Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 28 June 2012; 1530h - 1730h

Members

Mr R Samuda	(RS)	[Chair]
Mr R Trotman	(RT)	
Dr S Sahota OBE	(SS)	
Mrs G Hunjan	(GH)	
Prof D Alderson	(DA)	
Mrs O Dutton	(OD)	
Mr P Gayle	(PG)	
Mr J Adler	(JA)	
Dr D Situnayake	(DS)	
Mr R White	(RW)	
Miss R Barlow	(RB)	
Miss R Overfield	(RO)	

In Attendance

Mr M Sharon	(MS)	
Mr G Seager	(GS)	
Miss K Dhami	(KD)	
Mrs J Kinghorn	(JK)	
Mrs C Rickards	(CR)	
Mrs C Powney	(CP)	[Sandwell LINks]

Secretariat

Mr S Grainger-Payne	(SGP)	[Secretariat]

Guests

Mrs S Fitzpatrick MBE	(SF)	[Item 7]
Mrs J Dunn	(JD)	[Item 12]
Dr J Chilvers	(JC)	[Item 13.2]

Item	Title	Reference Number	Lead
1	**Apologies**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 31 May 2012 and 7 June 2012 as a true and accurate record of discussions*	**SWBTB (5/12) 147** **SWBTB (5/12) 148**	**Chair**
4	**Update on actions arising from previous meetings**	**SWBTB (5/12) 148 (a)**	**Chair**
5	**Chair and Chief Executive's opening comments**	**Verbal**	**Chair/ CEO**
6	**Questions from members of the public**	**Verbal**	**Public**
	PRESENTATION		
7	**Health Visiting**	**Presentation**	**SF**

MATTERS FOR APPROVAL			
8	**Quality Account 2011/12**	**SWBTB (6/12) 151** **SWBTB (6/12) 151 (a)**	**DS**
9	**Same sex accommodation declaration**	**SWBTB (6/12) 152** **SWBTB (6/12) 152 (a)**	**RB**
10	**Estates rationalisation proposal**	**SWBTB (6/12) 153**	**GS**
11	**Gamma camera replacement business case**	**SWBTB (6/12) 154** **SWBTB (6/12) 154 (a)** **SWBTB (6/12) 154 (b)**	**RB**
12	**Stroke reconfiguration business case**	**To follow**	**JD**
MATTERS FOR CONSIDERATION AND NOTING			
13	**Safety, Quality and Governance**		
13.1	Quality report	To follow	RO, KD & DS
13.2	Medical Education update	SWBTB (6/12) 155 SWBTB (6/12) 155 (a) - SWBTB (6/12) 155 (f)	JC
14	**Performance Management**		
14.1	Monthly finance report	SWBTB (6/12) 156 SWBTB (6/12) 156 (a)	RW
14.2	Draft minutes from the meeting of the Finance & Performance Management Committee held on 22 June 2012	To follow	RT
14.3	Monthly performance monitoring report	SWBTB (6/12) 157 SWBTB (6/12) 157 (a)	RW
14.4	NHS Performance Framework report	SWBTB (6/12) 158 SWBTB (6/12) 158 (a)	RW
14.5	Performance Management Regime – monthly submission	SWBTB (6/12) 159 SWBTB (6/12) 159 (a)	MS
14.6	Update on the delivery of the Transformation Plan	SWBTB (6/12) 160 SWBTB (6/12) 160 (a)	RB
15	**Strategy and Development**		
15.1	Communications and engagement strategy 2012 – 2017	SWBTB (6/12) 150 SWBTB (6/12) 150 (a)	JK
15.2	Communications and engagement update	SWBTB (6/12) 161 SWBTB (6/12) 161 (a)	JK
15.3	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (6/12) 162 SWBTB (6/12) 162 (a)	MS
15.4	Foundation Trust application programme		

▶	Programme Director's report	SWBTB (6/12) 163 SWBTB (6/12) 163 (a)	MS
16	**Operational Management**		
16.1	Listening into Action update	SWBTB (6/12) 164 SWBTB (6/12) 164 (a)	JA
16.2	Annual report from the Sandwell Community Adult Health division	SWBTB (6/12) 165 SWBTB (6/12) 165 (a)	RB
17	**Any other business**	**Verbal**	**All**
18	**Details of next meeting** *The next public Trust Board will be held on 30 August 2012 at 1530h in the Boardroom, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 7 June 2012

Present

Mr Richard Samuda (Chairman)
Mr Roger Trotman
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Mrs Olwen Dutton
Mr John Adler
Mr Robert White
Miss Rachel Barlow

In Attendance

Miss Kam Dhami
Mrs Jessamy Kinghorn
Mr Graham Seager

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson, Mr Mike Sharon, Miss Rachel Overfield and Dr Deva Situnayake.	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Questions from members of the public	**Verbal**
There were no members of the public present.	
4 Annual Accounts – year ended 31 March 2012	**SWBTB (6/12) 109** **SWBTB (6/12) 109 (a)** **SWBAC (6/12) 029 (b)**

Mrs Hunjan advised that the annual accounts for the year ended 31 March 2012 had been reviewed by the Audit Committee earlier in the day. She thanked the Finance department for its work to prepare the accounts ready for the audit and advised that the Committee had agreed to recommend the adoption of the accounts to the Trust Board. Mr White advised that when considering the accounts, the Audit Committee had requested further detail on non-tariff services, therefore a breakdown of those elements exceeding £1m would be prepared. The breakdown of consultancy costs was also reported to have been reviewed, with expenditure on fees in support of the Transformation Support Office being highlighted to be a major component. It was reported that the accounts remained unaltered following the audit. Mrs Dutton asked what fees were payable to the External Auditors and was advised that this was c. £170k. She also asked why legal fees had increased significantly and was informed that this was likely to have been associated with the work to transfer community services from Sandwell PCT to the Trust in 2011. Additionally, it was suggested that the number of cases progressing to litigation might have influenced the expenditure in this area. The Chairman asked whether the legal services contract was due to be retendered. Miss Dhami advised that the current legal services contract had been awarded in 2009 and that there was an option to review this for a further year, after which time there was an opportunity to retender the service if this was felt to be necessary. Mr Trotman noted that should this be the case, some residual work would continue to be processed by the existing provider. The Trust Board was asked for and gave its approval to the Audit Committee's recommendation to adopt the annual accounts for 2011/12.	
AGREEMENT: The Trust Board gave its approval to the Audit Committee's recommendation to adopt the annual accounts for 2011/12	
5 2011/12 audit memorandum	**SWBAC (6/12) 030**
Mr White advised that the audit memorandum outlined the basis of the work undertaken by the external auditors. The Board was pleased to note that the auditors planned to issue an unqualified opinion on the annual accounts. Mr White advised however, that the auditors had recommended a number of adjustments which the Trust had chosen not to action, including the treatment of transformation funding from commissioners which had been previously treated as deferred income. The value of the funds to which this related was reported to be £4.12m which although in the auditors' opinion did not meet the requirements of IAS37, was noted to not represent a material matter. A further recommendation was reported to concern the long term provision of consultancy services, where it was noted that payments of £138k had been made to one consultant over a 12 month period. It was reported however that this	

individual was part of a hosted service which had been inherited by the Trust, although it was agreed that a review of these arrangements would be needed. The recommendation concerning the lease on the Halcyon suite was noted to have been resolved, given that it had been determined that a lease was in place for this unit. The Board reviewed the previous recommendations made by the external auditors. Mrs Hunjan advised that the draft annual report had not been reviewed by the Audit Committee as had been expected, given that the issue had been raised in the 2010/11 review. It was agreed that a process for harmonising the review of the annual accounts and the annual report was needed. The Board accepted the audit memorandum.	
6 2011/12 Annual Governance Statement	**SWBAC (6/12) 032**
Mr White advised that the Annual Governance Statement had replaced the Statement of Internal Control (SIC). It was reported that the Annual Governance Statement covered all of the requirements of the Department of Health guidance and had been amended recently in line with feedback from the Trust's external auditors to provide greater detail on Board Development activity, explicit adherence to the Code of Governance and corporate risks. The auditors were noted to have remarked that the format of the Annual Governance Statement still resembled that of the SIC, therefore effort would be made in forthcoming years to develop a more flexible format. The Chairman asked where the Annual Governance Statement would be published. He was advised that this formed part of the annual report. The Trust Board was asked for and gave its approval for the Chief Executive to sign the Annual Governance Statement.	
AGREEMENT: The Trust Board gave its approval for the Chief Executive to sign the Annual Governance Statement	
7 Letter of representation	**SWBAC (6/12) 031**
The Board reviewed the letter of representation and agreed that the Chief Executive and the Director of Finance and Performance Management should sign the Letter of Representation.	
AGREEMENT: The Trust Board agreed that the Chief Executive and the Director of Finance and Performance Management should sign the Letter	

of Representation	
8 Any other business	**Verbal**
There was none.	
9 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 28 June 2012 and would be held in the Churchvale/Hollyoak Rooms at Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 31 May 2012

Present

Mr Richard Samuda (Chairman)
Mr Roger Trotman
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Mrs Olwen Dutton [Part]
Mr John Adler
Mr Robert White
Miss Rachel Barlow
Miss Rachel Overfield

In Attendance

Miss Kam Dhami
Mrs Jessamy Kinghorn
Mr Graham Seager
Dr Roger Stedman

Guests

Mr Jim Pollitt [Item 7 & 8]
Dr Jonathan Berg [Item 11]
Dr Natasha Ratnaraja [Item 12.3]
Mrs Gayna Deakin [Item 14.3]

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson.	
2 Declaration of Interests	**SWBTB (5/12) 084** **SWBTB (5/12) 084 (a)**
Mr Grainger-Payne presented the revised Register of Directors' Interests for approval, highlighting that it had been updated to reflect the Chairman's interests and a new interest declared by Mrs Hunjan. The Board was advised that since the preparation of the register, Mrs Dutton had	

also notified Mr Grainger-Payne of an additional two interests, which would be incorporated into a revised version prior to publication on the Trust's internet. The Board approved the Register of Interests.	
AGREEMENT: The Trust Board approved the Register of Interests	
3 Minutes of the previous meeting	**SWBTB (4/12) 081**
The minutes of the Trust Board meeting held on 26 April 2012 were approved.	
AGREEMENT: The minutes of the last meeting were approved	
4 Update on actions arising from previous meetings	**SWBTB (4/12) 081 (a)**
The Board reviewed the meeting action log and noted that there were no matters requiring escalation or needed to be raised for the Board's attention.	
5 Chair and Chief Executive's opening comments	**Verbal**
The Chairman advised that he had attended a clinical summit hosted by the Strategic Health Authority with had focussed on quality and patient safety. The Board was informed that he had chaired the recent Leadership Conference and had been impressed with the level of energy and commitment of managers at the Trust. The Chairman advised that he had attended a 'Listening into Action' event concerning development of Healthcare Sciences, which were to be aligned under the remit of the Associate Director of Healthcare Sciences. He added that he had spent much time familiarising himself with the organisation since his recent commencement with the Trust. Mr Adler thanked those members of the Executive Team who had taken responsibility for organising and presenting at the Leadership Conference. He highlighted that Sir Neil MacKay's speech had been particularly well received. Mr Adler advised that he had presented at an event launching the roll out of a new wave of Trusts implementing 'Listening into Action'. The Board was advised that divisional review meetings had been held recently and the annual round of Executive appraisals had been held. Mr Adler reported that the Trust was experiencing a high level of emergency care activity at present. It was also reported that on a national basis, doctors had voted in favour of industrial action as a result of the pension reforms that would take effect, however every effort would be taken to minimise the impact on patients. It was noted that the extent of support for the course of action within the Trust was unclear, however contingency plans would be developed.	
6 Questions from members of the public	**Verbal**
There were no members of the public present.	

7 Widening Participation	**SWBTB (6/12) 109** **SWBTB (6/12) 109 (a)** **SWBAC (6/12) 029 (b)**
The Trust Board received a presentation from Mr Jim Pollitt, Head of Learning & Development, which outlined the Trust's plans to provide work experience and work placement opportunities and to host apprenticeships and assistant practitioners. The Board was also appraised of the plans to develop a 'Learning Hub'. The Chairman asked whether there was a possibility that sponsorship could be secured to support the initiatives. Mr Pollitt confirmed that work was underway with a number of companies in this respect and that a number of additional links into commercial enterprises was also being considered. Dr Sahota remarked that the widening participation agenda was a positive development, particularly for apprenticeships. He suggested a potential source of funding that Mr Pollitt agreed to investigate. Dr Sahota advised that creation of links with the local skills academies, Sandwell College and the Local Authorities would be beneficial. Mr Pollitt confirmed that this was already in hand. Mr Trotman asked what staffing model would be needed for the 'Learning Hub'. Mr Pollitt advised that it would be staffed using existing resources available within the Trust. It was reported that the building used for this purpose would be a shared venture with a local community organisation, in which the Trust would have a permanent presence. It was highlighted that the venture supported the agile working philosophy. Mr Pollitt was thanked for his informative presentation.	
8 Update on Learning & Development	**SWBTB (5/12) 090** **SWBTB (5/12) 090 (a)**
Mr Pollitt presented an update on the key activities undertaken by the Learning and Development area, which he advised had recently been presented to the Trust Management Board. The Board was asked to note particularly the reduction in the Mandatory Training requirements for individuals from circa seven days per year to 11 hours. It was highlighted that a significant amount of investment had been directed to personal and professional development opportunities for staff. It was noted that the current redundancy and redeployment programme was delaying the full implementation of the apprenticeship framework at present, given that priority to opportunities such as these was given to individuals seeking redeployment.	
9 Register of Interests	**Verbal**
This item was discussed as part of the item for declarations of interests earlier in	

the meeting.	
10 Single Tender Action – recharge for academic posts	**SWBTB (6/12) 085** **SWBTB (6/12) 085 (a)**
The Board was asked for and gave its approval to make a payment of £,1,478,389 in respect of a recharge of salaries from the University of Birmingham Medical School for clinical academics based at the Trust.	
AGREEMENT: The Board gave its approval to make a payment of £,1,478,389 in respect of a recharge of salaries from the University of Birmingham Medical School	
11 Business case for integrated blood sciences	**SWBTB (5/12) 086** **SWBTB (5/12) 086 (a)**
Dr Jonathan Berg, Divisional Director for Pathology joined the meeting to seek the Board's approval of the business case for integrated blood sciences. Dr Berg reported that the Trust's Pathology services had been reconfigured to provide a 'hub and spoke' model within the past few years, with significant investment having been made to improve the Microbiology and Histopathology facilities. It was reported that this work had been a considerable success, however the development of a blood sciences facility was the next step to take and would underpin the Transformation Plan savings required of the Pathology area. It was highlighted a further driver concerned the inability to procure equipment that was suitable for the current environment. Dr Berg advised that the plans would provide a more efficient way of working for the area, however there were a number of risks and uncertainties with the approach. The business case was highlighted to be associated with a merger of services with those of Dudley Group of Hospitals NHS Foundation Trust and as such, the range of offering provided by the area could be expanded. The Chairman asked whether the business case had been reviewed and supported by the Strategic Investment Review Group (SIRG) and was advised that this was the case. He was further informed that Mr Trotman had taken a particular interest in the development of the plans. Mr Trotman advised the Board that the business case would facilitate the delivery of the required Transformation Savings Plans for the Pathology area and that as part of the new hospital project, the Pathology services would need to relocate regardless. Dr Sahota asked whether the Trust benefited from offering Vitamin D testing services. Dr Berg advised that this was the case and an appropriate pricing model had been agreed with commissioners. It was highlighted that a testing service was also offered directly to members of the public. In respect of the current region-wide pathology procurement exercise for GP direct access work, Mr Sharon reported that the business case would be presented to the local PCT clusters in July, with a view to awarding contracts for	

the work in May 2013. It was reported that the Finance & Performance Management Committee had recently reviewed Service Line Reporting and had noted that there was currently pressure on the GP access element. It was proposed therefore that there was a possibility that the plans might assist the position. Mr Adler remarked that the viability of the business case was compelling and that the plans had been discussed in much detail over recent months. He highlighted that they would provide a welcome opportunity to pursue an integrated approach to working. The Chairman summarised that the business case was clear and that it had been fully considered in the light of the uncertainty around the GP direct access work. The Trust Board was asked for and gave its approval to the business case for integrated blood sciences.	
AGREEMENT: The Trust Board approved the business case for integrated blood sciences	
12 Safety, Quality & Governance	
12.1 Quality report	**Hard copy paper**
Miss Overfield reported that the Safety Thermometer had been launched across the Trust in March 2012 and the first data had shown patients to be 91% harm free in April and 94% harm free in May. The Board was advised that this performance was in line with that of the region overall. It was reported that there had been a good reduction in the level of pressure damage, with the Strategic Health Authority confirming that performance was 'as expected'. A higher trend of falls at Sandwell Hospital than City Hospital was reported, which it was highlighted may reflect the different configuration of wards between the two hospitals. An outbreak of Norovirus was reported to have been experienced at Sandwell Hospital. Difficulties with recruiting midwives was highlighted, due to the requirement to pass literacy and numeracy tests, therefore additional measures were reported to be put into place to support, particularly for the numeracy testing requirement. In terms of Safeguarding, the Board was reminded that within the Provider Management Regime (PMR) return, the Trust's position concerning Learning Disabilities was flagged as red. It was reported however that this situation would be addressed by June 2012. Regarding nurse staffing levels, it was reported that the ratios looked to be acceptable, however there had been a need to use of bank and agency staff in a number of areas. The Board was advised that the previously high level of sickness absence within some areas of the Medicine & Emergency Care division had been improved through the use of a robust sickness absence phone line. Dr Situnayake reported that the downward trend on Hospital Standardised Mortality Ratio (HSMR) continued, with the current position being 93.1. The current Summary Hospital-level Mortality Indicator (SHMI) was reported to be	

1.01, 'as expected'. The Board was advised that a revised trajectory for the review of more mortality cases was currently being set. It was reported that the Trust had received a notification from the Care Quality Commission (CQC) in April 2012 that it was an outlier on the rate of mortality associated with biliary tract disease, however on investigation of this, it had been determined that this was reflective of a clinical coding issue that was currently being resolved and that there had been not been any preventable deaths identified within the cases reviewed. It was noted that although there had not been any new diagnoses flagged as an issue from a mortality perspective, deaths associated with fractured neck of femur needed to be given attention. In terms of the progress with embedding the requirements of the 'Five Steps to Safer Surgery', Dr Situnayake advised that an improvement plan had been developed for the Cardiology speciality to achieve a better performance than the current 75% rate of compliance and that overall work was underway to ensure that the briefing and debriefing steps were completed. Regarding stroke care, it was highlighted that there had been a deterioration in performance against the high and low risk TIA targets. Miss Overfield advised that the ward review process had identified that there had been a general improvement in standards across the Trust, however there remained a number of areas which were being given targeted support. It was highlighted that Emergency Assessment Unit at Sandwell Hospital had been placed into Special Measures. In terms of patient experience, it was reported that 800 patients had responded to the Inpatient Satisfaction Survey and a greater number of responses provided an 'excellent' rating. On the Net Promoter Score, it was reported that a performance of 56 had been achieved, with the CQuIN related to this being a requirement to achieve a 10% improvement by the end of the year. The Board was advised that this requirement would be challenging to achieve. Miss Overfield drew the Board's attention to the list of CQuIN targets attached to the report. Miss Dhami reported that the number of complaints breaching the failsafe targets was currently unacceptable, with 81 being in this position. The key reasons behind this position and the actions being taken to address the situation were outlined. The Board was advised that the CQC and Parliamentary Health Service Ombudsman (PHSO) had been alerted to the situation. It was reported that a trajectory had been set to issue 95 responses in each reporting period and that a change in senior leadership of the area was imminent. The Chairman asked whether the planned action was expected to deliver the results needed effectively. Miss Dhami advised that at present complaints were handled in a centralised manner, however there were plans to devolve the handling of the less serious complaints to the Trust's divisions. Mr Trotman reported that quality of responses was seen to be good, which reduced the number of linked responses received, yet meant that initial complaints responses took longer to issue. Mr Gayle noted that the caseloads of the individual complaints managers was high and that there appeared to be a number of administration issues. He asked in terms of devolving the less serious complaints, how this would be achieved. Miss	

Dhami advised that a set of templates for responses would be developed and that the Quality Assurance check of responses would continue to be undertaken centrally, in a manner analogous to that already in place within Community Services. Miss Overfield confirmed that the new ward based matron roles would assist with this work. Miss Dhami advised that the litigation cases would be supported by a secondment from the Trust's solicitors. Mr Adler confirmed that the responses issued at present were thorough and of a high quality and highlighted that very few cases were referred to the PHSO for resolution by unhappy complainants. He remarked that productivity of the team was low, which would be addressed in part by the change in leadership planned and the reorganisation of the team. The Chairman asked what next steps would be undertaken. He was advised that the key aim was to issue the 95 responses for the current reporting period and to see a month on month reduction in the backlog of complaints in breach of the failsafe targets.	
12.2 Approved minutes of the meeting held on 22 March 2012 and update on discussions held at the meeting held on 24 May 2012	**SWBQS (3/12) 034**
Mr Trotman asked the Board to receive and note the minutes from the Quality and Safety Committee meeting held on 22 March 2012, which had been approved at the meeting held on 24 May 2012. The Board was advised that at the meeting held on 24 May 2012, the Committee had received the annual update from the Local Security Manager, who presented the outturn report from 2011/12 and the forward workplan for 2012/13. It was reported that the updates detailed the objectives that had been achieved and those which had not in 2011/12. Of suggested interest for the Board, was the near completion of the lockdown capability at City Hospital. It was noted that the complaints handling situation had been discussed at the meeting and that the Committee had also considered the Integrated Risk Report and the Quarter 4 update of the Board Assurance Framework, which the Board would consider later in the meeting. It was reported that concern had been expressed with the mitigating activities to achieve an improved performance with compliance with the use of the World Health Organisation checklist. The other items of interest to the Committee were noted to have been the review of the clinical audit programme outturn report for 2011/12 and the forward clinical audit plan for 2012/13.	
12.3 Annual Infection Control report	**SWBTB (5/12) 087** **SWBTB (5/12) 087 (a)**
Dr Ratnaraja joined the meeting to present the annual Infection Control update. It was noted that the year had been challenging from an Infection Control perspective, however the annual targets for MRSA bacteraemia infections and *C difficile* infections had been met, with two MRSA bacteraemia having been reported against a maximum allowance of six and 92 *C difficile* infections reported	

against a trajectory of 109. It was reported that the Trust was below trajectory in terms of MRSA bacteraemia screening. A policy on MRSA screening on admission and after 28 days was reported to be being developed. Norovirus was highlighted to now be more widely occurring than within the traditional winter period. Work to reduce the number of contaminated blood cultures was reported to be underway to achieve a rate below 3%. The number of tuberculosis infections was reported to be stable, although the overall level was noted to remain high. A review of tuberculosis services was noted to have been undertaken, which reported that the Trust performed well in this area. Guidelines in respect of antibiotic stewardship were reported to be being revised at present. The Board was advised that there had been a recent focus on Pseudomonas cases, where it had been determined that the infection had been present in a number of babies. The source of the agent was reported to have been traced to some water outlets and therefore work was underway to resolve the issue on the Neonatal Unit and other areas as specified in national guidance. Regular audits were reported to show an improvement in compliance with hand hygiene measures. Miss Overfield advised that there was a need to strengthen the Infection Control screening measures. It was reported that the Community Services Infection Control activities were currently under discussion with the Trust's commissioners. Mr Gayle asked what training and awareness was planned in the community. Dr Ratnaraja advised that good links were in place with GPs for this purpose. She added that a screening project was underway to look at tuberculosis in the Cape Hill area of Smethwick, which revealed that approximately 10% of patients had a blood borne virus. Mr Adler observed that the trend on deaths associated with *C difficile* had reduced overall, however an upward trend had been seen recently. Dr Ratnaraja advised that this did not necessarily reflect the number of patients dying from *C difficile* as a primary reason, but was a cause cited on the patient's death certificate. It was reported that a table top review was undertaken on patients that had died specifically as a result of a *C difficile* infection. It was agreed that this distinction should be made clear within the report. Dr Ratnaraja was thanked for her update.	
12.4 Integrated risk report	**SWBTB (5/12) 088** **SWBTB (5/12) 088 (a)**
Miss Dhami reported that the full version of the quarterly integrated risk report had been considered by the Quality & Safety Committee at its meeting on 24 May 2012. She advised that there were no matters of exception that were not covered	

elsewhere on the agenda to raise to the Board.	
12.5 Being Open policy	**SWBTB (5/12) 089** **SWBTB (5/12) 089 (a)** **SWBTB (5/12) 089 (b)**
Miss Dhami presented the 'Being Open when things go wrong' policy for information, which she highlighted was designed to promote a culture of openness. It was reported that the policy had been refreshed to include the essence of the Department of Health report into Duty of Candour. It was reported that the policy had been considered by the Quality and Safety Committee and had been recently approved by the Trust Management Board. It was noted that there needed to be a mechanism for monitoring that staff were being open across the Trust and therefore the policy required the completion of a proforma in the event that a 'being open' discussion was needed. Mrs Kinghorn advised that she was considering how the policy linked with the Trust's Customer Care Promises.	
12.6 Board Assurance Framework – Quarter 4 update	**SWBTB (5/12) 083** **SWBTB (5/12) 083 (a)**
Mr Grainger-Payne presented the latest version of the Board Assurance Framework, which the Board was asked to receive and note. Good progress with addressing the actions to ensure closure of the gaps in control and assurance was highlighted.	
12.7 National inpatient survey	**SWBTB (5/12) 091** **SWBTB (5/12) 091 (a)**
Mrs Kinghorn presented the national inpatient survey, the benchmarking position was noted to show the Trust as performing in line with other trusts nationally. It was highlighted that the report was based on a small sample. Key elements of the survey included that more of the Trust's patients appeared to be offered a choice of hospitals than in other parts of the country and that fewer patients reported having shared sleeping accommodation with members of the opposite sex. Cleanliness scores were highlighted to have dipped. The Chairman asked whether this reflected a poorer standard of cleanliness in the Trust. Miss Overfield reported that the issue had been reflected in local audits, however the Trust remained to be performing well in national audits. It was suggested that the cleanliness issue concerned perception rather than the reality of increased infection rates. Dr Sahota noted the some patients had reported delayed discharges due to delays with preparing medicines to take home. Miss Barlow advised that actions to address this issue had been built into the plans for the patient flow workstream of the Transformation Plan. Mrs Dutton left the meeting.	

13 Performance Management	
13.1 Monthly finance report	**SWBTB (5/12) 092** **SWBTB (5/12) 092 (a)**
Mr White reported that the financial position in April had been stable and that as the income position was reported a month in arrears, it had been assumed that income was in line with plan. A surplus was reported to have been achieved in the month. It was highlighted that the divisional performance had been good, apart from in Facilities which it was reported had experienced some financial pressure in the month. Delivery of the Transformation Savings Plan was reported to have been £86k less than anticipated, with about half of the benefit delivered being associated with Internal Transitional Funding. The replacement schemes developed to address those not expected to deliver as expected, were reported to have been subjected to the usual scrutiny by the Performance Management Board.	
13.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 24 May 2012	**Hard copy**
Mr Trotman asked the Board to receive and note the draft minutes from the meeting of the Finance and Performance Management Committee that had been held on 24 May 2012. The Board was advised that at the meeting, a presentation had been given by the Facilities and Estates divisions, which had reported that there had been success in waste management, however the car parking scheme had suffered a shortfall due to initial issues within implementing a new barrier system. It was reported that in April 2012, Facilities was reporting a deficit of £19k, of which £9k was related to a shortfall in income from catering outlets, perhaps due to the recent Bank Holidays. Estates was reported to have generated a surplus of £3k. The Board was informed that Estates had presented a paper on energy and utility costs, with water costs being highlighted to be non-negotiable and electricity being purchased on a two-year contract through an NHS Framework agreement. Purchase of gas was reported to be within the gift of the Trust to control and therefore the Committee had supported an approach to purchase gas in the same way as that of the previous year, which had been successful in saving the Trust money against budget. Mr Trotman advised that there was nothing exceptional to raise from the Committee's discussions of the financial position or challenge, unlike in the previous year where there had been adverse results in the early months.	
13.3 Monthly performance monitoring report	**SWBTB (5/12) 093** **SWBTB (5/12) 093 (a)**

Mr White reported that the format of the performance dashboard was being considered at present. The level of delayed transfers of care was reported to be in excess of the threshold. Performance against the stroke care targets was highlighted to require further improvement.	
13.4 NHS Performance Framework report	**SWBTB (5/12) 094** **SWBTB (5/12) 094 (a)**
The Board was advised that according to the NHS Performance Framework the Trust's performance was classified as 'performing' and attracted a green governance rating.	
13.5 Provider Management Regime monthly return	**SWBTB (5/12) 095** **SWBTB (5/12) 095 (a)**
Mr Sharon reported that one of the key changes to the Provider Management Regime (PMR) submission concerned the performance against the new MRSA screening target. The Board declarations were highlighted to have remained the same as those of the previous month. It was highlighted that in terms of finance, there was a red status in respect of the income and expenditure surplus margin. Mr Adler asked if the Trust was now compliant with the requirements of the Learning Disability element of the PMR. Miss Overfield advised that the relevant documentation changes were nearly completed, however as the other measures had not been fully completed, it was necessary to continue to report non-compliance. On the Information Governance training position, it was highlighted that there was an expectation that the Trust would achieve compliance by December 2012, in line with the timetable set for compliance with all other mandatory training modules.	
13.6 Update on the delivery of the Transformation Plan	**Verbal**
Miss Barlow reported that the Transformation Plan had been the key theme of the recent Leadership Conference.	
13.7 Medical revalidation: update of organisational readiness and next steps	**SWBTB (5/12) 096** **SWBTB (5/12) 096 (a)** **SWBTB (5/12) 096 (b)**
Dr Situnayake provided a summary of the national guidance in respect of medical revalidation. He advised that final guidance from the General Medical Council (GMC) was awaited however. It was reported that the structure and format of medical staff appraisals had been published recently and a Medical Revalidation Implementation Group had been established, which would be supported by audit and clinical risk resources.	

An updated appraisal policy was reported to have been developed and reviewed by the Local Negotiating and Consultation Committee (LNCC) and the development of a programme for appraisal training was underway. The Board was advised that the medical revalidation requirements were a considerable challenge, given the number of staff which needed to be appraised. As such, a co-ordinated approach was suggested to be required to providing input to performance-related issues. It was also suggested that there was a need for software to be sourced to support the process and that a business case for investment in this software would be sought from the Strategic Investment Review Group (SIRG). The Chairman asked what resource implications were attached to the plans. Dr Situnayake advised that the requirements were annual and that the process would need to be Quality Assured. The Board was advised that the plans would be monitored by the Trust Management Board and that the Trust Board would receive an annual update. Mr Adler suggested that the performance against the revalidation plans should be tracked through the Trust's performance dashboards. Dr Stedman commented that the efficiency of revalidation provided a good view of clinical performance overall. Mr Sharon advised that the application for Foundation Trust status could be jeopardised, should the requirements not be met. It was agreed on this basis, that the matter should be added to the Foundation Trust risk register.	
ACTION **Mr White to arrange for medical revalidation progress to be included within the corporate performance monitoring dashboard** **ACTION:** **Mr Sharon to arrange for the medical revalidation plans to be added to the Foundation Trust risk register**	
14 Strategy & Development	
14.1 'Right Care, Right Here' programme: progress report, including an update on decommissioning	**SWBTB (5/12) 097** **SWBTB (5/12) 097 (a)**
The Trust Board received and noted the 'Right Care, Right Here' programme progress report.	
14.2 Clinical reconfiguration update	**SWBTB (5/12) 098** **SWBTB (5/12) 098 (a)**
Mr Sharon reported that the plans for the reconfiguration of Stroke Services would be presented to the Trust Board in June 2012. In terms of reconfiguration of Vascular Services, the Board was asked to receive and note the Equality Impact Assessment and Implementation plan that had been developed. It was highlighted that the timetable for Vascular Services reconfiguration looked uncertain at	

present.	
14.3 Workforce strategy and annual workplan	**SWBTB (5/12) 100** **SWBTB (5/12) 100 (a)**
Mrs Deakin joined the meeting to present the workforce strategy and workplan, which the Board was advised was a key supporting document to the Integrated Business Plan. It was reported that the strategy provided a high level view of how the organisation's objectives and vision might translate into how the workforce might operate in future. The strategy was noted to have been reviewed in a number of internal fora. Mrs Deakin was asked why there was little detail related to the current workforce. She advised that this would be included within the five year workforce plan, which would be implemented through an action plan. It was noted that leadership development was a key theme included in the strategy. The Chairman asked how the strategy was managed on a day to day basis. Mrs Deakin advised that the accompanying action plan set out the high level areas for implementation, progress with the implementation of which would be reported to the Organisational Development Steering group. Dr Situnayake asked whether the appraisal process was included within the strategy. He was advised that this was the case. Mr Adler asked whether the Strategic Health Authority had had chance to review the strategy. Mrs Deakin advised that this was the case and that feedback received as part of the review had been incorporated within the final version of the strategy. It was reported that the strategy would be published on the Trust's website and communication of key messages from the strategy would be undertaken. The Board was asked for and gave its approval to the strategy.	
AGREEMENT: The Trust Board approved the workforce strategy 2012-2018	
14.4 Foundation Trust application: programme director's report	**SWBTB (5/12) 105** **SWBTB (5/12) 105 (a)**
The Trust Board received and noted the Foundation Trust programme director's report.	
14.5 Midland Metropolitan Hospital project: programme director's report	**Verbal**
Mr Seager reported that approval of the Outline Business Case for the new hospital remained awaited.	
15 Update from the Committees	

15.1 Audit Committee	**SWBAC (2/12) 016**
The Trust Board was asked to receive and note the minutes of the Audit Committee meeting held on 9 February 2012. Mr White reported that the recent meeting of the Audit Committee on 17 May 2012 had comprised updates from Internal and External Audit and that the draft version of the Quality Accounts had also been considered.	
15.2 Charitable Funds Committee	**SWBCF (2/12) 003**
The Trust Board was asked to receive and note the minutes of the Charitable Funds Committee meeting held on 9 February 2012. Dr Sahota reported that the recruitment process for the Head of Fundraising had been discussed and the successful individual would take up post in September 2012. The Board was advised that an update had been received from the Trust's investment adviser, who had outlined the global economic situation and especially the recent instability in Greece. All spending plans from Charitable Funds managers were reported to have been requested. The Board was advised that support for the Trust Ball had been requested and approved.	
16 Any other business	**Verbal**
The Chairman reported that together with Mr Grainger-Payne he would be considering the balance of items considered on the public and private sessions of the Trust Board agendas.	
17 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1200h on 7 June 2012 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 28 June 2012, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 March 2012, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RS), Mr R Trotman (RT), Dr S Sahota (SS), Mrs O Dutton (OD), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

In Attendance: Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson, Mrs G Hunjan

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 June 2012

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	~~31/07/2011~~ ~~22/09/2011~~ ~~15/12/2011~~ 22/03/2012	Process flow of complaints process being developed at as part of the revised Complaints Handling strategy which will be shared with the ~~Trust Board~~ Quality and Safety Committee in ~~December February March April May~~ July ~~2011~~ 2012	A
SWBTBACT.220	Ward leadership capacity expansion plan	SWBTB (4/12) 070 SWBTB (4/12) 070 (a)	26-Apr-12	Prepare a Post Project Evaluation for the ward leadership capacity expansion plan for review by the Trust Board in April 2013	RO	01/04/12	ACTION NOT YET DUE	G
SWBTBACT.226	Medical revalidation: update of organisational readiness and next steps	SWBTB (5/12) 096 SWBTB (5/12) 096 (a) SWBTB (5/12) 096 (b)	31-May-12	Arrange for the medical revalidation plans to be added to the Foundation Trust risk register	MS	30/06/12	Not yet added	G
SWBTBACT.225	Medical revalidation: update of organisational readiness and next steps	SWBTB (5/12) 096 SWBTB (5/12) 096 (a) SWBTB (5/12) 096 (b)	31-May-12	Arrange for medical revalidation progress to be included within the corporate performance monitoring dashboard	RW	30/06/12	Appraisal rates now included in the corporate performance report	B

KEY:

R	Outstanding action due for completion more than 6 months ago. Completion has been deferred more than once or there is no firm evidence that it is being progressed towards completion
A	Oustanding action due for completion more than 6 months ago. Completion has been deferred more than once but there is substantive evidence that work is progressing towards completion
Y	Outstanding action raised more than 3 months ago which has been deferred more than once
G	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
B	Action that has been completed since the last meeting

Next Meeting: 28 June 2012, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 March 2012, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RS), Mr R Trotman (RT), Dr S Sahota (SS), Mrs O Dutton (OD), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Mr M Sharon (MS), Miss R Overfield (RO)

In Attendance: Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson, Mrs G Hunjan

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 21 June 2012

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.273	Minutes of the previous meeting	SWBTB (4/12) 081	31/05/2012	The minutes of the previous meeting were accepted as a true and accurate reflection of discussions held
SWBTBAGR.274	Declaration of Interests	SWBTB (5/12) 084 SWBTB (5/12) 084 (a)	31/05/2012	The Trust Board approved the Register of Interests
SWBTBAGR.275	Single Tender Action – recharge for academic posts	SWBTB (5/12) 085 SWBTB (5/12) 085 (a)	31/05/2012	The Board gave its approval to make a payment of £,1,478,389 in respect of a recharge of salaries from the University of Birmingham Medical School
SWBTBAGR.276	Business case for integrated blood sciences	SWBTB (5/12) 086 SWBTB (5/12) 086 (a)	31/05/2012	The Trust Board approved the business case for integrated blood sciences
SWBTBAGR.277	Workforce strategy and annual workplan	SWBTB (5/12) 100 SWBTB (5/12) 100 (a)	31/05/2012	The Trust Board approved the workforce strategy 2012-2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Quality Account- Final Version
SPONSORING DIRECTOR:	Deva Situnayake, Acting Medical Director
AUTHOR:	Rosey Monaghan, Senior Project Manager
DATE OF MEETING:	28 June 2012

SUMMARY OF KEY POINTS:

The Quality Account is a document which describes the Trust's activities against Quality Performance Indicators during 2011/12 and the quality indicators for 2012/13. It is a public facing document and every attempt has been made to write it in plain English.

It is written in a format prescribed by the Department of Health & Monitor and complies with their guidance.

The draft version of this document was presented to the Audit Committee & Private Session of the Trust Board in May 2012 and was amended following comment.

This document was sent to the External Auditor on 21st June 2012 and a Limited Assurance Report will be issued which will be appended to the Quality Account. This will be circulated as soon as it becomes available.

Section 1- Chief Executives Statement
Section 2- Priorities for Improvement 2012/13
Section 3- Review of Quality Performance 2011/12

This Quality Account is required to be published on the NHS Choices website and submitted to the Secretary of State by 30th June 2012. This Quality Account will be scrutinised by the SHA.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to approve and sign off this Quality Account

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Safe High Quality Care
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	Various
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial		
Business and market share		
Clinical	**Y**	
Workforce	**Y**	
Environmental	**Y**	
Legal & Policy		
Equality and Diversity	**Y**	
Patient Experience	**Y**	
Communications & Media	**Y**	
Risks		

PREVIOUS CONSIDERATION:

Initial draft to Execs, April 2012. Reviewed by Audit Committee & the Private Session of The Trust Board in May 2012 .

SWBTB (6/12) 151 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account

2011-2012

Where EVERYONE Matters

Part 1: Chief Executive's Statement

This is the third Quality Account for Sandwell and West Birmingham Hospitals NHS Trust (SWBH). It focuses on what we have done during 2011/12 to improve the quality of the care we give to our patients. In it we've included evidence that our work is of a high standard, and that we are continuing to get better.

The report begins with a description of our priorities for improvement in 2012/13 (part 2). Broadly, these will remain the same as those identified in our previous quality account, to give us an opportunity to build on the solid foundations that we laid during the course of this last year. In section two of this report we set out how we plan to do that and how we will go about measuring, monitoring and reporting our progress.

Our priorities for improvement, and the plans we have, were developed by working closely with the people we serve and those who have an interest in our trust; our stakeholders. Stakeholders and those who purchase our services on your behalf (commissioners) have been engaged at various points in the process, with their representatives and the Sandwell LINk involved in narrowing down the long list of options for quality priorities for 2012/13.

Throughout 2011 we also talked directly to the people we serve. In particular, we met with patients and local people and discussed what our priorities should be for the coming year. We also contacted over 7,500 members by post, sought input at the Annual General Meeting and used the local media to engage with local people.

As well as asking our patients, we've also talked to the people that work for us. We asked their views during a dedicated 'Team Brief', and these discussions were disseminated across the organisation, and discussed by the Trust Board. Finally, we included our own analysis of patient and staff surveys, service performance data, as well as other concerns that emerged throughout the year.

The third section of this year's quality account provides a review of our performance in 2011/12. The priorities we set focused on ensuring that we continue to provide safe, high quality care to our patients. As an organisation, this is our primary objective and everything else we do underpins this goal. This section recounts these objectives, and how well we performed against the plans we set.

As well as performing well against our priorities, we did a considerable amount of work on quality improvement that was not specifically set out in our last Quality Account. I would like to draw your attention to some of this now:

We achieved significant improvements in all of the quality objectives agreed with our local PCTs through the Commissioning for Quality and Innovation (CQUIN) schemes. By the end of the year, we fully met all the agreed targets in all 22 objectives. More details on this are contained in part 3.2 of this report.

The Care Quality Commission (CQC) has visited our trust during the past year. There has been a lot of publicity about it. They carried out several visits and I am glad to report that they have satisfied themselves that patients are receiving the standards of care they should expect. They have graded the trust as compliant with expected standards. Further information on this can be found in section 2.2.8.

In addition, during December 2011, a clinical review team from Sandwell PCT carried out a visit looking into the care of patients at both Sandwell Hospital and City Hospital. They commended the staff on both Trust sites on the development of high quality stroke services. They also commented that the patient and carer group made positive and constructive comments about their experience of care at both sites and the discharge arrangements from hospital.

Whilst we have made great steps in the right direction with stroke services, we have again made this one of our top priorities this year and will continue to improve the stroke services we offer.

The Quality and Safety Committee has been established to measure and monitor all aspects of quality in the trust. This group actively reviews and monitors progress and action plans associated with improving the service we provide. We are also making good progress with producing a monthly quality report which is seen by the Trust Board.

I confirm that to the best of my knowledge all of the information contained in this quality account is accurate.

John Adler
Chief Executive

Part 2: Priorities for improvement in 2012/13 and statements of assurance from the Board

In section 2 you will find a description of how we decided on our priorities for the coming year and who we have involved in making these decisions.

Section 2.1 sets out the priorities for 2012/13 and explains the rationale for selecting those priorities. This section also identifies how progress in each of the areas will be monitored, measured and reported.

Section 2.2 contains the statements of assurance from the Board. The purpose of these is to provide assurance to the public that SWBH is performing to essential standards, that we have appropriate systems to measure our clinical processes and performance, and that we are committed to implementing projects and initiatives aimed at improving quality. These statements are set out in a standard format to allow comparison with other similar providers.

Section 3 contains a review of Quality Performance in the Trust. It is in this section that you will find how we met the plans that we had from 2011/12. In addition, we describe our performance against other measures of quality.

2.1 Priorities for Quality Improvement in 2012/ 13

2.1.1 How we decided on the priorities for our Quality Account for 2012/13

Sandwell and West Birmingham Hospitals NHS Trust is always passionate about engaging with the people it serves. We began engaging with patients and local people about the 2012/13 Quality Accounts in September 2011 when Trust members and local people were invited to a discussion with the Chief Executive about progress on priorities in 2011/12 and priorities for the coming year. We promoted the event in letters to our 7,500 members and through local media.

Members of the public were asked for their input again at the Annual General Meeting and through a series of postcards that were returned and the feedback reviewed by the Trust Board in November, along with feedback from patient surveys and other patient engagement. Frontline staff were also asked for their views through a team briefing discussion topic that was disseminated across the organisation and this feedback was also discussed by the Trust Board.

Stakeholders and commissioners have been engaged at various points in the process, with the lay representatives and the Sandwell LINk involved in narrowing down the long list of options for quality priorities for 2012/13. Stakeholders have had the opportunity to comment before the report is finalised.

The Trust has continued to work on the development and implementation of its Quality and Safety Strategy. This is as outlined in our 4th Priority for last year.

Our Quality Accounts in 2011/12 were subject to audit and external feedback. Following a review of the feedback received in 2011/12 it was concluded that our priorities for improvement in 2012/13 should be presented in a format that aligns with the corporate priorities identified in the Quality and Safety Strategy.

With this in mind, it is proposed that, although the areas for improvement will remain generally the same in 2012/13, the objectives will be presented and monitored under the headings of Patient Safety, Clinical Effectiveness, and Patient Experience.

To establish what should be our highest 3 priorities this year, we have looked at our performance data from last year and have decided to increase our understanding further by adding more measures of our performance. This will help us to understand the needs of our patients even better, keep them safer, and improve their experience whilst under our care. Our performance will be reported in the Quality Report, once it has been finalised, to the Trust Board every month.

2.1.2 The priorities for improvement in 2012/13

In our Annual Plan 2012/13 we have identified our quality& safety priorities under the three domains described in our Quality and Safety Strategy:

Patient Safety	To reduce adverse events which result in avoidable harm	=	We do no harm to patients
Clinical Effectiveness	To reduce avoidable mortality and morbidity	=	Fewer patients dying and fewer having complications
Patient Experience	To increase the percentage of patients who would recommend the Trust to family and friends	=	Improved patient satisfaction

The 2012/13 Quality and Safety priorities are set out in Table 1. Although all the areas in Table 1 are key priorities, in this Quality Account we have selected four topics for particular focus and more detailed description. These topics are:

- Continuing to Improve the Stroke & TIA Services (Patient Safety);
- Essential Standards of Nursing Care (a combination of Patient Safety, Effectiveness of Care, and Patient Experience):
- Mortality reporting and analysis (Clinical Effectiveness);
- Improving Accident & Emergency Department Safety and Performance (Patient Safety).

Table 1. Quality & Safety Priorities 2012/13

Patient Safety
Improvements in Stroke services and outcomes and in the way in which we deal with Transient Ischaemic Attacks (TIA).
5 Steps to Safer Surgery – improvement in monitoring and assurance systems.
Reduction in avoidable weight loss in elderly patients (acute and community).
Delivery of national and local standards for reducing hospital acquired infections
Harm-free care in 4 key areas – pressure damage, falls with harm, venous thrombo-embolism (VTE), catheter associated infection.
Improvement in the safety and performance of our Accident & Emergency Departments (A&E).
Clinical Effectiveness
Improvement in outcomes for Trauma & Orthopaedic surgery.
Exceed CQUIN target for mortality reporting and analysis.
Improvement in awareness and diagnosis of Dementia.
Improvement in mortality of patients with pneumonia – avoiding admission where possible.
Patient Experience
Improvement in responsiveness to personal needs of patients.
Improvement in the experience of patients at the end of life.
Offering health improvement opportunities to expectant mothers who drink alcohol and smoke.
Introduction of the 'friends and family test' and establishment of real time monitoring and response to patient views.
Eradication of grade 2, 3 and 4 hospital acquired avoidable pressure ulcers.
Continuation of roll out of alcohol prevention strategy to specified outpatient specialties.

Focus Topic - Continuing to deliver service improvement and outcomes in Stroke and Transient Ischaemic Attacks (TIA) Services (Patient Safety)

We aim to maintain our stroke services in the top 25% nationally, and continue this performance long-term through 2012/13 and beyond. In 2011/12 we made good progress in this work, which we will build on through the Integrated Stroke Development Plan, which is linked to our Stroke and Transient Ischaemic Attack (TIA) Service Reconfiguration Project.

The improvements we intend to make are:

- Continuously deliver safe, timely care for stroke and TIA resulting in a reduction in long term complications including death
- Agree a preferred option for a reconfigured Stroke & TIA Service

- Continue to develop and implement our Stroke Strategy
- Improve the discharge arrangements for patients admitted with a stroke
- Achieve a target of early supported discharge for 40% of patients with Stroke by the end of March 2013
- Develop systems to monitor and respond to the experience of patients receiving treatment under our care
- Develop a monitoring system for stroke nursing competency training by the end of March 2013
- Carry out daily assessment of patients by specialist consultant clinicians for stroke
- Deliver value for money by ensuring delivery of stroke care that consistently achieves the expected quality indicators required to attract the Best Practice Tariff for Stroke. This means that the better care we give, the better the reimbursement from our commissioners, as set out in the Best Practice Stroke Tariff.

We will do this by:

- Participating in national and local audits of our stroke services
- Focusing and developing the Stroke and TIA pathways
- Completion of the public consultation and confirming the preferred option for the future
- We will meet all the main targets, some of which are new and are higher than last year, on the stroke dashboard and continue to improve the stroke discharge pathway which we achieved in 2010/11.

Table 2. This table shows the targets we plan to meet in 2012/13 which will indicate an improvement in our stroke care.

Main Stroke Targets	Target
Patients spending at least 90% stay on Acute Stroke Unit	80%
Patients admitted to Acute Stroke Unit within 4 hours	90%
Patients receiving CT Scan within 24 hours of arrival	100%
Patients receiving CT Scan within 24 hours of admission	90%
Patients receiving CT Scan within 1 hour of arrival	50%
TIA (High Risk) Treatment within 24 hours from initial presentation	60%
TIA (High Risk) Treatment within 24 hours of referral received by Trust	60%
TIA (Low Risk) Treatment within 7 days from initial presentation	60%
TIA (Low Risk) Treatment within 7 days referral received by Trust	60%
Stroke Discharge (meeting set criteria)	90%
Early supported discharge for stroke patients	40%

Monitoring, Measuring and Reporting

Our performance will be measured using a continuous stroke notes audit process, and using the stroke performance dashboard.

Performance will be measured and monitored by the Stroke Action Team, Trust Stroke Reconfiguration Project Board and Trust Management Board, in the Quality Report to Trust Board, and to the Quality & Safety Committee.

Focus Topic - Essential Standards of Nursing Care (Patient Safety, Clinical Effectiveness & Patient Experience)

We intend to continue to improve the safety and experience of our inpatients through specific attention to the reduction of harm events and through efforts to measurably improve the care we deliver.

We have given this priority the name of 'Essential Standards of Nursing Care' because it covers several of the quality priorities; reducing avoidable weight loss in elderly & vulnerable patients and health care associated infections (HCAIs) to below national and local standards; increasing harm-free care, including reducing pressure damage, falls with harm, VTE, catheter associated infection, dementia awareness and assessment. The indicators have been split in the sections below so that they can be linked to the indicators in the Annual Plan.

Reduction of avoidable hospital-acquired weight loss in elderly patients and vulnerable adults

Specifically we will:

- Introduce 'intentional rounding' (senior nurse ward rounds every 1-2 hours where a checklist of questions are asked, answered and documented) to ensure patients' essential care requirements are not missed
- Improve meal time experience
- Ensure patient hydration requirements are met
- Protect patients' dignity at all times

Monitoring, measuring and reporting

We will monitor progress/compliance through our ward performance review process. Data to support performance review will come from:

- Quarterly quality audits,
- Monthly audits of meal times and fluid balance recording,
- Point prevalence audit of avoidable weight loss in vulnerable adult wards (stroke and elderly care)
- Meal time, malnutrition universal screening test (MUST) assessment and fluid balance audits.

Specific measurable metrics:

- 90% or above achieved across all nursing quality measures recorded in quality audits
- 90% or above scores on meal time, malnutrition universal screening test (MUST) assessment and fluid balance audits
- Establish baseline (Quarter 1, 2012/13) and achieve 10% reduction by Q4 2012/13
- Ensure compliance with the CQC standards.

HCAIs - Control of Infection

We will continue to meet agreed standards and targets for infection control. This will include:

- Meet target set for C. Difficile (C. Diff)
- Meet target for Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia
- Monitor and record methicillin-sensitive Staphylococcus aureus (MSSA) and Escherichia Coli (E. coli) cases
- Monitor 30 day mortality for C. Diff
- Reduce the use of antibiotics associated with C. Diff
- Maintain Patient Environment Action Team (PEAT) scores at good or excellent
- Achieve hand hygiene standards
- Achieve MRSA screening targets
- Comply with CQC standards

We will monitor and measure our achievement by:

- Carrying out infection screening and ensuring that C.Diff mortality rates are monitored and reported monthly to Trust Board, Trust Management Board and the Infection Control Committee
- Carry out surveillance of MSSA & E-coli
- Monitoring cleanliness by carrying out audits and reporting to the Infection Control Committee
- Antibiotic usage is reported to Infection Control Committee and will be reported to the Trust Board and Trust Management Board on a monthly basis via the Quality Report
- Hand hygiene rates are monitored at Infection Control Committee.

Specific Metrics:

- The targets we have been set are that there will be no more than 2 incidences of MRSA bacteraemia, and 57 incidences of C.Diff during 2012/13
- MRSA screening target 2012/13 = 90% (to be finalised)
- Hand hygiene target to demonstrate a greater than 90% compliance
- Achieve an excellent rating against our PEAT assessment
- Demonstration of a reduction of antibiotic use based on Q1 baseline.

Increase harm free care across inpatient areas and District Nurse caseloads in 4 key areas

We intend to continue to improve the safety and experience of our inpatients through specific attention to the reduction of harm events and through efforts to measurably improve the care we deliver.

Specifically we intend to:

Introduce the Department of Health 'Safety Thermometer' (ST). This is a tool which will enhance our understanding of the totality of harm or harm free care experience of patients in 4 specific areas:

1. Pressure ulcers
2. Falls
3. Catheter-associated Urinary Tract Infections
4. Venous Thromboembolism (VTE).

Specifically we will achieve this through:

- Aiming to eradicate hospital acquired avoidable pressure ulcers grade 2, 3 and 4
- Reducing falls and associated harm
- Reducing hospital acquired avoidable weight loss in vulnerable adults
- Protecting patients' dignity at all times
- Introducing 'intentional rounding' as described above
- Increasing the number of patients on supportive care pathways (SCP) at end of life. This means keeping people well cared for at the end of their lives.

Monitoring, measuring and reporting

We will monitor progress/compliance through our ward performance review process. Data to support performance review will come from:

- Quarterly quality audits
- Incident reporting of pressure ulcers and falls

- Monthly ST completion on all patients staying in our hospitals
- Increasing the number of patients on the SCP – end of life audits

All of the above measures are already or will be included in the monthly Quality Report which goes to Trust Board, Quality and Safety Committee and Governance Board. More detailed reports go to the Trust Senior Nursing Forum and to divisional nurse cluster meetings and divisional governance meetings.

Performance is managed via the ward performance review process and directorate/ divisional reviews.

Specific measurable metrics:

- 90% or above achieved across all nursing quality measures recorded in quality audits
- 10 point improvement on net promoter score
- Eradication of hospital acquired avoidable grade 2, 3 and 4 pressure ulcers
- Reduction of 10% in falls with harm
- Completion of the 'Safety Thermometer' for all inpatients. Improvement in harm free numbers based on April baseline
- 60% or more relevant patients on supportive care pathways
- Achievement of privacy and dignity action plan and improvements in patient satisfaction relating to dignity, respect and inclusion in care and decision making.

Dementia awareness and assessment

We intend to raise dementia awareness and assessment by:

- Delivering a trust-wide campaign to raise awareness.
- Carrying out assessments of all people over the age of 75 who are admitted as emergencies who staying in more than 72 hours.
- As part of the 2 levels of the assessment a referral may result to a consultant or GP ensuring better care.

Focus Topic – Mortality Reporting & Analysis (Clinical Effectiveness)

We intend to continue to develop a system wide improvement in our knowledge and understanding of the Trust's mortality performance and the factors that influence deaths in our hospitals. We will use the Hospital Standardised Mortality Rates (HSMR) and Summary Hospital Mortality Index (SHMI), aiming to improve the Trust's performance. These measures allow us to measure our performance in comparison to other trusts' performance across the country. By adopting effective systems, processes

and practice at every level we aim to reduce avoidable harm and death.

The improvements we intend to make are:

1. Reduce mortality in the Trust
2. Understand the causes of deaths in our hospitals better, including in A&E Departments
3. Continue to review the agreed % of deaths in each month for all directorates using our Mortality Review System and learn from our findings
4. Develop an internal trigger system to alert specialties to trends or concerns in mortality
5. Broaden the tools we use to analyse the mortality data.

Specifically, we will:

- Review more than 60% of deaths that occur in our hospitals. This will be done by a senior doctor
- Ensure that any death that is identified as being potentially avoidable will undergo a root cause analysis to understand the issues further
- Review mortality with the Divisional and Directorate teams as part of the Quarterly Divisional Review process
- Continue with the introduction of the 'Sepsis Adult Care Pathway Proforma'
- Add the SHMI to the range of tools that we use to analyse mortality data
- Continue to develop our programme of Enhanced Clinical Audit of outlier areas which are identified by SHMI/HSMR data and our Mortality Review System.

Monitoring, measuring and reporting

Compliance against mortality reviews standards are communicated to Clinical Directors on a weekly basis. Performance is reported as part of the Quality Management Framework (QMF) to the Mortality and Quality Alerts Committee, Trust Surviving Sepsis Committee, Governance Board, Quality and Safety Committee, and Trust Board.

Focus Topic - Improving Accident & Emergency Department Performance (Patient Safety)

Whilst we do consider that progress has been made within our A&Es, we do feel that we could still do better. We intend to work to improve in all 3 domains of our Quality & Safety Strategy, but mainly in Patient Safety.

