengthen open, transparent, relatable communication on financial challenges, how quality and safety are being considered, and the purpose and impact of the Group model.
- Create opportunities for staff to raise questions and discuss specific concerns with senior leaders about the current climate through structured forums.
- Increase executive and senior leader visibility across frontline areas to listen and engage with staff.

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 by the end of June 2026.

Our overall risk submission status currently is 'Approaching standards'.

The DSPT continues to progress the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and Information Governance assurance.

There are 47 Questions split into 5 chapters. We have 'achieved' 18 (38%), 'partially achieved' 23 (49%) and 'not achieved' 6 (13%).

General Data Protection Regulation (GDPR)

Work continues to ensure that data protection obligations are implemented and monitored for all processing activities across our Trust. We recognise the importance of robust information governance, and the Information Governance Group oversees and leads on actions to make improvements.

Complaints

During the financial year 2025/26, our Trust received 895 complaints, compared to 680 in 2024/25. We continue to effectively resolve issues through PALS, and 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 2025/26 were:

Theme	2025/26	2024/25
Clinical Treatment	275 (31%)	226 (33%)
Communication	107 (12%)	97 (14%)
Values and Behaviours	101 (11%)	82 (12%)
Patient Care	103 (12%)	110 (16%)

Patient Advice and Liaison Service (PALS)

The PALS service handled 2296 concerns in 2025/26, compared to 2605 in 2024/25. 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.

We still have a patient-facing office at MMUH which enables improved accessibility to PALS, and we are reviewing our processes to ensure that all patients and enquirers can easily access our service.

Compliments

Throughout the year, 557 compliments were recorded by ward and clinic staff and the Complaints Team. This reflects the ongoing commitment of teams across our Trust to delivering positive patient experiences.

Management of change and team structure

The Complaints Team has recently gone through management of change and from April 2026 a new process and team will be in place, and this will be communicated to all staff via various trust-wide events.

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. There has continued to be development of this portal over the last 12 months and SWB are committed to aligning with the national reporting requirements.

The patient safety team have continued to work closely with frontline clinical teams to promote and embed the Patient Safety Incident Response Framework (PSIRF) learning tools alongside operational management of incidents to ensure effective incident management is undertaken. Feedback from frontline teams has been positive and have noted the shift to a positive learning culture. The Patient Safety team are also regularly publishing learning in newsletters, bulletins and presenting information at weekly governance meetings.

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 have a greater amount of potential learning points identified in initial debriefs can be investigated in closer detail than under 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.

No of PSII's (by date reported as PSII)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/26	2	2	1	2	3	1	2	3	1	3	0	TBC

Deep dive investigations have also been undertaken in falls, medication errors and never events.

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).

We reported four never events during 2025/26, an increase in reporting compared to the previous period. Two never events related to retained swabs in the maternity department, one wrong site eye injection, and one removal of an incorrect urinary stent.

Learning and safety controls were generated in each case, with the clinical divisions responsible for implementation and monitoring as part of our Trusts standard procedure. A national consultation process for Never Events Framework is ongoing and aims to clarify the definition and ensure an effective mechanism to drive patient safety improvement.

In September 2025, NHSE aligned never events with PSIRF and informed organisations to consider the most proportionate learning response method for never events. This resulted in two cases being investigated as Patient Safety Incident Investigations (PSIIs), and two as After-Action Reviews. All never event patient safety learning responses are reviewed at the Executive Quality Group for wider consideration and to share learning.

A Trust review of never events is ongoing focusing on system learning, and hierarchical controls where possible, as well as engagement and support for those impacted by incidents: patients, families and staff.

Staff supported every step of the way

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).

2025/26 Emergency Access Standards %

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
76.01	78.02	77.16	78.87	79.29	76.32	73.36	71.59	72.88	70.85	71.48	75.26

SWB benefited from improved UEC performance and inpatient flow following the move to Midland Metropolitan University Hospital in 2024, which continued through the first half of 2025/26 where we achieved the 78% target in three of the first six months and delivered performance improvements ahead of trajectory throughout the first half of the year. Emergency activity stabilised, having seen fluctuations following the alignment of the two Emergency Departments at Sandwell and City Hospitals.

In 2025/26 we achieved an average performance of 75.1% against the four-hour urgent and emergency care standard, which is a 3.5% performance increase on the 2024/25 average and a 5.7% increase on the 2023/24 average.

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.

Usually, the Health and Social Care Information Centre publish PROMs national level headline data every month, with additional organisation level data made available each quarter. Unfortunately, the data for 2024/25 is currently unavailable due to data collection/analysis challenges and there is no date set date for release.

Midland Met supporting improved patient flows and UEC performance

How we performed in 2025/26 against our Key Performance Indicator (KPI) standards

Access Metrics	Measure	Target	2024/25	2025/26	Comments
Cancer – 2 week wait	%	=>93	93.2	90.9	Up to end Feb 26
Cancer – 28 Day Faster Diagnosis Standard	%	=>93	76.77	75.95	Up to end Feb 26
Cancer – 31 day Decision to Treat to Treatment Standard	%	=>96	88.5	93.00	Up to end Feb 26
Cancer – 62 day Referral to Treatment Standard	%	=>90	69.3	71.5	Up to end Feb 26
Emergency Care – 4 hour waits	%	=>95	71.3	75.1	Full year
Referral to treatment time – incomplete pathway < 18 weeks	%	=>92	53.4	58.2	Full year

Outcome Metrics	Measure	Target	2024/25	2025/26	Comments
MRSA Bacteraemia	No	0	5	1	Full year
Never Events	No	0	2	4	Full year
WHO Safer Surgery Checklist 3 sections (% patients where all sections complete. Main theatres only)	%	=>100	100.0	100	Full year
VTE Risk assessments (adult IP)	%	=>95	96.9	95.5	Full year

