Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 26 April 2012; 1530h - 1730h

Members			**In Attendance**	
Mr R Samuda	(RS)	[Chair]	Mr G Seager	(GS)
Mr R Trotman	(RT)		Miss K Dhami	(KD)
Dr S Sahota	(SS)		Mrs J Kinghorn	(JK)
Mrs G Hunjan	(GH)		Mrs C Rickards	(CR)
Prof D Alderson	(DA)		Mrs C Powney	(CP) [Sandwell LINks]
Mrs O Dutton	(OD)			
Mr P Gayle	(PG)		**Secretariat**	
Mr J Adler	(JA)		Mr S Grainger-Payne	(SGP) [Secretariat]
Dr D Situnayake	(DS)			
Mr R White	(RW)			
Miss R Barlow	(RB)			
Miss R Overfield	(RO)			
Mr M Sharon	(MS)			

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 29 March 2012 as true and accurate records of discussions*	**SWBTB (3/12) 053**	**Chair**
4	**Update on actions arising from previous meetings**	**SWBTB (3/12) 053 (a)**	**Chair**
5	**Chair's opening comments**	**Verbal**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	MATTERS FOR APPROVAL		
7	**Ward leadership capacity expansion plan**	**SWBTB (4/12) 070** **SWBTB (4/12) 070 (a)**	**RO**
8	**Application of the Trust Seal to the Community contract Deed of Variation**	**SWBTB (4/12) 074**	**RW**

9	**Safety, Quality and Governance**		
9.1	Quality report	To follow	RO, KD & DS
9.2	Care Quality Commission's report into Outcome 17 and the complaints handling position	SWBTB (4/12) 056 SWBTB (4/12) 056 (a)	KD
9.3	Care Quality Commission revised regulatory approach for 2012/13	SWBTB (4/12) 057 SWBTB (4/12) 057 (a)	KD
9.4	Register of Seals	SWBTB (4/12) 058 SWBTB (4/12) 058 (a)	SG-P
10	**Performance Management**		
10.1	Monthly finance report	SWBTB (4/12) 059 SWBTB (4/12) 059 (a)	RW
10.2	Monthly performance monitoring report	SWBTB (4/12) 060 SWBTB (4/12) 060 (a)	RW
10.3	NHS Performance Framework report	SWBTB (4/12) 061 SWBTB (4/12) 061 (a)	RW
10.4	NHS Performance Framework for 2012/13 and mapping of Quarter 4 performance (2011/12) to New Indicators	SWBTB (4/12) 062 SWBTB (4/12) 062 (a)	RW
10.5	Performance Management Regime – monthly submission	SWBTB (4/12) 064 SWBTB (4/12) 064 (a)	MS
10.6	Outturn position on delivery against corporate objectives 2011/12	SWBTB (4/12) 063 SWBTB (4/12) 063 (a)	MS
10.7	Update on the delivery of the Transformation Plan	Verbal	RB
11	**Strategy and Development**		
11.1	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (4/12) 065 SWBTB (4/12) 065 (a)	MS
11.2	Foundation Trust application programme		
▶	Programme Director's report	SWBFT (4/12) 045	MS
11.3	Midland Metropolitan Hospital project: Programme Director's report	Verbal	GS
12	**Operational Management**		
12.1	Sustainability update	SWBTB (4/12) 067 SWBTB (4/12) 067 (a)	GS
12.2	National Staff Survey and action plan	SWBTB (4/12) 068 SWBTB (4/12) 068 (a)	MS
13	**Any other business**	**Verbal**	**All**
14	**Details of next meeting** *The next public Trust Board will be held on 31 May 2012 at 1530h in the Anne Gibson Boardroom, City Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 29 March 2012

Present

Mr Roger Trotman (Chair)
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Mr Phil Gayle
Mr John Adler
Mr Robert White
Miss Rachel Barlow
Miss Rachel Overfield
Mr Mike Sharon
Mr Deva Situnayake

Secretariat

Mr Simon Grainger-Payne

In Attendance

Miss Kam Dhami
Mrs Jessamy Kinghorn
Mr Graham Seager
Mr Richard Samuda [Part]

Guests

Ms Daphne Lewsley [Item 10]
Mrs Andrea Bigmore [Item 10]
Mrs Pauline Richards [Item 12.4]
Mrs Linda Pascall [Item 12.4]
Mr Mike Beveridge [Item 11 & 14.1]
Mrs Jayne Dunn [Item 14.1]
Mr Philip Nicholl [Item 14.1]

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson and Mr Graham Seager	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Minutes of the previous meeting	**SWBTB (2/12) 025**

The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 23 February 2012.	
AGREEMENT: The Trust Board approved the minutes of the last meeting	
4 Update on actions arising from previous meetings	**SWBTB (2/12) 025 (a)**
The updated actions list was reviewed and it was noted that there were no actions due for completion or that required escalation to the Trust Board for resolution.	
5 Chair's opening comments	**Verbal**
Mr Trotman welcomed Mr Richard Samuda who was in attendance at the meeting in his capacity as Chairman Designate. It was reported that Mr Samuda would take up his post substantively from April 2012. Dr Deva Situnayake was also welcomed to the meeting as Acting Medical Director.	
6 Questions from members of the public	**Verbal**
There were no questions.	
Items for Approval	
7 Trust Board reporting cycle for 2012/13	**SWBTB (3/12) 037** **SWBTB (3/12) 037 (a)**
Mr Grainger-Payne presented the proposed Trust Board reporting cycle for 2012/13 and advised that it was largely based on the model used within the Trust for the previous three years. The Board was asked to note the changes proposed to the reporting cycle, which included the rationalisation of some reports due to the introduction of the monthly Quality Report and a number of additional reports to ensure that all the relevant elements of the 'Organising for Excellence' framework were covered. It was highlighted that the requirement to sign off the new Provider Management Regime return was also included within the reporting cycle. Mrs Dutton asked whether there was flexibility to amend the reporting cycle should there be a need to customise it within the year. Mr Adler confirmed that this was the case, particularly given the Board Development work requirements as part of the application for Foundation Trust status that would be likely to arise within the coming months.	
AGREEMENT: The Trust Board approved its reporting cycle for 2012/13	
8 Annual financial plan 2012/13	**SWBTB (3/12) 048** **SWBTB (3/12) 048 (a)**

Mr White presented that Trust's annual financial plan for 2012/13, which he highlighted was forecast to provide an outturn surplus of £4.2m and was based on a forecast turnover of £422.8m. It was reported that the surplus forecast was in line with the requirements set out by the Department of Health and Strategic Health Authority to deliver a surplus of 1% of turnover. As such, the Board was advised that a shadow Financial Risk Rating of 3 was achieved. The Board was asked to note that the financial plan included the detail of the CQuIN framework. The detail of the Transformation Plan was also reported to have been included in the report. In terms of the forecast outturn position for 2011/12, the Board was advised that a surplus of £1.8m continued to be forecast. Mr Trotman advised that the plan was aligned to the Financial Information Management System (FIMS) submission that had been sent to the Strategic Health Authority. The Trust Board was asked for and gave its approval to the annual financial plan for 2012/13.	
AGREEMENT: The Trust Board gave its approval to the annual financial plan for 2012/13	
9 Application of the Trust Seal to the lease for the letting of shop premises to the WRVS at City and Sandwell Hospital	**SWBTB (3/12) 033**
Mr Trotman asked the Board for its approval to apply the Trust Seal to the lease for the letting of premises to the WRVS at City and Sandwell Hospitals. Miss Overfield advised that the rent for the premises had not been altered from that of previous years as the WRVS would be working in greater partnership with the Trust in forthcoming months.	
AGREEMENT: The Trust Board approved the proposal to apply the Trust Seal to the lease for the letting of shop premises to the WRVS at City and Sandwell Hospital	
10 Estates rationalisation plans	**SWBTB (3/12) 032** **SWBTB (3/12) 032 (a)**
Ms Lewsley and Mrs Bigmore joined the meeting to present the proposals for rationalisation of the Trust's estate, which it was highlighted formed one of the key workstreams within the Trust's Transformation Plan. The Trust Board was advised that the proposals involved the closure of a set of buildings as part of the long-term estates plan and the creation of agile working facilities within a purpose-built environment. It was reported that the plans would impact on c. 1000 staff and that an element of the gross savings arising from the buildings closures planned would be invested in the provision of capital	

solutions, IT and telephony services within the alternative facilities. It was highlighted that the agile working plans were in line with the proposals for the new hospital where less than one desk per member of staff had been allocated, a strategy that had been informed by a number of space utilisation surveys.

In terms of options considered, the Board was informed that the use of off site facilities had been investigated, however it had been determined that the cost of pursuing this solution was not favourable in comparison with an on-site option. It was reported that some of the key buildings impacted by the proposals included the Management Centre and DGM building at City Hospital and that some of the current wards would be converted to accommodate agile working space.

Voice and telephone solutions were highlighted to be critical to the proposals and therefore the use of a virtual desktop had been agreed to be the most practical solution.

Option 2, with the creation of an agile working solution benefiting from Voice Over IP (VOIP) was presented as the preferred option for the estates rationalisation plans, alongside the classification of the Sisters' Home at City Hospital and the Hallam Close residential blocks (1 – 4) as being non-operational, with no further intended use from 31 March 2012. Mr Trotman noted that the total costs saved by this option were forecast to be £1.2m, however the financial benefit overall was £743k. Ms Lewsley advised that this was reflective of the costs involved with delivering the capital solutions required and the revenue charges for the VOIP. Mr Adler added that the full year effect of the savings would not be expected to be delivered within 2012/13. Mr White encouraged the impairment of assets as a result of the plans to be built into the proposals.

Mr Trotman remarked that he understood that some staff who were largely desk-based might be dissatisfied with the plans. Ms Lewsley advised that the solution could only work if minimum protected space was allocated within the plans, however in reality it was anticipated that some individuals would book the same space within the area on a routine basis if they were usually desk-based.

Miss Overfield asked what timescale was planned for the purchase and implementation of VOIP. Ms Lewsley advised that the solution was currently being procured and that some technical elements had already been received. It was acknowledged that the installation and purchase of the required software solutions posed a potential risk to the original timescale of the plans as staff could not move until this was in place.

Mr Gayle remarked that agile working was in place within Sandwell PCT. Ms Lewsley reported that the same booking system as that being used by the PCT was being investigated for use by the Trust as part of these plans. Mrs Dutton underlined the benefits of open plan working in her experience.

Mrs Bigmore reported that significant engagement activity had been undertaken

to determine the requirements of individual areas and groups of staff. Ms Lewsley advised that the key considerations had concerned confidentiality, storage and IT. Mr Adler advised that from a cultural and team working perspective, he welcomed the agile working approach. However he commented that further consideration should be given to confidentiality considerations as a result of the shared working area arrangements.	
AGREEMENT: The Trust Board approved: • **the pursuance of the recommended Option 2 for estates rationalisation, the creation of an agile working environment and the implementation of VOIP** • **the classification of the Sisters' Home at City Hospital and the Hallam Close residential blocks (1 – 4) as being non-operational from 31 March 2012**	
11 Business case for the development of the Endoscopy unit at Sandwell Hospital	**SWBTB (3/12) 046** **SWBTB (3/12) 046 (a)**
Miss Barlow presented the business case for the development of the endoscopy unit at Sandwell Hospital, which she advised was necessary for maintaining service delivery in this area. Mr Mike Beveridge attended the meeting for this item. It was reported that maintenance of endoscopy washers was challenging and therefore the business case included the request to authorise the purchase of new decontamination washers and a dryer cabinet. The Board was asked to note that a key driver for the business case included the need for the unit to comply with National Decontamination and Joint Advisory Group (JAG) requirements. It was further highlighted that there was a need to improve the current arrangements from a privacy and dignity standards perspective. The Board was advised that the plans required the investment of £1.6m capital costs and a net recurrent revenue investment of £210k in Year 1. Mr Trotman asked whether the proposal had been endorsed by the Strategic Investment Review Group (SIRG). Miss Barlow advised that the case had been approved using the Chief Executive's authority as chair of the SIRG. Mr Beveridge advised that the various options to address the requirements had been considered and that the Board was asked to endorse the pursuance of Option 6.2, the upgrade of the current endoscopy facility at Sandwell Hospital and the creation of a dedicated decontamination facility in line with the retained estates plans.	

It was reported that the work to upgrade the facility would commence in November 2012 and would be concluded by March 2013, however there was a pressing need to replace the endoscopy washers. Miss Overfield expressed her support for the plans from the perspective of her Director of Infection Control & Prevention responsibilities. For the Board's benefit, Mr Adler asked whether consideration had been given to transferring the endoscopy service to City Hospital in its entirety. Mr Beveridge advised that from the point of view of the 'Right Care, Right Here' access model, the provision of a service from both City and Sandwell Hospitals was preferred. He added that some patients presenting in Accident and Emergency departments at both sites also required the use of the endoscopy facilities on an urgent basis. Mr Trotman asked when a project plan and risk mitigation strategy for the work would be developed. Mr Beveridge advised that this would be available in June 2012.	
AGREEMENT: The Trust Board approved the investment within the recommended option (6.2) for the development of the endoscopy unit at Sandwell Hospital	
12 Safety, Quality and Governance	
12.1 Integrated risk, complaints and claims report – Quarter 3	**SWBTB (3/12) 030** **SWBTB (3/12) 030 (a)**
Miss Dhami asked the Trust Board to receive and note the contents of the Integrated Risk Report which presented the position as at the end of Quarter 3. In terms of reporting incidents, the Board was advised that the Trust had improved to being within the middle 50% of trusts for reporting, according to the National Patient Safety Agency. The Board was informed that 39 claims had been reported in Quarter 3, of which five had raised concerns through the complaints process.	
12.2 Board Assurance Framework update – Quarter 3	**SWBTB (3/12) 028** **SWBTB (3/12) 028 (a)**
Mr Grainger-Payne presented the updated Board Assurance Framework (BAF) for receipt and noting, which he advised reflected the position as at the end of Quarter 3. The Board was advised that the update had been considered by the Quality and Safety Committee at its meeting on 22 March 2012. Mr Grainger-Payne advised that it was encouraging to note that good progress had been made with addressing the actions required to close the gaps in control and assurance that the risks associated with the delivery of the Trust's annual	

objectives were being managed. It was reported that the process with updating and setting the BAF was to be refreshed for 2012/13 to ensure that there was closer link between the BAF and the agendas of meetings and to promote a greater degree of oversight and debate of the contents of the report.	
12.3 Equality and Diversity update	**SWBTB (3/12) 027** **SWBTB (3/12) 027 (a)**
Mrs Pauline Richards and Mrs Linda Pascall joined the meeting to present an update on the Trust's work to comply with Equality and Diversity guidance and legislation. It was reported that a toolkit had been developed by the Department of Health to allow trusts to assess themselves against the requirements of the Equality Act 2012. It was highlighted that lay assessors had evaluated the Trust's position against the requirements and had largely identified that the Trust position reported represented good practice, however there was further work to do to strengthen compliance. As a result, the Board was asked to note the set of equality objectives that had been developed. In terms of general publishing duties, it was highlighted that there was further work to be done to improve the availability and detail of material required to be publically available. Mr Adler sought reassurance that this matter would be addressed as a priority, particularly given the plans for the Equality and Human Rights Commission to begin reviewing trusts' websites to assess compliance with this requirement. Mrs Richards advised that the position would be reviewed at the meeting of the Equality and Diversity Steering Group on 4 April 2012 in readiness for the deadline for the publication requirements to be met from 6 April 2012. Mrs Dutton asked how the equality duties would be delivered in the context of the estates rationalisation plans. Miss Overfield advised that all schemes within the Transformation Plan, including that concerning estates rationalisation, had been assessed for equality impact. It was reported that work was needed to improve the robustness of the assessment of service changes from an equality impact perspective. The action plan to achieve the proposed equality objectives was brought to the Board's attention. Mrs Pascall highlighted that the development of the objectives had taken into account feedback from members of the public as a result of an engagement exercise. Miss Overfield reported that there was further work required to ensure that training in equality and diversity was embedded within the Trust, howeverthis had now been included within the Mandatory Training suite and would therefore	

assist. Mrs Powney asked who trained the lay assessors that had assessed the trust's position against equality and diversity requirements. Mrs Richards reported that a training pack had been developed for this purpose, which ensured that assessors were trained in a consistent manner. It was noted that the Trust had been invited to present its good practice in terms its preparation for compliance with equality and diversity requirements to the Strategic Health Authority.	
12.4 Health and Wellbeing update	**SWBTB (3/12) 038** **SWBTB (3/12) 038 (a)** **SWBTB (3/12) 038 (b)**
Miss Overfield presented an update on health and wellbeing matters. It was reported that the required sickness absence target was likely not to be met, however there had been an overall downward trend in sickness absence. The Board was advised that against a number of indicators in the staff survey, the Trust's position had improved. It was noted that a significant health and wellbeing programme was in place within the trust, including exercise classes and targeted support around sickness absence. Mr Trotman asked what reason lay behind the high sickness absence within the community services teams. Mr Adler advised that the matter was being considered within the division's sickness absence review. Mr Gayle asked whether the position might be reflective of stress or exposure to infections in this group of staff. He was advised that the position was unclear, however work was underway to instil improved behaviour in terms of sickness absence. Dr Sahota noted that overall the sickness absence position of the Trust was good, however there were a number of wards on which sickness absence remained high. He asked what measures were being put into place to address the situation. Miss Overfield advised that the areas were subject to routine sickness absence reviews and that in exceptional circumstances, the areas might be placed in Special Measures. Dr Sahota remarked that previously a large number of sickness absence instances had been classified as being due to 'other' reasons and asked how this had been addressed. He was advised that processes within the revised sickness absence policy had assisted, including reinforcing the need for staff to call into their line manager to report the reason for the absence.	
13 Performance Management	
13.1 Monthly finance report	**SWBTB (3/12) 031** **SWBTB (3/12) 031 (a)**

Mr White reported that the financial performance during the month had been pleasing, including a particular encouraging position on income.	
13.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 22 March 2012	**Hard copy papers**
Mr Trotman reported that an informative, encouraging and detailed discussion with the Pathology department had been held at the start of the meeting. He reiterated that financial performance for February 2012 had been good and that it was reassuring to learn that the Medicine & Emergency Care division was within its agreed deficit and that the Women and Child Health division was also on the agreed schedule. Importantly, the Board was advised that there had been another favourable variance on pay costs and that overall it had been a very good outcome, considering the concerning start to the year. Mr Trotman advised that at the Trust Board meeting in February 2012, he had reported that there might be a shortfall against the Trust's Cost Improvement Plan (CIP) target, however this had not been entirely accurate. The position as it should have been stated was reported to be that the Trust was slightly ahead of its original target but a little behind its stretch target. The Board was advised that the Committee had discussed the 2012/13 medium term financial plan and had recommended it to the Board earlier in the meeting. Mr Trotman advised that the Committee had been informed that it looked likely that the Trust would finish the year strongly against the performance targets. The Board was informed that the Committee had received a report on service line reporting and that the frequency of reporting would be increased to bimonthly.	
13.3 Monthly performance monitoring report	**SWBTB (3/12) 040** **SWBTB (3/12) 040 (a)**
Mr White highlighted that issues continued regarding delayed discharges of care, however the position had improved from that of the previous month, with the year to date position being 5.3%. Good performance against the stroke care and TIA targets was noted. The Board was asked to note the pleasing performance against CQuIN targets and the overall Accident & Emergency waiting time target, which was highlighted to be in excess of 95% year to date.	
13.4 NHS Performance Framework/FT Compliance monitoring report	**SWBTB (3/12) 041** **SWBTB (3/12) 041 (a)**
Mr White presented the NHS Performance Framework/FT Compliance Framework update for receiving and noting.	

It was highlighted that the Trust's performance was rated amber due to the position against the Accident and Emergency waiting time target and the related clinical indicators in February 2012.	
13.5 Update on the delivery of the Transformation Plan	**Verbal**
Miss Barlow reported that from April 2012 a routine update on the delivery of the Transformation Plan would be presented.	
14 Strategy and Development	
14.1 Business case for the reconfiguration of Vascular Services	**SWBTB (3/12) 041** **SWBTB (3/12) 041 (a)**
Mr Beveridge, Mrs Dunn and Mr Nicholl joined the meeting to present the business case proposing the reconfiguration of Vascular Services. Mr Nicholl reported that a significant driver for the reconfiguration was the introduction of aneurysm screening with the anticipated effect that mortality rates associated with this condition would drop as a consequence. It was reported that the service model proposed suggested that a single model of care for vascular services be introduced, with the inpatient element of the service being transferred to University Hospital Birmingham NHS Foundation Trust (UHBFT). It was highlighted that the Trust would retain day case and outpatient work in this area. The Board was advised that discussions with the Imaging division were underway to determine the most appropriate location for the delivery of vascular Interventional Radiology, however should it be decided that this element should transfer to UHBFT, a significant number of patients currently treated at City Hospital would need to be transferred. Mrs Dunn reported that the plans had been discussed with the Joint Local Authority Overview and Scrutiny Committee and that given the strength of the clinical case for change, it had been agreed that public consultation was not required. The financial impact of the changes was discussed and it was reported that the loss of income to date would be incorporated within the construction of the Local Delivery Plan (LDP). The adverse income impact on the Trust had therefore been satisfactorily addressed. In terms of the impact of the plans on staff, it was reported that some individuals would need to transfer to UHBFT and would be subject to TUPE regulations (if applicable). It was highlighted that staff transferring over would include vascular consultants and potentially some nursing staff. The Board was asked to note the risks around staffing as a result of the plans, however Human Resources managers were closely engaged to support the plans. Mr Sharon remarked that he was supportive of the plans and advised that they had been discussed with the Trust's commissioners. Mr Beveridge added that the	

plans had received clinical support from surgeons and Interventional Radiology staff, however clarity continued to be sought as to the final details of the services to be provided. It was further highlighted that there were potential challenges with reducing Length of Stay for patients as a result of centralising inpatient services. Mrs Dutton asked whether an equality and diversity impact assessment had been undertaken and if so, what mitigating activities were planned. Mrs Dunn advised that many of the initial issues identified concerned patient information about matters, such as transport arrangements and car parking, however a further detailed equality impact assessment would be undertaken as part of the plans. It was agreed that this assessment, together with an implementation plan should be presented to the Trust Board in May 2012. Dr Situnayake raised an issue concerning the impact of the plans on teamworking and in particular Diagnostic Imaging. Mr Nicholl advised that the matter would be given due consideration, however it was agreed that the specifics of the issue would be discussed outside of the Trust Board meeting. The proposal to reconfigure Vascular Services was approved by the Trust Board subject to a presentation of a further paper at the meeting in May 2012, which would share the results of the equality impact assessment and implementation plan.	
AGREEMENT: The proposal to reconfigure vascular services was approved by the Trust Board subject to a presentation of a further paper at the meeting in May 2012, which would share the results of the equality impact assessment and implementation plan	
14.2 'Right Care, Right Here' programme: progress report including an update on decommissioning	**SWBTB (3/12) 036** **SWBTB (3/12) 036 (a)**
Mr Sharon advised the Board that a medical engagement event had been held and a review of the decommissioning process had been undertaken. It was reported that agreement had been reached on the principles of the decommissioning activities and the feedback would be built into the commissioner intentions. It was reported that a robust project management approach to the plans was needed.	
14.3 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (3/12) 049** **SWBTB (3/12) 049 (a)**
Mr Sharon presented the Foundation Trust Programme Director's report for receiving and noting.	
14.4 The Birmingham and Solihull Partnership Compact	**SWBTB (3/12) 045**