We intend to:

- Improve the flow of patients through our A&Es
- Ensure that alternatives to A&E are appropriately used
- Reduce the incidence of serious incidents and consequent harm to patients
- Increase the A&E workforce
- Ensure safer and more consistent clinical practice.

Specifically, we will:

- Continue to recruit more middle and consultant grade doctors to the A&Es
- Continue to develop and monitor systems to ensure that clinical care is of a consistently high standard
- Continue to closely analyse incidents and take action to eliminate identified root causes
- Ensure that there is a process in place for any deaths in A&E to be reviewed by senior doctors
- Support the delivery of the Integrated Development Plan for our A&E Departments, working in partnership with the commissioners
- Improve the Information Technology systems to support the development of automated clinical dashboards
- Continue work with our partners in Primary Care to ensure patients who do not need to be treated in the A&E Departments are appropriately redirected
- Continue to meet national standards in respect of 4 hour waits, and perform better against the other national standards for A&E Departments
- Ensure protocols/guidelines are being followed to provide a consistent level of high quality care.

Monitoring, measuring and reporting

Performance will be measured and monitored through the Emergency Department Action Team, reporting direct to the Trust Board. This is an action group, chaired by the Chief Executive, which is responsible for monitoring actions against the Integrated Development Plan. Compliance audits will be carried out to assess the level of compliance with agreed protocols.

Specific metrics are available via the national 4 Hour measure and A&E Clinical Indicators. All have target levels of performance.

2.2 Statements of Assurance from the Board

2.2.1 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;
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

…….. Date …….. Chair

…….. Date …….. Chief Executive

2.2.2 Annual Governance Statement

This Statement sets out for our staff and stakeholders of Sandwell & West Birmingham Hospitals NHS Trust the way in which it is governed and managed, and how it is accountable for what it does. The Governance Statement is Appendix 1, which can be found at the end of this Quality Account.

2.2.3 Review of Services

During the period 2011/12 the Sandwell and West Birmingham Hospitals NHS Trust provided and/or subcontracted 46 NHS services.

The Sandwell and West Birmingham Hospitals NHS Trust has reviewed all the data available to it on the quality of the care in all 46 of these services. Where the trust has subcontracted any activity, it would only be to a provider which was registered with the CQC. Agreements between the Trust and the subcontracted providers require that the same high standards of care given by SWBH are maintained when giving care on our behalf. The health benefit and activity data undergo the same level of scrutiny as that delivered in the Trust.

The income generated by the NHS services reviewed in 2011/12 represents 100% per cent of the total income generated from the provision of NHS services by Sandwell and West Birmingham Hospitals NHS Trust for 2010/11.

2.2.4 Participation in Clinical Audits

During 2011/12, Sandwell & West Birmingham NHS Hospitals Trust has participated in 41 (provisional) national clinical audits and 2 national confidential enquiries covering NHS services which the Trust provides.

The Trust has reviewed all the data available to it on the quality of care in all of these services.

During that period Sandwell and West Birmingham Hospitals NHS Trust participated in 98% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in. The reason SWBH did not participate in 2% of audits was because the Trust did not provide the service or procedure required for inclusion in the audit.

The national clinical audits and national confidential enquiries that Sandwell and West Birmingham Hospitals NHS Trust participated in and for which data collection was completed during 2011/12, are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (Table 3).

Table 3.

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Peri – and neonatal		
Perinatal mortality (CEMACH)	Yes	100%
Neonatal intensive and special care (NNAP)	Yes	100%
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	100%
Pain management (College of Emergency Medicine)	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100%
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Yes	100%
Non–invasive ventilation (NIV) – adults (British Thoracic Society)	No	0
Pleural procedures (British Thoracic Society)	Yes	67%
Cardiac arrest (National Cardiac Arrest Audit)	Yes	33%
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	100%
Seizure management (National Audit of Seizure Management)	Yes	100%
Long term conditions		
Diabetes (National Diabetes Audit)	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	57%
Chronic pain (National Pain Audit)	Yes	100%
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Yes	100%
Adult asthma (British Thoracic Society)	Yes	100%
Bronchiectasis (British Thoracic Society)	Yes	100%
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	93%
Elective Surgery (National PROMs Programme)	Yes	73%

Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	86%
Carotid interventions (Carotid Intervention Audit)	Yes	100%
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	93%
Elective Surgery (National PROMs Programme)	Yes	73%
Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	86%
Carotid interventions (Carotid Intervention Audit)	Yes	100%
Cardiovascular Disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	88%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SINAP)	Yes	13%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head & Neck Cancer (DAHNO)	Yes	100%
Oesophago- gastric cancer (National O-G Cancer Audit)	Yes	100%
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	42%
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	95%
Medical use of blood (National comparative Audit of Blood Transfusion)	Yes	100%
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	100%
End of life		
Care of dying in hospital (NCDAH)	Yes	100%

National Confidential Enquiries (Clinical Outcome Review Programmes)		
Maternal, infant and perinatal programme National maternal and perinatal mortality surveillance	Yes	100%
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following studies in 2011/12 - Bariatric Surgery (ongoing) - Peri-operative Care Study - Cardiac Arrest Procedures - Surgery in Children	Yes	Yes Ongoing 23% 100% 100%

The reports of 10 national clinical audits were reviewed by the provider in 2011/12 and Sandwell and West Birmingham Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare we provide:

Table 4. National Audits Reviewed

Report	Findings, Our Learning, & Our Actions
Provisional Monthly Patient Reported Outcome Measures (PROMs) in England <u>Audit description</u> An audit of outcomes reported by patients undergoing hip replacement, knee replacement, varicose vein surgery and surgery for inguinal hernia repair	<u>Key findings/learning</u> The provisional data has shown that improvements are required particularly in relation to procedure specific scores for patients undergoing knee replacement. <u>Action</u> A number of steps are being taken to ensure that patients consider that they are receiving the best service possible. The actions include: • To improve the scope and quality of pre-operative information. • To introduce a patient satisfaction questionnaire for patients undergoing joint replacement. • To expand the scope of the 'enhanced recovery programme. The programme focuses on making sure that patients are active participants in their own recovery' process. It also aims to ensure that patients always receive evidence based care at the right time.

NCEPOD: Are we there yet? Audit description This was an audit conducted by the National Confidential Enquiry into Post-operative Outcomes and Death (NCEPOD) The audit aimed to explore the remediable factors in the processes of care of children aged 17 and younger, including premature babies, who died prior to discharge and within 30 days of emergency or elective surgery.	Key findings/learning The baseline assessment against the key recommendations contained in the report identified some initial actions that needed to be taken. Action The action required includes reviewing the compliance with local transfer policies and to review the local policy on who can operate and anaesthetise children to ensure compliance with best practice.
National Confidential Enquiry into Suicide and Homicide for people with Mental illness - Annual Report 2011 Audit description The enquiry examines all incidences of suicide and homicide by people in contact with mental health services in the UK. They also examine all cases of sudden death in the psychiatric inpatient population.	Key findings/learning The report has been considered and although there are no specific recommendations requiring action, the Trust continues to ensure its systems are robust in order to assess the level of suicide risk and to take action if patients who have self-harmed. Action A Therapeutic Observation Policy which indicates the level of staff supervision dependent on the level of risk has been implemented. In addition, there is access to specialist Mental Health teams on both sites and training is available for a range of challenging Mental Health conditions. There is a tool for reviewing environmental risk to patients who are at risk of suicide and work to reduce ligature points is ongoing. All of the above is monitored via the Safeguarding Steering Group.
Perinatal Mortality West Midlands Perinatal Mortality Institute report: • Birmingham & Solihull and Black Country cluster Infant mortality reports 2010	Key findings/learning The Birmingham and Black Country Cluster areas have for some time recorded stillbirth, neonatal, perinatal and infant mortality rates significantly higher than national averages. This has not improved during 2010 and has historically been associated with social deprivation and ethnicity demographics concentrated in pockets within both

Audit description The report covers the Black Country NHS Cluster and the Birmingham and Solihull NHS Cluster and its constituent Local Authorities and provider units. It contains data with reference to the West Midlands (WM), and includes stillbirth, perinatal and infant mortality data up to 2010.	within both clusters. The Trust continues to serve populations with the highest incidence of these demographics of all the providers in the clusters. Action The Trust identified an action to work to enhance the scope of the risk assessment process undertaken in the community and its linkages with that undertaken in the acute hospital.
NCEPOD: Knowing the risk? This was an audit conducted by the National Confidential Enquiry into Post operative Outcomes and Death (NCEPOD) Audit description The study aimed to carry out a national review of the peri-operative care of patients undergoing inpatient surgery	Key findings/learning The baseline assessment against the key recommendations contained in the report identified some initial actions that needed to be taken. Action These included establishing a continuous audit of patients admitted and managed at a lower level of care because of a lack of capacity. Also to scope the further development of enhanced recovery pathways.
National Neonatal Audit Programme – Annual Report 2010 Audit description The key aims of the audit are: • To assess whether babies requiring neonatal care received consistent care across England in relation to the audit questions; • To identify areas for improvement in neonatal units in relation to delivery and outcomes of care; • To provide a mechanism for ensuring consistent high quality care in neonatal services	Key findings/learning The audit showed that compliance was below the national average for Retinopathy of Prematurity (ROP) screening, parent communication within 24 hours of admission and the antenatal steroid rate. It was considered that this was due in part to inadequate recording on the BADGER database system. Data from BADGER feeds into the national report. Action One of the key areas for action is to ensure that data recording on the system is improved and to audit these areas to check accuracy of results and to take action to improve compliance if this is indicated.

National Joint Registry (NJR) 8th Annual Report 2011 Audit description The NJR aims to improve patient safety and clinical outcomes by providing information to all those involved in the management and delivery of joint replacement surgery, and to patients. This is achieved by collecting data in order to monitor the effectiveness of hip, knee and ankle replacement surgery and prosthetic implants.	Key findings/learning The report encouraged all NHS Trusts and NHS Foundation Trusts to record all hip, knee and ankle replacement operations on the NJR. In addition, to ensure that consent from patients to store their personal details is taken and that the NHS number of patients is submitted in order that the ability to link all operations relating to a single patient is maintained. It was considered that the Trust had good systems already in place to ensure that this happened. The NHS number recording is monitored by the NJR Regional Coordinator and the Trusts compliance for 2010/11 was 98%. Action To continue to ensure that all relevant cases are recorded on the NJR database
National Pain Audit – Phase 1 Report Audit description The National Pain Audit has reported organisational data for the years 2010 – 2011 against a wide range of standards set by the Faculty of Pain Medicine, British Pain Society and International Association for the Study of Pain.	Key findings/learning The report indicated that patient waiting times for treatment needed to be better understood. The Trust currently monitors waiting times and local audits are conducted, however, further work is required to investigate the impact of any waits. The audit also recommended that patients should be provided with multidisciplinary care and that if this cannot be provided then they should be signposted appropriately. It was considered that the Trust provided multidisciplinary treatment but that there was no direct psychology input into the clinic. Action A key action arising from the audit was for the Trust to investigate funding for additional staff in the pain clinic or the provision for shared roles with community staff, mental health services and with GPs. Also to increase the levels of extended practitioner care e.g. nurses

	who are trained in Cognitive Behavioural Therapy (CBT) and to improve patient information leaflets for local service access.
National Diabetes Paediatric Audit Report 2009-2010 Audit description The audit presented the Key findings about the quality of care for children and young people with diabetes in England and Wales the report for the audit period 2009-2010.	Key findings/learning The audit examined the proportion of children and young people with diabetes that were receiving the key processes of diabetes care. The main care process which was low in the Trust was Retinopathy Screening. The audit results also highlighted the need for increased paediatric diabetes specialist nursing input. Action To send parents reminders to take their children for screening in the community and to improve monitoring through improved information technology. Deficiencies in specialist nursing support are due to be rectified with the appointment of a second paediatric nurse specialist. This will help provide more home support for diabetic children and hopefully reduce admissions.
National Bowel Cancer Audit 2011 Report Audit description The audit is run in conjunction with the Association of Coloproctology of Great Britain and Ireland and is designed to assess whether patients with colorectal cancer receive the appropriate treatment for their cancer when it is first discovered.	Key findings/learning The baseline assessment against the key recommendations highlighted that there was good compliance apart from on the recording of complications following surgical resection. This was a national key finding. Action To take steps to improve the recording of any complications following surgical resection.

The reports of 16 local clinical audits were reviewed by the provider in 2011/12 and Sandwell and West Birmingham Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Table 5. Local Audits Reviewed by the Trust

Audit Topic	Actions identified
Acute Pain 'Out of Hours' Audit Audit description To review the escalation of pain issues out of hours and to measure compliance with national standards.'	Key findings/learning Although the sample was small, the audit highlighted the need to raise awareness regarding the escalation of pain issues and to reinforce the guidelines for the management of pain 'out of hours'. Action To present the requirements for 'out of hours' pain management at junior anaesthetist inductions and at pain management study days. In addition to the above, a further action arising from the audit was to explore amending the Trust's shaded observation charts (incorporates psychological triggers for escalation and senior review) to include traffic lights and for alerts to the Emergency Medical Response Team (EMRT), based on pain scores.
Audit on Cranial Ultrasound screening in preterm Audit description To measure the Trust's compliance with South West Midlands Neonatal Network guidelines for cranial ultrasound screening in preterm babies.	Key findings/learning The audit showed that the majority of preterm babies received cranial ultrasound screening in accordance with South West Midlands Neonatal Network guidelines. The audit did highlight that some scans were delayed and that the documentation of the communications with parents needed to be improved. Action • To update cranial ultrasound screening documentation sheets to include a tick box to indicate that parents have been made aware of the results of the scan • Weekly Ward Round Sheet to identify when head scans are due • To emphasize the requirements for head scans during neonatal doctors' induction

Audit of post appendicectomy wound infections Audit description The audit aimed to assess wound infection rates following appendicectomy and to determine whether changes to the antibiotic guidelines and reconfiguration have affected wound infection rates.	Key findings/learning The audit findings indicated that there was some variability of antibiotics prescribing in terms of dose and duration and in the preoperative cleansing of the patients' skin. It also highlighted the need for ongoing staff education to facilitate standardisation of practice. Action To update the appendectomy protocol with a new antibiotic flowchart and to promote this in operating theatres.
Audit of anaesthetic record keeping in Obstetrics Audit description Audit of the documentation of consent, anaesthetic assessment, assessment of regional anaesthetic block adequacy, and chart to measure compliance with the standards set by RCOA & OAA.	Key findings/learning Overall the result demonstrated that there was an improvement in documentation compared to the previous audit findings. Some areas of weakness were found in the recording of preoperative assessment details and in the completion of the post-operative care and instructions sections. Action To make changes to the current documentation to improve the recording of the areas of weakness that were identified.
Audit of outcomes radiofrequency ablation of varicose veins Audit description The audit aimed to examine the patients' intra-operative and postoperative events and to measure compliance with NICE guidance.	Key findings/learning The majority of patients in the audit sample had no post operative complications. In the number that had post op complications, the main complication was phlebitis (inflammation of the wall of the vein). Action The action required as a result of the audit included updating patient information leaflets with further information on the possible side effects and complication rates.

An Audit of Visual Fields Requests Audit description An audit to measure the compliance with aspects of NICE clinical guideline 85 (Glaucoma).	Key findings/learning The audit highlighted the need to improve documentation to ensure that the outcomes of visual field tests are always recorded in patient records and in GP letters. Action To circulate reminders to junior doctors of the need for this to be documented and for the compliance to be monitored going forward.
An Audit of Neuropenic Sepsis Audit description To assess whether the door to needle time with intravenous (IV) antibiotics is achieved within the target of 1 hour for patients with neutropenia or suspected neutropenia.	Key findings/learning The audit found that not all patients received antibiotics within the recommended time frame and that the use of the Shift Coordinator reduced the door to needle times. Action • To continue education sessions for staff in A&E Departments to reduce times further • Chemotherapy and MDS alert cards to be issued to patients to carry with them, reinforcing the symptoms and the use of the helpline. • To monitor compliance on a rolling basis. This audit to be completed every 20 patients or 3 months, whichever occurs sooner.
An audit of patient consent Audit description To assess compliance Trust policy on obtaining consent to treatment.	Key findings/learning The audit found that although in the majority of cases the clinician taking consent for elective procedures prior to admission was a Consultant, Associate Specialist or Specialist Registrar grade doctor, there was need to reinforce with Directorates that to take delegated consent the appropriate training and authorization is required. The audit also found that the formal recording of whether the patient had

	been supplied with a copy of the consent form and whether they had been provided with an information leaflet needed to be improved. Action To implement a rolling audit to monitor compliance with local policy and to further scope the availability of national information leaflets in patient areas.
Essence of Care Audits & Observation of Care audits Audit description A biannual audit of records and a practical observation of care on the wards. The audit covers 7 categories: • Respect and dignity • Eating and drinking • Bladder and bowel care • Safety • Self Care (hygiene, mouth care, mobility) • Pressure ulcers • Environment and staff	Key findings/learning The most recent results demonstrated ongoing improvement against most standards in both the observations of care and in the record keeping of care. Action All wards and divisions are presented with tailored performance reports and action plans are developed to address specific areas of unsatisfactory performance against the standards being measured. Audit results are fed into the Ward Review process and are discussed with ward staff at a feedback session.
Hand hygiene audits Audit description As part of Trust's ongoing initiatives for the reduction and prevention of healthcare associated infections, all clinical areas are required to undertaken hand hygiene audits.	Key findings/learning Results for 2011 showed that overall there was an improvement in most standards compared to the year 2010. Ward/Department Hand Hygiene Audit scores ranged from 88% to 100% in 2011 (Mean 94%). Action Any ward /department whose score falls below 95% is required to undertake the audit weekly until 95% compliance has been achieved.

Mortality audits Audit description Audits of specific diagnostic groups to determine whether any quality of care issues are present. Audits conducted by specialties to review deaths that occur under their care. Reviews of data collected under the Initial Mortality Review System to determine whether there are any lessons that can be learned.	Key findings/learning The audits have identified areas where care processes and the recording of care can be enhanced. Action Some actions identified from the audits of mortality in specific diagnostic groups have included: • Development of local guidance to assist in the management of patient groups • Further audit to understand aspects of care in more detail, including compliance with policies • Review of coding practice to ensure that the most accurate information about a patient's diagnosis is recorded. Actions required to enhance the system for the initial medical review of deaths include: • Adding supplemental questions for specific diagnosis groups • Developing systems to evaluate and enhance the depth of clinical coding
Saving lives Audits Audit description The Trust has implemented the revised Saving Lives High Impact Interventions (HIIs) audit tools since 01/04/04. To enable the wards, departments and the Trust to monitor compliance against the HIIs the Trust has developed a database to facilitate the inputting, collating and reporting of data.	Key findings/learning The audit data continues to show good overall compliance (98% Feb 2012). Action Any clinical area where clinical practice/ interventions outlined in the audit are undertaken is required to complete the audit by the end of the first week of each month. If compliance scores achieved are below 95% there is a requirement for audits to be completed weekly until compliance above 95% is achieved.

Accident & Emergency Department Audits Audit description A series of specific audits covering the use of proformas to be used with patients presenting with a head Injury, alcohol intoxication or a headache.	Key findings/learning The spot check audits continue to show good compliance at greater than 90%. Action Instances of non compliance are addressed. Reminders are issued and training is provided if required.
World Health Organisation (WHO) Checklist Compliance Audit Audit description To assess the compliance with the "Five Steps to Safer Surgery" in the Trust. This includes use of the Surgical Safety Checklist.	Key findings/learning The Trust conducted an audit that indicated that the checklist was not completed and filed in the records of all patients where it was considered relevant. As a result a system was introduced to monitor compliance on an ongoing basis. Results now show good compliance with completion of the three sections on the checklist. Action Further work is required to ensure that a debrief session is recorded for all qualifying lists. The Trust is also working to ensure that all relevant procedures are included in the calculation of compliance data and that the WHO checklist process is quality assured.
An audit of readmission following discharge from an acute medical admission Audit description The aim of the audit was to determine the appropriateness of decisions to discharge patients admitted with acute medical conditions using emergency readmissions within 28 days as a proxy.	Key findings/learning The rate of readmissions that were considered to be definitely avoidable by the reviewers was low in this sample. The audit found that the recording of discharge decisions could be improved. In addition, steps needed to be taken to improve the recording of the clinician making the decision to discharge a patient and to ensure that the identification of the responsible consultant for each patient is accurately recorded at all times. Action • To scope the development of a real-time system to identify and alert to readmissions.

	• To take measures to ensure the full recording of discharge decisions • To ensure that the identification of the responsible consultant for each patient is accurate at all times.
Nutrition audits Audit description There are a number of audits aimed at monitoring compliance with nutritional standards. These include a rolling monthly audit to assess whether a target of 75% patients are nutritionally assessed using the MUST tool within 12 hours of admission, and to assess whether there is at least 80% compliance protected meal times for patients	Key findings/learning The data has shown that as for the 2011/12 financial year at January 2012, only 3 areas failed to achieve in excess of 85% with MUST assessments and all wards are achieving at least 80% compliance with protected meal times (based on snapshot audits). The audit also has demonstrated good compliance with the use of various risk mitigation actions, e.g. red trays was good at around 99% compliance. Food diaries are completed in 98% of patients who require them and Fluid Balance Charts are completed in 96% of patients requiring them. Action The results from the audits are fed into the Ward Review process and where required an action plan is developed to address the areas where practice is required to be improved.

2.2.5 Participation in Clinical Research

The number of patients receiving NHS services provided or subcontracted by SWBH in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1372 for National Institute for Health Research (NIHR) Portfolio studies and approximately 750 for non-NIHR Portfolio studies

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care offered, and to making a contribution to wider health improvement. Engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest treatments and techniques. If further ensures that clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Sandwell & West Birmingham Hospitals NHS Trust was involved in conducting over

280 clinical research studies during the 2011/12 period, of which 200 were UK Clinical Research Network (UKCRN) portfolio studies. Research is undertaken across a wide range of disciplines including Cancer (breast, lung, colorectal, haematology, gynaeoncology, urology), Rheumatology, Ophthalmology, Stroke, Neurology, Cardiovascular, Diabetes, Gastroenterology, Surgery, Dermatology and Women and Children's Health. Sandwell & West Birmingham Hospitals NHS Trust uses national systems to manage the studies in proportion to risk and implements the NIHR Research Support Service standard operating procedures.

As an example of the benefits that research can bring to our patients, one of our Rheumatology Research teams, led by a clinical nurse specialist, linked with the manager of Birmingham Arthritis Resource Centre and established a rheumatoid arthritis service with volunteers and colleagues. This was tailor–made for patients of South Asian Origin, and was a direct result of the team's research. The group raised awareness of treatments and helped patients manage their conditions. Community leaders trained local people as patient educators. The service developed multilingual educational material and established a helpline staffed by relevant language speakers. This work led to a National 'Nursing Standard Nurse Award' for Innovation in Rheumatology and Rheumatoid Arthritis at the end of April 2011.

2.2.6 Goals agreed with Commissioners for 2012/13

Use of the CQUIN payment Framework

The Trust has been working closely with the commissioners to develop a whole raft of quality schemes which are summarised in the table below. They are a combination of national and local priorities and some of them are included within our highest priorities and have been described in more detail at the beginning of our Quality Account.

The process of developing the schemes for inclusion in this year's CQUINs has been through discussion with the commissioners. As we indicated earlier in the report, we are continuing with some of the CQUINs from last year amongst our highest priorities. We are doing this with the approval of our commissions and we believe that patients will really benefit from this added attention and focus, particularly with regard to the nursing indicators. As you will recall from the Chief Executive's statement, the CQC carried out visits to the Trust and we have put action plans in place to address their findings. Things such as responsiveness to personal needs, the Safety Thermometer, the Net Promoter, nutrition and weight management and Stroke care will enhance patient care across the whole Trust, with benefit beyond the services identified in the CQC visit.

A proportion of SWBH's income is conditional on achieving quality improvement and innovation goals agreed between the commissioning clusters and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality Framework. In 2012/13 it will be 2.5% of our total income.

Table 6. This table describes an outline of the schemes which the Trust has agreed with the commissioners, to work on.

Goal Name	Description of Goal	Quality Domain
VTE Risk Assessment Acute and Community	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
Appropriate use of warfarin	Warfarin audit	Safety
Composite Indicator on Responsiveness to Personal Needs	Improve responsiveness to personal needs of patients	Patient Experience
Dementia	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	Effectiveness
Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, UTI infection in those with a catheter and VTE	Safety
Net Promoter	Patient Experience	Patient Experience
Use of antibiotics - Antimicrobial Stewardship Acute and community	Reduce the incidence of healthcare-associated infections	Safety
Reducing avoidable pressure ulcers	Reduction of avoidable pressure ulcers for all in-patients	Safety
Mortality review	Every death that occurs within the hospital will be subject to a mortality review involving senior medical staff. Root causes will be identified and avoidable deaths will be identified and learning propagated to the rest of the hospital teams	Effectiveness
Nutrition and weight management	Effective implementation of NPSA naso gastric tube guidance to ensure zero Never Events. Reducing avoidable hospital acquired weight loss in elderly care and stroke in 8 named wards caring for this patient group	Safety, Effectiveness, Patient Experience,

End of life care (EOL)	Improve the percentage of patients receiving effective EOL care from the integrated SWBH palliative care team, including dying in the place of their choice	Patient Experience
Safe surgery	To take measures to ensure zero Never Events for wrong site surgery and retained foreign object post-op to include policy, process, audit and reporting	Safety
Every contact counts - Alcohol	To improve the health of the population by ensuring that all patients who drink at harmful levels are identified and provided with brief advice by trained staff	Effectiveness, & Innovation
Every contact counts - smoking in pregnancy	To improve the health of the population by ensuring that all expectant mothers are provided with brief advice by trained staff and ensuring that expectant mothers who drink at harmful levels and those who smoke are identified and offered help and support	Effectiveness
Stroke	To ensure rapid access to diagnostics, swallow screens are undertaken in a timely manner, and antiplatelets and anticoagulants are prescribed	Effectiveness

2.2.7 What others say about us

2.2.71 Statement from The Care Quality Commission - Registration and Compliance

SWBH is required to register with the Care Quality Commission (CQC)

- Sandwell and West Birmingham Hospitals NHS Trust is registered without conditions with the CQC, the independent regulator of health and social care in England.
- The CQC has not taken enforcement action against the Trust during the period 1 April 2011 to 31 March 2012.
- The Trust has participated in the following reviews by the CQC:

  a) In June 2011 the CQC undertook a review of the Trust's compliance with Outcome 17: Complaints of the essential standards of quality and safety.

At that time they judged that there were minor concerns in how complaints were being managed. A compliance action was issued. In response the Trust submitted an improvement plan to the CQC. An updated action plan was forwarded to them in December 2011 which showed that the key objectives had been achieved. In March 2012 the CQC notified the Trust of their judgment that the organisation was compliant with Outcome 17.

b) In 2011 the CQC carried out reviews at City Hospital and Sandwell General Hospital as part of a targeted inspection programme in acute NHS hospitals to assess how well older people were treated during their hospital stay. The review included unannounced visits to both hospitals. The judgments arrived at by the CQC through this process are summarised in table 7 and were:

Table 7.	**Hospital**	**Inspection Date**	**CQC Judgment**
Outcome 1 Respecting and involving people who use services [dignity and respect]	City Hospital	May 2011	Compliant
	Sandwell General Hospital	March 2011 August 2011 December 2011	Moderate concerns Moderate concerns Compliant
Outcome 5 Care and welfare of people who use services [meeting nutritional needs]	City Hospital	May 2011	Minor concerns
	Sandwell General Hospital	March 2011 August 2011 December 2011	Major concerns Minor concerns Compliant

c) An improvement plan was put in place by the Trust to address the concerns identified by the CQC. This included reconfiguration of wards and stroke provision at Sandwell General Hospital. In December 2011 the CQC carried out a review to check whether the planned improvements at Sandwell General Hospital had been made. The evidence gathered during this review confirmed compliance with both outcome areas.

- The Trust is legally required to continually monitor and ensure compliance with the essential standards of quality and safety to maintain registration.
- A number of new processes have been developed to enable the Trust to monitor compliance with the essential standards, such as local 'mock' CQC inspections. These build on the existing assurance structures.

In 2012/13 the Trust plans to implement an organisation-wide electronic compliance framework designed to provide a mechanism to continuously monitor compliance with the 16 essential standards of quality and safety defined by the CQC.

2.2.8 Limited Assurance Report

The External Auditors have provided the Trust's management with a signed limited assurance report. This report is attached as Appendix 2.

2.2.9 Data Quality & Information Governance

Statement on relevance of Data Quality and our actions to improve our Data Quality

We take data quality very seriously. We need to know that we are counting, recording and storing information about people's care very carefully. During 2011/12 we undertook the following activities at organizational level to assess and improve our data quality.

The Board asked the Audit Committee to consider recent developments in data quality assurance as informed by the Audit Commission's publication "Taking it on Trust" and work undertaken elsewhere within the NHS. In considering its approach it was mindful of opportunities to learn from other organisations particularly those that had undergone a systematic approach to improving and strengthening assurance.

In one such case the committee identified the benefit of placing a rating on key performance indicators and specifically the data source on which it was based. The intended outcome is that the reader of the information could draw conclusions as to the degree of reliance to be placed on the data and well as provide a marker for improvement or further investigation.

The approach adopted focused on 200 plus performance indicators which currently comprise the Trust's Corporate Performance Report. For each of these the data source a 'supplying' individual within the organisation is indicated as is the format in which the data is received and/or made available to the author of the report, the Head of Planning and Performance Management.

The various indicator lines were assigned a Level (1, 2 or 3) of consequence:

- Level 1 indicators comprise those which feature within National and SHA assessment frameworks and those which comprise the range of CQUIN schemes agreed between the Trust and its commissioners
- Level 2 indicators are locally focused on areas such as clinical quality, workforce, patient experience, finance, activity, referrals and performance against contracted activity plans
- Level 3 indicators comprise a varied range of other local indicators, many complementary to other indicators, relevant to the corporate performance of the Trust.

At this stage a self-assessment has been conducted, initially of all Level 1 indicators, and a number of criteria used to identify a data quality risk rating of between 1 (high risk) to 5 (low risk). These numbers were chosen to mirror Monitor's range of Financial Risk Ratings. In assigning an initial scoring, the criteria and questions used included:

- Is the data quality of an indicator independently verified as part of any local and/ or national review process?
- Has the data previously been subject to a Care Quality Commission validation as part of the Annual Health Check process with the process for capture and data extraction not changing in the interim?
- Does the flow of data continue to follow a well-established process through the organisation?
- Are there well-established systems in place for data capture which are supported by a robust operational policy?
- Is the performance reported a composite of multiple data and / or is it a derived calculation?
- The magnitude of any volatility in terms of actual performance reported between periods.

In order to test the validity of this approach the committee agreed that, prior to completing this stage of the work, it should test the validity of the approach taken as the ultimate intention is to publish a DQ indicator alongside KPIs within the corporate performance report. Consequently, Internal Audit is to ensure that a programme of testing selected indicators is undertaken. Once complete the committee will consider the findings and formulate recommendations for providing assurance to the Trust Board and wider stakeholders.

In addition to the above overarching programme, our actions during 2012/13 will also include:

- A specific programme of work to assess the reliability of 18 week performance reporting following recent data quality concerns
- The inclusion of data quality reports on the Quality Management Framework
- Feedback to Clinical Directorates in respect of coding accuracy and the accuracy of information supplied locally to the Patient Administration System
- Continuing work to ensure the removal of any duplicated patient registrations
- Providing data and information to support Service Line Management

NHS Number and General Medical Practice Code Validity

Below is the National, SHA and Trust performance on validity of these data items as published through the Information Centre through Secondary User Service Data Quality Dashboard – Provider Based using 2011/12 financial month 9 data, which is the latest we have.

It shows we remain above the national benchmarks in line with all of the indicators.

NHS Number

	National	SHA	SWBH
Inpatients	98.7%	99.03%	98.7%
Outpatients	99.0%	99.28%	99.4%
A&E	92.9%	94.83%	96.2%

General Medical Practice Code

	National	SHA	SWBH
Inpatients	99.9%	99.97%	100%
Outpatients	99.7%	99.28%	100%
A&E	99.4%	99.97%	100%

Clinical Coding Error Rate

The latest final Payment by Results external clinical coding audit shows the trust has a 7.3% error rate against national error rate of 9.1%.

The overall error rate is 5.6% for clinical diagnosis coding, and 4.2% for clinical treatment coding.

Information Governance Toolkit (IGT) attainment levels

Sandwell and West Birmingham Hospitals NHS Trust Information Governance (IG) Assessment Report overall score for 2011-2012 was 85% and was graded unsatisfactory (RED) according to the IGT Grading Scheme, which was anticipated. This is because the Trust did not achieve Level 2 attainment across all IGT requirements. The Trust anticipates a satisfactory achievement status by the 31st December 2012.

The Trust is working towards IGT requirements attainment Level 2 in sections:

- 110 - Formal contractual arrangements that include compliance with information governance requirements are in place with all contractors and support organisations.
- 112 - Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained.
- 324 - This requirement will be achieved by default on attainment of level 2 for requirements 110 and 112.

Part 3: Review of Quality Performance 2011/12

3.1 Report on Quality Priorities for 2011/12

In last year's Quality Account, five priorities were identified for 2011/12. They were:

1. Stroke
2. Basic Nursing Care
3. Mortality
4. Quality & Safety Strategy
5. Service Improvement
   - Accident & Emergency
   - Trauma & Orthopaedics

The Board wanted the scope of priority 2, Basic Nursing Care, to be broadened to reflect the multi-disciplinary nature of modern health care. This was done so that issues identified by stakeholders during 2010/11 and during 2011/12 consultations would be taken into consideration further.

3.1.1 Priority 1: Stroke

Plans for 2011/12

Last year we said that we intended to continue the work of the Stroke Action Team and we remained determined to achieve our goal of providing the best possible Stroke Service within 5 years of our first report. Specifically, we intended to:

- Continue to develop and implement our stroke strategy
- Address the concerns identified by the West Midlands Quality Review Service (WMQRS) review
- Develop options for consideration in respect of acute stroke and rehabilitation
- Improve the discharge arrangements for patients admitted with stroke
- Develop and implement real-time alerts for the management of patients on stroke and TIA pathways
- Develop systems to monitor and respond to the experience of patients receiving treatment under our care

What we have achieved:

Strategy (Service Redesign) and actions on the WMQRS Review

Last year the WMQRS raised some concerns about the sustainability of continuing to deliver acute stroke care at our two acute sites and highlighted some aspects of stoke care in our Trust that required further development. We have taken these comments on board and a Reconfiguration Project Steering Group and Project Board were set up. The Project Board, working with our stakeholders including patients and clinical staff appraised a long list of options and reduced them to a short list using a carefully designed scoring process. This shorter list of options has been agreed and has gone out to public consultation after being approved by the Trust Board, the Overview and Scrutiny Committee, the NHS Gateway review team and the National Specialised Commissioning Team (NCAT).

In the meantime, the Trust Management Board has committed a comprehensive investment to support service development and quality improvement in all aspects of the stroke service (£397K May 2011). This has been achieved through improving the speed and delivery of the service for acute stroke, making sure our patients spend a maximum amount of their inpatient stay on our stroke wards and improving the speed of assessment and scanning for patients with transient ischaemic attack (mini strokes with a high risk of progressing to full stroke). These changes were also designed to ensure we improved in areas of performance to attract the Best Practice Tariff for Stroke.

The investment means that we have increased capacity in stroke medicine, imaging and data management to meet local and national quality outcomes for 2011/2012, delivered the CQUIN target for Stroke Discharge and supported the necessary work for consultation and planning for the reconfiguration of stroke services so that all acute work will be based at one of our hospital sites.

The Stroke Action Team has continued to focus on developing the capabilities and competence of its medical and nursing staff involved in stroke care. An additional consultant specializing in stroke care has been recruited to the City site and an existing consultant has become much more involved in the stroke pathway. There has also been continued provision of specialist-led training programmes for consultants and specialist registrars in general medicine who will continue to participate in the stroke pathway at least until reconfiguration of stroke services occur.

Following the concerns identified by the CQC about standards of nursing care in the Acute Stroke Unit (Newton 4), the service has been reconfigured at the Sandwell site by splitting acute stroke care (Priory 1) from stroke rehabilitation care (Newton 4) and focusing further on addressing concerns on the nursing establishment, training, the acquisition of key competencies and delivery of the required standards of care (WMQRS standards). Additional therapist support for the stroke wards has been provided at weekends.

The nursing and therapy leaders are working hard to ensure consistency of patient information and have developed systems to feedback suggestions for improvement to our clinical teams from our patients and carers. Recent patient survey data has been positive in this regard.

The National Sentinel Stroke Audit for 2010 is the most recent national audit for which the results have been released.

Table 8. National Sentinel Stroke Audit 2010, Round 7

		Received All Key 9 Indicators in 2008	Received All Key 9 Indicators in 2010	Received All Key 12 Indicators in 2010
	National Results	17%	32%	16%
	SWBH-City	16%	52%	50%
	SWBH-Sandwell	16%	38%	42%

In the last report we explained that the Trust performed in the top 25% in comparison to national benchmarks for the delivery of key indicators for stroke care and in 2011/ 2012 our performance in a range of measures designed to reflect the quality of stroke care has continued to improve.

Improved Discharge Arrangements

Led by a senior physiotherapist, the Stroke Action Team has established a project group linked to our community teams to develop Early Supported Discharge. Our patients and carers told us early and safe discharge to their own homes was important. By being linked with our community teams the service will improve patient experience.

You told us that you wanted better information about stroke and to feel more supported after discharge. We have worked hard on improving the quality of information given to patients as part of discharge planning. We set ourselves a target of ensuring that everyone being discharged will have a copy of the agreed discharge plan, including community and social care contacts and a follow-up clinical contact within 24 hours of discharge. The Trust has achieved a performance for this target of 95%.

Clinical Dashboard

The Stroke Action Team has continued to develop its clinical dashboard that captures the key measures of performance and quality of stroke care and has begun to track performance in a number of new areas so as to continue our drive to reliably deliver excellent care for our patients. Work is in progress to develop and implement real-time alerts for the management of patients with stroke and Transient Ischaemic Attacks (TIAs) or mini strokes.

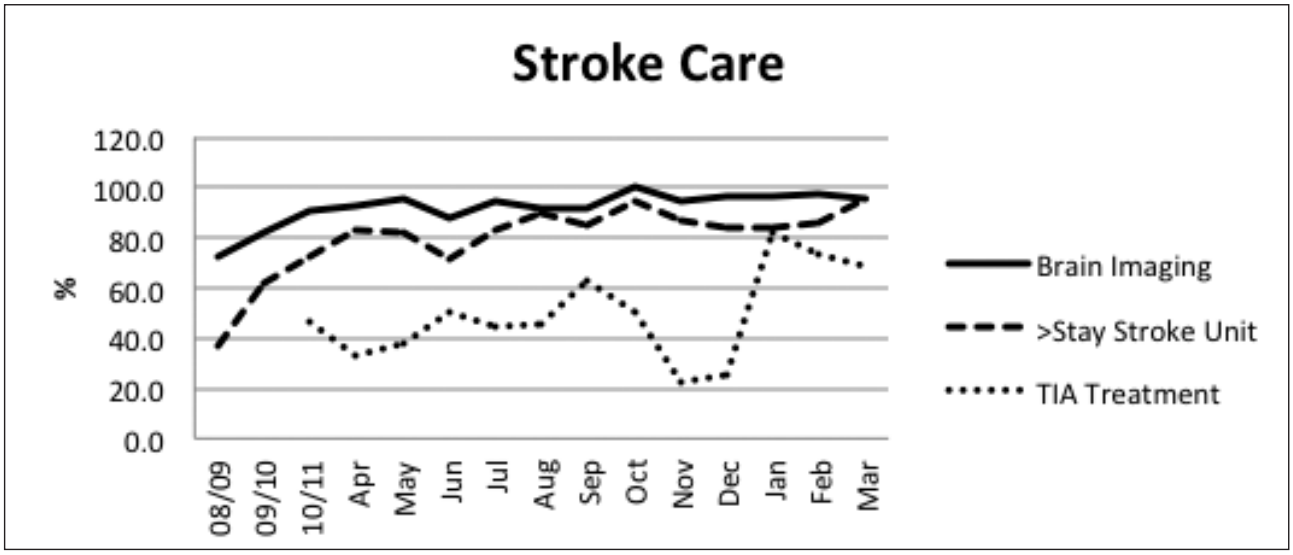


Table 9. This shows that performance against the main stroke targets for stroke care has improved during 2011/12. The figures show that the Trust is now more reliable at ensuring our aim that all patients with acute stroke are admitted directly to an acute stroke unit with a CT scan on the way to the ward and that our performance for mini strokes (TIA) has improved.

3.1.2 Priority 2: Basic Nursing Care

We said we would improve the experience of our patients by continuing to focus on care at ward level with particular attention to reducing the number of harm events. Specifically, we intend to:

- Further reduce the incidence of tissue damage and falls rates
- Reduce medication errors and improve the reporting of errors
- Improve end of life care by facilitating a greater number of patients dying in their preferred place of death
- Improve the nutrition and fluid intake of patients
- Improve the care offered to patients with learning disability, dementia or mental ill health
- Improve the care offered to deteriorating patients (rescue)

We said we would continue to monitor standards of basic nursing care at ward level using the audit and observational tools that have been effective in 2010/11. We said we would continue to develop audits and surveys to report the following:

- Monthly tissue damage, falls and nutrition audit reports
- Quarterly reporting on medication errors
- Quarterly reports on end of life care - patients dying in their preferred place
- Incidents affecting patients with learning disability, dementia and mental ill health
- Failure to rescue incidents
- Training on vulnerable adults - quarterly training reports
- Intermediate life support training - quarterly training reports
- Monthly patients satisfaction reports.

What we achieved:

Reducing incidence of tissue damage and falls rates

We have been successful in achieving a 38.6% reduction in pressure sores against a target of 10% reduction compared to January-March in 2011. We have also been successful in completing risk assessments of 95% of admissions in the acute hospitals.

Reducing medication errors

We have succeeded in reducing omissions of prescribed medications by 16% against a target of 10%. This reflects considerable effort around raising awareness, 'housekeeping' of medicines charts and improved prescribing practices.

Improving end of life care

We have succeeded in improving end of life care by facilitating a greater number of patients dying in their preferred place of choice. Our target was to increase the number of patients achieving preferred place of death by 10% in both the acute hospitals and in the community). This year, 81% of hospital patients achieved preferred place of death. 86% of community patients achieved preferred place of death which is an improvement on last year.

Improving the nutrition and fluid intake of patients

We are assessing our patients' nutritional state within 12 hours of admission. We have been carrying out frequent audits. All wards are achieving at least 80% compliance with protected meal times (based on snap shot audits). We are doing various things to improve compliance such as using red trays. The use of a red tray for serving meals is that this indicates to staff that the patient requires extra help with eating and drinking. This has improved compliance to 96% compliance compared to 69% in June 2010.

Improving the care offered to patients with learning disability, dementia or mental ill health

We have continued to invest in training to ensure that vulnerable adults are protected whilst in our care. The Lead Nurse for vulnerable adults continues to train newly qualified staff nurses and has been asked to teach on the apprentice training scheme. We have met our target for the number of staff undertaking Safeguarding Adults Training level 2, and we continue to improve. The table below illustrates compliance as of the end of January 2012.

Table 10.

Safeguarding Adults Level 2 Mandatory Target	Safeguarding Adults Level 2 Compliant	Safeguarding Adults Level 2 % Compliant
1190	793	66.64

Control of Infection

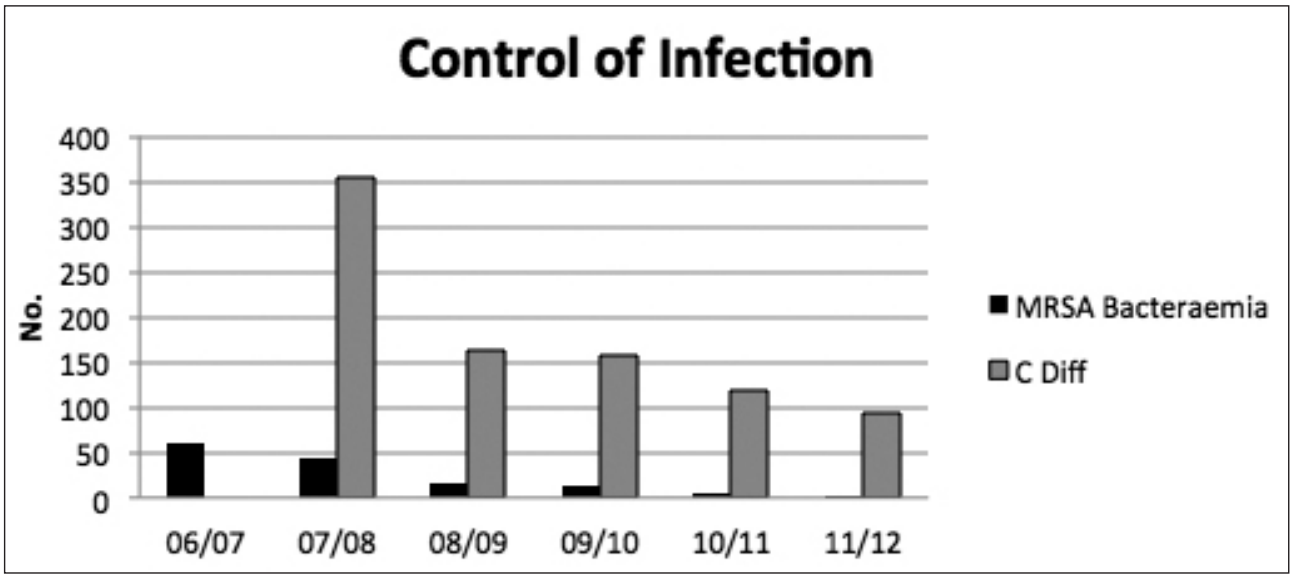
When people enter our hospitals, we make every effort to ensure that they do not catch infections that can possibly be prevented. This is so we can keep people safe from avoidable harm.

We have successfully maintained our excellent performance in respect of infection control, with cases of hospital acquired MRSA Bacteremia being cut from 61 in 2007/8 to only 2 in 2011/12, which is well below the trajectory agreed with the commissioners of 6 in a year.

For Clostridium difficile (C. Dif.) our numbers of reported infections have also seen a significant drop. There has been a reduction from 355 in 07/08 to 95 in 2011/12. These figures help us to reassure those we treat that we take avoiding hospital acquired infection seriously through the work of our infection control team, antimicrobial pharmacists and microbiologists who together promote good antibiotic stewardship.

We are, however, constantly and continuously seeking to improve areas of weakness so that we can continue to develop and progress. The risk team, which is led by the Director of Governance, has introduced an electronic reporting system and has formalized the process of ensuring that all serious incidents are thoroughly investigated and reported to the Board and that all action plans are pursued to conclusion.

Table 11. Control of Infection



MRSA Screening

One of the measures we know helps to reduce the risk of getting an MRSA bacteraemia is to carry out screening tests before patients are admitted to the hospital. MRSA frequently can be found doing no harm to the body.

The Trust carried out 3243 MRSA screening tests on people coming in for planned (elective) surgery during March 2012 and has achieved 35,897 tests across 2011/12 which is ahead of the year-end target of 30,000.

When patients are admitted as emergencies, we still try to ensure that MRSA screening is carried out. The Trust carried out 1687 MRSA screening tests on emergency patients during the month of March 2012 and we have achieved 20,293 tests during 2011/12, against a year-end target of 30,000. However, we are working on improving our performance against this target to meet it by the end of March 2013.

3.1.3 Priority 3: Mortality

During 2011/12 we committed to continuing to develop and implement our mortality review system (MRS). Our aim was for senior doctors to review the case notes of at least 60% of patients who had died so that areas of potential avoidable harm could be identified and lessons learned for what we could do better could be quickly applied. This process was part of our strategy to improve our Hospital Standardised Mortality Rates (HSMR) in comparison to the national average. We also intended to improve our understanding of how we care for patients at the end of life.

Specifically, we said we would:

- Exceed a CQUIN target, agreed with our commissioners, that, by March 2012, 60% of deaths in our care are reviewed and reported by a senior doctor
- Pilot and report on a project to have deaths in our care reviewed and reported by a senior nurse
- Improve our information coding of patients at the end of life in order to provide a better understanding of the performance of our care pathways
- Develop a Clinical Dashboard to support End of Life care

What we achieved:

Mortality Reviews

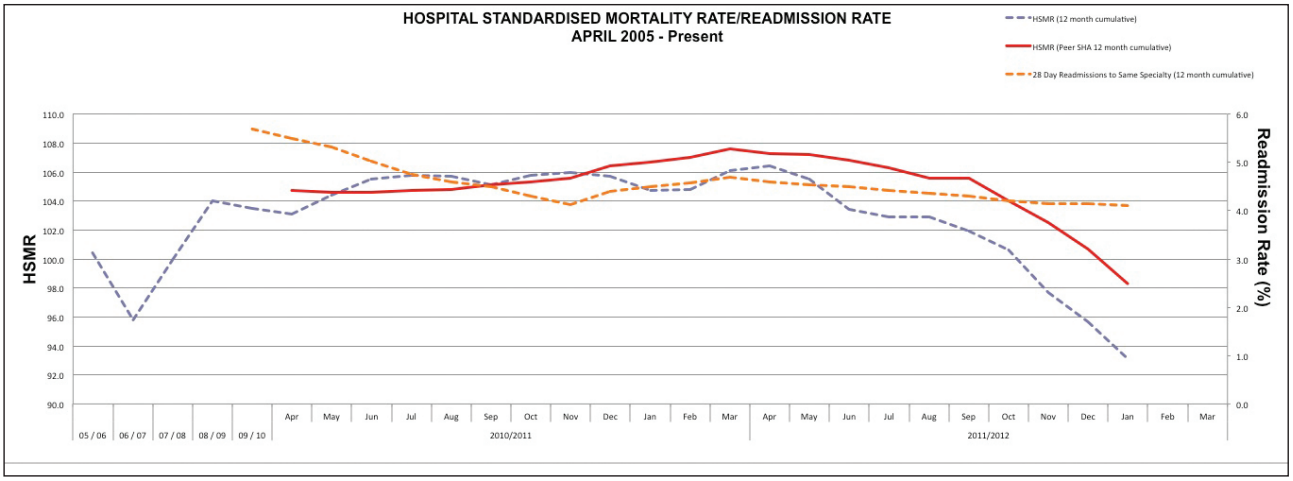
To check that people in our care were not dying unnecessarily, it was agreed with our commissioners that by March 2012 60% of deaths would be reviewed and reported by a senior doctor.

The Trust has been successful in meeting its commitment to our patients and commissioners with the target being exceeded. We met the target in 5 out if the first 8 months of the year (between April and November) and in the last 4 months (December 2011 to March 2012) we have exceeded the target, achieving the target early as we were tasked with reaching this level by the last month of the year. This demonstrates how keen we are to provide excellent clinical care to our patients. We are carrying out these reviews so that we can be sure that our patients are getting the most appropriate care that we can give them. Nurses are often also involved in multi-disciplinary team meetings where deaths have occurred and participate in developing an understanding of whether the death could have been prevented.

Mortality rates

The Trust received notification of two CQC Mortality Outlier Alerts in October 2011. They concerned mortality in hospital where the patient had been admitted as an emergency with a primary diagnoses of pneumonia or cerebrovascular disease. Following the submission of additional information to the CQC, they have now confirmed that they do not wish to take any further action at this stage. Despite that, the Trust undertook closer examination of why an alarm had been raised, and has reported the findings within the internal governance systems.

Table 12.



The table above illustrates that the HSMR has reduced based on the previous 12 months to below 100, which is good (100 being average). This compares favorably with the other trusts in the old West Midlands Strategic Health Authority area. Readmissions of patients, to the same specialty within 28 days, has also decreased implying that their treatment and discharge has been appropriate.

Mortality & Quality Alerts Committee

A new committee of clinical staff has been formed to review the results of the mortality review process and ensure that the necessary actions are taken. The committee review all new alerts triggered by the HSMR so areas of concern are identified and dealt with quickly. This process led to a stroke mortality alert, and a focus on biliary sepsis and those with a primary diagnosis of pneumonia.

We consider that it is very important to understand why patients in our care die as this will help us to improve the safety and effectiveness of the care we provide (two of our three top quality and safety priorities).

Significant work has gone on to improving our understanding of this, and clinicians are now able to check and change codes assigned to deaths, if necessary, to improve the accuracy of our information. The development of the Clinical Dashboard to support End of Life care teams is still in its early stages.

3.1.4 Priority 4: Quality & Safety Strategy

We said we intended to enhance the Trust Board's oversight of quality issues and performance and to ensure that all of our staff are working to deliver our three overarching priorities in the domains of Patient Safety, Clinical Effectiveness and Patient experience.

Specifically, we said we would:

- Establish a new Quality and Safety Committee to enhance Board oversight of quality performance
- Continue the development and implementation of the Quality Management Framework (QMF)
- Develop and implement systems to ensure that standards of clinical care at the specialty level are consistently high and regularly audited and monitored through the QMF
- Improve the rates of incident reporting across the Trust
- Develop and implement a strategy to increase the percentage of patients who would recommend the Trust to family and friends

What we have achieved

The Trust has continued to work on the development and implementation of its Quality and Safety Strategy during 2011/12. We identified the 3 main areas (domains) relevant for quality and safety as:

Patient safety	To reduce adverse events which result in avoidable harm	=	We do no harm to patients
Clinical Effectiveness	To reduce avoidable mortality and morbidity	=	Fewer patients dying and fewer having complications
Patient experience	To increase the percentage of patients who would recommend the Trust to family and friends	=	Improved patient satisfaction

Quality and Safety Committee

As part of the development of the Quality & Safety Strategy in 2010, the decision was taken to replace the existing Governance and Risk Management Committee with a Quality and Safety Committee, as one of the Trust Board's formal subcommittees. The Committee is chaired by a Non-Executive Director and meets six times per year.

The Committee's key agenda items focus on matters to ensure that adequate assurance is provided to the Board that clinical services are appropriately delivered

in terms of quality, effectiveness and safety. It is also to ensure that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance. In addition, it is to provide assurance that where quality and performance falls below acceptable standards, that action is taken to bring it back in line with expectations, and to promote improvement and excellence. It also ensures that service user and carer perspectives on quality are at the heart of the Trust's quality assurance framework.

Quality Management Framework (QMF)

Improving information about our performance both in terms of quantity of work done and measurement of quality of our services is vital for us to understand how well we are doing at providing care. Work has been progressing into developing a performance framework where information is gathered and fed back to staff to help them understand their progress against defined targets. This is called our QMF.

This is taking shape under the title of 'dashboards' which allows teams to look at their own specific collection of indicators which flag up how they are doing.

Led by Clinical Directorate Teams, teams are held accountable for the services they deliver. Clinical directorate teams are responsible to the Divisional Management Teams (Division Director (senior doctor), Senior Nurse & Senior Manager). In turn, they are responsible to the Board.

In addition, The Quality and Safety Committee and Governance Board monitor progress against all quality issues. A new report is being developed for the Trust Board which is totally focused on quality. This report is equally important as the financial reports and general performance reports. The progress of the Quality Account priorities will be included in this report. This is to ensure that patient care remains firmly at the heart of our business and that we remain committed to meeting our quality aims.

Patient Safety & Incident Reporting

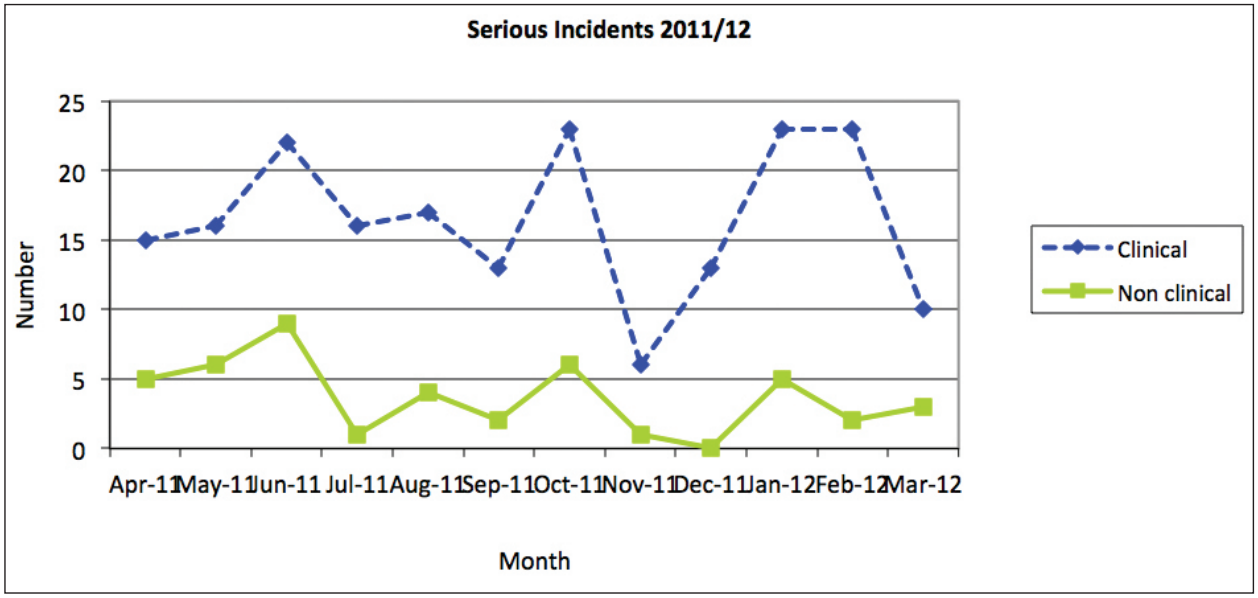
Organisations that report more incidents usually have a better and more effective safety culture. The comparative incident reporting rate, per 100 admissions, for 41 large acute organisations published by the National Reporting and Learning System in March 2012 placed the Trust in the middle 50% of reporters. This is a significant improvement as previously the Trust was in the lower 25%.

