Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 25 October 2012; 1530h

Members

Mr R Samuda	(RSM)	[Chair]
Mr R Trotman	(RT)	
Dr S Sahota OBE	(SS)	
Mrs G Hunjan	(GH)	
Prof R Lilford	(RL)	
Mrs O Dutton	(OD)	
Mr P Gayle	(PG)	
Mr J Adler	(JA)	
Dr R Stedman	(RST)	
Mr R White	(RW)	
Miss R Barlow	(RB)	
Miss R Overfield	(RO)	

In Attendance

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

Secretariat

Mr S Grainger-Payne	(SGP)	[Secretariat]

Time	Item	Title	Reference Number	Lead
1530h	**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 27 September 2012 as a true and accurate record of discussions*	**SWBTB (9/12) 231**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (9/12) 231 (a)**	**SG-P**
	5	**Chair and Chief Executive's opening comments**	**Verbal**	**Chair/ CEO**
	6	**Questions from members of the public**	**Verbal**	**Public**
1545h	**MATTERS FOR CONSIDERATION AND NOTING**			
	7	**Safety, Quality and Governance**		
	7.1	Quality report	To follow	RO/ KD/ RST

	7.2	Emergency Department performance update	SWBTB (10/12) 233 SWBTB (10/12) 233 (a)	RB
	7.3	Update from the meeting of the Quality & Safety Committee held on 19 October 2012	Verbal	OD
	7.4	Reporting schedule for the corporate meetings	SWBTB (10/12) 234 SWBTB (10/12) 234 (a)	SG-P
	7.5	Whistleblowing policy	SWBTB (10/12) 235 SWBTB (10/12) 235 (a)	RO
	7.6	Annual audit letter	SWBTB (10/12) 236 SWBTB (10/12) 236 (a)	RW
	7.7	Health and Wellbeing update	SWBTB (10/12) 247 SWBTB (10/12) 247 (a)	RO
1645h	**8**	**Performance Management**		
	8.1	Monthly finance report	SWBTB (10/12) 237 SWBTB (10/12) 237 (a)	RW
	8.2	Draft minutes from the meeting of the Finance & Performance Management Committee held on 19 October 2012	To follow	RT
	8.3	Monthly performance monitoring report	SWBTB (10/12) 238 SWBTB (10/12) 238 (a)	RW
	8.4	NHS Performance Framework report	SWBTB (10/12) 239 SWBTB (10/12) 239 (a)	RW
	8.5	Performance Management Regime – monthly submission	SWBTB (10/12) 240 SWBTB (10/12) 240 (a)	MS
	8.6	Progress update on delivery of the annual plan – Quarter 2	SWBTB (10/12) 241 SWBTB (10/12) 241 (a)	MS
	8.7	Update on the delivery of the Transformation Plan	SWBTB (10/12) 242 SWBTB (10/12) 242 (a)	RB
1715h	**9**	**Strategy and Development**		
	9.1	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (10/12) 243 SWBTB (10/12) 243 (a)	MS
	9.2	Foundation Trust application programme		
	▶	Monitoring report	SWBTB (10/12) 244 SWBTB (10/12) 244 (a)	MS
	9.3	Birmingham Compact update	SWBTB (10/12) 246	MS
1735h	**10**	**Operational matters**		
	10.1	Sustainability update	SWBTB (10/12) 245 SWBTB (10/12) 245 (a)	GS
	11	**Any other business**	**Verbal**	**All**

	12	**Details of next meeting** *The next public Trust Board will be held on 29 November 2012 at 1530h in the Anne Gibson Boardroom, City Hospital* *Non-routine agenda items due to be considered at the meeting are:* • Integrated Risk Report – Quarter 2 • Board Assurance Framework – Quarter 2 • Nursing annual report • Update on compliance with Same Sex Accommodation guidance

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 27 September 2012

Present

Mr Richard Samuda (Chairman)
Mr Roger Trotman
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Ms Olwen Dutton
Mr Phil Gayle
Mr John Adler
Mr Robert White
Miss Rachel Overfield
Dr Roger Stedman

In Attendance

Mr Mike Sharon
Miss Kam Dhami
Mr Graham Seager
Mrs Jessamy Kinghorn
Mr Matthew Dodd
Mr Bill Hodgetts [Sandwell LINks]

Secretariat

Mr Simon Grainger-Payne

Observer

Mrs Helen Dempsey (SHA)

Guests

Mrs Fiona Sanders [Item 7]
Dr Carl Clarke [Item 8]

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Richard Lilford and Miss Rachel Barlow.	
2 Declaration of Interests	**Verbal**
Mr Roger Trotman reported that he had been appointed as the Chairman of Money Angels Group Ltd. Dr Sahota advised that he had been appointed to the Court of the University of Birmingham.	
3 Minutes of the previous meeting	**SWBTB (7/12) 202**

The minutes of the Trust Board meeting held on 30 August 2012 were approved.	
AGREEMENT: The minutes of the last meeting were approved	
4 Update on actions arising from previous meetings	**SWBTB (7/12) 202 (a)**
The Board reviewed the meeting action log and noted that there were no matters requiring escalation or needed to be raised for the Board's attention.	
5 Chair and Chief Executive's opening comments	**Verbal**
The Chairman congratulated Mr Adler on his recent appointment as Chief Executive of University Hospitals of Leicester NHS Trust. He was thanked for the value he had added to the Trust since he had joined in 2002. The Board was advised that Mr Sharon would assume the role of Acting Chief Executive, should there be a gap before a substantive appointment was in post. The Chairman reported that the Trust had been successful in being awarded two Health Service Journal Efficiency Awards and congratulated the successful teams on behalf of the Board. The Board was advised that the Chairman had attended the Consultant Conference and that the 'Question Time' approach had been well received. It was further reported that the Chairman had met the Haematology services team. In terms of the Non Executive cadre, the Chairman advised that Mrs Clare Robinson, who would take the role of Chair of the Finance & Performance Management Committee, and Mr Harjinder Kang had been appointed as new Non Executive Directors. Mr Adler commented that the decision to accept the appointment as Chief Executive at Leicester had been difficult given his long association with SWBH. He was however looking forward to the new challenge and would take up post in January 2013. Mr Adler advised that he felt he had been offered the post partly on the basis of the reputation of the Trust for partnership working and performance delivery.	
6 Questions from members of the public	**Verbal**
There were no members of the public present.	
7 Health Informatics Services strategy	**SWBTB (9/12) 204** **SWBTB (9/12) 204 (a)**
Mrs Fiona Sanders, interim Chief Information Officer joined the meeting and advised that the Trust had commissioned a review of the Health Information Services (HIS) strategy, in addition to a review of capability and capacity to determine how improvements may be delivered to the care of patients through innovative and effective solutions.	

The Board was advised that an informatics strategy had been developed and a roadmap to deliver this had been prepared. It was reported that the previous focus had been on the Patient Administration System, however the new strategy sought to widen the brief. It was highlighted that the strategy was based on existing resources for integration, improvement and making more efficient use of technology already in place. The Board was informed that the strategy had been developed in line with emerging developments in healthcare and new technology.

The Board was asked to note the overall picture of how the Trust was situated and the plan to develop the organisation through a number of transitional phases. It was reported that a culture change to ensure that full advantage was taken of the new technology was required, although it was highlighted that this would not act as a solution to the current operational issues.

It was reported that a number of key system replacements were required, and that in terms of priority, the Patient Administration System needed to be replaced first.

In terms of costs, Mrs Sanders advised that much was to be decided regarding national funding, however approval had been given to £2m per annum of investment from the Trust's capital programme to be directed to the needs of the HIS strategy. The Chairman agreed that there was a need to make significant investment in this area. Mrs Sanders advised that historically a number of key systems had been funded nationally and that negotiations were ongoing as to how this might operate in future. Mr White advised that the agreed level of funding from the capital programme was circa three times the level of investment previously made. He highlighted that a significant level of investment in IT had also been factored into the negotiations with commissioners regarding the Local Delivery Plan.

Mr Adler commented that making IT systems more central to care was a key enabler to the delivery of better patient care. Dr Stedman added that there was an increasing reliance on the use of IT to drive change.

Mrs Sanders advised that the strategy would need to be clinically led, with deployment being organised by the Health Informatics Steering Group.

Ms Dutton remarked that it was good to see the inclusion of dedicated training and a focus on culture change as part of the strategy. She noted however, that these elements attracted a financial impact and asked whether this had been taken into account. Mrs Sanders confirmed that this was the case and that the investment would ensure that the system was viable and functional. She drew the Board's attention to the section of the strategy dealing with communications highlighting that Ms Dutton's points had been considered.

Dr Stedman advised that the strategy was in synchrony with the planned future models of care, in that the systems were adaptable and facilitated care closer to home.

The Chairman asked whether the clinicians were engaged with the development

and implementation of the strategy. Mrs Sanders advised that work was in progress to achieve this level of engagement and that workshops had been arranged for this purpose. Dr Sahota suggested that clinician 'buy in' would ensure that enhanced patient experience was delivered. He asked if there was a need to increase capacity and whether integration was possible. Mrs Sanders advised that this was the case as integration was more easily achieved in current times and that systems that were not capable of integration would not be procured. She added that there would be a need for a number of specialist systems, however interoperability of the outputs was crucial. Mr Sharon remarked that the Trust's overall intention was that services would be moved further into community locations and that shared services plans would be developed. He asked whether the strategy assisted with the achievement of this goal. Mrs Sanders advised that a key element of the strategy was to provide a local health community perspective, which was delivered by allowing access to systems at a number of GP practices and other trusts with a view to sharing information and creating fruitful relationships. Mr Adler informed the Board that consultation on the restructuring of the HIS team had been undertaken and the new structure would be put into place to facilitate effective delivery of the strategy. The Board was advised that the strategy would be reviewed on an annual basis and that a twice yearly update would be provided to the Trust Board. The Trust Board was asked for gave its approval to the Health Informatics Services strategy.	
AGREEMENT: The Trust Board approved the Health Informatics Services strategy	
8 Research and Development strategy	**SWBTB (9/12) 205** **SWBTB (9/12) 205 (a)** **SWBTB (9/12) 205 (b)**
Professor Carl Clarke joined the Board to present the refreshed Research and Development strategy. The Board was advised that key performance indicators within the strategy included the number of patients involved in clinical trials. As such, it was reported that much work had been undertaken by the Research and Development team to improve the recruitment, resulting in 1820 patients now involved in trials, with a further number likely to be recruited in the near future. A further key performance indicator was noted to be the speed that trials were set up, a position that the Board was advised had also improved. In terms of funds received regionally, Prof Clarke advised that £1.2m had been received initially, however the overall activity across the region was such that the level of funding was likely have to reduced, had the funding mechanism not been amended. As a consequence of the new funding arrangements and the higher	

number of patients recruited to trials, it was reported that the amounts of funding received by the Trust would increase.

Regarding embedding Research and Development into the organisation, it was reported that there was a requirement for better leadership on such matters by the Trust Board. It was reported that additionally, a resource to support the governance agenda was needed.

Further key performance indicators for agreement were highlighted, which were reported to be set by the Department of Health, which may include further targets around levels of involvement in clinical trials.

The Chairman encouraged Prof Clarke to seek support from Prof Richard Lilford, the recently appointed Non Executive Director representing the University of Birmingham.

Dr Stedman remarked that it was important to recognise that research led to improved patient care, in addition to improving the knowledge base of the medical staff.

Dr Sahota commented that it was important to engage the academic institutions in patient care through collaboration. Prof Clarke advised that Trust was very active in this respect.

Mr Sharon asked whether a key performance indicator concerned the number of trials ceased. Prof Clarke advised that nationally there was less interest in this than on other performance measures, however there was a keenness not to cease some of the commercial studies.

Prof Clarke was asked whether in terms of funding allocation, there were appropriate measures and resources to secure funds from the environment. Prof Clarke confirmed that this was the case and that at a local level, funding was received from the Comprehensive Local Research Network (CLRN).