	SWBTB (3/12) 045 (a)
Mr Sharon advised that the Compact set out a shared programme of work agreed by the Birmingham and Solihull Partnership. Mr Adler highlighted the specialist hospital programme, where the Paediatrics and maternity workstreams were being led by the Chief Executives of Birmingham Women's Hospital NHS Foundation Trust and the Birmingham Children's Hospital NHS Foundation Trust. The Board was asked for and gave its approval to the proposal that the Trust should sign up to the Compact. Dr Situnayake asked whether Public Health Departments linked in with the principles of the Compact. He was advised that the responsibility for Public Health was currently in transition to Local Authorities, however they were signed up to the Compact. Mrs Powney confirmed that as part of the plans, Health and Wellbeing Boards were providing six weekly updates.	
AGREEMENT: The Trust Board agreed to the proposal that the Trust should sign up to the Birmingham and Solihull Partnership Compact	
Minutes of the FT Programme Board	**SWBFT (1/12) 010**
The Trust Board received and noted the minutes of the FT Programme Board held on 26 January 2012.	
14.5 Midland Metropolitan Hospital project: progress report	**Verbal**
Mr Seager reported that the results of the national Private Finance Initiative review were awaited and therefore until the outcome was made known, further refinement of the timescales guiding the new hospital project was challenging. The Board was advised that preliminary discussions were being held with alternative sources of funding should the Treasury consider that an alternative model of funding is required.	
15 Update from the Trust Board Committees	
15.1 Minutes from the meeting of the Quality and Safety Committee held on 19 January 2012	**SWBQS (1/12) 015**
The Trust Board was asked to receive and note the minutes from the meeting of the Quality and safety Committee held on 19 January 2012.	
16 Any other business	**Verbal**
Mr Adler thanked Mr Trotman for his time as Acting Chairman during the period	

while a replacement Chair was recruited following Mrs Davis' departure in November 2011.	
17 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 26 April 2012 and would be held in the Boardroom at Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 26 April 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 Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), 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), Mr D O'Donoghue (DO'D)

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

Apologies: Prof D Alderson, Mr G Seager

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 20 April 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 ~~2011~~ 2012	A
SWBTBACT.218	Monthly performance monitoring report	SWBTB (11/11) 228 SWBTB (11/11) 228 (a)	24-Nov-11	Discuss the additional material needing to be included within the performance exceptions report with Mr White	JK	~~26/01/2012~~ ~~23/02/2012~~ 31/05/2012	Wider discussion to be held including comments from Executive Directors not in attendance at F & PMC to include more detailed quality metrics	A

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: 26 April 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 Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), 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), Mr D O'Donoghue (DO'D)

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

Apologies: Prof D Alderson, Mr G Seager

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 20 April 2012

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.261	Minutes of the previous meeting	SWBTB (2/12) 025	26/03/2012	The Trust Board approved the minutes of the last meeting
SWBTBAGR.262	Trust Board reporting cycle for 2012/13	SWBTB (3/12) 037 SWBTB (3/12) 037 (a)	26/03/2012	The Trust Board approved its reporting cycle for 2012/13
SWBTBAGR.263	Annual financial plan 2012/13	SWBTB (3/12) 048 SWBTB (3/12) 048 (a)	26/03/2012	The Trust Board gave its approval to the annual financial plan for 2012/13
SWBTBAGR.264	Application of the Trust Seal to the lease for the letting of shop premises to the WRVS at City and Sandwell Hospital	SWBTB (3/12) 033	26/03/2012	The Trust Board approved the proposal to apply the Trust Seal to the lease for the letting of shop premises to the WRVS at City and Sandwell Hospital
SWBTBAGR.265	Estates rationalisation plans	SWBTB (3/12) 032 SWBTB (3/12) 032 (a)	26/03/2012	The Trust Board approved: • the pursuance of the recommended Option 2 for estates rationalisation, the creation of an agile working environment and the implementation of VOIP • the classification of the Sisters' Home at City Hospital and the Hallam Close residential blocks (1 – 4) as being non-operational from 31 March 2012
SWBTBAGR.266	Business case for the development of the Endoscopy unit at Sandwell Hospital	SWBTB (3/12) 046 SWBTB (3/12) 046 (a)	26/03/2012	The Trust Board approved the investment within the recommended option (6.2) for the development of the endoscopy unit at Sandwell Hospital
SWBTBAGR.267	Business case for the reconfiguration of Vascular Services	SWBTB (3/12) 041 SWBTB (3/12) 041 (a)	26/03/2012	The proposal to reconfigure vascular services was approved by the Trust Board subject to a presentation of a further paper at the meeting in May 2012, which would share the results of the equality impact assessment and implementation plan
SWBTBAGR.268	The Birmingham and Solihull Partnership Compact	SWBTB (3/12) 045 SWBTB (3/12) 045 (a)	26/03/2012	The Trust Board agreed to the proposal that the Trust should sign up to the Birmingham and Solihull Partnership Compact

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Ward Leadership Capacity Expansion Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Overfield, Chief Nurse**
AUTHOR:	**Rachel Overfield, Chief Nurse**
DATE OF MEETING:	**26 April 2012**

EXECUTIVE SUMMARY:

Effective ward leadership is key to delivering safe, effective care; managing Trust resources and facilitating and embedding change to patient pathways and services.

Currently the resources allocated for ward leadership time are considered inadequate. There are increasing demands on nurses to deliver continuous improvements in care standards and this requires appropriate ward level governance arrangements and robust management with clear lines of accountability and expectations. It is highly likely that national priorities will continue to focus on nursing practice especially around care of vulnerable people and part of this will be the requirement that Trust's invest appropriately in nursing leadership.

REPORT RECOMMENDATION:

This paper proposes an investment of circa £700,000 to create ward level Matrons and a supporting infrastructure. This has been accounted for within this year's financial plan pending this proposal being approved. The Board is asked to support this proposal.

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	x
Clinical	**x**	Equality and Diversity		Workforce	x

Comments: There is the potential to market this as positive initiative for the Trust both internally and externally. An early decision is key as these structures impact on bed reconfiguration and other transformation plans.

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

- High Quality, Safe Care
- Improve care to vulnerable adults
- CQC standards – all
- NHSLA standards – all
- CQuIN delivery
- Transformation Plans

PREVIOUS CONSIDERATION:

- Exec Team
- SIRG
- Senior Nursing Forums

Report Title	*Ward Leadership Capacity Expansion Plan*
Meeting	*Trust Board*
Author	*Rachel Overfield, Chief Nurse*
Date	*26th April 2012*

1) Introduction

Nursing and nursing leadership have been subject to considerable scrutiny and comment in recent years. Most notably via high profile CQC reports; the Mid Staffordshire enquiry; the parliamentary commission reviews on nursing practice; Patients Association reports and high profile announcements from the Prime Minister.

Targets and standards for Trusts are far more focused on nursing quality issues than ever before, especially in relation to vulnerable adults and the frail elderly.

The Prime Minister recently announced an intention to review nursing practice and set national nursing metrics. This announcement is undoubtedly timed to coincide with the Frances report into events at the mid Staffordshire Hospitals FT. The Francis report is highly likely to make recommendations around nursing standards and practice; performance management of nursing and nursing leadership/management. Amongst nursing circles there is an expectation that this, plus the Cameron review, will lead to nationally defined staffing and management arrangements for nursing. We expect there to be recommendations that nurse managers should have sufficient time to properly lead and manage nurses and that they should not be distracted from this essential role by other demands on their time.

Locally the recognition of the importance of high quality nursing care to the patient experience and outcome is reflected in CQuINS and SHA priorities. These include specific CQuINs in 2011/12 around:

- Pressure Damage
- Falls
- Nutrition
- End of Life Care

For 2012/13 CQuINs relating to nursing care include:

- Pressure Damage
- Falls (via Safety Thermometer)
- End of Life Care
- Dementia Care
- Nutrition

One of the SHA priorities is around eradication of avoidable pressure damage and CQC interest continues to be high around nutrition, privacy and dignity and adult safeguarding.

The Trust Quality account and Trust priorities include an on-going desire to improve the experience of patients and especially vulnerable adults through continuous improvement in nursing standards. In recent years the performance framework around nursing care within the Trust has demonstrated continuous improvement, however, there is increasing pressure to improve faster and over a wider set of metrics. With this comes the need to sustain improvements and measure standards and outcomes continuously.

For all of these reasons the following proposals has been developed to increase and improve the leadership capacity at ward level. The proposal has been approved at SIRG and allowed for within the financial plan but because of the value of the scheme requires Trust Board approval to proceed.

2) Expansion and development of Ward Leadership Capacity

Ward Managers manage and lead more staff than any other Trust Manager. Their role is central to the provision of safe, effective and compassionate care through:

- Personal role model
- Team leadership
- Clinical expertise
- Management of ward resources
- Co-ordination of MD team
- Monitoring, implementing and evaluating standards of care
- Effective communication with patients and relatives
- Management of the patient environment
- Implementing Trust initiatives – including transformation plans, CQuINs, patient surveys, CQC standards
- Monitoring patient flows
- 'Prescribing' care/treatment

Currently Ward Managers have just one day per week to do their management role. The rest of their time is spent as part of the ward clinical numbers, working to a Band 5/6 level.

Matrons support Ward Managers in their leadership role but also co-ordinate resources across more than one ward; act increasingly as a Bed Manager/Patient Flows Manager and support directorate strategy and performance monitoring.

3) New Roles and Banding

- Nationally Matrons are banded at 8a and Ward Managers at Band 7. This is somewhat at odds with other professional groups and roles which are often banded higher. This is mainly because of the academic routes into nursing and the volume of nursing staff and posts. This is incongruous with the size, scope and responsibility associated with most Matron and Ward Manager posts compared to many other staff groups.
- This proposal tries to resolve this by creating a combined Matron and Ward Manager role, ie Ward Matron, at Band 8a. Band 7 senior Sisters/Charge Nurse will be employed to shift lead and to support Ward Matrons. Both posts will work throughout the 24 hour period – currently most Ward Managers and Matrons are only funded to work Monday – Friday during the main part of the day. This will assist with out of hours safety and relative liaison.
- Within this proposal the Ward Matron will be supernumerary to clinical numbers for their whole time. Senior Sisters/Charge Nurses will have their management/leadership time increased to .4 WTE from .2 WTE.
- For an average of 34 bedded ward or 40 bedded pair of wards, ward leadership capacity will increase from a total of 22.5 hours per week to 52.5 hours per week approximately.
- In order to enable this to happen there will be additional nurses employed at Band 5 to cover the time required to release senior nurses to manage/lead.
- Currently Matrons undertake a considerable amount of operational work and divisional projects. In order to make this proposal viable they will need to be focused purely on their wards. The proposal therefore includes the development of a Divisional Assistant Head of Nursing to undertake nursing related cross-division operational work and projects.
- The final part of the proposal is to support ward leaders with access to administration support which is currently virtually non-existent. Ward Clerks do not provide administration support to Ward Managers. Therefore, Ward Managers

currently do all of their own administration related to staff management and ward performance. The proposal will give every ward around 4 hours per week administration support.

4) Outcomes and Benefits

The ward review process will be expanded and made more specific around clearly measurable standards and targets.

As a result of this proposal we would expect to see all wards:

- Balance budgets
- Sickness absence at Trust target
- Staff ratios within Trust limits
- E-rostering in place and being fully used
- Safer Nursing Care Tool used at least quarterly
- Compliance MT and PDR
- No avoidable pressure damage
- 95% harm free care as a minimum (ST)
- Complaints responses where possible dealt with at ward level
- Other complaints handled within prescribed timescale
- All risk assessments complete
- Action plans as a result of incidents or complaints in place and being implemented
- Compliance with CQC standards
- Relevant attendance at TTR
- Delivery against all CQuINs
- Improved patient satisfaction scores
- No red ratings on ward review and no more than 2 amber ratings
- All patients with an EDD
- All main Consultant rounds supported by Senior Ward Nurse
- All MDT's/board meetings attended by a Senior Ward Nurse
- A ward SOP in place and adhered to
- Daily Matron or Sister ward round
- At least twice weekly Matron or Sister relative/visitor round/drop in session
- Completion of all ward audits and action plans
- At least monthly staff meeting and quarterly LiA style event
- Full compliance with documentation standards
- Up to date measure boards
- Full compliance PEAT/cleanliness standards
- No hospital acquired MRSA/CDiff
- Compliance with all Trust nursing standards

5) Cost of Proposal

The total cost of the proposal is £676,305. This relates to a total WTE difference of 15.9 WTE with the main workforce changes being:
2 x 8b Assistant Head of Nursing
3 x Band 3 A&C
Increase of 5 x 8a Matron
Increase of 5.9 Band 5 Staff Nurse

6) Proposed Timescale

It is proposed to have the changes implemented in full by July 2012.

7) Conclusion

The Chief Nurse, supported by the Exec Team, believe that investment in ward leadership capacity is essential in order to deliver sustained improvements in ward level nursing standards; changes required via transformation plans and the requirements of CQC and other standards.

Ward Managers are the only Trust Managers with this size and scope of role that are expected to manage and lead on essentially one day per week.

The Trust Board are asked to support this proposal.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Report: Final review of Trust's Compliance with Essential Standards of Quality and Safety: Outcome 17: Complaints & complaints update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami – Director of Governance**
AUTHOR:	**Hillary Mottishaw – Head of PALS, Complaints and Litigation**
DATE OF MEETING:	**26 April 2012**

EXECUTIVE SUMMARY:

This report comprises:

- A summary note of the Care Quality Commission's (CQC) Report dated April 2012: Final review of Trust's Compliance with the Essential Standards of Quality and Safety Outcome 17: Complaints (CQC Report appended)
- an update on the current status of the Trust's complaints to include that the Trust is at risk of recurrence of a complaints backlog situation and details of the corrective action taken and planned to prevent this from occurring.

REPORT RECOMMENDATION:

The Board is recommended to CONSIDER and DISCUSS the contents of this report.

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

Accept	Approve the recommendation	Discuss
		✓

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

Financial		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:

High Quality Care – 2.3. Learning from Concerns and Complaints

PREVIOUS CONSIDERATION:

None

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Care Quality Commission (CQC) Report: Final review of Trust's Compliance with Essential Standards of Quality and Safety: Outcome 17: Complaints and Trust Complaints status update

1. Summary of CQC's Final Report

1.1 On 14 March 2012, the Care Quality Commission (CQC) issued its draft report into its review of the Trust's compliance with Outcome 17 of the Essential Standards of Quality and Safety relating to Complaints. The CQC's review was to check whether the Trust had made improvements since the CQC's review in July 2011.

1.2 On 10 April 2012, the CQC issued the final report of its review and concluded that the Trust was compliant with Outcome 17. The final report is attached.

2. Current status of complaints

2.1 The findings in the CQC's Final Report require consideration within the context of the Trust's position statements on complaints as set out in the monthly Quality Reports from January 2012 onwards. This is also in light of the comparatively successful outcome of the Trust's strategy for the management / reduction of its complaints backlog in place from April 2011 and concluding at the end of December 2011.

Complaints data

2.2 The Quality Reports from January to March 2012 indicate an increase in the numbers of complaints in breach of the failsafe parameters (which identified those complaints which had breached a prescribed period of days considered reasonable for the Trust's response in the context of the risk grade (red (most serious); amber; yellow; green (least serious)) of the complaint).

2.3 It was concluded that the increase in the numbers of complaints in breach of the failsafe targets has resulted from a combination of:

- a reduction in the Complaints management team staffing level (towards the allocated establishment level)
- an increase in Total Active Complaints number (consequent on a monthly increase in the number of complaints received (range 65-79; average 74) and a decrease in the number of responses sent monthly (range 54 -70; average 60)
- revised failsafe parameters i.e. reduction in the prescribed period of days effective from 01 February 2012

On review, key contributory factors identified include:

- the competing priorities/timescales of the members of the Complaints management team with dual/integrated complaints and litigation/Inquest management responsibilities

- capability / performance of the Complaints management team
- a centralised complaints management process

In summary, the Trust is at risk of a recurrence of a complaints backlog situation.

3. Corrective action taken/planned

3.1 Corrective action taken to manage the position with the current complaints workload and prevention of recurrence of a complaints backlog includes:

- A senior Complaints manager now manages a complaints caseload on a full time basis
- Increased and closer supervision of the individual Complaints manager's day to day and overall management of their caseload to include closer tracking of dates
- Introduction of a weekly target for complaints responses for the individual Complaints managers
- Devolution of responsibility for investigating and responding to less serious complaints to identified areas of origin e.g. maternity, facilities

3.2 Action planned includes review and re-structuring of the Complaints and Litigation Department with consideration of:

- Separation of the Department into discrete complaints and litigation teams with clearly defined roles and responsibilities and senior manager for each team
- Upskilling/upgrading of the Complaints manager's role
- Trust-wide devolution of responsibility for investigating and responding to less serious complaints to the area of origin
- When the Total Active Workload and number of complaints in breach of the failsafe parameters reaches a prescribed threshold, outsourcing some of the workload of the Department.

4. Recommendation

4.1 The Board is recommended to CONSIDER and DISCUSS the contents of this report.

Kam Dhami
Director of Governance

April 2012

Review of compliance

Sandwell and West Birmingham Hospitals NHS Trust City Hospital	
Region:	West Midlands
Location address:	Dudley Road Birmingham West Midlands B18 7QH
Type of service:	Acute services with overnight beds
Date of Publication:	April 2012
Overview of the service:	City Hospital is a busy acute hospital providing specialist services and a broad range of emergency services including Accident and Emergency. The hospital provides a total number of 504 beds.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

City Hospital was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether City Hospital had made improvements in relation to:

Outcome 17 - Complaints

How we carried out this review

We reviewed all the information we hold about this provider, checked the provider's records and talked to people who use services.

What people told us

We reviewed the progress the Trust had made since our review of compliance in July 2011.

We found that there had been a significant amount of work undertaken in order to address the large backlog of complaints. This work has now been completed and the Trust is able to respond in a timely manner to all people who contact their complaints department.

We spoke with people who were waiting in this backlog for a response from the Trust. They told us they had been contacted. They said "it has taken a while for them to contact me but once they did they were very helpful and progress has been made". Another person said, "the people who contacted me were very clear with their information about what was happening, this made me feel that I was being listened to. I'm still waiting for resolution to my complaint but at least I know that someone is looking at my issues now", and "my issues are not yet resolved, I've had so many problems trying to get a response from them that things only moved forward when I contacted the Chief Executive in person".

We considered the statistical information the Trust sent to us following the last review of compliance. We also spent time speaking with the Trust's complaints and litigation manager and the head of the Patient Advise and Liaison Service (PALS).

What we found about the standards we reviewed and how well City

Hospital was meeting them

Outcome 17: People should have their complaints listened to and acted on properly

People who use the service can now be assured their complaints will be listened to and acted upon in a timely manner.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
We completed a review of compliance at this trust in June 2011. At this time we judged that there were minor concerns in how complaints were being managed. We issued a compliance action and the trust submitted an improvement plan to us. We have since seen an updated action plan which they forwarded to us in December 2011.

The trust told us they had a large backlog of complaints that had not been addressed during our last review. We wanted to check what progress had been made in dealing with these complaints. The trust has told us that all of the people waiting in the back log have now been contacted and their complaints have either been fully investigated or are in the process of being completed. This has effectively managed the backlog.

The trust had also looked at the way in which they manage complaints handling. This has meant that more staff have been recruited, existing staff have been given specialised training to enable them to investigate complaints more thoroughly. The complaints team have also strengthened their links with the Patient Advice and Liaison Service (PALS). This means that people are better supported in making their complaints known.

We also spoke with people who were waiting in this backlog for a response from the trust. They told us they had been contacted. They said "it has taken a while for them to contact me but once they did they were very helpful and progress has been made". Another person said, "the people who contacted me were very clear with their information about what was happening, this made me feel that I was being listened to.

I'm still waiting for resolution to my compliant but at least I know that someone is looking at my issues now", and "my issues are not yet resolved, I've had so many problems trying to get a response from them that things only moved forward when I contacted the Chief Executive in person".

People told us they thought there was more information available for people to help them make their views, concerns and complaints known. We spoke with the PALS manager for the trust who told us about the work they are doing alongside the ward staff in addressing people's concerns and helping them progress their complaints where needed. One person told us "the PALS team were very good, they showed us what to do and how to get things done".

During our last review, staff member told us that if anyone expressed concerns about their care this would be referred to the nurse in charge or ward sister. They would let the patient know about PALS (Patient Advice and Liaison Services) but would first try to deal with the issue locally to get the issues resolved. This has remained the same but further staff training is being arranged for frontline staff to help them deal with complaints as they arise.

We spoke with the complaints and litigation manager at the trust who told us that they have changed the way people's complaints are managed. A review of the system has meant that staff have had further training in customer care. New quality systems have been put in place to manage timescales for responses and encourage ownership from staff.

Information about complaints is submitted monthly to the quality and safety committee and a regular report is also prepared for the trust's board members. This process enables the trust to see how they can learn lessons from complaints and make sure that action plans from issues arising have been dealt with.

People we spoke with were also aware that they may refer their complaints to the Parliamentary and Health Service Ombudsman (PHSO) if attempts at local resolution had failed. We spoke with the Trust about how they have developed their own working relationship with the PHSO. Following each investigation by the PHSO the trust is asked to produce an action plan about the lessons they have learned and how they will reduce the risk of similar issue arising in future. We are also informed during this process and this tells us the trust is working well with the PHSO and is learning lessons from the process.

Other evidence
We have no further evidence to consider for this outcome.

Our judgement
People who use the service can now be assured their complaints will be listened to and acted upon in a timely manner.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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Review of compliance

Sandwell and West Birmingham Hospitals NHS Trust Sandwell General Hospital	
Region:	West Midlands
Location address:	Lyndon West Bromwich West Midlands B71 4HJ
Type of service:	Acute services with overnight beds
Date of Publication:	April 2012
Overview of the service:	Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust. It is a busy acute hospital with 470 beds. The Office of National Statistics information shows that Sandwell General Hospital serves a population of around 290,000.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Sandwell General Hospital was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Sandwell General Hospital had made improvements in relation to:

Outcome 17 - Complaints

How we carried out this review

We reviewed all the information we hold about this provider, checked the provider's records and talked to people who use services.

What people told us

We reviewed the progress the Trust had made since our review of compliance in July 2011.

We found that there had been a significant amount of work undertaken in order to address the large backlog of complaints. This work has now been completed and the Trust is able to respond in a timely manner to all people who contact their complaints department.

We spoke with people who were waiting in this backlog for a response from the Trust. They told us they had been contacted. They said "it has taken a while for them to contact me but once they did they were very helpful and progress has been made". Another person said, "the people who contacted me were very clear with their information about what was happening, this made me feel that I was being listened to. I'm still waiting for resolution to my complaint but at least I know that someone is looking at my issues now", and "my issues are not yet resolved, I've had so many problems trying to get a response from them that things only moved forward when I contacted the Chief Executive in person".

We considered the statistical information the Trust sent to us following the last review of compliance. We also spent time speaking with the Trust's complaints and litigation manager and the head of the Patient Advise and Liaison Service (PALS).

What we found about the standards we reviewed and how well Sandwell

General Hospital was meeting them

Outcome 17: People should have their complaints listened to and acted on properly

People who use the service can now be assured their complaints will be listened to and acted upon in a timely manner.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

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A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
We completed a review of compliance at this trust in June 2011. At this time we judged that there were minor concerns in how complaints were being managed. We issued a compliance action and the trust submitted an improvement plan to us. We have since seen an updated action plan which they forwarded to us in December 2011.

The trust told us they had a large backlog of complaints that had not been addressed during our last review. We wanted to check what progress had been made in dealing with these complaints. The trust has told us that all of the people waiting in the back log have now been contacted and their complaints have either been fully investigated or are in the process of being completed. This has effectively managed the backlog.