The Trust has a system for investigating incidents of all grades and learning from the mistakes. Staff are actively encouraged to report incidents and near misses, whether they directly affect patient safety or they relate to the health and safety of staff and members of the public.

The introduction of an electronic incident reporting system has improved reporting

rates across some clinical groups, which the previous paper-based system did not support. Where feedback mechanisms are being used by managers in dealing with incident reports, continued reporting is showing an increasing number of reports. Quality of data and information is better since moving to an electronic system.

Table 13.



Incidents are categorised according to the severity of the actual harm caused and the most serious are reported to the Board, the Department of Health (via the SHA) and our commissioners. The Trust uses its reporting system for specific incidents to highlight particular issues and ensure there is an analysis of the incident and resulting action plans. Such incidents currently include some Needlestick injuries and physical violence to staff from patients and visitors.

The chart above shows the numbers of clinical and health & safety incidents classed as serious by month through 2011/12. Every serious incident is investigated and undergoes a Root Cause Analysis (RCA). Each case in which system errors are identified has a detailed action plan prepared. This is then checked and monitored by the Adverse Events Committee (AEC), which is chaired by the Chief Executive. All action plans are followed to completion by that committee.

'Never Events'

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. We have reported 7 never events since 1 April 2011. Six were related to surgical procedures and one to a misplaced oro-gastric tube. At investigation one of the never events which related to wrong site surgery was declassified from a never event with the agreement of the PCT. This was because on further investigation the biopsy was

appropriately taken based on the clinical findings on the morning of surgery.

One never event involved retention of a guidewire (a wire used during a procedure to make sure a tube goes into the right place). These were not previously part of the count undertaken throughout and at the end of operating lists; however, this has now been adjusted within the theatre policy and processes.

One event was a retained scleral screw during ophthalmic surgery. The WHO surgical checklist was not completed and miscommunication prevented this incident being dealt with appropriately at the time. The WHO surgical checklist is now in full use within the ophthalmic theatre suite.

The remaining three surgical never events related to retained swabs; one in obstetrics, and two in gynaecology. The WHO surgical checklist would not have identified the events in any of these cases. In the obstetric case, the swab count was correct, but an incorrect swab was used during insertion of a cannula. These swabs have now been removed from the department to prevent reoccurrence. In both gynaecology cases the swab was intentionally left in post-operatively, for removal the next day. One event was found to have a causative factor of training and supervision, whilst the second event is currently being investigated.

Less serious incidents are also investigated and tracked, although the investigation is generally conducted by the department, directorate or Division in which the incident occurs. They will not be reviewed by the AEC unless a cluster or trend occurs, in which case they will be subjected to the same process as the most serious incidents. AEC has begun to monitor compliance at division level of completion of review and action planning for incidents graded as amber.

Improving Patient Experience

The Trust seeks patient views through a variety of methods including the national patient inpatient and outpatient surveys, and a trust-generated internal inpatient survey. The internal survey generates around 1000 replies every month, i.e. in excess of 10% of inpatient admissions. The survey is given out on discharge and is available in easy read and other language formats. What we find out from these surveys helps us to shape the services we deliver.

National Outpatient Survey

The Trust has seen an increase in the proportion of outpatients who rated their overall care as excellent over the past two years. 45% of patients said their overall care was excellent, compared to 36% in 2009. A further 36% said their care was very good, 14% good, 4% fair and 1% poor. No patients said their care was very poor. The Trust's overall scores for outpatient care and treating patients with respect and dignity were average.

Table 14. National Outpatient Survey *

Key indicators	2009	2011	Top 20% England (2011)	Lowest 20% England (2011)
Overall outpatient care	82/100	84/100	Above 86/100	Below 82/100
Treating patients with respect and dignity	92/100	94/100	Above 95/100	Below 92/100

*No National Outpatient Survey was carried out in 2010

Table 15. National inpatient survey

Key indicators	2009	2010	2011	Top 20% England (2010)	Lowest 20% England (2010)
Overall inpatient care	77/100	78/100	77/100	Above 81/100	Below 74/100
Treating patients with respect and dignity	82/100	87/100	87/100	Above 90/100	Below 86/100

The Trust's overall scores for inpatient care and treating patients with respect and dignity were average. A number of individual questions saw significant improvement, the largest improvement being patients saying they had enough help from staff to eat meals if needed, which rose from 54% in 2009 to 67% in 2010 and 65% in 2011. We are working to improve on this through our essential nursing care focused work.

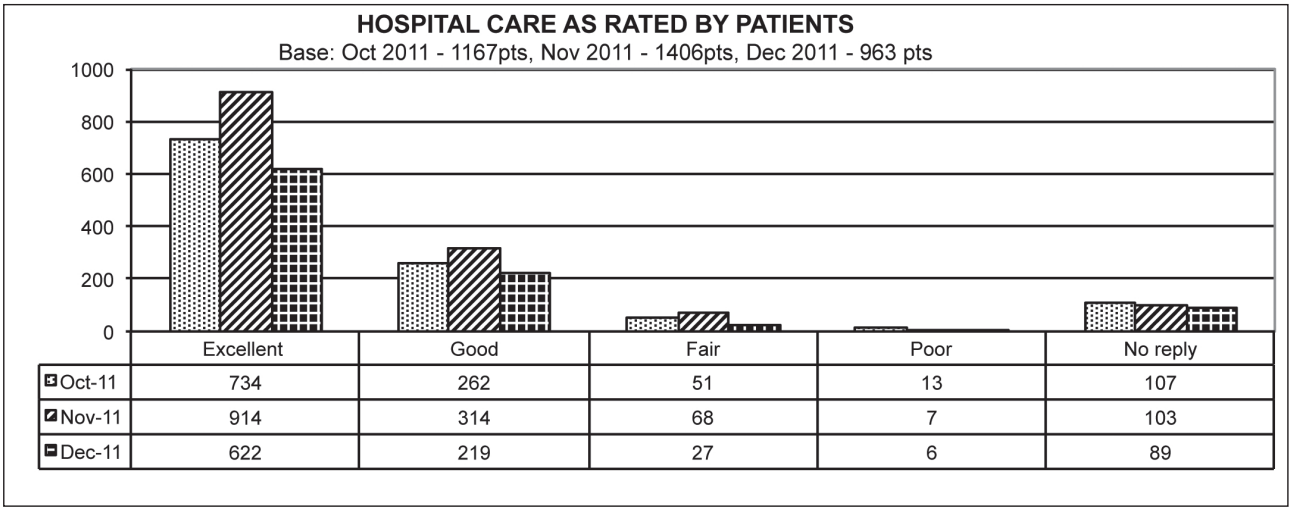
Local patient surveys

Monthly reports are generated for various Trust Committees, including Trust Board. Results are given to individual wards and are used as part of ward performance reviews.

Care as rated by patients

In the table below, the number of people rating the trust is displayed for October, November & December 2011. Fewer surveys were sent out in December so it appears our performance has not improved. But, if we look at the percentage of people who returned the survey it indicates that people who said their care was excellent or good was 90% in October it, 94% in November and 96% in December. So the percentage of people saying their care was better has gone up. The people who did not return the surveys are not included in the total as we do not know what they thought.

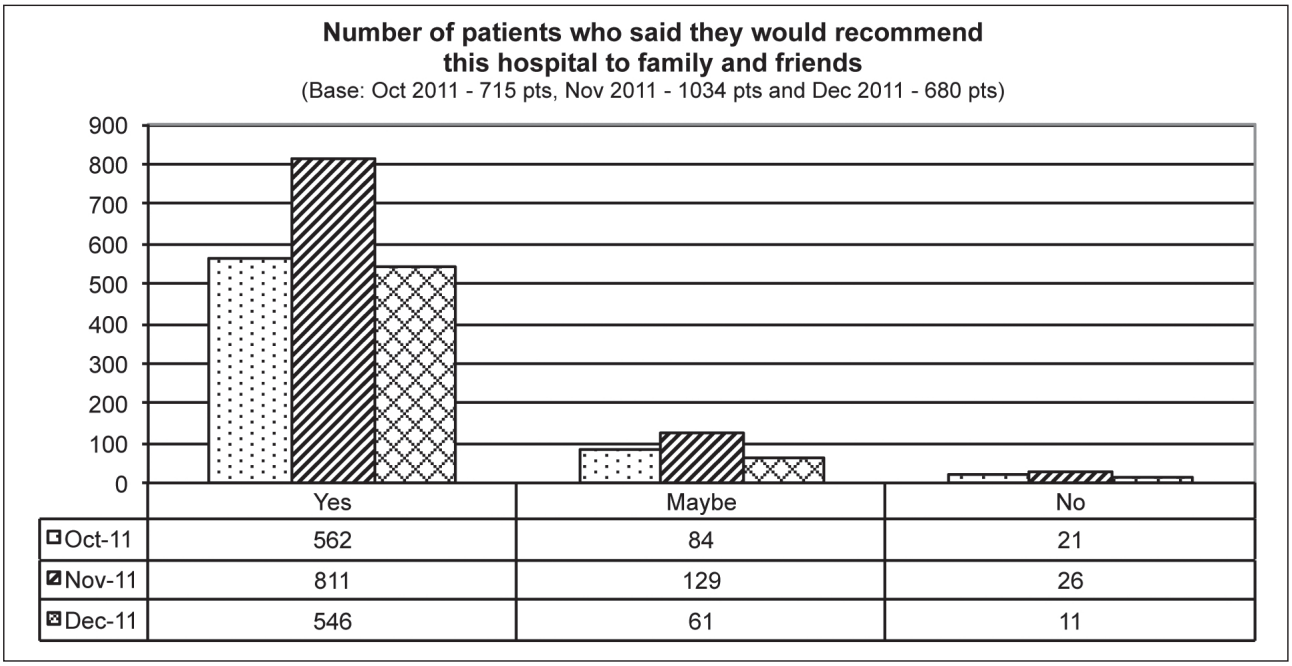
Table 16. Hospital care as rated by patients



	Excellent	Good	Fair	Poor	No reply
Oct-11	734	262	51	13	107
Nov-11	914	314	68	7	103
Dec-11	622	219	27	6	89

In the table below, the number of people indicating whether they would recommend the Trust to their families is displayed for October, November & December 2011. Fewer surveys were sent out in December so it appears our performance has not improved. But, if we look at the percentage of people who said that they would recommend the hospital to to family and friends, rather than numbers, this would show that in December 88% of people said that they would recommend this hospital to family or friends compared to 84% in October and 88% in November. So the percentage of people saying their care was better has gone up.

Table 17. Recommendation to Family and Friends



	Yes	Maybe	No
Oct-11	562	84	21
Nov-11	811	129	26
Dec-11	546	61	11

This year we will be including this these questions in the 'Net promoter' measure so we will ensure that we can compare like-for-like more easily across the year.

3.1.5 Priority 5: Service Improvement

Accident & Emergency Departments

In 2011/12 we committed to continue our work to improve the quality of service and safety within our A&E Departments. Specifically, we said we intended to:

- Complete the current work to increase the number of senior doctors and nurses in both departments
- Continue to develop and monitor systems to ensure that clinical care is of a consistently high standard
- Support the production of an Integrated Development Plan for our A&E Departments
- Improve the Information Technology systems to support the development of automated clinical dashboards
- Continue to meet National standards in respect of 4 hour waits as well as the other new national standards for A&E Departments.

What we have achieved:

Throughout 2011/12, the Emergency Department Action Team (EDAT), chaired by the Chief Executive, has continued to work with the A&E Departments at both City and Sandwell Hospital sites to secure the objectives listed above.

Our recruitment programme has continued, in order to increase the number of doctors and nurses in both departments. This has included looking at new and varied recruitment strategies to ensure that we attracted experienced, senior staff to our departments. We have continued to expand our non-medical workforce, particularly Physicians Assistants and Emergency Nurse Practitioners, an excellent alternative to doctors.

As you can see below, the number of clinical staff in the A&Es has changed and we have more consultants and specialist staff.

Table 18. ED specialist staff numbers

Whole Time Equivalent Staff	Mar-11	Mar-12
Consultants	7.6	9.6
Middle Grade Doctors	30.8	28.2
Emergency Nurse Practitioners	7.08	7.6
Physicians Assistants	1	4
Total number of clinical staff	215	220
Total number of staff	251	250

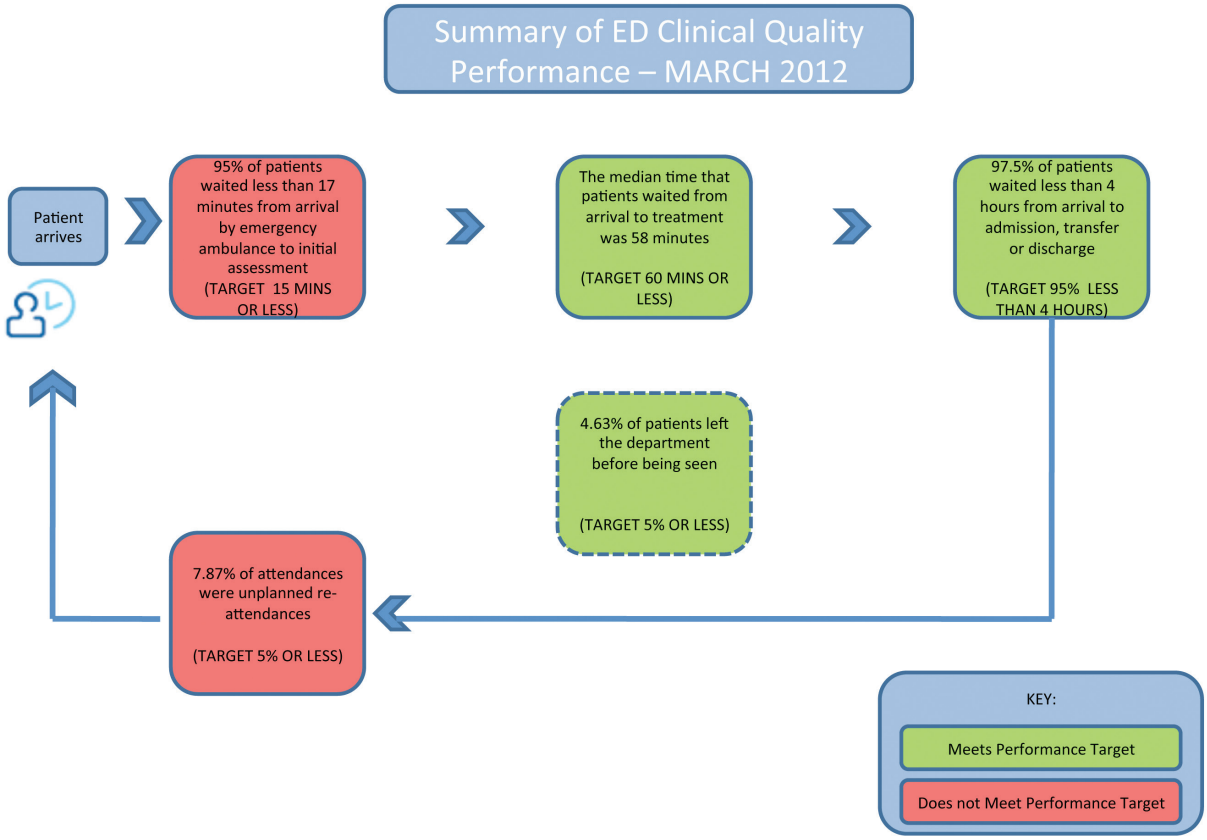
The directorate has continued to develop clinical policies and protocols for both departments, which are monitored through a series of regular audits. The importance

of using these protocols is now embedded amongst staff, leading to much improved audit results.

The EDAT has supported the production of an Integrated Development Plan which focuses on the wide ranging priorities of the directorate, including improving the quality of care we are providing, meeting the national A&E quality indicators and improving patient flow through the departments. The Integrated Development Plan is monitored through Trust Board and is shared with all A&E staff so that they are aware of the work that is being done and can contribute their own ideas.

We have used our current IT system to develop a live clinical dashboard, which displays our performance against the A&E Clinical Quality Indicators on computers within the A&E Department. We have also developed a specification for a new IT system for our A&E Departments. The processes for selecting and establishing the new system will commence in 2012/13.

The EDAT has ensured that the A&E departments continue to minimise the number of people waiting over four hour to be discharged or admitted for care, with performance reaching 97.5% by the end of the year, which is above the national standard. In 2011/12 further ED Clinical Quality Indicators have been introduced nationally. Throughout the year, the directorate has been changing and improving the way it works to improve our performance against the indicators, which is monitored through the Integrated Development Plan. Our most recent performance against these indicators is shown below. We will continue to improve performance in the A&Es and improve patients experience and safety.



Trauma & Orthopaedics

We said that in 2011/12 we would develop a strategy to improve the quality of service and performance of our Trauma & Orthopaedic Directorate. Specifically, we intended to:

- Analyse and understand the current position in respect of Quality and Safety, User Experience, Operational Standards & Targets, and Use of Resources
- Ask for support from the WMQRS in developing a set of Quality Standards for the service
- Produce a strategy that will ensure that the service meets those standards
- Work with other organisations, particularly University Hospital Birmingham, to ensure the successful development of Trauma Networks

What we achieved:

An Orthopaedic Taskforce has been established under the leadership of the Chief Operating Officer and the activities of this group reported to the Quality & Safety Committee. Performance and quality continues to be monitored using our performance management systems, particularly the Quality Management Framework (QMF).

The Trust has established a new clinical lead post to lead the development of the Trauma Unit. The Trust is an active member of the Trauma Network and has a work programme to achieve the Trauma Unit designation criteria by July 2012.

The orthopeadic service has worked in partnership with the 'Right Care, Right Here' programme, redesigning innovative pathways with primary care and community services. The implementation of these will be completed in 2012.

The service has delivered improvements in a number of areas, including a decrease in length of stay for elective and non-elective admissions, and better use of resources by reducing the number of premium rate sessions worked.

The Trust has invested in increased nurse staffing levels this year on the orthopaedic wards. As a result the experience of our patients is seen to be improving through local surveys. Complaints have decreased this year particularly in relation to waits for outpatient appointments where the wait for first appointments has reduced significantly.

Patient Reported Outcome Measures (PROMs)

The Health and Social Care Information Centre published the latest provisional Patient Reported Outcome Measures (PROMs) data in February 2012. Data was published for the period from April 2010 to the end of March 2011 and also for the period from April 2011 – September 2011. As for many Trusts, there were insufficient numbers of records for the Trust to be included in the analysis reported for the period

from April 11 – September 2011. Two of the PROMs relate to Orthopaedic procedures. Table 19 shows patients' views about how successful their procedure was.

The updated data for 2010/11 continues to show that the Trusts' performance with regard to the national average adjusted heath gain for the specified procedures is below the national figure for most of the measures.

The way the score is arrived at is by using the responses to patient questionnaires which ask about how the patient feels. The questionnaires are described in the following paragraphs and calculated to give a result.

EQ-5D Index – Questions that relate to the patients' quality of life which cover five dimensions – mobility, self-care, usual activities, pain/discomfort and anxiety/ depression.

EQ-VAS - A self-rating of health related quality of life measure. The respondent rates his or her health state by placing a line on a pre-drawn health status graph called 'Your health state today'

Procedure specific questions that relate directly to the condition itself e.g. Oxford Hip Score. No procedure specific score has been introduced for patients undergoing inguinal hernia repair.

The average adjusted patient reported heath gain versus the national figure is shown for the four index procedures in the table below. The average procedure specific scores are available to patients through NHS Choices website. The position relative to the previously published provisional data (November 11) for each indicator is indicated by the arrows.

Table 19. Updated provisional PROMs data - April 2010 – March 2011

	Health Status Questionnaire		Visual Analogue Scale		Procedure specific instrument (questionnaire)	
	National	SWBH	National	SWBH	National	SWBH
Hernia repairs	0.09 ⇔	0.09 ⇔	0.54 ⇩	0.28 ⇧	No measure	N/A
Knee replacement	0.30 ⇔	0.24 ⇧	3.09 ⇧	0.21 ⇧	14.88 ⇩	12.65 ⇩
Hip replacement	0.41 ⇔	0.37 ⇧	9.16 ⇧	4.21 ⇩	19.72 ⇩	18.01 ⇩
Varicose Vein surgery	0.09 ⇔	-0.01 ⇔	-0.08 ⇧	1.12 ⇔	-7.53 ⇧*	-7.05 (No data previously)

*The Aberdeen Varicose Vein questionnaire is scored from 0 to 100, where 0 represents a patient with no problems associated with varicose veins and 100 represents the most severe problems associated with varicose veins. A negative adjusted health gain and a lower average post-operative score than pre-operative score suggests an improved performance.

The trust has an action plan which includes a number of measures to improve patient outcomes for patients related to relating to joint operations, which will lead to improved outcomes in future.

3.2 CQUIN (Commissioning for Quality and Innovation)

This part of the 2011/12 Quality Account is intended to provide additional evidence of our performance in respect of the quality of our services and the care delivered to our patients during the last 12 months. Most of the data presented here is available in other reports and documents, particularly those presented at our Trust Board throughout the year. The detail behind many of the figures has been scrutinised by our commissioners and other stakeholders and the most critical indicators are discussed with our commissioners during monthly Quality Review Meetings, which also explore specific issues or concerns arising throughout the year.

Last year the Trust agreed CQUIN goals with our commissioners. We successfully met or exceeded our targets. These are targets are specifically to do with quality of care as we know that they make a real difference to patient safety, patient experience, and clinical effectiveness (how well a treatment works). The 2011/12 goals are shown in the table below and shows our performance against each CQUIN target. Some of the CQUINs are included in the key priorities such as stroke, end of life care and basic nursing where a broader explanation of achievement can be found. Following table 20, there are a few highlights with short explanations of what has been achieved.

Table 20. CQUIN performance 2011/12

CQUIN SCHEMES			Actual 11/12	Data Period	11/12 Target
Acute	VTE Risk Assessment (Adult IP)	%	92.4	FY	90
	Pt. Experience (Acute) - Personal Needs	Score	70.8	FY	69.3
	Smoking Cessation (Acute) - Training	No.	94.0	FY	90
	Smoking Cessation (Acute) - Delivery	%	2890	FY	2000
	End of Life Care	%	80.0	M11	66
	Medicines Management - Missed Doses	%	-22.0	M11	-10
	Nutritional Assessment	%	89.0	M12	75
	Enhanced Recovery	%	Met	M10-12	Meet
	Stroke Discharge	%	90.5	M10-12	90
	Mortality Review	%	68.2	M11	60
	Alcohol Screening	%	88.5	M10-12	80
Community	Pt (Community) Exp'ce - Personal Needs	Score	92.9	FY	69.0
	End of Life Care	%	50.0	M12	36.7
	Health Visiting	%	72.4	M12	70
	Falls Prevention	%	62.6	M12	55.0
	Smoking Cessation (Comm) - Training	%	98.8	FY	80
	Smoking Cessation (Comm) - Delivery	%	94.7	M12	90
Specialised Commissioners	Chemotherapy Out of Hospital - Addit. Pt's receiving Herceptin at Home	No.	16	FY	16
	Chemotherapy Out of Hospital - Other Ambulatory Chemo/Oral Treatment	No.	500	FY	500
	Improving Access to Organs for T'plant	%	Met	M1-10	Meet
	Screening for Retinopathy or Prematurity	%	95.5	M7-11	92
	Auditing Neonatal Pathways		Compliant	M1-11	Comply

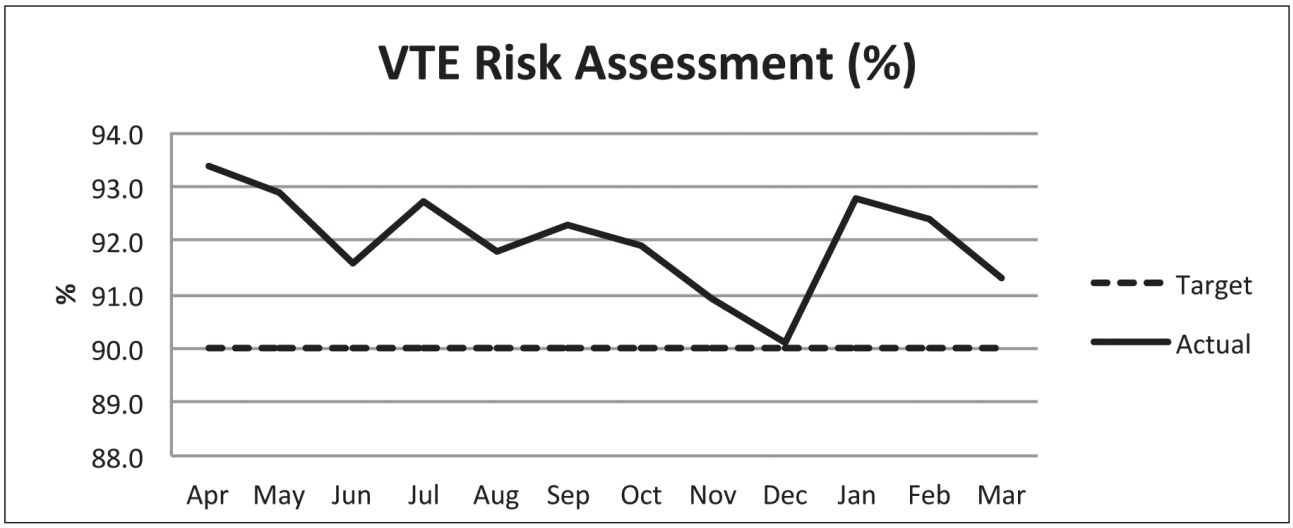
3.2.1 VTE (Venous thrombo-embolism)

Venous thrombo-embolism (VTE) is the term used to describe deep vein thrombosis (clots in the leg) and pulmonary embolism (where clots can break off and block the lung). This has long been recognised as a major problem that can affect patients whose mobility is impaired either by illness or following certain types of surgery. Doctors have, for many decades, included an estimate of the risk of developing deep vein thrombosis in certain patients and provided preventive treatment where the risk was deemed to be high.

This CQUIN target has been carried on from 2010/11 into 2011/12 which has meant that every Trust had to achieve VTE assessment rates of 90% in admitted patients.

We have been very successful in meeting this target throughout the year, and exceeding it by more than 1% in all but 2 months.

Table 21. VTE Performance



3.2.2 Smoking Cessation

Evidence over the years has demonstrated that stopping smoking benefits your health. We have been focused on 2 areas: training our staff how to help people to give up smoking, and people being referred to smoking cessation services.

This was both a target for acute services and community services. Both community services and acute services have been successful in training the target number of staff identified to receive training. In addition, the trust has been successful in exceeding their target for referral to smoking cessation services.

Table 22. Smoking Cessation Training Performance

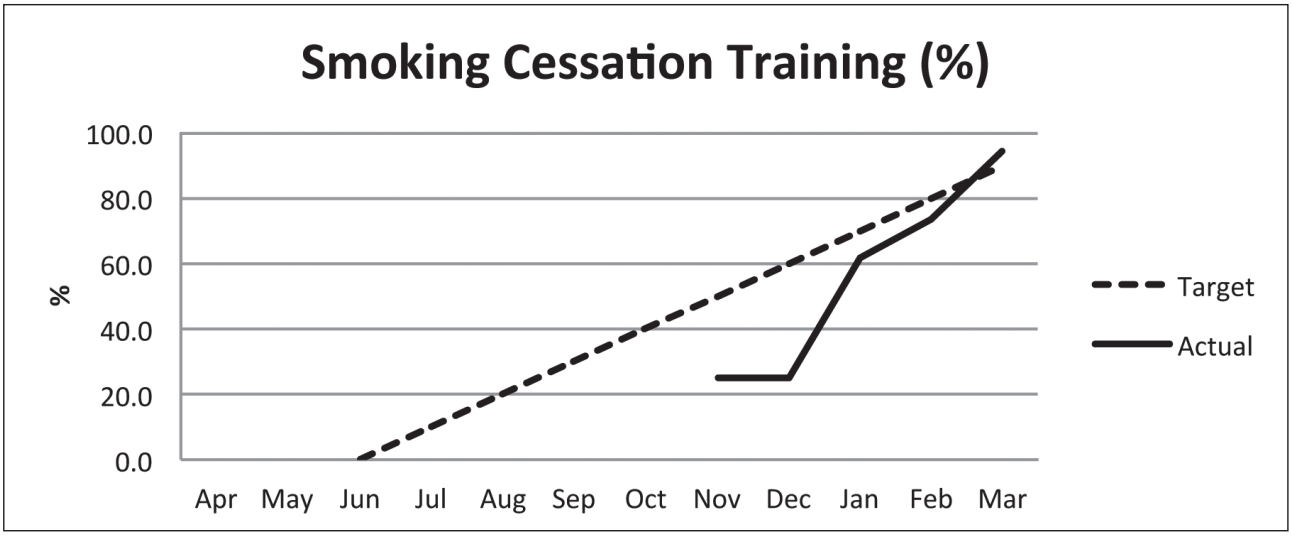
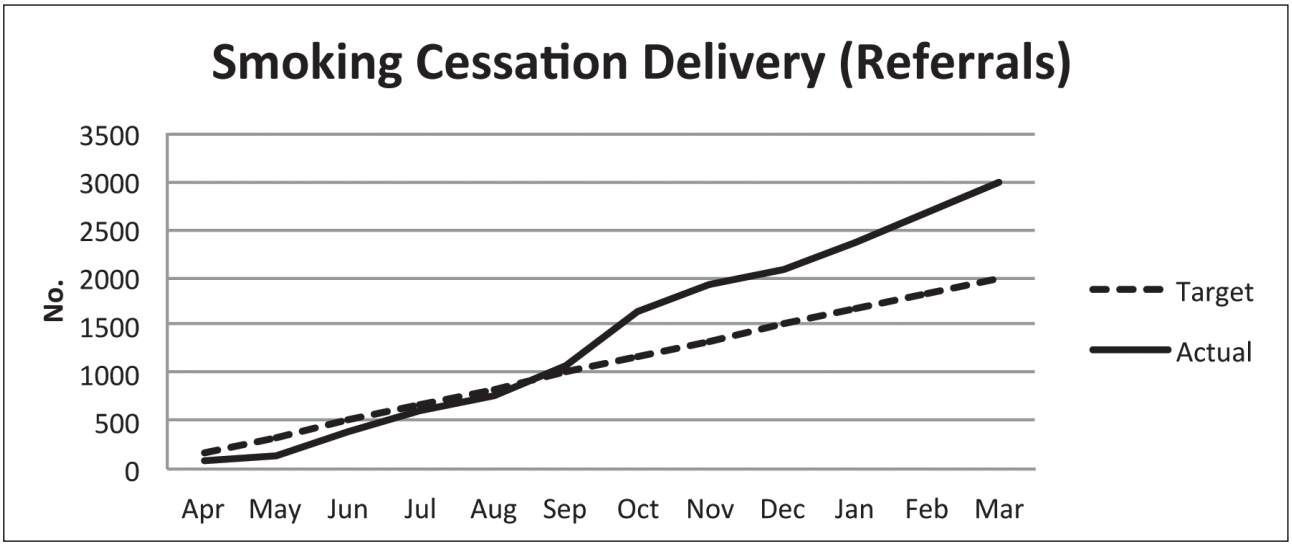


Table 23. Smoking Cessation Referrals Performance



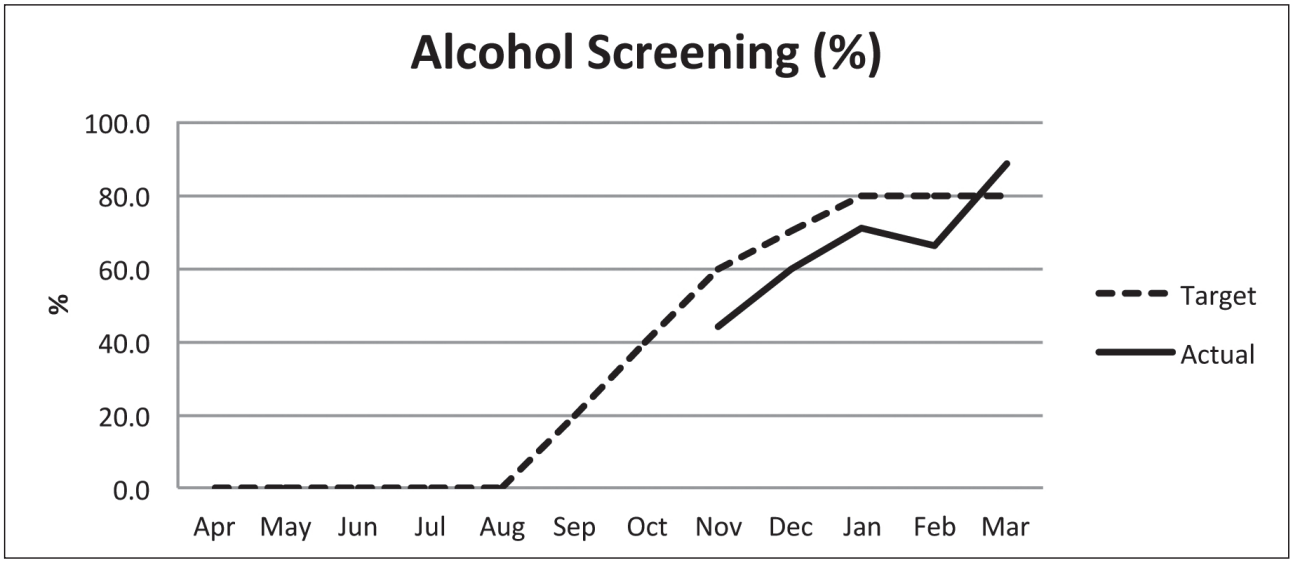
The table above demonstrates that we hit the referrals target for the year 3 months before we were required to do so.

3.2.3 Alcohol Screening Programme

We agreed with the commissioners to measure people being admitted into our hospitals against our alcohol screening form. It is very important to assess alcohol risk to ensure that patients are treated appropriately and also to be able to advise them on health issues if appropriate.

Although there was a slow start early in the year we have successfully achieved the target in March through very focused efforts.

Table 24. Alcohol Screening Performance



3.3 Other Indicators of Quality

3.3.1 Privacy and Dignity

Over the past year, the Trust has continued to promote the importance of privacy & dignity to ensure patients feel valued, listened to, and respected. This cumulated in a Dignity Campaign in December 2011 launching the role of the Dignity Champions on each ward. This has been followed up with regular workshops preparing the Champions to promote privacy and dignity in their area by checking that patients are called by their preferred name, assisted to use toilet facilities, encouraged to wear their own clothes to help protect patients' modesty, given choice in their care needs etc. (gowns have been removed from wards and over the next few months we will be supplying our own brand of pyjamas which means that patients are covered and comfortable).

Each patient's stay commences with a 'meet and greet' pack and welcome to the ward. Each bedside cabinet contains an information folder regarding access to advocacy, access to chaplains and other spiritual needs, ward routine, key staff and other messages. Individualised admissions allow the patient and carer to be involved in planning care. We have provided 'communication folders' to assist patients who do not speak English, are deaf/dumb or have Learning Disabilities to communicate their needs. Access to interpreters and telephone interpreting is also used wherever possible and the service has been advertised and training undertaken.

We want our staff to be as well trained as possible. Staff also receive training

regarding: equality and diversity, customer care and safeguarding vulnerable adults (including the Mental Capacity Act, dementia, self -harm). Policies guide this training and provide reference information to staff.

We evaluate and monitor how patients have found their hospital stay using patient surveys which we review monthly and follow this with actions every month. Senior nurses (matrons, charge nurses) directly observe care and evidence of care giving quarterly. These results are evaluated as part of ward reviews and help determine the standard of care provided and identify any actions required to improve.

We plan to continue the above strategies and further develop our user feedback systems to include more 'patient stories' to the Trust Board.

We know that dementia is increasing in the population. We plan to increase awareness and will be further developing staff knowledge regarding care of patients with dementia.

3.3.2 Same Sex Accommodation

We understand that as part of privacy and dignity, how we accommodate people in our hospitals is very important. Same Sex accommodation issues are very important to us.

Same sex accommodation means that the room where your bed is will only have patients of the same sex as you in it and that the toilet and bathroom will just be used by your gender and will be close to your bed area.

It is possible that there will be both male and female patients on the ward but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom but you will not have to walk through the opposite sex areas.

You may share some communal space such as day rooms or dining rooms and it is very likely that you will see both men and women patients as you move round the hospital, for example, on your way to the X-ray department or operating theatre.

It is probable that visitors of the opposite sex will come into your room where your bed is and this may include patients visiting each other. It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

The NHS will not turn away patients just because a 'right sex' bed is not available immediately.

If an occasion arises when a person of the opposite sex has to be located in a gender-specific area, the Executives are informed immediately. We also strive to ensure this happens as rarely as possible and arrange for patients to be moved at the first opportunity.

Over the past year there have been 109 breaches reported in the trust. This figure is deceptive. If a man was placed in a room where 10 women were sleeping, for example, that would count as 10 breaches. However, we have improved from 2010/11 when 1064 breaches were reported. We will continue to work to totally eliminate all same sex accommodation breaches.

3.3.3 Complaints

The Trust is committed to providing both comprehensive and timely responses to formal complaints about its services. Complaints give us a good picture of what has not worked very well for patients and their families, just as compliments tell us what people have found good.

The table below shows us the top themes of complaints over the past 3 years. Good progress has been made although we continue to monitor the complaints and use the themes to help us set our priorities.

Table 25. Complaints, by theme

Complaint Theme	2008/9	2009/10	2010/11
Clinical Treatment	386	350	377
Attitude of Staff	95	100	83
Appointment delay/ Cancellation Outpatient Appointment	178	105	71
Communication/ information to patient	56	53	36
Appointment delay/ Cancelled Inpatient	27	11	16
Long wait in Clinic	61	33	20
Transport Services	17	10	12
Cancelled appointment/ operation / treatment	48	17	12
Totals	868	679	627

Complaints Handling Process

In response to the NHS Complaints Regulations introduced in April 2009, the Trust changed to a system of formally investigating each complaint and providing a detailed and analytical investigation report with the response.

In light of the complaints backlog and the intervention of the CQC in March 2011, the Trust prescribed an Action Plan to maintain and improve compliance with the CQC's Essential Standards of Quality and Safety Outcome 17: Complaints.

The Action Plan's prescribed actions included review of the complaints handling policy; review and increase in complaints staffing capacity; staff training, introduction and implementation of a strategy for the reduction of the complaints backlog by the end of December 2011 and increased performance monitoring and reporting at Trust Board and Board Committee level.

In March 2012, the CQC issued its draft report which suggests that the Trust is regarded as being compliant with Outcome 17 and recognised the recent improvements made in the handling of complaints.

3.3.4 Staff Indicators

High quality care can only be delivered by well trained and highly motivated staff. We pay close attention to staff health and have seen significant improvements in the rates of sickness absence in recent years, particularly in respect of short term absence. Unplanned absence from work increases the workload for other colleagues and can diminish the amount of time available for caring for individual patients.

Training our staff has been a major priority for some time and this is reflected in the chart below. We were one of the best performing trusts in the NHS in 2009/10 and our performance has continued to improve in 2010/11.

Staff Survey

Every year, a Staff Survey is carried out nationally. The 2011 survey results show that there are some significant improvements from previous years and compare favorably with other trusts. This is summarized in the table below and gives a good indication how we have been doing over time across a range of measures.

Table 26. Staff Survey Findings

Key Findings	Sandwell and West Birmingham Hospitals NHS Trust					National Average				
	2007	2008	2009	2010	2011	2007	2008	2009	2010	2011
Percentage feeling satisfied with the quality of care and patient care they are able to deliver	-	63%	78%	77%	79%	-	62%	74%	74%	74%
Percentage agreeing that their role makes a difference to patients	-	90%	92%	91%	92%	-	89%	90%	90%	90%

Percentage of staff reporting errors, near misses or incidents witnessed in the last month	92%	96%	35%	38%	36%	95%	95%	37%	37%	34%
Staff recommendation of the trust as a place to work or receive treatment	-	-	3.56	3.53	3.59	-	-	3.50	3.52	3.50
Appraisal/KSF in the last 12 months	60%	86%	83%	80%	82%	61%	86%	70%	78%	81%
Good communication between senior management and staff	-	30%	33%	36%	40%	-	25%	26%	26%	26%
Care of Patients is my Trust's top priority	46%	58%	63%	64%	68%	46%	54%	59%	58%	58%
Percentage of staff feeling valued by their work colleagues	-	71%	72%	75%	74%	-	75%	77%	76%	76%
Staff Job Satisfaction	3.35	3.41	3.40	3.45	3.52	3.38	3.45	3.48	3.48	3.47
Satisfied with support from immediate manager	3.50	3.61	3.53	3.56	3.67	3.56	3.57	3.60	3.61	3.61
Trust commitment to work life balance	3.26	3.29	3.27	3.35	3.40	3.31	3.39	3.40	3.38	3.36
Overall Staff Engagement	-	-	-	3.62	3.67	-	-	-	3.62	3.62

The trust has been keen to respond to feedback it received from staff as the senior team knows that if you have staff who feel safe, don't feel too stressed and feel valued, they will do their jobs well in caring for patients.

Table 27. Staff suggestions and the organisations responses

You said we needed to improve ……	We did ……
Staff experiencing discrimination at work in the last 12 months Staff believing that the Trust provides equal opportunities for career progression or promotion Staff experiencing harassment, bullying or abuse from staff in the last 12 months Staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	A review of the findings against the HR dashboard (that is monitored quarterly across the diversity strands) Put in place a process to record and monitor any concerns about discrimination, equality of opportunity and harassment that are made outside of the formal processes Reviewed and revised the Trust's Dignity at Work Policy Raised the profile of the Trust's 'harassment advisors'
Staff experiencing physical violence from staff in the last 12 months Staff experiencing physical violence from patients, relatives, or the public in the last 12 months	Strengthened the Trust's approach towards dealing with violence and aggression by revising the Trust's procedure for 'managing aggressors' Reviewed Customer Care training content
% of staff suffered work-related stress in the last 12 months	Launched a comprehensive programme of health and well-being aimed at reducing stress, including an emphasis on the importance of taking regular exercise and healthy eating

3.3.5 What others think about our Quality Account

We invited our Commissioners, the Overview and Scrutiny Committees (OSC) in both Sandwell and Birmingham and both LINks groups in Sandwell and Birmingham what they thought about our Quality Account.

Our Commissioners, made the following statement:

Clinical Commissioning Group (CCG) Supportive Statement

'Sandwell and West Birmingham Clinical Commissioning Group (CCG), with Sandwell Primary Care Trust, is the lead commissioner for Sandwell and West Birmingham Hospitals NHS Trust and has the responsibility of seeking assurance that the services delivered by this Trust are of a consistently high standard. The CCG takes this task very seriously and works closely with the Trust throughout the year to ensure that services are of high quality. The Trust takes a proactive approach putting quality at the heart of their organisation. The CCG has undertaken a number of announced and unannounced visits to the Trust to see at first hand the quality of services provided, and that the experience patients have is as we would expect. The Trust has been open

and responsive to these visits. Good practice is acknowledged and a collaborative approach ensures that actions to address any problems identified are put in place at the earliest opportunity.

This Quality Account represents an accurate and well balanced view of the services delivered'.

Sandwell LINk made the following comments:

'The following constitute Sandwell LINk's comments on Sandwell and West Birmingham NHS Hospital Trust's Quality Accounts.

LINk members felt that the report reflects a lot of the good work done by the Trust over the past year, but that it is concerning that there remains a lack of clarity about the future of the new hospital. They also queried how the collection of data will be kept to a minimum with the vast number of audits being undertaken, and how improvements will be implemented and monitored as a result of the audits.

They felt that the Trust could be more proactive in its approach to consulting with patients and the public, particularly around changes such as the diabetic clinic and with LINk (or Healthwatch in future) on the Quality Accounts. Whilst understanding that the Trust has tight timescales for producing the data, the LINk members felt it would be highly beneficial for the Trust to look to arrange a meeting to present the report to the LINk ahead of time, thereby enabling a dialogue to occur around the contents and a more substantial commentary to be offered.'

Birmingham Overview and Scrutiny Committee made the following comment:

We recognise that Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the Overview & Scrutiny Committee (OSC) in the local authority area where the provider has its registered office, inviting comments from the OSC by the end of May. However the role of the OSC in providing assurance over a provider's Quality Account is a voluntary one. Birmingham City Council's Health & Social Care OSC (HOSC) will not be supplying a statement on any of the ten sets of 2011/2012 Quality Accounts it will be sent from nine different providers. In the local elections held on 3 May a third of the Council's members (councillors), including the Chairman of the HOSC, stood for re-election. It wasn't decided until 22 May whom the members of the new HOSC would be, and their first meeting will not be until June, so there is no opportunity for HOSC to provide a statement during May or even early June. HOSC is also reluctant to provide an assurance statement on quality Accounts which could compromise the HOSC's ability to scrutinise matters independently afterwards.

Birmingham LINk made no comment.
Sandwell OSC declined to make comment.

3.3.6 How to provide feedback on this Quality Account.

As an organisation, we would like to know what you thought of our Quality Account. After all, this document is for the public and we would like to know what you think. As a result of reading this document, do you think you have a better understanding of how committed we are to providing high quality care.

You can e-mail the Trust Board Secretary on *simon.graingerpayne@nhs.net*

Or send us a letter to Mr John Adler,
Chief Executive,
Management Centre
Sandwell & West Birmingham NHS Hospitals Trust
City Hospital
Dudley Road
Birmingham
B18 7QH

We will value your feedback.

Appendix 1

ANNUAL GOVERNANCE STATEMENT 2011/12

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

1. SCOPE OF RESPONSIBILITY

1.1 The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

1.2 In my role as Chief Executive of the Trust I fulfil my own responsibilities as its Accountable Officer in close association with the Chief Executive and senior officers of the Strategic Health Authority, the Chief Executives of the local Primary Care Trusts and the Council Leaders of the local authorities. Governance and risk issues are regularly discussed at a variety of Health Economy wide fora, including formal review meetings with the Strategic Health Authority, monthly meetings of Chief Executives and via the Partnership Board for the Health Economy-wide development plan, known as 'Right Care, Right Here'.

2. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

2.1 The organisation is led by the Trust Board, which in turn is supported in its duties by five committees, as follows:

Audit Committee

Chair: Non –Executive Director

- Considers the annual plans and reports of both the External and Internal Auditors
- Provides an overview and advises the Board of Directors on the internal control arrangements put in place by the Trust Board
- Acts as the co-ordinator of all support documentation in relation to assurance to the Chief Executive for the sign off of the Annual Governance Statement
- Reviews all matters of internal control
- Reviews the annual work plan and monitors progress with the work of the Local Counter Fraud Specialist function
- Liaises with the Quality and Safety Committee as appropriate
- After due process of review recommends the adoption of the Annual Accounts to the Trust Board

Frequency: Five times a year, including a specific meeting to review and approve the annual accounts

Membership: all Non Executive directors (excluding the Chair). The CEO and Director of Finance attend as required.

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Quality and Safety Committee

Chair: Non –Executive Director

- Monitors and provides assurance to the Board that clinical services are appropriately delivered in terms of quality, effectiveness and safety
- Ensures that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance
- Where quality and performance falls below acceptable standards, ensures that action is taken to bring it back in line with expectations, and to promote improvement and excellence
- Ensures that service user and carer perspectives on quality are at the heart of the Trust's quality assurance framework

Frequency: Six times per year

Membership: Four Non-Executive Directors and six of the Executive Directors with specialist advisers in attendance when required.

Finance and Performance Management Committee

Chair: Non –Executive Director

- Considers regular financial reports and forecasts, including prime statement of accounts and supporting analyses and forecasts
- Reviews the performance of the Trust's major clinical and corporate divisions and considers remedial action plans in the case of significant variances/deviations
- Reviews the annual financial plan and budget, prior to submission to the Trust Board for approval
- Monitors performance against external targets set by the Department of Health, Strategic Health Authority, commissioners and Monitor
- Monitors performance against a range of internally developed clinical, financial and operational indicators
- Considers plans and business cases in support of significant investment, prior to presentation to the Trust Board for approval

Frequency: Monthly

Membership: Four Non Executive directors, CEO, Director of Finance and Chief Operating Officer

Remuneration and Terms of Service Committee

Chair: Trust Chair

- Sets the pay and conditions of senior managers
- Recommends the remuneration and terms and conditions of employment for any employees who are not subject to national terms and conditions of service
- Scrutinises and agree any termination payments made to the Chief Executive and Executive Directors
- Ensures the consistent application of the Trust policy on remuneration and terms and conditions of employment for the Chief Executive and the Executive Directors

Frequency: The committee meets as required

Membership: All Non Executive Directors.

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Charitable Funds Committee

Chair: Non Executive Director

- Monitors the safeguarding of those assets donated or bequeathed in cash or other forms to the Trust's charitable funds
- Ensures as far as is practical that the expressed wishes of donors or benefactors are met in the deployment of funds.
- Monitors and reviews banking and audit arrangements
- Monitors the performance of the Trust's Charitable Funds portfolio
- Advises on the appointment of investment brokers

Frequency: Four times per year

Membership: All voting Directors

2.2 The Trust Board and its committees are administered by a Trust Secretary who maintains the Directors' Register of Interests and a register of attendance at meetings.

2.3 On an annual basis, the Trust Board is asked to consider and approve a proposed cycle of business for the forthcoming year, which is largely based on the best practice guidelines suggested in the Dr Foster publication, 'The Intelligent Board' and the National Leadership Council's report, 'The Healthy Board'. The reporting cycle is customised with items of local interest and significance to the Board, with matters being categorised into Quality, Safety and Governance; Strategy & Development; Performance Management; and Operational Management sections.

2.4 Integral to the preparation for the Trust's application for Foundation Trust status, is a number of Board development activities and opportunities. An independent facilitation of this work involved a comprehensive assessment of the skills and capabilities of Board members and the associated output has informed a development plan. Given the thoroughness of the external scrutiny and the Board's close engagement with the work, a formal internal self-assessment has not been necessary this year. The Board development work also included observations and feedback sessions on a series of Board and Committee meetings, a review of the Trust's Integrated Business Plan and a preparatory mock Board to Board meeting in advance of formal assessments. Again, the outcome from these processes has been carefully considered by the Board and informed the action plan to address areas in need of development. Finally, the development plan is monitored by the Board on a routine basis.

2.5 The Board considers that the Trust has, throughout the 2011/12 reporting year, applied the principles and met the requirements of the Code of Governance. In summary, the Trust has been headed throughout the by an effective board of directors, which has taken collective responsibility for leading the organisation, exercising its statutory powers and setting the strategic direction of the Trust.

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2.6 A particular area of development within the last year has been a revised approach for reporting to the Trust Board on the activities of and matters considered by the Trust's committees. In addition to the minutes of the Committee meetings being presented to the Trust Board as a matter of course, a comprehensive verbal update is provided by the relevant sub-committee Chair following the most recent Committee meeting. Annual reports on the work of each of the Committees are also presented as part of the annual reporting cycle of the Trust Board.

2.7 The publicly held Trust Board meetings cover the full gamut of clinical, corporate and business risk and discuss and monitor the delivery of corporate objectives and the detail of the Assurance Framework. Members of the Trust Board are encouraged to make as wide a range of public contributions in such discussions as possible and a representative from the Local Involvement Networks (LINks) regularly sits with the Trust Board during its monthly public meeting. For major service changes, more targeted work is undertaken to include the patient and public perspective within the decision-making process and associated risk assessments.

2.8 The Board's routine reporting includes a review of performance against the priorities of the Operating Framework, principally through the consideration of an assessment against the NHS Performance Framework. The assessment reported the Trust to be classified as a 'Performing' organisation throughout the year. As part of the work to meet the priorities, good progress has been made in a number of key areas, including the Trust's application for Foundation Trust status. The Trust was also successful in meeting its recruitment and expansion target for Health Visitors and as a result, has been identified as a national pilot site for Health Visitor improvement. In conjunction with this, the Trust is regarded as one of the regional leaders in respect of Family Nurse Partnerships, having delivered a number of measurable improvements for families as a consequence. In terms of Dementia care, a Rapid Assessment Interface and Discharge (RAID) service is fully embedded at the City Hospital site, which has proved highly successful in establishing a good practice model of care for patients with Mental Health difficulties within the Trust.

2.9 In support of the 'Right Care, Right Here' Programme and service reconfiguration proposals, the Trust has met frequently with the Joint Local Authority Overview and Scrutiny Committees in Birmingham and Sandwell. The risk associated with this project and wider Trust objectives is assessed in the context of external influences from patients, public, ministers and the DH and wider societal interests.

2.10 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust's compliance with equality and diversity issues is also monitored through the Equality and Diversity Steering Group, which reports quarterly to the Trust Board. During 2011/12, new Trust services, policies and functions have been subjected to an equality impact assessment, the details of which are publicly available on the Trust's internet site.

2.11 As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and

that member pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

2.12 The Trust has undertaken risk assessments and Carbon Reduction Delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.13 The Trust is fully compliant with the CQC essential standards of quality and safety. However within the year, the Trust has been subject to a responsive review of compliance by the CQC in connection with Outcome 17, Complaints. An action plan developed to address the shortfalls identified against the requirements was implemented and has been provided to the CQC for its consideration which recently confirmed its satisfaction with the measures taken. Additionally, within the year, the Trust's position was assessed for compliance against Outcomes 1 and 5, covering the Trust's responsibilities for privacy, dignity and nutrition. Following an initial inspection which reported major concerns at Sandwell Hospital in respect of compliance with Outcome 1, and later moderate concerns, a robust action plan was developed to address the issues raised, which received close Trust Board and Executive oversight. Compliance with the outcomes was confirmed following a third visit by the Care Quality Commission in December 2011.

3. RISK ASSESSMENT AND THE RISK & CONTROL FRAMEWORK

Management of risk and leadership

3.1 Sandwell and West Birmingham Hospitals NHS Trust has a comprehensive, trustwide system for managing risk, based on approved policies and strategies available on the Trust intranet.

3.2 The Trust has a Board approved Risk Management Strategy which identifies that the Chief Executive has overall responsibility for risk management within the Trust. The Chief Executive is supported with his responsibilities by the Director of Governance. All managers and clinicians accept the management of risks as one of their fundamental duties. Additionally the Strategy recognises that every member of staff must be committed to identifying and reducing risks. In order to achieve this the Trust promotes an environment of accountability to encourage staff at all levels to report when things go wrong, allowing open discussion to prevent their re-occurrence.

3.3 In Clinical Directorates, Clinical Directors, supported by Divisional Directors, General Managers and Heads of Nursing are responsible for managing risk. In all non-clinical directorates and departments, the appropriate Executive Director is responsible for managing risk through the chain of reporting.

3.4 The Trust has a designated Head of Risk Management within the Governance Directorate.

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Risk management process

3.5 The risk management process is an integral part of the Trust's business planning process and budget setting and performance review frameworks.

3.6 At a strategic level, risks are identified by the nominated directors against the Trust's strategic objectives and Annual Priorities. These identified risks provide information to support the Board Assurance Framework and where risks are identified as being 'serious', these are escalated to the Corporate (Trust) Risk Register and are monitored by the Trust Board and its delegated committees.

3.7 At an operational level, risks are maintained in appropriate local risk registers. Where a risk cannot be managed locally (requiring a supporting business case), has a major impact on service capability or Trust reputation or may result in major litigation, this will be presented for inclusion on the Corporate Risk Register.

3.8 Actions identified from risk assessments are mitigated at the appropriate level, and where actions require escalation, the risk will be escalated to the next tier of risk management.

3.9 The process is to be strengthened within the next year to ensure that those risks that are presented for addition to the corporate risk register will be presented monthly to the Trust Board. The Trust Board will be asked to decide whether a risk should be tolerated or treated. This information will be communicated to the 'owner' of the risk who will provide quarterly updates for the Trust risk register. An overview of the current status of risks on the Corporate Risk Register will be made available to the Trust Board on a quarterly basis.

3.10 The decision to treat a risk will be based on the actions required to mitigate that risk, its resource implications balanced against the possible financial penalty if the risk is realised. Every risk identified is backed up by a full risk assessment which covers the points above and an action plan to enable risk reduction, avoidance, transfer or elimination. The action plan defines the time for completion and who is responsible for carrying out the action. The status of the action plan will be monitored at intervals determined by the risk rating and be presented to the Board in a quarterly report. Any difficulties in meeting the deadlines of the actions or in securing resources to enable mitigation will be reported on the monthly risk register update that the Board receives.

Quality and Risk Profile (QRP)

3.11 The Trust routinely receives its Quality and Risk Profile (QRP), which is used by the Care Quality Commission to assist with identifying areas of potential non-compliance by producing a set of 'risk estimates' of non- compliance, one for each of the 16 essential standards. The QRP is presented to the Trust's Quality and Safety Committee at the soonest opportunity following publication. To date, there have been no matters of significance or concern to draw to the Committee's or Trust Board's attention.

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Quality Account

3.12 The Trust has in place robust processes to develop its annual Quality Account. Following the preparation of the Quality Account for 2010 and 2011, a comprehensive action plan was developed to address recommendations raised within the External Auditor's review of Quality Account and to pick up local matters of improvement identified. The progress with the action plan has received significant oversight and scrutiny, both at an Executive level and by the Trust Board via a report to the Audit Committee which is communicated upwards as part of the routine Committee updates.