Clinical Quality and Outcome	Measure	Target	2024/25	2025/26	Comments
Stroke care – patients who spend more than 90% stay on Stroke Unit	%	=>90	84.3	84.6	Full year
Stroke care – Patients admitted to an Acute Stroke Unit within 4 hours	%	=>80	59.5	62.4	Full year
Stroke care – patients receiving a CT scan within 1 hour of presentation	%	=>50	88.3	91.5	Full year
Stroke care – Admission to Thrombolysis Time (% within 60 minutes)	%	=>85	75.5	69.6	Full year
TIA Treatment within 24 hours from receipt of referral	%		96.7	99.8	Full year
MRSA screening elective	%	=>95	66.6	65.0	Full year
MRSA screening non elective	%	=>95	79.0	77.8	Full year

Patient Experience	Measure	Target	2024/25	2025/26	Comments
Primary angioplasty (Call to balloon time 150 mins)	%	=>80	90.8	85.3	Full year
Primary angioplasty (Door to balloon time 90 mins)	%	=>80	88.0	88.8	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 Group Chief Nursing Officer, who has Board level responsibility for IPC and chairs the Infection Control Strategic Group. SWB declares compliance with all 10 sections of the Hygiene Code. Compliance with the Hygiene Code continues to be monitored at the Infection Control Group.

What we said we would do in 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.

What we achieved

- The incidence of Clostridioides difficile has significantly reduced during the year with 34 cases against an NHSE set trajectory of no more than 52 for 2025/26, compared to 85 cases against an NHSE set trajectory also of no more than 52 for 2024/25. This has been driven by significant improvements in antimicrobial stewardship with an overall reduction in consumption of antibiotics at SWB to below the Midlands average. Consumption of the antibiotic Co-amoxiclav, which is high risk for triggering Clostridioides difficile infection, markedly reduced during 2024/25. The IPC Team also reiterated the importance of cleanliness of medical devices as another way to help prevent the spread of Clostridioides difficile.
- During 2025/26 a business case has been successful for the implementation of Chloroprep® the licenced skin preparation to be used for orthopaedic and caesarean section surgery with the principal aim of helping to reduce the rate of surgical site infection. During the year the Lead IPC Nurse for surgical site surveillance also implemented a digital wound management form on the patient management system Unity® which enables clinicians managing a surgical (or other) wound to document changes and updates in the management of a wound which forms part of the patient record.
- Following improvements in waste bin placement and work with Support Service Teams to ensure the correct placement of different waste stream bags into the correct bins in clinical area waste holds, SWB has now improved its position for the consignment of waste to meet the Department of Health's 60/20/20 target for waste leaving our Trust (60% offensive / 20% infectious / 20% incineration). Further work will be undertaken by IPC Team and Support Services and Estates, including for the consignment of waste to fully meet the target during 2026/27.
- The IPC Team have reviewed the process of hand hygiene audits and included a revised audit tool on our Trust audit system Tendable® based on the World Health Organisation '5 moments of hand hygiene'. Wards complete hand hygiene audits monthly and if they drop below 95% compliance, audit frequency is increased to weekly. Hand hygiene compliance is monitored at the Infection Control Group. Our soap and hand gel provider SC Johnson has also regularly been on site supporting hand hygiene observations and training in clinical areas. The IPC Team has also supported the development of a revised dress code policy for our Trust.

Mandatory reportable organisms (figures April 25 - March 26)

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. Clostridioides difficile cases during 2025/26 have been significantly below the NHSE set trajectory and cases of E. coli and Pseudomonas aeruginosa bacteraemia (blood stream infection) have also been below trajectory, with Klebsiella bacteraemia ending the year above trajectory. Cases of MRSA bacteraemia are reduced compared to the five reported during 2024/25 and the single case reported during 2025/26 was in a neonate where the likely source was from the mother and was not related to suboptimal practice.

Organism	NHSE set target	Reported cases
MRSA bacteraemia (post 48 hours admission)	0	1
C. difficile toxin	52	34
E. coli bacteraemia	67	64
Klebsiella bacteraemia	16	25
Pseudomonas aeruginosa bacteraemia	9	8

What we want to achieve for 2026/27

- Continue with collaborative working between the IPC Teams of SWB and DGFT as part of the Group Model established between our two Trusts, including identifying and sharing best practice from both teams and pooling resource where this benefits patient safety and outcomes.
- Continue to work on improving the surveillance of surgical site infection and introduce formal surveillance of caesarean section surgical site surveillance. In addition, as part of Group Model working with DGFT, Sandwell to adopt the existing Dudley process of surgical site surveillance data capture and post discharge questionnaire, to ensure surgical site surveillance processes are reflective across our two Trusts. This will enable production of comparable data that matches national criteria for data collection, thus forming a basis to propose improvements in practice.
- Roll out of training for personal protective equipment (PPE) for High Consequence Infectious Disease (HCID). This is to ensure that staff in admitting areas such as ED or high-risk areas such as critical care have the necessary training for donning and doffing for high level PPE, in the unlikely event of a serious or imported infectious disease such as a viral haemorrhagic fever. Members of the IPC Team have achieved "Train the Trainer" status and are working to ensure that staff are equipped to use PPE to care for patients while preventing direct contact with the suspected organism as part of plans to manage HCID.
- Contribute to the sustainability agenda by supporting the procurement of reusable equipment to replace disposables; and reiterate the "Gloves off" campaign to minimise the unnecessary use of disposable gloves for patient care.
- Further improve waste segregation through ensuring appropriate and intuitive bin placement and through training initiatives to help our Trust fully achieve the Department of Health 60/20/20 target for waste.

Venous thromboembolism (VTE)

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

We report our achievements for VTE against the national target (95%) and report this as a percentage. The calculation is based on the number of adults admitted to hospital as an inpatient and of that number, how many had a VTE assessment within 24 hours. Our compliance for 2025/26 is 95.5%.

2025/26 VTE Compliance %

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
95.71	96.16	97.19	95.69	95.15	95.66	96.03	95.84	95.00	95.60	93.50	96.03

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

Actions undertaken to support VTE performance:

- Guidelines and Policies: Six guidelines and policies relating to VTE have been reviewed. At the time of publication, three guidelines are confirmed as current or updated and two are in the final stages of ratification and will be 'live' once approved. The remaining guideline is under active revision.
- VTE Prophylaxis for Arthroplasty: Expert guidance from haematology and orthopaedics has been sought. A risk stratified approach is now in place, enabling individualised patient management for VTE prophylaxis following arthroplasty.
- Reporting of Hospital-Acquired Thrombosis (HAT): We are reviewing incident reporting processes for hospital-acquired thrombosis (HAT) to strengthen governance oversight, learning, and quality improvement.