The trust had also looked at the way in which they manage complaints handling. This has meant that more staff have been recruited, existing staff have been given specialised training to enable them to investigate complaints more thoroughly. The complaints team have also strengthened their links with the Patient Advice and Liaison Service (PALS). This means that people are better supported in making their complaints known.

We also spoke with people who were waiting in this backlog for a response from the trust. They told us they had been contacted. They said "it has taken a while for them to contact me but once they did they were very helpful and progress has been made". Another person said, "the people who contacted me were very clear with their information about what was happening, this made me feel that I was being listened to.

I'm still waiting for resolution to my compliant but at least I know that someone is looking at my issues now", and "my issues are not yet resolved, I've had so many problems trying to get a response from them that things only moved forward when I contacted the Chief Executive in person".

People told us they thought there was more information available for people to help them make their views, concerns and complaints known. We spoke with the PALS manager for the trust who told us about the work they are doing alongside the ward staff in addressing people's concerns and helping them progress their complaints where needed. One person told us "the PALS team were very good, they showed us what to do and how to get things done".

During our last review, staff member told us that if anyone expressed concerns about their care this would be referred to the nurse in charge or ward sister. They would let the patient know about PALS (Patient Advice and Liaison Services) but would first try to deal with the issue locally to get the issues resolved. This has remained the same but further staff training is being arranged for frontline staff to help them deal with complaints as they arise.

We spoke with the complaints and litigation manager at the trust who told us that they have changed the way people's complaints are managed. A review of the system has meant that staff have had further training in customer care. New quality systems have been put in place to manage timescales for responses and encourage ownership from staff.

Information about complaints is submitted monthly to the quality and safety committee and a regular report is also prepared for the trust's board members. This process enables the trust to see how they can learn lessons from complaints and make sure that action plans from issues arising have been dealt with.

People we spoke with were also aware that they may refer their complaints to the Parliamentary and Health Service Ombudsman (PHSO) if attempts at local resolution had failed. We spoke with the Trust about how they have developed their own working relationship with the PHSO. Following each investigation by the PHSO the trust is asked to produce an action plan about the lessons they have learned and how they will reduce the risk of similar issue arising in future. We are also informed during this process and this tells us the trust is working well with the PHSO and is learning lessons from the process.

Other evidence
We have no further evidence to consider for this outcome.

Our judgement
People who use the service can now be assured their complaints will be listened to and acted upon in a timely manner.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Changes to the way the Care Quality Commission regulate and inspect**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**29 April 2012**

EXECUTIVE SUMMARY:

The Care Quality Commission (CQC) introduced changes to the way it inspects providers of health and social care following a consultation on how it regulates. The changes came into effect from April 2012.

The emphasis of the changes is to return to regular inspections, increase enforcement and move away from self-regulation.

This paper explores the changes and what they mean for the Trust.

REPORT RECOMMENDATION:

The Board is recommended to CONSIDER and DISCUSS this report.

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

Accept	Approve the recommendation	Discuss
		✓

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

Financial		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:

Safe, High Quality Care

PREVIOUS CONSIDERATION:

None

SANDWELL AND WEST BIRMINGHAM HOSPIITAL NHS TRUST

CHANGES TO THE WAY THE CARE QUALITY COMMISSION REGULATE AND INSPECT

1. Introduction

1.1 The Care Quality Commission (CQC) introduced changes to the way it inspects providers of health and social care following a consultation on how it regulates. The changes came into effect from April 2012. The CQC has also published new versions of the Judgement Framework and Enforcement Policy, which include significant changes in the way the Commission exercises its powers.

1.2 The emphasis of the changes is to return to regular inspections, increase enforcement and move away from self-regulation. The CQC's aim is to have a process that is more streamlined and responsive.

1.3 This paper explores the changes and what they mean for the Trust.

2. Changes to the way the CQC will regulate and inspect

2.1 <u>More frequent inspections</u>

The changes, which will be phased in, mean that the CQC will inspect most services more often. It will inspect most hospitals, care homes and domiciliary care providers at least once a year. It will inspect dental services at least once every two years.

To help do this, the CQC is recruiting extra inspectors. This means that inspectors will be responsible for smaller numbers of services than in the past. They will be able to spend more time getting to know services, checking the information they have on each, and responding quickly to concerns about the quality of care. Inspectors will be able to spend more time inspecting and less time on paperwork.

2.2 <u>Provider Compliance Assessment</u>

The CQC will continue to carry out scheduled, responsive and themed inspections of services and they will continue to be unannounced (unless there is good reason for them to let the provider know they are coming).

Provider Compliance Assessments (PCAs) will no longer be requested as a matter of course before inspections. PCAs are self-assessments of how providers comply with the regulatory requirements. Although they will no longer be required, the CQC suggests that providers may still wish to use the tool for quality assurance. All providers are required to have adequate quality assurance systems and it seems sensible to use a tool which the CQC has itself designed. The tool is designed around the Essential Standards and so will help providers to ensure that they can evidence compliance when the inspector visits.

The regulator will continue to re-inspect those service that fail to meet the government standards and will inspect any service at any time if there are concerns about poor care.

Experts in different aspects of care often join the CQC inspections, including members of the public who have experience of care. The CQC will be making more use of experts in the future.

2.3 More targeted inspections

The CQC will now inspect most services on an annual basis. CQC inspectors have continual oversight of all 16 Essential Standards. Most inspections will focus on just five standards, one from each of the five 'chapter headings' used by the CQC in their Guidance about Compliance. The CQC retains the right to inspect a greater number of standards, and where the CQC has information which raises concerns about a particular standard at a particular location, or where concerns arise in the course of an inspection, it is to be expected that the CQC will look at that standard. Overall, it seems that inspections will be more focussed and less comprehensive enabling the CQC to devote their time and resources on services that are at high risk of delivering poor care.

2.4 Balanced approach

Following an inspection the CQC will judge providers either compliant or non-compliant with standards and will focus on identifying non-compliance, but will include positive findings where they see them to ensure that it is providing a balanced view when reporting its findings.

Improvement actions will disappear. (Previously a provider could be compliant but with some concerns about their ability to stay compliant, for which the CQC imposed 'improvement actions'.

Where non-compliance is found is found with one or more of the regulations, the CQC will go on to consider the level of impact on service users – either minor, moderate or major. This will be used by the CQC to decide whether to issue the provider with a compliance action or to take enforcement action.

3. Enforcement powers

3.1 The CQC has adopted a 'regulatory response escalator' to determine what action to take in response to regulatory breaches. As it must, the CQC retains discretion as to what sanctions (if any) to apply in particular cases, but the presumption will be to escalate enforcement where compliance is not achieved.

3.2 In most cases, providers can expect that non-compliance will lead to a warning notice in the first instance. The representation process for warning notices relates to the publication of the notice and not the judgement made within it.

3.3 If the CQC is not satisfied that the provider has complied following the Notice, progressively higher end enforcement is likely to follow. This is a change from the CQC's historical approach that allowed for multiple use of low end enforcement before finally resorting to more serious sanctions. More higher end enforcement can be expected.

3.4 Historically the CQC has tended to rely on its cancellation powers rather than its criminal sanctions, but it is possible that the CQC will begin to use fixed penalty notices and formal cautions more. Prosecutions may continue to be relatively rare as they are costly for the CQC and subject the regulator to proving offences beyond reasonable doubt.

4. Trust response to the changes

4.1 The nature and frequency of the changes introduced by the CQC, reinforce the need for the Trust to introduce an organisation-wide electronic solution to monitoring on-going compliance with the Essential Standards. A final decision on the best solution is imminent.

4.2 The Trust will continue to raise the profile of the Essential Standards across the organisation and remind staff of their duty to ensure compliance with the requirements.

4.3 As part of the annual review of the divisional / directorate performance review process it has been decided to include compliance against the Essential Standards as a standard agenda item, with particular focus on local plans to address any identified areas of non-compliance.

5. Recommendation

5.1 The Board is asked to CONSIDER and DISCUSS the report.

Kam Dhami
Director of Governance April 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Register of sealed documents**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Payne, Trust Secretary**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**26 April 2012**

EXECUTIVE SUMMARY:

An application for use of the Trust Seal is made when required. The Trust's Standing Orders (section 8) require a register to be kept of all documents to which the Trust Seal has been affixed.

Details of all documents that have been made under seal during the period 1st April 2011 to 31st March 2012 is attached.

REPORT RECOMMENDATION:

The Trust Board is asked to **RECEIVE**, **CONSIDER** and **ACCEPT** the list of sealed documents.

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	**x**	Patient Experience	
Clinical		Equality and Diversity		Workforce	

Comments: Accrds with requirements of the Trust's standing orders

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

None specifically

PREVIOUS CONSIDERATION:

The Board considers the register of sealed documents on an annual basis and is timed for presentation in the Board cycle of business for April.

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REGISTER OF SEALED DOCUMENTS

Detailed below is a summary of the documents sealed by the Trust during the period 1st April 2011 to 31st March 2012.

Register Ref. No.	Description of Document	Date Sealed
158	Contract and transfer document TR1 for the sale of 12 Overton Place	20/5/11
159	Lease documentation for Glebefields LIFT premises	20/6/11
160	National Deed of Variation	1/7/11
161	General Vesting Declaration for Compulsory Purchase Order	1/7/11
162	Sandwell NHS LIFT underlease plus agreement relating to part of Oldbury Health Centre B69 4DR	15/8/11
163	Sandwell NHS LIFT underlease plus agreement relating to part of Whiteheath Health Centre B69 1ER	15/8/11
164	Licence to underlet of premises at Oldbury Health Centre	15/8/11
165	Licence to underlet of premises at Oldbury Health Centre	15/8/11
166	Licence to underlet of premises at Whiteheath Health Centre	15/8/11
167	Licence to underlet of premises at Whiteheath Health Centre	15/8/11
168	Supplemental Deed of Amendment and variation between SWBH & Inhealth Ltd.	19/8/11
169	TCS Project – Yew Tree Clinic contract	1/9/11
170	Supply agreement and lease of rooms for the Krypton Generator Service	3/11/11
171	BBraun contract variation documentation	23/11/11
172	Halcyon standalone birthing centre contract documentation	19/12/11
173	Contract documentation for capital works: pharmacy reconfiguration; reconfiguration of Paediatrics; and Reconfiguration of Fracture Clinic	29/2/12
174	Phase II Section 106 agreements for the Midland Metropolitan Hospital scheme	1/3/12

April 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – March 2012
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	26 April 2012

EXECUTIVE SUMMARY:

The report provides an update on the financial performance of the Trust for March 2012.

For March, the Trust generated a "bottom line" surplus of £374,000 which is £67,000 lower than the planned position (as measured against the DoH performance target). This small adverse variance occurring during the month is manageable and taken together with actual results for the first 11 months of the year, combines to produce an outturn value that is very close to the control total surplus target of £1,808k set at the beginning of the year.

For the year to date, the Trust has a surplus of £1,863,000 which is £55,000 better than the planned position.

REPORT RECOMMENDATION:

The Trust Board is asked to ACCEPT the monthly finance report noting its contents.

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:

Month 11 Position at Finance Committee and Trust Board

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – March 2012

EXECUTIVE SUMMARY

• For the month of March 2012, the Trust delivered a "bottom line" surplus of £374,000 compared to a planned surplus of £441,000 (as measured against the DoH performance target). This slight adverse in month performance has been managed within the overall annual DoH control total in relation to bottom line net income & expenditure results.

• For the year to date, the Trust has a surplus of £1,863,000 compared with a planned surplus of £1,808,000 so generating an positive variance from plan of £55,000.

•At month end, WTE's (whole time equivalents), including the impact of agency staff, were 15 below planned levels.

• The month-end cash balance was approximately £15.3m 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	(67)	55	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(449)	(769)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	1,367	4,256	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(5,861)	(5,311)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	15	73	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	15,330	15,330	>= 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	1,808	1,863
Capital Resource Limit	21,955	15,365
External Financing Limit	---	15,330
Return on Assets Employed	3.50%	3.60%

2011/2012 Summary Income & Expenditure Performance at March 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	382,889	35,021	38,750	3,729	382,889	381,916	(973)
Other Income	39,196	3,735	4,051	316	39,196	40,455	1,259
Operating Expenses	(398,517)	(36,502)	(40,996)	(4,494)	(398,517)	(399,572)	(1,055)
EBITDA	23,568	2,254	1,805	(449)	23,568	22,799	(769)
Interest Receivable	25	2	11	9	25	115	90
Depreciation & Amortisation	(13,269)	(1,106)	1,060	2,166	(13,269)	(10,697)	2,572
PDC Dividend	(5,803)	(484)	(284)	200	(5,803)	(5,603)	200
Interest Payable	(2,156)	(180)	(98)	82	(2,156)	(2,074)	82
Net Surplus/(Deficit)	**2,365**	**486**	**2,494**	**2,008**	**2,365**	**4,540**	**2,175**
IFRS/Impairment Related Adjustments	(557)	(45)	(2,120)	(2,075)	(557)	(2,677)	(2,120)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,808**	**441**	**374**	**(67)**	**1,808**	**1,863**	**55**

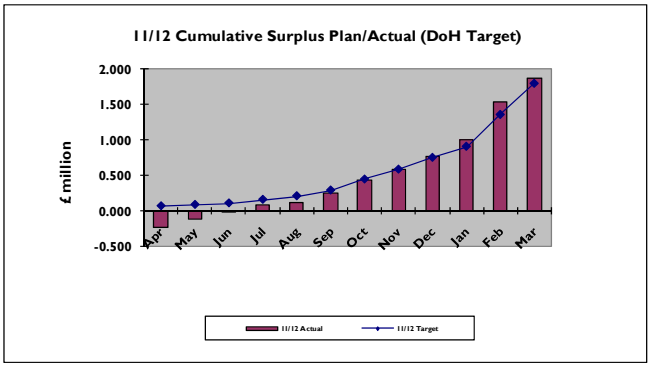
The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2012

Overall Performance Against Plan

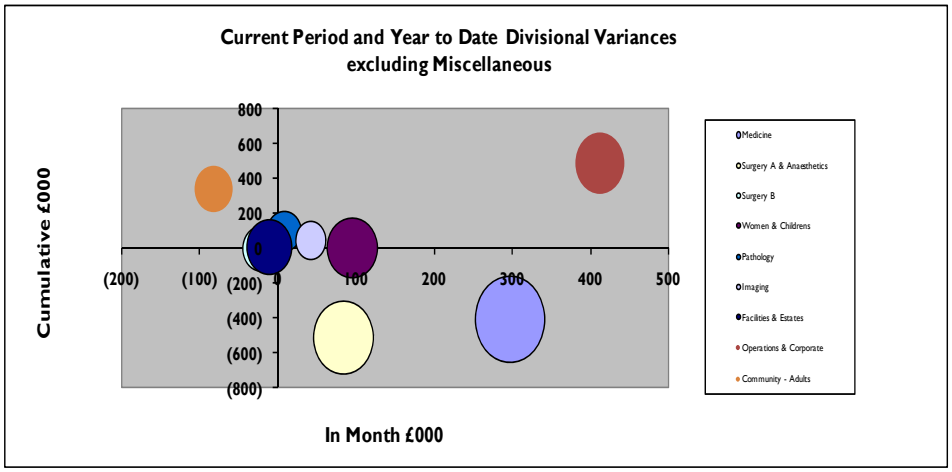
• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph



Divisional Performance

• With the exception of those divisions where an agreed deficit plan was in place, all divisions have delivered a bottom line position which is break even or better.

• Those divisions with in year deficit targets have achieved a position which is at least in line with their target.



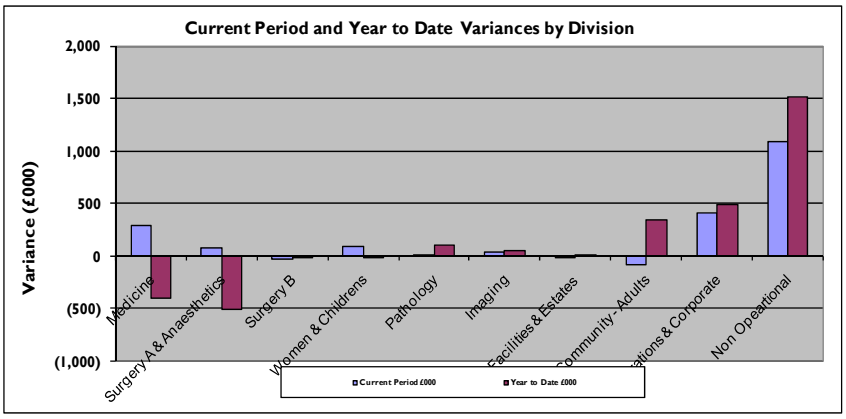
The tables adjacent and below show positive year to date variances against plan except for those divisions where a deficit plan had been approved.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2012

Divisional Variances from Plan

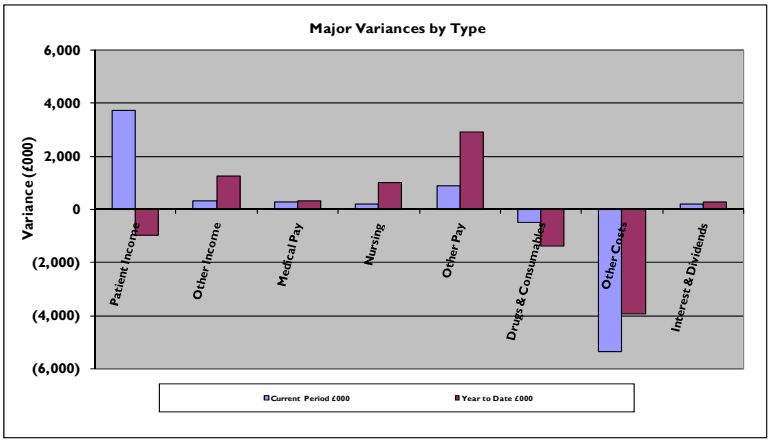
	Current Period £000	Year to Date £000
Medicine	298	(405)
Surgery A & Anaesthetics	84	(509)
Surgery B	(21)	0
Women & Childrens	95	3
Pathology	8	100
Imaging	42	49
Facilities & Estates	(12)	8
Community - Adults	(83)	347
Operations & Corporate	412	488
Non Opeartional	1,088	1,515



For March, overall patient related income shows a significant positive variance with a compensating adverse position for other costs, largely resulting from year end provisions made by the Trust.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	3,729	(973)
Other Income	316	1,259
Medical Pay	265	318
Nursing	212	1,014
Other Pay	890	2,924
Drugs & Consumables	(490)	(1,372)
Other Costs	(5,371)	(3,939)
Interest & Dividends	209	290



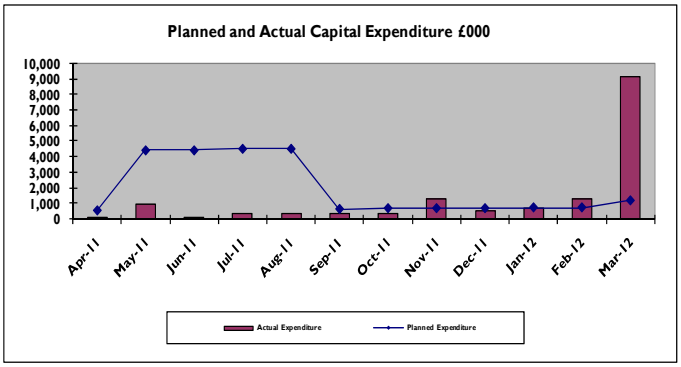
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2012

Capital Expenditure

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

•March expenditure is significantly higher than the rest of the year as completion of capital projects was accelerated.

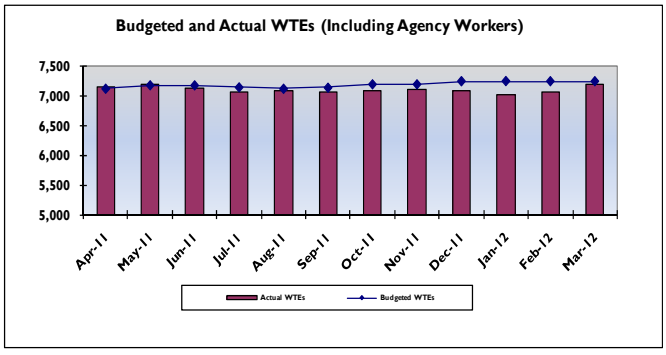


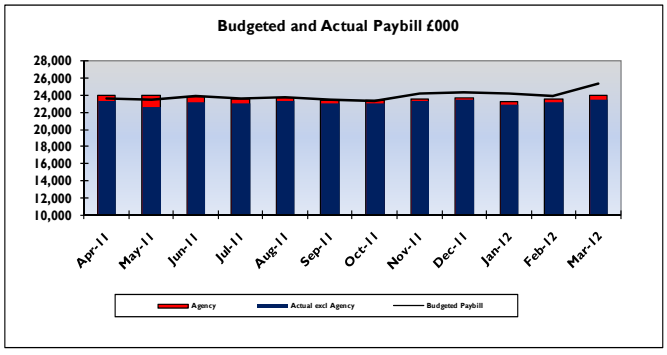
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 15 below plan for March.

• Total pay costs (including agency workers) are £1,367,000 lower than budgeted levels for the month , particularly within the administration and estates workgroup although the reported position for March in isolation will be distorted by year end accrued expenditure and use of reserves.

• Expenditure for agency staff in March was £609,000 which represents a rise compared with previous months but again will to some degree be distorted by year end accruals. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS Trust

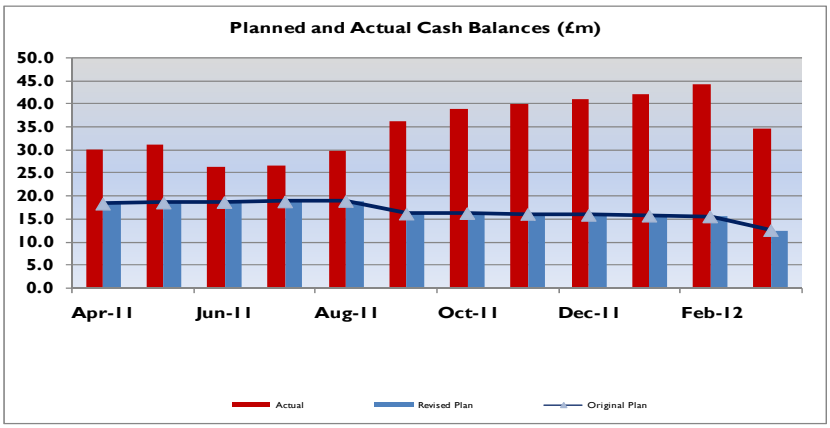
Financial Performance Report – March 2012

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2011.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance as at March 2012 £000
Non Current Assets	Intangible Assets	1,077	1,075
	Tangible Assets	216,199	227,072
	Investments	0	0
	Receivables	649	865
Current Assets	Inventories	3,531	4,065
	Receivables and Accrued Income	12,652	14,446
	Investments	0	0
	Cash	20,666	34,465
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(39,987)
	Loans	0	(2,000)
	Borrowings	(1,262)	(1,166)
	Provisions	(4,943)	(9,508)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	(5,000)
	Borrowings	(31,271)	(29,995)
	Provisions	(2,237)	(2,437)
		181,548	191,895
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	36,573	41,228
	Donated Asset Reserve	2,099	0
	Government Grant Reserve	1,662	0
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(28,075)	(18,622)
		181,548	191,895



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2012

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.4%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	96.7%	4
Return on Assets	Surplus before dividends over average assets employed	0.0%	2
I&E Surplus Margin	I&E Surplus as % of total income	1.1%	3
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	28.0	4
Overall Rating			**3.0**

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at March.
• 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 4.
•I&E Surplus Margin is lower than would normally be expected due to relatively low levels of surplus being delivered.