Transformation Plan Quality Impact Assessment

3.13 A major piece of work undertaken within 2011/12 has been the development of the Transformation Plan, a five year view of how the Trust means to achieve the required cost savings within the period 2012/13 – 2016/17 in line with national efficiency requirements and local strategy. Although acknowledging that efficiency savings within the NHS are an integral part of the yearly cycle of business and financial recovery planning, over the past few years it has become more important than ever to ensure that plans, whilst having the desired efficiency saving element, do not pose a risk to the quality of patient care that the Trust wishes to and does provide. As such, Quality Impact Assessment of plans put forward as part of the 2012/13 element of the Transformation Plan was undertaken, which highlighted some schemes where quality of care may be impacted and in these cases mitigation plans were produced, to minimise the effects of any risk realised. Responsibility for monitoring the actions has been devolved to divisions and where a risk is no longer controlled by those mitigating actions, the matter will be escalated.

NHSLA accreditation

3.14 Building on the successful accreditation against the NHSLA Risk Management general standards at Level 2 in February 2011, work continues to prepare for the reassessment against general standards in February 2013 and the assessment against CNST maternity standards at Level 2 also planned for February 2013.

Corporate risks

3.15 The Trust Board operates a comprehensive risk management system, one of the outputs of which is the corporate risk register. During the financial year risks have been identified which include, but are not limited to, a delay in the approval of the new hospital outline business case, adherence to the essential standards for quality and safety, financial risks associated with any shortfalls in savings plans, new GP led commissioning processes, service line economics, and general staff engagement issues during a period of change. Of these, the most significant new risks concern savings plans as related to the five year Transformation Plan as well as preparing for the introduction of new GP led commissioning arrangements. In each case, detailed consideration of the risk has been undertaken by the Board including approval of the Risk treatment plan, accountabilities, severity (pre and post mitigation) and expected date of completion. The overall risk management processes are designed to capture new risks alongside the monitoring and management of existing risks ensuring that these are mitigated in accordance with the treatment plan.

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Board Assurance Framework

3.16 The Trust has a Board Assurance Framework which includes all key components required, including objectives, risks, controls, positive assurance, gaps in control and/or assurance and remedial action. In a recent review by Internal Audit, it was determined that **Significant Assurance** was provided by the Board Assurance Framework, with further areas for development identified to assist the Trust with continued improvement to the effectiveness of the processes in 2012/13.

The Board Assurance Framework is considered on a quarterly basis by the Trust's Governance Board, Quality and Safety Committee and Trust Board.

The Board Assurance Framework informs the declarations made in this Governance Statement.

Gaps in controls and assurance of the management of the risks associated with the delivery of a number of the Trust's objectives were identified, however the Trust has taken remedial action to address them which is reported in the quarterly update of the Board Assurance Framework.

Information security

3.17 Senior responsibility for information security, risks and incidents rests with the Chief Executive, as supported by the Interim Chief Information Officer. The Information Security Senior Responsible Owner (SRO) is supported by the Information Governance Manager and Head of Risk Management. The Information Governance Manager manages information security risk and incidents on a day to day basis and seeks support from the Head of Risk Management and SRO.

Regular reports are produced to identify information security incidents and the appropriate action planned to reduce the risk impact or likelihood of reoccurrence. These incidents are reviewed by the Information Governance Steering Committee to ensure appropriate action is taken and are also reported on a quarterly basis to the Governance Board through the IM & T governance update.

3.18 Within the year, two serious data security breaches were reported.

In October 2011 a clinical operating diary was found to be missing from a consultant's office but was recovered in February 2012 when it was found inside a set of healthcare records. The Information Commissioner's Office was informed that the diary had been recovered.

In February 2012 a community midwife's car was stolen whilst undertaking a community clinic. The car contained a number of maternity records. The police were informed at the time of the incident and there is an ongoing police investigation. The Trust has controls in place, which have been reinforced to ensure all mobile staff groups are aware of their responsibilities. In parallel, the Trust, as part of the development of an agile working solution, is exploring the use of mobile devices to support this staff group with patient management in the community.

Both incidents were promptly reported to the Information Commissioners Office and Strategic Health Authority.

Counterfraud and Whistleblowing

3.19 The Trust is supported through its Internal Audit function by a Counter Fraud service, that reports routinely to the Audit Committee. The service, whose annual workplan is approved by the Audit Committee, is proactive in its role deterring fraudulent activity within the Trust. A whistleblowing policy also exists and may be accessed by staff via the Trust's intranet, which provides the basis by which legitimate concerns can be fairly, effectively and speedily aired and responded to by the use of internal mechanisms. The policy sets out that concerns should initially be raised at a local level with the facility for employees to register concerns directly with a designated Non Executive Director if necessary. This provides the Trust with the opportunity to address concerns and for remedial action to be taken where appropriate.

Alignment with the local context

3.20 The Trust is working closely with emerging Clinical Commissioning Groups to ensure alignment with their strategies and objectives these bodies have for improving the health, intervention, experience and outcomes for their patients within the overall context of the 'Right Care, Right Here' programme.

Internal Audit opinion

3.21 The **Internal Auditor's Year End Report** and opinion on the effectiveness of the system of internal control is commented on below. The internal auditor's overall opinion is that **Significant Assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The weighted opinion considers specific audit reviews and the level of assurance assigned to each. In addition to this, the overall arrangements put in place by the Board for conducting its own assessment of the system of internal control is reviewed. The principal tool for such an assessment is the Board Assurance Framework (BAF) and the internal auditor concluded that the BAF has been designed and is operating to meet the requirements of the 2011/12 Governance Statement and provides reasonable assurance that there is an effective system of internal control to manage the principal risks to the organisation.

The internal auditor concluded that in his view, taking account of the respective levels of assurance provided for each audit review, an assessment of the relevant weighting of each individual assignment and the extent to which agreed actions have been implemented, that the Trust has a generally sound system of internal control.

5. REVIEW OF EFFECTIVENESS

5.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the

Board Assurance Framework and on the controls reviewed as part of the internal audit work. The overall level of assurance provided by the Head of Internal Audit Opinion for 2011/12 is **Significant**. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by reports and comments made by the external auditor, the Care Quality Commission and the NHS Litigation Authority, clinical auditors, accreditation bodies and peer reviews.

5.2 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Finance and Performance Management Committee, Quality & Safety Committee, Clinical Quality Review Group, Governance Board, Health and Safety Committee and the Adverse Events Committee**.** A plan to address weaknesses and ensure continuous improvement of the system is in place.

5.3 The Trust Board is responsible for reviewing the effectiveness of internal control and the Board is supported in this by its corporate committees.

5.4 The Trust Board has received a quarterly update from the Director of Infection Prevention and Control (a role currently within the remit of the Chief Nurse) on performance against national infection rate targets, together with effectiveness of structures in place to support infection control and measures to ensure continuous improvement in this area

5.5 Individual Executive Directors and managers are responsible for ensuring the adequacy and effectiveness of internal control within their sphere of responsibility.

5.6 Internal Audit carries out a continuous review of the internal control system and report the result of their reviews and recommendations for improvements in control to management and the Trust's Audit Committee.

5.7 Specific reviews have been undertaken by Internal Audit, External Audit, NHS Litigation Authority as well as various external bodies.

6 Significant control issues

6.1 Within the year, two serious data security breaches were reported, the detail of which is included in section 3.18. In both instances, the incidents were promptly reported to the Information Commissioners Office and Strategic Health Authority.

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6.2 Two inspections by the Care Quality Commission which occurred within the year reported that there were concerns over compliance with Outcomes 1 and 5 at Sandwell Hospital, prompting the development of robust action plans to address the issues raised, progress with the delivery of which was given close Trust Board and Executive management and oversight. Compliance with the outcomes was confirmed following the Care Quality Commission's visit in December 2011.

7 Concluding remarks

7.1 With the exception of the internal control issues that I have outlined in this statement, my review confirms that Sandwell & West Birmingham Hospitals NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Signed ……. Chief Executive (On behalf of the Board)

Date …….

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Same Sex Accommodation compliance declaration**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow - Chief Operating Officer**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

The attached report updates the Board on Same Sex accommodation compliance. The Trust completed capital works to meet accommodation standards in June 2011. Since then there has been a small number of breaches. Gender specific bed management is part of daily capacity meetings. At times of increased activity this can be a challenge, but the Trust remains focussed on meeting same sex accommodation standards.

REPORT RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE the progress report on ensuring compliance with same-sex standards and performance last year

2. APPROVE the declaration of compliance with the national standards

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental	x	Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity	x	Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Accessible and responsive care
Safe high quality care.
Quality and safety

PREVIOUS CONSIDERATION:

This is an annual compliance declaration

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAME-SEX ACCOMMODATION
REPORT FOR TRUST BOARD – JUNE 2012

INTRODUCTION

The Trust declared compliance with single sex accommodation standards last June following the completion of capital works to fully meet accommodation standards.

PROGRESS

We continue our focus on standards of privacy and dignity on all of our wards through our system of regular ward reviews and audits.

Prior to last years declaration of compliance and completion of capital works there were 75 breaches in April 2011, this had reduced to 4 in May (all in assessment units at City).

Since the completion of the capital works, there has been 2 months when breaches have been declared. In August 2011, there were 22 breaches which occurred within a week, on 4 separate dates, in one bay on the City assessment unit.

As part of a debrief to this event, gender specific bed issues are included in daily capacity planning meetings.

Latterly in February 2012 there were 8 breaches during one day within winter pressures and were related to the placement of one patient. A root cause analysis completed and the escalation process reiterated.

Sometimes when emergency activity is exceptionally busy it has been necessary to admit patients to mixed-sex bays in these units and we are continuing to work with these units to avoid this by changing the gender profile of bays which makes the management of patient flow internally challenging. There remains the potential occasions when clinical issues may have to take priority. Escalation processes are in place to manage such an issue.

BREACH REPORTING

The national system for reporting breaches of same-sex accommodation standards to the Department of Health requires us to report the number of patients having to share sleeping areas each month. 109 were declared in 2011/12.

DECLARATION OF COMPLIANCE

All NHS Trusts and NHS Foundation Trusts are required to publish a formal annual declaration of compliance with the national same-sex accommodation requirements.

The proposed draft declaration of compliance for 2012, is attached as an appendix to this paper.

CONCLUSION AND RECOMMENDATIONS

This paper has provided the Trust Board with an update on progress in our work to ensure full compliance with the national same-sex accommodation standards.

The Trust Board is recommended to:

1. NOTE the progress report on ensuring compliance with same-sex standards and performance last year

2. APPROVE the declaration of compliance with the national standards

Rachel Barlow
21st June 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DRAFT

SAME-SEX ACCOMMODATION STANDARDS
ANNUAL PUBLIC DECLARATION

Our Approach

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Sandwell and West Birmingham Hospitals NHS Trust (SWBH) is committed to providing every patient with same-sex accommodation because it helps to safeguard their privacy and dignity.

Level of Compliance

SWBH is able to confirm full compliance with the Government's requirement to eliminate mixed-sex accommodation except when it is in the patient's overall best interest or reflects their personal choice.

All our wards at City Hospital, Sandwell General Hospital, Rowley Regis Hospital and Leasowes Intermediate Care Centre are compliant with the national standards.

What does Same-Sex Accommodation Mean?

Same-sex accommodation means:

- the room where your bed is will only have patient of the same-sex as you;
- the toilet and bathroom will be just for your gender and will be close to your bed area.

It is possible that there will be both men and women patients on the ward but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom but you will not have to walk through the opposite-sex areas.

You may share some communal space such as day rooms or dining rooms and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to x-ray or to the operating theatre).

It is probable that visitors of the opposite gender will come into the room where your bed is and this may include patients visiting each other. It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

If you need help to use the toilet or take a bath then you may be taken to a “unisex” bathroom used by both men and women but a member of staff will be with you and other patients will not be in the bathroom at the same time.

The NHS will not turn away patients just because a “right-sex” bed is not available immediately.

What This Means in Our Hospitals

In our Trust this means that:

- Patients admitted to Sandwell Hospital, Rowley Regis Hospital or the wards in the Sheldon Block at City Hospital are admitted to same-sex bays clearly separate from the main ward corridor. Patients have access to separate male and female toilet and washing facilities on each ward.

- Patients admitted to the main wards at City Hospital are admitted to same-sex wards.

- Patients admitted to Leasowes Intermediate Care Centre are admitted to single rooms with ensuite separate washing and toilet facilities. A shared large shower room is used however for patients unable to use their en-suite facilities as a result of their clinical condition.

- We are committed to ensuring high standards of privacy and dignity for all our patients all of the time. These standards are regularly audited on all of our wards to ensure they are maintained,

There are a small number of specialist areas where we may not always be able to separate men and women including:

- the Critical Care Units at both hospitals;
- the Coronary Care Units at both hospitals;
- the Acute Stroke and Brain Injury unit at City Hospital
- Recovery areas in our Theatres.

Our Emergency Assessment Unit at Sandwell Hospital and the Medical Assessment Unit and Surgical Assessment Unit at City Hospital operate with a series of same-sex bays. Sometimes when we are exceptionally busy it has been necessary to admit patients to mixed-sex bays in these units and we are continuing to work with these units to avoid this in future.

What are our plans for the future?

We are continuing to work to improve standards of privacy and dignity including:

- continuing our focus on standards of privacy and dignity on all of our wards through our system of regular ward reviews and audits;

- ensuring that high standards of privacy and dignity are built into the estates plans.

How do we measure success?

We measure our success in meeting these standards in a range of ways including:

- patient surveys – both the annual national patient survey and our rolling programme of local surveys;

- monitoring the number of occasions on which we breach these standards – these are reported monthly to our board in public;

- regular reviews of standards of care on all of our wards;

- regular (six-monthly) reports to the Trust Board on progress with delivering same-sex accommodation.

Who do I contact for more information?

For more information or if you have any comments or concerns please contact:

Rachel Barlow
Chief Operating Officer

0121 507 4439
Rachel.barlow2@nhs.net

This declaration was approved by the Trust Board on 28th June 2012. It will be formally reviewed annually.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Estates Rationalisation**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager, Director of Estates/ New Hospital Project**
AUTHOR:	**Graham Seager, Director of Estates/ New Hospital Project**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

The Board will recall the approval of the Estates Rationalisation programme at its March 2012 meeting. The paper outlined an ongoing programme of building closures as part of the rationalisation programme.

The process for declaring buildings surplus requires Board approval as they occur. The following buildings are planned to be unused from the 30th June 2012 and so are recommend to be declared non-operational.

- Sandwell Block 11 Former Drs Mess
- City Block 79 Squash Court
- City Block 138 Transport Portacabin
- City Block 007 Security Bungalow

The Board is recommended to approved the closure of the buildings identified above.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Strategic Objective -Good Use of Resources
Trust Priority- Delivering the Transformation Plan

PREVIOUS CONSIDERATION:

Estates Rationalisation was considered by the Trust Board in March 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Replacement Program for two Gamma camera systems in Physics and Nuclear Medicine at City Hospital**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow, Chief Operating Officer**
AUTHOR:	**Dr Bill Thomson, Consultant Radiologist**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

In February 2012 SIRG approved a replacement programme for two old (11 years and 15 years) gamma camera systems in the Physics and Nuclear Medicine department on City site. This requires modifications to the current imaging rooms and reporting area, and the reception and waiting room areas are also being improved to comply with current patient standards.

The total budget approved by SIRG was £1.483m. Following further detailed investigations into the optimum camera configurations and also the required layout, the scheme remains on budget and within planned timescales.

In order to proceed with orders for the capital equipment and contracts for the associated building works, we request that the Trust Board give consideration to the planned scheme with a view to approving this expenditure.

REPORT RECOMMENDATION:

We are seeking approval from the Trust Board to proceed with the replacement programme for two gamma cameras within the budgetary schedule as described and as approved by the Strategic Investment Review Group.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	**X**	Environmental		Communications & Media	
Business and market share	**X**	Legal & Policy		Patient Experience	X
Clinical	**X**	Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The Gamma Camera Replacement Programme ensures -

- Provision of a high quality and safe nuclear medicine service
- A service with 21st century facilities, with compliance with CQC standards
- Improvements to patient Privacy and Dignity in compliance with Trust standards
- Improvements to Infection Control within the clinical Imaging areas
- Sustained performance through delivery of KPI for nuclear medicine investigations
- Ensures continued external contracts and associated income
- Allows for nuclear medicine reconfiguration (Imaging TSP)
- Mitigates risks of failure of aging equipment as highlighted on the Divisional Risk register

PREVIOUS CONSIDERATION:
SIRG has previously considered and approved the gamma camera replacement programme

HOLBROW · BROOKES
CONSTRUCTION CONSULTANTS
Regulated by RICS

By email

Mr Dave Beale
Sandwell & West Birmingham Hospitals NHS Trust
City Hospital
Brookfield House
Western Road off Dudley Road
Birmingham B18 7QH

Our Ref:- PFK/SPD/3247

15th June 2012

Dear Dave

Sandwell & West Birmingham Hospitals NHS Trust
Proposed Gamma Camera

Following receipt of IPD's latest drawn proposal (C1353/03C), we have reviewed the Project Cost and anticipate a value of **£1,483,000.00** which is inclusive of an allowance for the Specialist Equipment required in Rooms 1 and 2.

The breakdown of this cost is as follows:-

Works Cost	£250,000.00
Design Fees - allowance	£37,500.00
F&E Cost – Standard Group 2, 3 & 4 Equipment	£16,000.00
Specialist Equipment (incl Business Continuity Plan)	£909,000.00
Planning Contingency - allowance	£30,000.00
VAT (@ 20%, fees excepted)	£236,500.00
Project Cost	**£1,483,000.00**

In advising the costs, the following caveats are still applicable:-

1. The costs are based on a contract commencing on site in the next 3 months.

2. The costs assume that the existing Services infrastructure has sufficient capacity to accommodate the proposals. This is still subject to further investigation by the Services Engineer.

3. The M&E costs are as verbally advised by Stewart Associates.

Continued…

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- Continuation One -

4. The costs assume the existing structure can accommodate the proposals without the need for any structural upgrades. In terms of the camera fixing, the same utilises a similar construction as for the Gamma Camera (Nr 3) Replacement works undertaken a few years ago.

5. The costs still assume that a contractor will be given uninterrupted access to the site during the normal construction hours, albeit allowances are included for undertaking service interruptions etc at times to suit the Trust.

6. The Trust has identified a solution which will allow the Clinical Service to be delivered without significant impact on the aforementioned project cost.

7. Allowance is included for any asbestos strip out works that may be required. It is envisaged that any works required in this regard will be the part of the contingency funding.

8. The costs generally allow for the Schedule of Works as described on the drawing and only to the following rooms:- Reception, Waiting Area, Camera Rooms 1 and 2, the Control Room (serving Gamma Camera Rooms 1 and 2), Reporting Room and the Corridor outside of Gamma Camera Rooms 1 and 2.

9. The specialist equipment cost is subject to final confirmation and is inclusive of an allowance for Business Continuity. This reflects the advice of the Trust. An allowance has also been included for other Group 2, 3 and 4 F&E items. Again, this is subject to a final review by the Trust.

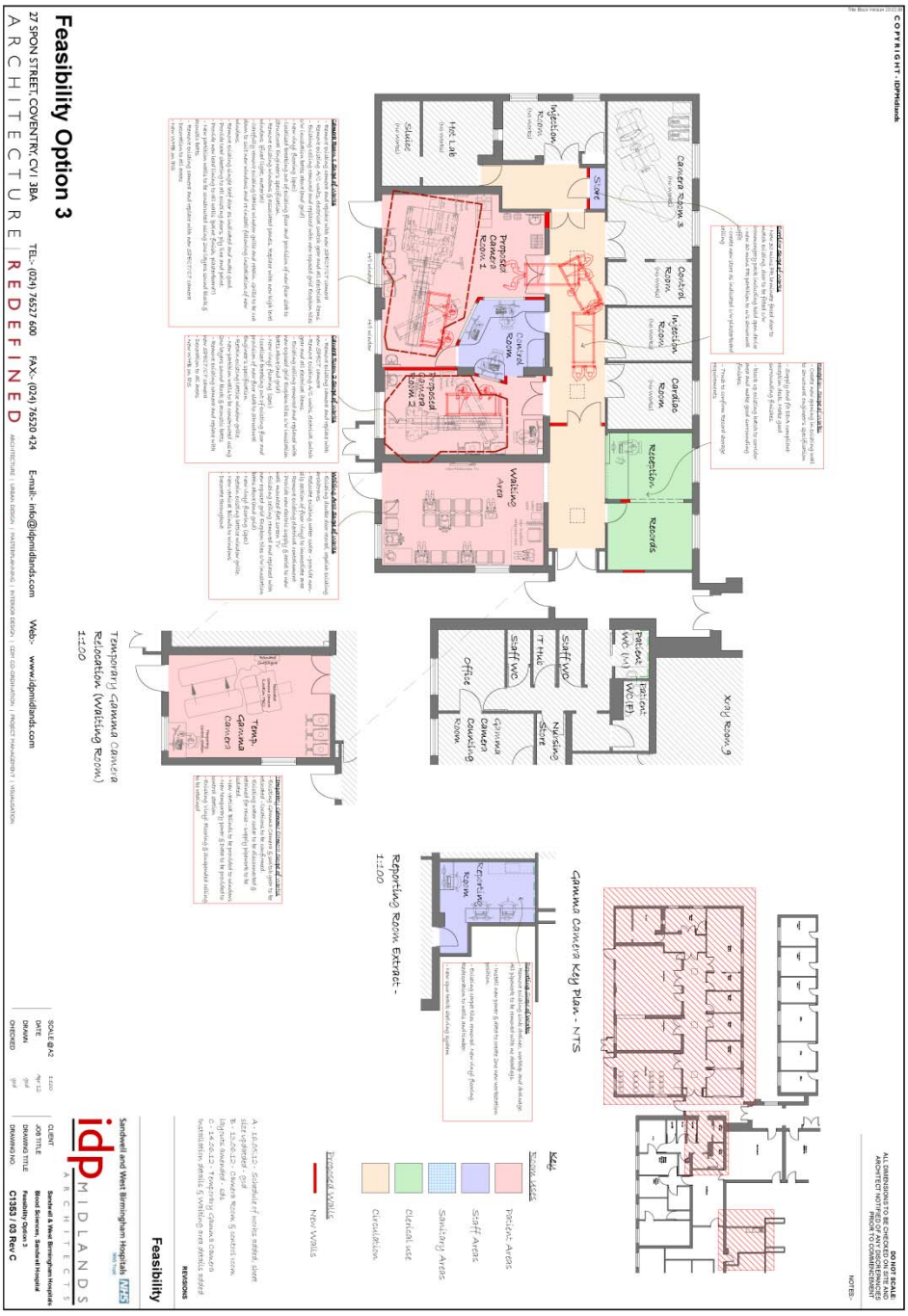
10. No allowance has been included for VAT Recovery. This will be advised upon in due course.

Yours sincerely

Paul Kinsella

SIRG – February 2012 scope of works

June Trust Board scope of works



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Summary of Quality Assurance Process for Postgraduate Medical Education (RAG system)**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Deva Situnayake, Acting Medical Director**
AUTHOR:	**Saket Singhal and Julian Chilvers (Postgraduate Clinical Tutors)**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

The report is an update from the previous report in March 2011. It summarises the Internal Quality Assurance process and Educational Structure for Postgraduate Medical Education, highlighting areas of good practice.

It also summarises Specialties and areas where there are specific concerns with the provision of Postgraduate Medical Education and subsequent agreed Action Plans.

A summary of external Deanery QA visits (with agreed Action Plans) over the past 12 months is also included.

REPORT RECOMMENDATION:

The Trust Board is requested to receive and consider the update.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical	X	Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically

PREVIOUS CONSIDERATION:

The Trust Management Board in May 2012

Update of Quality Assurance Process for Postgraduate Medical Education (RAG System) at SWBHT: March 2011 – April 2012

1. Background

Over recent years a number of factors – both Internal and External to the Trust, have had a significant impact on the delivery of Postgraduate Medical Education locally.

These include:

- The Trust's Interim Reconfiguration plans in a number of Specialties
- The impact of the European Working Time Directive (EWTD)
- Reduction in Training numbers, particularly in some Specialties
- A move towards models of increased Community-based care with the advent of Commissioning of Services by Primary Care

2. Quality Assurance

The West Midlands Workforce Deanery QA Team runs a rolling programme of 'routine' Visits to Trusts to conduct an external review of Postgraduate Training (including the Foundation Programme). In addition, 'triggered' Visits are conducted where there are concerns in a particular Specialty. The provision of Medical Education during these Visits is assessed against the standards as documented in the "Fifteen Requirements for Doctors and Dentists in Training Posts in the West Midlands Deanery" [enclosed]. These standards form the basis of JEST feedback surveys that are regularly completed by Doctors in Training and have been mapped against GMC standards.

All Local Education Providers (City and Sandwell are separate LEPs for this purpose) are also required to complete an Annual West Midlands Deanery Self-Assessment Report summarising local QA processes and highlighting notable practice and areas of concern (with Action Plans) – these were last completed in September, 2011 for both City and Sandwell [enclosed].

In September 2009, it was agreed that a robust Internal process should be set up in order to formally review local practice against the above standards. This process would enable the Medical Director and Postgraduate Clinical Tutors to be kept aware at all times about notable practice and areas of concern with respect to the delivery of Postgraduate Medical Education. The process would also facilitate completion of the Annual LEP Self-Assessment Report and would prepare the Trust and individual Specialties for the increasingly regular QA Visits conducted by West Midlands Deanery. The attached diagram summarises the Trust's Internal Reporting Mechanisms following (and in preparation for) QA Visits and the Educational Structure with respect to Postgraduate Medical Training.

3. RAG (Red / Amber / Green) Meetings

Central to the Internal QA Process is the RAG meeting, at which the Associate Medical Director, both Postgraduate Clinical Tutors and College / Specialty Tutors (cross-site) from Individual Specialties review Training Standards within that Specialty. Specialties are reviewed on a rotational basis and each Specialty is reviewed at least annually. Additional meetings are held in advance of (and if necessary subsequent to) QA Visits or if specific concerns have been highlighted in any Specialty by the RAG process.

A standard format is adopted at each meeting, in that the following evidence is reviewed:

(a) Most recent West Midlands Deanery QA Visit (if applicable)

(b) Most recent GMC Trainee Survey

(c) Local (Specialty) JEST feedback (4 monthly from Foundation Trainees, 4-12 monthly Specialty Trainees) – this is identical to the standards listed in the 'Fifteen Requirements…' document

At the conclusion of each meeting a summary of notable practice and areas of concern (with agreed Action Plans) is recorded on a rolling Master Document (ECAM, enclosed) and a Red / Amber / Green rating is awarded to the Specialty being reviewed.

All Specialties are currently rated as Green with the exception of the following:

(i) **Trauma and Orthopaedics** (RED) – this relates to an issue raised at the Deanery Visit on 15/11/2011 and is discussed in detail below (section 4)

(ii) **Accident and Emergency** (AMBER)

Many areas of good practice on both sites and all Trainees would recommend the posts, but some red flags on GMC survey including **Handover, Work Intensity and Undermining by Other Staff.**

These concerns in large part are likely to relate to Understaffing (vacant posts) at Middle Grade and Consultant level, which is being addressed through recruitment and a change in the Consultant working pattern. The ratio of Trainees to Consultant is also high, so that some Consultants are required to act as Educational Supervisor for more than 2 Trainees; this is not recognised in Job Plans.

(iii) **Obstetrics and Gynaecology** (AMBER)

Many areas of good practice: good subspecialty Induction, excellent Handover on the Maternity Unit and Gynaecology wards and improved opportunities for Training of ST Trainees since Reconfiguration to the City Site.

A concern remains regarding the lack of availability of Gynaecology ward rounds in the mornings to review Emergency Admissions (there is a process for review of these patients after 1pm).

In addition (i) a Trainee Forum still needs to be formalised, (ii) it is noted that the College Tutor is responsible for 34 Trainees therefore consideration should be given to appointing a Deputy Tutor and (iii) a possible issue of Security has been raised; there is an SpR on-call at the weekend at Sandwell and this person is frequently the only person residing in the old Maternity Block at Sandwell out of hours.

These issues have all been fed back to the College Tutor and relevant Clinical Director.

4. External West Midlands Deanery QA Visits since March 2011 (All Deanery Reports and subsequent Action Plans attached)

(a) Dermatology (15/3/11)

The Dermatology Team was congratulated for a very positive outcome and the Trust were thanked for excellent organisation of the Visit.

Quotes from the Report subsequent to the Visit include:

- Two Senior Trainees felt that SWBH was the best training centre that they had worked at
- Trust and Departmental Induction very good
- Educational Supervisors all trained, engaged with the process, regularly conducted Trainee appraisals and Dr Velangi was clearly identified as the Educational Lead
- Consultant contact excellent, staff supportive and approachable
- Feedback, clinical workload and protected teaching all well balanced and at the right level

No specific areas of concern were highlighted

(b) General and Neonatal Paediatrics Re-Visit (6/12/11)

It was noted by the Visiting Team that considerable effort had been made to address the concerns raised at the Visit on 13/12/10. It was noted that each concern had been dealt with in detail and action plans had been put into place.

Specifically:

- Education and Training a high priority with excellent supervision, support and monthly Consultant meetings to discuss Trainees

- The work of the RCPCH Tutors noted, especially Dr Makwana
- Workplace-based assessments prioritised
- Rota well balanced with a flexible leave system that is appreciated

Issues remaining to be addressed:

- Clarity about Neonatal Consultant on-call
- Computer access
- Community Paediatric ST4 Training needs some attention
- Some inappropriate tasks (babychecks at weekends)

(c) Radiology (3/5/11)

Several areas of Notable practice highlighted, including high overall level of satisfaction, good local Induction, Junior Doctors' Forum, Service-based Teaching that accommodates the needs of the Trainees and Appraisals / Workplace-based assessments conducted appropriately.

Areas to be addressed:

- Some imbalance between service and training; several Senior Trainees felt that Service was being undertaken at the expense of subspecialist training
- PACS system slow and cumbersome
- Some concern regarding poor inpatient ultrasound experience and concern regarding covering both sites for ultrasound when on-call
- An issue of potential 'bullying and harassment' in that Trainees felt that they were forced to do scans with an inappropriate level of urgency from a particular Consultant Surgeon. **This has been addressed following discussion with the Consultant concerned, the issue has been resolved and no further concern of a similar nature has been reported**

(d) Core Medical Training (7/2/12)

The Visiting Team commented that this was a very positive Visit, excellent organisation and there was evidence of a considerable amount of good practice.

Specifically:

- Excellent JEST / GMC surveys and high MRCP pass rate
- Teaching programme well-organised, well attended and appreciated
- Clinical and Education Supervision effective and reliable, communication good and atmosphere supportive
- Induction well-organised and informative
- Clinical workload high but appropriate
- Junior Doctors' Forum at Sandwell particularly well run
- The Teaching programme is "100% better than that received in London"; particular praise given to Dr Albaaj, Dr Sturman and Dr Sarkar

Areas to address:

- Some concern about insufficient access to Outpatients because of ward work
- Some concerns regarding patient safety following amalgamation of Respiratory and Gastroenterology wards at Sandwell
- Some concern about handover in Neurology
- Concern regarding the proposed transfer of responsibility for Head Injuries to Medicine
- Clearer recognition in job plans (SPA) for work done by Educational Supervisors and College Tutors

(e) Anaesthetics Paper-based Review (22/2/12)

This was a review to specifically address a Red Triangle that appeared in the 2011 GMC Survey for Anaesthetics with reference to "Procedural Skills Score".

This is addressed in the attached Report and Action Plan, which details plans to set up a Multi-disciplinary Simulation Area and to make Simulation Training mandatory for Anaesthetic Trainees.

(f) Foundation Trainees (28/6/11: City; 5/7/11: Sandwell)

A good environment for Education and Training was noted at both Visits.

Specifically at City:

- Supportive Clinical Tutor, Educational Supervisors and Postgraduate Centre staff
- Good Induction, Appraisals and Audit support
- Clinical Workload acceptable and appropriate
- Good Senior Cover especially in ITU, Emergency Medicine, Cardiology and Paediatrics
- Excellent Training opportunities especially in ITU, Acute and Emergency Medicine, Respiratory Medicine and Paediatrics
- Proficient phlebotomy service highly regarded

Specifically at Sandwell:

- Strong and supportive leadership by Clinical Tutor and Medical Education Centre Manager
- Strong Junior Doctors' Forum, where issues raised get investigated
- Good Induction, Senior Cover, Supervision and Appraisal
- Protected Teaching, Handover, Hospital at Night all work well
- Occupational Medicine F2 post and F2 post at Warley Medical Centre singled out for praise

Areas of concern at City:

- Poor supervision at 4 GP Practices (**this has been investigated and addressed**)
- High workload in Clinical Pharmacology
- Variable workload and Poor Induction in Surgery (**this has since been addressed and rectified**)

Areas of concern at Sandwell:

- Need for greater integration of curriculum into teaching programme
- T+O Workload remains high
- Variable quality of Educational Supervision
- Handover in Surgery could be improved

(g) Trauma and Orthopaedics (15/11/11)

A good relationship between Trainees and Trainers was noted, with excellent Training Opportunities, and no Patient Safety issues were highlighted. Appraisal, Educational Supervision and recent Teaching opportunities (including Journal Clubs and Trauma meetings) were mentioned.

However, recent RITA / ARCP failures by a number of Trainees was raised as a concern by the Visiting Team. This was felt to relate to limitations in the Training Opportunities for Senior Trainees, especially with regard to exposure to Trauma work, for a number of reasons including (i) a significant requirement to do Night Shifts (directly impacting on training opportunities) and (ii) a need to cover clinics with reduction in opportunity to attend Trauma Theatre lists.

In light of these concerns a Re-Visit is planned for June 2012, at which these concerns will be reviewed. An Action Plan has been set up (attached) which is currently being put into place.

ALL DEANERY VISITS IN 2011 / 2012 RECOMMENDED CONTINUED RECOGNITION OF TRAINING POSTS

Forthcoming Visits:

Surgery and Trauma & Orthopaedic Re-visit (June, 2012)

Ophthalmology (Summer, 2012)

Foundation (early 2013, both sites)

R D SITUNAYAKE / S SINGHAL / J CHILVERS

(May 2012)

Fifteen Requirements for Doctors and Dentists in Training Posts in the West Midlands Deanery

1. Patient Safety Issues *All criteria below must be understood in terms of this overarching concept of patient safety*
2. Programme Director's Planning *Named programme director who accepts responsibility for planning the programme and ensuring that the standards set out below are met*
3. Induction to post *Clinical guidelines, written information on timetables etc, occupational health services, bullying and harassment issues, and whistle blowing in the NHS.*
4. Appraisal and assessment *A named educational supervisor, initial and interval appraisals and assessments and feedback - all properly documented*
5. Feedback on your work *Regular helpful constructive feedback on performance in daily clinical supervision, including both good and poor performance.*
6. Protected teaching (bleep free) *Based on relevant Royal College curriculum, on a regular basis, evaluated by trainees – 70% attendance at minimum.*
7. Service based teaching *Teaching and learning in routine work, with appropriate consultant ward rounds, outpatient clinics, operating sessions per week. Handovers.*
8. Senior doctor cover *The immediate personal assistance of a senior doctor (normally a consultant or trainer) must always be available to trainees.*
9. Clinical workload *Exposure to an appropriate level of clinical activity, to develop their clinical knowledge, skills and attitudes and achievement of educational objectives.*
10. EBM and audit *Local written EBM guidelines for common clinical conditions. Audit involving trainees, who receive guidance and support for audit.*
11. Inappropriate tasks *No work for which the trainee is inadequately trained, or of no relevance to educational objectives, or which is prohibited by GMC / GDC guidelines.*
12. Rota compliance *Rota is compliant with current legislation, and monitored regularly to ensure that it remains compliant. Trainees must take part in monitoring processes.*
13. Accommodation and catering *The employer is responsible for a safe working environment, and accommodation and catering to current national standards.*
14. Leave *Allowed to undertake annual leave and study leave within their Terms and Conditions of Service. Study leave must be appropriate to educational objectives.*
15. Junior doctors' forum *This forum must meet regularly, and the meetings must be documented and minuted, including details of decisions made.*
Overall Satisfaction – Recommendation of post? (Summary):

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
Anaesthetics Cross site	Lucinda Homer (City)/ Dr Krishnan (Sandwell)	TBC CD Zoe Huish	Many examples of good practice available. Cross site working has been further developed for on call work and subspecialty training at all grades. This has been viewed positively by trainees and trainers alike. Obstetric reconfiguration is providing excellent training opportunities. . Teaching: Cross site trainees now attend CT teaching on a Monday morning (protected.) Active cross site trainee forum. Enthusiastic and supportive education supervisors now established at Sandwell. . Generally very good JEST feedback. Protected teaching score explained by the fact that 'novice trainees' do not attend teaching in the first 8 weeks of training. At this stage clinical exposure takes priority over working for FRCA! GMC survey praised regional teaching, Clinical supervision and hours of education. Procedural skills were	All action points from previous review and deanery visit completed apart from assessing whether FY1 trainees can attend preadmission clinics. 1) Audit numbers of CVP line insertion on emergency list. If found to be excessive action needs to be taken by CD. 2) Dr Homer to discuss with BSA regarding making simulation training mandatory. 3) Dr Krishnan to review Skills simulation aids (epidural and fiber optic intubation.) To establish lead for delivering this skills training. 4) Dr Chilvers to highlight the need for a simulation training area in the trust medical education strategy.	**Level 1 Paper review March 2012.**	**Green**	03/12

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			highlighted as an area of concern. Inappropriate tasks : High rate of CVP line insertion on emergency list.				
Medicine City	Stuart Hutchinson/ Parijat De	Matthew Lewis	Many areas of good practice. Well established educational and appraisal process. Development of H@N and multi-disciplinary handover. EWTD 2009 compliant rotas. Specialty Induction in place and works well. Good CMT teaching programme cross-site (bleep free). Good ARCP results and excellent MRCP exam results. Good recent JEST feedback especially in Elderly Care Supervisors all receive excellent feedback.	Trainee Forum – first meeting November 2011; needs to be held regularly. Written evidence of Specialty Induction now being collected. Formal arrangements to pair Surgical Team with Medical Team for managing Medical Outliers in the Winter now in place – no problems so far this Winter. Increasing time commitment for College Tutor role recognized – CT encouraged to record in CRMS to inform job planning. * Potential concern raised by College Tutors re discussions around	**Cardiology Jan 2011** **Derm 15/3/11** **CMT 7/2/12**	**Green**	01/12

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
				transferring management of Head Injuries to the care of Medicine from T+O. Emphasized that this is still in the consultation phase and College Tutors encouraged to canvass opinions of colleagues and be involved in discussions before a final decision is reached.			
Medicine Sandwell	Jattinder Khaira	Matthew Lewis	Many areas of good practice. Well established educational and appraisal process. Development of H@N and multi-disciplinary handover. EWTD 2009 compliant rotas. Specialty Induction in place and works well. Good Subspecialty Induction with evidence of Written Induction proformas. Good JEST feedback 2010/2011. Good CMT teaching programme (cross-site). Good ARCP results and excellent MRCP exam results.	Concerns raised re recent Merger between Resp and Gastro onto P5. Concerns re patient safety owing to heavy nursing workload and management of patients by nurses from the 'wrong' specialty raised – these are being looked into and addressed by the Consultants from each Specialty and the Divisional Director. Also issues re how this affects Training within Resp and Gastro Increasing time commitment for College	**CMT 7/2/12**	**Green**	01/12

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			Elderly care: excellent feedback. Overall JEST feedback excellent. No major issues from GMC survey 2011 feedback	Tutor role recognized – encouraged to record in CRMS to inform job planning. See note above under 'City' re Head Injuries Cross-site: PACES teaching part of Wed PM teaching not always happening – Trainers have been informed of the need to provide this. However, excellent PACES pass rate and noted that much PACES training takes places at times other than the Wed PM sessions.			
Orthopaedics Cross site	Bhuvan Machani Siten Roy	TBC CD: Sailesh Parekh	Notable Practice: **Junior doctor supervision** has improved with the on-call SpR being present on ward at all times. Daily review of sick patients by care of the elderly team, **Trainee Forum**: Mr Roy is meeting with junior doctors every 6 weeks. **Induction**: Has improved with introduction of written induction pack.	***Consultant Teaching ward round has stopped owing to changes in rota – CD and CTs looking into ways to re-introduce this** **Documentation:** * This has improved, confirmed by feedback from juniors. **Still some issues re Consultants**	**VISIT 15/11/11**	**Red**	10/11

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			Areas of concern: **Handover**: Can be poor, confounded by poor documentation, especially before weekends. **DNAR:** ongoing reluctance by some Consultants to initiative DNAR decisions	**making and documenting DNAR decisions** – Training to be put in place with help from Resus Team / Trainers **Workload**: Much improved. Good feedback. * This has improved significantly, although an issue about **workload at weekends** remains an issue. A formal system of ensuring clearer handover before weekends is being instituted to try and improve this. **Hospital at Night:** Mr Roy will encourage the T+O SHO to attend the H@N meeting at 9pm on EAU. **Induction:** The need to provide cross site induction needs to be addressed. **Education**: Consider having the SpR trainees attending the non training grade teaching.			

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
				* Still a problem with Service-based teaching – nil apart from Trauma meeting every morning. **Encourage teaching during post call ward round.** **Feedback**: A system to provide regular individual feedback needs to be established - this is happening via the regular Forum with Mr Roy *** * SpR Training. This is a major issue as the SpR posts are under threat owing to poor RITA outcomes. This is as a result of low operating numbers which is partly due to cross-site rota therefore SPRs are on a 1:8 rather than 1:16 rota. Imminent discussions to take place with management to try and put in place a plan to address this such as removing SpR from clinics and reviewing on call service.**			

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
A & E City	GBemi Okunribido	Matthew Lewis / Kalyana Murali	Many areas of good practice Regular trainee forums are occurring JEST fine, no consistent concerns, all would recommend Regional Teaching and overall satisfaction GREEN on GMC survey Service based teaching moved to 8-10am, which may improve teaching attendance Issues raised by GMC survey: **Handover, Work Intensity / Undermining by other staff**	Foundation trainees encouraged to attend cross site foundation teaching / considering cross-site A+E teaching / Register to be kept of specialty teaching 1. Problems may relate to understaffing (1 Consultant and 1 Middle Grade down) – national problem; recruitment ongoing 2. Concerns fed back to staff and managers 3. Closer supervision encouraged and processes put in place to ensure all patients seen by		**Amber**	03/12

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
				trainees reviewed by middle grade 4. Consultant work pattern may change to later working * Issue re Time for ES (meant to be 0.25 SPA per trainee) – too many Trainees / Consultant therefore too many trainees each therefore pressure on Consultants			
A & E Sandwell	Kalyana Murali	Matthew Lewis / Kalyana Murali	Good local induction Appraisals, assessment, senior doctor cover all well received on JEST feedback All would recommend on JEST GREEN areas on GMC – Responsibility for Clinical Supervision and Other Learning Opportunities Areas of concern are: (i) Supernumerary F2	Foundation trainees encouraged to attend cross site foundation teaching / considering cross-site A+E teaching / Register to be kept of specialty teaching		**Amber**	3/12

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			Military Trainee being withdrawn from August reducing flexibility for taking study leave – clear rules about advance planning for S/L and swapping on-calls have been told to Trainees (ii) inadequate staffing levels - 2 of 4 SpRs and 1 Consultant down (iii) recent issue of possible Undermining by Other staff raised – being looked into	See above; recruitment ongoing **Ensure that there is a regular junior doctors' forum to raise issues early** * Issue re Time for ES (meant to be 0.25 SPA per trainee) – too many Trainees / Consultant therefore too many trainees each therefore pressure on Consultants			
Obs & Gynae Sandwell & City	Shagaf Bakour	David Leusley P Bosio (CD) J Nevin (CD)	Overall many areas of good practice. Subspecialty induction is now good (3 days with no clinical commitment for	** Gynae ward round identified as an issue – still not resolved – **no morning ward Rounds**	**2009**	**Amber**	05/11

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
(Redistribution of many services Jan 2011 so all trainees work cross-site)			F2). Excellent handover, EWTD compliant rota achieved. Deanery commended continuity of care and handover process. Educational approval for 3 yrs for ST3 – 7 (Nov 2009). All trainers have received TTT 'memory stick' College Tutor role is now recognized with 0.5 PA. Good Team handover is occurring on the maternity unit and Gynae wards – electronic handover lists. Since Reconfiguration – Gynae clinics and Obstetrics Theatres better run, better opportunities for teaching, especially for ST trainees (2 tiers of Trainees). Emergency Obstetrics Course as part of Induction for FY2 and VTS. Post-merger – generally went better than might be expected. Initially some concerns /	**by Consultants** – cover exists for Gynae emergency admissions from 1pm; still under discussion since Redistribution. Need a clear plan for how Emergency Admissions are seen. **<u>** THIS SHOULD BE A STRONG DRIVER FOR COMPLETE RECONFIGURATION **.</u>** Formalise the trainee forum – still under review, not yet formalized. Make case for middle grade trainee for Gynae oncology – this has been achieved (non-career grade doctor) as well as an advanced nurse practitioner. All Trainees moved to City therefore Ms Bakour now CT for all 34 Trainees. Workload significant Suggest developing a Deputy CT.			

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			anxieties raised by Trainees about changing sites (and concerns by midwives, etc), but feedback from **CURRENT** set of Trainees much better, with no negative points raised.	On-call SpR at weekends in Old Maternity block at Sandwell; some issues re security as this is the only person in the building out of hours – looking at alternative accommodation for this person ?in the doctors' mess. Some negative feedback from Specialty Docs (Intrepid) re Protected teaching – did not happen as much as should have during Merger, but has improved since.			
Paediatrics City & Sandwell	Penny Broggio / Niten Makwana	David Leusley	1. Excellent Induction – provided 6x per year by College Tutor (2 days each time) – verbal and comprehensive written package. Trainees sent a one page reminder each month with key points from Induction highlighted! 2. Excellent process for educational appraisal, development and audit. 3. Ongoing development of training roles. 4. High-quality Teaching programme with fixed Teaching	(1) Rota still tight although EWTD compliant. Can be stretched if sickness –this applies to Specialty NOT Foundation trainees. Clear 'rules' for leave booking, etc have been explained to trainees and this will be monitored. (2) No specific recognition of College Tutor time – need to advise CD / DD that all job plans in Specialty should be	**Cross-site Visit December 2010 Re-Visit December 2011**	**Green**	07/11

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			session each day for different grades of doctors. Trainee led with individualized written Consultant feedback. 5. Reconfiguration of services achieved Trust-wide with PAU at City and IP unit at Sandwell with excellent senior and middle grade supervision. EWTD 2009 compliant rotas (done by juniors but overseen by CT). Excellent handover (wriiten / verbal / electronic). 6. VTS trainees receive similar quality of appraisal to Specialty Trainees, and a "Professional Report" is created on the e-portfolio to aid GP Supervisor to conduct meaningful appraisal. 7. Neonates – Supervisors all trained, Trainee Forum in place, excellent Induction package, extensive daily handover which is both 'business' and 'teaching' in nature.	reviewed together to see if time (SPAs) can be redistributed to recognize College Tutor work. (3) Possibly still an issue with neonatal middle grade doctors who are in the community but do on-calls out of hours, in terms of getting IT access, access to shared drive, etc. College Tutor for neonates (PB) is sorting this out.			
Ophthalmology City & Sandwell (BMEH)	Mr Mirza, Mr Aralikatti Ms Mushtaq	Sashi Aggarwal	Many areas of good practice, excellent academic programme and educational opportunities. Robust guidance on emergency handover now given in handbook. Junior doctors forum now	Continue junior doctors forum. Forward minutes to Karen Parry. Review induction booklet to include information about Sandwell site. **25.10.2011. Added:**		**07.11**	07/11

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			started. All rotas EWTD compliant. Good JEST feedback. Good induction inc. booklet, however does not include section for Sandwell.	Ensure appropriate workload and supervision in accordance to trainees experience when starts in the trust. Plan to release academic trainees for research (4 days per week.)			

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
Surgery and subspecialties (cross-site)	Mehboob Mirza(Sandwell Tutor), Uday Kale (City Tutor), Ugo Otite (Urology, Sandwell), Uday Kale (ENT), Rachel Sam (Vascular) Jonathan Staiano (plastics City)	Neil Cruicksank (CD), Divisional Director TBC	Notable Practice / Update on previous action plans : • No patient safety concerns raised. • Established teaching programme on both sites • Cross site induction established • SpR's now do all 'out of hours' on call on Sandwell site improving exposure to acute emergencies. • Formal arrangement for foundation doctors to clark acute admissions on EAU at Sandwell. • Redistribution of foundation trainees between specialties has led to a more even spread of workload and experience. Attendance at H@N is still variable particularly on the City site. Attendance at Sandwell is now around 90%. Vascular trainees were not able	For college tutors to continue to emphasize the importance of H@N attendance to trainees. Attendance will be monitored. Ensure arrangements are put in place to enable vascular trainees to attend induction and have the necessary cover on the day of induction. This is mandatory. Protected meal times must be respected. Therefore the ENT directorate may have to review the booking numbers in ENT clinics Directorate to review junior doctors room on level 2 SGH with respect to providing a desk and computer work station. Need to ensure Forum meetings become a regular occurrence.	**22/2/11 Revisit June 2012**	**Green**	01/12

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			to attend the December induction Protected meal times has resulted in the ENT SpR being delayed attending clinic due to the morning ward round finishing later General surgery doctors office in need of refurbishment. Trainee forum well established on Sandwell site. First forum to be held at City in February. JEST: • All plastic surgery trainees at Sandwell would not recommend their post. • Compliance with EWTD for foundation trainees doing Urology. • Induction. GMC: • Regional teaching. – It is recognized that sessions are cancelled at short notice • IT Access – This was discussed and felt to be	especially at City. Clinical Tutor to investigate why no plastic surgery trainees at SGH would recommend their placements. Since review of surgical foundation trainee placements, workload in urology is thought to have improved. This will be kept under review. Induction booklets need to be combined to produce one cross site booklet. Dr Chilvers to D/W Mr Harper RE regional teaching. Dr Chilvers to D/W Mr Ryan RE 'undermining consultant' in GMC survey.			

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			appropriate. • Undermining by a consultant in Urology. This was at odds to the JEST feedback which complimented the specialty on having 'friendly approachable consultants'.				
Pathology City & Sandwell	Christine Wright	Jonathan Berg	Excellent JEST feedback. Good educational programme. Regular appraisal.	Reinforce communication channels between College Tutor and Educational Leads. Review Specialty induction material for all subspecialties. Raise awareness of Trust Junior Doctors Forum. Good induction booklet for microbiology.		**Green**	10/11
Radiology Cross site	Claire Winkles (City) / Sarah Yusuf (Sandwell)	Jonathan Benham	Areas of good practice: Regular appraisal and feedback process by CT. All educational supervisors have now attended TTT. A cross site trainee forum is now established. A trainee rep now attends the imaging meeting and consultant meeting. Protected regional teaching	All action points from last RAG review achieved. Further action points: 1) Review handover system used for trainees. Consider SBAR format. 2)Ensure trainees complete and present at least 1 audit per year. 3) Encourage trainees to	**Cross site Visit 3/5/11**	**Green**	04/11

Specialty	Leads	Divisional Director	Comments (includes Notable Practice, JEST Feedback and issues highlighted by GMC Trainee Survey)	Summary for Action	Most recent Deanery QA visit	RAG rating	Date
			programme. Three sessions of in-house teaching (MDT and interventional) which is protected. Trainees are encouraged to follow guidelines issued by Birmingham School. Good induction with booklet Areas of concern: Handover and 'other learning opportunities' have been highlighted to be poor by the GMC trainee survey. The department scored poorly at 'serviced based teaching' in the JEST feedback.	attend MDT's / specialty meetings.			

R D SITUNAYAKE / J CHILVERS / S SINGHAL March 2012

NHS West Midlands

Annual Deanery Report 2011
LEP Annual Self Assessment: Foundation and Specialty Training

Please complete the following self assessment **separately for each trust site** and send back to Education Development **by 30th September 2011**: QAmedical@westmidlands.nhs.uk. Please ensure that each site review is inclusive of both **Foundation** and **Specialty Training**. These reports must easily differentiate between the specialties that the site supports for placements as the report will be shared with Heads of Schools to assist with developing their specialty specific ADR reporting for the GMC. For any queries please contact Education Development: QAmedical@westmidlands.nhs.uk | 0121 695 2504. Thank you.

SECTION 1: Local Education Provider (LEP) - Site Profile

Please use this section to provide an overview of the educational management structure at the site:

LEP Name:	**SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST**				
Sites Covered:	**Sandwell General Hospital**				
Period of Assessment:	All activity between **August 2010** to **August 2011**				
Medical Director:	Mr D O'Donoghue	**Email:**	Via PA Elaine Quinn Elaine.quinn@nhs.net	**Phone:**	0121 507 4818
Site Clinical Tutor:	Dr Saket Singhal	**Email:**	Saket.singhal@nhs.net	**Phone:**	0121 507 3646 (PA – Mrs N Smith)
Site Centre Manager:	Miss J Davies	**Email:**	Janedavies5@nhs.net	**Phone:**	0121 507 3044
Site Centre Admin:	Mrs N Smith (PA to Clinical Tutor) Mrs L Tomkins (CMT Administration)	**Email:**	Nicola.smith16@nhs.net Louise.tomkins@nhs.net	**Phone:**	0121 507 3646 0121 5073955

Site College Tutors:	**Specialty of College Tutor**	**Name**	**Email**
	Medicine	Dr J Khaira	Jattinder.khaira@nhs.net

	Surgery	Mr M Mirza	Mehboob.mirza@nhs.net
	Paediatrics	Dr N Makwana	Niten.makwana@nhs.net
	Ophthalmology	Ms B Mushtaq	bushramustaq@nhs.net
	Anaesthetics	Dr N Krishnan	k.krishnan@nhs.net
	A&E (Lead for Education)	Mr J Rizkalla	Jonha.rizkalla@nhs.net
	T&O (Lead for Education)	Mr S Roy	Siten.roy@nhs.net
	O+G	Mrs S Bakour	Shagaf.bakour@nhs.net
	Radiology	Dr S Yusuf	Sarah.yusuf@nhs.net
	Pathology	Dr C Wright	Christinewright1@nhs.net
	Psychiatry (Sandwell)	Dr S Khalil	Salwa.khalil@smhft@nhs.net
	Psychiatry (BSMFT)	Dr G Milner	Gabrielle.milner@bsmhft>nhs.uk
	GP (Educational Lead)	Dr R MacRorie	Rod.macrorie@nhs.net
	Public Health (Educational Lead)	Dr A Macherianakis	Alexis.macherianakis@sandwell-pct.nhs.uk
	Occupational Medicine (Educational Lead)	Dr T Radford	Tamsin.radford@nhs.net

Training Placements Provided at LEP Site (Foundation and Specialty)

Please utilise this section to provide a rough overview of the placements your organisation provides, number of trained educational supervisors and rough number of trainees that rotate throughout these posts.

Specialty School *(including Foundation)*	**Specialty Programme Provided** *(including Foundation)*	**Current No. Of Trained Education Supervisors in this Specialty**	**No. Trainees Placed in this Specialty this Year (Approximate)**
e.g. Medicine	*e.g. Cardiology*	*e.g. 5*	*e.g. 6*

Specialty School *(including Foundation)*	**Specialty Programme Provided** *(including Foundation)*	**Current No. Of Trained Education Supervisors in this Specialty**	**No. Trainees Placed in this Specialty this Year (Approximate)**
e.g. Foundation	*e.g. General Medicine, Paediatrics, General Surgery*	*e.g. 15*	*e.g. 45*
Medicine	Cardiology/Respiratory/Geriatric Medicine/Acute Medicine	10	1 – SpR Academic (Rheumatology) 10 – SpRs Gen Med 3 - CT1 trainees 4 - CT2 trainees 5 – GPVTS Trainees
Surgery	Upper & Lower GI/Breast Surgery/Trauma & Orthopaedics		7 – SpR 2 – ST1 trainees 2 – ST2 trainees 1 – GPVTS2
Foundation	Gen Medicine/Gen Surgery (including T&O)/O&G/A&E/Paediatrics/Ophthalmology/Gen Practice/Psychiatry/Public Health and Occupational Health Medicine		33 – F1 Trainees 30 – F2 Trainees
Paediatrics	General Paediatrics/Community		7 – SpRs 4 – Flexible SpR Trainees 2 – SpRs (community) 3 – ST1 trainees 3 – GPVTS1 Trainees (2 of which are flexible) 2 – GPVTS2 trainees
Emergency Medicine	Acute and A&E		2 – SpRs Acute Medicine 4 – SpRs A&E 3 – GPVTS1 Trainees (A&E) 2 – ACCS CTY1 Trainees (A&E)
Anaesthetics	General anaesthetics & ITU		3 – SpRs 1 – CT1 4 – CT2 1 – CT1 (ITU)

Service Changes and Vacancy Overview

Please utilise this section to provide an overview of services that place trainees where you are expecting changes (expansion / closure / transformation) or where you are experiencing vacancies (staff grade / mid grade / consultant etc). Please ensure that any actions to address concern are added to your action plan for next year (**Section 7**).