The Trust intends to take the following actions to further improve VTE prevention and patient safety:

- Complete review of HAT reporting and governance processes.
- Undertake a Trust-wide audit of VTE prophylaxis prescribing and administration standards.
- Continue education, monitoring, and feedback to improve compliance and reduce preventable harm.

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).

SWB	Number of Patients	Total Number of Readmissions	Percentage of Readmissions
4 - 15			
2025/26 (Apr - Dec)	3031	189	6.24%
2024/25	4341	247	5.69%
16+			
2025/26 (Apr - Dec)	54693	3447	6.30%
2024/25	62643	4078	6.51%
All ages			
2025/26 (Apr - Dec)	57724	3666	6.35%
2024/25	66982	4758	6.83%

The data in the table above shows a reduction in our adult readmission rates. Paediatric readmission rates show an increase in 2025/26 which is due to a change in recording and reporting following the development of a Paediatric Same Day Emergency Care (PSDEC) department. We went live with use of Firstnet for PSDEC patient records in October which has since resolved the issue.

Safeguarding and vulnerable adults

Following the Safeguarding and Vulnerable adult review last year, the service introduced a new structure and leadership model which has responded to identified learning from statutory reviews, serious incidents and complaints. The team have embedded a robust governance structure and a forum for the safeguarding team to share learning.

The Adult Team consists of an Associate Director for Safeguarding, 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, Learning Disability Nurse and full-time administrative support post. The team are presently exploring scope for a dementia resource.

During the past year, the team has focused on supporting frontline staff to recognise and respond to safeguarding concerns. Safeguarding training has been reviewed, and our training needs analysis now requires all front-line registrant's competencies to be mandated at Level 3 training for both Adults and Children. This is to support a 'think family' trauma informed approach to safeguarding practice. Compliance will be reported over a three-year period.

The team continue to support wards with Mental Capacity, Deprivation of Liberty and Least Restrictive Practice. This has included supporting consent work streams to improve staff understanding and documentation. The team are participating in a discharge task and finish group, with an aim to improve discharge documentation and safety netting for vulnerable adults.

We have prioritised participation in Enhanced Therapeutic Observation of Care (ETOC) NHSE improvement project. The project aims to align assessment, interventions and workforce management for patients identified as requiring enhanced observations to improve patient experience.

The Learning Disability Team has developed strong relationships with community partners and implemented policies and pathways to support our patients living with a learning disability. The team work closely with Patient Experience and have introduced a pilot of sensory bags in our emergency department. The team are working on patient learning disability, autism and reasonable adjustments. This year has seen a focus on waiting list and triage. The team continue to contribute to Structured Judgement Reviews (SJR) 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 Safeguarding Adult Team continues to work closely with Sandwell and Birmingham multi agency Safeguarding Boards, ICB and partners and are building relations with charities in the third sector.

The team is committed to ensuring SWB compliance by contributing to all cases that meet the threshold for statutory public enquiries. They actively participate in a range of workstreams focused on improving services for people with learning disabilities and vulnerable adults. In addition, the team fully supports the national PREVENT strategy, engaging in NHS England forums and contributing to local steering groups.

For the year ahead, a structured workplan will be developed to set out the key priorities for Safeguarding Adults. Multi-agency partnership working, the application of learning from statutory reviews, and the provision of support and advice to the workforce will continue to form the core of service delivery.

The team will also maintain required standards within statutory safeguarding frameworks through ongoing self-assessment, regular audit activity, and continuous quality improvement.

Safeguarding children

Keeping children safe remains an important priority for our Trust and this principle is embedded into practice across all disciplines and roles, from our Group Chief Nursing Officer, as the executive lead for safeguarding through to our frontline staff. We have a dedicated team of specialist safeguarding professionals who offer safeguarding training, advice, support, and supervision to our employees. This enables them to fulfil their safeguarding responsibilities and duties on a wide range of 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 through targeted home visits, clinics, Care leaver drop in clinics and follow up clinics for unaccompanied children and young people who are new to the country and seeking asylum. The team also deliver training to frontline staff and foster carers.

A Named Midwife for Safeguarding Children supported by Deputy Safeguarding Midwives provides focused oversight of safeguarding arrangements within maternity services and offers bespoke 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 presenting through the emergency department and the wider Trust, with safety planning and sign posting to community support services.

The service has strived to achieve a Trust wide approach of 'All Age Safeguarding' through embedding an integrated and co-located Safeguarding Children and Vulnerable Adults Team. This service development enables a robust approach to supporting whole family needs. The approach also supports early interventions to achieve 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 harm outside the home and Sudden Unexpected Death in Infants (SUDIC) 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. There is an embedded safeguarding governance structure and a process of self-assessment of statutory safeguarding standards.

Throughout 2025/26 assurance, quality and accountability has been demonstrated by the inclusion of quarterly 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 Executive Quality Group to ensure senior executives are fully sighted on key safeguarding developments, priorities and any challenges faced during the year.

The workplan for 2026/27 is being updated and the team look forward to building on last year's work to further embed quality assurance and innovation around safeguarding practices within our Trust.

Teamwork in practice

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 our 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 2025/26 1122 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: 276 deaths in Q1, 258 deaths in Q2, 313 deaths in Q3 and 275 in Q4.

Of the 1122 deaths reported during 2025/26, 1094 (98%) underwent a tier one mortality review by medical examiners. This equated to 276 reviews in Q1, 258 in Q2, 309 in Q3 and 251 in Q4. Of these, 75 deaths were referred for further review in the form of a Structured Judgement Review (SJR) or for panel discussion at Tier 3 level , Joint Learning Review Group (previously known as Clinical and Professional Review of Mortality Group or CAPROM) to determine if they were avoidable. This consisted of 16 cases in Q1, 19 cases in Q2, 23 in Q3 and 17 in Q4.