Conclusions

• Based on the draft statutory accounts, the Trust has marginally exceeded its bottom line DoH performance target delivering a surplus of £1,863,000 against a target of £1,808,000.

•All divisions have generated year end performance which is break even or better with the exception of those divisions with an agreed deficit target where performance has also been better than plan.

Recommendations

The Board is asked to:

i. NOTE the contents of the report.

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:	26 April 2012

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2011– March 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, Trust Management Board on 17 April 2012.

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY AND PERFORMANCE MONITORING REPORT - MARCH 2012 - EXCEPTION REPORT

AREA	PERFORMANCE				COMMENTS
	National Indicator(s)		Local Indicator(s)		
	Current	Year to date	Current	Year to date	
Cancer	■	▼			All high level Cancer Waiting times targets were met within month (February) with the exception of the 62-day referral (upgrade) to treatment from hospital specialist, where this standard was met in 81.3% of cases (85% performance threshold). Other cancer waiting times standards were met within month, and all continue to be met for the year to date.
Cancelled Operations	■	■	■	■	The overall percentage of Cancelled Operations reduced on both sites to 0.4% overall during the month of March, for the year cancellations were 0.6% (0.8% during 2010/11). There were no breaches of the 28-day guarantee reported.
Delayed Transfers of Care	▼	▲			During the month (March) Delayed Transfers of Care increased to 4.2%. The overall delays during the year were 5.2% 4.6% during 2010/11).
Stroke Care	▲	▲	▲	▲	Performance against the national target for patients who spent at least 90% of their hospital stay on a Stroke Unit continues to be maintained above the 80% threshold, with performance for the year recorded as 85.9%. TIA (High Risk) Treatment (within 24 hours of initial presentation) during Quarter 4 has also been maintained above the national threshold of 60%. Improvement in performance against a range of local indicators of stroke Care continues.
Accident & Emergency	■	▲			The A/E 4-hour wait target of 95% was met during the month (97.50%), the quarter (95.30%) and for the year (95.38%).
	■	▲			Accident & Emergency Clinical Quality Indicators - for the purpose of performance monitoring the indicators are grouped into two groups, timeliness and patient impact. Organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups. the Trust met 3 of the 5 indicators during the month of March, and the year.
Infection Control	■	■			There were 9 cases of C Diff reported across the Trust during the month of March, within the trajectory also of 9 for the month. The overall number (95) for the year is within the trajectory of 109. There were no cases of MRSA Bacteraemia reported during the month. For the year there were 2 cases of MRSA Bacteraemia reported compared with a trajectory of 6.
Referral to Treatment	▼	■	▼	■	All 5 National and 3 Local high level RTT Performance Indicators were met in month (March). The exception by specialty was Trauma & Orthopaedics, where 68.3% of admitted patients commenced treatment within 18 weeks of referral (target 90%).
Cervical Cytology			■	■	The Turnaround Time of Cervical Cytology requests has been less than 9 days for each month for the year to date.
Same Sex Accommodation	■	■			There were No Breaches of Same Sex Accommodation reported during the month of March. A total of 109 were reported for the year, 8 since August 2011.
Mortality				▲	The Hospital Standardised Mortality Rate (HSMR) for the Trust for the most recent 12-month cumulative period (ending December 2011) is 95.7, compared with a Peer (SHA) rate of 100.7.
Sickness Absence			▲	▲	Overall Sickness Absence for the month of March reduced to 4.13% (4.39% February), with reductions in both long-term and short-term absence. the average across Quarter 4 is 4.28% compared with a local target of less than 3.5%.
Learning & Development			▼	▼	PDR compliance is approximately 71% with over 5300 staff reported as receiving a PDR during the year. Compliance by Division is variable (25% - 98%). Overall Mandatory Training compliance at the end of March remains 71.9%.
CQUIN	■	■			Acute Schemes - final data for the month of March for 2 schemes is awaited, but provisional data, previous performance and performance trends all suggest that all performance targets for the month (March) and for the year, or final period of assessment were MET for ALL SCHEMES.
	▲	▲			Community Schemes - performance targets in-month (March) and for the year were MET for ALL SCHEMES.
	■	■			Specialised Schemes - performance targets in-month (March) and for the year, or final period of assessment (e.g. Neonatal Retinopathy Screening) were MET for ALL SCHEMES.
Referrals			▲	▲	For the period April - February inclusive overall referrals are approximately 7200 (4.3%) fewer and GP Referrals are approximately 5600 (5.0%) fewer than the corresponding period last year. Overall Referrals from Sandwell and Other (non-Sandwell / HOB) PCTs are 3669 (4.3%) and 3782 (10.2%) less respectively for the 11 months year to date than for the same period last year. Referrals from HOBtPCT for the same period are 472 (1.1%) greater.
Activity			▲	▲	Overall Elective activity for the month is well in excess of the plan for the month and exceeds the plan for the year by 10.6%.
			■	▼	Non Elective activity is 5.5% below plan for the month and 6.4% less than plan for year.
			▲	▲	Outpatient New and Review activity has continued to exceed the plan for the year by 9.1% and 10.9% respectively. The Follow Up to New Outpatient Ratio for the year is 2.65, compared with a ratio derived from plan of 2.61, but represents a reduction from 2.70 during 2010 / 2011.
			▲	▲	A/E Type I activity during the month of March was 8.5% greater than plan, and is 1.1% greater than plan for the year. Type II activity is 7.1% greater than plan for the month, and exceeds the plan for the year by 4.4%.
Ambulance Turnaround			▲	■	The proportion of ambulances waiting greater than 30 minutes improved (reduced) to 40.1% during March (West Midlands average 35.4%). There were 78 instances recorded of ambulances with a turnaround time in excess of 60 minutes.

KEY TO PERFORMANCE ASSESSMENT SYMBOLS (compared with previous period)	
▲	Met - Performance improved
■	Met - Performance maintained
▼	Met - Performance deteriorated
▲	Not quite met - performance improved
■	Not quite met - performance maintained
▼	Not quite met - performance deteriorated
▲	Not met - performance 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:	26 April 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 (March):
There was 1 area of underperformance during the month of March; Delayed Transfers of Care. The overall average weighted score is 2.93 for the Trust which attracts a **PERFORMING** classification.

Formal assessment of Acute Trust's performance by the Department of Health is quarterly. For the period January – March inclusive (Quarter 4), areas of underperformance are identified as; A&E Clinical Indicators and Delayed Transfers of Care. The overall average weighted score for the Trust for this period is 2.79 which attracts a **PERFORMING** classification.

Financial Performance (March):

Not available for inclusion at the time this report was produced.

Foundation Trust Compliance Summary report:

Within the Service Performance element of the Risk Rating there were no areas of underperformance reported within the framework during the month of March or for the quarter.

No scores were identified within the period for the other 4 elements of the Risk Rating. As such the overall score for both the month and quarter is 0.0, 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 and Trust Management Board on 17 April 2012.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2011/12

Operational Standards and Targets

Indicator		Weight	Thresholds		Quarter 2 2011/12	Score	Weight x Score	Quarter 3 2011/12	Score	Weight x Score	March 2012	Score	Weight x Score	Quarter 4 2011/12	Score	Weight x Score
			Performing	Underperforming												
A/E Waits less than 4-hours		1.00	95.00%	94.00%	95.02%	3	3.00	95.06%	3	3.00	97.50%	3	3.00	95.30%	3	3.00
A/E Unplanned re-attendance rate	{Patient Impact Group}	2.00	=<5.00%	>5.00%	8.62%	3	6.00	7.97%	3	6.00	7.87%	0	6.00	8.00%	2	4.00
A/E Left Department without being seen rate			=<5.00%	>5.00%	4.70%			4.93%			4.67%			5.18%		
A/E Time to Initial Assessment - 95th centile	{Timeliness Group}		=<15mins	>15mins	23.00			20.00			17.00			17.00		
A/E Time to treatment in department (median)			=<60mins	>60mins	56.00			54.00			58.00			60.00		
Cancelled Operations - 28 day breaches		1.00	5.0%	15.0%	0%	3	3.00	<5%	3	3.00	<5%	3	3.00	<5%	3	3.00
MRSA Bacteraemia		1.00	0	>1.0SD	0	3	3.00	1	3	3.00	0	3	3.00	1	3	3.00
Clostridium Difficile		1.00	0	>1.0SD	19	3	3.00	25	3	3.00	9	3	3.00	27	3	3.00
18-weeks RTT Admitted 95 Percentile(weeks)		0.50	<=23.0	>27.7	<=23.0	3	1.50	<=23.0	3	1.50	21	3	1.50	<=23.0	3	1.50
18-weeks RTT Non Admitted 95 Percentile(weeks)		0.50	<=18.3	>18.3	<=18.3	3	1.50	<=18.3	3	1.50	15	3	1.50	<=18.3	3	1.50
18-weeks RTT Incomplete Pathway 95 percentile (weeks)		0.50	<=28.0	>36.0	<=28.0	3	1.50	<=28.0	3	1.50	16	3	1.50	<=28.0	3	1.50
18-weeks RTT 90% Admitted		0.75	=>90.0%	85.0%	=>90.0%	3	2.25	=>90.0%	3	2.25	93.0	3	2.25	=>90.0%	3	2.25
18-weeks RTT 95% Non -Admitted		0.75	=>95.0%	90.0%	=>95.0%	3	2.25	=>95.0%	3	2.25	97.4	3	2.25	=>95.0%	3	2.25
Cancer - 2 week GP Referral to 1st OP Appointment		0.50	93.0%	88.0%	94.2%	3	1.50	94.7%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms		0.50	93.0%	88.0%	95.8%	3	1.50	94.4%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers		0.25	96.0%	91.0%	99.2%	3	0.75	99.4%	3	0.75	>96.0%*	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)		0.25	94.0%	89.0%	98.6%	3	0.75	99.7%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)		0.25	98.0%	93.0%	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)		0.25	94.0%	89.0%	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers		0.50	85.0%	80.0%	86.8%	3	1.50	87.3%	3	1.50	>85.0%*	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening		0.50	90.0%	85.0%	100.0%	3	1.50	96.5%	3	1.50	>90.0%*	3	1.50	>90.0%*	3	1.50
Stroke (Stay on Stroke Unit)		1.00	80.0%	60.0%	86.30%	3	3.00	88.70%	3	3.00	95.20%	3	3.00	88.40%	3	3.00
Delayed Transfers of Care		1.00	3.5%	5.0%	7.20%	0	0.00	<5.00%	2	2.00	4.20%	2	2.00	3.70%	2	2.00
Sum		**14.00**														
Average Score							**2.79**			**2.93**	* projected		**2.93**	* projected		**2.79**

Scoring:	
Underperforming	**0**
Performance Under Review	**2**
Performing	**3**

Assessment Thresholds	
Underperforming if less than	**2.1**
Performance Under Review if between	**2.1 and 2.4**
Performing if greater than	**2.4**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management
DATE OF MEETING:	26 April 2012

EXECUTIVE SUMMARY:

This report provides the key features of the NHS Performance Framework for 2012/13 and an assessment of the Trust's performance for the months of January, February and March 2012 as well as Quarter 4, **mapped against the indicators which comprise the NHS Performance Framework for 2012 / 13.**

Service Performance (March and Quarter 4):

There were 2 areas not meeting the performance threshold during the month of March for indicators contained within the Integrated Performance Measures; RTT Delivery in all specialities and Delayed Transfers of Care. The overall average weighted score is 2.86 for the Trust.

The overall QUALITY OF SERVICE RATING is **PERFORMING.**

Financial Performance (March):

Not available for inclusion at the time this report was produced.

REPORT RECOMMENDATION:

The Trust Board is asked to NOTE the report.

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 on 17 April 2012

Introduction

Having initially been introduced in 2009 The NHS Performance Framework sets out the Department's approach to identifying underperforming NHS organisations and stipulates when intervention should occur in such organisations.

In 2011, the Department agreed Tripartite Formal Agreements (TFAs) with every NHS Trust, detailing dates and key milestones for each organisation on its journey to achieving Foundation Trust status. Each trust is assessed every month on progress towards achieving the key milestones; this is reflected by RAG ratings agreed between the Department and the relevant SHA.

For 2012/13 the NHS Performance Framework will be integrated with the Tripartite Formal Agreement (TFA) Red/Amber/Green (RAG) rating process. This is to give clarity on the performance position for each Trust and consistency to Strategic Health Authorities (SHAs), Primary Care Trust (PCTs) and NHS Trusts through one integrated system. This will help to progress the remainder of NHS Trusts to Foundation Trust (FT) status and will support the establishment of the NHS Trust Development Authority (NTDA).

Scope and implementation of the NHS Performance Framework

The 2012/13 Performance Framework applies to all NHS providers that are not yet FTs. The Framework will largely be underpinned by existing national indicators and mandatory data collections for 2012/13.

FTs will not be assessed under this Framework, and will continue to be regulated by Monitor as set out in their Terms of Authorisation.

How the Framework operates

The Department, in conjunction with the NHS and other stakeholders, has determined the aspects of performance to be measured, as well as when and how they will be measured. The Framework is administered by the Department and in previous years has been applied quarterly. The results are communicated in the Departmental publication *The Quarter*. For 2012/13 the Framework will be applied monthly to ensure the best alignment with the TFA RAG rating process and the results will continue to be published in *The Quarter.*

In 2012/13 organisational performance will continue to be assessed against a series of indicators using the most current data available. The Framework results will inform the overall TFA RAG rating for each organisation and this rating will trigger intervention by the Department, SHAs and PCTs in the case of performance concerns.

SHAs will continue to be notified of their local Performance Framework results in advance of formal publication and expected to cascade this as necessary. Where the Framework identifies performance concerns relating to an organisation, it triggers intervention by SHAs and PCT commissioners as necessary. The Performance Framework does not prescribe how to respond to performance concerns but rather leaves room for local knowledge and judgement. This process is mirrored for the TFA RAG ratings where the initial performance management role remains the responsibility of SHAs working with trusts and their local health economies.

Based on the indicators underpinning the Performance Framework, organisations will be categorised as:

- **Performing**
- **Performance under review**
- **Underperforming**

Each organisation assessed by the Framework will be given two, equally weighted ratings using the performance categories indicated above: one rating for performance on Finance, and one for performance on Quality of Services (which is comprised of Integrated Performance Measures, CQC Registration Status and User Experience). Continued compliance with CQC's registration regime will form the basis of judgements about a Trust's performance on essential standards of quality and safety, meaning a warning notice will lead to a trust's score deteriorating.

An organisation will, therefore, receive two performance categories. The rating for performance on Quality of Services will be determined by the lowest score across the relevant domains.

In the case of acute and mental health trusts, User Experience data will only be used as a moderator of overall performance. This means that if an organisation's User Experience score renders it *Underperforming* it could not be categorised overall as better than *Performance under review.*

Exceptional circumstances (**over-riding rules)** may occasionally arise that are so serious that an organisation would automatically be designated as *Underperforming* in one, or both, of the overall performance categories. These would include, but are not limited to, the following:

- Major failings of clinical governance, or
- Major failings of service or financial performance

Major failings of service or financial performance would include misleading reporting to DH.

Each domain, Finance and Quality of Service (including Integrated Performance Measures, Registration Status and User Experience) is underpinned by a series of weighted indicators with associated performance thresholds, and a scoring system to determine performance on the domain.

Monthly assessment of TFAs

The discussion and assessment of TFAs each month are based on four variables and a judgement is taken based on these

- Delivery of TFA milestones
- Delivery of quality, operational and financial performance targets
- Local intelligence on Local Health Economy and Trusts issues which may impact on delivery, and
- DH overview of the whole FT pipeline and judgements about complexity of challenges.

Intervention and Escalation

The Framework sets out who is responsible for intervening when underperformance is identified:

- If a provider is categorised as *Performance under review* in either of the two domains, the remedial intervention is led by the relevant PCT commissioner, with reference to the terms of the provider's contract. It is expected that the SHA will oversee this process
- If a provider is categorised as *Underperforming* the remedial intervention is led by the SHA

As previously stated, the Framework does not prescribe the interventions to be taken. However, as a minimum, a remedial action plan with defined timescales for improvement should be agreed by the SHA.

For 2012/13, a single escalation process will be in place for organisations where serious concerns exist on their performance and their overall TFA RAG rating is red. The current escalation processes for the Performance Framework and the TFA RAG ratings will be combined providing a formal assessment of the delivery of quality, operational and financial performance targets and trend analysis. The process for doing this and the resulting escalation process is described below.

Overall ratings will be completed by applying the following rules:

- If a Trust is "underperforming" on either quality or finance, the TFA RAG rating must be red;
- If a Trust is rated "performance under review" on quality or finance, the TFA RAG rating must be no better than amber/red.

SHAs may use local knowledge to supplement this information if performance has materially changed since the last Performance Framework scores were issued.

The overall performance management role of Trusts and their TFAs, remains the responsibility of PCT and SHA Clusters working with Trusts and their local health economies. The existing processes developed by SHA Clusters will continue to be used and the TFA position will be discussed on a monthly basis.

Any issues that can be resolved locally to enable the Trust to get back on track should only be reported to the DH for information. Those issues that cannot be resolved locally should be discussed with DH who hold SHA Clusters to account for their performance management role.

The escalation process is summarised as:

- One red RAG rating will result in established SHA Cluster performance management processes being used and reported through the monthly teleconference calls and via the usual performance management routes into DH.
- Three consecutive red RAG ratings will result in:
  - A meeting between the Trust, SHA and the appropriate combination of the National Director of Provider Delivery and/or the DH Director of Performance/ Finance depending on the "performance" issue. Following the meeting a letter will be sent detailing the discussion and action points required to address issues; **and**
  - If no improvement by the next month a judgement will be made in DH on whether escalation to second stage is appropriate. If it is, a further meeting will be held with the Strategic Health Authority Chief Executive and Director of Provider Development (DPD), Trust CE (and others by individual agreement e.g.

Chairman, Executive Directors), the Senior Responsible Officer (SRO) for the FT Pipeline and NTDA and DH DPD and/or the Director of Performance/Finance depending on the "performance" issue. This meeting aims to agree a course of action which could include a change of application date linked to other changes within the TFA and organisation.

- A missed overall application submission date would automatically trigger a red rating and a move immediately to an SHA Cluster and DH discussion, unless a delay of less than three months is anticipated. In such cases the SHA Cluster and DH would agree that the three month escalation approach would apply although resolution would be agreed on a case-by-case basis
-

Framework indicators

- Financial Performance

  The indicators which comprise the Finance domain within the NHS Performance Framework remain unaltered from 2011 / 12.

- Service Performance

  The indicators which comprise the Integrated Performance Measures within the Quality of Service domain are aligned to those set out on the Operating Framework for 2012 / 2013.

  Indicators which no longer feature within the Framework are:
  - Accident & Emergency Clinical Indicators (4)
  - Cancelled Operations – 28 day breaches
  - 18-weeks RTT Admitted, Non-Admitted and Incomplete Pathway 95th percentiles
  - Stroke – Stay on Stroke Unit

  The above indicators have been replaced by the following:
  - 18-weeks RTT – percentage of Incomplete Pathways (92% target, 87% or below underperforming)
  - 18-weeks RTT – number of treatment functions (admitted, non-admitted and incomplete pathways) where standards are not delivered (0 target, 20 or more underperforming)
  - Diagnostic Waiting Times – percentage of patients waiting 6 weeks or more for a diagnostic test in 15 key areas (<1% target, 5% or more underperforming)
  - Mixed Sex Accommodation Breaches – percentage relative to number of FCEs that finished in the month (0% target, 0.5% or more underperforming)
  - VTE Risk Assessment (90% target, 80% or less underperforming)

Current Performance

Financial Performance

Not available for inclusion at the time this report was produced.

Service Performance

A copy of the Trust's performance for the months of January, February and March 2012 as well as the Quarter (4) mapped against the NHS Performance Framework Indicators for 2012 / 13 is attached as an appendix to this paper.

There were 2 areas not meeting the performance threshold during the month of March for indicators contained within the Integrated Performance Measures; RTT Delivery in all specialities and Delayed Transfers of Care. The overall average weighted score is 2.86 for the Trust.

The overall QUALITY OF SERVICE RATING is **PERFORMING.**

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2011/12 (2012/13 Indicators)

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Score 2	Underperforming (Score 1)	January 2012	Score	Weight x Score	February 2012	Score	Weight x Score	March 2012	Score	Weight x Score	Quarter 4 2011/12	Score	Weight x Score
A/E Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	95.50%	3	3.00	92.70%	0	0.00	97.50%	3	3.00	95.30%	3	3.00
MRSA Bacteraemia	1.00	0		>1.0SD	0	3	3.00	1	3	3.00	0	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	9	3	3.00	9	3	3.00	9	3	3.00	27	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	93.8	3	3.00	93.4	3	3.00	=>90.0%*	3	3.00	=>90.0%*	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	97.0	3	3.00	98.9	3	3.00	=>95.0%*	3	3.00	=>95.0%*	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	96.5	3	3.00	96.7	3	3.00	=>92.0%*	3	3.00	=>92.0%*	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	4	2	2.00	4	2	2.00	>0 but <21*	2	2.00	>0 but <21*	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	1.65%	2	2.00	0.40%	3	3.00	0.96%	3	3.00	0.99%	3	3.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	95.6%	3	1.50	96.1%	3	1.50	>93.0%*	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%	94.4%	3	1.50	98.0%	3	1.50	>93.0%*	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%	99.5%	3	0.75	100.0%	3	0.75	>96.0%*	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%	99.0%	3	0.75	100.0%	3	0.75	>94.0%*	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	>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	100.0%	3	0.75	>94.0%*	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%	85.7%	3	1.50	85.0%	3	1.50	>85.0%*	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%	97.9%	3	1.50	100.0%	3	1.50	>90.0%*	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	3.5%	3.5 - 5.00%	5.0%	3.50%	3	3.00	3.50%	3	3.00	4.20%	2	2.00	3.70%	2	2.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.00%	3	3.00	0.06%	3	3.00	0.00%	3	3.00	0.02%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.80%	3	3.00	92.40%	3	3.00	91.30%	3	3.00	92.60%	3	3.00
Sum (all weightings)	**14.00**															
Average Score (Integrated Performance Measures)							**2.86**			**2.71**	* projected		**2.86**	* projected		**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**			**Performing**

Overall Quality of Service Rating

							Performing			**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**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Provider Management Regime return – March 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:	26 April 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 March 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)	A
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:
Mar 2012

NHS Midlands & East
Provider Management Regime
2011/12

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

NHS Trust Governance Declarations : 2011/12 In-Year Reporting

Name of Organisation:	Sandwell & West Birmingham Hospitals NHS Trust	Period:	Mar 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)	A
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	April 2011	May 2011	Jun 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	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	YES	YES	
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	**1.0**									YES	YES	YES	YES	
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	**1.0**								YES	YES	YES	YES	YES	February performance confirmed from National Cancer Waiting times System report. March 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	YES	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	YES	YES	
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	**1.0**									YES	YES	YES	YES	
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	**0.5**								YES	YES	YES	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	YES	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**									NO	YES	NO	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	5	2	Time to Initial Assessment 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	NO	NO	
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	**1.0**									NO	NO	NO	NO	
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	**2.0**									NO	NO	NO	NO	
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	**1.0**									NO	NO	NO	NO	
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	**2.0**									NO	NO	NO	NO	
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	**2.0**									NO	NO	NO	NO	
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	**4.0**									NO	NO	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	NO	NO	
				TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.5**	**0.5**	**1.5**	**0.5**	

RAG RATING :

GREEN	**= Score Less than 1**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score Over 4**

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 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	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**	

RAG RATING :

GREEN	**= Score Less than 1**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score Over 4**

AMBULANCE
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 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	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**	

RAG RATING :

GREEN	**= Score Less than 1**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score Over 4**