Mr Adler asked whether the creation of the Clinical Research Unit for Ophthalmology would assist with the recruitment of patients into trials. Prof Clarke confirmed that this step would assist, however he advised that there was additional benefit to be gained by expanding research in a number of additional smaller units.

Dr Stedman asked whether, with cognisance of the national position, consideration had been given to seeking alternative sources of funding. Prof Clarke advised that funds were being sought from commercial sources where possible, however charitable sources were primarily designed to support new build facilities.

The Trust Board was asked for and gave its approval to the Research and Development strategy.

AGREEMENT: The Trust Board gave its approval to the Research and Development strategy	
9 Clinical Services strategy	**SWBTB (9/12) 206** **SWBTB (9/12) 206 (a)**
Mr Sharon advised that the clinical services strategy was one of the supporting strategies which was to accompany the Integrated Business Plan when it was submitted as part of the application for Foundation Trust status. The high level summary of the strategy was highlighted to outline the mandated requirements and the constraints that the organisation faced leading up to the opening of the new hospital. The Board was asked to note the strategy articulated the organisation's key strengths clinically, including ophthalmology services, gynaecology and rheumatology. Dr Stedman reported that the different models of care to be provided were outlined in the strategy, such as those for the treatment of long term conditions and the development of partnership models. The strategy was pointed out to provide the overarching framework within which each clinical service featured to form a cohesive model. The Board was asked to note that a key aspect of the strategy was the plan to develop clinical leadership in the Trust. The Chairman asked how the strategy linked into business planning in the future. He was advised that the strategy linked into the strategic planning work by informing the 'bottom up' planning and supported the aim of developing the Trust into a clinically led organisation. Mr Sharon advised that the strategy was consistent with the content of the Integrated Business Plan and was supported by a set of individual service strategies. It was reported that an assessment of the strengths, weaknesses, opportunities and threats had been made for each service which would inform the overall plan. Mr White suggested that individual specialities would wish to understand more about their income and costs in future. Ms Dutton remarked that the strategy was pleasing, however she asked how realistic the plan was seen to be, noting in particular that there was a set of issues that the Trust needed to overcome to be able to deliver the strategy. Dr Stedman agreed that the strategy was aspirational, however the work to deliver it was already in progress in a number of areas. Mr Adler commented that he was pleased that a clinical strategy had been developed, given that this overarching view had not been articulated to this level previously. He observed that the document provided a clear vision for the Trust's directorates as part of this. Mr Gayle asked how the strategy fitted with the Health Informatics Services (HIS) strategy. He was advised that the HIS strategy strongly supported the delivery of the clinical services plan. It was noted that the strategy did not include detail on finance or funding. Dr	

Stedman advised that this was included within the individual supporting services strategies. The Board was asked for and gave its approval to the clinical services strategy.	
AGREEMENT: The Trust Board approved the clinical services strategy	
10 Membership strategy	**SWBTB (9/12) 207** **SWBTB (9/12) 207 (a)**
Mrs Kinghorn reminded the Board that it had previously reviewed the membership strategy at the FT Programme Board. It was highlighted that the strategy included the way in which the Trust would work in partnership with community organisations. The Board was also asked to note that the way in which gaps in membership within the local constituencies would be handled was outlined in the strategy, including monitoring the level of membership and the demography of the constituencies. The Board was informed that a new interactive virtual membership site had been established. Dr Sahota suggested that the entry regarding working with other organisations needed to be broadened out to include a wider range of other organisations. Mr Sharon advised that the document was a further strategy which would support the submission of the Integrated Business Plan. The Trust Board was asked for and gave its approval to the membership strategy.	
AGREEMENT: The Trust Board approved the membership strategy	
11 Estates strategy	**SWBTB (9/12) 208** **SWBTB (9/12) 208 (a)**
Mr Seager presented the estates strategy, which he reminded the Board had been previously considered within a Board seminar. The Board was asked to note that the strategy provided the framework for the provision of care in a safe environment and the way in which the estate would need to be managed in the future. The Chairman asked to which of the Care Quality Commission's essential standards the strategy related. He was advised that the strategy supported those concerning management of premises and of medical devices. The Board was advised that the Trust's estate was ageing and that in the longer term this would be addressed by the opening of the new hospital, however the estates strategy articulated how the current estate would be managed on an interim basis. It was noted that at present, there was a high degree of backlog maintenance, although the risks were systematically assessed and mitigated. The required investment to continue to address the position was to be presented to the Strategic Investment Review Group shortly as part of an ongoing process. It	

was reported that a recent review by an external company concluded that the Trust was operating effectively. It was suggested that this review should be considered by the Audit Committee when appropriate. Mr Sharon noted that the strategy included much information related to ERIC returns and the expenditure on hard facilities management and asked whether benchmarking information against the Trust's position had been considered. Mr Seager advised that ERIC returns were mandatory and no significant issues had been raised in connection with these. It was reported that benchmarking information on utilisation had been considered and that any anomalies identified as part of this would be addressed by the estates rationalisation plans. The Board was asked for and gave its approval to the estates strategy.	
AGREEMENT: The Trust Board approved the estates strategy	
12 Execution of a lease of the Old Chapel, Sandwell Hospital	**SWBTB (9/12) 209** **SWBTB (9/12) 209 (a)**
Mr Seager presented a proposal to lease the Old Chapel at Sandwell Hospital to HHI Ltd., trading as Healthy Hearts. The Board was advised that the accommodation was largely disused at present and could be offered for a nominal rental sum. The Chairman observed that the lease proposed was on a short term basis. Mr Seager confirmed that this was the case, in line with the estates strategy. Mr Trotman asked whether Healthy Hearts were liable to pay business rates. He was advised that this was the case. Mr Adler advised that Healthy Hearts delivered good public health work and on this basis he supported the proposal. Dr Sahota added that the plan provided a good link into the local community. Mr White asked whether the proposal meant that the operational status of any adjoining buildings to the chapel would be affected. Mr Seager advised that this was not the case and that any nominal capital charges as a result of the plans had been considered. The Board was asked for and gave its approval to the plan to lease the Old Chapel to Healthy Hearts.	
AGREEMENT: The Board gave its approval to the plan to lease the Old Chapel to Healthy Hearts	
13 Estates rationalisation – closure of City Hospital Block 70 former cook chill	**SWBTB (9/12) 210** **SWBTB (9/12) 210 (a)**
Mr Seager asked for the Board's approval to decommission the former cook chill facility at City Hospital in line with the estates rationalisation plan agreed previously by the Trust Board.	

The Board approved the proposal.	
AGREEMENT: The Board gave its approval to the plan to decommission the former cook chill facility at City Hospital	
14 Safety, Quality & Governance	
14.1 Quality Report	**Tabled paper**
Miss Overfield reported that the recent safety thermometer audit had shown a slight improvement of the delivery of harm free care towards the 95% target. A downward trend for pressure damage was highlighted and the Board was informed that the Trust was performing well against this indicator in comparison to the regional position. The level of falls was reported to be broadly static. In terms of infection control, Miss Overfield reported that work was underway to improve the position regarding MRSA screening. The Board was informed that a robust action plan was in place to ensure that the target of 85% was reached by the year end. It was reported that the current shortfall was reflective of the national discussion previously concerning the value of screening elective patients, therefore a decision had been taken to slow the rate of this work, however the policy position had shifted and targets had now been set to which the Trust needed to work. The Chairman asked what practice was in place within the Community Services area in this respect. Miss Overfield advised that no screening was undertaken in line with national practice. The Board was advised that Extended Spectrum Beta-Lactamases (ESBL) had been detected again in the neonatal units, however babies were not symptomatic or unwell at present. It was highlighted that not all trusts screened for this infection, however the Trust operated best practice by so doing and had detected the infection early. It was reported that additional isolation units needed to be arranged as part of the plans to handle the infection. The Chairman asked what deadline had been agreed for this action. He was advised that a plan would be presented to the Infection Control Committee within a month, which would provide this detail. Regarding nurse staffing ratios, the Board was advised that there were issues in some areas, which were mainly associated with the decision to pause the bed reconfiguration plan. It was reported that the situation had been mitigated by the use of bank and agency staff, in addition to a successful recent recruitment exercise. Staffing levels on the Trust's delivery suite at City Hospital were reported to have been of concern, however the situation had been addressed by the movement of some midwives from the Halcyon Midwifery-led Unit, with the situation to be addressed on a substantive basis by the end of October 2012. Miss Overfield advised that some instances of missed Down Syndrome screening	

had been identified, where women had not been offered the option of screening or had not been screened when they had accepted the offer. It was reported that a comprehensive review was being undertaken, which would include all women currently within the Trust's caseload. It was highlighted that a robust IT solution was needed to support the work, given that there was current difficulty with reviewing what care had been provided on a retrospective basis. Mr Sharon advised that a business case was being developed for this purpose which would propose the development of a system in line with these requirements, however the lead time for this was six months.

Dr Stedman reported that the latest Hospital Standardised Mortality Rate was currently 96.4, which he highlighted was below the expected rate of 100. The Board was informed that the mortality position in connection with stroke, fractured neck of femur and pneumonia was currently higher than anticipated, therefore action plans had been developed to achieve a more acceptable position.

It was reported that significant focus was being given to the use of the World Health Organisation (WHO) checklist and that currently compliance stood at 99.7%. The Board was advised that there had been a reduction in the number of Never Events reported, however Dr Stedman advised that the use of the WHO checklist could not prevent the occurrence of all Never Events.

Dr Stedman advised that the level of VTE assessments had deteriorated in August, therefore work was underway to recover the position.

Performance against the stroke care indicators was reported to have deteriorated slightly. It was highlighted that area was now operating without the assistance of stroke co-ordinators. Mrs Hunjan asked whether these posts would be refilled. Mr Dodd advised that these were fixed term appointments, which had been funded by the Stroke Network however the funding had been withdrawn and the decision had been taken not to continue supporting the posts as a cost pressure to the organisation. It was highlighted that the situation would be resolved as part of the stroke care reconfiguration plans. The Chairman asked when the position would be addressed. Dr Stedman offered to report back to the Quality & Safety Committee at a future meeting to outline the plans if needed. Mr Adler noted that the performance in the stroke care area had not shown sustainable improvement, however the reconfiguration was planned for February 2013, which would assist with this.

Miss Overfield reported that a number of external reviews of Imaging Services had flagged a number of issues and problems with reporting of results and other aspects of quality governance, however an integrated governance plan had been developed to address the position which had been presented to the Governance Board.