Of the cases which received further scrutiny, 4 cases for 2025/26 (representing 0.38 per cent of all patient deaths during 2025/26) 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: 2 patient deaths representing 0.19 per cent of the patient deaths for Q1, 0 patient deaths representing 0.00 per cent of the patient deaths for Q2 and 2 patient deaths representing 0.19 per cent of the patient deaths for Q3. There were 0 patient deaths in Q4 representing 0.00 per cent of the patient deaths..

2025/26

	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
Total Inpatient spells	25,283	25,378	24,281	22,905
Total deaths	276	258	313	275
Avoidable deaths	2	0	2	0

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 2025/26. All comments are analysed and fed back to the caring team for review/action.

Next of Kin Contact 2025/26

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
90%	88%	90%	85%	87%	85%	92%	93%	86%	86%	85%	92%

Primary care deaths

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 non–coronial 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 Medical Certificate of Cause of Death (MCCD) is competed and sent to a Registrar.

Mortality Indices (SHMI)

The Standardised Hospital-Level Mortality Indices is the ratio between the actual number of patients who die following hospitalisation at SWB 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 with associated potential predisposition to avoidable harm. It includes death up to 30 days post discharge and does not adjust for palliative care.

The SHMI reported in February 2026 (reporting period up to November 2025) is 107.52 which falls within the "as expected" SHMI range.

Across the NHS there are differences in how hospitals record Same Day Emergency Care (SDEC) activity in national datasets. The Summary Hospital-level Mortality Indicator (SHMI) is calculated using information from the Admitted Patient Care (APC) dataset. However, some hospitals record SDEC activity in other datasets, such as the Emergency Care Data Set (ECDS) or outpatient data, rather than APC. When this happens, those patient episodes are not included in the SHMI calculation.

This can affect the SHMI value. Patients seen through SDEC generally have a very low risk of death, so removing large numbers of these cases from the dataset does not significantly change the number of deaths recorded. However, it reduces the number of expected deaths used in the calculation, which can make the SHMI appear higher even when the quality of care has not changed.

Nationally, many hospitals are moving towards recording SDEC activity in the ECDS. Around half of acute NHS trusts now record SDEC this way. SWB is one trust within the Birmingham and Black country systems not to submit SDEC data into the APC data set. Because SHMI is calculated from APC data, this change can lead to higher SHMI values in hospitals with large SDEC services.

SWB has a large SDEC service, with many patients receiving treatment on the same day rather than being admitted to hospital. While this approach benefits patients by avoiding unnecessary admissions, it can influence how the SHMI statistic appears. In organisations with high levels of SDEC activity, this effect can increase the SHMI score by several points.

Strategies to improve SMHI include:

- *Dissemination of information:* Building upon the processes implemented in the previous year, 2025/26 saw the implementation of a Joint Learning Review Group. This meeting brought together the Patient Safety and Learning from Deaths processes in closer alignment, to improve triangulation of data and reduce duplication of work. Learning taken from the meeting is communicated via the regular PSIRF newsletter, shared in the PSIRF oversight meeting and local governance meetings. There are plans now to explore alternative formats of disseminating learning across SWB teams.
- *Factors influencing SHMI for SWB and peers:* Work has been undertaken during 2025/26 to understand the LfD policies at neighbouring trusts and attempt to align processes. An evaluation of the digital systems used to record SJRs is currently underway with a view to determining an effective analysis and management system to support timely sharing of learning.
- *Thematic analysis of SJRs:* A review of the SJRs completed during this period has been conducted in Q4 and will be presented and disseminated on completion. It is hoped the digital system evaluation will facilitate regular and timely analysis to provide regular learning updates in a range of formats in the forthcoming year.

- *Specialty Reviews:*
  - To provide clinical assurance, the LfD Group asks each specialty to review their deaths routinely and report into the Group to share key learnings and actions taken. In 2025/26 the following specialties presented an overview of their SJRs, key learning points and what action they have taken in response.

Specialty	Division	Date
Acute Medicine	Medicine and Emergency Care	Sep 25
Cardiology	Medicine and Emergency Care	May 25 and Feb 26
Community PCCT	Primary Care, Communities and Therapies	May 25
Critical Care	Surgical Services	Apr 25
Emergency Department	Medicine and Emergency Care	Apr 25 and Mar 26
Elderly care	Medicine and Emergency Care	Jun 25 and Mar 26
ENT	Surgical Services	Jul 25
Gastroenterology	Medicine and Emergency Care	Aug 25
General Surgery	Surgical Services	Sep 25 and Mar 26
Gynaecology oncology	Women and Child Health	Mar 26
Haematology	Medicine and Emergency Care	Nov 25
Neonates	Women and Child Health	Nov 25
Obstetrics	Women and Child Health	May 25
Paediatrics	Women and Child Health	Jun 25
Respiratory	Medicine and Emergency Care	May 25
Urology	Surgical Services	Mar 26
Vulnerable Adults (inc Learning disabilities)	Corporate Services	June 25

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

- ***Coding:*** We consistently have more 'observed' than 'expected' deaths of patients across many clinical conditions, therefore creating alerts for conditions, which on deeper analysis have not been contributory to the death. A quality improvement programme will be implemented to review coding data quality and improvements options.
- ***SHMI Alerts:*** In 2025/26 we have continued to optimise learning opportunities and ownership of actions. We receive a pre-warning of diagnostic groups where we may have more deaths than expected and trends are monitored and a deep dive into the alerts completed where required.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2025/26 that were recruited to participate in research approved by a research ethics committee was 2626. 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 64 studies were open for participation across 19 specialties at SWB. Of these eight are commercially sponsored/funded and 3% percent of recruits are from the commercial portfolio. This year has seen a continued increase in the areas of research in which we are active including: MSK, RH&C, Primary Care and infection.

We have delivered on numerous deliverables that were set out in Year two of our Research Strategy "Improving Lives Through Research". Such deliverables included:

- Launching a Research Exemplar Award Scheme
- Appointing and training lay representatives for our key meetings
- Patient Research Ambassadors to promote and share research within our local communities
- Streamlined study set up
- Time taken to recruit the first participant.