Service Area / Specialty	Description of Issue (Service Change / Vacancies etc)	Planned Actions to Address	Planned Resolution Date
e.g. Cardiology	*e.g. 2 consultant vacancies*	*e.g. Going out to advert to replace*	*e.g. January 20XX*
A+E	1 Consultant Vacancy	Gone out to advert	Dec 2011 (see issue 1 in Section 7)
EAU	1 Consultant Vacancy	Currently covered by Locum	? Dec 2011
EAU	1 SpR Vacancy	Should be resolved at next rotation date	Oct 2011 (see issue 2 in Section 7)
Respiratory	1 SpR Vacancy	Should be resolved at next rotation date	Dec 2011

SECTION 7: Next Year's Improvement Action Plan

Please use this space to document current outstanding issues and concerns that you are aware of and the actions that you plan to take to resolve these over the next reporting year. This action plan should include issues arising from:

- Actions from service change and vacancies (**Section 1**)
- Actions that were unachieved from last year's action plan (**Section 2**)
- Actions that have been identified through quality review visits which are ongoing at the time of this report (**Section 3**).
- Actions outstanding as a result of survey analysis and investigation (e.g. JEST and GMC) review (**Section 4**)
- Actions arising from self assessment against GMC quality standards (**Section 5**)

No.	Issue Identified (Brief description)	Related Training Programmes (list 'All' if applicable to all programmes supported at LEP)	Actions List of Actions to Mitigate these Identified Issues. Use SMART methodology.	Named Lead and Title Responsible	Target Date
	e.g. Issue....	*e.g. CMT and General Medicine*	*e.g.* ***1.1*** *– Action A we will ...* *e.g.* ***1.2*** *– Action B we will...*	*e.g. Consultant A, Clinical Tutor*	*e.g. March 2012*
1	**Consultant Vacancies**	A+E EAU	Awaiting interviews and appointments	Clinical Directors in A+E (Peter Ahee) and EAU (Carol Cobb)	January 2012
2	**SpR vacancies**	EAU Respiratory	Will be resolved at next SpR rotational date	Will be monitored by Dr Khiara (College Tutor in Medicine)	October 2011
3	**Lack of Junior Doctors' Forum**	Radiology Anaesthetics A+E Surgery	Meet with new College Tutors in Radiology and Anaesthetics to advise that a Forum be established. New College Tutor in Surgery planning a Forum	S Yusuf K Krishnan M Mirza (College Tutors)	January 2012
4	**Heavy Workload for Foundation Trainees (and issues regarding Clarity of patient ownership, Senior**	T+O	Much improved from previous Year but ongoing monitoring needed to assess full impact of Surgery and T+O Reconfiguration. Weekend on-calls remain busy for T+O F1s	Siten Roy (College Tutor)	December 2011 (next Foundation changeover)

No.	Issue Identified (Brief description)	Related Training Programmes (list 'All' if applicable to all programmes supported at LEP)	Actions List of Actions to Mitigate these Identified Issues. Use SMART methodology.	Named Lead and Title Responsible	Target Date
	Review of patients, Service-based teaching and rotas)				
5	**Insufficient Training Experience for Specialty Trainees**	T+O	Meetings have been held with the Chair of the Training Committee (David Ford) and a Deanery Visit is due on 15th November, 2011. Ongoing work involving Clinical Director in T+O and College Tutor, with support from Clinical Tutors.	Siten Roy / Sailesh Parekh (Clinical Director) / Clinical Tutors	December 2011
6	**Disorganised Induction**	General Surgery	Newly appointed College Tutor at Sandwell to work with College Tutor at City to put together cross-site Induction to ensure Trainees at both sites receive Induction at both sites, as nearly all Trainees now work cross-site	Mehboob Mirza Uday Kale (College Tutors)	December 2011 / April 2012
8	**Curriculum Integration**	F2	Clinical Tutors, PGC Managers and Trainees liaising in order to make the Programme more receptive to Trainee needs. Trainers given link to the Foundation Curriculum to ensure that Training sessions are mapped to the Curriculum.	Saket Singhal / Jane Davies	By August 2012
9	**Variability of Educational Supervision**	Foundation	Changes made to Educational Supervisor complement to ensure all Foundation ES have undergone Training in Supervision, e-portfolio, etc. Database being maintained and monitored, Trainers given link to Deanery website to access Training sessions	Saket Singhal / Jane Davies	By August 2012
10	**Service-based Teaching**	General Surgery	New College Tutor has instituted service-based teaching which had been 'lost during Reconfiguration. Needs monitoring to ensure it continues	Mehboob Mirza / Saket Singhal / Jane Davies	By August 2012
11	**City and Sandwell Hospitals under different Schools of Anaesthesia**	Anaesthetics	Postgraduate Dean made aware that the two Hospital Trust sites are under different Schools, which causes administrative difficulties but more importantly inequity in Training, particularly apparent as the Trainees work cross-site within the Trust	Clinical Tutors / Postgraduate Dean	By August 2012?
12	**Recognition of College Tutor Work in Job Plans**	All Specialties (variable)	There is discrepancy in the amount of recognition for College Tutors in Job Plans – this has been raised to the Trust Management Board. The Trust will be developing plans to ensure such roles have time identified through a more robust job planning process.	Clinical Tutors / Associate Medical Director	By August 2012?
13	**Gynaecology Consultant**	O+G	Since Reconfiguration there has been an issue with variability in the	James Nevin,	December 2011

No.	Issue Identified (Brief description)	Related Training Programmes (list 'All' if applicable to all programmes supported at LEP)	Actions List of Actions to Mitigate these Identified Issues. Use SMART methodology.	Named Lead and Title Responsible	Target Date
	Ward round		Consultant ward round for Emergency Gynae patients. This has been raised to the Clinical Directors in O+G as an urgent priority to resolve	David Luesley, Clinical Tutors	
14	**Attendance at Hospital At Night**	General Surgery	Patchy attendance by Surgery Juniors to Hospital At Night has been a problem since Inception of H@N owing to shift patterns changing at different times to Medicine. This is improving and will be monitored	M Mirza / Saket Singhal	By April 2012

NHS West Midlands

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SECTION 1: Local Education Provider (LEP) - Site Profile

Please use this section to provide an overview of the educational management structure at the site:

LEP Name:	**Sandwell and West Birmingham Hospitals NHS Trust**				
Sites Covered:	**City Hospital**				
Period of Assessment:	All activity between **August 2010** to **August 2011**				
Medical Director:	Mr D O'Donoghue	**Email:**	donal.o'donoghue@nhs.net	**Phone:**	0121 554 3801
Site Clinical Tutor:	Dr J Chilvers	**Email:**	Julian.chilvers@nhs.net	**Phone:**	0121 507 4041
Site Centre Manager:	Mrs J Collins	**Email:**	Jo.collins3@nhs.net	**Phone:**	0121 507 4980
Site Centre Admin:		**Email:**		**Phone:**	

Site College Tutors:	**Specialty of College Tutor**	**Name**	**Email**
	Surgery	Mr U Kale	uday.kale@nhs.net
	Medicine	Dr S Hutchinson Dr P De	stuart.hutchinson2@nhs.net p.de@nhs.net
	Emergency Medicine	Mr G Okunribido	o.okunribido@nhs.net

	Anaesthetics	Dr L Homer	lucinda.homer@nhs.net
	Pathology	Dr C Wright	christinewright1@nhs.net
	Obstetrics and Gynaecology	Mrs S Bakour	shagaf.bakour@nhs.net
	Radiology	Dr C Winkles	claire.winkles@nhs.net
	Paediatrics	Dr P Broggio	penny.broggio@nhs.net
	Ophthalmology	Ms Stavrou	panagiota.stavrou@nhs.net

Training Placements Provided at LEP Site (Foundation and Specialty)

Please utilise this section to provide a rough overview of the placements your organisation provides, number of trained educational supervisors and rough number of trainees that rotate throughout these posts.

Specialty School *(including Foundation)*	**Specialty Programme Provided** *(including Foundation)*	**Current No. Of Trained Education Supervisors in this Specialty**	**No. Trainees Placed in this Specialty this Year (Approximate)**
Foundation Year 1			*30*
Foundation Year 2			*34*
Medicine	Cardiology, Acute, Care of the Elderly, Diabetes and Endocrinology, Rheumatology, Gastroenterology, Respiratory, Dermatology	45	50
Surgery	General Surgery, Breast, Vascular, Urology, ENT, Plastics	26	23
	Trauma and Orthopaedics	7	8
Anaesthetics	Anaesthetics and Critical care	7	22
Radiology	Radiology	3	6
Obstetrics and Gynaecology	Obstetric and Gynaecology	20	33
	Gynae Oncology		5
Paediatrics	General and Neonatology	6	24
Pathology	Haematology, Microbiology, Histopathology	14	5
Emergency medicine	Emergency medicine	4	15

Specialty School *(including Foundation)*	Specialty Programme Provided *(including Foundation)*	Current No. Of Trained Education Supervisors in this Specialty	No. Trainees Placed in this Specialty this Year (Approximate)
Ophthalmology	Ophthalmology	21	7

Service Changes and Vacancy Overview

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Service Area / Specialty	Description of Issue (Service Change / Vacancies etc)	Planned Actions to Address	Planned Resolution Date
e.g. Cardiology	*e.g. 2 consultant vacancies*	*e.g. Going out to advert to replace*	*e.g. January 20XX*
Emergency Medicine	In the time period covered by this report we have lost 2 Consultants in Emergency Medicine. We have a number of vacancies in SAS doctors in Emergency Medicine.	We have advertised twice this year and have now appointed 6 Consultants in Emergency Medicine. 2 to replace the outgoing consultants and an additional 4 Consultants. We have a range of recruitment and retention initiatives for SAS doctors in Emergency Medicine and we are undertaking an overseas recruitment exercise with interviews due to take place in October 2011.	End of 2011

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- Actions that have been identified through quality review visits which are ongoing at the time of this report (**Section 3**).
- Actions outstanding as a result of survey analysis and investigation (e.g. JEST and GMC) review (**Section 4**)
- Actions arising from self assessment against GMC quality standards (**Section 5**)

No.	Issue Identified (Brief description)	Related Training Programmes (list 'All' if applicable to all programmes supported at LEP)	Actions List of Actions to Mitigate these Identified Issues. Use SMART methodology.	Named Lead and Title Responsible	Target Date
	e.g. Issue....	*e.g. CMT and General Medicine*	*e.g.* ***1.1*** *– Action A we will ...* *e.g.* ***1.2*** *– Action B we will...*	*e.g. Consultant A, Clinical Tutor*	*e.g. March 2012*
1	Bleep policy	All	Policy will be rewritten.	Dr Chilvers, Clinical Tutor	Jan 2012
2	Occasional difficulty in gaining adequate numbers of procedures	Orthopaedics	Reworking on call rota. Re assess role of Trust Grade doctor. Meetings have been held with the Chair of the Training Committee (David Ford) and a Deanery Visit is due on 15th November, 2011. Ongoing work involving Clinical Director in T+O and College Tutor, with support from Clinical Tutors	Mr Machani Siten Roy / Sailesh Parekh (Clinical Director) / Clinical Tutors	Feb2012 December 2011
3	SHO rota EWTD compliant but "tight" during the daytime when stretched by sickness. This is because 1 of the 8 slots is formed by the ANNPS. At present there are only 2 ANNPS in post instead of 3, following 1 ANNP moving to another unit. Therefore they work all	Paediatrics - Neonates	Currently training a 3rd ANNP.	Dr Nycyk	Dec 2011

No.	Issue Identified (Brief description)	Related Training Programmes (list 'All' if applicable to all programmes supported at LEP)	Actions List of Actions to Mitigate these Identified Issues. Use SMART methodology.	Named Lead and Title Responsible	Target Date
	out of hours duties but are unable to work all the daytime duties (as they need time for nursing, admin & teaching duties).				
4	To address the disorganised operational issues with regard to trainee induction.	Surgery	Arrange cross site induction programme.	Mr Kale and Mr Mirza	Dec 2011
5	Opportunity for teaching in Vascular Surgery is limited.	Foundation - Surgery	Review teaching opportunities on firm.	Mr Kale	Dec 2011
6	The FY1 surgical rota, although reported as EWTD compliant, has a poorly distributed shift pattern which needs to be reviewed.	Foundation - Surgery	Rewrite on call rota.	Mr Kale Mr Mirza Mr Cruickshank.	Dec 2011
7	The time spent at Sandwell hospital on the Surgical rota is not thought to be beneficial to learning; time is spent on the ward and not with acute patients which is the purpose of these shifts. No local induction at Sandwell leaves trainees without access to wards and not feeling part of the Sandwell team.	Foundation - Surgery	A review of the City F1 role at Sandwell is currently under review to incorporate time tabled sessions on the EAU admitting acute patients. See above regarding induction.	Mr Kale Mr Mirza Mr Cruickshank	Dec 2011
8	Accommodation	Paediatrics	On going discussion regarding providing reclining chairs in rest areas.	Dr Atkins / Dr Broggio	Dec 2011

No.	Issue Identified (Brief description)	Related Training Programmes (list 'All' if applicable to all programmes supported at LEP)	Actions List of Actions to Mitigate these Identified Issues. Use SMART methodology.	Named Lead and Title Responsible	Target Date
9	Undermining by other staff	Emergency Medicine	The system currently does its best to facilitate achieving four hour targets in the Emergency Department. This unfortunately results at times in persistent nagging of medical staff seeking decisions on patient care that are yet to be finalised. This I think may be partly responsible for the undermining referred to here. We continue to try to take the pressure off the junior doctors by taking on responsibility for their patients especially when delays are occurring as early as possible in the patient journey. We continue to work on this.	Mr Ahee	Jan 2012
10	Workload	Foundation	Assess the impact of reconfiguration of wards (same sex) and specialty (Surgery)	Dr Chilvers	Dec 2011
11	Service Based Teaching	Surgery	New College Tutor has instituted service-based teaching which had been 'lost during Reconfiguration. Needs monitoring to ensure it continues	Mehboob Mirza / Saket Singhal / Jane Davies	By August 2012
12	Recognition of College Tutor Work in Job Plans	All Specialties (variable)	There is discrepancy in the amount of recognition for College Tutors in Job Plans – this has been raised to the Trust Management Board. The Trust will be developing plans to ensure such roles have time identified through a more robust job planning process.	Clinical Tutors / Associate Medical Director	By August 2012
13	Gynae Consultant Ward round	O+G	Since Reconfiguration there has been an issue with variability in the Consultant ward round for Emergency Gynae patients. This has been raised to the Clinical Directors in O+G as an urgent priority to resolve	James Nevin, David Luesley, Clinical Tutors	December 2011
14	Lack of Junior Doctors' Forum	Surgery	College Tutors in Surgery planning a Forum	Mr Kale and Mr Mirza (College Tutors)	January 2012
15	Feedback	Surgery	College Tutors to encourage the Educational Supervisors in surgical specialties to provide formal as well as informal feedback to their trainees. The formal feedback can be undertaken either as a part of midterm assessment meeting or as a meeting on its own. Informal feedback to be given during various clinical settings including ward rounds, theatre and out patient clinics and as a part of their assessments including CBDs, DOPS and mini-CEX.	Mr Kale and Mr Mirza (College Tutors)	January 2012

No.	Issue Identified (Brief description)	Related Training Programmes (list 'All' if applicable to all programmes supported at LEP)	Actions List of Actions to Mitigate these Identified Issues. Use SMART methodology.	Named Lead and Title Responsible	Target Date
			To encourage the Surgical trainees to have regular assessments, some of which from their Educational Supervisor to enable the feedback process.		
16	Educational supervisor training	O&G	Ensure all supervisors have completed electronic training the trainers	Mrs Bakour (College Tutor)	January 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – May 2012
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	28 June 2012

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the period of May 2012.

Measured against the DoH target, the Trust generated an actual surplus of £17,000 during May against a planned deficit of (£16,000). For the purposes of its statutory accounts, the in month surplus was slightly higher at £46,000.

REPORT RECOMMENDATION:

The Finance & Performance Management Committee is requested to NOTE the contents of the report and ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	**x**	Environmental		Communications & Media	
Business and market share		Legal & Policy	**x**	Patient Experience	
Clinical		Equality and Diversity		Workforce	**x**
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Good use of Resources (under 11/12 OfE, key Strategies & Programmes)

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 19 June 2012 and Finance & Performance Management Committee on 22 June 2012

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2012

EXECUTIVE SUMMARY

• For the month of May 2012, the Trust delivered a "bottom line" surplus of £17,000 compared to a planned deficit of (£16,000) (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £38,000 compared with a planned deficit of (£33,000) so generating an positive variance from plan of £71,000.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 194 below planned levels. After taking account of the impact of agency staff, WTE's were 133 below plan. This compares with 71 below plan in April. Total pay expenditure for the month, inclusive of agency costs, is £143,000 below the planned level.

• The month-end cash balance was approximately £11.8m above the planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	33	71	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	22	67	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	143	193	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(242)	(312)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	160	116	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	11,837	11,837	>= Plan	> = 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	(33)	38
Capital Resource Limit	890	364
External Financing Limit	---	11,837
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at May 2012	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
Income from Activities	382,171	31,860	31,937	77	63,679	63,765	86
Other Income	38,012	3,226	3,270	44	6,355	6,455	100
Operating Expenses	(395,017)	(33,323)	(33,422)	(99)	(66,539)	(66,658)	(119)
EBITDA	25,166	1,763	1,785	22	3,495	3,562	67
Interest Receivable	100	8	20	12	17	21	4
Depreciation & Amortisation	(13,525)	(1,127)	(1,127)	0	(2,254)	(2,254)	0
PDC Dividend	(5,396)	(450)	(450)	0	(899)	(899)	0
Interest Payable	(2,114)	(181)	(182)	(1)	(363)	(363)	0
Net Surplus/(Deficit)	**4,231**	**13**	**46**	**33**	**(4)**	**67**	**71**
IFRS/Impairment/Donated Asset Related Adjustments	(353)	(29)	(29)	0	(29)	(29)	0
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,878**	**(16)**	**17**	**33**	**(33)**	**38**	**71**

The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

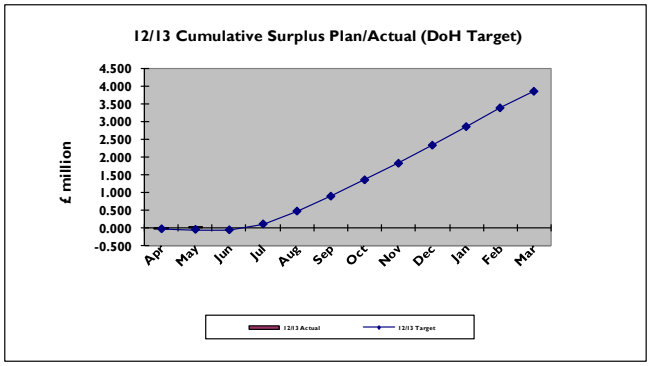
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2012

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Net bottom-line performance delivered an actual surplus of £17,000 in May against a planned deficit of (£16,000). The resultant £33,000 positive variance moves the year to date position to £71,000 above targeted levels.

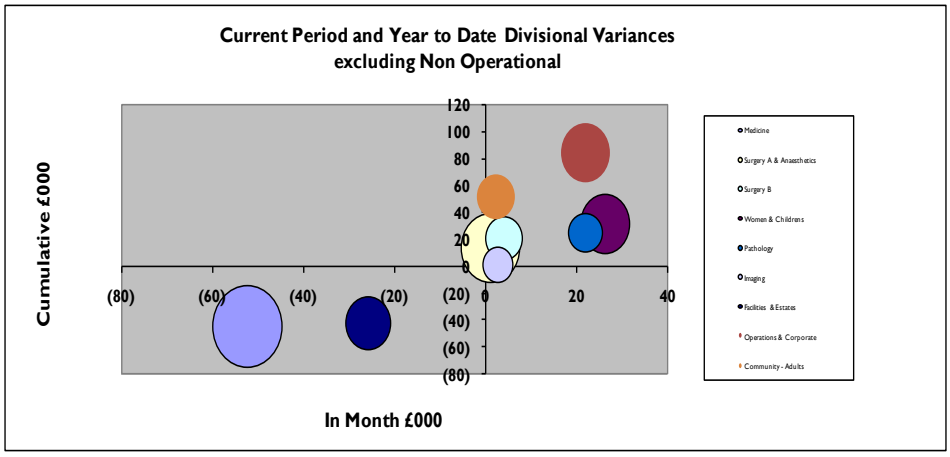


Divisional Performance

• For May, there are no material variances from plan among operational divisions although Medicine and Facilities have posted small in month deficits of (£52,000) and (£24,000) respectively.

• SLA performance which is based on fully costed information for April shows little overall variation from plan with Medicine showing a small positive variance offset elsewhere by minor adverse variances.

• The only two areas with adverse in month variances from plan are Medicine and Facilities (other than a very marginal adverse variance for Estates). The former is primarily driven by higher than planned nursing costs, including bank staff, required to cover additional bed capacity although there is a sizeable offsetting variance on medial staffing pay costs. The latter is mainly the result of a combination of lower then planned income levels from car parking and catering coupled with the ongoing high levels of spend on support staff , particularly ward services.



The tables adjacent and below show some adverse variance for Medicine and Facilities, otherwise no significant in month or year to date adverse variances from plan.

Sandwell and West Birmingham Hospitals NHS

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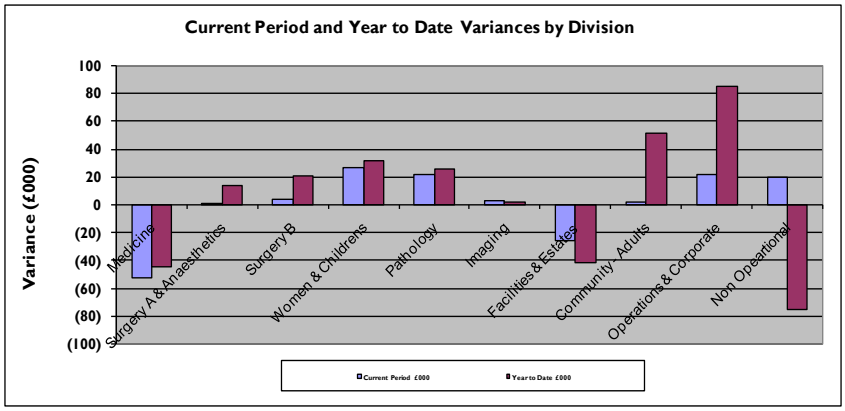
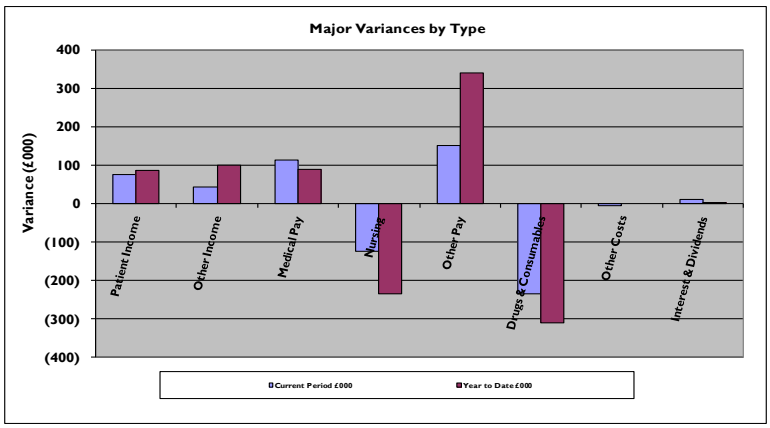
Financial Performance Report – May 2012

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	(52)	(45)
Surgery A & Anaesthetics	1	14
Surgery B	4	21
Women & Childrens	26	32
Pathology	22	25
Imaging	3	2
Facilities & Estates	(26)	(42)
Community - Adults	2	52
Operations & Corporate	22	85
Non Opeartional	20	(75)



For May, both patient related and other income show small positive variances (for the latter, mainly ICR charges and research & development income) along with pay (primarily in medical and scientific, therapeutic & technical pay groups) but an adverse variance for non pay.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	77	86
Other Income	44	100
Medical Pay	114	89
Nursing	(123)	(236)
Other Pay	152	340
Drugs & Consumables	(236)	(312)
Other Costs	(6)	0
Interest & Dividends	12	4



Sandwell and West Birmingham Hospitals NHS

NHS Trust

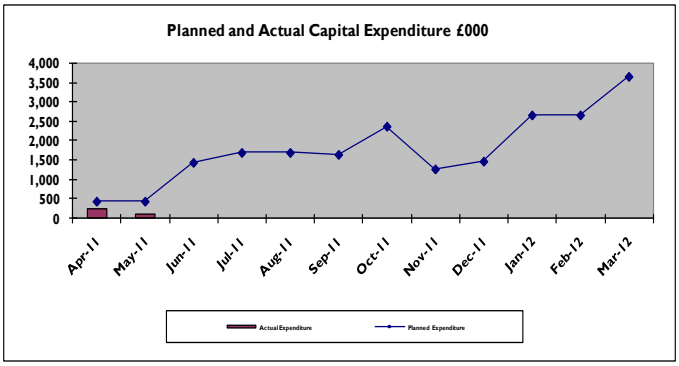
Financial Performance Report – May 2012

Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph.

• Both May and year to date expenditure remains lower than planned although the plan is already significantly phased towards the latter part of the year.

• For the year to date, expenditure of £0.4m primarily related to balances on brought forward schemes, capitalised salaries and land acquisition.

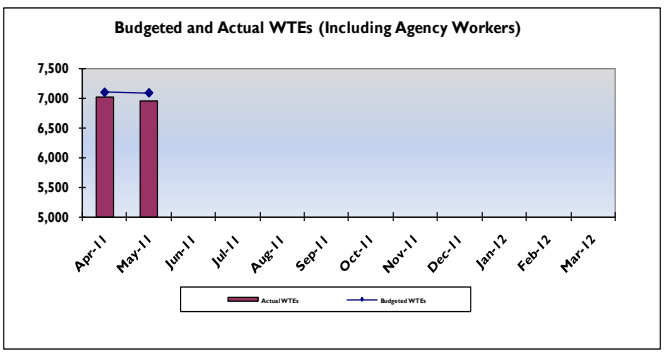


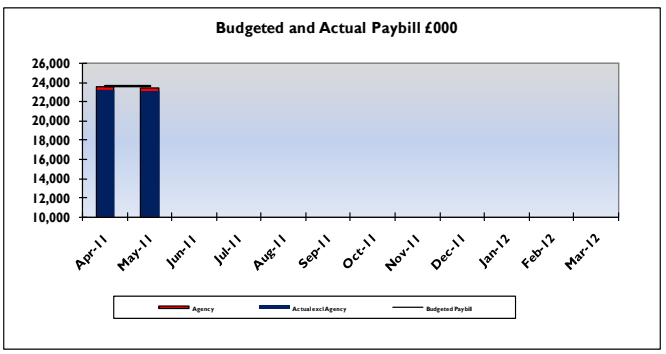
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 133 below plan compared with 71 below plan for April. Excluding the impact of agency staff, wte numbers are around 194 below plan. Actual wte's have decreased by 72 compared with April.

• Total pay costs (including agency workers) are £143,000 lower than budgeted levels for the month , particularly on medical and scientific, therapeutic & technical pay groups.

• Expenditure for agency staff in May was £328,000 compared with £391,000 in April, an average of £526,000 for 2011/12 and a May 2011 spend of £782,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – May 2012

Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major staff category with actual expenditure analysed for substantive, bank and agency costs.

Analysis of Total Pay Costs by Staff Group

	Year to Date to May					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	12,535	12,012		434	12,446	89
Management	2,541	2,415		0	2,415	126
Administration & Estates	5,244	4,919	187	64	5,170	74
Healthcare Assistants & Support Staff	5,215	4,909	348	2	5,258	(43)
Nursing and Midwifery	14,352	13,876	592	120	14,588	(236)
Scientific, Therapeutic & Technical	7,313	7,001		99	7,100	213
Other Pay	(53)	(23)			(23)	(30)
Total Pay Costs	47,147	45,109	1,126	719	46,954	193

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st May reflects the draft statutory accounts for the year ended 31st March 2012.

• Cash balances at 31st May are approximately £40m which is around £5.5m higher than at 31st March.

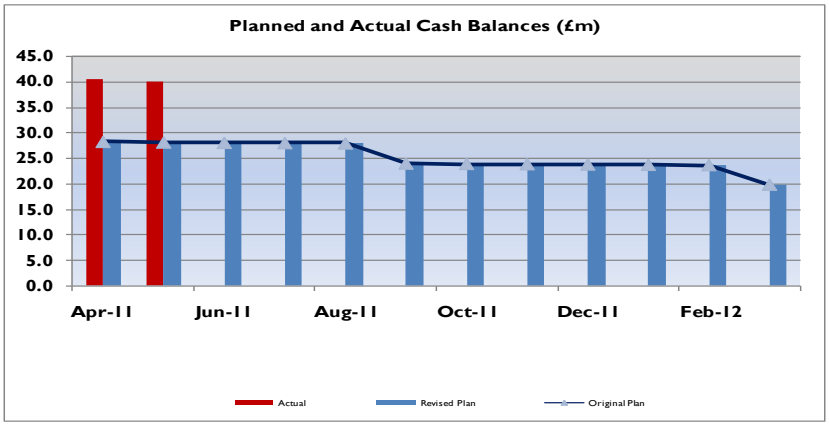
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2012 £000	Balance as at end May 2012 £000
Non Current Assets	Intangible Assets	1,075	1,055
	Tangible Assets	227,072	225,182
	Investments	0	0
	Receivables	865	865
Current Assets	Inventories	4,065	4,184
	Receivables and Accrued Income	14,446	15,092
	Investments	0	0
	Cash	34,465	39,963
Current Liabilities	Payables and Accrued Expenditure	(38,987)	(38,428)
	Loans	(2,000)	(2,000)
	Borrowings	(1,166)	(1,175)
	Provisions	(10,508)	(15,466)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	(5,000)	(5,000)
	Borrowings	(29,995)	(29,873)
	Provisions	(2,437)	(2,437)
		191,895	191,962
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	41,228	41,228
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(18,622)	(18,555)
		191,895	191,962

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2012



Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT May 2012

ACTUAL/FORECAST	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s	Aug-12 £000s	Sep-12 £000s	Oct-12 £000s	Nov-12 £000s	Dec-12 £000s	Jan-13 £000s	Feb-13 £000s	Mar-13 £000s	Apr-13 £000s	May-13 £000s
Receipts														
SLAs: Sandwell PCT	**15,649**	**17,511**	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165	17,165
HoB PCT	**11,392**	**11,367**	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,341
Associated PCTs	**562**	**703**	629	629	629	629	629	629	629	629	629	629	629	629
Pan Birmingham LSCG	**0**	**4,012**	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750
Education & Training	**1,269**	**1,253**	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449	1,449
Loans														
Other Receipts	**2,424**	**2,154**	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900
Total Receipts	**31,296**	**33,650**	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234	35,234
Payments														
Payroll	**13,578**	**13,564**	13,534	13,417	13,304	13,266	13,220	13,215	13,215	13,215	13,215	13,214	13,200	13,200
Tax, NI and Pensions		**9,429**	9,771	9,692	9,616	9,591	9,559	9,556	9,556	9,556	9,556	19,110	9,550	9,550
Non Pay - NHS	**1,230**	**2,430**	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	3,000	2,500	2,500
Non Pay - Trade	**8,197**	**7,434**	6,087	7,541	6,814	6,814	7,541	6,814	5,361	8,995	8,314	10,881	8,000	7,500
Non Pay - Capital	**1,788**	**714**	445	1,445	1,700	1,700	1,750	2,375	1,275	1,475	2,665	2,665	1,750	1,750
PDC Dividend						2,698						2,698		
Repayment of Loans						1,000						1,000		
Interest						30						25		
BTC Unitary Charge		**416**	416	416	416	416	416	416	416	416	416	832	430	430
Other Payments	**463**	**205**	175	175	175	175	175	175	175	175	175	175	175	175
Total Payments	**25,256**	**34,192**	32,928	35,186	34,525	38,190	35,161	35,051	32,498	36,332	36,841	53,600	35,605	35,105
Cash Brought Forward	**34,465**	**40,505**	39,963	42,269	42,317	43,026	40,070	40,143	40,326	43,062	41,964	40,357	21,991	21,620
Net Receipts/(Payments)	**6,040**	**(542)**	2,306	48	709	(2,956)	73	183	2,736	(1,098)	(1,607)	(18,366)	(371)	129
Cash Carried Forward	**40,505**	**39,963**	42,269	42,317	43,026	40,070	40,143	40,326	43,062	41,964	40,357	21,991	21,620	21,749

Actual numbers are in bold text, forecasts in light text.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2012

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.1%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	101.9%	5
Return on Assets	Surplus before dividends over average assets employed	4.8%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.1%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	21.2	3
Overall Rating			**3.0**

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at May.

• An adjustment has now been made to the liquidity ratio to reflect an uncommitted overdraft facility (which would be in place as an FT) as this more accurately reflects performance against the Monitor risk rating regime. The changes the Liquid Ratio score from 2 to 3.

•I&E Surplus Margin is lower than would normally be expected due to relatively low levels of surplus being delivered in the early months of 2012/13 (surpluses are profiled towards the latter part of the year).

External Focus

• Both the national and international economic situations continue to be weak and the recent support to the Spanish Banking System places further commitments on the eurozone as well as strict controls on Spain's financial sector.

• The Bank of England Base Rate remained unchanged at 0.5% (the most direct impact of this for the Trust is the on the rate earned for its cash deposits which remains very low).

•.Strategic health authorities continue to lead the remaining NHS trusts towards full FT status and this includes Sandwell and West Birmingham Hospitals. The second phase of the Single Operating Model will be implemented over the next few months focussing on the means by which SHA clusters can work with trusts as they prepare for life as autonomous FTs.

• At this point in the financial year, it is too early to have any meaningful feedback on potential financial issues being experienced within the NHS, and specifically with local commissioners, although with the current tight financial regime, there can be no doubt that delivering against financial targets will be difficult for all organisations. It is unlikely that any significant update on specific NHS financial issues will be raised until the end of Q1 and feedback on national financial and operational performance for the quarter will not be available until several weeks after 30th June.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2012

Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £17,000 during May against a planned deficit of (£16,000). For the purposes of its statutory accounts, the in month surplus was slightly higher at £46,000.

• The £17,000 surplus in May is £33,000 better than planned for the month.

• For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £38,000 which is £71,000 better than the planned position.

• In month capital expenditure is £119,000 which is lower than planned although the plan is significant weighted towards the latter part of the year.

•At 31st May, cash balances are approximately £11.8m higher than the cash plan which is around £5.5m greater than the position at 31st March.

• The only adverse operational variances in month have been recorded by the Medicine and Facilities Divisions although even these are relatively small. The performance of other divisions is around break even or better for the month.

• Monitoring of divisional performance will take place as in previous years with action being taken as necessary to rectify any potential and/or actual variances. Monitoring of the performance of the Transformation Programme will be a key component of this.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

ii. ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management
DATE OF MEETING:	28 June 2012

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – May 2012.

REPORT RECOMMENDATION:

The Trust Board is asked to NOTE the report and its associated commentary.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 19 June 2012 and Finance & Performance Management Committee on 22 June 2012

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - MAY 2012

SUCCESSES AND EXCEPTIONS

Note	Patient Safety
	SUCCESSES
b	**Infection Control -** There were 2 cases of C Diff reported across the Trust during the month of May, one on each site. There were no cases of MRSA Bacteraemia reported during the month. Both C Diff and MRSA numbers in month and year to date remain within trajectory. Improvement trajectories to an end year target of 85% were met for both Elective and Non-Elective MRSA Screening, with compliance of 39.9% and 64.1% for May respectively.
c	**VTE (Venous Thromboembolism) Risk Assessment** - performance remains in excess of the minimum 90% threshold.
	Appropriate use of Warfarin - this CQUIN requires a quarterly audit of patients admitted taking warfarin with an International Normalised Ratio (INR) above 5.0 whose dosage has been adjusted or reviewed prior to the next warfarin dose.
	Safety Thermometer (Acute Services) - this CQUIN requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre. Data collection systems have been established and data submitted for the months of April and May.
	Use of Antibiotics - Antimicrobial Stewardship - requires a quarterly self-assessment audit of prescribing of antibiotics in agreed specialities. A baseline compliance score of 60 has been established. An improvement trajectory / action plan to an end of year target of 90 is identified.
	Reducing avoidable pressure ulcers for all (Acute) inpatients - comprises 3 elements, a) Percentage of all inpatients with documented assessment of risk of developing a pressure ulceration, b) Percentage of patients identified as at risk who have an action plan to prevent / treat ulceration, c) Evidence of quarterly reduction in avoidable pressure ulcers. Requires a Q1 baseline and improvement trajectory.
	Nutrition and Weight Management (Acute Services) - this CQUIN is to reduce avoidable hospital acquired weight loss in elderly care and stroke patients. A comprehensive definition is required and baseline assessment during Q1, upon which an improvement trajectory will be determined.
	Ensuring Safe Surgery - To take measures to ensure 100% compliance with SHA defined areas (effective April 2012) and improvement trajectory for other (non-SHA defined) areas following Q1 baseline assessment.
	Stroke Discharge - comprises 4 components, a) CT Scan within 24 hours of arrival (95%), b) Swallow Screen completed within 4 hours of presentation (70%), c) Prescription / Administration to eligible patients within 24 hours of presentation of anti-platelet agents (90%), d) Commencement of anti-coagulation / Management Plan in place on discharge (60%). a) is assessed quarterly. b), c) and d) require Q1 baseline assessment and improvement trajectory. The first component (CT Scans within 24 hours of arrival) was met in 100% of cases during the month.
	Safety Thermometer (Community IP Services - Henderson and Leasowes) - this CQUIN requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre. Submission of data for 3 consecutive months within the quarter triggers payment for the period Quarters 2 - 4 inclusive.
	Reducing avoidable pressure ulcers (Community IP Services - Henderson and Leasowes) - comprises 3 elements, a) Percentage of all inpatients with documented assessment of risk of developing a pressure ulceration, b) Percentage of patients identified as at risk who have an action plan to prevent / treat ulceration, c) A process for the effective review and elimination of all Grade 3 and 4 pressure ulcers . Requires a Q1 baseline and improvement trajectory.
	Nutrition and Weight Management (Community IP Services - Henderson and Leasowes) - this CQUIN is to reduce avoidable hospital acquired weight loss in elderly care (aged 65+) and all stroke patients. A comprehensive definition is required and baseline assessment during Q1, upon which an improvement trajectory will be determined.
d	**Cervical Cytology Report Turnaround** continues to remain at less than 9 days.
	EXCEPTIONS
a	**Stroke Care** - performance against the target for patients who spent at least 90% of their hospital stay on a Stroke Unit continues to be maintained above the 80% threshold. Provisional data for May for **TIA** (High Risk) Treatment (within 24 hours of initial presentation) indicates reduced (56.3%) performance during the month, with performance similar on both acute sites.
e	**PDR** (12-month rolling) compliance remains fairly stable at 72.9% with approximately 5400 staff reported as receiving a PDR during the most recent 12 month period. Compliance by Division remains variable (26.5% - 94.1%). Overall **Mandatory Training** compliance at the end of May is 77.8%, again compliance by Division is varies (73 - 95%). A minimum 95% compliance is required by December, an improvement trajectory to achieve this requires a minimum level of compliance of 80% by all Divisions, by the end of June.
	Effectiveness Of Care
	SUCCESSES
f	**Dementia Risk Assessment (Acute Services)** - comprises 3 elements, a) Assessment (by screening question) of all emergency admissions aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories. A system to gather, report and record data has been established.
	Mortality Review - target to review 60% of all qualifying (adult) deaths within hospital within 42 days of death each month. 60.6% of deaths occurring within April were reviewed.
	Dementia Risk Assessment (Community Services) - comprises 3 elements, a) Assessment (by screening question) of all new patients to District Nursing caseload (wef April 2012) aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories.
g	The **Hospital Standardised Mortality Rate** (HSMR) for the Trust for the most recent 12-month cumulative period (ending February 2012) remains below 100 (92.3), and compares with a Peer (SHA) rate of 97.4 for the same period. The report includes data for the **Summary Hospital-level Mortality Indicator** (SHMI) for 12-month cumulative periods. The SHMI includes all deaths up to 30-days after hospital discharge and because of this linkage to other (ONS) data is not as timely as HSMR data.
	EXCEPTIONS
h	Provisional data for May indicates 61.5% of patients with a **Fractured Neck of Femur** received an operation within 24 hours of admission. This compares with a target of 70.0%. A recovery plan has been formulated by the Division / Specialty.
	Patient Experience
	SUCCESSES
k	**Mixed Sex Accommodation -** no breaches have occurred during the period year to date.
l	**Improve responsiveness to personal needs of patients (Acute Services)** - this CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The average composite score during the period September - November (66.6%) defines the baseline, against which an improvement of 5% is required during Quarter 4. Performance during April was 68.3%, compared with a trajectory of 67.1%.
	Net Promoter Score (Acute Services) - the target is to deliver a 10 point improvement (by Q4) in the Net Promoter Score from a minimum survey size of 10% of inpatients. The month of April determined the baseline score of 55 with performance during May attracting a score of 57, from a sample size of 11.4% of discharges.
	End Of Life Care (EOL) - To improve the percentage of patients receiving effective EOL care from the integrated SWBH NHST palliative care team including dying in their place of choice, and reduce the variation in use by ward of the supportive care pathway by patients known to palliative care. Q1 baseline and improvement trajectory required.

l (cont'd)	**Alcohol Screening** - screen all defined (EAU, MAU and Cardiology, Diabetic Medicine and Gastroenterology Outpatients) patients aged 16 and over and offer brief intervention. Q1 baseline and improvement trajectory to 80% to be determined. SWBTB (6/12) 157 (a)
	Smoking Pregnancy - comprises 2 elements, a) 80% eligible maternity staff to complete locally agreed training in delivering brief stop smoking advice by Q4 and improvement trajectory following Q1 baseline assessment of patient smoking status checking and recording at booking or first midwife contact.
	Improve responsiveness to personal needs of patients (Community IP Services - Henderson and Leasowes) - this CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The baseline score is to be assessed during Q1, which will then determine an improvement trajectory.
	Net Promoter Score (Community IP Services - Henderson and Leasowes) - the target is to deliver a 10 point improvement (by Q4) in the Net Promoter Score from a minimum survey size of 10% of inpatients. During Q1 the baseline and process is to be established.
	Every Contact Counts (Community Services - new patients to District Nursing caseload (wef April)) - comprises 3 elements, a) Staff completing locally agreed training in delivering brief advice as required to implement the Making Every Contact Count (MECC) ambition, b) Delivery of advice, c) Referrals to any lifestyle service from contacts. Requires a Q1 baseline and improvement trajectory.
	Smoking Cessation (Community Services - new patients to District Nursing caseload (wef April)) - comprises 3 elements, a) Number of patients with smoking status recorded, b) Number of patients given brief stop smoking advice, c) Number of patients referred to the Stop Smoking Service. Requires a Q1 baseline and improvement trajectory.
	Clinical Quality Dashboards (Specialised Services) - CQUIN is to implement and demonstrate routine use of clinical quality dashboard for specialised services (Cardiology, Paediatric Intensive Care and Neonatal Services).
	Neonatology (Specialised Services) - **Increase effective use of hypothermia treatment** - CQUIN is for pathway for therapeutic hypothermia to be utilised for all babies meeting criteria (excluding those born at home).
	Neonatology (Specialised Services) - **Discharge Planning / Family Experience and Confidence** - CQUIN is for 95% of babies transitioned / discharged from neonatal care by 44 weeks corrected gestation.
	HIV (Specialised Services - Ensure therapy is optimised) -Number of patients failing therapy (as measured by a detectable viral load) who are stabilised quickly and regain an undetectable viral load.
	EXCEPTIONS
i	**Accident & Emergency -** performance against the 4-hour maximum wait target improved during the month of May to 95.7% (95.5% year to date). The Trust achieved 3 of 5 **Clinical Quality Indicators** during the month. and continues to achieve 2 of the 5 indicators for the year to date.
j	**Ambulance Turnaround -** the indicators within the report have been revised to reflect those contained in the Quality section of the Trust's 2012 / 2013 contract with its commissioners, which focus on Clinical Handovers (% in <15 mins), Average Turnaround (mins : secs) and the number of ambulances turned around in excess of 60 minutes. Currently the Trust is not meeting any of the targets identified.
	Transformation Plan
	SUCCESSES

m

Activity (trust-wide) to date is compared with the contracted activity plan for **2012 / 2013** - Month and Year to Date.

	Month				Year to Date			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%
IP Elective	917	996	-79	-7.9	1632	1840	-208	-11.3
Day case	5003	4261	742	17.4	9130	7875	1255	15.9
IPE plus DC	5920	5257	663	12.6	10762	9715	1047	10.8
IP Non-Elective	4911	4700	211	4.5	9474	9468	6	0.1
OP New	15663	13428	2235	16.6	28439	24449	3990	16.3
OP Review	35673	40413	-4740	-11.7	66429	74019	-7590	-10.3
OP Review:New	2.28	3.01	-0.73	-24.3	2.34	3.03	-0.69	-22.8
AE Type I	15951	15655	296	1.9	30260	30609	-349	-1.1
AE Type II	2777	3327	-550	-16.5	5539	6506	-967	-14.9
Adult Community	41538	37333	4205	11.3	41538	37333	4205	11.3
Child Community	11589	10925	664	6.1	11589	10925	664	6.1

Activity to date is compared with **2011 / 12** for the corresponding period

	2011 / 12	2012 / 13	Variance	%
IP Elective	1742	1632	-110	-6.3
Day case	8275	9130	855	10.3
IPE plus DC	10017	10762	745	7.4
IP Non-Elective	8948	9474	526	5.9
OP New	24953	28439	3486	14.0
OP Review	67245	66429	-816	-1.2
OP Review:New	2.69	2.34	-0.36	-13.3
AE Type I	30699	30260	-439	-1.4
AE Type II	6677	5539	-1138	-17.0
Adult Community	39005	41538	2533	6.5
Child Community	9498	11589	2091	22.0

Overall Elective activity for the month and year to date remains in excess of the plan by 12.6% and 10.8% for the periods respectively. Non Elective activity exceeded the plan for the month by 4.5%, and is on plan for the year to date. Month and year to date New and Review Outpatient performance is such that the Follow Up : New Outpatient Ratio is 2.34 which compares favourably with a ratio derived from plan of 3.03. A&E Type I activity is marginally below plan to date although Type II (BMEC) activity remains well below plan (-14.9%). Adult and Child Community activity is currently 11.3% and 6.1% in excess of plan respectively. For reference, activity for the period to date is compared with the corresponding period last year in the table opposite.

	EXCEPTIONS
n	**Sickness Absence** - overall Sickness Absence increased from 4.06% to 4.50% within month. The rate for the quarter to date is 4.29% compared with a trajectory of less than 3.40%. The range by Division is 0.00 - 5.64%.
	Key Access Targets
	SUCCESSES
o	**Cancer** - all high level Cancer Targets were met during the month of April.
r	**Cancelled Operations** - the overall number and proportion of cancelled operations increased during the month but continue to remain within the target for both the month and the period to date.
	EXCEPTIONS
p	**RTT & Diagnostic Waits** - provisional data for May indicates that all high level RTT targets were met during the month. The specialities of Trauma & Orthopaedics and Plastic Surgery did not meet Admitted and Non-Admitted RTT pathways targets during the period. Diagnostic Waits in excess of 6 weeks reduced by 50% during the month to 0.67%.
q	During the month (May) **Delayed Transfers of Care** increased to 4.4% overall influenced by an in-month increase at Sandwell. Year to date delays are 4.1% which compares with 4.6% for the corresponding period last year.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - MAY 2012

Exec Lead	PATIENT SAFETY						January	February	March	April			May			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
DS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	83.6 ▼	87.8 ▲	94.1 ▲	→		91.2 ▼	→		88.2 ▼	89.7	83	83	a	No Variation	0 - 2% Variation	>2% Variation	●	72.8	85.9
	K			Pts admitted to Acute Stroke Unit within 4 hrs		%	56.1 ▲	75.0 ▲	68.7 ▼	→		82.1 ▲	→		64.7 ▼	75.6	90	90		No Variation	0 - 2% Variation	>2% Variation	●●		68.7
	K			Pts receiving CT Scan within 24 hrs of arrival		%	97.6 ▲	96.6 ▼	100 ■	→		100 ■	→		100 ■	100	100	100		No Variation	0 - 2% Variation	>2% Variation	●		100
	K			Pts receiving CT Scan within 1 hr of arrival		%	36.6 ▲	53.9 ■	54.6 ▲	→		71.4 ▲	→		52.9 ▼	64.4	50	50		No Variation	0 - 2% Variation	>2% Variation	●		37.5
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	81.8 ■	73.0 ▼	70.6 ▼	71.4 ■	50.0 ■	61.5 ▼	57.1 ■	55.6 ▲	56.3 ■	58.6	60	60		No Variation	0 - 2% Variation	>2% Variation	●	46.15	53.2
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	15.6 ▼	57.6 ▲	77.8 ■	66.7 ■	47.4 ■	53.6 ■	56.3 ■	45.5 ▼	51.9 ▼	52.7	60	60		No Variation	0 - 2% Variation	>2% Variation	●●		30.4
R0	A	4	Infection Control	C. Difficile (DH Reportable)		No.	9 ▼	9 ■	9 ■	1 ▲	2 ▲	3 ▲	1 ■	1 ▲	2 ▲	5	10	57	b	No variation		Any variation	●	120	95
	K			C. Difficile (Best Practice Numbers)		No.	→	→	→	3	4	7	2	4	6	13	No. Only	No. Only							
	A			MRSA Bacteraemia		No.	0 ▲	1 ▼	0 ▲	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0	1	2		No variation		Any variation	●	5	2
				MSSA Bacteraemia		No.	0	0	6	1	0	1	4	2	6	7	No. Only	No. Only						22	12
				E Coli Bacteraemia		No.	4	5	5	1	2	3	1	2	3	6	No. Only	No. Only						73	50
	F	3		MRSA Screening (Elective)		%	40.8	39.5	41.0	Numerator = 946	Denominator = 2459	38.5 ■	Numerator = 1311	Denominator = 3288	39.9 ▲	39.9	35	85		No variation		Any variation	●	40.3	40.6
	F			MRSA Screening (Non-Elective)		%	18.8	26.7	36.0	Numerator = 1231	Denominator = 1751	70.3 ■	Numerator = 1182	Denominator = 1843	64.1 ▼	64.1	35	85		No variation		Any variation	●	18.9	26.0
DS	A	3	Acute CQUIN	VTE Risk Assessment (Adult IP)	396	%	92.8 ▲	92.4 ▼	92.6 ▲	→		92.5 ▼	→		91.9 ▼	91.9*	90	90	c	=>90		<90	●	92.3	92.4
RB	K	20		Appropriate Use of Warfarin	372		→	→	→	Quarterly Audit			Quarterly Audit				Comply with audit			No variation		Any variation			
RB	H	8		Safety Thermometer	396	%	→	→	→	→		Data Submitted	→		Data Submitted	Data Submitted	Monthly data collection			No variation		Any variation	●		
RB	H	20		Antibiotic Use	743	Score	→	→	→	→		60 Base	Quarterly Audit					90		No variation		Any variation	●		
RO	D	8		Reducing Avoidable Pressure Ulcers	372	No.	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment					0		No variation		Any variation			
RO	H	8		Nutrition and Weight Management	743		→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
DS	H	9		Safe Surgery	743		→	→	→	→			→												
DS	H	10		Stroke Care	743	%	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
RO	H	11	Community CQUIN	Safety Thermometer	88	%	→	→	→	→			→				Monthly data collection			No variation		Any variation			
RO	D			Reducing Avoidable Pressure Ulcers	176		→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
RO	H			Nutrition and Weight Management	176		→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
KD	F	14	Never Events - in month			No.	1 ■	1 ■	1 ■	→		0 ■	→		0 ■	0	0	0		No variation		Any variation	●		
KD	F		Open Serious Incidents Requiring Investigation (SIRI)			No.	8	8	2	→		8	→		7	7*	No. Only	No. Only							
KD	F		Open Central Alert System (CAS) Alerts			No.	14	19	23	→		20	→		19	19*	No. Only	No. Only							
DS	D		100% Compliance WHO Surgical Checklist			Y / N	N ■	N ■	N ■	→		N ■	→		N ■	No	Y	Y		Y		N	●		N
RO	D		Falls Resukting In Severe Injury or Death			No	2 ■	6 ▼	2 ▲	→		3 ▼	→		0 ■	0*	0	0		No variation		Any variation	●		
RB	F	11	Community Services	New Birth Visits (consistent with contract)		Y / N	Y ■	Y ■	Y ■	→		Y ■	→		Y ■	Yes	Y	Y		Y		N	●		Y
RB	F			HPV Uptake (consistent with contract)		Y / N	Y ■	Y ■	Y ■	→		Y ■	→		Y ■	Yes	Y	Y		Y		N	●		Y
RB	F			Community Equipment Store Response <7 days		%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	100	100		=100		<100	●		100
RO	F			Urgent Distric Nurse response <24 hours		%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	100	100		=100		<100	●		100
RO	F			Non - Urgent Distric Nurse response <48 hours		%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	100	100		=100		<100	●		100
RO		8	High Impact Nursing Actions	Inpatient Falls reduction		%	93 ■	55 ■	71 ▼	→			→			763	924	924		=<77/m		>77/m	●	1024	763
RO				Nutritional Assessment (MUST)		%	90.5 ▼	92.0 ▲	89.0 ▲	→		98.0 ▲	→		96.0 ▼	96.0	75	75		=>75		<75	●		89.0
				Fluid Balance Chart Completion		%	96.0	96.0	100.0	→		100.0	→			100							●		100

Exec Lead				PATIENT SAFETY (Continued)		January	February	March	April		May			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
DS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	3 ▼	1 ▲	0 ▲	→		0 ■	→		0 ■	0	8	48		=<2	3 - 4	>4	●	9	7
				Admissions to Neonatal ICU	%	10.6 ▼	9.5 ■	10.8 ■	→			→				=<10	=<10		=<10	10.0-12.0	>12.0	●	7.2	10.7
				Adjusted Perinatal Mortality Rate	/1000	1.9 ▲	6.4 ▼	11.9 ■	→		4.1 ■	→		2.0 ▲	2.0*	<8.0	<8.0		<8	8.1 - 10.0	>10	●	6.5	11.9*
				Caesarean Section Rate	%	15.6 ▲	19.0 ▼	20.8 ▼	→		22.9 ▼	→		24.1 ▼	23.5	<25.0	<25.0		=<25.0	25-28	>28.0	●	23.6	22.2
	H			Early Booking (Completed Assessment <12+6 weeks)	%	66 ■	70 ▲	76 ■	→		78 ▲	→			78*	=>90	=>90		=>90	75-89	<75	● ● ●		76.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates	%	→	→	10.1 ▲	→		→	→		→		<11.5	<11.5		<11.5	11.5 - 12.5	>12.5		11.9	9.8
				Breast Feeding Initiation Rates	%	→	→	72.1 ■	→		→	→		→		>63.0	>63.0		>63.0	61-63	<61.0		65.6	73.0
RB	H	12	Number of Health Visitors in Post		No.	→	→	→	→			→					83.5							
RB		5	Cervical Cytology	Diagnostic Report Turnaround	Days	<9 days ■	<9 days ■	<9 days ■	→		<9 days ■	→		<9 days ■	<9 days	<9 days	<9 days	d	<9 days	9-12 days	>12 days	●	<9 days	<9 days
RB		7	Learning & Development	PDRs (12-month rolling)	No. (%)	5336 (72.2) ▲	5276 (71.4) ▼	5348 (72.4) ▲	→		5291 (71.6) ▼	→		5390 (72.9) ▲	5390 (72.9)	7389 (100)	7389 (100)	e	0-15% variation	15 - 25% variation	>25% variation	●	4635	5348
				Medical Appraisal and Revalidation	%				→			→												
	K	3		Mandatory Training Compliance	%	74.8 ▼	71.9 ▼	71.9 ■	→		74.6 ▲	→		77.8 ■	77.8	100	100		=>80	76 - 80	<76	●	86.8	71.9
EFFECTIVENESS OF CARE																								
RO	H	8	Acute CQUIN	Dementia	396	%	→	→	→	→		→				70	90	f	No variation		Any variation			
DS	H	3		Mortality Review	743	%	71.4 ▲	75.1 ▲	67.6 ▼	→		60.6 ▼	→		60.6*	60	60		No variation		Any variation	●		66.9
RO	H	11	Community CQUIN	Dementia	44	%	→	→	→	→			→			70	90		No variation		Any variation			
DS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	100.6 Nov '10 to Oct '11	97.7 Dec '10 to Nov '11	95.7 Jan'11 to Dec'11	→		93.1 Feb'11 to Jan'12	→		92.3 Mar'11 to Feb'12	92.3			g						
				Peer (SHA) HSMR		HSMR	104.0	102.5	100.7	→		98.3	→		97.4	97.4								
				Peer (National) HSMR - Quarterly		HSMR	→	→	92.2	→		→	→		→	92.2								
	D	19		SHMI		SHMI	100.5 Jun'10 - May'11	99.4 Jul'10 - Jun'11	99.8 Aug'10 - Jul'11	→		100.6 Sep'10-Aug'11	→		99.8 Oct'10 - Sep'11	99.8								
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	109	122	112	→		135	→		152	287	No. Only	No. Only							1463
				Following initial Elective Admission		%	0.97	1.15	1.00	→		1.35	→		1.33	1.34	No. Only	No. Only							1.15
				Following initial Non-Elective Admission		No.	692	639	527	→		595	→		582	1177	No. Only	No. Only							6842
				Following initial Non-Elective Admission		%	6.17	6.01	4.72	→		5.94	→		5.08	5.48	No. Only	No. Only							5.38
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	76.5 ▲	47.6 ■	61.1 ▲			70.0 ■			61.5 ■	65.2	70.0	70.0	h	No Variation	0 - 2% Variation	>2% Variation	●	64.7 (Q4)	66.4
RB		3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	94 ■	94 ■	95 ■	→		94 ▼	→		95 ▲	94	90	90		>/=90	89.0-89.9	<89	●	94.5	95
		3		Maternity HES		%	6.2 ▲	6.5 ▼	6.1 ▲	→		6.2 ▼	→		6.1 ▲	6.1	<15	<15		=<15	16-30	>30	●	5.4	6.0
	G	11		Data Completeness Community Services		%	→	→	→	→			→				=>50	=>50		=>50		<50			
	H	2		SUS Altered Data		%	→	→	→	→			→												
PATIENT EXPERIENCE																								
RB	A	2	A&E 4-hour waits	4-hour waits		%	95.5 ■	92.7 ■	97.5 ■	94.9 ■	95.6 ▼	95.3 ▼	95.7 ■	95.7 ▲	95.7 ▲	95.52	=>95	=>95	i	=>95		<95	●	96.99	95.38
	D	3	A&E Timeliness	Total Time in Department (95th centile)		h : m	3 : 59 ■	5 : 08 ■	3 : 57 ■	→		3 : 59 ▼	→		3 : 59 ■	3 : 59	=<4hrs	=<4hrs		=<4hrs		=<4hrs	●		3 : 59
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	17 ▲	18 ▼	17 ▲	→		18 ▼	→		15 ■	17	<15	<15		<15		<15	● ●		21
	D			Time to treatment in department (median)		mins	60 ▼	64 ■	58 ■	→		64 ■	→		62 ▲	63	=<60	=<60		=<60		>60	●		59
	D		A&E Patient Impact	Unplanned re-attendance rate		%	8.05 ▲	8.13 ▼	7.87 ▲	→		7.70 ▲	→		7.94 ▼	7.82	=<5.0	=<5.0		=<5.0		>5.0	● ● ●		8.66
	D			Left Department without being seen rate		%	4.78 ▲	6.17 ■	4.67 ■	→		4.88 ▼	→		4.91 ▼	4.88	=<5.0	=<5.0		=<5.0		>5.0	●		4.83
KD	F	14	Complaints	First Formal Complaints Received		No.	59	69	72	→		60	→		51	111	No. Only	No. Only							834