It was reported that the Net Promoter Score was currently 60% and that there was a plan to meet the year end target of an improvement on the baseline position by 10 points. Miss Overfield advised that the way in which the indicator

was used had been discussed at the recent Consultant Conference. In terms of complaints handling, it was reported that there remained much work to do to address the timeliness issues. Miss Overfield advised that the application of Special Measures to the Emergency Assessment Unit was to be lifted shortly as a result of an updated condition report. The Board was asked to note that the key clinical risks had been added into the Quality Report. Mr Gayle advised that he had undertaken a Board Walkabout in the Medical Assessment Unit, which had identified that good leadership was in place in the area. The Board was informed that the walkabout had also included ward D11, the stoke ward at City Hospital, on which he advised Protected Mealtimes were being well observed.	
14.2 Update from the meeting of the Quality & Safety Committee held on 20 September 2012	**Verbal**
Ms Dutton advised that the Quality and Safety Committee had received an update from the Imaging division on the plan to address the shortcomings in governance arrangements and results reporting, however additional assurances had been requested as to the delivery of the plan in the form of a follow up presentation to the Committee at the October 2012 meeting. The Board was informed that the plan to address the missed Downs Syndrome screening situation had been received, which was well developed, however a further update was reported to have been requested for the next meeting of the Committee. Ms Dutton advised that the situation concerning the complaints backlog had been considered, which had indicated that further effort was needed to address the issue. Mr Adler advised that the backlog currently stood at 96 cases, however a plan was in place to clear this by the end of November 2012. It was reported that the Committee had agreed that patient stories would be presented to the Trust Board on a rotational basis by the Directorates. The Board was advised that the meetings of the Quality & Safety Committee would be held monthly.	
14.3 Integrated Risk Report – Quarter 1	**SWBTB (9/12) 211** **SWBTB (9/12) 211 (a)**
The Board was asked to receive and note the Integrated Risk Report.	
14.4 Delivering the Health Visiting Officer – appraisal of progress and support requirements	**SWBTB (9/12) 212** **SWBTB (9/12) 212 (a)**
Miss Overfield reported that a region wide review of Health Visiting had been undertaken by an external agency. The Board was advised that the Trust	

performed well in comparison to other areas. Mrs Hunjan asked whether a dashboard for performance in this area was to be developed and whether the position was to be monitored through the current corporate performance monitoring report. Miss Overfield confirmed that this would be the case in due course.	
15 Performance Management	
15.1 Monthly finance report	**SWBTB (9/12) 213** **SWBTB (9/12) 213 (a)**
Mr White reported that an in month surplus of £365k had been delivered, providing a year to date surplus of £620k. The Board was advised that the plan to achieve a year end surplus of £4.2m remained on track. The cash balance was reported to be higher than plan at present, which the Board was advised was reflective of the lower than planned spend on land purchase and the improved position in relation to recovery of debts. Pay costs were reported to have been £23.5m against a plan of £23.6m. In terms of the delivery of the Transformation Plan, it was highlighted that there was currently a shortfall of £400k, which was attributable mainly to the Surgery, Anaesthetics & Critical Care and Medicine & Emergency Care divisions. The Board was advised that there was considerable pressure expected within the next period as a consequence of the delay to the bed reconfiguration plan and the development of the winter bed plan, however Mr White advised that this would be unlikely to impact on the forecast end of year position. It was reported that work was underway with the Medicine & Emergency Care division to rephase the bed reconfiguration plan and that discussions were being held with commissioners to discuss the winter bed plans.	
15.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 20 September 2012	**Tabled paper**
Mr Trotman provided a summary of the discussions held at the Finance and Performance Management Committee meeting held on 20 September 2012. The Board was informed that a performance update had been received from the Imaging division, which had highlighted some significant changes in activity for various modalities from -49% to +34%. It was highlighted that although the Committee had been advised that there had been savings on payroll costs, adverse variances in medical staffing and agency costs due to consultant cover, vacancies and holidays had been pointed out. Mr Trotman advised that the Medicine and Emergency Care area had incurred an adverse financial variance of £52k due to bed pressures and reconfiguration delays, however any planned staffing reductions would be paused to avoid any negative quality and safety implications. It was reported that the Committee had been advised that Surgery, Anaesthetics	

and Critical Care division had recorded a larger adverse variance, however assurances had been given that this was being addressed robustly. The Board was advised that in view of the performance of the Medicine & Emergency Care division, it has been agreed to bring forward the performance update presentation by this division to the October 2012 meeting. Ms Dutton suggested that there was a need to triangulate the information presented to the Quality & Safety Committee with that available to the Finance & Performance Management Committee. Mrs Hunjan remarked that although she was not a member of the Finance & Performance Management Committee, she had concerns over the performance of the Medicine & Emergency Care and the Surgery, Anaesthetics and Critical Care divisions and was pleased to see that sharp focus was being directed to these areas.	
15.3 Monthly performance monitoring report	**SWBTB (9/12) 214** **SWBTB (9/12) 214 (a)**
Mr White reported that current areas of performance shortfall related to MRSA screening, VTE risk assessment and Accident and Emergency targets. It was reported that performance against the CQUIN targets was satisfactory at present.	
15.4 NHS Performance Framework report	**SWBTB (9/12) 215** **SWBTB (9/12) 215 (a)**
The Board was advised that according to the NHS Performance Framework the Trust was classified as 'performing'. It was highlighted however that given the current areas of underperformance, the rating against the FT Compliance Framework was amber/red.	
15.5 Provider Management Regime monthly return	**SWBTB (9/12) 216** **SWBTB (9/12) 216 (a)**
Mr Sharon presented the proposed Provider Management Regime return for submission to the Strategic Health Authority. It was noted that the return reported that the Tripartite Formal Agreement timetable remained on track. The Board was advised that the governance risk rating was impacted at present by performance in respect of data completeness and performance against the Accident & Emergency operational targets. It was highlighted however, that there was an expectation that the position concerning the Community Information data set would be addressed shortly, however rectifying performance against the Accident & Emergency care targets was a longer term matter. The financial risk rating position was noted to be at green status across all areas. In terms of the contractual position, it was highlighted that the performance notices received had not yet been withdrawn. The Chairman asked whether the performance against the diagnostic waits target had been addressed in this respect. Mr White advised that this was the case as of May 2012.	

Regarding Quality measures, it was reported that the performance against the Standard Hospital Mortality Indicator remained unchanged. The Board was advised that 100% compliance with the use of the WHO checklist could not yet be declared. The assessment against the Board statements was highlighted to be consistent with the declarations made in August 2012. It was highlighted that there remained an expectation that compliance with the requirements of the Information Governance toolkit could be declared from December 2012. Miss Dhami added that a number of means were being used to ensure compliance with the target date. The Board approved the proposed submission of the Provider Management Return.	
AGREEMENT: The Trust Board gave its approval to the submission of the Provider Management Regime return	
15.6 Update on the delivery of the Transformation Plan	**SWBTB (9/12) 217** **SWBTB (9/12) 217 (a)**
Mr Dodd reported that the work to deliver the outpatient workstream was continuing and the feedback to the clinicians to identify areas of productivity as a result of the plans was due to be discussed shortly. It was highlighted that some of the key elements of the Transformation Plan had been discussed at the Consultant Conference on 21 September 2012.	
16 Strategy & Development	
16.1 Clinical reconfiguration update and draft minutes from the Reconfiguration Board meeting held on 13 September 2012	**SWBTB (9/12) 218** **SWBTB (9/12) 218 (a)**
Mrs Hunjan reported that the Clinical Reconfiguration Board had met on 13 September 2012. The Board was advised that the preferred option for emergency gynaecology was being developed. It was reported that the Deanery has raised issues concerning senior site cover at Sandwell Hospital and the impact on training in gynaecology, therefore plans were being developed to address the concerns. Inpatient vascular services and associated interventional radiology work were reported to have been transferred to University Hospital Birmingham NHS Foundation Trust recently, therefore monitoring of the service delivery was in place. In terms of surgical reconfiguration, it was reported that inpatient work was being delivered from Sandwell Hospital, however the outpatient work and therapy would continue to be delivered from both sites. Breast services were reported to continue to be delivered from the Birmingham Treatment Centre following reconfiguration.	

It was reported that from February 2013, stroke services would be delivered from Sandwell Hospital. It was reported that the recent Gateway review had assessed the reconfiguration plans as being at green status. The Board was informed that a peer review had been hosted to assess the Trust's readiness for its classification as a trauma unit. It was reported that the plans to develop blood science laboratory facilities at Sandwell Hospital were underway and progressing well. Mr Sharon reported that tenders had been issued in respect of Cytology and HPV work.	
16.2 'Right Care, Right Here' programme: progress report, including an update on decommissioning	**SWBTB (9/12) 220** **SWBTB (9/12) 220 (a)**
The Trust Board received and noted the 'Right Care, Right Here' programme progress report. It was reported that the delivery of the QIPP schemes needed to be finalised. The Board was advised that the 'Right Care, Right Here' programme team remained committed to the opening of the new hospital.	
16.3 Foundation Trust application: programme director's report	**SWBTB (9/12) 219** **SWBTB (9/12) 219 (a)**
The Trust Board received and noted the Foundation Trust programme director's report. It was reported that a FT Readiness Event would be hosted by the Strategic Health Authority on 10 October 2012 and a planning session for this had been scheduled for 5 October 2012.	
17 Update from the Board Committees	
17.1 Audit Committee – 13 September 2012	**Hard copy update**
Mrs Hunjan reported that in addition to routine business, the Audit Committee had received an update on overpayments made to trust staff and that it had been agreed that it was appropriate to consider imposing sanctions for those managers who had been responsible for the overpayments incurred. It was reported that the Committee had supported a plan to market test Internal Audit services provided to the Trust. The Board was advised that a closer link between the Audit Committee and Quality and Safety Committee was being forged.	
17.2 Charitable Funds Committee – 13 September 2012	**Hard copy update**
Dr Sahota advised that the Charitable Funds Committee had been attended by the new head of Fundraising, Carly Jones, who had presented her initial plan and vision for the fundraising function to the Committee. The Board was advised that the investment market remained volatile and that it had been agreed that the current asset allocation within the Charitable Funds investment portfolio should remain unchanged at present. It was reported that it	

had been agreed to continue to retain the current investment advisers for the present time. The Chairman advised that a fundraising strategy was being developed and would be presented as a draft at the December 2012 meeting of the Trustees. Mr Adler added that he was impressed that the Head of Fundraising appeared to have made good progress within her short period of employment by the Trust.	
18 Any other business	**Verbal**
There was none.	
19 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 25 October 2012 and would be held in the Boardroom at Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 25 October 2012, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

27 September 2012, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RS), 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), Dr R Stedman (RST), Miss R Overfield (RO)

In Attendance: Mr M Sharon (MS), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK)

Apologies: Prof R Lilford (RL), Miss R Barlow (RB)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 19 October 2012

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.220	Ward leadership capacity expansion plan	SWBTB (4/12) 070 SWBTB (4/12) 070 (a)	26-Apr-12	Prepare a Post Project Evaluation for the ward leadership capacity expansion plan for review by the Trust Board in April 2013	RO	01-Apr-13	ACTION NOT YET DUE	G
SWBTBACT.227	Same Sex Accommodation declaration	SWBTB (6/12) 152 SWBTB (6/12) 152 (a)	28-Jun-12	Present an update on compliance with the Single Sex Accommodation guidance at the October meeting of the Trust Board	RB	~~26/10/2012~~ 29/11/2012	ACTION NOT YET DUE	G
SWBTBACT.232	Information and reporting map	SWBTB (8/12) 198 SWBTB (8/12) 198 (a)	30-Aug-12	Present a proposal for the future handling of reports at a future meeting of the Trust Board	SG-P	25/10/12	Included on the agenda of the October 2012 Board meeting	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Department update**
SPONSOR (EXECUTIVE DIRECTOR):	**John Adler, Chief Executive**
AUTHOR:	**Rachel Barlow, Chief Operating Officer**
DATE OF MEETING:	**25 October 2012**

EXECUTIVE SUMMARY:

The attached paper provides an update on quality and waiting time performance in the 2 main Emergency Departments on the City and Sandwell sites.

Key points:

- Special measures plan with focus on quality and system improvements on track and highlights of progress outlined in attached plan
- Key leadership roles: New Clinical Director and Assistant Head of Nursing appointed
- Revised Governance structures in place in Directorate
- Staff engagement and development programme commenced
- Underperformance against 4 hour target YTD = 94.45%. This is significant risk to the Trust in the latter half of the year. Recovery plan to and risk assessment within paper.
- The EDAT governance infrastructure has been reviewed recently to support the ED's and fortnightly meetings of an executive and directorate task and finish group will oversee delivery of the above.

REPORT RECOMMENDATION:

The Board is asked to receive and note the update.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		x

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

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

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

Access and performance, FT,

PREVIOUS CONSIDERATION:

None

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD

October 2012

EMERGENCY DEPARTMENT
Update on Quality & Performance

1.0 Introduction

The Emergency Departments were placed into Special Measures in June 2012, due to a continued trend of serious incidents.