COMMUNITY TRUST
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 MIU/A&E

Ref	Area	Indicator	Sub Sections	Thresh-old	Weight-ing	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	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	YES	YES	
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0									YES	YES	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	N/A	N/A	
19	Patient Experience	GUM Access - within 48 hours	95th percentile	≤ 48 hrs	0.5									YES	YES	YES	YES	
20	Effectiveness	Chlamydia Screening		Contract with PCT	0.5									N/A	N/A	N/A	N/A	
21	Effectiveness	Smoking quitters		Contract with PCT	0.5									N/A	N/A	N/A	N/A	
8a	Quality	Minor Injuries Unit / A&E (Q1):	Total time (95th percentile)	≤ 4 hrs	1.0									N/A	N/A	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	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	YES	YES	
23	Safety	New birth visits		Contract with PCT	0.5									YES	YES	YES	YES	
24	Effectiveness	HPV (Human Papillomavirus) Uptake		Contract with PCT	0.5									YES	YES	YES	YES	
25	Patient Experience	Community equipment store response within seven days	100%	≤ 7 days	0.5									N/A	N/A	N/A	N/A	
26a	Safety	Urgent District Nurse response within 24 hours	100%	≤ 24 hrs	0.5									YES	YES	YES	YES	
26b	Patient Experience	Non-urgent District Nurse response within 48 hours	100%	≤ 48 hrs	0.5									YES	YES	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	NO	NO	
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding.	0	1.0									NO	NO	NO	NO	
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding.	0	2.0									NO	NO	NO	NO	
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0									NO	NO	NO	NO	
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0									NO	NO	NO	NO	
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0									NO	NO	NO	NO	
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0									NO	NO	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	NO	NO	
				TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.5**	**0.5**	**0.5**	**0.5**	

RAG RATING :

GREEN	**= Score Less than 1**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score Over 4**

FINANCIAL RISK RATING 2011/12

Sandwell & West Birmingham Hospitals NHS Trust

Insert the Score (1-5) Achieved for each Criteria Per Month

			Risk Ratings																	
Criteria	**Indicator**	**Weight**	**5**	**4**	**3**	**2**	**1**	**Annual Plan 2011/12**	**Apr 2011**	**May 2011**	**June 2011**	**Jul 2011**	**Aug 2011**	**Sept 2011**	**Oct 2011**	**Nov 2011**	**Dec 2011**	**Jan 2012**	**Feb 2012**	**Mar 2012**	**Comments on Performance in Month**
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1										3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50										4	5	5	4	
Financial efficiency	**Return on assets %**	20%	6	5	3	-2	<-2										3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2										2	2	2	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10										4	4	4	4	£25m notional working capital facility added to convert to FT comparability
Average	**Weighted Average**	**100%**						**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.2**	**3.3**	**3.3**	**3.2**	
Overriding rules	**Overriding rules**																-0.2	-0.3	-0.3	-0.2	
Overall rating	**Final Overall rating**							**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	

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 2011/12

Sandwell & West Birmingham Hospitals NHS Trust

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

	Criteria	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters									NO	NO	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	NO	NO	
3	FRR 2 for any one quarter									NO	NO	NO	NO	
4	Working capital facility (WCF) agreement includes default clause									NO	NO	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	YES	YES	
6	Creditors > 90 days past due account for more than 5% of total creditor balances									NO	NO	NO	NO	
7	Two or more changes in Finance Director in a twelve month period									NO	NO	NO	NO	
8	Interim Finance Director in place over more than one quarter end									NO	NO	NO	NO	
9	Quarter end cash balance <10 days of operating expenses									NO	NO	NO	NO	
10	Capital expenditure < 75% of plan for the year to date									YES	YES	YES	YES	
	TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**2**	**2**	**2**	

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 2011/12

Sandwell & West Birmingham Hospitals NHS Trust

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

Criteria	RAG	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2011	Feb 2011	Mar 2011	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	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 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	SHMI - latest data	Ratio									99.7	99.7	99.7	99.7	SHMI data relates to period July 2010 - June 2011 which is the most recent period for which data is available (source Dr Foster).
2	Venous Thromboembolism (VTE) Screening	%									90.1	92.8	92.4	91.3	
3a	Elective MRSA Screening	%									100	100	100	100	Derived from actual screens and projected numbers who require screening.
3b	Non Elective MRSA Screening	%									54	52	67	71	Derived from actual screens and projected numbers who require screening.
4	Single Sex Accommodation Breaches	Number									0	0	8	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number									8	8	8	2	
6	"Never Events" in month	Number									1	1	1	1	
7	CQC Conditions or Warning Notices	Number									0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number									10	14	19	23	
9	RED rated areas on your maternity dashboard?	Number									4	4	4	4	February data most recent - In-house comprehensive dashboard. Red areas relate to; workforce (3) and clinical activity (1).
10	Falls resulting in severe injury or death	Number									4	2	6	2	
11	Grade 3 or 4 pressure ulcers	Number									5	14	5	7	
12	100% compliance with WHO surgical checklist	Y/N									NO	NO	NO	NO	Compliance with the 3 sections of the WHO Surgical Checklist at SWBH is 99% as at 20 April 2012.
13	Formal complaints received	Number									51	59	69	74	
14	Agency and bank spend as a % of turnover	%									2.9	2.8	3.0	3.2	
15	Sickness absence rate	%									4.28	4.34	4.39	4.13	

Board Statements

well & West Birmingham Hospitals NHS

Mar 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.	
4	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	

	For SERVICE PERFORMANCE, that:	Response
5	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
6	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	✓
7	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	✓
8	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
9	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)	✓
10	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
11	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*
12	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
13	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	✓
14	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
15	The management team have the capability and experience necessary to deliver the annual plan	✓
16	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**	**26/04/2012**
Chair	**To be added**	**Richard Samuda**	**26/04/2012**

Key for drop down list:

- ✓ ü
- ✗ û

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 considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issu 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 t line with the MRSA objective target figures calculated for them by DH. The SHA expects those NHS trusts without 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 yea 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 ar objective in-year, but has not yet done so, it will be required to [provide, and then] report monthly against, an MRS 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 thresh 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 screenin other consultants, including consultant upgrades. Failure against either threshold represents a failure against the 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 or These breaches may be reallocated in full back to the referring organisation(s) provided there is written agreemer between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly
5a&b	RTT	While performance is measured on an aggregate basis, NHS trusts are required to meet the threshold on a montl consequently failure in any month represents failure for the quarter and should be reported via the exception repo
6	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or quarter.
7	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners a care professional). Failure against either threshold represents a failure against the overall target. The target will n 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 s • Time to treatment decision: time from arrival to see a decision-making clinician (defining management plan and • Unplanned reattendance rate: within 7 days of original attendance. Includes patients referred back by another he 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 r
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 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 dischar Contact can include face-to-face or telephone contact. Guidance on what should and should not be counted wher 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 las 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 Progr at any point during the reporting period.

NHS Midlands and East Provider Management Regime

Ref	Area	Details
		For full details of the changes to the Care Programme Approach process, please see the implementation guidanc 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 c followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be ma 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 qua **Denominator:** Number of non-acute patients (aged 18 and over) admitted to the trust, summed across the quarter. Delayed tran attributable to social care are excluded.

NHS Midlands and East Provider Management Regime

Ref	Area	Details
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 • 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 admis 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 C the Department of Health's website. As set out in Guidance Statement on Fidelity and Best Practice for Crisis Services the crisis resolution home treat 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 f unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where fa contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action 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 agai 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 Ir 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 the assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those assessments or reviews were carried out during the reference period. The reference period is the last 12 months 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 tl 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 asse review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were the reference period. The reference period is the last 12 months working back from the end of the reported quarte **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on tl 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. M implemented MHMDS v4 will allow services to report all HoNOS variants, including those for young people and pe 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 Progr during the reference period.
16a	Ambulance Cat A	Life threatening

NHS Midlands and East Provider Management Regime

Ref	Area	Details
17	Learning	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set
a)	Disabilities: Access	Does the NHS trust have a mechanism in place to identify and flag patients with learning disabilities and protocols pathways of care are reasonably adjusted to meet the health needs of these patients?
b)	to healthcare	Does the NHS trust provide readily available and comprehensible information to patients with learning disabilities following criteria?: • treatment options; • complaints procedures; and
c)		Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with
d)		Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with le for all staff?
e)		Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and th
f)		Does the NHS trust have protocols in place to regularly audit its practices for patients with learning disabilities and 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 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:	Corporate Objectives 2011/12 – Progress Report (Quarter 4)
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Ann Charlesworth, Head of Corporate Planning
DATE OF MEETING:	26 April 2012

EXECUTIVE SUMMARY:

The report contains a summary of progress at the end of Quarter 4, towards the achievement of the Trust's Corporate Objectives set out in the Annual Plan 2011/12.

REPORT RECOMMENDATION:

- NOTE the progress made on the corporate objectives for 2011/12 at the year-end.

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:

Aligns to all corporate objectives and elements included on the Board Assurance Framework

PREVIOUS CONSIDERATION:

Trust Management Board on 17 April 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2011/12
CORPORATE OBJECTIVES PROGRESS REPORT (QUARTER FOUR)

INTRODUCTION

The Trust's Annual Plan for 2011/12 set a series of corporate objectives for the year to ensure that we make progress towards our six strategic objectives. Progress on the majority of these objectives is reported to the Board at regular intervals either through routine monthly reports on finance and performance or through specific progress reports. Progress across all objectives is also reported quarterly to ensure the Board has a clear overview of our position.

QUARTER FOUR PROGRESS

A summary of the position on each objective at the end of Quarter 4 is set out in the table that accompanies this report. An overview of the Q4 RAG assessment for each objective is set out in the table below. (Please note that a revised RAG rating has been applied in Q4 to accurately assess the year end position - see page 3).

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
1. Accessible and Responsive Care				
1.1 Identify & implement specific ways to improve health of popn.				
1.2 Close & effective relationship with GP consortia, PCT clusters & Local Authorities				
1.3 Deliver access performance measures				
1.4 Continue to improve outpatient booking systems				
1.5 Improve patient flow from admission through discharge to home				
2. High Quality Care				
2.1 Improve reported levels of patient satisfaction				
2.2 Continue to embed Customer Care promises				
2.3 Improve the care we provide to vulnerable adults				
2.4 Make improvements in A&E services				
2.5 Make improvements in Trauma & Orthopaedic services				
2.6 Make improvements in Stroke services				
2.7 Embed the Quality & Safety Strategy				
2.8 Reporting and learning from incidents				
2.9 Deliver the CQUIN targets				
3. Care Closer to Home				
3.1 Successful integration of adult & children's community services				
3.2 Deliver changes in activity as part of RCRH programme				
3.3 Actively promote healthy lifestyles and health education				
3.4 Develop local response to national plans for Health Visiting				
3.5 Make fuller use of Rowley Regis Community Hospital				

Objective	R / A / G Assessment			
	Q1	Q2	Q3	Q4
4. Good Use of Resources				
4.1 Deliver £21.1m CIP & plans for £20m CIP for further 3 years				
4.2 Achieve a £2m surplus				
4.3 Reduce premium rate working				
4.4 Develop plans to improve service line position of the Trust				
5. 21st Century Facilities				
5.1 Begin to procure a new hospital				
5.2 Continue to improve current facilities				
5.3 Develop detailed plans for development of community estate				
6. An Effective NHS Organisation				
6.1 Make significant progress towards becoming a Foundation Trust				
6.2 Organisational Development activities – stronger voice for staff				
6.3 Clinical systems & processes – safe, error free care				
6.4 Improve staff satisfaction, health and well being				
6.5 Agree IT strategy inc. route to procurement of EPR				
6.6 Continue approach to sustainability, transport and access				
6.7 Develop resourced Training Plan to support workforce plan				

At the end of quarter four, 22 of our 33 objectives are now assessed as light or dark green being either fully or substantially achieved. 7 objectives are assessed as amber, where some progress has been achieved but work will continue into 2012/13.

There are 3 objectives assessed as red:

- 1.1 Identify and implement specific ways to improve the health of the population – where progress has been slow but work with Public Health colleagues will continue in 2012/13.
- 3.2 Deliver changes in activity as part of RCRH Programme – where implementing decommissioning plans proved a challenge and agreement has been reached with Commissioners that the RCRH activity trajectories should be reviewed in 2012/13.
- 5.1 Begin to Procure a New Hospital – where DH approval of the Outline Business Case has been delayed.

CONCLUSION AND RECOMMENDATIONS

This report and the accompanying table present an overview of the position on our corporate objectives for 2011/12 at the end of Quarter 4. The Trust Board is recommended to:

- NOTE the progress made on the corporate objectives for 2011/12 at the year-end.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
TRUST OBJECTIVES 2011/12: QUARTER FOUR PROGRESS REPORT

PROGRESS REPORTING

Progress with many of the corporate objectives has been reported to the Board monthly through for example the monthly performance and finance reports (e.g. progress with 2011/12 financial plan and progress with national access targets) or through specific monthly reports (e.g. 'Right Care Right Here' programme reports). In addition to this and in order to ensure that the Board has a clear view of progress across the corporate objectives, this report has been presented quarterly.:

- Q1 position reported to July Board meeting;
- Q2 position reported to October Board meeting;
- Q3 position reported to January Board meeting;
- Q4 position reported to April Board meeting.

CATEGORISATION

Progress with the actions in the plan has been assessed on the scale set out in the table below. (N.B. This is a revised assessment rating for Q4 to accurately reflect the year end position).

Status	
4	Fully achieved
3	Substantially achieved, with relatively minor areas of non-achievement
2	Partly achieved, with some more significant areas of non-achievement
1	Not achieved, or major areas of non-achievement

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
1.	***Accessible and Responsive Care***				
1.1	**Identify and implement specific ways of improving the health of the population we serve.** **DS**	• Catalogue of relevant indicators drawn from primary care but mapped to each directorate • Discussions with Directors of Public Health to establish priorities • Identify data sources and create data flow for each indicator • Incorporate indicators into SWBH QMF dashboards for each directorate or specialty • Incorporate indicators into a Clinical Quality dashboard for RCRH		• Data items not yet agreed • Process not yet agreed for defining and assuring data quality in QMF • April 2012 Discussions held with DPH. With regard to nominating a public health lead from within the trust.	**1**
1.2	**Ensure close and effective relationships with local GP consortia, PCT Clusters and Local Authorities.** **MS (with DS)**	• Deliver on medical engagement LIA action plan. • Identify leaders and opinion formers in each consortium and continue active engagement. • Promote and improve direct contacts between directorates and primary care clinicians. • Trust represented by Executive or senior Medical leads at all Cluster meetings for Birmingham and Solihull and the Black Country. • Integrate work of Business Development Team with representatives from each Division.	Consortia emerging, regular contact established but lack of systematic approach involving clinical divisions	• SWBCCG now agreed and seeking authorisation • Engagement event now held in February • Excellent relationships maintained with clusters • Full engagement with both cluster system plans and participation in wider cluster activities • CCG involved in agreeing LDP • Not yet identified regular meetings/engagement with CCG	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
		• Improve flow of information and communication between hospital doctors and GPs.			
1.3	**Deliver Access performance measures including those set out in the Operating Framework for 2011/12.** **RB**	• New A&E standards.	Not available Not available Not available Not available Not available 96.99%	A/E Clinical Quality Indicators: - Total time (hrs:mins) in Dep't (95th centile) Actual 3:59 (Q4) (Target <4:00) GREEN - Time (mins) to Initial Assessment (95th centile). Actual 17 mins (Q4)(Target =<15) RED - Time (mins) to Treatment in Dep't (median) Actual 60 mins (Q4)(Target =<60) GREEN - Unplanned reattendance rate (%) Actual 8.0% (Q4)(Target =<5.0) RED - Left Dep't without being seen rate (%) Actual 5.18% (Q4)(Target =<5.0) RED A/E 4-hour waits - 95.3% (Q4)(Target =>95.00) The Integrated Develop Plan for ED continues to be progressed and reports to the EDAT chaired by the CEO. Achievements include pathway redesign in City ED improving performance in assessment and over all waits. Interim CD appointed. February performance poor related to winter pressures and capacity issues secondary to unpredicted bed closures. Special measure successfully put in place to meet quarter 4, 4 hour targets.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
		• 18 weeks referral to treatment standard maintained (95th percentile).	20 weeks (March 2011) 16 weeks (March 2011)	18 weeks RTT Standards: - Admitted Care (weeks) (95th centile) Actual 21 weeks (Feb 2012)(Target =<23) - Non-Admitted (weeks)(95th centile) Actual 13 weeks (Feb 2012)(Target =<18.3) Orthopaedics and plastic surgery are 18 week outliers at specialty level. Waiting list initiatives have delivered a reduction in backlog in Q4. Service improvement recovery plans to deliver full recovery plan at specialty level in 2012/13.	
		• Cancer waiting times (2 wks, 31 days & 62 days) standards maintained.	94.5% 94.7% 99.7% 88.0%	Cancer Waiting Times: - 2 weeks all cancers (%) Actual 96.0% (Nov 11-Feb 12)(Target =>93) - 2 weeks Breast Symptomatic (%) Actual 95.6% (Nov 11-Feb 12)(Target =>93) - 31 days diagnosis to treatment (%) Actual 99.8% (Nov 11-Feb 12)(Target =>96) - 62 days urgent GP referral to treatment (%) Actual 87.2% (Nov 11-Feb 12)(Target =>85)	
		• GUM 48 hr access standard maintained.	100%	GUM 48 hour access: - Patients Offered App't within 48 hours (%) Actual 100% (Q4) (Target =>98%)	
		• Rapid access chest pain standard (2 wk) maintained.	100%	Rapid Access Chest Pain: - Patients seen <14 days following urgent GP referral Actual 98.0% (Nov 11-Jan12) most recent complete 3 month period (Target =>98%)	

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
1.4	**Continue to improve outpatient booking systems.** **RB**	• Hospital short notice cancellations reduced so that less than 20% of total are short notice. • DNA rate reduced to less than 10%. • Hospital initiated cancellations reduced to less than 15% of appts made in month.	(35% in Feb) (12% in Feb) (16% in Feb)	- Short notice cancellations actual 35.2% (Mar 2012) - DNA Rate New OP appointments actual 12.4% (Mar 2012) - DNA Rate Review OP appointments actual 10.9% (Mar 2012) - Hospital initiated cancellations actual 11.6% (Mar 2012) Progress made across a number of specialties to improve booking systems. Pan trust transformation project will continue to further advance booking systems.	**2**
1.5	**Improve patient flow from admission through discharge to home care / after care.** **RB**	• Acute delayed discharges reduced to less than 4% of acute beds. • Average hospital length of stay maintained at less than 4.5 days. • Numbers of very long stay patients (>28 days) reduced to 150 or less. • Reduced readmissions within 30 days.	(5% in Feb) (4.4 in Feb) (187 in Feb) (8.0% following initial Elective or Non Elective Admission)	- Acute delayed discharges actual 3.7% (Q4) Multiagency work stream in train to improve performance. Additional capacity purchased as part of winter plan externally with PCT and social services. - Average length of stay actual 4.0 days (Dec-Feb) - Long Stay Patients >28 days actual 139 (Feb 2012) - Readmission Rate actual 9.0% (Q4) The Transformation Plan has defined enabling work streams which focus on improvements in initial assessment through to discharge planning. An integrated discharge team in partnership with Sandwell Social Services is now established at Sandwell Hospital. Down ward trend in DTOC over Q3 and 4.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
2.	***High Quality Care***				
2.1	**Improve reported levels of patient satisfaction.** **RO (with all Execs)**	• Establish systems to seek patient/carer/user views that ensure all groups are represented. • Establish reporting and feedback systems of patient views at the Trust, Division, Directorate and Department level. • To ensure action plans exist and are delivered against areas of dissatisfaction/requiring improvement. • To have a list of priority patient experience improvement themes/topics and corporately plan and deliver the action. • Ensure external views are fed into internal feedback systems. • To deliver CQUIN target for patient experience improvement. • To measure behaviours against Trust Promises. • To develop an approach to 'customer care' training.		• Patient satisfaction survey (internal) showing overall improvement in ratings. • National survey results currently embargoed. • Net promoter commenced 1/4/12. • Regular reports to TMB, TB and into divisions.	**3**
2.2	**Continue to embed Customer Care promises.** **JK**	• Refresh the customer care promise action plan in line with the feedback from Hot Topics. • Regular analysis of patient survey results and complaints by customer care promises. • Revised recruitment, induction		Embedding of the customer care promises continues to take place in recruitment and operational matters in line with feedback received from Hot Topics. Corporate Induction now features Promises prominently. Action plan updated.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
		and appraisal processes focusing on customer care.			
2.3	**Improve the care we provide to vulnerable adults.** **RO**	• Ensure systems and processes for vulnerable adults are embedded in all clinical areas – including Deprivation of Liberty, Safeguarding, and Mental Health. • Deliver level 1 and 2 training targets. • Relevant policies are in place. • Delivery of targets set within dementia action plan. • Establishment of domestic violence training. • Achievement of standards/rules of the Mental Health Act. • CQC and NHSLA standards met. • Nutrition CQUIN achieved. • Falls and pressure damage targets achieved.		• Regular reports via Quality report. • Key metrics show improvement. • 'Worry wards' identified and targeted with support. • Training trajectory on track. • Intentional rounding commenced. • Safety Thermometer commenced.	**3**
2.4	**Make improvements in A&E services.** **JA**	• Build on the work from 2010/11 in respect of integration. • Ensure that newly developed systems become embedded and continue to support safer and more responsive care. • Ensure that the agreed financial investments lead to the successful recruitment of high quality Clinical staff (Medical and Nursing). • Implement systems to monitor and manage performance in respect of the new ED quality	Baseline to be established at EDAT from evaluation new national quality standards (not previously monitored)	EDAT has met monthly throughout the year, chaired by the CEO and well attended. Comprehensive Integrated Development Plan developed and in implementation. Relatively minor areas of slippage, reported monthly to Trust Board. Much improved (90% +) compliance with safety procedures designed to target serious incident trends (proformas). Reflected in reduced incidents but requires ongoing monitoring. Met 4 hour target for year. Mixed performance on 5 clinical indicators, reflecting national position. See 1.3 for detail. Importance	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
		standards.		downgraded for 12/13. 4/6 Consultant posts recruited to. All other posts funded in workforce plan recruited to.	
2.5	**Make improvements in Trauma and Orthopaedic services.** **RB**	• 18 week waiting time standard achieved for orthopaedics (c. 70% in 18 weeks in Feb). • Workforce plan agreed and delivered for T&O wards. • Improved service line position for T&O. • Improved outpatient performance (reduced cancellations, short notice cancellations and review rates).	74.4% (March 2011)	- 18 week Admitted RTT 69.3% (Feb 2012) 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 orthopaedic service has worked in partnership with the RCRH 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, better use of resources through reduced premium rate working and use for additional sessions. The Trust has invested in increased nurse staffing levels this year on the orthopaedics wards and the experience of our patients is seen to be improving through local surveys. Complaints have decreased this year particularly in relation to waits for outpatients where the wait for first appointments has	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
				reduced. Taskforce established to deliver 18 weeks for speciality including transformational aspects of theatres utilisation and bed flow over 2012/13.	
2.6	**Make improvements in Stroke services.** **DS**	• Stroke dashboard fully populated and incorporated into the Quality Management Framework. • Ensure that performance remains in the top Quartile nationally. • Continued improvements in KPIs for Stroke and TIA pathways. • Ensure robust management structure for stroke services including clarity on reporting lines and accountability. • Develop an option appraisal in partnership with commissioners to ensure optimal configuration of Acute and rehabilitation components of stroke/TIA services and pathways.		• Stroke dashboard continues to evolve. • Trajectories agreed for delivery of performance to attract best practice tariff. • Business case approved by SIRG being implemented • Additional Stroke Consultant appointed • Weekend ward rounds covering Stroke and TIA across sites continuing with imaging slots for high risk TIA delivered. • Work on high risk TIA pathway continues. • March 2012 significant improvements achieved with 95.5% pts spending 90%+ time on stroke unit & 100% having thrombolysis within 4.5hours of onset of symptoms. TIA also above target in Q4. • Option appraisal process on track.	**3**
2.7	**Embed the Quality and Safety Strategy incorporating the FT Quality Governance Framework.** **KD**	• Achieve the plan developed to ensure effective implementation of the Quality and Safety Strategy. • Positive outcomes to support the Trust's top 3 quality related priorities.		A number of the key outcomes of success set out in the Strategy have been achieved, in particular: • Continued CQC registration without conditions. • A positive CQC Quality and Risk Profile maintained through the year. • Successful re-assessment at CNST Maternity Level 1 • All indicators within the CQUiN met	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
				• Improved scores in the 5 in-patient survey questions linked to the CQUiN. • Priorities in the Quality Account achieved. An externally commissioned review of the Trust against the requirements of the Quality Governance Framework was completed in March 2012. A report on the findings and any areas for improvement identified is awaited.	
2.8	**Improve and heighten awareness of the need to report and learn from incidents.** **KD (with all Execs)**	• Annual rate of incident reporting increased at least 10% on previous year. • Improved position with the NRLS report as benchmarked against similar size Trusts. • Reduced number of incidents that cause harm, of a similar nature and / or within the same environment / location.	Q1 – 2891 Q2 – 3286 Q3 – 3263 Q4 – 3322 Total - 12744	• Data for year-end shows that 13334 incidents have been reported. This is not the required 10%, however, it is a good improvement on the previous year, particularly as we introduced electronic incident reporting and expected a dip. • The latest data from the NRLS shows that we are at the mean of reporting for like sized Trusts (5.9) and are at mid-point of the middle 50% of similar Trusts. This is a significant improvement. • There has been an overall reduction in serious incidents. Further work is planned to continue to ensure actions resulting out of investigations are SMART.	**3**
2.9	**Deliver the CQUIN targets** **RO/DS/RB**	22 Targets including: • VTE prevention • Improve patient experience • Alcohol prevention • Smoking cessation • Nutrition assessment on	See Performance report and Quality Account for detail.	All CQUIN targets were achieved in full. See Performance Report for detail.	