This year has seen more engagement, and opportunities for engagement and delivery of research, amongst our Vertically Integrated GP partnerships, with at least two studies opened and recruiting patients in this area. We also have new Principal Investigators. This has further enhanced the offer to our local communities, especially those from minority ethnic backgrounds due to the nature of the studies opened. Several grant applications have also been submitted in collaboration with wider partners from this group. We have secured capital investment, commencing from 2026, to procure two mobile clinical research buses which will be utilised to promote, and deliver research in the communities.

The Community of Research Practice events continue to be successful and have been made available for other providers across the Black Country. A specific training day was developed based on the needs of our Principal Investigators with numerous workstreams now in progress including a mentoring network and further tailored training.

A trust wide research experience and skills survey was completed and analysed. This has been shared with divisional leads with recommendations for action. These are at varying stages but will be overseen by the Research and Development Oversight and Strategy groups in the coming year to further enhance the offer of research across the organisation and our communities.

This year we invested a further £500,000 in research fellowships with more applications being submitted for nationally competitive funding. Fellowship outputs for this year include publications, applications for NIHR funding and negotiations for a joint substantive academic research fellow.

The organisation paid tribute to those who have contributed to research during the month of June with numerous patient and staff thank you events, our hospitals being lit up red for the week and red shrubs planted with plaques at each of our hospital sites to signify the impact research has on future generations.

Lyndon Primary Care Centre at Sandwell Health Campus

Integrated Primary Care

Participation in clinical audits

During 2025/26, a total of 68 national clinical audits and national confidential enquiries were relevant to the services that are provided at our Trust: Sandwell and West Birmingham.

During this period, of those that we were eligible to participate in (excluding those which were paused by the provider) we participated in 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 2025/26.
- **Column 2:** The national clinical audits and national confidential enquiries that we participated in during 2025/26.
- **Column 3:** The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2025/26, 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)
Healthcare Quality Improvement Partnership (HQIP) - National Joint Registry (NJR)	Yes	99.49%
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	100%
King's College London - Sentinel Stroke National Audit Programme (SSNAP)	Yes	>95%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Managing acute illness people with learning disability	Yes	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Child Health Clinical Outcome Review Programme – Stabilisation of the critically ill child	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Pleural Procedures	Yes	Ongoing
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Medical and Surgical Clinical Outcomes Review Programme – Rib Fractures	Yes	Ongoing
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	Yes	>95%
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	Yes	>95%
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes	>95%
National Institute for Cardiovascular Outcomes Research (NICOR) - National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	>95%
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: 2025 Major Haemorrhage Audit	Yes	55%
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	Yes	100% from Primary care Partial return from Secondary care
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	0%
NHS Digital - National Diabetes Audit (NDA) – Transition (adolescents and young adults) and young type 2	Yes	100% from Primary care Partial return from Secondary care
NHS Digital - National Diabetes Audit (NDA) – Type 1 Diabetes (including insulin technologies)	Yes	100% from Primary care Partial return from Secondary care
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	26 cases
Parkinson's UK – UK Parkinson's Audit	Yes	100%
Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - EMLAP	Yes	100%
Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) – NO LAP	Yes	13 cases
Royal College of Anaesthetists - Perioperative Quality Improvement Programme (PQIP)	Yes	190 cases
Royal College of Emergency Medicine (RCEM) - Emergency Medicine QIPs: Care of Older People – Year 3	Yes	8%
Royal College of Emergency Medicine (RCEM) - Emergency Medicine QIPs: Care of Older People – Year 4	Yes	Ongoing
Royal College of Emergency Medicine (RCEM) - Emergency Medicine QIPs: Mental Health Self Harm – Year 3	Yes	56%
Royal College of Emergency Medicine (RCEM) – Emergency Medicine QIPs: Adolescent mental health – Year 1	Yes	Ongoing
Royal College of Emergency Medicine (RCEM) – Emergency Medicine QIPs: Time critical medications – Year 2	Yes	29%
Royal College of Emergency Medicine (RCEM) – Emergency Medicine QIPs: Time critical medications – Year 3	Yes	Ongoing
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%

Provider and Title	Are we participating in this?	Case ascertainment (1% cases submitted)
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): 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	100%
Royal College of Physicians - National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Yes	>95%
Royal College of Physicians - National Respiratory Audit Programme (NRAP): Asthma and COPD Primary Care	Yes	>95%
Royal College of Physicians - National Respiratory Audit Programme (NRAP): Children and Young people's Asthma Secondary Care	Yes	>90%
Royal College of Physicians - - National Respiratory Audit Programme (NRAP): COPD Secondary Care	Yes	>95%
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	Postponed by provider	Postponed by provider
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 Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre (NATCAN) – National non-Hodgkin lymphoma	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre - National Audit of Breast Cancer, Primary	Yes	100%
Royal College of Surgeons of England (RCS) - National Cancer Audit Collaborating Centre - National Audit of Breast Cancer, Metastatic	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%
The British Association of Urological Surgeons (BAUS) - British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	No	0%
The British Association of Urological Surgeons (BAUS) – Evaluating the Management Pathway for Suspected Testicular Cancer Referrals	No	0%
University 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% of National Audits with no participation in 2025/26:

National Diabetes Audit (adults) - National Pregnancy in Diabetes Audit (NPID): NPID requires manual data entry into the Clinical Audit Platform (CAP). Data is continuously collected by antenatal diabetes services and supplemented by linkage to the National Diabetes Audit, HES, and PEDW datasets. At the point of writing this, the national audit dashboard currently shows no data for Sandwell, indicating that no submissions have yet been made. Clinical Effectiveness have reached out to NPID clinical lead for confirmation of process and whether participation occurred. Following clarification with the NPID clinical lead, Clinical Effectiveness will work with the team to understand what barriers to data submission remain and put mitigations in place to secure data submission in 2026/27.

The British Association of Urological Surgeons (BAUS) - British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG): Due to capacity challenges within the Clinical Effectiveness team in 2025, the usual corporate support provided to the Clinical Lead (i.e. clarifying requirements and deadlines) did not take place, therefore we missed the opportunity to submit the data. The Clinical Effectiveness Standard Operating Procedures and the Business Continuity Plan have been reviewed to mitigate against any future challenges to mitigate the impact on national audit data submission.