The Emergency Department Action Team terms of reference were immediately revised to ensure more frequent monitoring of the Special Measures Action Plan, led by the Executive Team. There has been some good progress against the quality initiatives and the rate of occurrence of red incidents has dropped; however, Trust performance against the 4 hour standard and ED Clinical Quality Indicators remains unsatisfactory.

This paper provides an update on ED Quality & Performance and outlines key areas of focus to correct performance and sets a revised trajectory for this improvement.

2.0 Emergency Department Quality

The Special Measures Action Plan is monitored fortnightly by the EDAT & Special Measures Project Group.

2.1 Progress & Successes

Leadership

- The directorate Management Team has been strengthened by the appointment of a Clinical Director for Emergency Medicine & an Assistant Head of Nursing for Medicine; both post holders started in October and September respectively.

- An Organisational Development Proposal has been written by the Head of Learning & Development and implemented by the Directorate, to provide coaching and leadership development for the senior teams.

Governance Structures

- The Directorate has introduced a revised Governance Structure which includes the following which take place on a 4-6 weekly basis:

- Directorate Meeting (weekly)
- Governance Meeting
- ED Task Group
- Guidelines, Policies & Procedures Group.
- ED Departmental Team Meeting

Actions from these meetings are tracked through the ED Integrated Development Plan.

- The Directorate has appointed a Risk & Governance Coordinator to establish a robust data collection system for clinical incidents & complaints management, to co-ordinate the Directorate Risk Register and provide support to the Governance & Guidelines, Policies & Procedures Groups.

Staff Engagement & Ownership of Improvements

- The Divisional Management Team have started to deliver monthly Emergency Department Hot Topics Sessions to provide information of improvements which are taking place within the Directorate & Division and to answer any questions from staff;

- Twice daily Departmental Multidisciplinary Team Reviews are embedding on both sites, to allow identification of areas of concern, for these to be addressed and to ensure appropriate review;

Peer Reviews & Inspections

- The Emergency Departments has had a number of visits in recent months:
  - SHA Quality Assurance Visit - Monday 23 July 2012;
  - John Heyworth Peer Review - Tuesday 21 August 2012;
  - Deanery Review Visit – Monday 17 September 2012.
  - CQC Unannounced Inspection – Thursday 27 September 2012;

- The visits confirmed that the Trust is sighted on the key challenges and areas for concern in the Emergency Department most notably:
  - Medical Staffing & Recruitment;
  - Clinical Leadership;
  - Team Working;
  - Governance Structures & Processes;
  - Training & Supervision;
  - Communication;

- Emergency Department Staff have received an initial de-brief from the external visits which was given by the Chief Nurse & Chief Operating Officer, with the Divisional Management Team;

- All the visits have noted the strong commitment to improvement in the Emergency Department from all staff concerned, from Departmental, Directorate, Divisional and Executive level.

No immediate serious safety issues were identified on the visits and the current trend of serious incident appears to have reduced.

2.2 Key Milestones

The Directorate must continue to focus on the quality improvements required through the Special Measures Programme:

- Undertake Governance training programme, bespoke for the Emergency Medicine Directorate team's needs. November 2012 – January 2013;

- Workforce proposal sign off and consequent recruitment. October 2012 – March 2013;

- Completion of Leadership Development Programme & Team Building exercises. September 2012 – March 2013;

- Review of all protocols/policies procedures within Emergency Medicine and introduction of standardised Policies & Procedures to meet the needs of the departments. October 2012 – October 2013.

- Staff engagement sessions to develop a vision for the future of the Emergency Departments. October 2012.

2.3 Risks to delivery & mitigation

RISK	RAG	MITIGATION	RAG
1. Failure to recruit to hard to fill posts, e.g. Consultant, Middle-grade.	16	• Trust commitment to increasing establishment to 16 Consultants; • Overseas recruitment of middle-grades; • Recruitment of Junior Specialty Doctors to 'grow our own' Middle-grades; • Consideration of Consultant joint appointments with neighbouring Trust's;	12

		• Appointment of a Clinical Director.	
2. Ability to attract staff to work in the Emergency Department at all levels and professions due to identified areas of weakness.	12	• Appointment of Clinical Director; • Focus from Assistant Head of Nursing to support Emergency Care. • Delivery of development plan	9
3. Ability to secure level of investment perceived as necessary to improve quality and reduce clinical risk.	16	• Workforce paper to include options appraisal and risk assessment to be presented in November •	12
4. Limited medical representation at required meetings in order to drive change and complete required actions	12	• Appointment of Clinical Director; • Review job plans to ensure consultant share the same SPA day, where possible to promote involvement; • Allocation of responsibilities to ensure workload is shared; • Meeting structure scrutinized to ensure appropriate ToRs; • List of attendance to meetings monitored at EDAT.	9
5. Inability to release required staff from the Emergency Departments to take part in essential training and teaching, e.g. Leadership Development Courses,	12	• Authorisation through the Special Measures Programme to release staff and backfill with bank & agency, ensuring safe staffing levels met; • Directorate Management Team commitment to identifying staff and ensuring attendance.	9
6. Resistance to change	16	• Staff engagement sessions; • Appointment of Clinical Director & Assistant HoN, strengthening the Directorate Management Team; • Additional support to Directorate Management Team – Risk & Gov Coordinator & Project Manager.	12

3.0 Emergency Department Performance

Emergency Department performance is deteriorating and the Trust failed to reach 95% for quarter 2. Currently, the Trust's YTD performance is running at 94.45%. In order to meet 95% for 2012/13, the organisation now has a breach tolerance of 24 breaches per day.

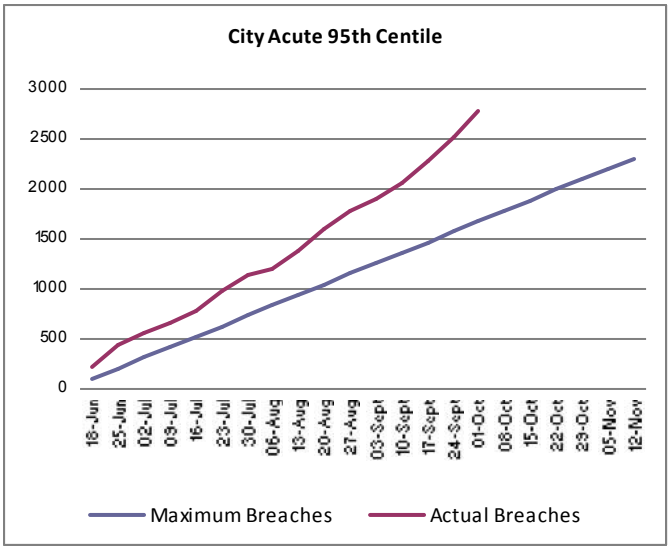
Table 1: ED Performance – 4 hours

Month	4 hour performance			
	EYE	CITY	SGH	TRUST
April 2012	98.6%	94.5%	94.9%	95.3%
May 2012	99.6%	94.5%	95.7%	95.7%
June 2012	99.5%	92.2%	95.3%	94.3%
July 2012	99.5%	92.7%	95.0%	94.5%
August 2012	99.8%	90.7%	94.4%	93.4%

September 2012	99.2%	90.6%	96.4%	94.4%
October 2012	99.5%	89.7%	93.5%	92.4%
Q1	**99.21%**	**93.72%**	**95.33%**	**95.14%**
Q2	**99.50%**	**91.36%**	**95.41%**	**94.09%**
YTD	**99.35%**	**92.34%**	**95.25%**	**94.45%**

Performance at City is of greatest concern and there has been failure to achieve 95%, month on month from the beginning of the year. Performance is deteriorating significantly and needs to be turned around rapidly in order for the organisation to meet the 4 hour standard. The 'ready reckoner' in Graph 1, highlights the rate at which performance is deteriorating and the departmental breach tolerance for achievement of 95% is being far exceeded.

Graph 1: Breach Ready Reckoner, City ED



Both departments have experienced problems with patient flow and lack of beds available within the trust at times throughout the year; however, at City there are also major concerns relating to the waiting times and inter-departmental delays. This is confirmed by breach analysis, recorded by the department which shows that the two main reasons for breaches at City from April 2012 to present are:

1. Patient waiting for an ED Review;
2. Patient not seen by ED at 3 hours.

The third reason is 'patient waiting for a bed on MAU'.

The breaches recorded at Sandwell are most frequently due to a lack of acute capacity; however, more detailed breach analysis is required.

Escalation on both sites is inconsistent and current responses to peaks in demand are not robust from a departmental or organizational perspective.

3.1 Focus & Initiatives to correct performance

The Directorate Management Team has identified the following areas of focus:

- Escalation

  Departmental & Organisational response to emergency demand;

- Departmental Leadership / Shop-floor Management

  Competent medical and nursing co-ordination of the ED

- Departmental Flows & Patient Pathways

  Fit for purpose infrastructure for patient flow and agreed pathways to eliminate delays.

- Performance Monitoring

  Meaningful performance monitoring to identify and resolve problems

Table 2 on the following page, identifies the initiatives required to improve performance.

Table 2: Initiatives for Improving Performance

Areas of Focus & Initiatives	
Key Area 1: Escalation	
	Timescale
1.1 Internal Professional Standards are agreed and set Including: • When a request from the Emergency Department for a specialist opinion, a response from the specialty team occur within 30 minutes; • When a request from the Emergency Department for an inpatient bed, the patients is transferred within 30 minutes;	1 Nov 2012
1.2 Emergency Department Escalation Policy is re-written & agreed • All staff in the ED aware of the optimal functioning of the department; • When there are delays within the Emergency Department, action is taken; • Escalation and communication is appropriate & timely.	5 Nov 2012
1.3 Trust Escalation Policy is written & agreed • When Internal Professional Standards are breached, this is escalated promptly and to Executive level; • When there is inadequate site capacity to support flow, action is taken to unblock the Emergency Department;	Nov 2012
1.4 Capacity Management / Site Team • Consistent in hours and out of hours site co-ordination and leadership.	Jan 2012
Key Area 2: Departmental Leadership & Workforce	
2.1 Agree revised standard for Consultant working • Role & Responsibility of Consultant on the shop-floor	19 Nov 2012
2.2 Agree revised standard for Shift Coordinator • In conjunction with Assessment Units	19 Nov 2012
2.3 Extend hours of Consultant cover • Revise Consultant job plans to allow 08:00 – 22:45	31 Oct 2012
2.4 Workforce Proposal • Increase in Consultant cover • Nursing establishment review • Advanced Nursing Roles	22 Oct 2012
Key Area 3: Departmental Flows and Patient Pathways	
3.1 IT System • To support management of patient flow, allowing: o Patients to be tracked through department by location; o Waiting times for Triage, RAM, Treatment, Referral, Transfer to be monitored; o Breach analysis to be recorded and data generated;	31 Jan 2013