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
		admission • End of life care – choice of place to die • Mortality Reviews • Enhanced recovery Stroke discharge • Medicines management – missed doses • Health Visiting response times • Falls assessment			**4**
3.	***Care Closer to Home***				
3.1	**Ensure a successful integration of adult and children's community services that has benefits for patients.** **RB (with RO)**	• Transfer successfully completed in April. • Agreed benefits realisation plan in place by end Q1. • Integration / benefits realisation delivered as planned.		Successful transfer of community services on plan and the Division are establishing more integrated approaches to supporting patient pathways across the organisation. New reablement model introduced on new Henderson Unit at RRH.. IT integration identified on Trust's Health Informatics Strategy. Owning the Future election on Ambassadors piloted in community servicves.	**4**
3.2	**Deliver the agreed changes in activity required as part of the Right Care Right Here programme.** **RB**	• Decommissioning plan agreed with commissioners (value = £16m). • Plan successfully delivered by end of the year.		Decommissioning plan developed by SWBHT currently identifies 85% of the total value to be decommissioned (FYE). The part year effect for 2011/12 still needs to be identified and will be less.	**1**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
				Agreement in Q4 (LDP round) to review RCRH trajectory in 2012/13.	
3.3	**Play a key role in the local community, actively promoting healthy lifestyles and health education.** **JK**	• Development and approval of health promotion strategy. • Delivery of health promotion / education LiA and resulting action plan, involving all key stakeholders. • Launch of involvement website to promote healthy lifestyles. • Lead the development of a RCRH health promotion and education strategy. • Participate in joint venture tender for lifestyle services.	No baseline for 2010/11	• Feedback on health promotion was received from teams across the Trust via Hot Topics. A vast amount of health promotion activity is taking place within the local communities although an overarching strategy has not yet been finalised. • An LiA event with members, staff and stakeholders is scheduled to take place in May, before the strategy is finalised and the 'Engage' website is launched. • The content for the 'Engage' website has largely been populated and is being assessed against the Information standard while the site itself is currently undergoing technical testing before launch. • Opportunities with RCRH. • Lifestyle services tendered for in JV but not successful.	**2**
3.4	**Develop a local response to national plans for Health Visiting.** **RO**	• Implementation plan supported by PCT/SHA. • Clear recruitment plans. • Increase University commissions. • Review of team skill mix. • Retention plan in place. • New models of care developed, including family partnerships.		• Implementation plan progressing. • Commissions increased and on target for additional posts this year. • Pilot site approved for national HV pilot roll out.	**3**
3.5	**Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to**	• Launch of new intermediate care unit in June. • Agree and deliver plan for services		The new Henderson Reablement Unit opened as planned in September. PCT visit in March reviewed the unit's performance well.	

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
	home. **RB**	at Rowley in 2011/12. • Increased numbers of outpatient clinics scheduled at Rowley.		Working with PCT on business case to establish a primary urgent care facility at RRH.	**3**
4	***Good Use of Resources***				
4.1	**Deliver a £21.1m CIP and produce detailed plans to deliver a £20m annual CIP for a further three years.** **RW (with all Execs)**	• Presentation of the line by line CIP plan for the next financial year as assessed for quality and risk, deliverability and presented to the Finance and Performance Committee as part of the Trust Board's approval of the overall plan. Continuation of the robust monitoring and management of the plan via the Performance Management Board including tracking of replacement schemes, Full year/part year effects and any shifts from recurrent categories to non-recurrent. • Develop and agree the basis of allocating operational targets as part of 3 year CIP, ensuring capacity and expertise is developed so that plans are expressed in QUiPP and QuEP categories making use of all internal and external benchmarking data, e.g. SLR. Completion target to be consistent with commencement of strategic CIP work, end of Q1.		The current forecast position shows full achievement of the CIP target in 2011/12. The new savings programme ("Transformation Plan") for 2012/13 and years beyond is well developed and there will be enhanced monitoring arrangements to capture not just financial deliverables but also the activities that lead to improved cost efficiency.	**4**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
		• Integration of the plan within overall financial modelling including explicit cross-model audit trails of the impact of CIPs within the external and internal financial models (e.g. LTFM, LTSM, FIMS)			
4.2	**Achieve a £2m surplus.** **RW**	• Prepare a detailed financial plan with sufficient income based resources to meet anticipated expenditure in accordance with operating framework imperatives, capacity plans and risk reserves. • Ensure that Board reporting is clear between the DH target surplus and IFRS based bottom line results that take account of on-balance sheet treatment of long term contracts • Ensure that variations in the plan are reported at the earliest opportunity together with corrective mitigating plans as developed and implemented through the Performance Management Board.		Forecast year-end performance indicates that the Trust will meet or exceed this targeted surplus.	**4**
4.3	**Reduce premium rate working.** **RB**	• Premium rate working reduced by £1.8m compared with 2010/11 outturn. • Theatre utilisation improved: <20% late starts, <25% early finishes, average of >3.5 cases per list).	80% prompt starts (March 2011) 46% on time finishes	• Premium rate working data TBC. • 69% prompt starts (<15 mins late) (Mar 2012) • 54% on time finishes (<15 mins early) (Mar 2012)	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
			(March 2011) 2.9 cases per list (March 2011)	• 3.1 average cases per list (Mar 2012) Some progress in year based on available data. Theatres workstream of the Transformation Plan established and on-going improvement programme defined for 2012/13.	
4.4	**Develop plans to improve the service line position of the Trust.** **MS**	• Identify three services. • Evaluate baseline position. • Develop improvement plan for each service.	Three services identified – Orthopaedics, Obstetrics and Dermatology	• Specialties have agreed baseline position • Benchmark services identified and other Trusts contacted to provide benchmark data • Plans agreed for three services: • Obstetrics – increase activity (repatriation plans agreed with Dudley and marketing activity carried out) and achieve NHSLA level 2 • Dermatology, merge Dermatology beds • Orthopaedics, redesigned pathways • Greater need to identify profitability at sub specialty level	**3**
5	***21st Century Facilities***				
5.1	**Begin to Procure a new hospital.** **GS**	• OJEU notice placed. • GVD executed. • Clarity on Deed on Safeguard achieved.	Awaiting OBC approval.	Progress delayed by national review of PFI. GVD 1 executed as planned as next stage of land purchase. Deed of Safeguard issue resolved.	**1**
5.2	**Continue to improve current facilities.** **GS**	• Updated Estates Strategy. • Capital programme on plan. • Satisfactory environmental assessments (CQC, Hygiene Code, PEAT etc).	2010/11 Capital Programme delivered to plan.	Estates strategy updated. Capital programme for 2011/12 implemented as planned. PEAT assessments all good-excellent.	**4**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
5.3	**Develop detailed plans for the development of the community estate.** **GS**	• RCRH Community Facilities Programme Team embedded. • Programme for development agreed. • Initial projects commenced.	Engagement with PCTs commenced.	RCRH Community Facilities Programme team established, feasibility work being undertaken.	**3**
6	***An Effective NHS Organisation***				
6.1	**Make significant progress towards becoming a Foundation Trust.** **MS**	• Develop a detailed project plan. • Ensure delivery of all milestones in the project plan. • Secure any additional support required for the application including stakeholder support.	Project structure set up	• IBP submitted on time • TFA agreed • Delayed by at least four months due to delay in OBC approval • Options for revised approach developed to ensure progress in 12/13.	**2**
6.2	**Deliver a set of Organisational Development activities including a stronger voice for front line staff.** **MS**	• Develop an OD framework and action plan to support FT application. • Deliver a model of staff engagement and incentive system.	Lack of coherent set of OD activities	• OD strategy approved • OD steering group set up • OtF staff ambassadors being piloted in community services and pathology • Ambassador elections and welcome event held	**3**
6.3	**Develop our clinical systems and processes to reduce variability and ensure safe, error free care.** **DS**	• Continue diagnostic project in respect of Clinical Back Office Systems. • Establish Project Board to deliver on Paperlite and Clinical Back Office Projects. • Relevant processes (including SBAR for reliable clinical handover, "kitemarking" clinical offices and departments for information standards & root		• Paperlite and Clinical Back Office projects on track and expected to deliver 1st phase implemented • Plans to implement e-requesting of pathology postponed • Self-assessment tool under development but delayed • March 2012 Electronic requesting of Imaging 71%. • March 2012 E-acknowledging of imaging progressing well. Paper not yet turned off	**2**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
		cause analysis) developed and embedded in all clinical departments.		but scheduled for May 2012. • There are still challenges with robustness of the technology	
6.4	**Improve staff satisfaction, health and wellbeing.** **MS/RO**	• System of gathering staff views throughout the year. • Identify actions arising from staff views. • Publish staff survey results. • Regular communications to staff. • Health and Wellbeing action plan – delivery against timescales. • Reduction in sickness absence. • Measurable improvements in survey results. • Links to OD/OTF plans around staff engagement and ownership.		• Reduced sickness rates being achieved. Targets not fully met • Significant improvement in staff satisfaction score in 2011 • Health and wellbeing action plan being delivered to timescales, new focus on nutrition advice • Extensive programme of H&WB activities publicised monthly.	**3**
6.5	**Agree an IT strategy including an affordable route to procurement of an Electronic Patient Record.** **DS**	• Programme board set up and running. • Option appraisal complete. • Decision-making process agreed and underway.		• 1st workshop held to develop a plan for the plan • Project delayed until IM&T review complete • January 2012 IM&T review complete. Improvement Plan approved by Board and Interim CIO appointed. • Strategy document will now be deferred to 2012/13	**2**
6.6	**Continue to develop and implement the Trust's approach to sustainability and transport and access.** **GS**	• Carbon Management Plan agreed. • Sustainability action plan on target. • Review and update travel plan.	Sustainability Action Plan being implemented.	Sustainability action plan and carbon management plan on track.	**3**

Trust Objectives 2011/12					
Ref.	**Objective**	**Measure of Success**	**Baseline (2010/11)**	**Summary Position as at end of Quarter Four (March 2012)**	**Red /Amber /Green Assessment**
6.7	**Develop a training plan that reflects service needs, is resourced and supports the workforce plan.** **RO**	• Trust Training Plan developed by May. • Funding to support plan agreed June/July. • LBR and JIF funding identified. • Commissions with higher education institutions agreed. • L&D Committee monitoring of plan. • Plan clearly linked to workforce plan due September. • Learning Hub/Health tech proposal written and presented to relevant parties.		Training plan developed and submitted to SHA. LBR funding agreed. Non-medical commissions agreed. Learning Hub development proposal prepared.	**4**

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT APRIL 2012

Introduction

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Project performance

The RCRH Programme activity performance reports related to service redesign are included in Appendix 1 for information. They attempt to summarise overall progress with the Programme in key areas by providing data for the first ten months of 2011/12 and comparing it with actual performance in 2010/11, the trajectory in the RCRH Activity and Capacity (A&C) for 2011/12 and the targets in the A&C model for 2016/17.

Whilst there has been an increase in acute activity in January, across the year it appears there has been a downward trend in Inpatient and Outpatient acute activity although remaining above the 2011/12 trajectory and significantly higher than the 2016/17 trajectory. However, our Emergency Department Attendances are higher than the 2010/11 end of year level and 2011/12 trajectory. Further work is required to ensure maintenance of these trends and ongoing progress towards the 2016/17 position. It is anticipated that the re-commissioning work (see below) will help to achieve this as will the cross cutting work streams in our Transformation Programme.

In summary activity trends for April 2011- January 2012 show:

- Inpatient Activity: Our Acute Occupied Bed Days (OBDs; in Summary A, figure 1) are 7.4% below 2010/11 levels but 15% above the 2011/12 trajectory and 49% above the 2016/17 trajectory. Whilst the overall trend in downwards there has been a further increase in January as a result of higher levels of emergency admissions. Emergency inpatient OBDs which are 7.9% lower than last year but 20% above the 2011/12 trajectory and 45% above the 2016/17 trajectory. Our elective inpatient OBDs continue to show a downward trend and are 8% below last year, 6% below the 2011/12 trajectory and 39% above the 2016/17 trajectory (Summary A, figures 4 and 5).

- Community OBDs (in Summary B, figure 3) have shown a further increase over January and are now 8% below 2010/11 levels and 15% below the 2011/12 trajectory. This is likely to be due to the opening of the intermediate care/re-ablement beds at Rowley Regis Hospital in October.

- Emergency Department Attendances: There has been a sharp increase in our Emergency Department (ED) attendances in January (in Summary A, figure 2) which

are now 1.3% above the 2010/11 end of year level, and 7% above the 2011/12 trajectory.

- The Urgent Care Centre attendances (in Summary B, figure 2) are 15% above 2010/11 end of year level, 93% above the 2011/12 trajectory and 34% above the 2016/17 trajectory.

- Outpatient Attendances: Our acute Outpatient Activity (in Summary A, figure 3) has also shown an increase in January and is 4% below the 2010/11 end of year level and 0.7% above the 2011/12 trajectory. It is 124% above the 2016/17 trajectory.

- Community Outpatient Activity (including our community and new Community Provider activity, in Summary B, figure 1) remains below the 2010/11 end of year level by 4.% but is still 223% above the 2011/12 trajectory although still some way (49%) from the 2016/17 trajectory.

- Referrals to acute services showed a slight increase in January but still remain 7% below the 2010/11 level (in Summary B, figure 4).

Transfer of Activity (Re-commissioning)

Work has continued to deliver and monitor the schemes in the Re-commissioning Programme for 2011/12. The LDP agreement for 2012/13 has set a target of re-commissioning activity worth £10 million and it has been agreed that this 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 GP Clinical Commissioning Group (SWB GP CCG) to reduce the demand for acute care.
- Implementation of the approved RCRH care pathways.

These schemes will need to be translated into a detailed schedule with clear agreement between ourselves and the SWB GP 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.

RCRH Activity and Capacity Model

As reported last month the RCRH Activity and Capacity Model has formed the basis for both our long term plans (including the Outline Business Case for the Midland Metropolitan Hospital) and the PCTs' long term commissioning plans. The model was last updated in 2010/11 (version 5.3) and work continues to produce an updated version as part of their Foundation Trust application and transformation plan process. This will result in version 5.6 of the model and will incorporate a new set of base year data, a number of changes to key assumptions and a review of the scope of the areas of service provision under consideration. A full revision of the RCRH Activity and Capacity model is also overdue and there are ongoing discussions within the local health economy to develop the next phase of this work.

RCRH Partnership

The RCRH Partnership Board has discussed the need for a refresh of the Partnership/Programme and concluded that an away-event would be extremely useful. It was agreed that this should await key changes affecting partner organisations, such as the formation of the Sandwell and West Birmingham GP Clinical Commissioning Group (SWB GP CCG), the completion of the latest NHS LDP/Contracting round and the outcome of the Local Government Elections in May for both Councils.

Discussions have also been continuing in relation to long-term management arrangements for RCRH Programme Team as part of the NHS re-organisation under the White Paper/Act. The SWB GP CCG is keen to include the Programme within its corporate remit, taking on that responsibility from Sandwell PCT/Black Country PCT Cluster. This proposal clearly seeks to address the challenge of retaining focus around service redesign and implementation, together with maintaining key partnership arrangements.

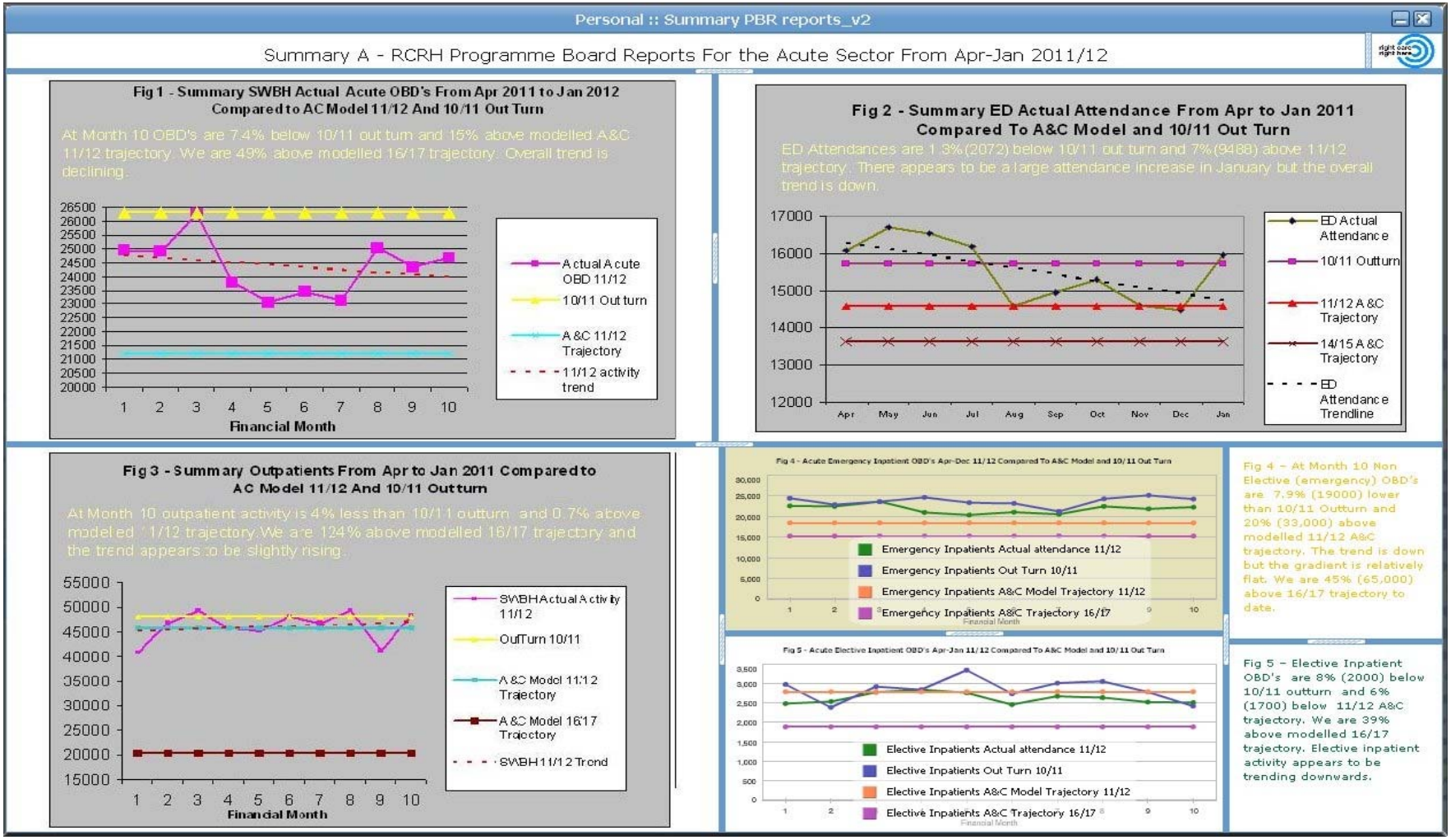
In preparation for the above chances the RCRH Programme Team is actively involved in a stocktake of areas of work, with a view to ensuring that key topics are not overlooked and where appropriate are handed over to a responsible organisation in a structured way.

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: 17th April 2012

APPENDIX 1 - RCRH Activity Summaries



Summary PBR Community reports

Summary B - RCRH Programme Board Reports For Community Sector From Apr-Jan 2011/2012

Fig 1 Summary Community Outpatients From Apr 2011-Jan 2012 Compared to A&C Model and 10/11 Out Tu...

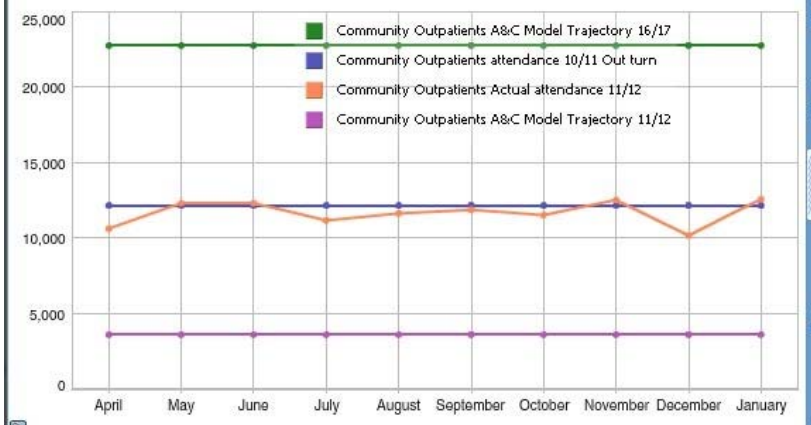


Fig 1 – At Month 10 community outpatient attendance is 4% less than 10/11 outturn. In comparison to the A&C model it is 223% above 2011/12 Trajectory and 49% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 15% above 10/11 outturn. Urgent care activity appears to be trending up and we are 34% above 16/17 Trajectory and 93% above 11/12.

Fig 3 – Community OBD's are 8% below 10/11 outturn and 15% below modelled trajectory for 11/12. Please note that McCarthy ward at Rowley Regis closed in May 2011 and a new enablement ward (Henderson ward) has a phased opening since October 2011.

To meet 11/12 trajectory we need to introduce a further 16,154 OBD's .The Community OBDS total now includes Henderson Ward and the following:

Leasowes IC Centre,Barthalomew Lodge Nursing Home,Waterside Nursing Home,Greenhaven Care Home,Moseley Hall,Riverside Lodge,RCRH Exemplar projects

Fig 4 – Show referral activity which includes GP as well as other types. At month 10 referrals are 7% (11,000) below last years out turn.