The British Association of Urological Surgeons (BAUS) – Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST): This national audit was started by the Clinical Lead, however, due to our service's limited involvement in the care pathway of eligible patients, we were unable to populate all data required for data submission. This limitation was escalated to BAUS multiple times without response or mitigations, therefore we were unable to submit data to this national audit. The Clinical Effectiveness team continue to contact BAUS to request this issue be resolved for any relevant future studies so our participation is not restricted.

Local Quality Improvements in response to National Clinical Audit Findings:

The reports of 40 national clinical audits and confidential enquiries were reviewed in 2025/26 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 table below.

National Audit	Quality Improvement Activity
National Confidential Enquiry into Patient Outcomes and Death – ICU Rehabilitation	Following this national study, our service has agreed to complete a local audit using the NCEPOD audit tool. They will compare our local findings to the national report to identify areas for improvement and which national recommendations require implementation.
National Hip Fracture Database	Following the external review by the British Orthopaedic Association in 2024/25, which happened in response to a mortality outlier alert from the NHFD, we have spent 2025/26 reviewing and improving the NAIF pathway. Teams have launched a new NAFF service, which has improved length of stay from an average of 15.5 days in Aug 2025 to an average of 6.6 days in Dec 2025.
Society Acute Medicine Benchmarking Audit – Summer 2025	Findings from this audit indicated good Acute Medical performances at MMUH in early observations, timely senior decision making, and SDEC utilisation. Consultant involvement is good within the out of hours pathways. The service has identified the following areas to improve flow bottlenecks, hand overs and daytime capacity. Initial actions in place are: • Acute medicine consultant acting as RMO holding the admissions bleep each afternoon. • Acute Medicine consultant as ED in reach on Fridays and Weekends. • Local audit planned to look at each step in process as the service believe the findings indicate that there are no intrinsic delays in consultant review but there is room to improve individual steps in the process.
Royal College of Emergency Medicine: Care of older people	This audit identified issues relating to screening, assessments and documentation of management plans and mitigations. To promote learning and improvement from this audit the following actions have been recommended: • Staff training on delirium. • Early recognition of delirium and completion of care bundles. • Universal assessments. • Improve medication review, constipation/urinary retention assessments. • Strengthen falls mitigation (add non-slip footwear packs). • Implement checklist style safety rounds.
Royal College of Emergency Medicine: Time critical medications	This audit identified some opportunities to improve identification of patients requiring time critical medications, reducing delays and improving clarity around prescribing and administration. Recommended actions for improvements are: • Update Standard Operating Procedure (SOP) /guidelines. • Improve Unity documentation. • Training and education. • Increase protocol awareness. • Strengthen systems that support timely administration.

Local quality improvements in response to local clinical audit findings

At the time of writing, a total of 186 local clinical audits have been completed by our People at Sandwell and West Birmingham NHS Trust in 2025/26, with 117 of these having improvement actions in place.

A further 278 clinical audits are still ongoing at the time of writing this report. The table below 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 (see table below).

Local audit title and Specialty/ Department	Quality Improvement Activity
Compliance with Documentation of eOutcomes in General Surgery Outpatient Clinics – Colorectal General Surgery	To improve outcome documentation the service utilised their Quality Improvement Half Day to raise awareness. They also implemented a local process to directly notify via email doctors running relevant clinics. The service continues to work with the Unity Development Team with the aim of building a function that prevents closure of records prior to eOutcomes being completed.
Post Caesarean Section Infection Rates - Maternity	To reduce the rate of infections post-caesarean the service has agreed to standardise practice of allowing a 3-minute antiseptic drying period before procedures, as well as improving the standardisation of documentation through tools like checklists and SOPs. They also plan to start using vaginal prep for women with known ruptured membranes and review and implement the use of antimicrobial dressings for patients with BMI over 35, where evidence supports. The service will also update local guidelines to reflect improvements in practice.
Long Term Outcomes of Tubes in Uveitic Glaucoma - Ophthalmology	To improve outcomes in uveitic glaucoma surgery, the service has agreed to reduce or avoid using Molteno tubes. To improve patient experience, the service will also provide counselling to phakic patients to communicate the risk of subsequent cataract surgery.
Prescription of anti-coagulation for stroke prevention in atrial fibrillation – Acute Medicine	This audit identified opportunity to improve standardisation. As a result of this the service has updated the local SWB guideline to reflect current best practice. They plan to reaudit following a period of time to embed and raise awareness of the updated guideline.
Management of patients presenting with Diabetic Ketoacidosis, 2025 Re-audit – Diabetes & Endocrinology	The audit team delivered a session as part of the FY2 teaching timetable, to raise awareness of standards, clinical guidelines and encourage colleagues to advocate for effective DKA management and ensuring timely prescriptions and monitoring are completed.
Advice given to parents/carers at point of provision of equipment – Children's Community Therapy	When comparing SWB practice to the Royal Colleague of Occupational Therapist standards for equipment provision, it was identified that fewer equipment items were now being prescribed in the team due to changes in service provision. The team have agreed a change in strategy is needed to encourage consistent use of equipment handover sheets. The team are also reviewing supervision paperwork, to include regular reminders about the importance of using the handover sheets to evidence compliance with standards.