Exec Lead	PATIENT EXPERIENCE (Continued)						January	February	March	April			May			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
RB	H	18	Ambulance Turnaround	Clinical Handovers completed in >15 minutes		%	→	→	18:41 ■	21:18 ▼	17:41 ▼	19:27 ▼	22:45 ▼	16:44 ▲	19:29 ▼	19:28	=<15:00	=<15:00	j	=<15:00		>15:00	● ●		18:41
				(West Midlands average)		%	7.3	7.6	6.8	→		6.7	→		6.3	6.3*	No. Only	No. Only							8.0
	H			Average Turnaround Time		m : s	30:45 ▲	32:44 ▼	29:44 ■	32:35 ■	30:21 ■	31:20 ■	32:16 ▲	29:56 ■	30:56 ▲	31:07	=<30:00	=<30:00		=<30:00		>30:00	●		29:23
	H			In Excess of 60 minutes		No.	115 ▲	203 ▼	78 ▲	71 ▼	35 ▲	106 ▼	65 ▲	57 ▼	122 ▼	228	0	0		0		>0	● ● ●		1256
RB	B	2	Mixed Sex Accommodation (Total Number of Breaches)			%	0.00 ■	0.06 ■	0.00 ■	→		0.00 ■	→		0.00 ■	0.00	0.0	0.0	k	0.00	0.00 - 0.50	>0.50	●		0.07
RO	H	8	Acute CQUIN	Personal Needs	396	%	→	→	→	→		68.3 ■	→			68.3	67.1	71.6		No variation		Any variation	●		
RO	H	8		Net Promoter	372	No.	→	→	→	→		55 Base	→		57 ■	57	56	65		No variation		Any variation	●		
RO	H	8		End of Life Care	372	%	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
RB	H	10		Every Contact Counts - Alcohol	372	%	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment					80							
RO	H	12		Every Contact Counts - Smoking	372	%	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
RO	H	11	Community CQUIN	Pt. (Community) Exp'ce - Personal Needs	44	Score	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment							No variation		Any variation			
RO	H	11		Net Promoter	88	No	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment						l	No variation		Any variation			
RO	H	11		Every Contact Counts	132	%	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
RO	H	11		Smoking Cessation	132	%	→	→	→	Requires Q1 baseline assessment			Requires Q1 baseline assessment												
DS	H		Specialised Commissioners	Clinical Quality Dashboards	49		→	→	→	Implementation plans req'd by end Q1			Implementation plans req'd by end Q1							No variation		Any variation			
DS	H	13		Neonatal - Hypothermia Treatment	73	%	→	→	→	→			→							No variation		Any variation			
DS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	→	→	→			→					95		Met		Not Met			
DS	H	12		HIV - Optmum Therapy	147	%	→	→	→	→			→							No variation		Any variation			
RB		15	Elective Access Contact Centre	Number of Calls Received		No.	10270	9465	9541	→		10379	→		13128	23507	No. Only	No. Only						137824	111793
				Average Length of Queue		mins	0.12 ▼	0.20 ▼	0.23 ▼	→		0.35 ▼	→		0.35 ■	0.35	<1.0	<1.0		<1.0	1.0-2.0	>2.0	●	0.21	0
				Maximum Length of Queue		mins	7.2 ■	13.2 ■	10.1 ■	→		16.4 ■	→		18.5 ▼	18.5	<6.0	<6.0		<6.0	6.0-12.0	>12.0	● ●	6.3	10
			Telephone Exchange	Number of Calls Received		No.	74781	73010	74183	→		69821	→		75443	145264	No. Only	No. Only						909301	849502
				Calls Answered		%	92.6	91.7	90.7	→		92.2	→		92.6	92.4	No. Only	No. Only						90.5	90.2
				Answered within 15 seconds		%	58.8	55.4	50.8	→		57.0	→		57.9	57.5	No. Only	No. Only						52.4	52.5
				Answered within 30 seconds		%	74.7	71.6	67.2	→		72.7	→		73.7	73.3	No. Only	No. Only						68.4	68.1
				Average Ring Time		Secs	19.6	21.6	24.5	→		21.1	→		20.6	20.6*	No. Only	No. Only						21.2	25
				Longest Ring Time		Secs	604	326	718	→		523	→		940	940*	No. Only	No. Only						731	718
TRANSFORMATION PLAN																									
RB		2	Spells	Elective IP		No.	810 ▲	752 ▼	950 ■	→		717 ■	→		917 ▼	1632	1840	10981	m	No Variation	0 - 2% Variation	>2% Variation		11748	10610
				Elective DC		No.	4641 ▲	4549 ▼	4908 ▲	→		4123 ▼	→		5003 ▲	9130	7875	46983		No Variation	0 - 2% Variation	>2% Variation		53959	53685
				Total Elective		No.	5451 ▲	5301 ▼	5858 ▲	→		4840 ▼	→		5920 ▲	10762	9715	57964		No Variation	0 - 2% Variation	>2% Variation	●	65707	64295
				Non-Elective - Short Stay		No.	1264 ■	1060 ■	1151 ■	→		581 ▲	→		504 ■	1085	1064	6416		No Variation	0 - 2% Variation	>2% Variation		16460	13918
				Non-Elective - Other		No.	3823 ■	3682 ■	3806 ■	→		3982 ■	→		4407 ■	8389	8404	50689		No Variation	0 - 2% Variation	>2% Variation		42540	41757
				Total Non-Elective		No.	5087 ■	4742 ■	4957 ■	→		4563 ■	→		4911 ■	9474	9468	57105		No Variation	0 - 2% Variation	>2% Variation	●	59000	55675
			Outpatient Attendances	New		No.	13511 ■	12769 ▼	14445 ▲	→		12629 ▼	→		15663 ▲	28439	24449	144072		No Variation	0 - 2% Variation	>2% Variation	●	163493	159051
				Review		No.	36074 ▲	33737 ▼	36177 ▲	→		30272 ■	→		35673 ▼	66429	74019	430846		No Variation	0 - 2% Variation	>2% Variation	●	440812	421494
			A/E Attendances	Type I (Sandwell & City Main Units)		No.	14945 ■	14259 ▼	14463 ▼	6249 ■	8060 ■	14309 ■	7179 ■	8772 ■	15951 ■	30260	30609	175107		No Variation	0 - 2% Variation	>2% Variation	●	181494	177201
				Type II (BMEC)		No.	2792 ■	2616 ▼	2834 ▲	→	2762 ■	2762 ■	→	2777 ▼	2777 ▼	5539	6506	37217		No Variation	0 - 2% Variation	>2% Variation	● ●	36756	36362
		16	Community	Adult - Aggregation of 18 Individual Service Lines		No.	44409 ■	41529 ▼	43846 ▲	→		41538 ▼	→			41538	37333	447996		No Variation	0 - 2% Variation	>2% Variation	●	461797	493163
				Children - Aggregation of 4 Individual Service Lines		No.	13529 ▲	11605 ▼	13016 ▲	→		11589 ▼	→			11589	10925	131100		No Variation	0 - 2% Variation	>2% Variation	●	102773	143400

Exec	TRANSFORMATION PLAN (Continued)	January	February	March	April	May	To Date (*=most	TARGET	Exec Summary	THRESHOLDS	12/13 Forward	10/11	11/12

Lead			TRANSFORMATION PLAN (Continued)			Trust		Trust		Trust		S'well		City		Trust		S'well		City		Trust		recent month)	YTD	12/13	Note				Projection	Outturn	Outturn
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.67	▲	2.64	▲	2.50	▲	2.75	▲	2.25	■	2.40	■	2.61	▲	2.14	▲	2.28	■	2.34	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	●	2.70	2.65
RB		2		DNA Rate - New Referrals	%	12.3	▲	12.7	▼	12.2	▲	11.5	▲	12.7	▼	12.4	▼	11.2	▲	11.8	▲	11.6	▲	11.6	10.0	10.0		No variation		Any variation	● ●	13.1	11.8
				DNA Rate - Reviews	%	11.0	▲	11.0	■	10.9	▲	11.6	▼	11.6	▼	11.6	▼	10.8	▲	11.8	▼	11.4	▲	11.1	10.0	10.0		No variation		Any variation	● ●	11.9	10.5
RB		2	Patient Flow	Average Length of Stay	Days	4.0	▼	4.0	■	3.8	▲	4.8	■	3.7	▼	4.2	▼							4.2	4.3	4.3		No Variation	0 - 5% Variation	>5% Variation	●	4.3	4.2
RB		2		Day of Surgery (IP Elective Surgery)	%	92.2	▲	89.7	▼	91.7	▲	93.3	▲	89.3	▼	90.6	▼	92.9	▼	91.0	▲	91.6	▲	91.3	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	●	88.7	89.5
				Daycase Rate - All Procedures	%	83.8	▲	84.9	▲	82.4	▼	86.9	▲	81.6	■	83.8	▲	86.8	▼	80.6	▼	83.2	▼	83.8	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	●	81.5	82.7
RB		7	Sickness Absence	Long Term	%	3.29	▼	3.27	▲	3.17	▲	→				3.28	▼	→				3.51	▼	3.40 (Q1)	<2.35	<2.35		<2.35	2.35-2.70	>2.70		3.12	2.95
RB		7		Short Term	%	1.05	▲	1.12	■	0.96	■	→				0.78	▲	→				0.99	▼	0.89 (Q1)	<1.05	<1.05	n	<1.05	1.05-1.20	>1.20		1.05	0.95
	D			Total	%	4.34	▼	4.39	▼	4.13	▲	→				4.06	▲	→				4.50	▼	4.29 (Q1)	<3.40	<3.40		<3.40	3.40-3.90	>3.90	● ●	4.17	3.90
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	85.0		84.4		84.5		→				86.3		→				90.6		88.3	No. Only	No. Only						86.2	87.2
RB		17		Nurse Bank Shifts covered	No.	4574	▼	4820	▼	5424	▼	→				4446	▲	→				4403	▲	8849	7830	46980		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ●	54952	56396
				Nurse Agency Shifts covered	No.	761	▼	791	▲	766	▼	→				654	▲	→				495	▲	1149	638	3830		0 - 5% Variation	5 - 10% Variation	>10% Variation	● ●	4550	6948
KEY ACCESS TARGETS																																	
RB	A	1	Cancer	2 weeks	%	95.6	▼	96.1	▲	96.2	▲	→				94.6	▼	→						94.6	=>93	=>93		No variation		Any variation	●	94.5	94.8
	A			2 weeks (Breast Symptomatic)	%	94.4	▲	98.0	▲	98.7	▲	→				96.5	▼	→						96.5	=>93	=>93		No variation		Any variation	●	94.7	95.8
	A			31 Day (diagnosis to treatment)	%	99.5	▼	100	▲	100	■	→				99.3	▼	→						99.3	=>96	=>96		No variation		Any variation	●	99.7	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	99.0	▼	100	▲	100	■	→				98.9	▼	→						98.9	=>94	=>94		No variation		Any variation	●	99.5	100.0
	A			31 Day (second/subsequent treatment - drug)	%	100	■	100	■	100	■	→				100	■	→						100	=>98	=>98	o	No variation		Any variation	●	100	99.2
	A			31 Day (second/subsequent treat - radiotherapy)	%	n/a		n/a		n/a		→				n/a		→						n/a	=>94	=>94		No variation		Any variation	●	100	100
	A			62 Day (urgent GP referral to treatment)	%	85.7	▼	85.0	▼	89.7	▲	→				86.5	▼	→						86.5	=>85	=>85		No variation		Any variation	●	88.0	86.9
	A			62 Day (referral to treat from screening)	%	97.9	▲	100	▲	100	■	→				100	■	→						100	=>90	=>90		No variation		Any variation	●	99.2	98.5
	H			62 Day (referral to treat from hosp specialist)	%	88.9	▼	81.3	■	95.1	■	→				98.0	▲	→						98.0	=>85	=>85		No variation		Any variation	●	95.6	91.6
RB	A	2	RTT 18-Weeks	Admitted Care (RTT <18 weeks)	%	93.8	▼	93.4	▼	93.2	▼	→				94.1	▲	→				93.5	▼	93.5*	=>90.0	=>90.0		=>90.0	85-90	<85.0	●	92.7	93.2
	A			Non-Admitted Care (RTT <18 weeks)	%	97.0	▼	98.9	▲	97.5	▼	→				98.8	▲	→				98.8	■	98.8*	=>95.0	=>95.0		=>95.0	90 - 95	=<90.0	●	96.7	97.5
	A			Incomplete Pathway (RTT <18 weeks)	%	96.5	▲	96.7	▲	97.2	▼	→				96.7	▼	→				97.4	▲	97.4*	=>92.0	=>92.0		=>95.0	87 - 92	=<87.0	●		97.2
	E			Treatment Functions Underperforming	No.	4	▼	4	■	2	▲	→				4	▼	→				4	■	4*	0	0	p	0 / month	1 - 6 / month	>6 / month	●		10 (Q4)
	H			Audiology D.A Patients seen in <18 weeks	%	100	■	100	■	100	■	→				100	■	→						100	100	100		100		<100	●		100
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	1.65	■	0.40	■	0.96	▼	→				1.34	■	→				0.67	■	0.67*	<1.0	<1.0		<1.0	1.0 - 5.0	>5.0	●		0.99
RB	F	11		Community Diagnostic Waits greater than 6 weeks	%	0.00	■	0.00	■	0.00	■	→				0.00	■					0.00	■	0.00	0.0	0.0		<0.0		>0.0	●		0.00
RB	C	2	Delayed Transfers of Care	Acute	%	3.5	■	3.5	■	4.2	▼	2.9	■	4.2	▲	3.6	▲	4.7	■	4.2	■	4.4	▼	4.1	<3.5	<3.5		<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
RB		2		Pt's Social Care Delay	No.	14	■	23	■	13	■	5	■	11	■	16	▼	10	■	9	■	19	■	19*	<18	<18	q	No Variation	0 - 10% Variation	>10% Variation		23	13
				Pt.'s NHS & NHS plus S.C. Delay	No.	9	■	6	▲	20	■	7	▲	5	■	12	▲	2	■	5	■	7	■	7*	<10	<10		No Variation	0 - 10% Variation	>10% Variation		22	20
RB	H	2	Cancelled Operati	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.5	■	0.8	■	0.4	■	0.1	▲	0.3	▲	0.2	▲	0.2	▼	0.6	▼	0.4	▼	0.4	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
RB	H	2		28 day breaches	No.	0	■	0	■	0	■	→				0	■	→				0	■	0	3	3	r	3 or less	4 - 6	>6	●	1	1
				Sitrep Declared Late Cancellations by Speciality	No.	23	■	31	▼	20	▲	3		9		12	▲	3		24		27	▼	39	55	320		0-5% variation	5 - 15% variation	>15% variation	●	500	363
RB		10	Cardiology	Primary Angioplasty (<150 mins)	%	80.0	▼	85.7	▲	88.2	▲	100	■	100	■	100	■							100.0	=>80	=>80		=>80	75-79	<75	●	90.7	88.4
RB		10		Rapid Access Chest Pain	%	98.2	■	100	▲	100	■	96.8	■	100	■	98.2	▼							98.2	=>98	=>98		=>98	96 - 97.9	<96	●	100.0	99.1
RB	F	12	GUM 48 Hours	Patients offered app't within 48 hrs	%	100	■	100	■	100	■	→				100	■	→				100	■	100	=>98	=>98		=>98	95-98	<95	●	100.0	100
RO	G	8	Access to healthcare for people with Learning Disability (full compliance)		Y / N	N	■	N	■	N	■	→				N	■	→				N	■	No	Full	Full		Y		N	●		N

KEYS AND SUMMARY PERFORMANCE AGAINST INDICATORS WHICH COMPRISE NATIONAL PERFORMANCE FRAMEWORKS

NHS PERFORMANCE FRAMEWORK	January	February	March	April		May	
Performing	17	17	17	→	16	→	17
Underperforming	2	1	2	→	3	→	2
Failing	0	1	0	→	0	→	0
No Data	0	0	0	→	0	→	0
Average weighted Score	2.86	2.71	2.86	→	2.79	→	2.86

MONITOR COMPLIANCE FRAMEWORK	January	February	March	April		May	
Performing	13	12	13	→	14	→	14
Underperforming	0	1	0	→	1	→	1
No Data	0	0	0	→	1	→	1
Overall Governance Rating	0.0	1.0	0.0	→	0.5	→	0.5

DATA SOURCES	
1	Cancer Services (National Cancer Database)
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	Histopathology Department
6	Dr Foster
7	Workforce
8	Nursing Division
9	Surgery A Division
10	Medicine Division
11	Adult Community Division
12	Women & Child Health Division
13	Neonatology
14	Governance Division
15	Operations Division
16	Finance Division
17	Nurse Bank
18	West Midlands Ambulance Service
19	Healthcare Evaluation Data Tool (HED)
20	Pharmacy Department

FORWARD PROJECTION ASSESSMENT	
●	Maintain (at least), existing performance to meet target
●	**Improvement** in performance required to meet target
● ●	**Moderate Improvement** in performance required to meet target
● ● ●	**Significant Improvement** in performance required to meet target
XXX	**Target Mathmatically Unattainable**

INDICATORS WHICH COMPRISE THE PERFORMANCE ASSESSMENT FRAMEWORKS	
A	NHS Performance F'work, Monitor Compliance F'work, SHA Provider M'ment Return & Local Priority / Contract.
B	NHS Performance F'work, SHA Provider M'ment Return & Local Priority / Contract.
C	NHS Performance Framework & Local Priority / Contract.
D	SHA Provider Management Return & Local Priority / Contract.
E	NHS Performance Framework only
F	SHA Provider Management Return only
G	Monitor Compliance Framework only
H	Local & Contract (inc. CQUIN)
K	Local

PERFORMANCE ASSESSMENT SYMBOLS	
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no sign of improvement
▼	Not met - performance shows further deterioration

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	28 June 2012

EXECUTIVE SUMMARY:

The report provides an assessment of the Trust's performance mapped against the indicators which comprise the NHS Performance Framework.

Service Performance (May) - There were 2 areas of underperformance during the month of May; RTT Delivery in all specialities (projected) and Delayed Transfers of Care. The overall average weighted score for service performance is 2.86. CQC Registration Status remains Unconditional. As such for the month of May the Trust attracts a **PERFORMING** classification.

Financial Performance (May) - The weighted overall score remains 2.95 with underperformance confined to Creditor Days. The classification for the month of May remains **PERFORMING.**

Foundation Trust Compliance Summary report (May):

Within the Service Performance element of the Risk Rating the Trust is not fully compliant with the, Requirements regarding access to healthcare for people with a learning disability. The Trust is also unable currently to report its performance against the 'Data Completeness Community Services Indicator'.

Performance in areas where no data are currently available for the month are expected to meet operational standards.

The overall score for the month of May (excluding the Data Completeness indicator) is 0.5, which attracts a GREEN Governance Rating.

REPORT RECOMMENDATION:

The Trust Board is asked to NOTE the report and its associated commentary.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

PREVIOUS CONSIDERATION:

Performance Management Board, Trust Management Board and Finance & Performance Management Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Score 2	Underperforming (Score 0)	Quarter 4 2011/12	Score	Weight x Score	April 2012/13	Score	Weight x Score	May 2012/13	Score	Weight x Score
A/E Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	95.30%	3	3.00	95.30%	3	3.00	95.70%	3	3.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	3	3.00	0	3	3.00	0	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	27	3	3.00	3	3	3.00	2	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	>90.0%	3	3.00	94.1%	3	3.00	93.5%#	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	>95.0%	3	3.00	98.8%	3	3.00	98.8%#	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	>92.0%	3	3.00	96.7%	3	3.00	97.4%#	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	10	2	2.00	4	2	2.00	4#	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	0.99%	3	3.00	1.34%	2	2.00	0.67%	3	3.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	96.0%	3	1.50	94.6%	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	97.2%	3	1.50	96.5%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	99.8%	3	0.75	99.3%	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	99.7%	3	0.75	98.9%	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	n/a	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	86.8%	3	1.50	86.5%	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	99.3%	3	1.50	100.0%	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	3.5%	3.5 - 5.00%	5.0%	3.70%	2	2.00	3.60%	2	2.00	4.40%	2	2.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.02%	3	3.00	0.00%	3	3.00	0.00%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.60%	3	3.00	92.50%	3	3.00	91.90%	3	3.00
Sum (all weightings)	**14.00**												
Average Score (Integrated Performance Measures)							**2.86**			**2.79**	* projected # provisional		**2.86**

CQC Registration Status

Unconditional or no enforcement action by CQC	The assessment of non-compliance / outstanding conditions from the initial registration	Enforcement action by CQC

	Performing	**Performing**	**Performing**

Overall Quality of Service Rating

	Performing	**Performing**	**Performing**

Assessment Thresholds for Integrated Performance Measures Average Score	
Underperforming if less than	**2.1**
Performance Under Review if between	**2.1 and 2.4**
Performing if greater than	**2.4**

SW

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

Financial Indicators				SCORING			2011 / 2012			2011 / 2012			2011 / 2012			2012 / 2013			2012 / 2013		
Criteria	**Metric**	**Weight (%)**		**3**	**2**	**1**	**January**	**Score**	**Weight x Score**	**February**	**Score**	**Weight x Score**	**March**	**Score**	**Weight x Score**	**April**	**Score**	**Weight x Score**	**May**	**Score**	**Weight x Score**
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**	**0.01%**	**3**	**0.15**	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	**0.24%**	**3**	**0.6**	**0.37%**	**3**	**0.6**	**0.44%**	**3**	**0.6**	**0.00%**	**3**	**0.6**	**0.01%**	**3**	**0.6**
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	**5.43%**	**3**	**0.15**	**5.53%**	**3**	**0.15**	**5.40%**	**3**	**0.15**	**5.13%**	**3**	**0.15**	**5.07%**	**3**	**0.15**
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	**5.56%**	**3**	**0.15**	**5.52%**	**3**	**0.15**	**5.40%**	**3**	**0.15**	**5.97%**	**3**	**0.15**	**5.99%**	**3**	**0.15**
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.01%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	**0.43%**	**3**	**0.15**	**0.43%**	**3**	**0.15**	**0.44%**	**3**	**0.15**	**0.92%**	**3**	**0.15**	**0.92%**	**3**	**0.15**
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	**5.56%**	**3**	**0.15**	**5.52%**	**3**	**0.15**	**5.40%**	**3**	**0.15**	**5.97%**	**3**	**0.15**	**5.99%**	**3**	**0.15**
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	**84.00%**	**2**	**0.05**	**93.00%**	**2**	**0.05**	**97.00%**	**3**	**0.075**	**96.00%**	**3**	**0.075**	**96.00%**	**3**	**0.075**
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	**84.00%**	**2**	**0.05**	**96.00%**	**3**	**0.075**	**95.00%**	**3**	**0.075**	**97.00%**	**3**	**0.075**	**95.00%**	**3**	**0.075**
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	**1.16**	**3**	**0.15**	**1.17**	**3**	**0.15**	**1.01**	**3**	**0.15**	**1.04**	**3**	**0.15**	**1.04**	**3**	**0.15**
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	**18.31**	**3**	**0.15**	**14.13**	**3**	**0.15**	**13.23**	**3**	**0.15**	**11.31**	**3**	**0.15**	**13.11**	**3**	**0.15**
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	**46.62**	**2**	**0.1**	**43.48**	**2**	**0.1**	**36.53**	**2**	**0.1**	**38.09**	**2**	**0.1**	**35.51**	**2**	**0.1**
						Weighted Overall Score			**2.90**			**2.93**			**2.95**			**2.95**			**2.95**

*Operating Position = Retained Surplus/Breakever/deficit less impairments

Assessment Thresholds	
Performing	> 2.40
Performance Under Review	2.10 - 2.40
Underperforming	< 2.10

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Provider Management Regime return – May 2012
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy & Organisational Development & Kam Dhami, Director of Governance
AUTHOR:	Mike Harding, Head of Planning & Performance Management & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	28 June 2012

EXECUTIVE SUMMARY:

The Provider Management Regime (PMR) return is to be submitted to the SHA on a monthly basis and comprises a dashboard of performance against key quantifiable targets, together with a declaration of compliance against a series of Board Statements.

The organisational risk ratings as reported for April 2012 are as follows:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per NHS Midlands and East PMR guidance)	G
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	G
Contractual Position (RAG as per NHS Midlands and East PMR guidance)	G

One declaration of non-compliance with Board Statements is as follows:

- Requirements to meet Level 2 of the IG toolkit

REPORT RECOMMENDATION:

That the Trust Board:

APPROVES the submission of the Provide Management Regime submission.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Financial	X	Environmental	X	Communications & Media	X
Business and market share	X	Legal & Policy	X	Patient Experience	X
Clinical	X	Equality and Diversity	X	Workforce	X
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The PMR covers performance against a number of the Trust's objectives, standards and metrics

PREVIOUS CONSIDERATION:

Routine monthly update.

NHS
Midlands and East

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
May 2012

NHS Midlands & East
Provider Management Regime
2012/13

Returns to provider.development@westmidlands.nhs.uk by the last working day of each month

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	Sandwell & West Birmingham Hospitals NHS Trust	Period:	May 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance as per the 2011/12 Provider Management Regime, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per NHS Midlands and East PMR guidance)	G
Financial Risk Rating (Assign number as per NHS Midlands and East PMR guidance)	G
Contractual Position (RAG as per NHS Midlands and East PMR guidance)	G

*** Please type in R, A or G**

Governance Declarations

NHS Midlands and East organisations, subject to the Provider Management Regime, must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:	To be added	Print Name:	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:	Trust Chairman	
Signed by:	To be added	Print Name:	John Adler
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

ACUTE
GOVERNANCE RISK RATINGS 2011/12

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr-12	May-12										Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	**1.0**	YES	YES										
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	**1.0**	YES	YES										
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	**1.0**	YES	YES										April 2012 performance confirmed from National Cancer Waiting times System report. May performance projected.
			Anti cancer drug treatments	98%													
			Radiotherapy	94%													
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT	85%	**1.0**	YES	YES										As above
			From consultant screening service referral	90%													
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	**1.0**	YES	YES										
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	**1.0**	YES	YES										
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	**0.5**	YES	YES										As above
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	**0.5**	YES	YES										As above
			for symptomatic breast patients (cancer not initially suspected)	93%													
8a	Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	**1.0**	YES	YES										
8b	Quality	A&E: NB Please record the areas not being met in the comments sheet	Total time in A&E (95th percentile)	≤4 hrs	**No weighting**	3	2										Time to Treatment in Department and Unplanned Reattendance Rate
			Time to initial assessment (95th percentile)	≤15 mins													
			Time to treatment decision (median)	≤60 mins													
			Unplanned re-attendance rate	≤5%													
			Left without being seen	≤5%													
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	**0.5**	NO	NO										
		CQC Registration															
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	**1.0**	NO	NO										
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	**2.0**	NO	NO										
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	**1.0**	NO	NO										
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	**2.0**	NO	NO										
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	**2.0**	NO	NO										
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	**4.0**	NO	NO										
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**	NO	NO										
				TOTAL		**0.5**	**0.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

MENTAL HEALTH GOVERNANCE RISK RATINGS 2011/12

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr-12	May-12											Comments where target not achieved in month?
10	Quality	Care Programme Approach (CPA) patients, comprising either:	Receiving F/U contact within 7 days of discharge	95%	**1.0**													
			Having formal review within 12 months	95%														
11	Quality	Minimising mental health delayed transfers of care		≤7.5%	**1.0**													
12	Quality	Admissions to inpatients services had access to crisis resolution home treatment teams		90%	**1.0**													
13	Quality	Meeting commitment to serve new psychosis cases by early intervention teams	95th percentile	Contract with PCT	**0.5**													
14	Effectiveness	Data completeness: identifiers		99%	**0.5**													
15	Effectiveness	Data completeness: outcomes for patients on CPA		50%	**0.5**													
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	**0.5**													
		CQC Registration																
A	Safety	CQC Registration	Compliance condition's on registration	0	**1.0**													
B	Safety	CQC Registration	Restrictive compliance conditions on registration	0	**2.0**													
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	**1.0**													
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	**2.0**													
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	**2.0**													
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	**4.0**													
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**													
				TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

AMBULANCE
GOVERNANCE RISK RATINGS 2012/13

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr-12	May-12											Comments where target not achieved in month?
16a	Quality	Category A call –emergency response within 8 minutes	Life Threatening	75%	**1.0**													
16b	Quality	Category A call – ambulance vehicle arrives within 19 minutes		95%	**1.0**													
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	**0.5**													
		CQC Registration																
A	Safety	CQC Registration	Compliance condition's on registration	0	**1.0**													
B	Safety	CQC Registration	Restrictive compliance conditions on registration	0	**2.0**													
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	**1.0**													
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	**2.0**													
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	**2.0**													
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	**4.0**													
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**													
			TOTAL			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

COMMUNITY TRUST
GOVERNANCE RISK RATINGS 2012/13

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for MIU/A&E

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr-12	May-12										Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	YES	YES										
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	YES	YES										
18	Quality	Delayed Transfers of Care	Are you below the ceiling for your monthly trajectory	Contract with PCT	0.5	N/A	N/A										
19	Patient Experience	GUM Access - within 48 hours	95th percentile	≤ 48 hrs	0.5	YES	YES										
20	Effectiveness	Chlamydia Screening		Contract with PCT	0.5	N/A	N/A										
21	Effectiveness	Smoking quitters		Contract with PCT	0.5	N/A	N/A										
8a	Quality	Minor Injuries Unit / A&E (Q1):	Total time (95th percentile)	≤ 4 hrs	1.0	N/A	N/A										
8b	Quality	MIU / A&E/ WiC (from Q2): NB Please record the areas not being met in the comments column	Total time (95th percentile)	≤4 hrs	No weighting	N/A	N/A										
			Time to initial assessment (95th percentile)	≤15 mins													
			Time to treatment decision (median)	≤60 mins													
			Unplanned re-attendance rate	≤5%													
			Left without being seen	≤5%													
22	Patient Experience	6 week wait for diagnostic	100%	≤ 6 wks	0.5	YES	YES										
23	Safety	New birth visits		Contract with PCT	0.5	YES	YES										
24	Effectiveness	HPV (Human Papillomavirus) Uptake		Contract with PCT	0.5	YES	YES										
25	Patient Experience	Community equipment store response within seven days	100%	≤ 7 days	0.5	N/A	N/A										
26a	Safety	Urgent District Nurse response within 24 hours	100%	≤ 24 hrs	0.5	YES	YES										
26b	Patient Experience	Non-urgent District Nurse response within 48 hours	100%	≤ 48 hrs	0.5	YES	YES										
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	NO	NO										Compliance expected to be achieved in July 2012
		CQC Registration															
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0	NO	NO										Conditional formatting in cell incorrect!
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0	NO	NO										Conditional formatting in cell incorrect!
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	NO	NO										Conditional formatting in cell incorrect!
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	NO	NO										Conditional formatting in cell incorrect!
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0	NO	NO										
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0	NO	NO										
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	NO	NO										
				TOTAL		0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

FINANCIAL RISK RATING 2012/13

Sandwell & West Birmingham Hospitals NHS Trust

			Risk Ratings						Insert the Score (1-5) Achieved for each Criteria Per Month											
Criteria	Indicator	Weight	5	4	3	2	1	Annual Plan 2011/12	#####	######										Comments on Performance in Month
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	3	3	3										
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	5	5	5										
Financial efficiency	Return on assets %	20%	6	5	3	-2	<-2	3	3	3										
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	2	2										
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	3										£25m notional working capital facility added to convert to FT comparability
Average	**Weighted Average**	**100%**						**3.2**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	
Overriding rules	**Overriding rules**							-0.2												
Overall rating	**Final Overall rating**							**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

Overriding Rules :

Max Rating	Rule
3	Plan not submitted on time
3	Plan not submitted complete and correct
2	PDC divident not paid in full
2	One Financial Crieterion at "1"
3	One Financial Crieterion at "2"
1	Two Financial Criteria at "1"
2	Two Financial Criteria at "2"

FINANCIAL RISK TRIGGERS 2012/13

Sandwell & West Birmingham Hospitals NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Apr-12	May-12											Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No											
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No											
3	FRR 2 for any one quarter	No	No											
4	Working capital facility (WCF) agreement includes default clause	No	No											Guidance states Non-FT organisations should assume a working capital facility.
5	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes											
6	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No											
7	Two or more changes in Finance Director in a twelve month period	No	No											
8	Interim Finance Director in place over more than one quarter end	No	No											
9	Quarter end cash balance <10 days of operating expenses	No	No											
10	Capital expenditure < 75% of plan for the year to date	Yes	Yes											
	TOTAL	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

NB Scoring: An answer of "YES" = 1.0

RAG RATING :

GREEN	**= Score between 0 and 1**
AMBER	**= Score between 2 and 4**
RED	**= Score over 5**

CONTRACTUAL RISK RATINGS 2012/13

Sandwell & West Birmingham Hospitals NHS Trust

Insert R, A or G into appropriate row for the Month

Criteria	RAG	Apr-12	#####										Comments on Performance in Month
All key contracts are agreed and signed. Both the NHS Trust and commissioner are fulfilling the terms of the contract. There are no disputes or performance notices in place.	G	G	G										
The NHS Trust and commissioner are in dispute over the terms of the contract. Performance notices have been issued by one or both parties.	A												
One or more key contract is not signed by the start of the period covered by the contract. There is a dispute over the terms of the contract which might, or will, necessitate SHA intervention or arbitration. The parties are already in arbitration.	R												

QUALITY

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

	Criteria	Unit	Apr-12	May-12										Comments on Performance in Month
1	SHMI - latest data	Ratio	99.75	99.8										SHMI data relates to period October 2010 - September 2011 which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	92.2	91.9										
3a	Elective MRSA Screening	%	38.5	39.9										Data represents actual screens matched to specific patients requiring screens. An improvement trajectory leading to a 85% March 2013 target has been set. Please note revised April data.
3b	Non Elective MRSA Screening	%	70.3	64.1										Data represents actual screens matched to specific patients requiring screens. An improvement trajectory leading to a 85% March 2013 target has been set. Please note revised April data.
4	Single Sex Accommodation Breaches	Number	0	0										
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	8	7										
6	"Never Events" in month	Number	0	0										
7	CQC Conditions or Warning Notices	Number	0	0										
8	Open Central Alert System (CAS) Alerts	Number	20	19										
9	RED rated areas on your maternity dashboard?	Number	2	1										April data most recent - In-house comprehensive dashboard. Red area relates to workforce; midwifery vacancies.
10	Falls resulting in severe injury or death	Number	3	0										
11	Grade 3 or 4 pressure ulcers	Number	12	4										
12	100% compliance with WHO surgical checklist	Y/N	NO	NO										
13	Formal complaints received	Number	60	51										
14	Agency and bank spend as a % of turnover	%	3.94	2.61										
15	Sickness absence rate	%	4.06	4.51										

Board Statements

well & West Birmingham Hospitals NHS

May 2012

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓

If the Trust Board is unable to make the above statement, the Board must:

2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	
5	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	

	For SERVICE PERFORMANCE, that:	Response
6	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✓

	For RISK MANAGEMENT PROCESSES, that:	Response
7	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
8	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
9	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
10	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓
11	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✗

	For COMPLIANCE WITH THE NHS CONSTITUTION, that:	Response
12	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓

	For BOARD, ROLES, STRUCTURES AND CAPACITY, that:	*Response*
13	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
14	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
15	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
16	The management team have the capability and experience necessary to deliver the annual plan	✓
17	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO	**To be added**	**John Adler**	**28/06/2012**
Chair	**To be added**	**Richard Samuda**	**28/06/2012**

NHS Midlands and East Provider Management Regime

Ref	Area	Details
Thresh-olds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1	C.Diff	Performance against contract with main commissioner
2	MRSA	MRSA objective: those trusts which are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by DH. The SHA expects those NHS trusts without a centrally calculated MRSA objective to agree an MRSA target for 2011/12 that at least maintains existing performance. Where a trust has an annual MRSA objective of six cases or fewer and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of the SHA's Provider Management Regime If a trust with an annual objective of six cases or fewer declares a risk of exceeding the de minimis level and its annual MRSA objective in-year, but has not yet done so, it will be required to [provide, and then] report monthly against, an MRSA action plan until the risk has been satisfactorily addressed.
3	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter.
4	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants, including consultant upgrades. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. For patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided there is written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA.
5a&b	RTT	While performance is measured on an aggregate basis, NHS trusts are required to meet the threshold on a monthly basis – consequently failure in any month represents failure for the quarter and should be reported via the exception reporting process.
6	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter.
7	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional). Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
8a	A&E (Q1)	In Quarter one - 95th percentile waits for 4 hours or less to be used
8b	A&E (Q2)	From Quarter two: • 95th percentile waits for 4 hours or less to be used • Time to initial assessment: for ambulance arrivals. Initial assessment to include a pain score and early warning score. • Time to treatment decision: time from arrival to see a decision-making clinician (defining management plan and may potentially discharge the • Unplanned reattendance rate: within 7 days of original attendance. Includes patients referred back by another health professional. The SHA will not score this for paediatric specialist NHS trusts. • Left without being seen The SHA will keep these measures under review during 2011/12 and may change its implementation in line with national policy.
9	Stroke	The SHA will consider its introduction during 2011/12 following publication of DH's technical guidance.
10	Mental Health: CPA	7-day follow up: **Numerator**: The number of people under adult mental illness specialties on Care Programme Approach who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on Care Programme Approach who were discharged from psychiatric inpatient care. Contact can include face-to-face or telephone contact. Guidance on what should and should not be counted when calculating the achievement of this target can be found on Unify2. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** The number of adults in the denominator who have had at least one formal review in the last 12 months. Date last seen by care coordinator will be used as a proxy for formal Care Programme Approach review during 2011/12. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach at any point during the reporting period. For full details of the changes to the Care Programme Approach process, please see the implementation guidance, Refocusing the Care Programme Approach on the Department of Health's website. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: • patients who die within seven days of discharge; • where legal precedence has forced the removal of a patient from the country; or • patients discharged to another NHS psychiatric inpatient ward.
11	Mental Health: DTOC	**Numerator:** The number of non-acute patients (aged 18 and over) whose transfer of care was delayed averaged over the quarter. **Denominator:** Number of non-acute patients (aged 18 and over) admitted to the trust, summed across the quarter. Delayed transfers of care attributable to social care are excluded.
12	Mental Health: I/P and CRHT	This indicator applies only to admissions to the NHS trust's mental health psychiatric inpatient care. The following cases can be excluded: • admissions to psychiatric intensive care units; • internal transfers of service users between wards in a trust and transfers from other trusts; • patients recalled on Community Treatment Orders; or • patients on leave under Section 17 of the Mental Health Act 1983. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in Guidance Statement on Fidelity and Best Practice for Crisis Services the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven day a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face to face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team
13	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
14	Mental Health: MDS	Patient identity data completeness metrics (from Mental Health Minimum Data Set) to consist of: • NHS number; • Date of birth; • Postcode (normal residence); • Current gender; • Registered General Medical; • Practice organisation code; and • Commissioner organisation code. Numerator: count of valid entries for each data item above. NB For details of how data items are classified as VALID please visit the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq Denominator: total number of entries.
15	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** The number of adults in the denominator in paid employment (i.e. those recorded as 'employed') at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • In settled accommodation: **Numerator:** The number of adults in the denominator who were in settled accommodation at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • Having an HoNOS assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. NOTE: When implemented MHMDS v4 will allow services to report all HoNOS variants, including those for young people and people in secure services. Until this time trusts should report standard HoNOS inclusive of all ages and ward types. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach during the reference period.
16a	Ambulance Cat A	Life threatening
17 a) b) c) d) e) f)	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (2008): a) Does the NHS trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the NHS trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria?: • treatment options; • complaints procedures; and • appointments. c) Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the NHS trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: Boards are required to certify that their trusts meet requirements a to f above at the annual plan and in each quarter. Failure to do so will result in the application of the service performance score for this indicator.
18	DTCs	Performance against contract with main commissioner
19	GUM Access	Access to GUM within 48hours against a target of 95% compliance.
20	Chlamydia Screening	Performance against contract with main commissioner
21	Smoking Quitters	Performance against contract with main commissioner
22	6 Wk Wait Diagnostics	Access to diagnostics against a target of 100% compliance
23	New birth visits	Performance against contract with main commissioner
24	HPV	Human Papillomavirus (HPV) uptake Performance against contract with main commissioner
25	Comm'ty Equip Store	Responses within 7 days
26 a	Urgent DN	Response by a DN within 24 hours of receiving an urgent request / referral
26 b	Non-Urgent DN	Response by a DN within 48 hours of receiving a non-urgent request / referral

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Transformation Plan update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Paul Crabtree – Transformation Plan Advisor**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

The attached slides are intended to update the Trust Board on the following areas:

1. **Bed Reconfiguration Plan**

The Trust has a bed configuration plan to reduce length of stay and redesign patient pathways. This will result in an overall bed reduction programme of 132 beds pan Trust. The length of stay reduction will take the Trust to upper quartile in length of stay performance. The initial plans were scheduled to commence at the end of Quarter 1. A number of factors have contributed to the slippage within the programme, namely;

- an increase in activity levels that has prevented the timely closure of the winter beds, a pre-requisite to further bed closures.
- unseasonal infection control issues that have resulted in ward closures during May and June.
- the complexity of the programme requires a number of divisional and corporate schemes to align. While this has been recognised, the programme structure put in place was not robust enough and did not have the level of dedicated divisional management team or TSO support to ensure delivery.

The bed configuration plans has been reviewed and a re-phasing of bed reductions is now planned over July – September. At the time of writing the financial slippage is being confirmed and will be reported in a separate paper to the Transformation Plan Steering Group.

A number of enabling projects exist both within the divisions and corporately to support the programme. These are:

- daily board rounds and senior reviews embedded as standard practice across all wards including robust weekend planning with a Saturday and Sunday model in place;
- daily discharge planning meeting happening where the emphasis is on facilitating safe discharge rather than bed capacity management;
- Job planning and on-call arrangements: From September onwards within Medicine Division there will be changes to job schedules for all consultants taking part in General Medicine on-call so that they can provide an extra 3 hours of work on Sat/Sun.
- Investment in ward leadership with new matron and ward leader structure in place by July.

For each of the defined phases there is a requirement that the clinical model is reviewed to ensure safe care continues to be provided within the new bed configuration.

The risks identified at programme level include:

- Capacity and capability of the divisional leadership teams to support programme delivery
- Pan-divisional schemes are more challenging

- Ability to reconfigure pathways internally and to secure external support as and when required
- External engagement with regard to the T&O reconfiguration
- Potential increase in A&E attendances and impact on non-elective profile
- Unforeseen operational issues
- Delivery of capital schemes

Governance of this programme is strengthened by increased Transformation Advisor capacity which has been allocated to this change programme. This will ensure robust project delivery through a weekly project meeting using visual management via a bed configuration dashboard which tracks a weekly profile of configuration activity. This project meeting will report to the fortnightly Transformation Plan Steering Group

2. TPRS reporting through COO meeting

The TPRS weekly reporting to the COO meeting has been refined. The first of the alternate meetings cover a TPRS Trust overview of generic issues, which the group work through mitigation and enabling solutions. The second week a detailed review of line by line exceptions for divisions is completed with actions recorded and followed up with project leads. Exception reports will be reported to the TPSG.

3. KPI development

Work is near completion on KPI reporting for the transformation plan. The TPSG have approved the approach presented in the slide pack of a KPI hierarchy. This has a full suite of KPI at project level which will inform a primary KPI scorecard for the TPSG. These will be reviewed on a monthly basis and will go live from 29th June.

Abbreviations:
TP – Transformation Plan
TSP - Transformation Savings Plan
TPRS - Transformation Plan Reporting System
TPSG – Transformation Plan Steering Group

REPORT RECOMMENDATION:

None.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	**x**	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical		Equality and Diversity		Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Delivery of the Transformation Plan

PREVIOUS CONSIDERATION:

Material presented to Transformation Plan Steering Group and Trust Management Board

Transformation Plan

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Transformation Plan update

1. Bed reconfiguration plan
2. TPRS reporting through COO
3. Development of TP KPIs

Paul Crabtree – June 2012

Revised Bed Reconfiguration Programme
(See attached paper for detail)

Revised Bed Reduction Numbers (cumulative)

Divisions	4th Jun	2nd Jul	6th Aug	3rd Sep	30th Sep
Medicine	4	39	76	94	98
Surgery A	2	7	16	34	34
TOTAL	6	46	92	128	132

Reasons for timeline slippage

1. Increase in activity
2. Unseasonal infection control issues
3. Complexity of the programme – governance not robust enough

Financial Implications of timeline slippage to be confirmed

Divisions	Non-recurrent	Recurrent	TOTAL
Medicine			TBC
Surgery A			TBC
Therapies			TBC
Facilities			TBC
Estates Rationalisation			TBC
TOTAL			TBC

Non-recurrent element

- Timeline slippage

Recurrent element

- Original assumptions in staffing model overestimated the potential release of posts

Key Risks – Bed Numbers

Pan-divisional schemes

- Gastro/GI
- City EAU model

Bed reconfiguration - dashboard

Ward	Division	Site	Change	Speciality 31-Mar-1	31-Mar-12	14-May-12	21-May-12	28-May-12	04-Jun-1
MAU	Medicine	City	No	Acute Med	28	28	28	28	28
D5	Medicine	City	No	Cardiology	17	17	17	17	17
D7	Medicine	City	Yes	Acute Med (Female)	15	15	20	15	19
D11	Medicine	City	Yes	Acute Stroke/Neuro	21	21	21	21	20
D12	Medicine	City	No	Isolation	10	10	10	10	10
D15	Medicine	City	No	Resp/Gastro	24	24	24	24	24
D16	Medicine	City	No	Elderly (F)	23	23	23	23	23
D17	Medicine	City	No	Respitory/Gastro (F)	26	26	26	26	26
D18	Medicine	City	No	Elderly (M)	16	16	16	16	16
D20	Medicine	City	Yes	N/A	0	0	0	0	0
D41	Medicine	City	Yes	Acute Med (Male)	17	17	17	17	17
D43	Medicine	City	Close	Stroke/Neuro Rehab	28	28	28	28	28
				Geriatric Rehab					

TPRS reporting in COO meeting

COO TPRS reporting process

Reporting cycle

Ensures we are addressing the generic big concerns

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
TPRS status overview		All		All		All		All
Detail review of RED items	Medicine Surgery A Imaging Pathology		Surgery B W&C Community		Medicine Surgery A Imaging Pathology		Surgery B W&C Community	

Ensures we are keeping TPRS up to date and hence reporting accurately

Last week's meeting

Meeting details:

- **Wednesdays 10-11 (followed by other COO meeting content from 11:00)**
- **For detail review sessions, only identified divisions need attend**

COO TPRS reporting process

Detail review of red items

Real time actions agreed and issued to DGM to feed into divisional meetings

COO TPRS Reporting process

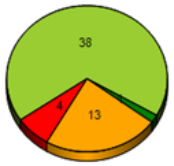
Detail Review of Red items

Transformation Plan

ON TRACK | COMPLETE | OBJECTIVE | SOME DELAYS/CONCERNS | NOT YET STARTED | SIGNIFICANT DELAYS | CLOSED/REPLACED

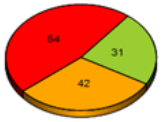
Project Status

Medicine and Emergency Care



Project Milestones

Medicine and Emergency Care



Outstanding Milestones and Projects with severe delays will appear below:
Colour of Project code determined by division, milestone determined by system.

Go Back to Menu

Project	Project Description	Planned	Actual YTD	Project Lead	Objective	Milestone	Progress	Last Week	Due	04-2012	05-2012	06-2012	09-2012	ACTIONS
ME001	MED001-Targeted Redundancy / VR/ vacancy freeze within Division	105	0	M Dodd	Target Redundancy	Identify Further Posts to be removed	Work on identifying additional posts is ongoing, however posts	- - - - - - -	30-Apr	No				Still working to identify additional posts due to athers being used for slippage. Target to identify by mid July
						Costs for staff CR		- - - - - - -	31-May		No			
ME002	MED002-Restructure Admin management	22.485	0	H Jenkinson/	Restructure Admin management cross site	Consultation	staff at riks have are being consulted in line	- - - - - - -	30-May		No			Been to PPAC 2 weeks ago. Letters to be
ME007	MED007-Review Cardiology technicians on call	17.5	0	D Sadhra	Review Cardiology technicians on call	Consultation	On-Going discussions. Should be finished end	- - - - - - -	30-Apr	No				Target end June
						Revised Rotas Developed		- - - - - - -	31-May		No			Target end June
ME010	MED010-Closure of the Day Hospital at RRH	126.725	0	Anne OLeary	Closure of Rowley Regis Day Hospital	Set up Steering group, Sign off project plan, Identify services that can transfer	Updated by Anne O'Leary. 16 May 2012. Waiting written	- - - - - - -	30-Apr	No				Planning done and services identified. Write paper for JA to approve moving forward
						Write to Commissioners	Anne O'Leary working	- - - - - - -	31-May		No			Complete when above milestone complete
ME011	MED011-Front door Reception staff -	20	0	K Lennon	Front door Reception staff - restructur	Agree new shift patterns	Costed. Await VR	- - - - - - -	31-May		No			Milestone complete but timing delayed and
ME012	MED012-Relocation of SCAT to main ward block	10.876	0	L Rea	Relocation of S		ks held with	- - - - - - -	30-Apr	No				Need to finalise staff reduction plan
							greed with Directorate	- - - - - - -	31-May		No			As above
ME013	MED013-Chemotherapy capacity review /rationalisation - note services will continue to be provided on both sites	16.667	0	L Rea	Chemotherapy		bjective revised hrough Exec Team - roposal that chemo at	- - - - - - -	30-Apr	No				Plans slipped - need to revise title to reflect latest project scope - confirm with MC.
						Agree revised working	Working with Pan	- - - - - - -	31-May		Yes			
						Implementation - 1st Step		- - - - - - -	30-Jun			No		
ME014	MED014-Revi of Neurophysiology technicians	22.5	0		of	Meet with HR and confirm if 24 hour retirement and	Band 7 post still in process of being	- - - - - - -	30-Apr	No				Needs closing down and identified replacement adding
						Take Paper to PPAC	Met with AB and MD.	- - - - - - -	31-May		No			As above
ME017	MED017-Renal - income for renal consultants doing Sandwell clinics for	12	0		or renal	Confirm agreement for		- - - - - - -	30-Apr	No				
					ion to cation		UHBFT have failed to attend x4 meetings that	- - - - - - -	31-May		No			Letter issues - need to add milestone ref actiual change.
ME018	MED018-Review Consultant PAs	32.083	0	L Rea	Review Consultant PAs	Directorate team to identify where PA's to be reduced, activity loss to be	Linked to the move to reduce activity for diabetes - awaiting	- - - - - - -	30-Apr	No				Paper to JA to get approval to proceed. However this does not directly link to PA

Overall status

Red (late) milestones

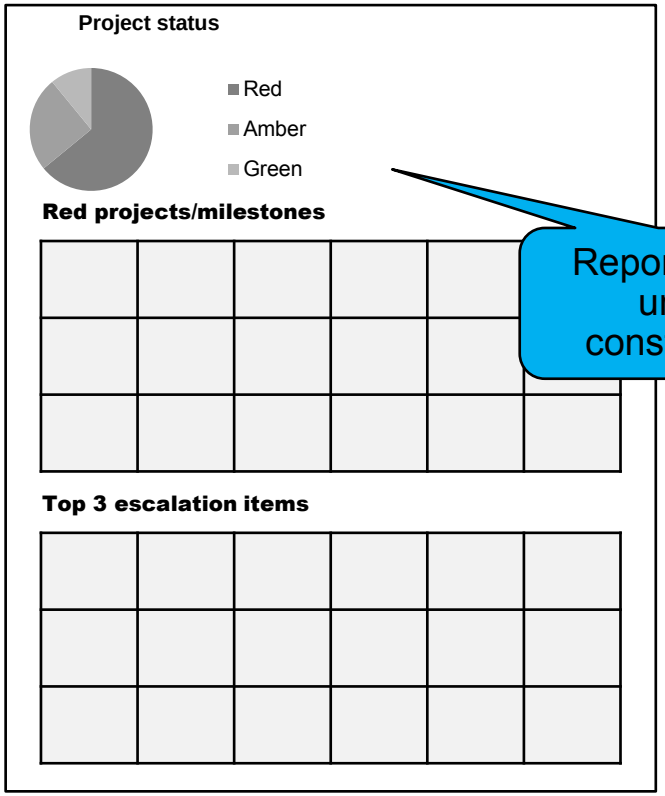
Red rated projects

Focus points:

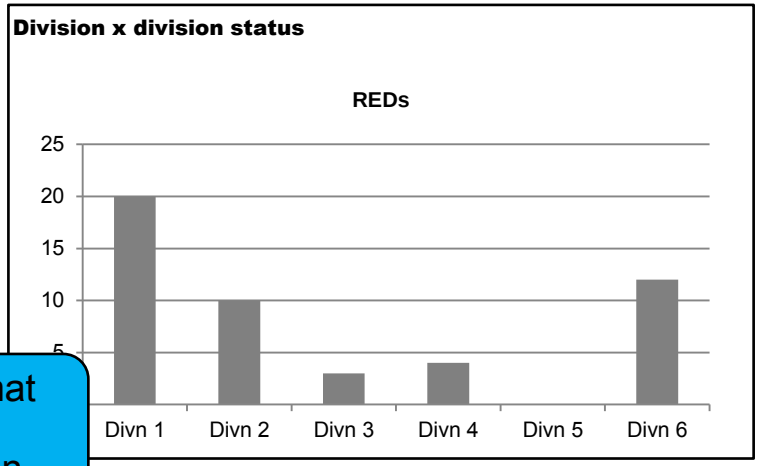
- **Review of all items rated red**

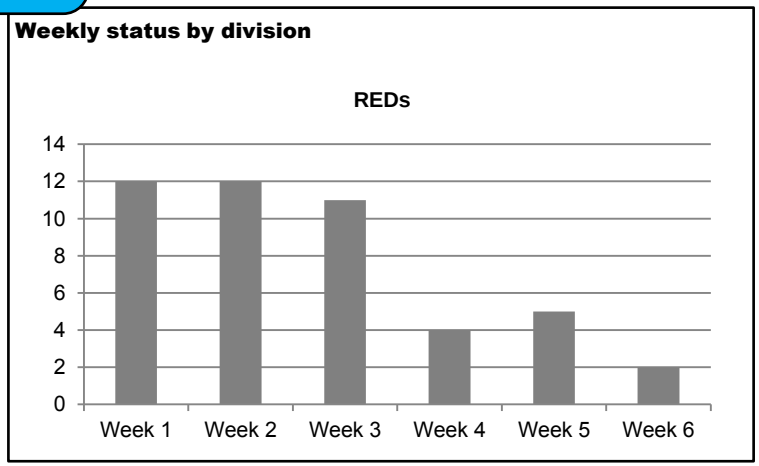
COO TPRS reporting process

TPRS status overview



Report format under construction





Focus points:

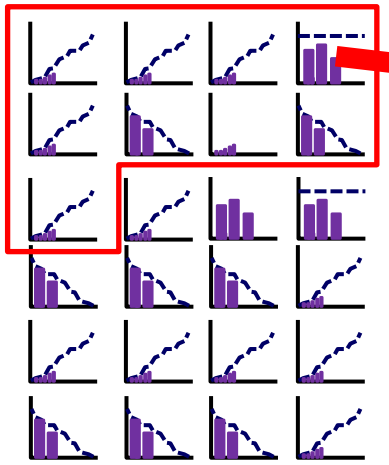
- **Divisional escalation points of concerns / share**
- **Division by division status and how each division is managing projects and milestones**

Transformation Plan KPI development

KPI hierarchy

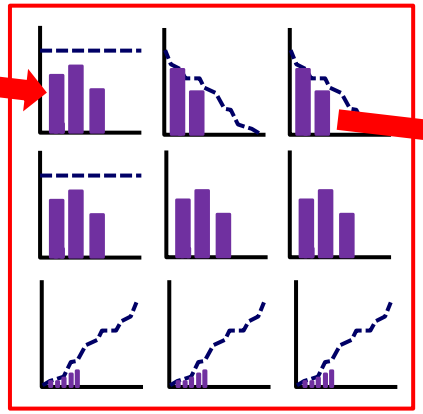
Fortnightly workstream steering

Full KPI suite covering all aspects of projects



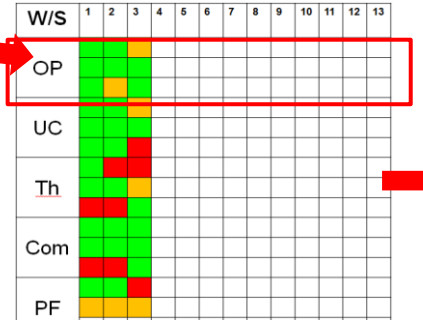
Weekly Friday TSO reporting meeting

Primary workstream KPIs



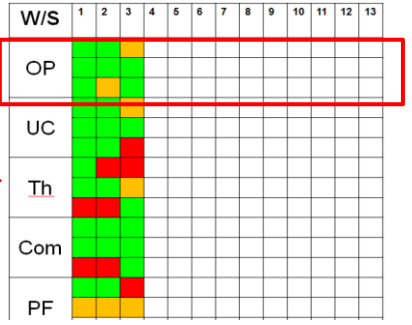
Fortnightly TPSG

TPSG scorecard



Trust Board

TPSG scorecard



KPI type

Inputs	Process	Outputs
Internal & external factors having impact on overall activity	Measuring the transformation activity	Measuring the results
Eg	Eg	Eg
Referral rates	Cohort roll outs	Bed reduction
A&E attendances	MDT roll out to wards	PA reduction
Admission rates	Consolidating contact #s	Length of stay

Balance measures

Monitor KPIs to measure un-intended affects of activity

Eg

Infection rates

Re-admissions

Slips & falls

KPI schedule

1. KPI format

i.	Agree method	15th June
ii.	Define standardised format	15th June

2. Identify required KPIs

i.	Clinical input	21st June
ii.	Agreed with workstream steering group	21st June
iii.	Identified data source	25th June

3. Develop KPI reports

i.	Review in workstream steering group	28th June
ii.	Review scorecard in TPSG	28th June

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Communications and Engagement Strategy 2012-2017**
SPONSOR (EXECUTIVE DIRECTOR):	**Jessamy Kinghorn, Head of Communications and Engagement**
AUTHOR:	**Jessamy Kinghorn, Head of Communications and Engagement**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

The Trust's communications and engagement strategy ran from 2009-2012 and has been reviewed over the last few months. A new communications and engagement strategy has been developed for 2012-2017 and is presented for discussion and approval. It has previously been discussed on two occasions by the Organisational Development Steering Group.