Fig 2 Summary UCC Attendance From Apr 2011 to Jan 2012 Compared to A&C Model and 10/11 Out ...

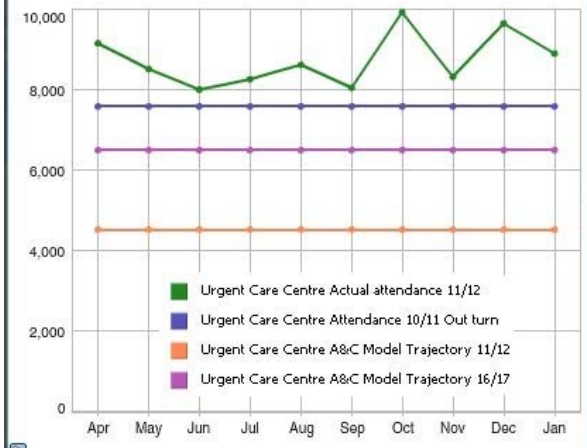


Fig 3 Summary Community OBD's From Apr 2011 to Jan 2012 Compared to A&C Model and 10/11 O...

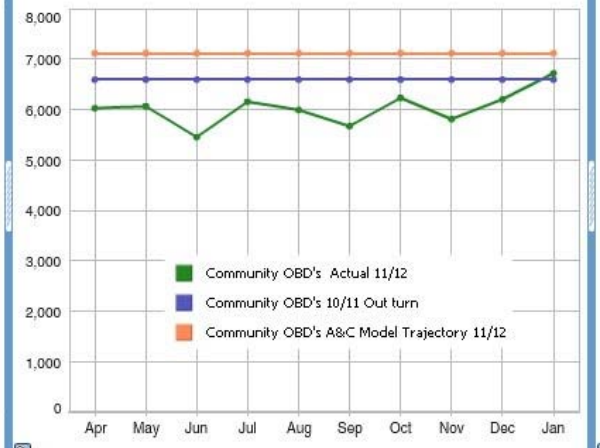
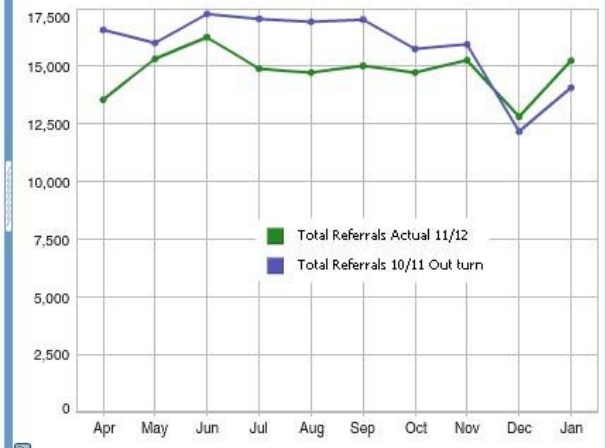


Fig 4 Summary Referrals From Apr 2011 to Jan 2012 Compared to 10/11 Out Turn



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Transfer of Activity (Re-commissioning)

Work has continued to deliver and monitor the schemes in the Re-commissioning Programme for 2011/12. The LDP agreement for 2012/13 has set a target of re-commissioning activity worth £10 million and it has been agreed that this 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 GP Clinical Commissioning Group (SWB GP CCG) to reduce the demand for acute care.
- Implementation of the approved RCRH care pathways.

These schemes will need to be translated into a detailed schedule with clear agreement between ourselves and the SWB GP 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.

RCRH Activity and Capacity Model

As reported last month the RCRH Activity and Capacity Model has formed the basis for both our long term plans (including the Outline Business Case for the Midland Metropolitan Hospital) and the PCTs' long term commissioning plans. The model was last updated in 2010/11 (version 5.3) and work continues to produce an updated version as part of their Foundation Trust application and transformation plan process. This will result in version 5.6 of the model and will incorporate a new set of base year data, a number of changes to key assumptions and a review of the scope of the areas of service provision under consideration. A full revision of the RCRH Activity and Capacity model is also overdue and there are ongoing discussions within the local health economy to develop the next phase of this work.

RCRH Partnership

The RCRH Partnership Board has discussed the need for a refresh of the Partnership/Programme and concluded that an away-event would be extremely useful. It was agreed that this should await key changes affecting partner organisations, such as the formation of the Sandwell and West Birmingham GP Clinical Commissioning Group (SWB GP CCG), the completion of the latest NHS LDP/Contracting round and the outcome of the Local Government Elections in May for both Councils.

Discussions have also been continuing in relation to long-term management arrangements for RCRH Programme Team as part of the NHS re-organisation under the White Paper/Act. The SWB GP CCG is keen to include the Programme within its corporate remit, taking on that responsibility from Sandwell PCT/Black Country PCT Cluster. This proposal clearly seeks to address the challenge of retaining focus around service redesign and implementation, together with maintaining key partnership arrangements.

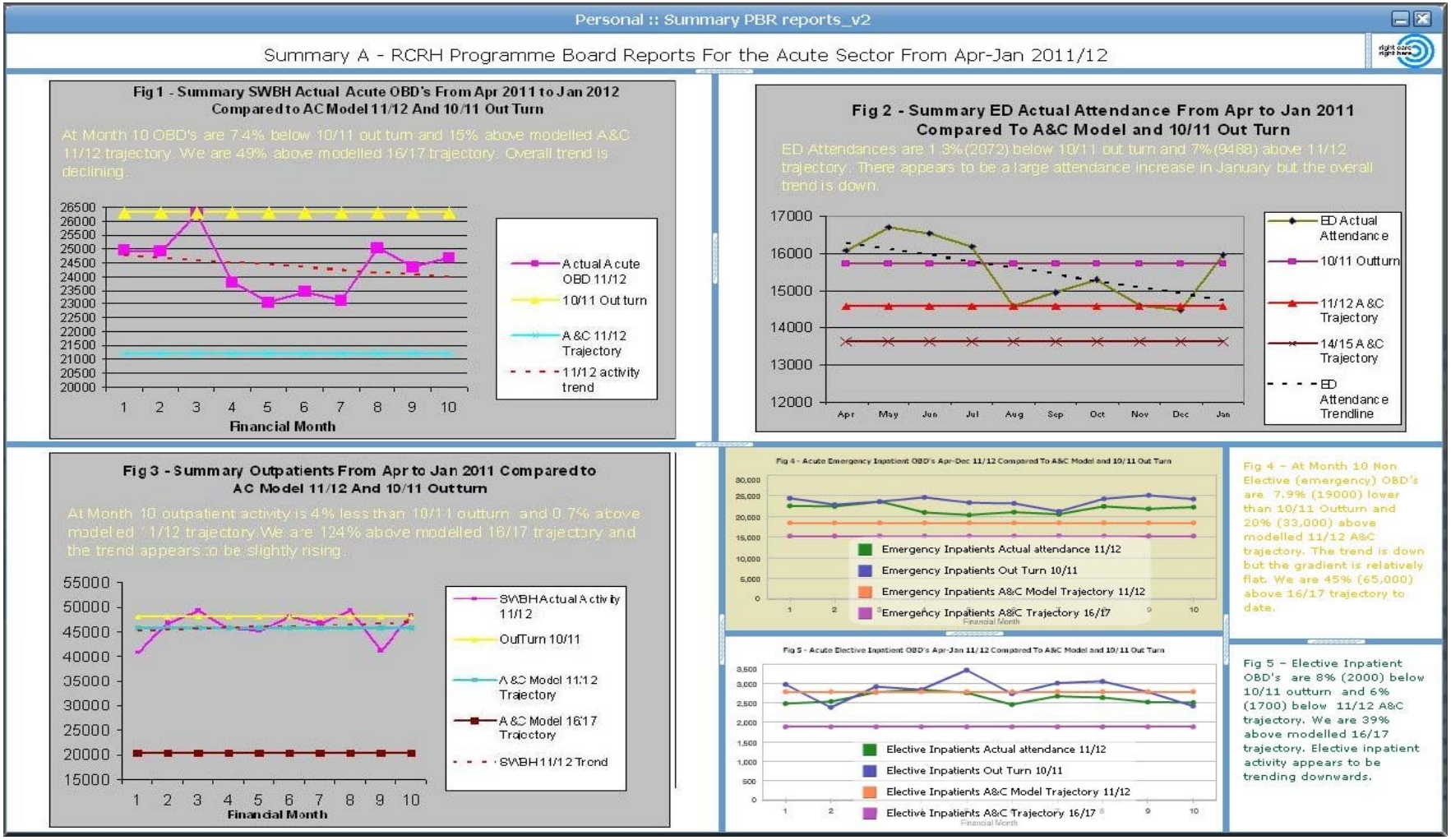
In preparation for the above chances the RCRH Programme Team is actively involved in a stocktake of areas of work, with a view to ensuring that key topics are not overlooked and where appropriate are handed over to a responsible organisation in a structured way.

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: 17th April 2012

APPENDIX 1 - RCRH Activity Summaries



Summary PBR Community reports

Summary B - RCRH Programme Board Reports For Community Sector From Apr-Jan 2011/2012

Fig 1 Summary Community Outpatients From Apr 2011-Jan 2012 Compared to A&C Model and 10/11 Out Tu...

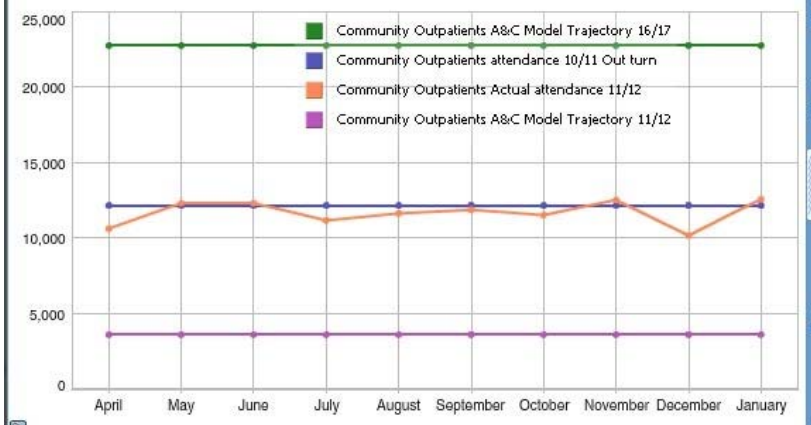


Fig 1 – At Month 10 community outpatient attendance is 4% less than 10/11 outturn. In comparison to the A&C model it is 223% above 2011/12 Trajectory and 49% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 15% above 10/11 outturn. Urgent care activity appears to be trending up and we are 34% above 16/17 Trajectory and 93% above 11/12.

Fig 3 – Community OBD's are 8% below 10/11 outturn and 15% below modelled trajectory for 11/12. Please note that McCarthy ward at Rowley Regis closed in May 2011 and a new enablement ward (Henderson ward) has a phased opening since October 2011.

To meet 11/12 trajectory we need to introduce a further 16,154 OBD's .The Community OBDS total now includes Henderson Ward and the following:

Leasowes IC Centre,Barthalomew Lodge Nursing Home,Waterside Nursing Home,Greenhaven Care Home,Moseley Hall,Riverside Lodge,RCRH Exemplar projects

Fig 4 – Show referral activity which includes GP as well as other types. At month 10 referrals are 7% (11,000) below last years out turn.

Fig 2 Summary UCC Attendance From Apr 2011 to Jan 2012 Compared to A&C Model and 10/11 Out ...

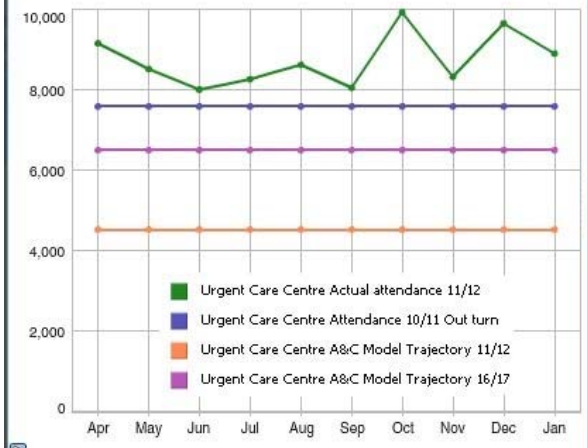


Fig 3 Summary Community OBD's From Apr 2011 to Jan 2012 Compared to A&C Model and 10/11 O...

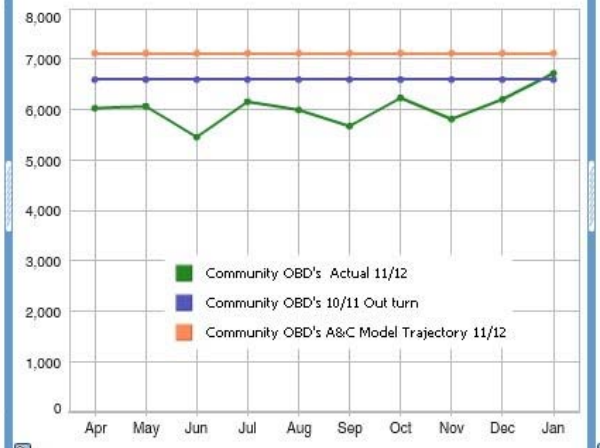
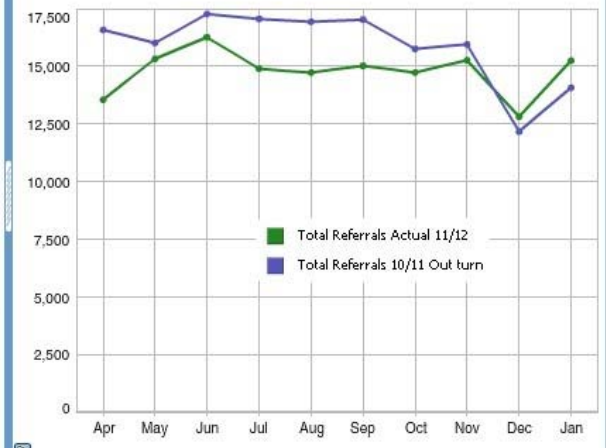


Fig 4 Summary Referrals From Apr 2011 to Jan 2012 Compared to 10/11 Out Turn



FT Programme Director Report April 2012 – Overall status - Red

Activities this period

- Conclusion of public engagement events
- Draft outline TFA timetable and case for change prepared and discussed informally with SHA
- Patient access modelling to inform activity flow modelling commenced
- Market research to inform activity flow modelling commissioned
- Deloitte Quality Governance review initial findings developed
- Revised activity and capacity model presented to CCG/PCTs

Activities next period

- Report outlining findings following 8 week engagement to be prepared
- Formal renegotiation of TFA commences
- Reach agreement with PCTs on Activity and Capacity model
- Commence market research to inform activity flow modelling
- Patient access modelling report to be received
- Board Quality Governance self-assessment to be undertaken

Issues for resolution and risks in next period

- Reach agreement with SHA on revised approach to developing 5 year IBP

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sustainable Development Management Plan Update
SPONSOR (EXECUTIVE DIRECTOR):	Graham Seager, Director of Estates/New Hospital Project Director
AUTHOR:	Rob Banks, Head of Estates
DATE OF MEETING:	26 April 2012

EXECUTIVE SUMMARY:

The Trust's Carbon Management Plan (CMP) is progressing with recent work including energy efficient lighting surveys, steam traps work, estates rationalisation and on-going IT Powersave software energy savings. Waste reduction and recycling is progressing well and sustainability engagement events and campaigns have been run recently with a further event planned for May.

Work continues on gathering data for annual reporting to the Environment Agency though the Carbon Reduction Commitment (CRC) Energy Efficiency Scheme.

REPORT RECOMMENDATION:

The Trust Board is asked to note the current progress in relation to Sustainability against key points.

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		Legal & Policy	X	Patient Experience	X
Clinical		Equality and Diversity		Workforce	x

Comments:

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

Strategic objectives
Improve the environmental sustainability of the Trust's operations by responding to the national carbon reduction strategy

Annual priorities

- Cost Improvement Programme
- Carbon Reduction Programme
- European Emissions Trading Scheme (EU ETS)
- Carbon Reduction Commitment (CRC)

CQC essential standards of quality and safety
Regulation 11

PREVIOUS CONSIDERATION:

Sustainability Working Group (SWG) reviews areas of work discussed in this paper.

Trust Board last considered an update on sustainability at its meeting on 23rd February 2012.

SUSTAINABILITY UPDATE

TRUST BOARD – 26 APRIL 2012

1. Introduction

The purpose of this report is to update the Trust Board on progress to date with implementing the Trust's sustainability agenda.

2. Carbon Management Plan (CMP)

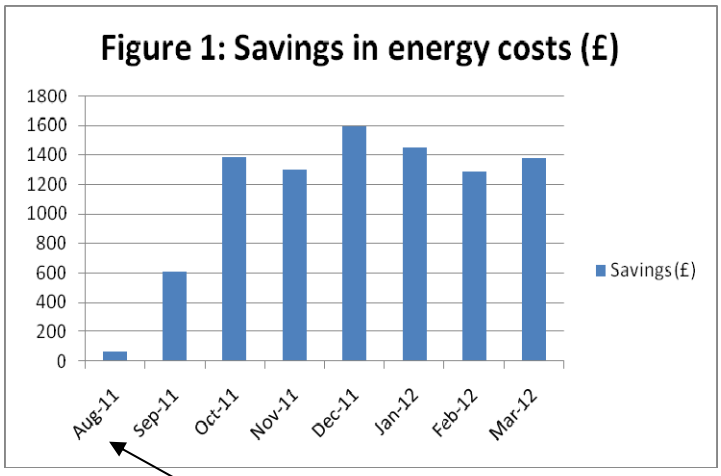
The Trust is working on the CMP to deliver savings of approx 15% of the 2008/09 baseline (22,184 tonnes of Carbon). The CMP will be assessed and accredited by the Carbon Trust over the next few months and an order has been placed for this work.

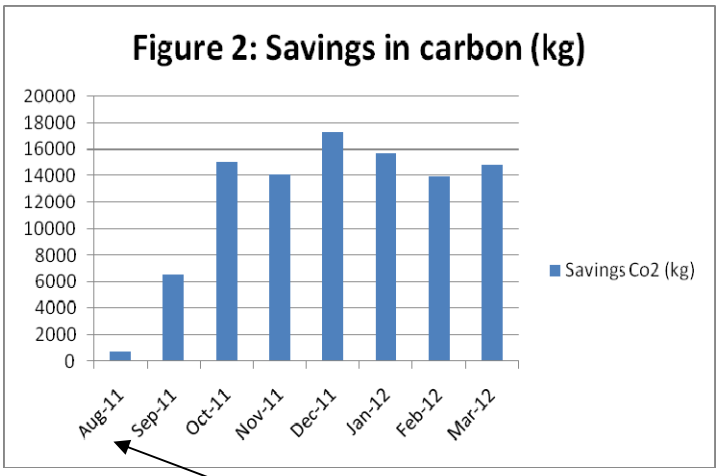
2.1. Energy efficient lighting surveys

Energy is a very large part of our carbon footprint at just over 90% of total carbon emissions. Work has already been done on reducing gas consumption through the installation of energy efficient boilers; however there is work to be done to reduce electricity consumption across the Trust. Lighting surveys are currently being undertaken at City Hospital in Pathology, Estates and the Library. These surveys will provide information on the technologies that can be implemented and estimates on energy consumption reductions that will consequently lead to reduced energy costs and carbon emissions.

2.2. IT Powersave Management Software

To help the Trust save unnecessary waste in energy, IT Powersave software was installed in August 2011 and gradually rolled out to around 3,000 computers. The Powersave software automatically shuts down non-emergency computers at 6pm. **Error! Reference source not found.** and 2 illustrate the savings that have been made from August 2011 to March 2012 in terms of carbon and energy spent. The IT Powersave software is saving (on average) £1,402 per month and 15,161 kg of carbon per month.





Installation being rolled out during August-September 2011

2.3. Steam Traps

Work is being undertaken at City and Sandwell to repair failed closed/blocked traps and to install where needed to prevent energy losses. Surveys have shown that taking action will save an estimated £44,199 and 400 tonnes of carbon per annum.

2.4. Estates Rationalisation

The estates rationalisation project will greatly reduce energy consumption and therefore carbon emissions. Data has been requested from the capital projects team on estimated energy savings from the rationalisation work.

3. Carbon Reduction Commitment (CRC)

Energy data has been collected over the last 12 months in preparation for the CRC reporting process. The Evidence Pack is currently being compiled and in July 2012 this, alongside an Annual Report, will be submitted to the Environment Agency.

4. Sustainability Events - 2012

Climate Week and the NHS Sustainability Day of Action took place in March at the Trust and were successful. A Sustainability event is being planned for mid-end of May to engage and inform staff on all aspects of Sustainability, including energy and resource efficiency, waste, travel and health and well-being.

5. Waste Management

5.1. Recycling Scheme - City

The recycling scheme (for paper, cardboard and plastics) at City Hospital is running well and is continuing to be rolled out to other areas. By summer 2012, all key areas at City Hospital will be included in the recycling scheme.

5.2. Recycling Centre at City

Due to popular demand, a new recycling centre for paper and plastics generated on site has been created at City Hospital. The recycling centre is located between the Management Block and the Pathology department. Figure 3 (left) shows the paper and plastic recycling bins in situ at City Hospital.

5.3. Food Waste Digesters at Sandwell

Two food waste digesters have recently been installed and are awaiting commissioning at the catering kitchen at Sandwell. The food waste digesters use a bio enzymatic formula to convert bio-degradable food waste into grey water with no harmful effects to the environment.

The food waste digesters have been put in place to ensure the Trust is compliant with forthcoming legislation that prevents the discharge of food waste into the domestic waste water stream. The digesters will also save the Trust approximately £8,174 in direct electricity and water savings (from not using the macerators to process food waste) and around 14.7 tonnes of carbon each year.

5.4. Ink Cartridge Recycling Scheme

The Trust is working with 'Takeback', an organisation that collects and re-uses our empty ink and toner cartridges, ensuring that they are not sent to landfill whilst also donating money to a number of charities.

All monies raised from the scheme will be put into the Sustainability Trust Fund. This Trust Fund has been set up to fund local project initiatives put forward by the Sustainability Champions. All suggestions put forward by the Sustainability Champions will be reviewed by the Sustainability Working Group.

6. NHS Forests and 'Fones4Forests' Campaign

As part of Climate Week, the Trust supported NHS Forests in running a 'Fones 4 Forests' campaign. Staff, patients and visitors were asked to donate old mobile phones and, in return, the Trust was given 1 tree per mobile phone. A total of 72 phones we collected. To start the planning process and to also mark the 'NHS Sustainability Day of Action' in March, the Trust planted two young trees just outside of the BTC. The remaining 70 trees will be banked until the end of the year when the planning season starts again. Where possible, trees will be planted on the Trust sites or within local designated forests.

7. Nottingham Energy Partnership - Study of Published NHS Carbon Footprint Work

Nottingham Energy Partnership (NEP) has undertaken a unique study of published NHS carbon footprints. The Trust scored 5/5 for having a full detailed carbon footprint with relevant information about water, waste, building, whilst also having regular, detailed and up to date information on this in our Annual Report. The results table can be found here:
http://www.nottenergy.com/images/uploads/pdfs/NHSTABLE.htm

Next Steps

- Continued work on the Carbon Management Plan (CMP)
- Promotion of Sustainability Champions and Supporters (uptake and training opportunities)
- Continue with waste reduction and recycling initiatives across the Trust
- Collection of carbon footprint data
- Utilise carbon data to monitor, action and inform staff of progress against targets
- Annual CRC reporting
- Regular communications to staff

Recommendations

The Trust Board is asked to:

- Note the current progress in relation to Carbon Management Plan, Carbon Reduction Commitment, sustainability event in May, waste management, NHS Forests and Nottingham Energy Partnership study.