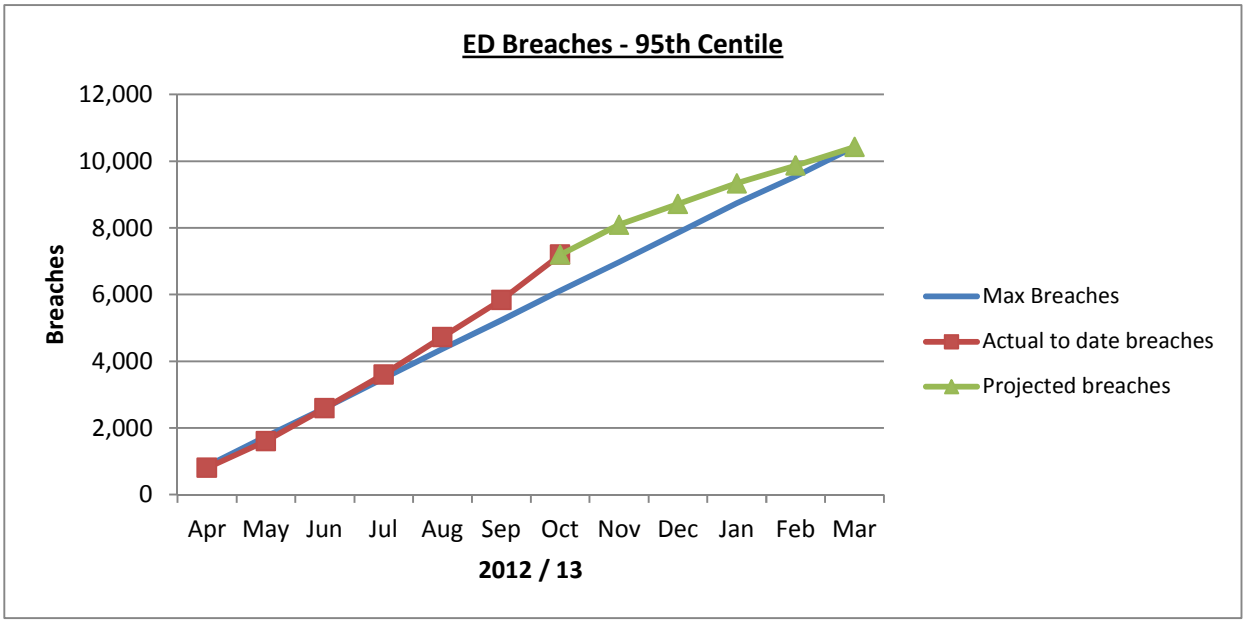
o Patient pathways/algorithms/proformas to be completed electronically	
3.2 City ED Refurbishment / Capital Work • To improve departmental flows and co-locations; • To clearly define patients streams: Resus, Majors, Fast-Track, Pediatrics, Urgent Care • To create more capacity for monitoring patients; • To boost staff morale; To improve patient experience	12 month timescale
3.4 Co-located Urgent Care Centre / GP service • To reduce demand on the Emergency Department	Dec 2012
3.3 Reduce delays in diagnostics Key areas: • Imaging reporting • Blood results	Dec 2012
3.4 Patient Pathways • Reduce demand on the ED and delays in patient care. Areas of focus, where significant number of breaches are occurring or patients are waiting in the ED unnecessarily: o Poisons pathway o GP referred patient pathway o Mental Health pathway • Implementation of West Mercia Guidelines.	Nov '12 – Jan 2013
3.5 Development of Clinical Decision Unit • Within the Emergency Department function; • Clear admission and discharge criteria.	Next financial year
Key Area 4: Performance Monitoring	
4.1 Live Performance Monitoring • Regular Trust wide communications on 4 hour performance including running total for daily, monthly, quarterly and yearly performance; • Revised ED performance dashboard to support communication.	12 Nov 2012
4.2 Weekly Breach Analysis • Lead by the Clinical Director, with the Directorate Management Team; • Identify key issues & corrective action.	22 Oct 2012

3.2 Trajectory to improve performance and meet 95%

The trajectory towards achieving 95% against the 4 hour target is set out below. Based on a total activity of 208,698, the breach tolerance assumptions for the remainder of this year pan Trust have been modeled as:

October	44
November	30
December	20
January	20
February	19
March	18

The table below shows the recovery trajectory required to meet 95%. This is dependent on delivery of plans and is a significant risk to the Trust at this stage.



3.4 Risks to delivery & mitigation

RISK	RAG	MITIGATION	RAG
1. The pace of change and staff engagement required to ensure achievement of 95%	20	• Fortnightly performance monitoring chaired by the CEO and COO/CN;	12
3. Perceived tolerance to breaches & delays in ED, leading to reduced ability & compliance of Specialty Teams to review patients within 30 minutes	12	• Set clear policy; • To include escalation to Medical Director if required; • Allocate Executive Lead for communication of policy.	9

RISK	RAG	MITIGATION	RAG
3. Failure to transfer patients out of the EDs within 30 minutes of referral to a specialty	16	• Winter Plan and effective capacity management	12
4. Limited influence on pathway for Mental Health patients, due to multi-agency responsibilities.	20	• CD, Assistant HoN, GM to provide report on issues to ED Task & Finish Group; • Executive involvement; • Development of CDU for 2013/14.	16
5. Timescale of delivery of more significant initiatives, e.g. IT System, Capital works/ Refurbishment.	20	• Scoping work to be completed by 31 October 2012 to confirm likely timescales	16
6. Reliance on locums to fill additional shifts currently in place to support performance, reducing the efficacy	12	• Workforce proposal sign off to enable recruitment of substantive Specialty Doctors; • Clinical Director to review and set minimum experience/PS for middle-grade locums	9
7. Local leaders understanding of the breadth of change required	12	• Clinical Director and Assistant HoN appointed to manage local leaders and drive change	9
8. Continuity of leadership at Directorate, Divisional & Strategic Level.	12	• Clinical Director in post for 12 months. • Interim position of DGM filled.	9

4. Conclusion

Initial focus in special measures has been on the quality aspects in the ED's. Progress has been made against the plan and recent key appointments of new clinical leadership is pivotal to leading departmental change.

The Trust is underperforming against the 4 hour target. A recovery and mitigation strategy is in place but traction on improvement particularly at City hospital is still to be realised. This is significant risk to the Trust in the latter half of the year.

The EDAT governance infrastructure has been reviewed recently to support the ED's and fortnightly meetings of an executive and directorate task and finish group will oversee delivery of the above.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Corporate Meeting Reporting**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Payne, Trust Secretary**
DATE OF MEETING:	**25 October 2012**

EXECUTIVE SUMMARY:

The Board is reminded that a number of key recommendations arising from the external FT readiness reviews undertaken by Deloitte (Board Effectiveness) and Price Waterhouse Cooper (Historical Due Diligence) suggested that there was a need for a review to be undertaken of the information flows between the Trust's Boards and Committees with a view adhering to the following principles:

- To avoid duplication of information considered
- To ensure that information received by the bodies is tailored appropriately, including presenting information by exception vs. a more detailed analysis
- To reduce the volume of reports for the bodies to consider and explore alternative ways of communicating information
- To encourage the Board's Committees to take more of a role in considering detail and providing assurance to the Board

The Board will recall that an initial view of all reports considered by the Trust Board, its Committees and the Executive-led Governance & Trust Management Boards was presented at the Trust Board meeting on 30 August 2012.

Since this report was considered, all Executive Directors were asked to review the set of reports for which they are assigned as the sponsor, the output of which is attached.

Reports are graded as red, amber or green, according to the level of proposed changes.

The Board is asked to note that a key outcome of this work is the greater consideration of the detailed reports by the Board's committees, which, together with more robust reporting back from the Committee chairs, serves to strengthen the role of these bodies in providing assurance to the Trust Board.

REPORT RECOMMENDATION:

The Board is asked to note the plans to rationalise the reports being presented to the corporate meeting bodies.

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:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Satisfies actions: 20, 30, 48, 99 & 131 in the FT IDP
PREVIOUS CONSIDERATION:
Considered by the Board as part of the Integrated Development Plan and external FT readiness reports considered. The initial view of all reports presented to the corporate meeting bodies was considered at the Trust Board meeting held on 30 August 2012.

CORPORATE BOARD AND COMMITTEE REPORTS SCHEDULE

Report	Considering Body						Current frequency	Changes planned
	GB	TMB	QSC	AC	FPC	TB		
QUALITY, PATIENT SAFETY & PATIENT EXPERIENCE								
Quality Report	✓		✓			✓	Monthly	Add to agenda of Q & S Ctte
Integrated risk report	✓		✓			✓#1	Quarterly	Present exceptions to TB
Annual risk report	✓					✓	Annual	Remove from Q & S Cttee
Significant events report	✓		✓			✓	Monthly	Add to agenda of Q & S Ctte
Annual complaints report	✓					✓	Annual	Remove from Q & S Cttee
Severe graded complaints report	✓					✓	Monthly	No change
Complaints for independent review			✓			✓#2	Alternate months	No change
NPSA safety alerts update	✓					✓#2	Monthly	Remove from Q & S Cttee
NRLS update	✓		✓				Twice yearly	No change
PROMs update	✓		✓			✓#2	Monthly	No change
Clinical Audit forward plan: monitoring report	✓		✓			✓#2	Monthly	No change
Clinical Audit forward plan: outturn report	✓		✓	✓			Annually	Add to agenda of Audit Ctte
Infection Control update		✓	✓			✓#2	Quarterly	No change
Infection Control annual report	✓					✓	Annually	Remove from Q & S Cttee
Nursing annual report	✓					✓	Annually	No change
ED action team update	✓		✓			✓	Monthly	Include in Quality Report & full report to QSC & GB
Safeguarding update	✓		✓			✓#2	Annually	Annual update to Q & S Ctte
Equality and Diversity update		✓	✓			✓	Quarterly	Add to agenda of Q & S Ctte
Quality Account	✓		✓	✓		✓	Annually	No change
National patient survey and action plan		✓	✓			✓	Annually	Add to agenda of Q & S Ctte
CQC Quality & Risk Profile	✓		✓			✓#2	As published	No change
Update on NHSLA/CNST assessments	✓		✓				Monthly	No change
Compliance with the '5 Steps to Safer Surgery'	✓		✓			✓#2	Monthly	Add to agenda of Q & S Ctte
Local Security Management Specialist update	✓		✓				Annually	No change
FINANCE AND PERFORMANCE								
Financial performance update		✓			✓	✓	Monthly	Present exceptions to TB
Performance monitoring report		✓	✓		✓	✓	Monthly	Present exceptions to TB. Add to agenda of Q & S Cttee
NHS Performance Framework update		✓			✓	✓	Monthly	No change

Report	Considering Body						Current frequency	Changes planned
	GB	TMB	QSC	AC	FPC	TB		
FT Compliance update					✓	✓	Monthly	Add to agenda of PMB and F & PMC
Annual financial plan					✓	✓	Annually	No change
TSP Delivery report		✓			✓	✓	Monthly	Include key highlights within the Financial Perf'ce update to TB
Performance Monitoring Regime					✓	✓	Monthly	Add to agenda of PMB and F & PMC
Annual accounts				✓		✓	Annually	No change
Corporate Objectives/annual plan activity progress report		✓				✓	Quarterly	No change
Debtors report					✓		Monthly	No change
Service Line Reporting update					✓		Alternate months	No change
STRATEGY								
'Right Care, Right Here' update						✓	Monthly	No change
FT Programme Directors report		✓				✓	Monthly	No change
Clinical reconfiguration update						✓	Quarterly	No change
Update on delivery of the TP		✓					Monthly	No change
National Staff survey and action plan		✓				✓	Annually	No change
Workforce strategy and annual work plan		✓				✓	Annually	No change
Research strategy update		✓				✓	Twice yearly	No change
HIS strategy update						✓	Twice yearly	No change
Estates strategy annual review						✓	Annually	No change
OPERATIONAL MATTERS								
Radiation protection update						✓	Annually	No change
Fire safety update						✓	Annually	No change
Sustainability update		✓				✓	Quarterly	No change
National staff survey and action plan		✓				✓	Annually	No change
Medical Education update		✓				✓	Twice yearly	No change
Workforce dashboard		✓			✓	✓	Monthly	Present exceptions to TB
Communications and engagement update incl OTF		✓				✓	Quarterly	No change
GOVERNANCE, AUDIT AND ASSURANCE								
Board Assurance Framework	✓		✓	✓		✓	Quarterly	No change
Corporate Risk Register	✓		✓			✓	Quarterly	Present monthly to Trust Brd
External Audit progress report				✓			Quarterly	No change