In summary, the strategy is to:

- Listen
- Involve
- Act
- Engage

Four key priorities sit beneath each of these aims, along with high level actions and expected outputs.

The Trust's principles, roles and responsibilities and governance for communication and engagement are also outlined in the strategy.

A draft SWOT (strengths, weaknesses, opportunities, threats) analysis is also included for reference.

REPORT RECOMMENDATION:

The Trust Board is asked to discuss and approve the strategy.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	x
Business and market share	**x**	Legal & Policy	x	Patient Experience	x
Clinical		Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

- Supports delivery of all priorities, particularly delivery of the Quality and Safety Strategy, Transformation Plan, and Foundation Trust application
- NHSLA – Patient Information
- CQC Standards - Supports delivery of Quality Objectives

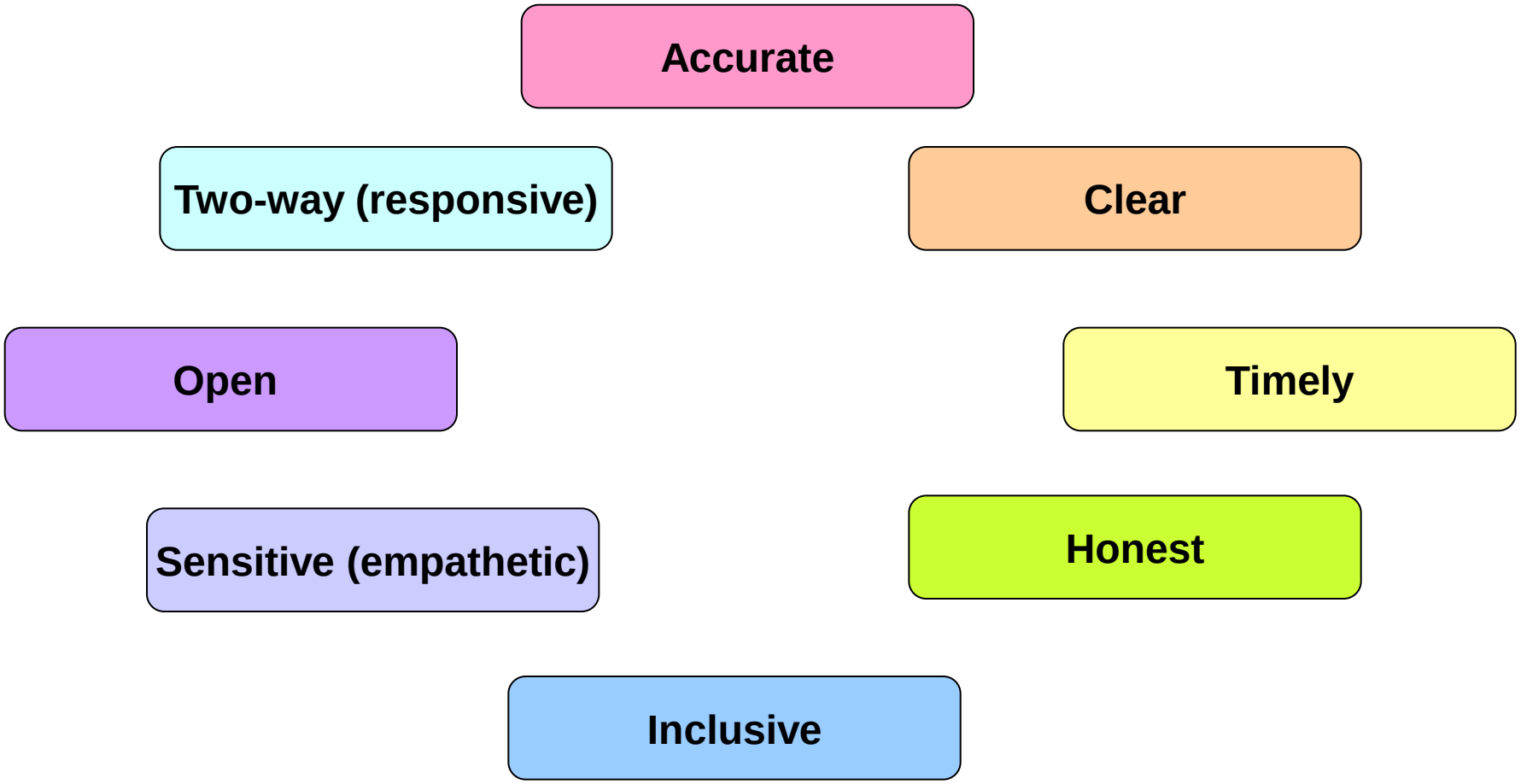
PREVIOUS CONSIDERATION:
OD Steering Group – March 2012, April 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

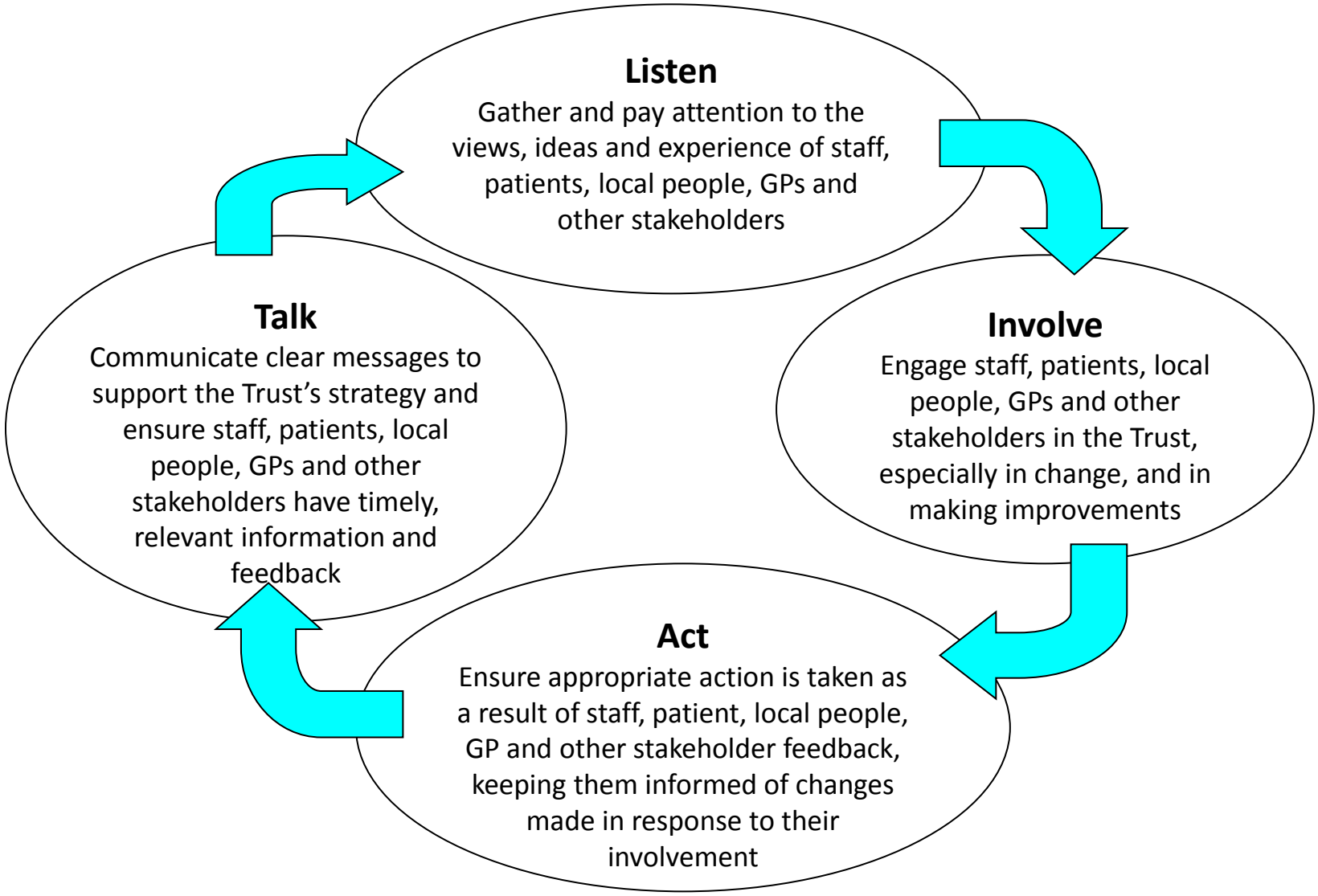
Listen, Involve, Act, Talk

A strategy for communications and engagement 2012-2017

Principles of communication and engagement



Purpose of the strategy



Our strategy is to:

Listen

- ✓ **Routinely listen to the views of our patients, staff, stakeholders and local people**
- ✓ **Establish effective systems for engaging with patients and the public**
- ✓ **Ensure local people, staff and patients have a say in the development of our services and priorities**
- ✓ **Increase the visibility of senior managers**

Outputs over the life of the strategy:

Number of teams feeding back through Hot Topics	⇧ 25%
Proportion of staff who say their manager does not listen to staff about improving services	⇩ 5%
Survey inpatients, outpatients, A&E attendances, day case, maternity, children's and parents of neonatal babies	⇧ 10% of all
Proportion of staff who say their immediate manager is accessible, approachable and visible to staff and patients	⇧ 6%

Our strategy is to:

Involve

- ✓ **Engage frontline staff in service improvement, redesign and the delivery of the transformation plan**
- ✓ **Expand the range of opportunities for staff engagement**
- ✓ **Involve public and patients in the activities of the Trust**
- ✓ **Involve patients and their carers in their care and treatment**

Outputs over the life of the strategy:

Proportion of staff who think senior managers want staff to be involved in the way the Trust is run	↑ 8%
Number of staff attending an LiA event relating to their own area	↑ 8%
Proportion of patients who said they were definitely involved in decisions about their care and treatment	↑ 5%-8%
Number of members using 'Engage'	↑ 3,000

Our strategy is to:

Act

- ✓ **Become more firmly established as an integral member of the local community**
- ✓ **Raise funds for the Trust through the involvement of staff, patients and local people**
- ✓ **Improve staff attitude and customer care through embedding the Customer Care Promises**
- ✓ **Provide effective feedback to patients, local people and staff**

Outputs over the life of the strategy:

Membership demographics reflective of the local community	⇨
Proportion of staff in the staff survey who believe senior management builds strong, positive relationships with the community	⇧ 6%
Proportion of inpatients who say that doctors and nurses never talked in front of them as if they weren't there	⇧ 7%-17%
Proportion of staff who have seen or heard about improvements for patients following staff engagement	⇧ 7%

Our strategy is to:

Talk

- ✓ **Effectively promote the Trust's services**
- ✓ **Manage the reputation and promote the strategy of the Trust**
- ✓ **Raise the profile of quality**
- ✓ **Meet the information requirements of patients, carers and staff**

Outputs over the life of the strategy:

Conversion rate of press releases and positive enquiries to positive news coverage	↑ 25%
Proportion of staff who say management sets out a clear vision for the organisation	↓ 8%-11%
Proportion of staff who have seen or heard about improvements for patients following staff engagement	↑ 7%
Increased proportion of staff reporting patient care as our top priority	↑ 7%
Provision of patient information	↑ Top 20%
Staff reporting good communication	↑ Best
Increased Net Promoter score year on year in all areas	↑

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Listen, Involve, Act, Talk

A strategy for communications and engagement 2012-2017

1.0 Context

Sandwell and West Birmingham Hospitals NHS Trust is a large teaching Trust providing the full range of hospital services to patients in Birmingham and Sandwell from two main hospitals and two community hospital sites, as well as adult and child health services to patients in Sandwell. The Trust has an income of £423 million and employs around 7000 WTE staff. It has about 900 beds and serves a population of over 500,000.

The Trust has been in the top 20% of trusts in the country for staff communication scores for the last few years, according to the national staff survey. In 2011, the national average for staff reporting good communication between senior management and staff was 26% with most trusts scoring between 21% and 31%. However, 40% of staff at Sandwell and West Birmingham Hospitals NHS Trust reported good communication, the highest score of any acute trust in the West Midlands. The best performing Trust in England scored 42%. The lowest score nationally was 8%.

The Trust is a leader in NHS employee engagement with its staff engagement model – Listening into Action – increasingly adopted across the country.

Genuine involvement of patients and local people is very important to the Trust. An active 'membership' of 7,500 local people has been actively running since 2008, even though the Trust does not plan to become an NHS Foundation Trust until 2014.

Sandwell and West Birmingham Hospitals NHS Trust enjoys good relationships with local media, through taking an open and responsive approach to press enquiries.

The Trust is one of a relatively small number of NHS Trusts to achieve the Information Standard, a scheme for health and social care information promoted by the Department of Health, whereby organisations provide assurance that their internal processes for producing reliable patient information are 'fit for purpose.'

The Vision for the Trust is:

"We will help improve the health and well-being of people in Sandwell, western Birmingham and surrounding areas, working with our partners to provide the highest quality healthcare in hospital and closer to home."

Six strategic objectives are designed to ensure we make progress towards the successful delivery of the vision:

- Accessible and Responsive Care
- Safe, High Quality Care
- Care Closer to Home
- Good Use of Resources
- 21st Century Facilities
- An Engaged, Effective Organisation

In 2008 the Trust Board agreed five sets of values to underpin activity at the Trust:

- Caring and Compassionate
- Open and Accountable
- Accessible and Responsive
- Professional and Knowledgeable
- Engaging and Empowering

Effective communication and engagement is essential to living these values.

Sandwell and West Birmingham Hospitals NHS Trust has placed quality and safety at the centre of its agenda and has an ambitious Transformation Plan to change the way services are run, improve their quality and become more efficient. There is also a significant amount of service reconfiguration underway.

There are a number of 'internal' factors driving the Trust's communications and engagement strategy, including:

- The extent of transformational change underway and the importance of involving and informing staff
- The need to ensure good quality internal communications to enable staff to carry out their duties effectively, meet targets and ensure a safe, responsive service for patients
- The need to ensure all staff are sufficiently focused on quality in order to meet internal and external quality expectations
- The NHS Foundation Trust application
- The Trust's part in the Right Care Right Here programme and the movement of patient activity out of hospital and into community or primary care
- The Trust Board's commitment to staff, patient and community communication and engagement

There are also a number of 'external' factors driving the Trust's communications and engagement strategy, including:

- The Trust has a legal duty to involve and consult with patients and local people.
- The new Health and Social Care Act sets out a new role for Healthwatch, which replaces the current LINk organisations, and increases the role of Governors, and therefore the influence of members, in NHS Foundation Trusts.
- The introduction of Clinical Commissioning Groups which changes the relationship between the Trust and local GPs
- The global economic position which has led to an end to the 'growth' of NHS budgets
- Patient choice gives patients and their GPs the option to 'shop around' for the best service, and with so many other providers close by, it is important patients and GPs know and understand what the Trust offers
- The introduction of 'Any Qualified Provider' which increases the potential number of organisations offering the same service to the same patients, and therefore increases the competition. It may also present marketing opportunities.
- A significant increase in the amount of 24 hour media and social media activity and in the use of social media by patients to influence patient choice

2.0 Our principles of communication and engagement:

Eight principles of communication and engagement were approved by the Trust Board in March 2009. They build on the Trust's values and underpin communications and engagement at the Trust. They are:

Principle	What this means
Two-way (responsive)	• We will listen and act on feedback • We will give people the opportunity to ask questions • We will encourage communications that starts at the front line
Accurate	• We will ensure our communication with staff, patients, stakeholders and local people is correct • Spelling and grammar will be of high quality
Clear	• Our communications will be clear, simple and consistent • Communications will be to Plain English standards • Our standard font will be Arial, size 12 for most documents, size 14 for publications intended for patients and local people - we will not use small or hard-to-read fonts • We will produce large-print documents when appropriate • Handwritten correspondence will be legible • We will avoid information overload • We will consider the impact of our body language on communication
Open	• We will use the most appropriate form of communications, including face to face communication and engagement whenever possible • We will reinforce messages using a range of communication channels • We will be prepared to engage about all aspects of the Trust
Honest	• Our communications will be honest and factual • We will own up to mistakes and offer appropriate apologies • We will not mislead our audiences • We will be up front about the influence people can have when we ask their views
Timely	• Our communications will be prompt • Engagement will take place as early in the process as possible
Sensitive (empathetic)	• We will try to put ourselves in the position of those we are communicating with and treat people how we would like to be treated • We will aim to be reassuring • We will respect the views, opinions and rights of others • We will treat others with dignity
Inclusive	• We will make appropriate efforts to include staff, patients and local people who may otherwise be excluded • We will encourage involvement • We will consider the needs and views of under represented groups

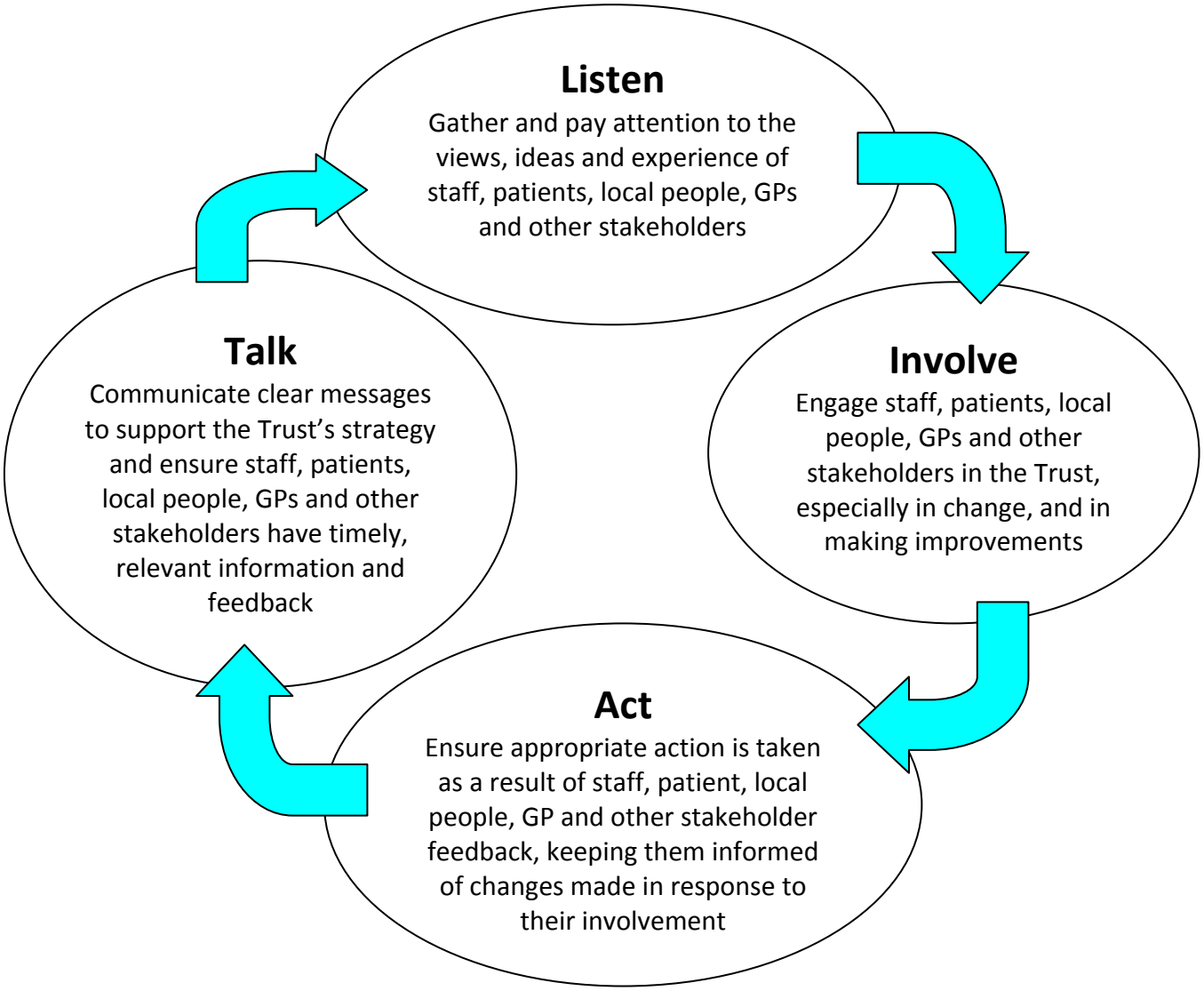
3.0 Purpose of the Trust's Communications and Engagement Strategy

The purpose of the Trust's communications and engagement strategy is to set out an approach to communicating clearly about the business of the Trust to all audiences, listening to them and engaging and involving them in improving the Trust.

In effect it is a continuous cycle of:

- What do you think / want to know?
- This is what I want / need to tell you
- Now join me in planning what we need to do
- Help me do it

This can be paraphrased as 'Listen, Talk, Involve, Act, Listen, Talk, Involve, Act, Listen, Talk, Involve, Act....'



The strategy sets out a range of long term aims, shorter term actions actions and measures designed to achieve this, continuing to improve staff, patient, public and stakeholder communication and engagement and deliver more effective change and greater patient and staff satisfaction. The next section describes the detail of this.

4.0 Our strategy for communications and engagement between 2012 and 2017 is to:

Listen

Routinely listen to the views of our patients, staff, stakeholders and local people

This means that when we have completed implementation of the strategy, we will:

- Have comprehensive systems in place to capture the views of at least 10% of our patients
- Fully analyse those views and regularly report them to local managers and the Trust Board
- Increase the numbers of staff involved with Listening into Action and teams regularly providing feedback on key issues

To that end, in 2012/13 we will:

- Introduce regular patient surveys into A&E and outpatients
- Incorporate Hot Topics data into the leadership dashboard
- Roll out Owning the Future to the Imaging and Surgery B divisions

Establish effective systems for engaging with patients and the public

This means that when we have completed implementation of the strategy, we will:

- Have systems in place to capture patient and public involvement activity in every area of the Trust, including processes to capture the views of communities that are seldom heard
- Run an active membership with a clear ways for members to become involved with and provide feedback, effective roles for public Governors and good communication between Governors and members
- Have well established online systems to engage patients and local people

To that end, in 2012/13 we will:

- Produce a toolkit for effective patient and public engagement
- Develop our plans for the role of Governor
- Launch 'engage' – an online 'virtual membership' for local people and staff to engage with the Trust

Ensure local people, staff and patients have a say in the development of our services and priorities

This means that when we have completed implementation of the strategy, we will:

- Have embedded systems to involve members and Governors in setting our annual and quality priorities
- Be able to demonstrate high levels of patient engagement in service change, providing assurance to NCAT review teams and Overview & Scrutiny Committees that patients and local people have been listened to
- Routinely engage staff in service and priority development

To that end, in 2012/13 we will:

- Deliver engagement plans in stroke, orthopaedics, vascular, diabetes, trauma and breast services

Increase the visibility of senior managers

This means that when we have completed implementation of the strategy, we will:

- Have embedded senior staff participation in the back to the floor programme
- Improve communication and engagement in the areas where management visibility and communication are poorest, reinforcing the importance of visibility of senior managers through leadership development

To that end, in 2012/13 we will:

- Review key messages issued to new staff at induction

Over the life of the strategy, examples of the measurable outputs we aim to see are:

- A 25% increase in teams feeding back through Hot Topics
- A reduction in the proportion of staff who say their manager does not listen to staff about improving services to 2% (currently 7%)
- Survey analysis of at least 10% of all inpatients, outpatients, A&E attendances, day case, maternity, children's and parents of neonatal babies (currently only achieving this for inpatients)
- An increase in the proportion of staff who say their immediate manager is accessible, approachable and visible to staff and patients to 75% (currently 69%)

Involve

Engage frontline staff in service improvement, redesign and the delivery of the transformation plan

This means that when we have completed implementation of the strategy, we will:

- Achieve high levels of staff engagement involvement in the delivery of the Transformation Plan
- Have delivered communications plans to support the Transformation Plan, with effective methods to measure the levels of staff engagement with the Transformation Plan, such as pulse checks and surveys
- Have systems to ensure staff engagement techniques are used in all service change and reconfiguration

To that end, in 2012/13 we will:

- Deliver the actions in the Transformation Plan communications and engagement plan
- Ensure frontline staff are involved in the development of plans for estates rationalisation, stroke, orthopaedics, vascular, diabetes, trauma and breast services

Expand the range of opportunities for staff engagement

This means that when we have completed implementation of the strategy, we will:

- Run Owning the Future across the Trust (subject to ongoing evaluation), creating a strong link between Governors and Ambassadors and implementing Governor and Ambassador development programmes
- Have well-established, measured and effective links between Staff Governors and frontline staff
- Have increased the number of engagement champions within the Trust
- Have delivered and monitored a programme of events to ensure staff engagement activities are visible and accessible to all staff

To that end, in 2012/13 we will:

- Roll out Owning the Future to the Imaging and Surgery B divisions
- Establish the new Engagement Sponsor Group
- Develop our plans for the role of staff Governor and their link with Ambassadors and staff

Involve public and patients in the activities of the Trust

This means that when we have completed implementation of the strategy, we will:

- Demonstrate effective participation of local people in Trust activities through online involvement
- Show successful delivery of the membership strategy, continuing to maintain a membership that is reflective of our local communities, and increasing opportunities for member involvement and influence that are relevant to members in terms of interest, age, gender, ethnicity and geography
- Capture all member and patient involvement activities within the Trust in a programme of events that is accessible to patients and local people, from all communities and walks of life

To that end, in 2012/13 we will:

- Launch the 'Engage' website
- Review the membership strategy and publish the member calendar of activities widely

Involve patients and their carers in their care and treatment

This means that when we have completed implementation of the strategy, we will:

- Be able to demonstrate patient and carer involvement in improving the acute/community pathway
- Have raised awareness of staff of the importance of involving patients and their carers in their treatment
- Routinely use patient feedback as a key component of Table Top Reviews

To that end, in 2012/13 we will:

- Examine how patient involvement could be incorporated in clinical leadership development programmes
- Consider inviting patients to Table Top Reviews

Over the life of the strategy, examples of the measurable outputs we aim to see are:

- An increase from 44% to over 52% in the proportion of staff who think that senior managers want staff to be involved in the way the Trust is run (2011 staff survey)
- Over half of all staff attending an LiA event relating to their own area (currently 42%)
- Over 3,000 members using 'Engage'
- An increase in the proportion of patients who said they were definitely involved in decisions about their care and treatment from 54% to 62% (inpatient survey) and from 70% to over 75% (outpatient survey)

Act

Become more firmly established as an integral member of the local community

This means that when we have completed implementation of the strategy, we will:

- Be able to demonstrate actions taken in response to member feedback on services and priorities
- Have undertaken a wide range of activities to educate local young people in healthcare related careers and provide opportunities for local people to gain experience that will help them find work
- Have developed the role of volunteers in the Trust and introduced volunteer surveys
- Have improved our approach to health promotion, working with the community to promote healthy lifestyles and involving local people in addressing health inequalities

To that end, in 2012/13 we will:

- Agree a health promotion strategy
- Develop and promote the Learning Hub
- Organise a health promotion community event to coincide with the Olympic Torch passing City Hospital

Raise funds for the Trust through the involvement of staff, patients and local people

This means that when we have completed implementation of the strategy, we will:

- Be more effective in fundraising through the implementation of an effective fundraising strategy
- Have in place a fundraising function providing support to staff and local people raising funds
- Have increased the use of charitable funds by frontline staff for improving the patient experience

To that end, in 2012/13 we will:

- Establish a fundraising function and develop and approve a fundraising strategy

Improve staff attitude and customer care through embedding the Customer Care Promises

This means that when we have completed implementation of the strategy, we will:

- Have delivered the Customer Care Promise Action Plan
- Publish current patient story sections for every service and ward on the Trust website with statements from clinical leaders in those areas
- Have raised the awareness of staff of the importance of good communication

To that end, in 2012/13 we will:

- Review the Customer Care Action Plan
- Begin to gather specialty and ward patient stories and publish on the Trust website (aim for 20)

Provide effective feedback to patients, local people and staff

This means that when we have completed implementation of the strategy, we will:

- Regularly provide feedback through the 'speak out' campaign, member newsletter and other publications
- Have improved the use of the internet (i.e. the Trust website, Engage, NHS Choices, and Patient Opinion) as mechanisms for providing timely feedback to patients and members of the public
- Have developed and implemented a recognition strategy outlining an approach to rewards and incentives
- Have continued to implement Your Right To Be Heard, feedback actions arising through Hot Topics and launched staff forums on a new intranet system

To that end, in 2012/13 we will:

- Review and promote the Speak Out Campaign, linking it to the 'Engage' website
- Review our presence on the Patient Opinion website
- Develop a recognition strategy

Over the life of the strategy, examples of the measurable outputs we aim to see are:

- Membership demographics reflective of the local community
- An increase to 45% in the proportion of staff in the staff survey who believe senior management builds strong, positive relationships with the community (currently 39% - 'national' average is 29%)
- The proportion of inpatients who say that doctors and nurses never talked in front of them as if they weren't there increased to 85% (currently 78% nurses, 68% doctors)
- Proportion of staff who have seen or heard about improvements for patients following staff engagement increased from 43% to over 50% (excluding those who think improvements will not happen)

Talk

Effectively promote the Trust's services

This means that when we have completed implementation of the strategy, we will:

- Demonstrate delivery of reconfiguration marketing plans to help mitigate the impact of any catchment loss
- Have developed marketing plans for all directorates and community services
- Have increased the quality of proactive media coverage
- Have effective systems to ensure accurate, timely information is routinely published on relevant websites

To that end, in 2012/13 we will:

- Deliver a marketing plan for maternity
- Develop communication and marketing plans for stroke, vascular, and trauma and orthopaedics
- Create website profiles for each Trust specialty and community service

Manage the reputation and promote the strategy of the Trust

This means that when we have completed implementation of the strategy, we will:

- Have improved awareness of the Trust's strategy and values
- Be able to show a consistently good relationship with local media through media reputation audits
- Have implemented a long term stakeholder communications plan
- Have developed and implemented a proactive social media strategy

To that end, in 2012/13 we will:

- Run a media training course for key Directors and deputies not yet media trained
- Conduct a media reputation audit
- Develop a social media strategy
- Promote the Trust's strategy, vision and values through a range of activities

Raise the profile of quality

This means that when we have completed implementation of the strategy, we will:

- Have delivered a range of ongoing activities to increase staff understanding of important quality matters, including the Trust's quality and safety strategy and objectives, performance against quality measures, risk assessment, whistleblowing, CQC standards, training and appraisal, and monitoring of establishments
- Have systems to ensure feedback from Board Safety Walkabouts, lessons learned and quality outcomes is routinely shared across the Trust, raising awareness of the Board's commitment to quality

To that end, in 2012/13 we will:

- Feature risk assessment prominently in Heartbeat
- Run a campaign to promote the CQC standards

Meet the information requirements of patients, carers and staff

This means that when we have completed implementation of the strategy, we will:

- Have developed comprehensive patient information, meeting the needs of patients with learning disabilities
- Maintain NHSLA standards for information and consent and the Information Standard
- Have robust governance systems in place to ensure high quality website information
- Have improved internal communications across the Trust, including in the event of major incidents

To that end, in 2012/13 we will:

- Review the information available for patients with learning disabilities
- Develop a Surgery B Communications Plan to improve staff communication and engagement
- Promote the Trust's quality and safety objectives

Over the life of the strategy, examples of the measurable outputs we aim to see are:

- 25% increased conversion rate of press releases and positive enquiries to positive news coverage
- Increased proportion of staff who say management sets out a clear vision for the organisation from 57% to 65% (staff survey), ensuring at least 50% in each division agree (2011 lowest is 39%)
- Increased proportion of staff reporting patient care as our top priority from 68% to 75% (staff survey)
- Being rated within the top 20% of trusts on all questions on the provision of information (inpatient survey)
- Achieving the highest rate in England for staff reporting good communication
- Increased Net Promoter score year on year in all areas

5.0 These aims support our strategic objectives:

	Accessible and Responsive Care	Safe, High Quality Care	Care Closer to Home	Good Use of Resources	21st Century Facilities	An Engaged, Effective Organisation
Listen						
To listen to the views of our patients, staff, stakeholders and local people	✓	✓		✓		★
Establish effective systems for patient and public engagement	✓					★
Ensure local people, staff and patients have a say in the development of our services and priorities	★	✓				✓
Increase the visibility of senior managers	✓					★
Involve						
To engage frontline staff in service improvement and redesign	✓	✓		✓		★
Expand the range of opportunities for staff engagement						★
To involve public and patients in the activities of the Trust						★
Involve patients and their carers in their care and treatment	★	✓				
Act						
Become more firmly established as an integral member of the local community						★
To raise funds for the Trust through the involvement of staff, patients and local people	✓			★		✓
Improve staff attitude and customer care through embedding the Customer Care Promises		★				✓
Provide effective feedback to patients, local people and staff	✓					★
Talk						
Effectively promote the Trust's services	✓		✓	★		✓
Manage the reputation and promote the strategy of the Trust	✓	✓	✓	✓	✓	★
Raise the profile of quality	✓	✓				★
Meet the information requirements of patients, carers and staff	✓	★				✓

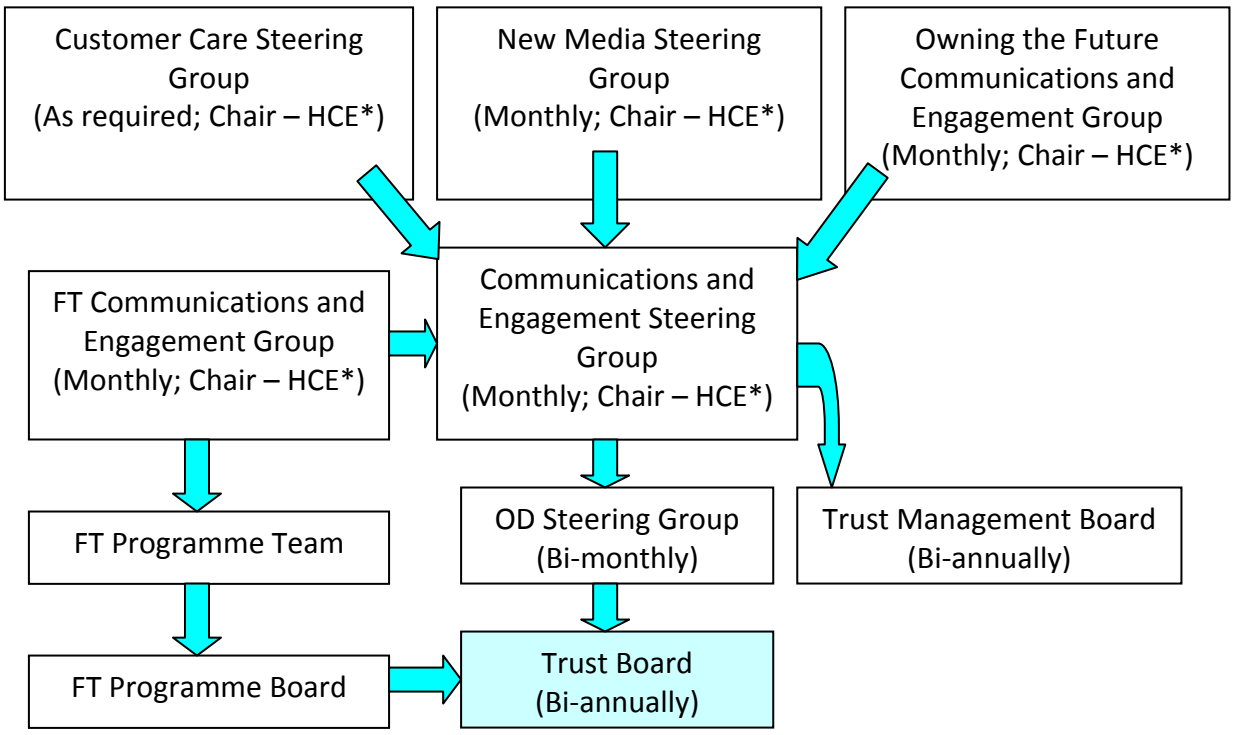
6.0 Governance

Each of these aims will be underpinned with an action plan that will be monitored by the Communications and Engagement Steering Group, reporting to the Organisational Development Steering Group. Progress and key performance measures will be reported to the Trust Board bi-annually.

Supporting and relevant documents are available on request:

- Audience profiles
- Communications and Engagement SWOT analysis (draft attached at appendix one)
- Supporting strategies / policies, i.e. Membership Strategy, Patient Information Policy
- Linked strategies, i.e. Workforce Strategy, Leadership Development Framework, Transformation Plan

A range of supporting strategies and plans are in development, i.e. health promotion strategy, recognition strategy, staff engagement strategy (incorporates Listening into Action and Owning the Future), new media strategy, media management strategy and internal communications plan.



*HCE = Head of Communications and Engagement

7.0 Roles and Responsibilities

The role of the **Trust Board** is to:

- Oversee the delivery of the Communications and Engagement Strategy, ensuring high quality communications and engagement
- Listen to staff, patients, local people and stakeholders
- Involve staff, patients, local people and stakeholders
- Act on feedback and play a key role in the local community
- Communicate feedback and key messages to staff, patients, local people and stakeholders

The role of the **Chief Executive** is to:

- Champion communications and engagement with staff, patients, local people and stakeholders

The role of the **Head of Communications and Engagement** is to:

- Advise the Trust Board and the Executive Team on communications and engagement matters relating to staff, patients, carers, local people, stakeholders and the reputation of the organisation,
- Ensure timely, appropriate and effective communication and engagement is integrated in the business of the Trust
- Provide clear strategic direction for communication and engagement
- Ensure effective communication and engagement support is provided to the Trust
- Manage the Trust's reputation
- Establish the quality drivers and measures for communication and engagement

The role of the **Communications and Engagement department** is to:

- Support the business of the Trust through effective communications and engagement activities
- Advise and support staff and departments in communications and engagement matters
- Establish effective communications and engagement channels for staff
- Handle media enquiries
- Promote the Trust
- Involve staff, patients and the public in Trust activities and run the Trust's membership
- Manage public information about the Trust
- Manage patient information
- Promote excellent customer care

The role of **managers** is to

- Communicate effectively with their patients and staff
- Engage effectively with their patients and staff
- Lead by example and demonstrate and encourage excellent customer care

The role of **staff members** is to

- Communicate effectively with their patients and colleagues
- Engage effectively with their patients and colleagues
- Demonstrate and encourage excellent customer care

Appendix One: Draft Communications and Engagement SWOT Analysis 2012

Strengths

- Track record of consultation and engagement
- Well established membership
- High proportion of BME Foundation members
- Good levels of patient satisfaction around levels of information received and achievement of the Information Standard
- Good reputation with local journalists
- Experienced major incident communications response
- Strong calibre of media spokespeople with excellent feedback from media training programme
- Experienced communications department
- High levels of staff engagement through Listening into Action
- Availability of communications performance information
- Trust Board commitment to communications and engagement
- Good (best in the West Midlands) communication between management and staff, according to staff

Weaknesses

- Proactive media activity often takes second place to other work priorities
- No dedicated patient engagement support
- Reductions in corporate communications and engagement team creating pressure on delivery, particularly on proactive media management, service change, patient surveys, Owning the Future and member / Governor activities

Opportunities

- High levels of interest from local people in Foundation Trust membership and Trust activities
- Highly diverse population with differing clinical and communication needs
- Significant proportion of patients with long term contact with the Trust
- Volunteers
- Right Care Right Here programme
- Service developments
- Listening into Action
- Owning the Future
- Fundraising opportunities
- Social media and online engagement
- Good relationships with local journalists

Threats

- 'Any Qualified Provider' – competitive local market with increasing number of providers, including private practices with more opportunities to advertise their services
- Media appetite for news about the health service, with some media having a particular emphasis on adverse and sensational coverage
- Expectations of commissioners and local people
- Highly diverse population with wide ranging communications and engagement needs / wishes
- Increasingly young population in Birmingham (young people traditionally not interested in getting involved, but with higher expectations than older people)
- Increasing older population in Sandwell, with potential for more people with long-term illnesses which impacts on communications and engagement methods (and those with long-term illnesses tend to be more critical)
- Extent of change taking place within the NHS
- Reductions in growth in NHS spending

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Communications and Engagement Strategy update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jessamy Kinghorn, Head of Communications and Engagement**
AUTHOR:	**Jessamy Kinghorn, Head of Communications and Engagement**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

This is the bi-annual communications and engagement update, outlining activity over the last six months. It includes data on media coverage, social networking, website use and membership.

REPORT RECOMMENDATION:

None

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

- Aligns to all annual priorities

PREVIOUS CONSIDERATION:

Twice yearly update to Trust Board as part of its reporting cycle

Communications and Engagement

Trust Board Report

Paper by Jessamy Kinghorn, Head of Communications and Engagement

June 2012

1.0 Introduction

This report includes an update on delivery of the communications and engagement strategy, as well as the communications and engagement performance of the Trust.

2.0 Communications and Engagement Strategy Update

As reported in December, the previous Communications and Engagement Strategy ran until the end of March 2012. A revised Strategy for 2012-17 is due to be presented to the Trust Board for approval this month (June). As a result, this report provides an update on communications and engagement activity within the Trust, rather than progress against the strategy itself.

3.0 Communications and Engagement Performance

3.1 Internal Communications

Regular internal communications methods include the Trust's newsletter, Heartbeat which includes 'Your Right To Be Heard', Hot Topics, daily e-bulletins, monthly Chief Executive's Key Messages, daily updating of the intranet and use of posters and displays. Listening into Action and Owning the Future are further methods used to engage with frontline staff.

Hot Topics

Each month a topic is discussed by teams throughout the Trust through the monthly team briefing session, Hot Topics. Each team feeds back the outcome of their discussion and the feedback is shared with teams the following month. It is also used to influence policy, strategy and planning in the organisation. Recent subjects are:

December	Health and Wellbeing
January	Diversity Staff Support Networks
February	NHS Foundation Trust application
March	Violence and Aggression in the workplace
April	Revised Workforce Strategy
May	Transformation Plan
June	Seasonal Flu Vaccination

The briefing starts with a core brief, held by the Chief Executive each month at City, Sandwell and Rowley Regis Hospitals. Attendance figures, together with the number of teams providing feedback on the 'hot topic' each month are below:

Month	Rowley Attendance	Sandwell Attendance	City Attendance	Total Attendance	Total Feedback
January	12	95	108	215	53
February	11	76	93	180	53
March	17	103	82	202	63
April	19	76	81	176	64
May	25	65	90	180	58
June	12	66	79	157	-

The introduction of Hot Topics in 2009 saw average attendance at core brief increase from just 62 across the three meetings in 2006/07 to more than 130 in 2009/10.

The main difference made by Hot Topics was in opening up the core brief to any member of staff nominated by their manager. More than a third of the total attendance at core brief meetings since March 2009 has been made up of people who are not on the Hot Topics Managers list.

The addition of Sandwell's community health services in April, 2011 has seen core brief attendance increase to an average 185 so far this year.

After some initial enthusiasm in the first year of Hot Topics, the number of teams feeding back regularly to the Communications Department on the monthly discussion topic fell away in the second half of 2010. The average for the year fell from 95 teams in 2009 to 65 in 2010.

An increase in the number of community teams feeding back this year has masked a continuing fall in the number of teams from the acute which feedback every month.

The inclusion of figures for attendance and feedback in the leadership dashboard, which forms part of divisional management reviews should raise the profile of the importance of Hot Topics meetings and lead to feedback increasing during the course of the year. Considering there are 218 separate teams listed on the leadership dashboard there is plenty of scope for increased feedback from the average so far this year of 58.

Your right to be heard

In 2012 to date, on average 17 letters published in the Your Right To Be Heard section of Heartbeat each issue, along with a response from the relevant manager (an increase from an average of 15 in 2011). The busiest issue was March 2012 which saw 22 letters submitted to Heartbeat.

Staff lottery

In May 2012 683 staff lottery tickets were put into the monthly draw. This is decrease since out last update in December 2011 when there were 738 tickets sold. This is accounted for by there being many long standing players who have recently retired from the trust and many of them were multiple ticket holders. The role and promotion of the Trust lottery will be reviewed by the new Head of Fundraising who takes up post in September.

Staff survey

The Trust was in the top 20% of Trusts in the 2011 national staff survey for staff reporting good communication between senior management and staff.

The Trust's score was the highest of any acute Trust in the West Midlands (see below).

The Trust achieved a score of 40%, which although less than half of staff, was just 2% behind the best scoring Trust in the country.

The national average for staff reporting good communication between senior management and staff was 26% with most trusts scoring between 21% and 31%. The best performing acute Trust in England scored 42%. The lowest score nationally was 8%.

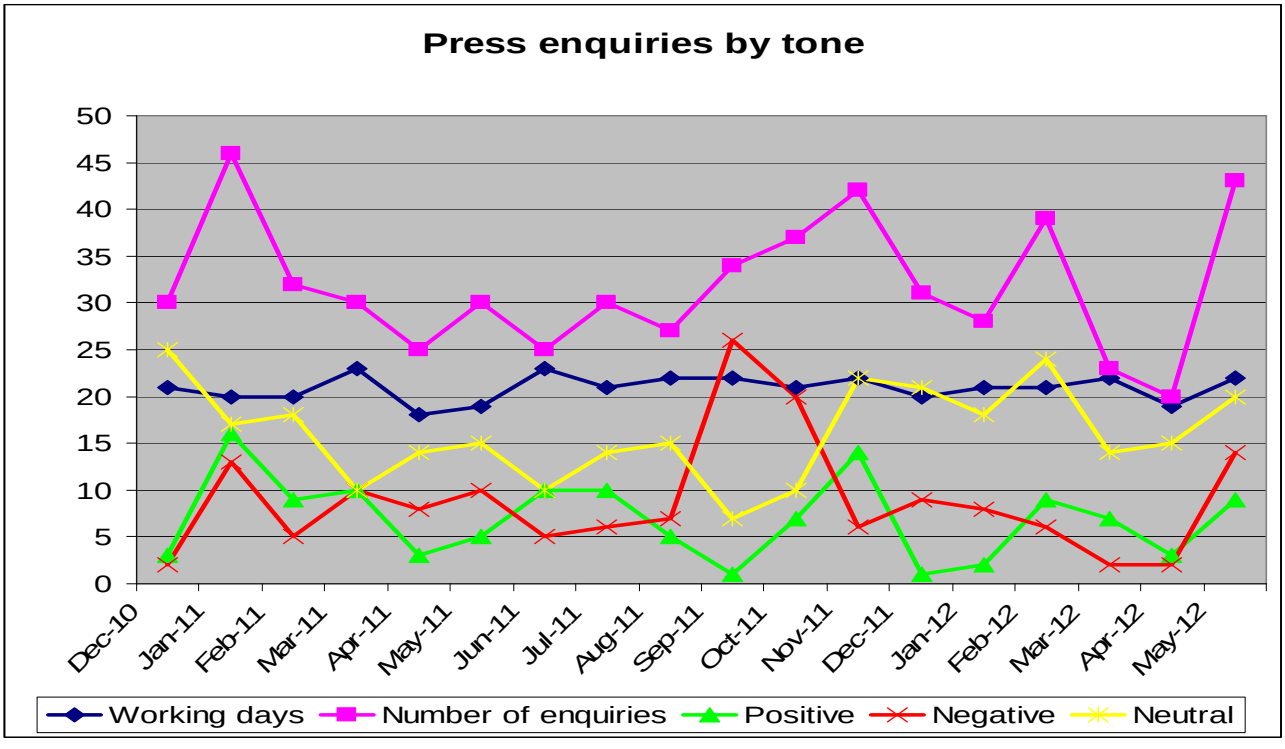
Acute Trust	% staff reporting communication as good (2011)	Highest score nationally (acute)	Highest score nationally (specialist)
Mid Staffordshire NHS Foundation Trust	19	42	
Shrewsbury and Telford Hospital NHS Trust	20	42	
George Eliot Hospital NHS Trust	21	42	
University Hospital of North Staffordshire NHS Trust	21	42	
Wye Valley NHS Trust	22	42	
University Hospitals Coventry and Warwickshire NHS Trust	23	42	
Worcestershire Acute Hospitals NHS Trust	23	42	
The Royal Wolverhampton Hospitals NHS Trust	24	42	
Walsall Healthcare NHS Trust	25	42	
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust	25		44
Heart of England NHS Foundation Trust	26	42	
Burton Hospitals NHS Foundation Trust	27	42	
Birmingham Women's Hospital NHS Foundation Trust	28		44
University Hospital Birmingham NHS Foundation Trust	28	42	
Birmingham Children's Hospital NHS Foundation Trust	32		44
Dudley Group NHS Foundation Trust	32	42	
South Warwickshire NHS Foundation Trust	36	42	
Royal Orthopaedic Hospital NHS Foundation Trust	40		44
Sandwell and West Birmingham Hospitals NHS Trust	40	42	

3.2 Media activity

We monitor the rate and tone of press enquiries with a view to recognising patterns and developing a more proactive strategy to dealing with enquiries. Data from December 2010 to May 2011 has previously been reported to the Trust Board but is included for information.

3.2.1 Press enquiries

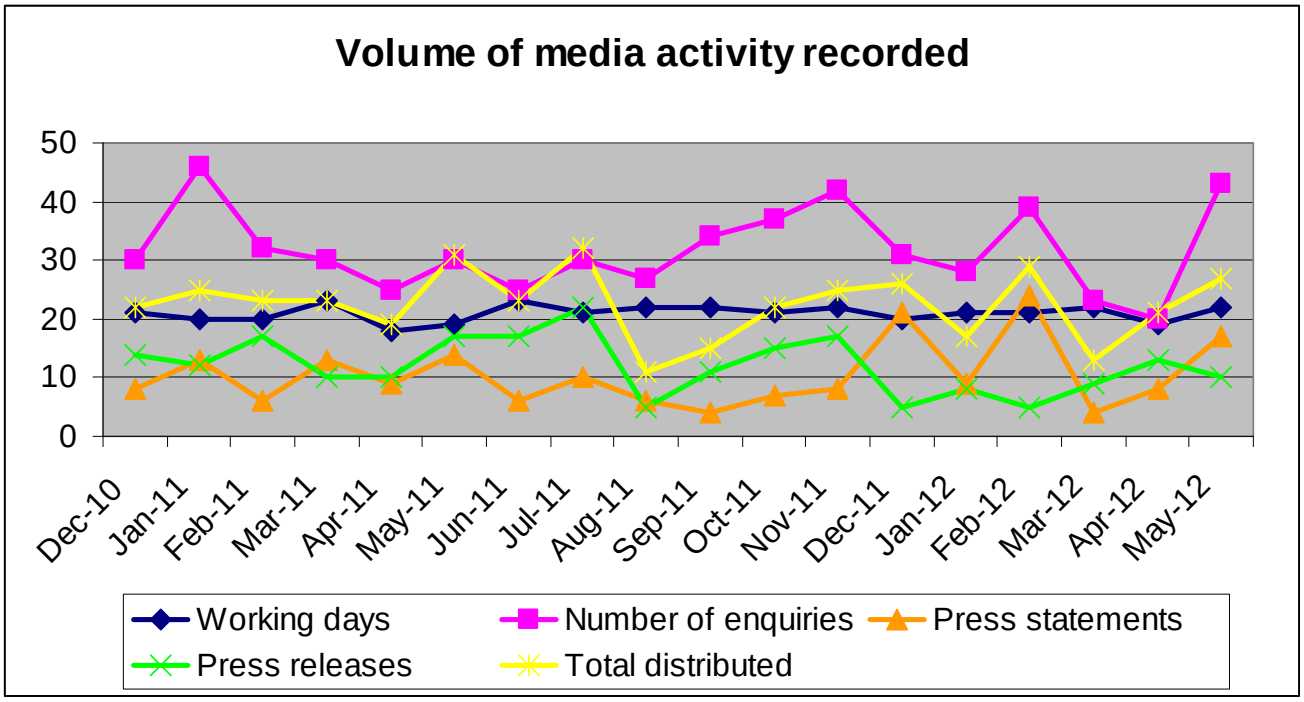
	Month	Working days	Number of enquiries	Positive	Negative	Neutral
2010	December	21	30	3	2	25
2011	January	20	46	16	13	17
	February	20	32	9	5	18
	March	23	30	10	10	10
	April	18	25	3	8	14
	May	19	30	5	10	15
	June	23	25	10	5	10
	July	21	30	10	6	14
	August	22	27	5	7	15
	September	22	34	1	26	7
	October	21	37	7	20	10
	November	22	42	14	6	22
	December	**20**	**31**	**1**	**9**	**21**
2012	**January**	**21**	**28**	**2**	**8**	**18**
	February	**21**	**39**	**9**	**6**	**24**
	March	**22**	**23**	**7**	**2**	**14**
	April	**19**	**20**	**3**	**2**	**15**
	May	**22**	**43**	**9**	**14**	**20**



The number of enquiries received, and statements and press releases issued, is recorded below. This indicates the volume of work undertaken by the press office, but does not reflect the different levels of complexity this activity generates.