Local audit title and Specialty/ Department	Quality Improvement Activity
Adult sepsis management in ED – Emergency Care	To address gaps in compliance identified by this audit, the service are working with Unity developers on a series of amendments: Urine Output field, Target SpO2 and O2 given/time In the short term, they are using the smart text function to promote recording, and have implemented changes to local practice such as hourly monitoring by the nurse in charge when indicated, and having a "Sepsis Champion" identified every shift (i.e. SHO carrying the bleep) The service are also aiming to improve staff awareness of sepsis care standards through teaching at handover; compliance activity being displayed on dashboard; Daily 2-minute safety brief will commence soon; micro-learning weekly; induction pack updated; hot debriefs for any missed 1-hour element.
Evaluation of an Electronic Triage Tool for Cauda Equina Syndrome (CES): Assessing Accuracy, Safety, and Clinical Appropriateness – Community Medicine and Ambulatory Care	This initial baseline evaluation indicated that the electronic triage tool supported effective management of Cauda Equina Syndrome. The team have a plan for multi-site or external validation audits to benchmark triage tool performance and generalisability. They will develop a follow-up pathway to collect patient-reported outcomes and correlate them with triage allocations. Additionally, the plan is to embed automated CES safety-netting within the digital triage system to ensure standardised advice for all patients. Refining the automated risk-stratification algorithms, introducing mandatory symptom progression capture fields and strengthen clinician documentation prompts are also changes being made to the electronic tool to improve effectiveness.
Beyond 'Treat the Cause': Are We Aligning with NCEPOD Standards in Acute Pancreatitis? – Surgical Assessment Unit	This local audit based on the NCEPOD standards identified opportunities to improve identification and treatment of acute pancreatitis. The service has agreed they need to conduct an abdominal ultrasound and venous blood gas in all patients with suspected acute pancreatis. The service identified the need for more prompt referrals to alcohol services and importance of improving the documentation or cholecystectomy and intravenous fluids.
Anaemia in pregnancy – Maternity Theatres	The team has agreed to update pathways so that ferritin is recorded at booking and repeat Hb is done at 4 weeks. They will standardise the escalation criteria and provide additional training to midwives and obstetricians. They also plan to improve communication methods with the GPs regarding prescriptions to treat anaemia in pregnancy in the community.
DOAC, digoxin and soltalol and creatinine clearance audit – Integrated Primary Care	To improve compliance with recording creatinine clearance rates within the last 12 months in patients prescribed high risk renal drugs across the YHP clinical network, it has been agreed that a priority responsibility for the new Medicines Management Lead within YHP will work with colleagues to understand barriers to completing medication reviews and work to mitigate against these.
Audit of ADHD treatment in Adults – Integrated Primary Care	To ensure that the monitoring of adults with ADHD complies with the NICE guidelines, the service has established a working group, which will review the current standard operating procedure for recall of patients on medication, with the aim of identifying areas for improvement.
Speed of Access to Temporal Artery Ultrasound Scans for Suspected Giant Cell Arteritis, Jul 2025 re-audit - Rheumatology	To bring SWB more in line with the national 3-day target between requesting and performing ultrasound scans, the service will work closely with the radiology department to streamline the booking process and increase scan capacity. This audit also identified a high prevalence of borderline scan results, which anecdotally is higher than other centres, so the medical team have agreed to work more closely with reporting radiologists to better understand this issue and see if there are improvement opportunities.

Local audit title and Specialty/ Department	Quality Improvement Activity
Compliance of Category 3 Caesarean section in maternity theatres- SOP – Maternity Theatres	Following this audit, the team plan to provide thorough, clear counselling on the induction process-including benefits, expectations, and possible outcomes-while also discussing the risks and indications for caesarean section to support informed decision-making and reduce refusal rates. They will regularly monitor induction failure rates and review contributing factors to find opportunities for improvements within induction protocols. They also plan to Implement clearer and timely documentation practices for any delays, ensuring that staff record the reason, duration, and contributing factors to support analysis and improvement of workflow and patient care.
The success of imaging guided biopsy procedures – Interventional Radiology	This local audit evidenced consistently high standards being met at SWB. The main focus area for improvement is around documentation: The service is reviewing current documentation methods to identify potential opportunity to promote standardisation.
Assessment, Diagnosis and Initial Treatment of Testicular Cancer at SWB - Urology	To improve compliance with the EAU guidelines, the service will implement a proforma/clinic template for new testicular tumour patients.
Small for gestational age audit – Maternity & Perinatal Medicine	Following this audit, the team have decided to focus on thorough and timely risk assessments to support identification of babies small for gestational age. The team agree that performing regular growth surveillance using Symphis-Fundal Heigh (SFH) measurements at each appropriate antenatal visit, and ensuring that requested uterine artery doppler studies are performed along with the anomaly scan, will help improve compliance with identification and management of babies small for gestational age.
Evaluating the impact of a hospital move on Door to Balloon (DtB) times for ST-segment Elevation Myocardial Infarction (STEMI) patients – Catheter Lab	This local audit identified that there was a slight decrease in compliance with 'Door-to-balloon' standards after the service moved to MMUH. To return compliance to previous standards, the team are implementing pathway adaptations and reviewing communication strategies. This is in addition to putting on staff training and continuous monitoring of activity against the standards for the MINAP national audit.
Unplanned Readmission Rates within 30 days for Tonsillectomy - ENT	In response to the findings of this audit, the team have agreed to continue current safe peri-operative practices in tonsillectomy, as this showed low complications and readmission rates. They have also agreed to enhance adult patient counselling regarding risk of post-operative bleeding and then to seek urgent medical attention. The team will review return to theatre cases to identify any preventable factors and further opportunities for continuous quality improvement.
Rotational thromboelastometry (ROTEM) usage and documentation in Major Obstetric Haemorrhage - Anaesthetics	This audit identified the opportunity to create a standardised autotext within unity to support the use of and documentation of ROTEM. The team have also delivered a teaching session for staff members who are involved with ROTEM interpretation. There are ongoing discussions with the transfusion lead to integrate ROTEM more formally into major haemorrhage protocols, and the team are working on improving awareness and communication with the obstetrics team to ensure early involvement of anaesthetics in obstetric haemorrhage.
Getting it Right First Time (GIRFT) - Review of Surgical Skin Procedures within the Birmingham Skin Centre - Dermatology	This audit was completed prior to the introduction of teledematology at SWB and found that our biopsy to excision and non-definitive to definitive ratios were higher than the national average. The team will review the pathways and processes for clinical decision making, triage and assessment, and senior oversight. Where necessary, additional training will be delivered to increase confidence in avoiding unnecessary biopsies and better utilise methods like enhanced dermoscopy. The team are also reviewing the teledermatology pathway to develop KPIs to ensure diagnostic accuracy and avoidance of biopsies where appropriate. There is also an action to standardise documentation templates, and mandate recording of senior involvement.