Report	Considering Body						Current frequency	Changes planned
	GB	TMB	QSC	AC	FPC	TB		
Internal Audit progress report, including rec. tracking				✓			Quarterly	No change
Internal Audit Plan				✓			Annually	No change
Counter fraud progress report				✓			Quarterly	No change
Counter fraud annual report				✓			Annually	No change
Annual Governance Statement				✓		✓	Annually	No change
Audit Committee self-assessment of effectiveness				✓			Annually	No change
Changes to the Trust's SOs/SFIs and Scheme of Delegation				✓		✓	Annually	No change
Register of waived tenders and breaches to SOs/SFIs				✓			Annually	No change
Register of seals						✓	Annually	No change
Losses and compensation (special payments) register				✓			Annually	No change
Gifts and Hospitality register				✓			Annually	No change
Directors' Register of Interests						✓	Annually or as req'd	No change
Board Committees' Terms of Reference review			✓	✓	✓	✓	Annually	No change

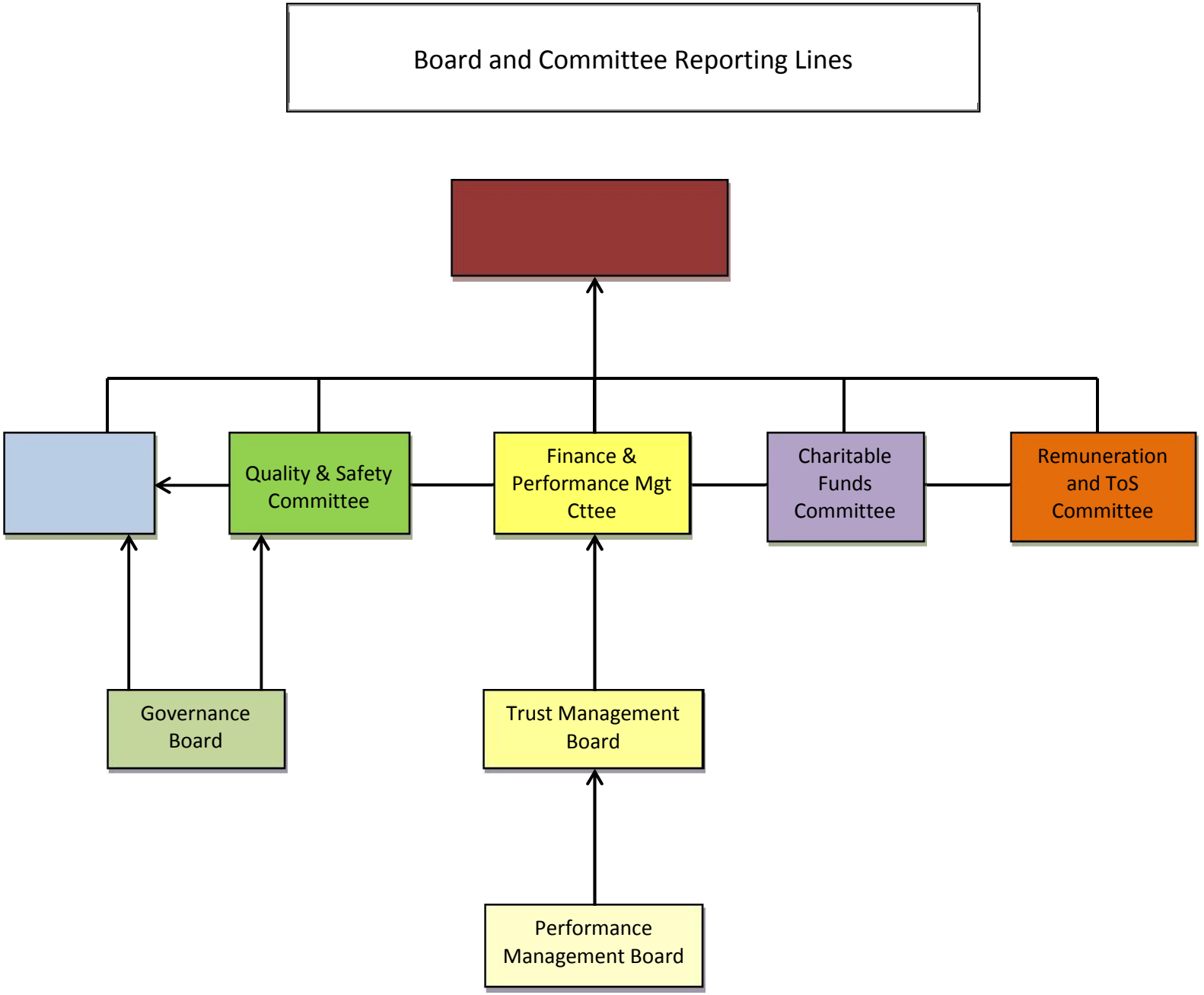
NOTES:

#1 Summary report presented to Trust Board

#2 Currently included within Quality Report

KEY:

GB	Governance Board
TMB	Trust Management Board
QSC	Quality & safety Committee
AC	Audit Committee
FPC	Finance and Performance Management Committee
TB	Trust Board


Board and Committee Reporting Lines
Quality & Safety Committee
Finance & Performance Mgt Cttee
Charitable Funds Committee
Remuneration and ToS Committee
Governance Board
Trust Management Board
Performance Management Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Whistleblowing Policy**
SPONSOR:	**Rachel Overfield, Chief Nurse**
AUTHOR:	**Alison Newcomb-Ferreday – HR Business Partner**
DATE OF MEETING:	**25 October 2012**

EXECUTIVE SUMMARY:

The Whistleblowing Policy is about the disclosure of information that relates to some danger, criminal activity, failure to comply with a legal duty, failure to apply standards of care, unethical conduct, miscarriage of justice, danger to health and safety or the environment, whether this is in relation to the Trust or by other staff members.

The reason we need a Whistleblowing Policy is to ensure the Trust is delivering high quality, safe care it is essential that its staff understand that they are empowered and expected to raise concerns if they believe that patient safety may be compromised or errors are occurring and that they have the confidence to put this into practice.

The policy is designed to set out the framework that staff can follow if they have any concerns, and it encourages and an effective whistleblowing culture which supports the safe delivery of care to the patients we serve.

The aim of this policy is to encourage staff to raise legitimate concerns at the earliest possible opportunity through internal mechanisms.

In the event that staff don't feel able to raise their concerns internally, this policy sets out the process for making an external disclosure.

The refreshed Policy has been revised to harmonise policies between Sandwell PCT following the TUPE transfer of community staff in 2011.

The Policy has also been refreshed and updated with new national guidance published by NHS employers.

The Policy is also required for completion to support the Trust's application to become a Foundation Trust.

What are the key changes?

By reviewing and harmonising the policy there are only minimal changes to the new policy which include:

* Refreshing the national guidance for NHS employers as set out by NHS Employers
* Updated contact information for raising internal and external concerns
* A step by step flowchart of how to raise a concern
* Inclusion of an Employee Guide to Whistleblowing
* Inclusion of a Manager's Guide to Whistleblowing

It is proposed that a dedicated email address is set up to channel the Whistleblowing concerns through which would be promoted to managers/staff at the point the policy is launched formally to the business. In order to support this suggestion it would be beneficial if we could identify who would be the lead to track and audit concerns received so that we ensure a robust monitoring, escalation plan is in place to support robust management of this policy for audit and reporting purposes. A few named leads will need to be identified so that IT access rights can be set up for these key leads.

REPORT RECOMMENDATION:

The Board is asked to note this policy.

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

Comments: An Equality Impact Assessment has been completed for this policy and is attached

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

This policy supports a key action in the Integrated Ft Development Plan to review and refresh the whistleblowing arrangements in the Trust.

PREVIOUS CONSIDERATION:

The Policy was circulated to PPAC/JCNC members and Executive & Senior Management Teams concurrently on 29th August 2012.

The Policy was taken to PPAC on Monday 3rd September 2012.

The Policy was tabled at JCNC on Thursday 6th September 2012 and approved on Thursday 4th October 2012 by JCNC members.

The Policy was submitted in draft to the Trust Management Board in September and resubmitted to the October TMB where it was approved.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

WHISTLEBLOWING POLICY (DRAFT)

POLICY AUTHOR:	HR Business Partner
ACCOUNTABLE EXECUTIVE LEAD:	To be discussed and agreed at Trust Management Board
APPROVING BODY:	Trust Board

ESSENTIAL READING FOR: **All Staff Groups** STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES: **All Staff Groups**	POLICY APPROVAL DATE **To be inserted after approval** POLICY IMPLEMENTATION DATE **To be inserted after approval** DATE POLICY TO BE REVIEWED **To be inserted after approval**

Document Control History

Version No	Date Approved	Date of Implementation	Next review Date	Reason For Change
1.0				**Policy Harmonisation with Sandwell PCT and SWBH**

Whistleblowing Policy

SUMMARY OF KEY POINTS

1. To encourage a culture where Trust staff may speak out freely and report any concerns at the earliest possible opportunity. This supports the principles of the NHS Constitution, Staff Pledges, and empowers staff to "Speak up for a Healthy NHS".

2. To support individuals raising concerns by giving them the confidence that they will be taken seriously and will not be victimised as a result of raising a complaint.

3. To define the process for Trust staff to report concerns, and to set out a clear procedure to support the investigation of those concerns.

4. To ensure that action is taken, and improvements are made where appropriate.

5. To direct potential whistle blowers to the Trusts Local Counter Fraud Team if they have any concerns this may involve potential fraudulent/corrupt activity.

6. To direct potential whistle blowers to policies which relate to the safeguarding of vulnerable adults, and children e.g Management and Protection of Vulnerable Adults (Pt Care/011) and Safeguarding Children Policy (PT Care/013)

7. To ensure that the Trust meets its legal obligations under the Public Interest Disclosure Act1998.

8. It is important to note that this policy applies to any person who undertakes work for the Trust including employees, workers, volunteers, and contractors, including agency staff, temporary staff, trainees and Trust Bank staff.

9. It is <u>not</u> the intention of this policy to deal with personnel matters or issues relating to employment/working arrangements as these should be dealt with through existing Grievance policies (HR/007 /Sandwell PCT Grievance policy) and Dignity at Work policy (HR/009).

10. This policy does <u>not</u> replace the Trust's Complaints Procedure, which should be used by patients or those acting on behalf of the patient.

CONTENTS

1. Introduction

1.1 This policy sets out the framework that staff should follow if they have any concerns (about danger or illegality) that they may have about other people within the Trust or the way in which the Trust is run. The concern will have a public interest to it, usually because it threatens others, for example patients and the public. It is important to note that this policy is not intended to replace the Trust's Grievance and Disputes Policy (HR/007), which should be referred to when employees have concerns relating to them that have no additional public interest.

1.2 This policy aims to encourage an effective whistleblowing culture which supports the safe delivery of care to the patients we serve.

1.3 The Public Interest Disclosure Act 1998 (PIDA) is known in the UK as the Whistleblowing Law and the Act provides legal protection for workers from dismissal, victimisation or other detrimental treatment when they raise concerns at work in relation to 'protected disclosures'. Protected disclosures are disclosures alleging:

- Criminal offences or failure to comply with legal obligations
- Fraud, Corruption or malpractice
- Miscarriages of justice
- Dangers to health and safety
- Damage to the environment
- Any attempt to deliberately conceal any of the above

Disclosures are protected whether they concern:

- An act or omission that took place in the past
- Improper conduct occurring in the present, or
- The prospect of likelihood of an act or omission occurring in the future

1.4 The aim of this policy is also to encourage staff to raise concerns at the earliest possible opportunity through the internal mechanisms provided. In the event that staff do not feel able to raise their concerns internally, this policy sets out the process for making an external disclosure.

1.5 In cases of suspected fraud and/or corruption, concerns should be reported to the Trusts Local Counter Fraud Specialists (LCFS) and/or the Trust's Director of Finance and Performance.

Note: This list is not exclusive or exhaustive and there may be other serious public interest concerns, which would align to this Policy.