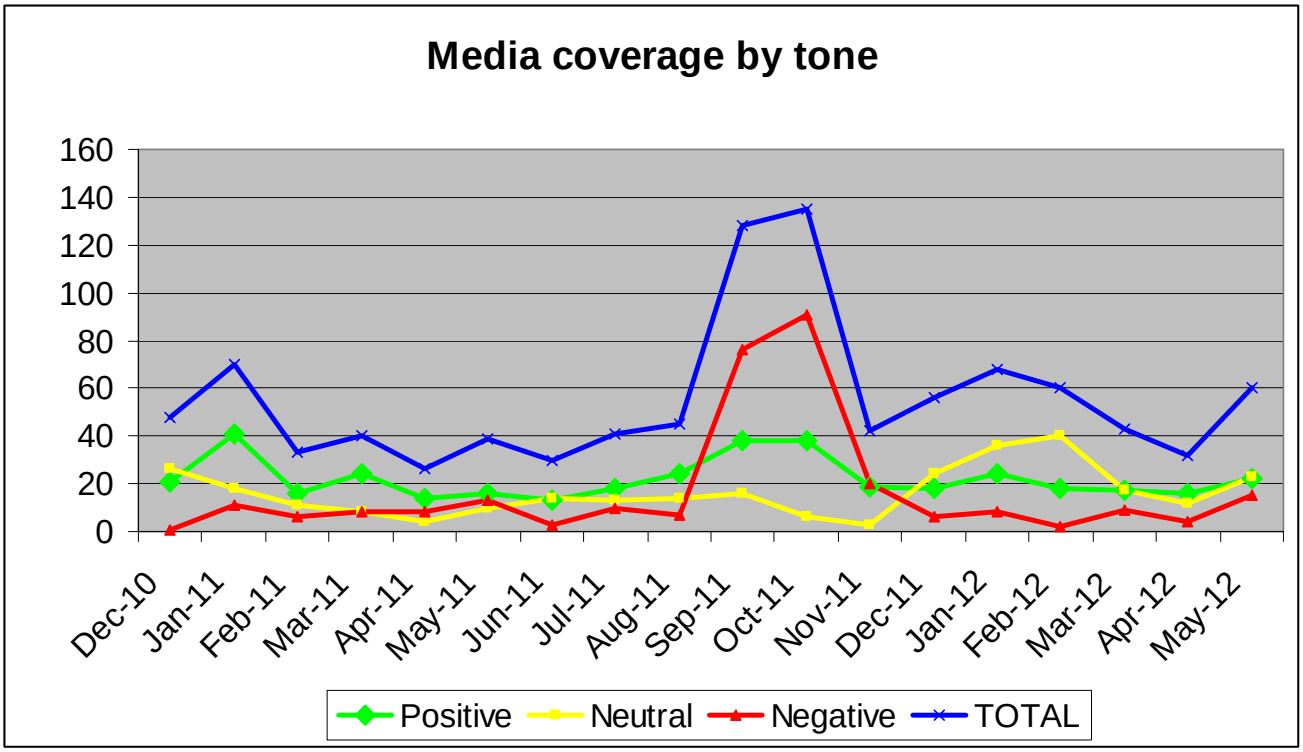
3.2.2 Media Activity

	Month	Working days	Number of enquiries	Press statements	Press releases	Total distributed
2010	December	21	30	8	14	22
2011	January	20	46	13	12	25
	February	20	32	6	17	23
	March	23	30	13	10	23
	April	18	25	9	10	19
	May	19	30	14	17	31
	June	23	25	6	17	23
	July	21	30	10	22	32
	August	22	27	6	5	11
	September	22	34	4	11	15
	October	21	37	7	15	22
	November	22	42	8	17	25
	December	**20**	**31**	**21**	**5**	**26**
2012	**January**	**21**	**28**	**9**	**8**	**17**
	February	**21**	**39**	**24**	**5**	**29**
	March	**22**	**23**	**4**	**9**	**13**
	April	**19**	**20**	**8**	**13**	**21**
	May	**22**	**43**	**17**	**10**	**27**



3.2.3 Actual Press Coverage

		Media articles			
	Month	**Positive**	**Neutral**	**Negative**	**TOTAL**
2010	December	21	26	1	48
2011	January	41	18	11	70
	February	16	11	6	33
	March	24	8	8	40
	April	14	4	8	26
	May	16	10	13	39
	June	13	14	3	30
	July	18	13	10	41
	August	24	14	7	45
	September	38	16	76	128
	October	38	6	91	135
	November	19	3	20	42
	December	**18**	**24**	**6**	**56**
2012	**January**	**24**	**36**	**8**	**68**
	February	**18**	**40**	**2**	**60**
	March	**17**	**17**	**9**	**43**
	April	**16**	**12**	**4**	**32**
	May	**22**	**23**	**15**	**60**



In December we had positive coverage on the 10th Anniversary of the Cancer Support Centre and on the introduction of new hospital robes for patients on the dignity agenda, whilst the reconfigurations of breast and stroke services was viewed negatively. January brought substantial positive media coverage on the airing of the 'Confessions of a Nurse' documentary, whilst we endured much negative commentary on social networking sites, mainly from professional nurses. The £500k revamp at Sandwell Hospital Children's wards was covered positively, whilst an interview with Ken Taylor and follow up with John Adler regarding the challenging financial situation within the NHS and the Trust's plans to tackle it was portrayed negatively.

February brought great national coverage for our breast reconstruction service as a 72 year old patient made a compelling case study. Graham Seager featured on the Adrian Goldberg show re the new hospital project and gave a good performance when pitted against some angry tenants. Infection Control came under the spotlight with a positive feature on our Sterinis robots. Another great story in March was that of a retired midwife who took a trip down memory lane at City Hospital, Birmingham to celebrate her 100th birthday. A little humour was injected into a plea by midwives for knitters to get their woollen boobs out for the ladies. This release generated some good local coverage, and a surplus of 'boobs' enough to share with our neighbouring trusts. Another human interest story was that of Sister Mary Proffitt retiring from Sandwell Hospital after 46 years as a nurse, which attracted coverage from national papers in her home country of Ireland. On the negative side we attracted substantial negative coverage around the publication of a Serious Case Review which named us as at fault in the 'preventable' death of baby Jayden Warr who was shaken to death by his father.

In April Rachel Overfield was interviewed by Ed Doolan regarding the nurse who was held hostage at City Hospital, while a new study into Parkinson's disease at City hospital heralded our hope to one day find a cure. Hot-desking came in for a bashing whilst car parking was positive for our patients with prices frozen, yet negative for staff as they face 10pc car park fee rises. The appointment of our new Chairman featured locally while a very negative story about a 19in swab left inside a patient for eight months ran on the front page of the Birmingham Mail. The month of May saw the marking of the second year of our birth centre Serenity, while the scheme to 'bring back matron' was portrayed positively. However an FOI over vermin in the hospital brought negative coverage, as did our scheme to offer unemployed people an opportunity to gain valuable work experience within the NHS.

3.2.3 Staffing

In September 2011 we lost a full time press officer, and our full time senior communications manager transferred to a new job in January 2012. Our part time communications assistant became full time in May after finishing university and being awarded a First Class degree in marketing, advertising and public relations, from Birmingham City University.

3.3 Emergency Planning

Communications Officer Helen Eden attended the West Midlands Conurbation Resilience Forum meeting (held twice a year) to discuss planning for the Olympics.

Helen Eden and Communications Support Officer Abigail Parkin both completed a full day of Loggist training at the end of May, organised by Sandwell PCT.

Press and PR Manager Vanya Rogers represents communications at monthly internal meetings focusing on Emergency Planning.

3.4 Media Training

Due to budget limitations, no media training has taken place in the six months to June 2012. However, the next media training exercise is scheduled to take place in July.

3.5 Documentaries

The Blast! Documentary series of 4 programmes was broadcast in January 2012 on More 4. In May we facilitated filming at BMEC for a Channel 5 documentary entitled 'The men who make faces', where Aiden Murray one of our surgeons was filmed in theatre operating on a patient who need reconstructive surgery on her eyes. The documentary is due to be broadcast in late summer 2012.

We have also facilitated filming again in BMEC for a special programme in the 'Embarrassing Bodies' series. Our patient was already featured in an earlier programme but has been filmed again undergoing an operation by eye surgeon Omar Durrani. The programme is due to be shown later this year.

We are currently in negotiation with the BBC regarding a documentary following pregnant mothers-to-be up to the delivery of their babies. One of the ladies they are following plans to give birth in the labour ward at City hospital in September this year. It is possible we will grant them permission to film within the hospital with our patient's consent.

We were mentioned in an episode of 'Emergency Bikers' screened on Channel 5 on 16th May 2012.

We have declined another BBC documentary request on workfare as our work experience programme is not the same, although we have provided them with some background information.

We declined a request to take part in a documentary being planned by the BBC to follow fathers-to-be and get them more involved in the birth of their child. We investigated this opportunity and had a number of meetings and telephone conversations with the BBC, but declined due to a disagreement over the level of involvement of relatives with no midwifery training or qualifications.

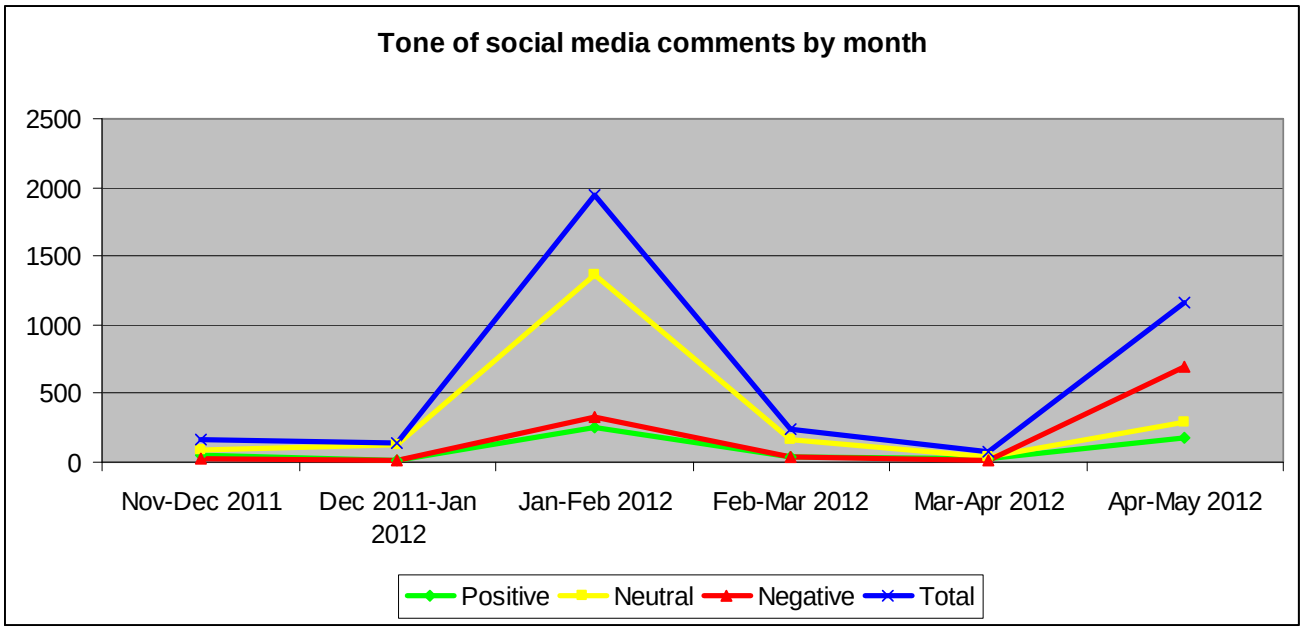
We have also declined a request to take part in a programme where a celebrity chef (James Martin) comes into the trust and improves our menus, on the grounds that we have undergone a significant change to patient menus in the last few years, involving patients in the development and testing of the menu.

3.6 Social Media

The Trust has started to monitor and collect data on social media activity, where there is public access to it. This is still in its infancy and currently excludes a wide range of specialist websites, such as mums.net where we know comments are left, but the search tools required to monitor these sites require significant investment. The data captured also

excludes comments left on news websites relating to articles about the Trust or our services, (which can comprise significant numbers for high profile stories), or the number of times comments, news articles or blogs are 'liked' or 'shared' on social networking platforms.

Outlet	Nov-Dec 2011	Dec 2011-Jan 2012	Jan-Feb 2012	Feb-Mar 2012	Mar-Apr 2012	Apr-May 2012
Twitter	151	127	1172	220	69	379
Blog	4	0	3	2	2	7
Facebook	7	18	677	13	3	21
Forums	3	0	135	0	0	0
Other	0	0	305	0	1	750
Total	165	145	2292	235	75	1157
Tone	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**
Positive	54	16	251	39	21	177
Neutral	91	120	1361	160	41	290
Negative	20	9	331	36	13	690
Total	165	145	1943	235	75	1157



The spike in activity in January and February relates to More 4's broadcast of 'Confessions of a Nurse.' Comments that were not directly positive or negative about the Trust were classed as neutral, including positive comments about the programme that didn't mention the Trust itself.

A range of other information about topic trends and links to articles about the Trust is also monitored by the Communications team.

Whilst a social networking strategy is in development, the team's approach is to monitor activity but not to proactively try to increase the Trust's social media presence at this time, apart from news updates on twitter. It is important that once a proactive social media strategy is launched, the Trust is in a position to maintain its involvement in social media.

However, activity is monitored and top level statistics are below:

	November 2011	May 2012
Twitter followers	234	490
Facebook friends	130	205
Facebook page likes	28	37

Proactive 'tweets' to date = 369

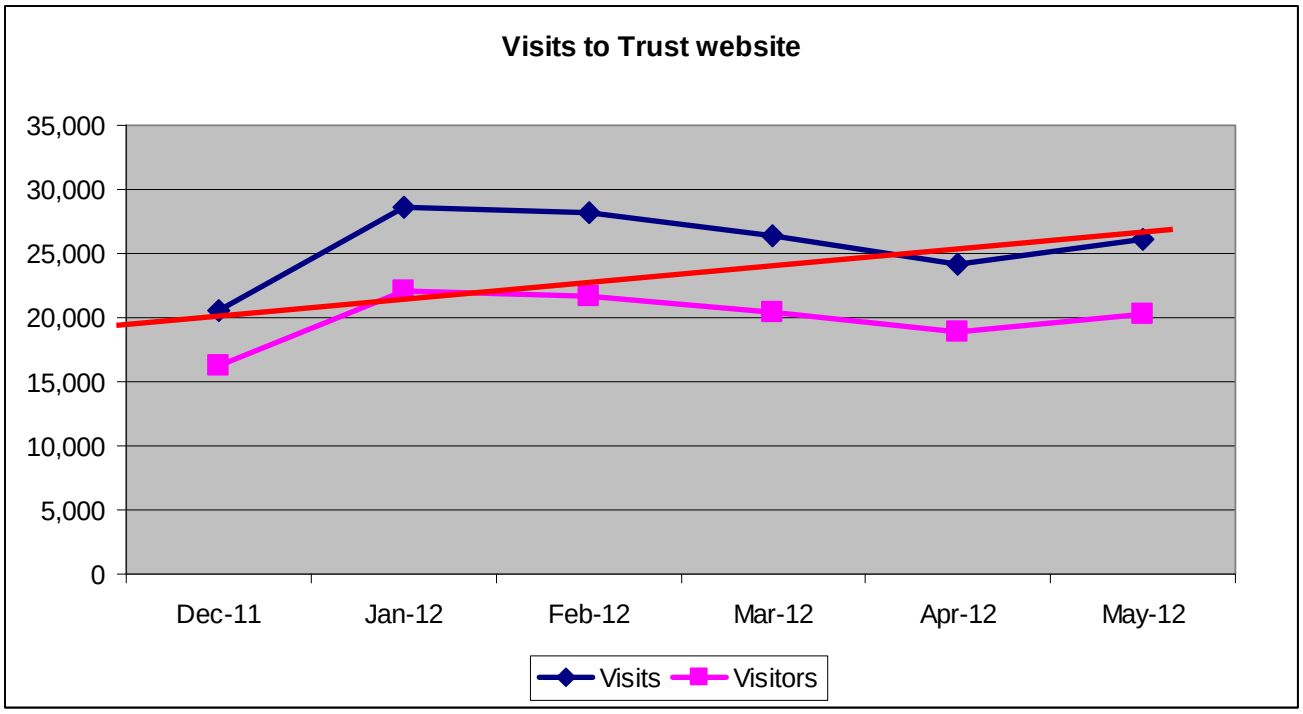
In addition, a number of members of the Communication Team have individual Twitter accounts which they use to promote Trust activities.

3.7 Website

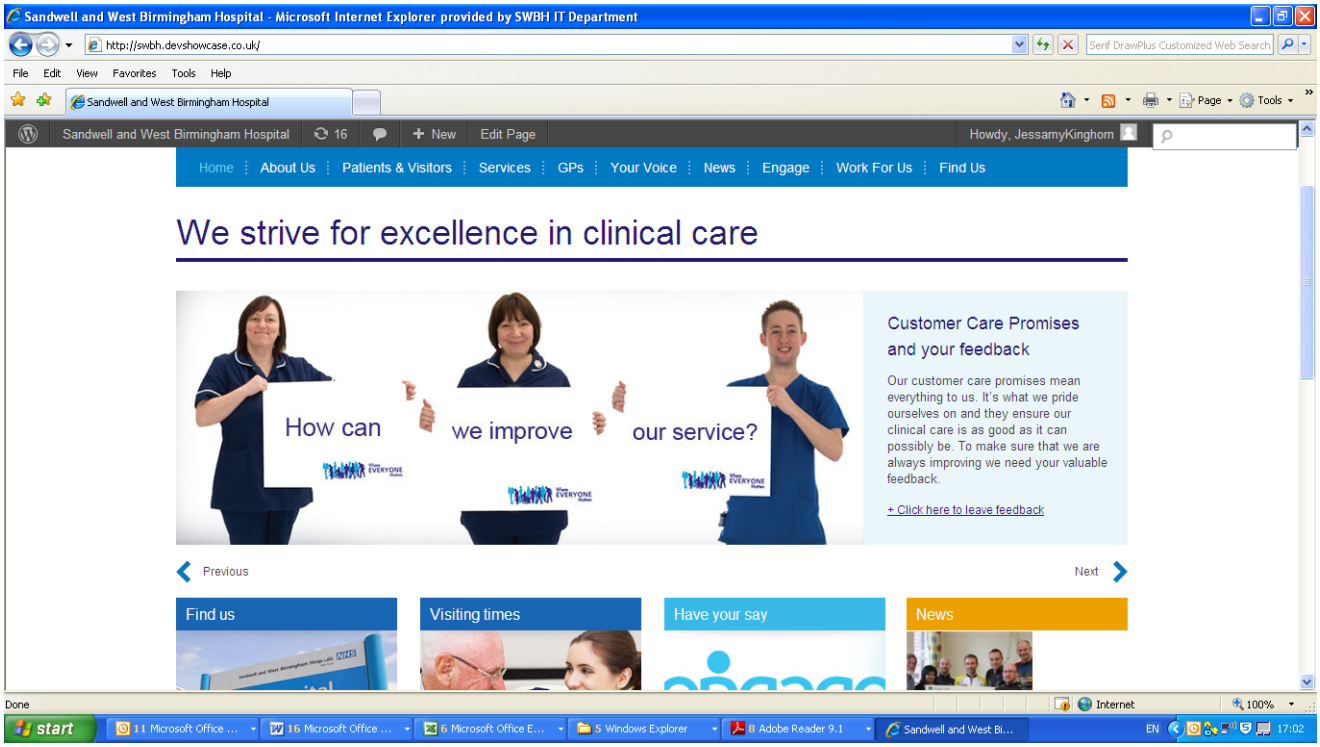
Over the last six months May to November 2011, there were 105,315 visits to the Trust website, an average of 577 per day.

July 2010 saw just over 15,000 visits to the website, reaching just over 19,000 in November 2011, although with a significant drop in September 2011.

The proportionate increase in website traffic over several months remains the same.



The website is currently being redesigned. The new site will be launched in July.



3.8 Patient Information

Following an inspection in February this year, the Trust has retained the Information Standard which it was first awarded in 2011. Only a handful of acute Trust's have obtained the Information Standard which is recognised as a symbol for high quality, informed patient information.

3.9 Patient and public engagement

A significant amount of patient and public engagement takes place across the organisation, in various forms including surveys, user groups, special engagement events, and attendance at community meetings. Some of this is led or supported by the Communications and Engagement team, some is part of the Trust's membership strategy, and other engagement is led by clinicians and managers across the Trust engaging directly with their patients.

Particular engagement activities have taken place regarding stroke services, with a public consultation on their future configuration carried out in the last few months. Trauma and Orthopaedics and vascular services have been a particular focus for engagement activities, as well as the Trust's NHS Foundation Trust application.

3.10 Membership:

Over the last 12 months attendance at member's talks has dropped off, in the last edition of the member's newsletter we surveyed members to ask about member's talks, and how we can increase attendance at the events. We had 57 responses.

1. **What would make it more convenient for people to attend**

   Responses focused around time of the meetings and the importance of having a variety of times. Some members indicated they found it difficult to attend events due

to public transport. Members suggested changing locations and doing more events out in the community so it's easier for people to get to.

2. What do you think are the benefits of the events?

Members said they liked hearing about what was going on in the Trust especially relating to the services they were interested in. When we have talks focusing on health conditions, members appreciated the way clinicians explained medical terms and that clinicians are also happy to explain further and answer questions.

3. What subjects would you like to see the Trust put on?

- Unusual illnesses
- More information on the Trust, how its structured and how it differs from other trusts
- Infection Control
- Day in the life 'doctor or nurse'
- Diabetes
- First aid
- Chronic illnesses
- Cancer
- Alternative medicines
- Volunteering

The membership strategy is currently being redeveloped.

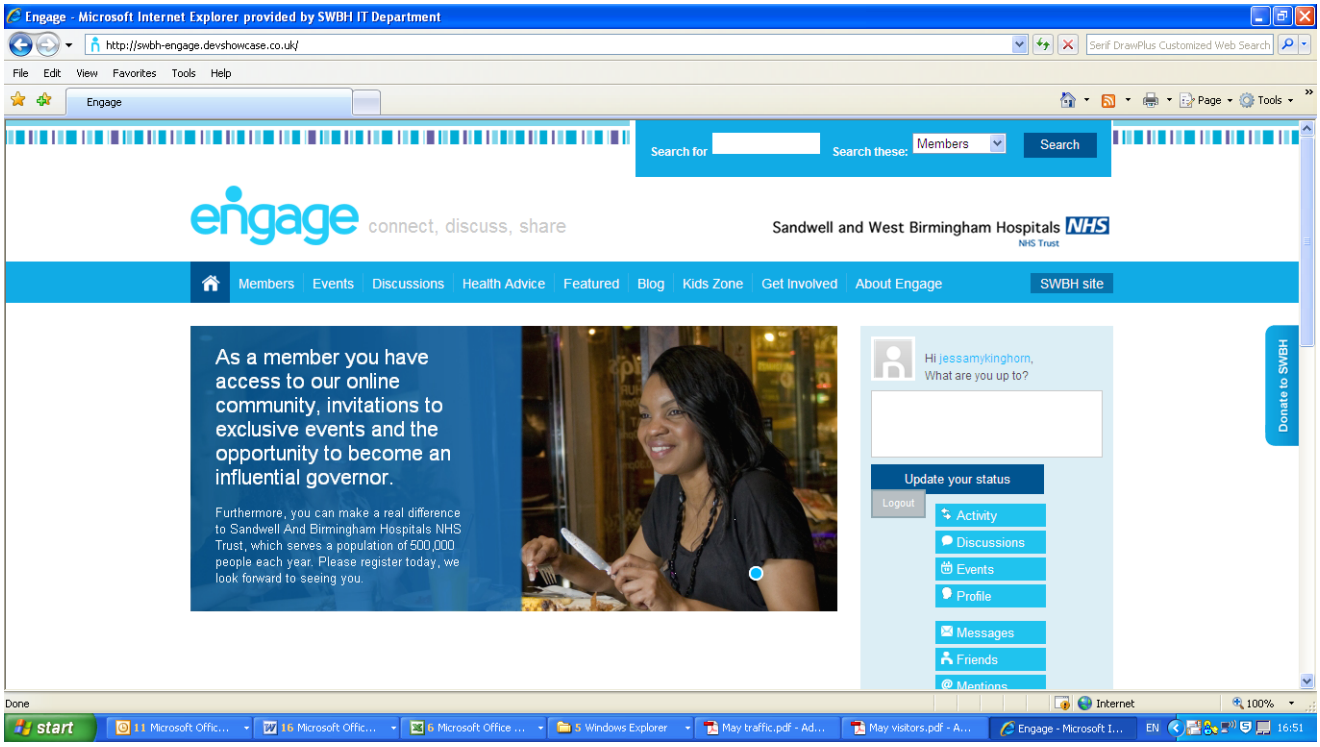
Membership at June 2012 is broken down by constituency below. A full demographic breakdown is produced annually in the December Communications and Engagement report.

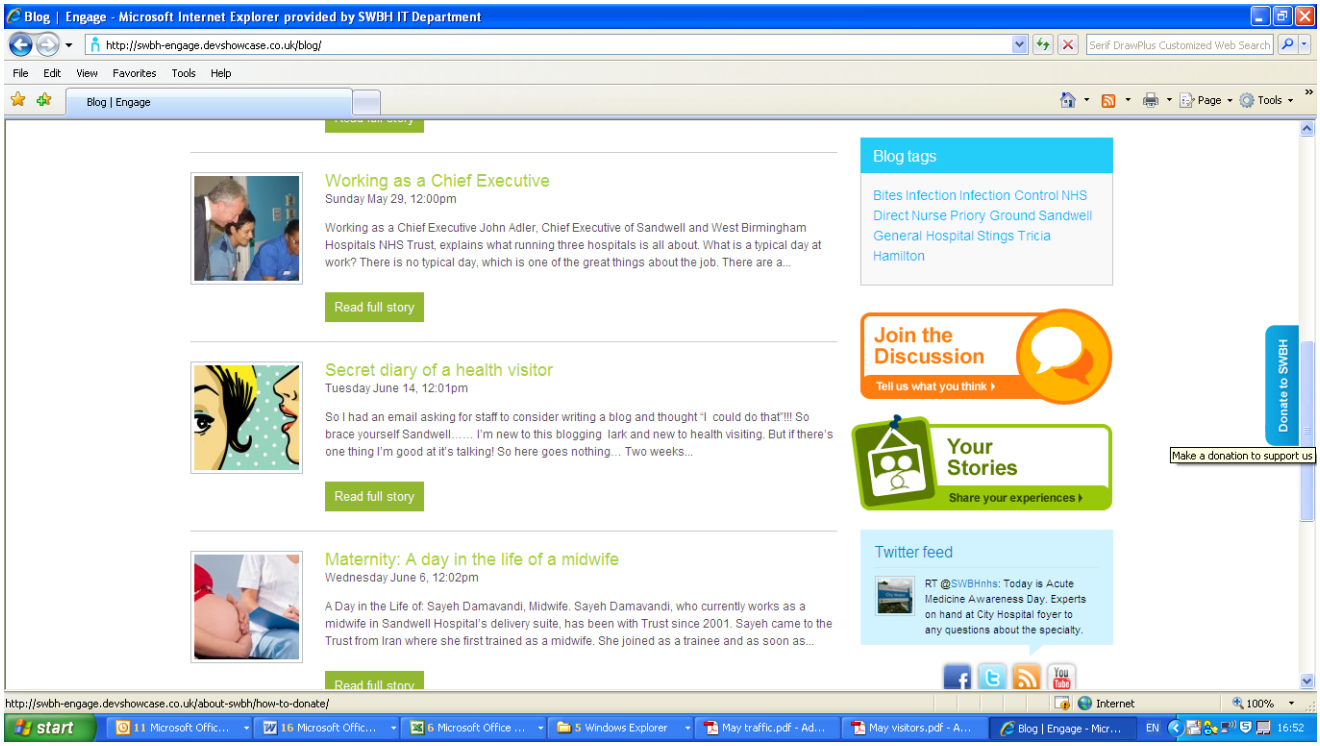
Constituency	Governor seats	Minimum member target	Members	Population	Change since last report
Ladywood	3	900	**829**	94538	↓
Edgbaston and Sparkbrook	1	300	**369**	96388	→
Perry Barr	3	900	**1053**	100476	→
Erdington	1	300	**315**	90654	↑
Wednesbury and West Bromwich	3	900	**1077**	105770	↑
Oldbury and Smethwick	3	900	**1314**	94969	↑
Tipton and Rowley Regis	3	900	**748**	82165	↓
The Wider West Midlands	2	600	**1654**	4602348	→
Not Specified	0		**9**		
Total	19		**7368**	5267308	→

The largest increase in membership was in Tipton and Rowley where there were 49 new members

	Over minimum target	↑	Increase, or no reduction in membership size
	Within 5% of target	→	Reduction in members by less than 10 members per Governor seat
	More than 5% below target	↓	Reduction in members by more than 10 members per Governor seat

A virtual membership website – 'Engage' will be launched on the 30th June as part of the Olympic torch event. In preparation for this, staff across the Trust have been involved in testing the site. The feedback so far has been positive, with staff hoping the site becomes well used.





4.0 Owning the Future

At the beginning of 2011 it was agreed to pilot the Trust's Owning the Future staff engagement models in three areas of the Trust: the Sandwell Community Adult Health Division, the Sandwell Community Child Health Directorate and the Pathology Division. The pilot commenced in May 2011 with the first elections, and a welcome event was held on the 1st July 2011.

The first stage evaluation was initiated in October/ November 2011. Highlights were included in the December Communications and Engagement update to the Trust Board and have been reported more fully to the Organisational Development Steering Group. The first stage evaluation has been useful in identifying what has worked well so far and what we can improve upon moving forward. It is clear that most staff, managers and Ambassadors believe that OtF is a good thing and will be beneficial.

In April 2012, the OD steering group agreed to undertake two further pilots:

4.1 Surgery B

In the pilot areas, Owning the Future has been successful in improving communication between managers and staff and involving staff in the business of the area or directorate. According to the 2011 national staff survey, Surgery B is the division in the Trust where least staff had been directly involved with Listening into Action and the division where staff were most likely to strongly disagree that their immediate manager was accessible, approachable and visible to staff and patients (12% of staff completing the survey – almost twice as many as the next division). Staff in the division were the least consulted or involved in decisions (50 % of staff in surgery B feel that there are not consulted about changes to their team), and most dissatisfied with the recognition they get for good work. The division also had one of the lowest scores in the Trust for effective communication.

4.2 Imaging

Imaging is similar in many ways to Pathology, in that it is not a bed holding division, but is a clinical division. Building on the success of the pilot in Pathology, it seems a logical next step. In contrast to Surgery B, the imaging division is one of the most engaged areas of the Trust, with some of the highest satisfaction scores. The division is quite proactive in thinking about customer care and patient experience, and one of the largest users of LiA methodology. This may make it a natural home for the Owning the Future engagement model, with greater buy-in from managers and less onerous in terms of support required.

We are hoping to start the elections in these areas in September.

5.0 Recommendations

The Trust Board is asked to NOTE the report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	'Right Care Right Here': Progress Report
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	28 June 2012

EXECUTIVE SUMMARY:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of April 2012.
It covers:

- Progress of the RCRH Programme including activity monitoring for the period April-January 2012.

REPORT RECOMMENDATION:

The Trust Board is asked to ACCEPT the progress made with the Right Care Right Here Programme.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	X	Environmental		Communications & Media	X
Business and market share		Legal & Policy		Patient Experience	
Clinical	X	Equality and Diversity	X	Workforce	X

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Supports strategic objective : Care Closer to Home
Supports 2012/13 Annual Priority: Progressing the 'Right Care Right Here' vision of service change

PREVIOUS CONSIDERATION:

Monthly report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT JUNE 2012

Introduction

This brief paper provides a progress report for the Trust Board on the work of the Programme as at the beginning of June 2012. It summarises the Right Care Right Here Programme Director's report that was presented to the Right Care Right Here Partnership Board in June. It should be noted that a RCRH Service Redesign Report was not produced for the June meeting. The work of the Right Care Right Here Programme and involvement of the Trust in this is also discussed on a monthly basis at the Trust's Right Care Right Here Implementation Board meetings.

Transfer of Activity: QIPP (Quality Innovation Productivity and Prevention) Schemes

The LDP agreement for 2012/13 has set a target for the cessation of and transfer out of acute activity into community or primary care worth £10 million of acute SWBH income. The schemes that will deliver this reduction in acute activity will be identified as QIPP schemes. It has been agreed that this activity and income reduction will be delivered through a range of schemes falling into three broad headings:

- Schemes identified within our Transformation Plan that result in a reduction in acute activity and/or transfer of acute activity to community or primary care.
- Schemes identified by the Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) to reduce the demand for acute care.
- Implementation of the approved RCRH care pathways.

Work continues to translate these schemes into a detailed schedule with clear agreement between ourselves and the SWB CCG about how and when they should be implemented and arrangements to monitor progress. A coherent programme of communication and engagement with clinical staff, patients and the public will be essential to successful delivery. In addition the intention is to ask our Clinical Directors to identify other potential areas for service redesign.

In discussion with SWB CCG representatives implementation of Cardiology and elective Orthopaedic RCRH Care Pathways and service redesign work within Diabetes and Ophthalmology have been identified as potential first phase schemes. This is expected to be confirmed at a meeting with executive representatives from the Trust and SWB CCG at the end of June.

RCRH Activity and Capacity Model

As reported last month a full revision of the RCRH Activity and Capacity model is overdue and discussions continue within the local health economy to develop the next phase of this work.

The RCRH Activity and Capacity Model Working group chaired by Mike Sharon (SWBH Director of Strategy and Organisational Development) has been reconvened to oversee the next steps. A business plan and more detailed project plan are being developed for this.

RCRH Partnership

The RCRH Partnership Board has discussed the need for a refresh of the Partnership/Programme and planning has started for an away-event in September.

Future arrangements for the RCRH Programme Team within the corporate remit of the Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) continue to evolve. As part of the next stage in the authorisation process, the CCG has embedded RCRH within its strategic approach and reflected this in its organisational management structure.

Work continues to identify and scope areas that RCRH has been involved with, to ensure that it is clear where this work will be picked up within the CCG structure and/or other emerging successor organisations. The Black Country PCT Cluster and Birmingham and Solihull PCT Cluster have now confirmed agreement to a joint budget for the RCRH Programme.

Recommendations:

The Trust Board is asked to ACCEPT the progress made with the Right Care Right Here Programme.

Jayne Dunn
Redesign Director – Right Care Right Here
19th June 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

The report gives an update on:

- Milestone status
- Activities this period
- Activities next period
- Issues for resolution and risks in next period

REPORT RECOMMENDATION:

To review the planned activities and issues that require resolution as part of the FT Programme

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		x

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

'Becoming an effective organisation' and 'Achieving FT Status'

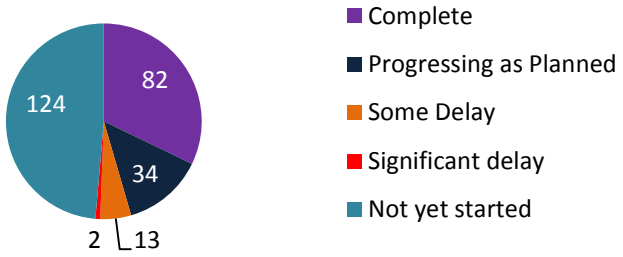
PREVIOUS CONSIDERATION:

Routine monthly update

FT Programme Monitoring Status Report

Milestone status

Milestone Deliverables



Milestones with significant delay:

Milestone	Lead	End Date	RAG	Actions
Reconcile Prosene Position with 12/13 LDP	IK/RK	31/05/12	2	The LDP figures have been received and the reconciliation is almost complete. Further work is required to reconcile the LTFM at POD level
Receive amendments from FTPT members for development profiles	Various	10/06/12	2	List of service developments drawn up and final developments to be agreed by Exec Team. Agreed that total expenditure for the developments will equate to 95% of income

Issues for Resolution/Risks for Next Period

- Formally agree revised TFA with SHA and DH

Activities Last Period

- Draft patient access modelling report received
- Draft high-level outputs from patient and GP market research activities received
- Work commenced on review of key risks for downside planning
- Refreshed Board seminar programme developed
- Initial work re-commenced on Constitution
- Council of Governors proposal, Governance Rationale and Membership Strategy developed
- Chapter leads commenced rewriting chapters for IBP revision
- SWOT updated
- Integrated Plan structure drafted

Planned Next Period

- Formal re-negotiation of TFA with DH
- Final patient access modelling report received
- Focus groups with patients/residents as part of market research activities undertaken
- Final report on market research activities received
- Draft IBP developed
- First draft constitution developed
- Second downside planning seminar conducted

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Listening into Action update**
SPONSOR (EXECUTIVE DIRECTOR):	**John Adler, Chief Executive**
AUTHOR:	**Sally Fox. Listening into Action Facilitator**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

This paper provides an update on the use of 'Listening into Action' and more widely, staff engagement within the Trust, together with the future plans for the approach.

REPORT RECOMMENDATION:

None

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

- Aligns to all annual priorities

PREVIOUS CONSIDERATION:

Twice yearly update to Trust Board as part of its reporting cycle

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Briefing on Staff Engagement for the Trust Board

Trust Board –28 June 2012

Introduction

The Trust has been using the 'Listening into Action' approach since April 2008 as the principal means of engaging with staff about improving services for patients and also their own daily experience of working within the Trust. LiA is now well embedded across the organisation.

Recent major LiA events have included a Patient and Staff Safety Event and a Healthcare Science event, both hosted by the Chief Executive, as well as two events run by the Imaging Division as part of their Transformation work.

However, the Trust now recognises that it needs to adopt a more inclusive approach to engagement. It is increasingly apparent that teams are using LiA, Owning the Future (OtF) and other methods of engagement in their daily work. The Transformation Plan (TP) has also impacted on engagement activity, and in the future much of it will be centred around the large scale service redesign needed to achieve the TP.

The Trust has therefore re-designated the LiA Executive Sponsor Group as an Engagement Sponsor Group. It is still chaired by the Chief Executive and has the same membership, and receives reports on a rolling 3 month basis from the Divisions. It also now receives reports on engagement activity occurring across all the cross cutting themes in the TP and any patient related engagement activity, as well as updates on more "classic" LIA activity, which remains very extensive.

Current position

A new engagement action plan is now in place and includes plans to:

- Continue to monitor engagement activity via the Engagement Sponsor Group on a divisional and cross cutting theme basis
- Organise a 'buddying up' system so that LiA champions work with the Transformation Leads, to ensure they have access to expertise in using LiA
- Post all the resources needed to use LiA (and the other methods of engagement covered in the 'Easy Guide to engaging and involving staff') on the new Trust intranet
- Provide continued support to the LiA champions as they increasingly take responsibility for advising teams on using LiA

- Produce guidelines for managers in how to use engagement techniques appropriately in transformation work
- Maintain the LiA brand in Hot Topics and Heartbeat
- Provide training to the Transformation Leads on using LiA
- Continue the Chief Executive walkabouts to areas that have used LiA/other engagement techniques

Summary

The new Engagement Sponsor Group will continue for the foreseeable future and will ensure that the focus on engaging with staff and patients continues to be a priority.

The LiA champions will continue to be a valuable resource for teams, who will have easy access to all the materials they need via the Trust intranet. This will particularly important once the current LiA Facilitator leaves the Trust at the end of July to take up a new post.

Recommendation

The Trust Board is asked to RECEIVE and NOTE the update.

Sally Fox
LiA Facilitator
June 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Sandwell Community Adult Health Division: One year on Post Integration Review**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Trish Everett, Head of Service, Sue Lane DGM, Neetu Sharma Senior Project Manager**
DATE OF MEETING:	**28 June 2012**

EXECUTIVE SUMMARY:

The attached paper outlines: the position of the Sandwell Community Adult Health Division, at the first anniversary of Integration. It provides an overview of the Division's performance, and progress in realising benefits from integration. It outlines service developments, and a summary of the future developments and development of a strategy to achieve a further level of integration for community adult health services.

REPORT RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE the progress in 2011/12

2. APPROVE the approach to strategic development

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	**x**	Environmental	x	Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

- Accessible and responsive care
- Safe high quality care
- Quality and safety

PREVIOUS CONSIDERATION:

Last update given to the Trust Board in October 2011.

Sandwell Community Adult Health Division: One year on Post Integration

1. Introduction

The community services provided to adults in Sandwell integrated with Sandwell and West Birmingham Hospitals on April 1st 2011, and formed the Sandwell Community Adult Health Division (SCAHD). Tissue Viability ,Safeguarding Adults and Equality and Diversity services transferred into the Nursing and Therapies Division on integration, and Palliative Care Services (including Bradbury House Day Hospice) transferred to that division in February 2012 in order to integrate the acute and community palliative care services.

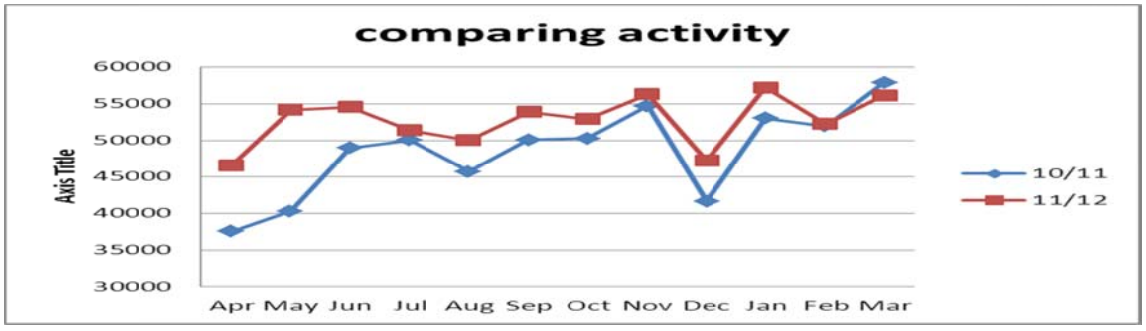
Services provided by SCAHD include District Nursing, Community Rehabilitation, Community Respiratory, Continence, Diabetes, Heart Failure, Foot Health, Musculo-Skeletal, Intermediate Care facilities at Leasowes and Henderson, Nutrition and Dietetics and Admission Avoidance services.

Good progress has been made in terms of Divisional integration and notable achievements have been made in the development of admission avoidance and re-ablement services.

This paper reports on activity and progress on benefits realisation of integration during of 2011/12 and outlines a proposal to realised further integration benefits going forward.

2. Activity

The chart below trends the overall community chargeable activity which over performed against target (464,756)by 28,407chargeable activities .



Activity by service line:				
Service	2010-11	2011-12	difference	percentage
District Nursing	218,632	204,675	-13,957	94
Rehabilitation	27,764	38,647	10,883	139
Respiratory	14,140	16,957	2,817	120
Admission Avoidance	553	1,268	715	229
MSK	63,332	72,485	9,153	114
Foot Health	52,205	54,098	1,893	104
Diabetes	3,122	5,576	2,454	179
Continence	4,217	3,486	-731	83
Heart failure	5,127	6,809	1,682	133
Dietetics	17,490	18,308	818	105
COS	9,180	10,953	1,773	119
Cardiac Rehab	3,142	4,211	1,069	134
Community Matron	7,220	10,601	3,381	147

3. Overview of performance and service developments

Access: All access targets and response times at service level were achieved.
Achievement of CQUIN Targets - Scheme value £394,193
All CQUIN's were met in full for this year, and demonstrated the provision of greater choice for patients at the end of life, improved patient safety through falls assessment and the links to the wider falls project, successful contribution to health promotion and the healthy lifestyles agenda, and positive patient feedback on services received.

- **Patient Questionnaires** This was for District Nursing Services only. 1000 questionnaires sent out 178 returned. The goal was to reach a score of **69** against a scoring criteria . The actual value achieved was **93**
- **End of life preferred place of death** The target was 37% this was exceeded exiting March with 51%
- **Falls assessment** The target was 55% March exited with 63%
- **Smoking training T**he target was 80% trained by September. Achieved 99% by September
- **Smoking Advice** 90% target Exited March with 95%

District Nursing: District nurse activity is marginally down on the previous year. Patient experience is rated as good although notably on low survey return rate. The Division have received anecdotal feedback from the PCT and latterly written feedback which reflects some degree of dissatisfaction with the service model. As part of the transformation plan a District Nurse service review has been commenced which includes

- Demand and Capacity review
- Review accessibility and response of service in line with specification
- Identify quality improvement opportunities and service development programme
- Review of the team structure and skills – ensure right skills, numbers, capacity and capability to respond to the local need
- Review and development of competency programmes – the HCA programme has already commenced
- Relationship management and customer service orientation
- Patient experience
- Communication strategy

Admission Avoidance activity has increased, in line with investment into community matron support for care homes and additional therapy support for STAR (short term assessment and re-ablement service).

The increasing integration of community matrons and SPARTIC (single point of access, response team and intermediate care) resulted in an average increase of 130 per month. The service extended it's hours and is now providing a service from 8am – 8pm across the week, enabling a single point of access for community beds and admission avoidance services.

Of the total referral activity 41% were from secondary care/A&E, 35% from GPs, 18% from community services and 16% from ambulance and social care services. 89% of referrals resulted in an avoided admission with the remainder staying at home with additional nursing and/or therapy support, or social care fast response services.

Community Orthopaedic (COS) The Community Orthopaedic service now provide an orthopaedic triage service for both the Black Country Locality Commissioning Group (BCLCG) and the Sandwell Health Alliance (SHAC) in line with the RCRH strategy. Of the referrals from SHAC 95% were seen by COS with 3.9% forwarded to secondary care. From BCLCG, 74% were

seen in COS and 19% referred to secondary care both reducing unnecessary referral to the acute service.

Intermediate Care and re-ablement: The opening of the Henderson Re-ablement Unit at Rowley Regis Hospital in September 2011 has been successfully reviewed. The 22 bedded unit is nurse / therapy led and supported by GPs. The unit operates an enabling framework to provide time limited, outcome focussed support for people whose assessed level of need can be safely provided outside of an acute hospital. Patients are referred both as step up and step down pathways of care. Experience is rated highly and the service is popular with patients and referrers. A formal review of the Unit has been carried out and concluded the model of care as effective, it noted the strong ethos of the unit to promote excellence in care and strong multidisciplinary working. Audit features across all domains and informs service development. Readmission rates are in the region of 30% and are reviewed as part of on-going governance systems. Occupancy rates are high at the end of the first 6 months and length of stay 37 days. There is an objective to reduce this by 1 week in 2012/13.

Community Respiratory Service: has developed to a seven day service. Asthma referral have increased by 60% in Q4 through the Lung Improvement Programme.

Intravenous antibiotic therapy services for patients with cellulitis has been developed. The intention is to further extend the remit of this service to avoid hospital admissions as part of the on-going transformation plan.

Working with acute services: The community matron and on call team are part of the Trust capacity planning meetings and were integral to supporting the winter pressures through in reach activity from community matrons and therapists, and the management of spot purchased care home beds.

Joint working with colleagues in the Division of Medicine and Social Care has seen the introduction of Early Supported Discharge for Stroke patients, which will contribute to a reduced length of stay for this patient group.

Rowley Regis site management The Division have taken over management of the Rowley Regis site and is better used as a hub for community staff. The team are working with commissioners on business opportunities for use of unutilised space on the site.

Trust IT systems: Community staff have access to the Trust Clinical Data Archive (CDA) which has improved communication around patient pathways. There has been successful integration of the Electronic Staff Record (ESR) with community managers benefitting from the self serve functionality for accurate record keeping.

Staff engagement: The Listening into Action approach has been adopted and used to continue to engage staff in the process of service development. In addition the Community services have been piloting the Owning the Future approach, with ambassadors identified across all teams.

Transformation plan A Community work stream is part of the core clinical transformation programme. The terms of reference for this work at Divisional level includes implementation of the productive community module and a review of district nursing services. Pan health economy the programme includes a demand and capacity model of community beds, developing a single point of access across all services and developing a rehabilitation model across acute and community pathways.

4. Governance /Quality

The Division's Governance programme and structures are fully integrated with Trust reporting systems. The Divisional programme has included governance focus sessions on Mobile technology and Systmone, Pressure Sores, Clinical Audit and Safeguarding Adults. The Clinical Audit process is now harmonised with Trust register and a full programme identified for 2012/13.

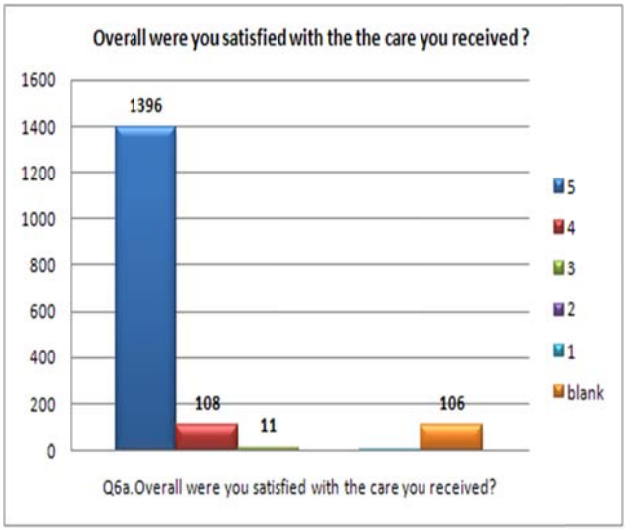
The Division has continued to focus its efforts on Tissue Viability and Pressure sore damage. A team leader forum has been set up to explore key issues around pressure damage and safer ways of working. Key staff have now undertaken Root Cause Analysis training . The Division has integrated into the Trust's process which provides greater opportunity to learn from experience, and share good practice across services.

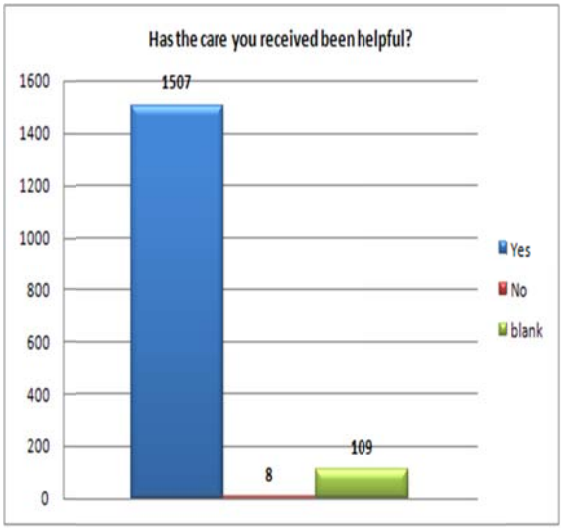
The Division received 27 formal complaints during 2011/12. Of these, 10 were graded green, 16 yellow and 1 amber. There were no complaints graded as red. All complaints have had appropriate action either implemented or underway. The Divisional approach to dealing with complaints locally and the timeliness and quality of responses has been commended in executive reviews.

Incident reporting in the Division has remained high, which indicates good staff engagement with the process. There were 1,866 incidents reported via the Datix system. Of these 1 was graded red, 527 amber, 1067 yellow and 271 green. 1743 of these incidents have been closed, 54 are pending closure and 50 are still under investigation. The top 3 incident categories are clinical care (1083), violence and aggression (118) and medication and workforce/organisation (both with 109). Increases in clinical care incidents were in respect of pressure ulcers. There has also been increased reporting of safeguarding issues, both of these increases have followed Divisional Governance away afternoons which focussed on these areas.

5. Patient Experience

Results from the survey carried out from July 2011 to March 2012 indicate that the experience of patients using our services has been good.





A separate patient experience study of the first six months of the Henderson Unit bat Rowley was carried out by AgeWell , and formed part of the commissioners review of the service. Overall satisfaction scores were very high from both patients and relatives and friends. The report's conclusions stated that
the attitude and compassion of the staff is to be commended as well as the care and treatment

staff give to their patients.

6. Workforce

At March 2012, the Division had 491.04 wte staff in post, with 40.94 posts vacant. Sickness absence has remained consistently above the Trusts target averaging at 4.89%, but sickness absence rates are improving, and showed a significant decrease of 1.94% in Quarter 4.

Mandatory Training is now provided on a Trust wide basis for all staff, through a new Trust programme. Community staff have also benefitted from access to wider development opportunities, for example the Ward managers development programme, the senior nurse forum and the HCA development matrix.

7. Financial performance

Sandwell Community Adult Health Division had a budget of £24.413m for the year 2011/12. Over the year, it generated a surplus of £346k.

	Budget £000s	**YTD** £000s	**Variance** £000s
Income	25,257	25,329	72
Expenditure			
Pay	(18,476)	17,667	809
Non Pay	(5,937)	(6,472)	(535)
Net Income and Expenditure Surplus/(Deficit)	844	1,191	346

The Division met its CIP target of £ 1.016m for 2011/12 in full and the TSP target of £1.561m for 2012/13 has been fully identified. Benefits on procurement standardisation as part of a larger organisation have been achieved in year and continue under the productive community project and procurement programme.

8. Benefits Realisation and next stage of integration

Previous papers to the Board reporting on Post Transaction Integration and Benefits Realisation have focussed on the actions taken to achieve organisational integration. There has been good progress in this regard at a Divisional level but further opportunities are to be gained from a more strategic review of community configuration and integration.

A review of the leadership, commercial and business infrastructure will be completed in year to ensure stakeholder engagement expertise and business development capability to lead the further integration and strategic development of community services. This will also take into account the work required for Any Qualified Provider.

The attached appendix is a list of proposed future configurations that will be in the scope of the next phase of integration.

This categorisation is based on the following:

- Those services considered ‘core’ community – District Nursing, Admission Avoidance. These need to be reviewed and have service strategies defined.

- Duplicate services – further alignment of those services hosted in both acute and community services which could merge to avoid duplication eg orthotics

- Pathway re-design and integration- of services spanning acute and community care with options for alignment at service level in existing Clinical Directorates eg MSK, cardiology. Some aspects of this are already in train as part of other speciality strategy reviews.

In order to take forward the next phase of integration, a project framework and overarching reporting process for delivery of the community strategic review will be established based on the 3 categories above. The framework would include:

- Identifying where programmes for delivery are already established and the respective reporting processes to track performance are clear (eg; Transformation Plan projects/specialty strategy development/existing process)
- Identifying new work streams/projects that would need to come on line for those additional services now 'in-scope'
- Identify leads/support, deliverables, scheduling and timescales for each of the service areas
- Identify scope for growth / expansion
- Identify stakeholder engagement
- Identify communication and marketing strategy

An overarching steering group will oversee the next phase of integration and will report as part of the Community Specialty Service Strategy review. A further report on this progress against this work will be presented to the Trust Board in 6 months.

Appendix 1 Sandwell Community Adult Health Division potential configurations for further integration.

Existing Services

Service	Scope	Features	Proposed Future Configuration
District Nursing Service	Covers all housebound adults over the age of 16 years and adults who have difficulty in accessing Primary Care and have a physical healthcare need.	DN service takes self referrals, provides a 24 hour service and is able to respond within 4 hours for urgent referrals. It has a single point of access and works with integrated model of care. It supports the environment of choice care for end of life care	Core community service Potential to become more aligned to a group of practices in a geographical area with similar sized populations for each team.
Rehabilitation Service	Provides specialist assessment and treatment to people 16^{+} requiring rehabilitation and care management. Services include: • Falls and Bone Health • Elderly Care • Admission Avoidance • Care management • Neurology • Stroke • Therapy in EAU • Therapy in Star • Therapy in Palliative Care	Multidisciplinary integrated team comprising: • Physiotherapist • Occupational Therapist • Speech and Language Therapist • Specialist Nurses • Community Matrons • Home Accident Prevention Officers Maintains or improves level of independence. Provides admission avoidance service. Proactive case finding and management of people with long term conditions.	Pathway based re-design to align elements delivering admission avoidance and therapy respectively
Community Respiratory Service	Offers assessment, diagnosis treatment and management to patients, families and carers of people with Chronic Obstructive Pulmonary Disease (COPD), asthma, bronchiectasis and interstitial lung disease	The service consists of an integrated team offering a full spectrum of respiratory services including oxygen assessment and prescription, pulmonary rehabilitation, spirometry and development of self care skills. The service operates Monday – Sunday and until 8 p.m. Monday –	Pathway re-design to deliver integrated service

		Friday. The extended hours along with acceptance of self referrals maximises the impact the service has on decreasing hospital admissions and unnecessary A&E attendances.	
Admission Avoidance Service **Single Point of Access Responsive Team and Intermediate Care (SPARTIC)**	Provides rapid assessment of patients within the community or at the 'front end' of the hospital to offer and co-ordinate the appropriate support to avoid an unnecessary admission to an acute hospital service and management of community beds by a specialist team.	Single point of access for admission avoidance and community bed management. Clinician to clinician referral 7 day service 08:00 – 20:00 Response within 3 hours	Core community service
Community Musculo-skeletal service	Provides support for people aged over 8 years with a problem relating to their skeleton or muscles	The orthopaedic service provided within MSK manage the service from assessment, treatment and through to surgery providing a 'one stop' management service. The service includes first orthopaedic appointment, provision of peripheral joint steroid treatment and pain management programmes.	Pathway re-design to deliver integrated service
Community Foot Health Service	Provides treatment and advice for people with foot health needs to assist their mobility and independence as well as offering training and self care techniques to maintain good foot health	The service provides a single point of access with an automated appointment system. Assessment and treatment of need is delivered within the same appointment and the provision of 'in shoe' orthotics if appropriate	Pathway re-design to deliver integrated service and review to consider duplicate service provision
Nutrition and Dietetic Service	Provides evidence based information on nutrition related issues and translates scientific information about food into practical, dietary advice for	**Adult and some Paediatric Services** Service is provided via community clinics and home visits across Sandwell. The service	Pathway re-design to deliver integrated service

	individuals to improve outcomes of clinical conditions.	includes a comprehensive adult and paediatric enteral feed service which includes both dietetic and nutrition nurse service supporting admission avoidance. Programmes of structural education for these with Diabetes – X-PERT, DAFNE.	
Continence Service	Provides assessment, treatment and management of urinary and faecal incontinence	The service has well established bladder symptom clinics (in operation since 1998 continuously improved through benchmarking)	Pathway re-design to deliver integrated service
Specialist Community Nursing	**Palliative Care Service** Provides support and management to patients with a life limiting illness **Heart Failure Service** Provides specialist nursing for the management, support and education for patients with chronic heart failure. **Tissue Viability Service -** Promotes the efficient and effective care for patients with compromised tissue viability	Specialist nursing provides: Non medical prescribing Advanced assessment and care management Is working to provide seamless path of care across Palliative care diagnosis in patients preferred place of care. Utilises a holistic approach to wound management	Elements of core service and pathway re-design to deliver integrated service
Community Diabetes Service	Provides a specialist service for adult patients with diabetes to optimise their diabetes control.	Provides advice to patients, families and carers via community clinics, home visits, care home visits and telephone advice and through liaison with other healthcare professionals offers programmes of structured education for those with Type 2 Diabetes – X-PERT.	Pathway re-design to deliver integrated service
Wheelchair	Provides wheelchairs, specialist seating and	Provides assessment of pressure areas using	Core community service

Service	pressure cushions to clients of all ages who have a Sandwell GP and who require a wheelchair for their indoor mobility	pressure mapping equipment to ensure specific needs are met. The service maintains competitive assessment times	
Leasowes	A 24/7 bed based intermediate care service	The service prevents avoidable hospital admission, supports timely discharge from hospital and reduces the need/dependence on long term care. Rated excellent for privacy and dignity by regulators.	Some elements core and pathway re-design for admission avoidance elements