Rob Banks
Head of Estates

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**2011 National Staff Survey Results**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Gayna Deakin, Deputy Director of Workforce**
DATE OF MEETING:	**26 April 2012**

EXECUTIVE SUMMARY:

The Trust's response rate is 46% and the national average for acute trusts is 54%. The 2011 National Staff Survey results show that of the 38 Key Findings:

- 7 have changed significantly (+/- 5%)
- 31 have not changed significantly (28 show an improving trend, 4 remain the same, 6 show a deteriorating trend)

The Trust's overall Staff Engagement score has risen from 3.62 to **3.67** in 2011 and is above the national average (3.62). The Staff Satisfaction score has risen from 3.45 to **3.52** in 2011 and is also above the national average (3.47).

The results show that overall good progress has been maintained both in terms of improving trends across the majority of key findings and in many areas, such as staff engagement and staff satisfaction levels, performance has been very good.

Good progress has been made against the areas targeted for action following the 2010 survey with the majority of areas showing an improving trend.

REPORT RECOMMENDATION:

1. To receive and note the results of the 2011 National Staff Survey
2. To receive and note progress against the 2010 National Staff Survey Action Plan
3. To discuss and agree the approach/action plan for the 2011 National Staff Survey

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		Equality and Diversity		Workforce	x

Comments:

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

Corporate Objective 6 :An Engaged, Effective Organisation

CQC monitoring of compliance against essential standards

Risk No: 1107EXE05 [disengagement of staff leading to resistance to change, increase in sickness absence levels and a negative impact on national staff survey results]

PREVIOUS CONSIDERATION:
The results have been presented to the Organisational Development Steering Group in March 2012 and to the April JCNC and Trust Management Board meetings.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

2011 NATIONAL STAFF SURVEY RESULTS

1. Introduction

1.1 This paper provides an overview of the Trust's results from the ninth annual national survey of NHS staff carried out in 2011, sets out progress against the action plan in response to the 2010 survey and highlights areas for improvement and action to be taken in response to the findings of the 2011 survey.

2. Background

2.1 The 2011 NHS staff survey involved 366 NHS organisations in England. 250,000 NHS staff were invited to participate using a self-completion postal questionnaire survey method. Responses were received from 134,967 NHS staff, a response rate of 54%.

2.2 The results are primarily intended to help NHS organisations to review and improve staff experience so that staff can provide better patient care. The Department of Health is working to ensure that accountability for improving staff experience and well-being is part of the new Health and Social Care system. The Care Quality Commission will use the results from the survey to monitor ongoing compliance with essential standards of quality and safety. The survey will also support accountability of the Secretary of State for Health to Parliament for delivery of the NHS Constitution.

2.3 In January 2009, the NHS Constitution outlined the principles and values of the NHS in England including four pledges that set out what staff should expect from NHS Employers. They are part of the commitment to the NHS to provide high-quality working environments for staff. The national staff survey key findings are arranged under the four staff pledges (and two additional themes of staff satisfaction and equality and diversity):

Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers, and to communities.

Pledge 2: To provide all staff with personal development plans, access to appropriate training for their jobs and the support of line management to succeed.

Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety.

Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

2.4 The National Staff Survey ran between October and December 2011 and the Trust's survey was administered by Quality Health. The sample included 850 staff from across all staff groups, areas, and sites.

2.5 Extensive communication was undertaken to feed back to staff the action being taken to address the areas highlighted for improvement in the 2010 survey. A detailed communication plan was introduced to promote the 2011 survey to encourage maximum participation in the survey and achieve the best possible response rate.

3. 2011 National Staff Survey Results

Summary and Highlights

3.1 The Trust's response rate is 46%. The national average for acute trusts is 54%.

3.2 31 out of the 38 Key Findings have not changed significantly (+/- 5%) since the 2010 survey.

3.3 7 Key Findings have changed significantly (+/- 5%) since the 2010 survey:

Key Findings		Change since 2010 survey
5	Work pressure felt by staff	Decrease (better)
8	% working extra hours	Decrease (better)
9	Using flexible options	Decrease (worse)
16	% receiving health and safety training in last 12 months	Decrease (worse)
18	% suffering work-related stress in last 12 months	Decrease (better)
22	Fairness and effectiveness of incident reporting procedures	Increase (better)
26	% experiencing harassment, bullying or abuse from staff in last 12 months	Decrease (better)

3.4 4 out of the 31 Key Findings (that have not changed significantly) show no movement and remain the same as in 2010:

Key Findings	
10	% feeling that there are good opportunities to deliver their potential at work
13	% having well structured appraisals in last 12 months
23	% experiencing physical violence form patients/relatives in last 12 months
25	% experiencing harassment and bullying or abuse from patients in last 12 months

3.5 6 out of the 31 Key Findings (that have not changed significantly) show a deteriorating trend:

Key Findings	
3	% feeling valued by work colleagues
9	% using flexible working options
16	% receiving health and safety training over the last 12 months
21	% reporting errors, near misses or incidents witnessed in the last month
31	% able to contribute towards improvements at work
36	% having equality and diversity training in the last 12 months

3.6 28 out of the 31 Key Findings (that have not changed significantly) show an improving trend.

3.7 The 2011 staff survey results, changes in key findings since the 2010 survey and the Trust's ranking compared to all acute trusts in 2011 are set out in Appendix 1.

Staff Engagement and Staff Satisfaction Scores

3.8 The Trust's overall Staff Engagement score has risen from 3.62 to **3.67** in 2011 and is above the national average (3.62) for all acute Trust's in the country. The Trust compares well when benchmarked against acute Trust's in the Black Country Cluster and similar local Trust's:

Trust	Staff Engagement Score
University Hospitals Birmingham NHS Foundation Trust	3.75
The Royal Wolverhampton Hospitals NHS Trust	3.69
Sandwell and West Birmingham Hospitals NHS Trust	3.67
The Dudley Group of Hospitals NHS Foundation Trust	3.65
National Average	**3.62**
Heart of England NHS Foundation Trust	3.59
Walsall Hospitals NHS Trust	3.58

3.9 The Staff Satisfaction score has risen from 3.45 to **3.52** in 2011 and is above the national average of (3.47) for all acute Trust's in the country. The best score for acute trusts in 2011 is 3.67. The Trust, along with Wolverhampton, is the best performing Trust in this key finding when benchmarked against acute Trust's in the Black Country Cluster and similar local Trust's.

Trust	Staff Satisfaction Score
Sandwell and West Birmingham Hospitals NHS Trust	3.52
The Royal Wolverhampton Hospitals NHS Trust	3.52
University Hospitals Birmingham NHS Foundation Trust	3.49
The Dudley Group of Hospitals NHS Foundation Trust	3.49
National Average	**3.47**
Walsall Hospitals NHS Trust	3.46
Heart of England NHS Foundation Trust	3.46

Staff Recommendation of the Trust as a Place to Work or Receive Treatment

3.10 This finding is becoming more high profile as an indicator of quality. The Trust's score has increased from 3.53 to **3.59** in 2011 and is above the national average (3.50). This compares reasonably well when benchmarked with similar acute Trusts locally and in the Black Country Cluster:

Trust	Staff recommendation of the trust as a place to work/receive treatment
University Hospitals Birmingham NHS Foundation Trust	3.78
The Royal Wolverhampton Hospitals NHS Trust	3.68
The Dudley Group of Hospitals NHS Foundation Trust	3.60
Sandwell and West Birmingham Hospitals NHS Trust	3.59
National Average	**3.50**
Heart of England NHS Foundation Trust	3.43
Walsall Hospitals NHS Trust	3.41

Local Questions on Listening into Action (LiA) and Leadership Quality

3.11 In 2008 the Trust introduced a set of local questions into the standard national staff survey questionnaire to evaluate the effectiveness of LiA:

% of STAFF WHO SAID THAT:	2008 %	2009 %	2010 %	2011 %
They have definitely heard about LiA in the Trust	70	89	91	89
They can already see improvements in services for patients or have heard about planned improvements that they think will be implemented	31	43	43	43
They have a clear idea of what LiA is/have read about LiA	45	66	66	67
LiA is giving, or might be giving, more power to staff to change things	44	47	47	51
Their immediate manager listens/sometimes listens to staff about improving services	69	74	74	71
Their manager does act/sometimes acts on staff suggestions for improving services	62	65	65	46
LiA is succeeding/is likely to succeed	34	45	47	49

The long range results indicate a significant increase in staff opinion in relation to the profile and effectiveness of the LiA approach driving change and service improvements between 2008 and 2009. 2010 saw a stable position with more staff (91%) than in previous years saying that they have heard about LiA and an increase (2%) in staff saying that LiA is likely to succeed. The most recent results remain positive in relation to the effectiveness of LiA in increasing levels of staff engagement and its role in delivering our future plans but also indicate that there is a requirement for embedding the use of LiA in service improvement and managing change at an operational level and on a day to day basis.

3.12 In 2010 the Trust introduced a set of local questions into the standard national staff survey questionnaire to test staff opinion to evaluate the impact of the Trust's leadership behaviours and as a measure of the quality of leadership in the Trust:

% of STAFF WHO AGREE / STRONGLY AGREE THAT:	2010 %	2011 %
their immediate manager is accessible, approachable and visible to staff and patients	67	69
their manager is caring and compassionate and focused on the service	62	65
their manager is consistent, fair and equitable in their treatment of staff	58	60
their manager takes a positive interest in their health and well-being	52	55

The results in 2011 show further improvement in staff opinion in relation to support from immediate line managers and suggest that the Trust's leadership behaviours are becoming more embedded throughout the organisation.

Trust Ranking Compared with All Acute Trusts in 2011

3.13 The Trust is ranked average, above average or in the best 20% of all acute Trusts for 28 out of the 38 Key Findings in 2011. 10 Key Findings are ranked as below average or in the worst 20% of trusts:

RANKING CATEGORIES	2010	2011
Best 20%	2 findings	9 findings
Above Average	11 findings	14 findings
Average	6 findings	5 findings
Below Average	14 findings	7 findings
Worst 20%	5 findings	3 findings

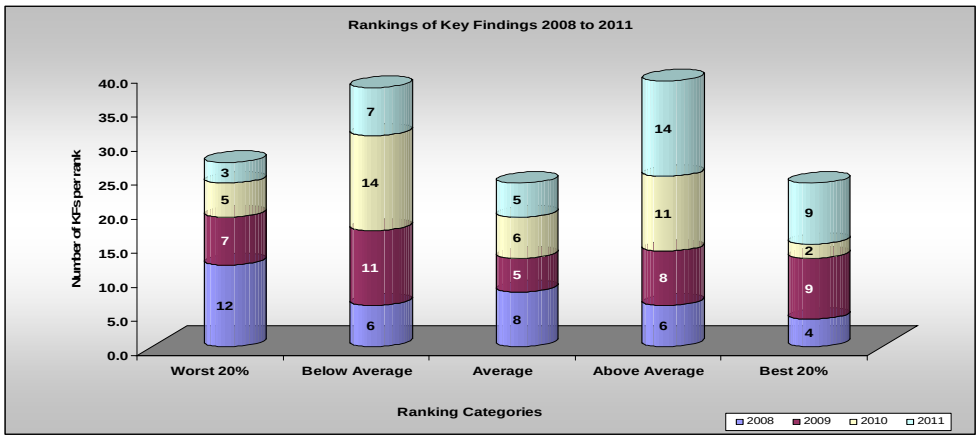
3.14 The Trust is ranked in the **Best 20% of Trusts** for the following findings:

Key Findings	
1	% feeling satisfied with the quality of work and care they are able to deliver
2	% agreeing that their role makes a difference to patients
5	Work pressure felt by staff
8	% working extra hours
11	% receiving job relevant training, learning or development in last 12 months
17	% suffering work-related injury in last 12 months
18	% suffering work-related stress in last 12 months
26	% experiencing harassment, bullying or abuse from staff in last 12 months
30	% reporting good communication between senior management and staff

3.15 The Trust is ranked in the **Worst 20% of Trusts** for the following findings:

Key Findings	
9	% using flexible working options
23	% experiencing physical violence from patients, relatives, or the public in last 12 months
25	% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

3.16 The CQC/DH ranking of our key findings over the past 3 years is shown in the chart below. Over this time period the number of Key Findings in the worst 20% of Trusts has shifted from 12 to 3 and the number of Key Findings in the best 20% of trusts has increased from 4 to 9.



4. Progress against 2010 Staff Survey Action Plan

4.1 A set of actions were drawn up to make improvement in the 19 Key Findings that were ranked 'below average' and in the 'worst 20%' of trusts in 2010. The results in 2011 show a significant improvement in 3 of these key findings and an improving trend for 13. 3 areas failed to show any improvement, one of which showed a deteriorating trend (staff feeling valued by work colleagues).

4.2 Full details are set out in Appendix 2

5. Action Plan for 2011 Staff Survey Results

5.1 It is proposed that the approach to action planning adopted last year is repeated again. The overarching action plan sets out the key areas for improvement that will be overseen by the relevant existing committee and group governance structures and the overall position monitored by the OD Steering Group.

5.2 The priority areas for action to respond to the 2011 survey are contained in Appendix 3.

5.3 A detailed communication plan is being developed to ensure regular feedback to staff on the actions taken to secure improvements in the areas identified.

6. Conclusion

6.1 The results of the 2011 National Staff Survey show that overall good progress has been maintained both in terms of improving trends across the majority of key findings and in many areas, such as staff engagement and staff satisfaction levels, performance has been very good.

6.2 The areas identified for improvement present further challenges and will require a co-ordinate approach and considerable effort to secure improvements in time for the 2012 survey.

6.3 The spreading and embedding of the LiA approach and techniques to engage staff in improvement and change is key to ensuring levels of staff engagement and the successful delivery of the Trust's strategic objectives, and in particular our ambitious transformation plan. The launch of the Trust's leadership behaviours to improve leadership quality and the high profile approach towards staff health and well-being are all likely to have contributed significantly to improving levels of staff engagement and staff satisfaction and must be maintained.

7. Recommendations

7.1 To receive and note the results of the 2011 national staff survey.

7.2 To receive and note the progress against the 2010 national staff survey action plan.

7.3 To discuss and agree the approach/action plan for the 2011 national staff survey.

Gayna Deakin, Deputy Director of Workforce April 2012

APPENDIX 1

Changes in Key Findings between 2010 and 2011 staff surveys and comparison with the National Average for Acute Trusts

KEY: ✓ Improved in 2011 ✘ Deteriorated in 2011 ↔ No change in 2011

	KEY FINDING	2010	2011	Change since 2010	National Average	Trend
STAFF PLEDGE 1:	**To provide all staff with clear roles, responsibilities and rewarding jobs**					
1	% feeling satisfied with the quality of work and patient care they are able to deliver	77%	79%	+2%	74%	✓
2	% agreeing that their role makes a difference to patients	91%	92%	+1%	90%	✓
3	% feeling valued by their work colleagues	75%	74%	-1%	76%	✘
4	Quality of job design	3.43	3.44	+0.01	3.41	✓
5	Work pressure felt by staff	3.02	2.90	-0.12	3.12	✓
6	% working in a well structured team environment	3.69	3.75	+0.06	3.72	✓
7	Trust commitment to work-life balance	3.35	3.40	+0.05	3.36	✓
8	% working extra hours	68%	59%	-9%	65%	✓
9	% using flexible working options	63%	54%	-9%	61%	✘
STAFF PLEDGE 2:	**To provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed**					
10	% feeling there are good opportunities to develop their potential at work	43%	43%	0%	40%	↔
11	% receiving job-relevant training, learning or development in last 12 months	77%	81%	+4%	78%	✓
12	% appraised in last 12 months	80%	82%	+2%	81%	✓
13	% having well structured appraisals in last 12 months	36%	36%	0%	34%	↔
14	% appraised with personal development plans in last 12 months	68%	69%	+1%	68%	✓
15	Support from immediate managers	3.56	3.67	+0.11	3.61	✓
STAFF PLEDGE 3:	**To provide support and opportunities for staff to maintain their health, well-being and safety**					
16	% receiving health and safety training in last 12 months	90%	85%	-5%	81%	✘
17	% suffering work-related injury in last 12 months	17%	12%	-5%	16%	✓
18	% suffering work-related stress in last 12 months	31%	19%	-12%	29%	✓

	KEY FINDING	2010	2011	Change since 2010	National Average	Trend
19	% saying hand washing materials are always available	60%	61%	+1%	66%	✓
20	% witnessing potentially harmful errors, near misses or incidents in last month	38%	36%	-2%	34%	✓
21	% reporting errors, near misses or incidents witnessed in the last month	96%	95%	-1%	96%	✗
22	Fairness and effectiveness of incident reporting procedures	3.41	3.48	+0.07	3.46	✓
23	% experiencing physical violence from patients /relatives in last 12 months	11%	11%	0%	8%	↔
24	% experiencing physical violence from staff in last 12 months	2%	1%	-1%	1%	✓
25	% experiencing harassment, bullying or abuse from patients / relatives in last 12 months	17%	17%	0%	15%	↔
26	% experiencing harassment, bullying or abuse from staff in last 12 months	18%	12%	-6%	16%	✓
27	Perceptions of effective action from employer towards violence and harassment	3.57	3.62	+0.05	3.58	✓
28	Impact of health and well-being on ability to perform work or daily activities	1.59	1.52	-0.07	1.56	✓
29	% feeling pressure to attend work when feeling unwell in last 3 months	32%	26%	-6%	26%	✓
STAFF PLEDGE 4:	**To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services**					
30	% reporting good communication between senior management and staff	36%	40%	+4%	26%	✓
31	% able to contribute towards improvements at work	64%	63%	-1%	61%	✗
32	Staff job satisfaction	3.45	3.52	+0.07	3.47	✓
33	Staff intention to leave jobs	2.59	2.49	-0.10	2.59	✓
34	Staff recommendation of the trust as a place to work or receive treatment	3.53	3.59	+0.06	3.50	✓
35	Staff motivation at work	3.80	3.85	+0.05	3.82	✓
36	% having equality and diversity training in last 12 months	49%	43%	-6%	48%	✗
37	% believing trust provides equal opportunities for career progression or promotion	82%	85%	+3%	90%	✓
38	% experiencing discrimination at work in last 12 months	21%	16%	-5%	13%	✓

APPENDIX 2

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Movement in the 19 Key Findings targeted for improvement in the Trust action plan following the 2010 staff survey

KEY: ✓ Improved in 2011 ✗ Deteriorated in 2011 ↔ No change in 2011

Action	Key Finding		2010	2011	Difference	2011 Ranking	Trend
Increase levels of staff engagement	3	Relationship with work colleagues	75%	74%	-1%	Below Average	✗
	15	Support from immediate manager	3.56	3.67	+0.11	Above Average	✓
	32	Staff job satisfaction	3.45	3.52	+0.07	Above Average	✓
	33	Staff intention to leave	2.59	2.49	-0.10	Above Average	✓
	35	Staff motivation at work	3.80	3.85	+0.05	Above Average	✓
Patient Safety	19	Availability of hand washing material	60%	61%	+1%	Below Average	✓
	20	Harmful errors, near misses, or incidents	38%	36%	-2%	Below Average	✓
	22	Fairness and effectiveness of incident reporting procedures	3.41	3.48	+0.07	Above Average	✓
Tackle bullying, harassment, physical violence and discrimination	23	Physical violence from patients, relative and public	11%	11%	0%	Worst 20%	↔
	24	Physical violence from staff	2%	1%	-1%	Average	✓
	25	Harassment/bullying from patients, relatives and public	17%	17%	0%	Worst 20%	↔
	26	Harassment/bullying from staff	18%	12%	-6%	Best 20%	✓
	37	Equal opportunities for career progression or promotion	82%	85%	+3%	Below Average	✓
	38	Discrimination at work	21%	16%	-5%	Below Average	✓
Support staff health and well-being	7	Trust commitment to work-life balance	3.35	3.40	+0.05	Average	✓
	8	Working extra hours	68%	59%	-9%	Best 20%	✓
	17	Work-related injury	17%	12%	-5%	Best 20%	✓
	18	Work-related stress	31%	19%	-12%	Best 20%	✓
	29	Pressure to attend work when feeling unwell	32%	26%	-6%	Average	✓

APPENDIX 3

NATIONAL STAFF SURVEY 2011
ACTION PLAN

Key Finding	Priority Areas for Improvement/	2011 Ranking	Proposed Actions*	Governance	Operational Lead
23	% experiencing physical violence from patients, relatives, or the public in last 12 months	Worst 20%	1. Triangulate all available data to publish facts and determine targeted action: • Staff survey analysis by division/staff group • Incident reporting • Patient complaints (staff attitude/communication) 2. Review individual patient information and general communication material in key areas i.e. ED and MAU to strengthen staff security and sanctions 3. Review content of customer care training to ensure key messages regarding customer care promises and add stats if possible 4. Review outputs from TTRs on V&A and establish root causes 5. Explore approaches to managing V&A in relation to patients lacking capacity (dementia village approach) 6. Consider 'spot checks'/mystery customer approach to 'hot-spot' areas 7. Consider mini LiA conversations with high risk areas	Health and Safety Committee	GD
25	% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Worst 20%			
9	% using flexible working options	Worst 20%	1. To be driven as part of workforce rationalisation programme in relation to workforce reduction, flexible workforce, e-rostering. 2. Article in Heartbeat on flexible working policy (work-life balance). Link with HWB action plan	Workforce Efficiency Group Staff Health and Well-Being Committee	LB LB/HR Lead
3	% feeling valued by their	Below Average	1. Article in Heartbeat – link to staff survey finding along lines of 'what makes a good colleague' - re-publish what	-	SF

	work colleagues		staff said makes a good colleague and at same time reinforce 'leadership behaviours' emphasising that our staff shaped these.		
21	% of staff reporting errors, near misses or incidents witnessed in the last month	Below Average	1. will be addressed as part of Patient Safety LiA and action plan	Risk Management Group	AB
20	% witnessing potentially harmful errors, near misses or incidents in the last month	Below Average			
36	% having equality and diversity training in last 12 months	Below Average	1. Review compliance with mandatory training requirements/records (may be influenced by training requirement frequency).	Equality and Diversity Committee L&D Committee	LB/JP
37	% believing the trust provides equal opportunities for career progression or promotion	Below Average	1. Undertake an analysis of all EO monitoring data from internal recruitment processes, and study leave applications and analyse across EO profile i.e. age, ethnicity, gender etc. to establish if there are any 'hot-spot' areas	Equality and Diversity –employment monitoring sub-group	LB
38	% experiencing discrimination at work in last 12 months	Below Average			
19	% saying hand washing materials are always available	Below Average	1. Review compliance with audits and alternative information 2. target 'hot-spot' areas 3. staff communication piece	Nursing Directorate Management Team	Infection Control Lead
10	% feeling that there are good opportunities to deliver their potential at work	Above Average	These key findings show above average performance in the 2011 but the ranking remains the same or shows a slight deterioration. Close attention will be given to securing improvements through the review of the Trust's appraisal and KSF review project and a corporate LiA event is planned for June 2012. Progress will be monitored by the OD Steering Group as part of the annual Workforce Work Programme and through the LiA Sponsor Group.		
13	% having well structured appraisals in last 12 months	Above Average			
16	% receiving health and safety training over the last 12 months	Above Average			
31	% able to contribute towards improvements at work	Above Average			

** To be determined and overseen by the relevant Committees and, wherever possible, incorporated into existing action plans. Key actions will be distilled into an overarching action plan and progress will be monitored bi-monthly by the OD Steering Group.*