Local audit title and Specialty/ Department	Quality Improvement Activity
Intubation of preterm babies at SWBH NHS trust – Neonatal Unit	When our practice was compared to NICE standards, it was identified that documentation required strengthening, so the team have agreed to implement a mandatory, standardised BadgerNet procedure template to ensure complete recording of indication, operator, attempts and complications. The indication form will also see the introduction of a mandatory, predefined list of rationale for using intubation as per the BAPM guidance. Structured simulation-based training and supervised opportunities will be provided to support Tier 1 clinicians develop their airway skills. An awareness piece will be completed to reinforce non-invasive respiratory support pathways. A change to process will see the introduction of a two-attempt limit per clinician with early escalation to senior staff and routine use of laryngoscopy.
Review of breast reduction referrals to the Sandwell and West Birmingham trust as per trust guidelines and national BAPRAS standards – Breast Surgery	The audit team are using the findings of this audit to develop visual resources to share with primary care clinicians to support effective referrals based on NHS criteria. The team are also pursuing the establishment of an "advice and guidance" service for clinicians to ensure more effective triage before clinic booking.
Idiopathic intracranial hypertension pathway - Neurology	Following this audit, the team plan to introduce a standardised IIH referral checklist to ensure all key assessments (acuity, RAPD, fields, fundoscopy, OCT) are completed and compliance with the standard of ST3+ review documentation is improved. Education sessions will also be provided. A review of the visual field-testing workflow will also be completed to identify opportunities for alternatives or streamlining of pathways.
Antibiotic Prophylaxis in Closed Fracture Fixation: Compliance with Local and NICE Guidelines at SWB – Trauma & Orthopaedics	To address poor compliance with the standards on antibiotic selection, timing adherence, and documentation, the T&O team plan to implement mandatory training on formulary adherence, correct timing and documentation. They also aim to raise awareness of accessible antibiotic protocols in operating theatres and clinics. They will also review checklists and template to strengthen documentation.
Baseline Audit of Compliance with Haemophagocytic Lymphohistiocytosis (HLH) Management Guidelines - Rheumatology	Since this audit, Rheumatology colleagues have agreed to strengthen communication with parent teams to ensure daily HLH screening bloods are sent, therefore aiding condition management. An update to the Unity HLH careset panel has been made to include all relevant blood tests, therefore making it easier for clinicians to understand the whole blood panel. A grand round was also completed to raise awareness trust wide of the new trust guidelines for this condition.

Stakeholder Comments

Statement of Assurance from NHS Birmingham, Black Country and Solihull Integrated Care Board

1.1 NHS Birmingham, Black Country and Solihull Integrated Care Board (ICB), in its role as commissioner for Sandwell and West Birmingham NHS Trust, welcomes the opportunity to provide this statement for inclusion in the Trust's 2025/26 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 27th May 2026, and this review has been undertaken in accordance with Department of Health and Social Care guidance. This statement of assurance has been prepared on the basis of the information made available at the time of review.

1.3 The information presented within this account provides a balanced overview of the healthcare services delivered by Sandwell and West Birmingham NHS Trust. It describes the progress made against the Trust's 2025/2026 priorities, identifies areas of strong performance, highlights where further improvement is required, and sets out the actions necessary to support delivery of the priorities for 2026/2027.

1.4 Throughout 2025/2026, the ICB has worked closely with Sandwell and West Birmingham NHS Trust, particularly in relation to Maternity and Neonatal services. This has included identifying areas requiring improvement following a recent Care Quality Commission inspection, the findings of the Baroness Amos Review and concerns raised by NHS England and working collaboratively with the Trust to support delivery of the necessary improvements. The Trust is focusing on reducing stillbirth rates, improving the safety and quality of care, reducing term admissions to neonatal care, and optimising induction of labour. Actions include strengthening triage arrangements, enhancing fetal growth surveillance, improving community pathways, and embedding learning from reviews into practice.

Further progress is required, and the ICB will continue to work with and support the Trust in this area throughout 2026/2027.

1.5 The Trust has made improvements in the interface between primary and secondary care, which is essential to supporting seamless patient pathways, reducing delays and strengthening communication across care settings. This has been identified as an important area of focus because of its direct impact on patient experience and wider system efficiency.

1.6 The ICB remains committed to working with the Trust in an inclusive and collaborative manner and to strengthening commissioner and provider relationships as arrangements continue to develop during 2026/2027.

Yours sincerely,

Sally Roberts
Chief Nurse/Clinical & Quality Officer
Birmingham, Black Country and Solihull (Cluster) Integrated Care Board

Healthwatch Sandwell

Thank you for forwarding the Quality Account for 2025/26 for comment.

There are some very interesting and informative areas like Martha's Law and the work that has been carried out which is commendable. It would have been good to know whether the trust had a positive result from translating the Patient Wellness Questionnaire (PWQ) into the 10 top languages.

Excellent work on no grade 4 pressure ulcers in the last 24 months and some very interesting research projects noted.

It would be good to understand the reported 100% Who Safer Surgery checklist compliance considering the wrong site eye injection never event.

The trust has been asked to amend some acronyms identified to ensure they are written in full in the account.

Amritpal Randhawa
Chair

Trust response

Sandwell and West Birmingham MHS Trust would like to thank our stakeholders for their valuable feedback on our Quality Account for 2025/26.

In response to the feedback received regarding the Who Safer Surgery checklist compliance. We confirm that the WHO Safer Surgery Checklist is completed for procedures carried out in our theatres. The wrong site eye injection never event was a procedure performed in an outpatient department. We are in the process of implementing local checklists for procedures in outpatient departments.

We look forward to continuing to work with our stakeholder partners in the coming year.

Sandwell and West Birmingham NHS Trust

Sandwell General Hospital
Lyndon
West Bromwich
West Midlands
B71 4HJ
Tel: 0121 553 1831

Birmingham City Hospital
Dudley Road
Birmingham
West Midlands
B18 7QH
Tel: 0121 554 3801

Birmingham Treatment Centre
Dudley Road
Birmingham
West Midlands
B18 7QH
Tel: 0121 507 6180

Leasowes Intermediate Care Centre
Oldbury Rd
Smethwick
B66 1JE
Tel: 0121 612 3444

Rowley Regis Hospital
Moor Lane
Rowley Regis
West Midlands
B65 8DA
Tel: 0121 507 6300

www.swbh.nhs.uk

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