2. Other Policies to Which This Policy Relates

2.1.1 If there are concerns which relate specifically to the safeguarding of vulnerable patients within our care, or matters which relate to employment matters then the following policies should be reviewed before a whistleblowing concern is raised:

- The Management and Protection of Vulnerable Adults (Pt Care/011)
- Safeguarding Children Policy (PT Care/013)
- Disciplinary Policy HR/003
- Grievance and disputes Policy HR/007
- Dignity at Work Policy (HR/009)
- Capability Policy (HR/030)

3. Glossary and Definitions

Whistleblowing

Whistle blowing is about the disclosure of information that relates to some danger, criminal activity, and failure to comply with a legal duty, standards of care, unethical conduct, miscarriage of justice, danger to health and safety or the environment, be it of the Trust or by other staff members.

4. Principles

4.1 The Trust wishes to create an organisational culture that:

- Empowers all of its staff groups to raise concerns that they may have at the earliest possible opportunity.
- Ensures that all Trust managers in receipt of a whistleblowing concern act promptly and appropriately to address the concern and provide feedback to the member of staff raising the issue.

4.2 The Trust will not tolerate harassment or victimisation of any individual who does decide to whistle blow. Any such action will be dealt with in line with the Trust's Disciplinary Policy (HR/003).

4.3 Trust staff are encouraged to consult with, and seek guidance from, their Professional Registration organisation/statutory bodies such as the Nursing and Midwifery Council (NMC), or the General Medical Council (GMC) related to their profession, or appropriate Trade Union about matters of concern. By doing so, this will complement existing professional/ethical rules/guidelines/codes of conduct about freedom of speech. It is important to note that a number of Trade Union bodies have their own Whistleblowing Helplines and details of these can be obtained from your local trade union representatives, details of the registered regional offices for the recognised trade unions can be seen at appendix 1.

4.4 With regards to safeguarding concerns that involve a member of staff as the perpetrator, these may need to be referred to the Independent Safeguarding Authority (ISA). A referral if deemed necessary will be undertaken in accordance with the relevant policy by the relevant Executive Director.

4.5 Where a member of staff has concerns regarding the care of a patient detained under the Mental Health Act 1983, it would be appropriate to raise these concerns with the Trust Safeguarding leads in line with the Vulnerable Adults and Children Act as they may need to refer the matter to the "Mental Health Act Commission", if the concern remains unresolved.

4.6 Staff may access independent advice from the charity Public Concern at Work (PCaW), an organisation which provides free, confidential advice to people concerned about crime, danger or wrong doing at work. There is a specific telephone helpline for NHS staff which is 020 7404 6609. Alternatively advice can be sought from the PCaW email link which is at the following email address: helpline@pcaw.co.uk. Further information can also be obtained through the PCaW website - www.pcaw.co.uk.

4.7 The Trust recognises that there may be circumstances when an individual feels that it is necessary to report their concerns to an external body (see section 7). The appropriate regulatory bodies prescribed by legislation are listed in Appendix 1. For wider disclosures where these are raised through the police, media, MPs, or other non-prescribed regulatory bodies these are protected where concerns are reasonable and not made for personal gain (see section 7).

4.8 If an investigation confirms that a member of staff has made a disclosure for malicious or vexatious reasons this could lead to disciplinary action being taken against them.

5. Roles And Responsibilities

5.1 Chief Executive

Overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation develops an organisational culture that empowers staff to raise matters of concern, adopts best practice guidance, and complies with all relevant legislation and regulatory reporting requirements.

5.2 Trust Board

5.2.1 To create a safe environment which encourages a culture where individuals can speak out freely and report any genuine concerns at the earliest possible opportunity in the confidence that they will be taken seriously and will not be victimised as a result.

5.2.2 Designated Non Executive and Executive Directors should be aware of their responsibilities in line with this policy.

5.2.3 To ensure that there is a wide awareness about this policy, and also the support that is available to managers and staff

5.2.4 To ensure all managers and staff are aware by everyone of their roles and responsibilities within this policy.

5.3 Designated Non Executive Director

5.3.1 To be aware of their responsibilities in line with this policy and to attend any relevant training as deemed appropriate to support the implementation of this policy.

5.3.2 To treat concerns raised seriously and sensitively, recognising the difficulty/concern Trust staff may have in raising concerns.

5.3.3 To ensure that staff raising whistle blowing concerns are not victimised or harassed and that where possible staff anonymity is preserved.

5.3.4 To seek advice from other healthcare professionals where appropriate.

5.3.5 To refer fraud related concerns to the Trust's Counter Fraud Department.

5.4 Lead Executive Director

5.4.1 To be aware of the roles and responsibilities in line with this policy.

5.4.2 To be responsible for ensuring that the policy is implemented appropriately and that the numbers of concerns and associated outcomes made in line with this policy are monitored (refer to section 12 Monitoring) and that concerns that are raised are concluded within a 4-week timescale unless under exceptional circumstances the outcome is delayed by reason of the complexity of the case. To also ensure that all parties involved with the investigation are fully informed where delays have been identified and the anticipated timescale for completion.

5.5 All Trust Managers and Clinical Leaders

5.5.1 To be aware of their responsibilities in line with this policy and to attend any relevant training as deemed appropriate to support the implementation of this policy.

5.5.2 To treat concerns raised seriously and sensitively, recognising the difficulty staff may have in raising concerns.

5.5.3 To ensure that staff raising whistle blowing concerns are not victimised or harassed and that where possible staff anonymity is preserved.

5.5.4 To seek advice from other healthcare professionals where appropriate.

5.5.5 To refer fraud related concerns to the Trust's Counter Fraud Department.

5.5.6 If concerns are regarding the safeguarding of vulnerable adults or children within their care, referral must be made to the Policy for Management and Protection of Vulnerable Adults and Safeguarding Children Policy (PT Care/013).

5.6 Local Counter Fraud Specialists (LCFS)

5.6.1 To treat concerns raised seriously and sensitively, recognising the difficulty Trust staff may have in raising concerns.

5.6.2 To support staff to ensure that in the event they raise concerns they are be protected against victimisation.

5.6.3 The LCFS's role is to ensure that all cases of actual or suspected fraud and corruption are notified immediately to the Director of Finance and Performance and are reported accordingly.

5.6.4 To be responsible for the day-to-day implementation of the seven generic areas of counter fraud and corruption activity, and to investigate all cases/suspicions of fraud reported to them.

5.6.5 To report any cases to the police, or NHS CFS as appropriate, and to ensure that other relevant parties are informed where necessary, e.g. Human Resources Department.

5.6.6 To protect the integrity of any investigation being carried out by the LCFS, all staff, including senior managers, have a responsibility to protect the Trust. The policy supports staff to voice their concerns, in confidence, to the appropriate officer without fear of any kind of retribution.

5.6.7 To raise any concerns in a reasonable and responsible way, acting in good faith.

5.6.8 To follow the procedure as detailed within this policy when raising concerns within the Trust.

5.6.9 To recognise that the Trust will not tolerate harassment or victimisation of any individual who whistle blows.

5.6.10 To recognise that if a disclosure is found to have been made for malicious or vexatious reasons this could lead to disciplinary action.

5.6.11 To comply with the requirements set out by the Local Counter Fraud Team.

5.7 All Staff

5.7.1 To raise genuine concerns in a reasonable, responsible way at the earliest possible opportunity.

5.7.2 Follow the procedure as detailed within this policy when raising concerns within the Trust.

5.7.3 To recognise that the Trust will not tolerate harassment or victimisation of any individual who whistle blows.

5.7.4 To recognise that if a disclosure is found to have been made for malicious or vexatious reasons this could lead to disciplinary action.

5.8 Trade Unions

5.8.1 To work in partnership with the Trust to develop a culture where staff feel empowered and supported to raise concerns at the earliest possible opportunity.

5.8.2 To support Trust employees as appropriate, and to treat all concerns in line with this policy seriously and sensitively. Please note that some Trade Unions may have their own Whistleblowing Policies and procedures.

6. Procedure for Raising Concerns

6.1 **Line Manager**

6.1.1 In the first instance staff are encouraged to raise their concerns with their immediate line manager (for alternative internal options see section 6.5). For matters of potential fraud and/or corruption, these should be raised with the Trusts Local Counter Fraud Specialist.

6.1.2 If the staff member does not feel able or that it is appropriate to make a disclosure to their line manager, they may elect to approach any of the senior leaders within their division/directorate or the Trust's designated non-executive director (see sections 6.2 and 6.3 below).

6.1.3 The line manager will always take whistle blowing concerns seriously, register them centrally on receipt of the concerns using the electronic whistle blowing concerns form which is available on the intranet and is submitted directly to a dedicated local email address. The manager should then make an initial assessment of the issues involved and seek guidance prior to investigating the concerns raised UNLESS they are in respect of potential fraudulent activity or in respect to safeguarding of vulnerable adults and Children. If the concerns are fraud and/or corruption related the Trusts Local Counter Fraud Specialist must be contacted. If concerns relate to safeguarding issues the Management and Protection of Vulnerable Adults (Pt Care/011) or the Safeguarding Children Policy (PT Care/013) should be followed.

6.1.4 Upon receipt of a whistle blowing concern managers should: -

- Recognise the difficulty the member of staff may have in raising concerns. Offer support measures such as Occupational Health, referral or BDMA Counselling support services.
- Register concerns by using the electronic whistle blowing concerns form which is available on the Trust's intranet site. The form collects some baseline information about the concerns being raised, and the action being taken to investigate and these are submitted and collated in a central email inbox set up for audit purposes only to ensure that concerns raised have been reviewed, and actioned appropriately. Appendix 2 and 3 also provide a procedure flowchart, and useful checklist to help staff and managers when making a disclosure.
- Ensure that the member of staff raising concerns is protected against victimisation.
- Ascertain whether the member of staff wishes to disclose their identity as part of this process. In the event that they want their anonymity to be preserved every attempt should be made to comply with this request, although staff should be advised that there are limitations – see section 6.4.
- Seek advice from other healthcare professionals where appropriate
- Contact details for the Trusts Local Counter Fraud Specialist are detailed in section 9. Alternatively whistle blowers are able to report suspicions anonymously by calling the NHS National Fraud and Corruption Reporting Line, which is 0800 028 40 60.

6.1.5

The line manager should:

- make contact with the employee raising concerns as soon as reasonably practicable to ensure appropriate supportive measures (if appropriate) are in place.

- undertake an initial assessment of the issues involved and within ten calendar days notify the employee when they anticipate being in a position to be able to provide a comprehensive response.

- provide a final formal written response. This should normally be within four weeks but it is acknowledged that complex issues may require a longer time frame. The important factor is to ensure that the employee who has raised the concern is kept appropriately informed.

- Forward a copy of the original concern and the written response to the designated Trust Non-Executive Director for Whistleblowing for information and recording.

- Ensure that all identified actions are undertaken or escalate the report and associated recommendations to the relevant Trust manager.

6.1.6 If a member of medical staff wishes to raise an issue of concern about a colleague's performance they have a duty under their General Medical Council registration to raise it in the first instance with the Trust's Medical Director. (See Procedure for Doctors to Report Concerns about the Conduct, Performance or Health of Medical Colleagues SHC/HR/032).

6.2 Next Level of Management: i.e. Heads of Nursing/Midwifery/Divisional General Manager/Clinical Director/Divisional Director

6.2.1 If an individual does not feel it is appropriate to raise their concerns with their line manager or continues to feel concerned after feedback from their line manager he/she has the option of either escalating their concern to a senior leader (of their choice) within their division/directorate, or, alternatively to raise their concern with the Trust's designated Non-Executive Director for whistle blowing. The appointed Non-Executive director can be contacted via the Trust Secretary.

6.2.2 The procedure detailed within section 6.1 should be followed to register and investigate the concerns raised. The Divisional/Directorate leader may elect to investigate the concerns themselves or allocate an appropriate manager to investigate.

6.3 Designated Non-Executive Director

6.3.1 In the event that individuals do not feel able or believe it appropriate to raise their concerns internally with their line manager or continues to feel concerned after feedback from their line manager he/she has the option of either escalating their concern to a senior leader (of their choice) within their division/directorate, or, alternatively to raise their concern with the Trust's designated Non-Executive Director for whistle blowing. The appointed Non-Executive Director can be contacted via the Trust Secretary

6.3.2 Staff may also elect to escalate their concerns to the designated non-executive director if they are not satisfied with the outcome of a previous disclosure to their line manager or a divisional leader.

6.3.3 Upon receipt the Non-Executive Director will acknowledge their written concerns within 5 working days of receipt If the Non-Executive Director decides that it would be appropriate for an initial assessment and investigation to take place, he/she will decide who is to investigate these concerns. This will normally be an appropriate Executive Director. The Non-Executive Director will be responsible for deciding on the time scales for the investigation and will keep the member of staff regularly informed of progress in writing.

6.3.4 On completion of the investigation, the designated Non-Executive Director should advise the individual in writing of the outcome. A copy of this correspondence must be sent to the Chief Executive for information and for appropriate follow up action. For monitoring purposes details of the concerns and a copy of the written outcome must also be sent to the designated monitoring manager.

6.4 Anonymity

6.4.1 The Trust recognises that some members of staff would prefer to maintain their anonymity. When initial concerns are being raised there will be a need identify the information source/point of contact and from this point forwards the Trust will make every reasonable effort to protect and support requests for anonymity to be maintained where possible.

6.4.2 Staff should however be aware that where the matter in question is of a particularly serious nature (for example in relation to criminal or unlawful behaviour) it may be necessary to conduct formal internal processes e.g. disciplinary and inform the appropriate external bodies, for example Nursing and Midwifery Council or Health Professions body (see also Appendix 1 for list of prescribed regulatory bodies) and the Independent Safeguarding Authority, in which case individual anonymity cannot be guaranteed. In this event the Trust will provide support to the disclosing employee, and also to those team members which have had a complaint raised against them as appropriate throughout the process.

6.5 Trade Unions, Professional Bodies and Independent Advice

6.5.1 All staff have the right to consult and seek guidance and advice from their professional organisation or trade union and from statutory bodies such as the Health Professions Council, National Midwifery Council, or General Medical Council.

6.6 External and Wider Disclosures

6.6.1 The Trust hopes that this policy and procedure will give its staff the confidence to raise concerns internally and therefore encourages them to raise their concerns under this procedure in the first instance. However, it is recognised that there may be circumstances where they may properly report matters to external bodies. This includes circumstances where staff are dissatisfied with the outcome of the internal investigation.

6.6.2 Providing disclosures are made in good faith and the member of staff reasonably believes that the allegations of wrong doing are substantially true, external routes of disclosure that are protected are:

- To Public Concern at Work (PCaW) – which is a leading authority on Whistleblowing, this organisation provides confidential advice to individuals who are witness to wrong doing at work and are unsure how to raise a concern. Contact information: www.pcaw.co.uk; free advice line – 0207 404 6609
- To a legal advisor, if made in the course of obtaining legal advice
- To a minister of the crown, where the worker is engaged in crown or public employment
- To a 'prescribed person (body)'. For example HM Revenue & Customs; the Health & Safety Executive (see appendix A for list of bodies that have been prescribed for this purpose)
- Elsewhere in defined or exceptionally serious circumstances or conditions, , subject to certain conditions (see section 6.12.2)

6.6.3 A disclosure made elsewhere, for example to the police, the media, an MP or a non-prescribed regulator, may qualify for a protected disclosure providing certain conditions are met. These conditions are that the disclosure is made in good faith and not for personal gain. That the person making the disclosure must reasonably believe that the information disclosed is substantially true and it must be reasonable in the circumstances for the person to have made the disclosure in that way. The worker must also:

- Reasonably believe that he or she would be subjected to a detriment by the employer if they had raised the matter internally or to a prescribed body
- If there is no prescribed body, he or she reasonably believes the employer would react to the disclosure by concealing or destroying evidence OR
- Have already raised the concern with the employer or a prescribed body to no avail

If members of staff are contemplating making a wider disclosure they are strongly advised to first seek further specialist guidance from professional or other representative bodies.

6.6.4 Trust staff need to be aware that such action, if entered unjustifiably may result in disciplinary action.

6.7 Fraud and the Disclosure of Information.

6.7.1 LCFS contact details:

Address: Room S37,
Second floor,
Arden House,
City Hospital,
Dudley Road,
Birmingham, B18 7QH.

Tel: 0121 507 5087
Fax: 0121 507 4440

6.7.2 The Local Counter Fraud procedures are set out in the Counter Fraud and Corruption Policy (SWBH/Finance/01) which details processes to follow when reporting alleged fraud or fraudulent activity.

6.7.3 To protect the integrity of any investigation being carried out by the LCFS, all staff, including senior managers, have a responsibility to protect the Trust. The policy supports staff to voice their concerns, in confidence, to the appropriate officer without fear of any kind of retribution.

7.0 Communication and Information

7.1 By the nature of this policy and the importance to communicate the detail of this policy, a Managers support guide, and an Employee's support guide has been developed and can be seen at Appendix 4 and 5 to further support the understanding and appreciation of this policy.

8. Process for Monitoring Effectiveness

8.1 Sandwell and West Birmingham Hospitals NHS Trust will be responsible for monitoring the number of concerns made in line with this policy, how they have been handled and their outcome. An annual report will be submitted to the Trust Board for review at the end of the Trust's financial year which will assess the effectiveness of this policy.

9. Training and Awareness

9.1 Reference to this policy will be made during the Trust's Local Induction. Information will also be made available to staff in the form of information booklets for Managers, and staff members which can be obtained from the Trust's intranet site.

9.2 Copies of this policy will also be made available to all staff via the Trusts intranet site and Managers are advised to hold a hard copy in their local policy folder for ease of reference.

10. Equality & Diversity

10.1 The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the Equality initial screening toolkit, the results for which are monitored centrally.

11. Review

11.1 This policy will be reviewed in two years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

12. Reference Documents and Bibliography

12.1 Trust policies and procedures:
Disciplinary Policy HR/003
Grievance and disputes Policy HR/007
Policy for the Management and Protection of Vulnerable Adults Pt Care/011
Safeguarding Children Policy (Pt Care/013)
Child Abuse – Guidelines for Medical and Nurse Management
Dignity at Work Policy (HR/009)

12.2 Legislation

The Public Interest Disclosure Act 1998

13. Further Enquiries

Further information relating to this policy can be obtained from the Trust Human Resources Department - See Appendix 1.

14. Appendices

Appendix 1 – Further information/contact details of prescribed persons/bodies/Trade Union bodies
Appendix 2a – Whistleblowing Procedures Flowchart for Staff Members
Appendix 2b – Whistleblowing Procedures Flowchart for Managers
Appendix 3 – Guidance on information required when raising a concern
Appendix 4 – Managers guide to Whistleblowing
Appendix 5 – Employee guide to Whistleblowing

Further information

Further information about how to implement and review whistleblowing arrangements in the organisation can be obtained from the sources as listed below:

BSI Code of Practice on Whistleblowing Arrangements
Organisations can download a free copy of the 2008 British Standards Institution's Code of Practice on Whistleblowing Arrangements from www.pcaw.co.uk/bsi

Public Concern at Work
For information about the Public Interest Disclosure Act 1998, please visit:
www.pcaw.co.uk/law/uklegislation.htm

National Advisory organisations contact information:

Audit Commission
1st Floor, Millbank Tower, Millbank, London SW1P 4HQ
Tel: 0844 798 1212 or 020 7828 1212

Care Quality Commission (CQC)
Finsbury Tower, 103–105 Bunhill Row, London EC1Y 8TG.
Tel: 020 7448 9200

Health and Safety Executive (HSE)
Redgrave Court, Merton Road, Bootle, Merseyside, L20 7HS.
www.hse.gov.uk

Monitor
4 Matthew Parker Street, London SW1H 0NP.
Tel: 020 7340 2400

National Patient Safety Agency (NPSA)
4–8 Maple Street, London, W1T 5HD
Tel: 020 7062 1620

NHS Counter Fraud and Security Management Services (CFSMS)
Weston House, 246 High Holborn, London WC1V 7EX.
Tel: 020 7895 4500

NHS Employers
Main Office: 2 Brewery Wharf, Kendell Street, Leeds, LS10 1JR
www.nhsemployers.org
Tel: 0113 306 3000

Professional regulator contact information:

General Chiropractic Council
44 Wicklow Street, London, WC1X 9HL.
www.gcc-uk.org
Tel: 020 7713 5155

General Dental Council

37 Wimpole Street, London, W1G 8DQ
www.gdc-uk.org
Tel: 020 7887 3800

General Medical Council
Regents Place, 350 Euston Road, London, NW1 3JN
www.gmc-uk.org
Tel: 0161 923 6602

General Optical Council
41 Harley Street, London W1G 8DJ
www.optical.org
Tel: 020 7580 3898

General Osteopathic Council
176 Tower Bridge Road, London, SE1 3LU
www.osteopathy.org.uk
Tel: 020 7357 6655

Health Professions Council
Park House, 184 Kennington Park Road, London SE11 4BU
www.hpc-uk.org
Tel: 0845 300 4472 or 020 7840 9802

Nursing and Midwifery Council
23 Portland Place, London, W1B 1PZ
www.nmc-uk.org

Royal Pharmaceutical Society of Great Britain
1 Lambeth High Street, London, SE1 7JN
www.rpsgb.org.uk
Tel: 020 7735 9141

Trade Unions contact information:

In the first instance please contact your local trade union representatives however the registered trade union offices can be contacted at the contact addresses as detailed below:

British Dental Association (BDA)
64 Wimpole Street, London, W1G 8YS, Tel: 02079350875, email: enquiries@bda.org

British Medical Association (BMA)
BMA House, Tavistock Square, London WC1H 9JP, Tel: 020 7387 4499, www.bmahouse.org.uk

British Orthodontic Society (BOS)
12 Bridewell Place, London, EC4V 6AP, Tel: 02073538680

Chartered Society of Physiotherapy (CSP)
14 Bedford Row, London, WC1R 4ED, Tel: 0207 306 6666

Federation of Communication Services (FCS)
FCS Limited, Provident House, Burrell Row, Beckenham, Kent, BR3 1AT, Tel: 02082496363

GMB
Regional Office, Will Thorne House, 2 Birmingham Road, Halesowen, West Midlands, B63 3HP, Tel: 0121 550 4888, www.gmb-westmidlands.org.uk

Royal College of Midwives (RCM)
15 Mansfield Street, London, W1G 9NH, Tel: 0207 312 3535, www.rcm.org.uk

Royal College of Nursing (RCN)
RCN West Midlands Regional Office, Lyndon House, 58-62 Hagley Road, Edgbaston, Birmingham B16 8PE.Telephone: 0345 772 6100 (charged as a local rate call)
Email: westmidlands.region@rcn.org.uk.

The Society of Radiographers
207 Providence Square, Mill Street, London, SE1 2EW
Tel: 020 7740 7200

Unison West Midlands
24 Livery Street, Birmingham, B3 2PA
Tel: 0845 355 0845
Email: westmidlands@unison.co.uk

Unite (West Midlands Region)
Transport House, 9-17 Victoria Street, West Bromwich, B70 8HX
Tel: 0121 553 6051

Whistleblowing Procedure for Staff
Flowchart – Internal Stages

Stage 1

If you are worried that something is wrong, or have witnessed an unreported dangerous situation at work, for example you notice a health and safety risk, a malpractice by a colleague, a fraudulent activity being undertaken, or note a wrongdoing has occurred within your working environment then please proceed to stage 2 of this whistleblowing procedure

↓

Stage 2

In the first instance - raise your concern with your line manager or lead clinician – either verbally, in writing, or via the dedicated email address. To submit a concern please access the Trust intranet site and click on the electronic whistleblowing form to submit your concerns to the following email address:

SWBH-GM-Whistleblowing.nhs.uk

Before submitting your concern please take some time to think about some solutions that could be put forward which will support us to resolve these concerns at a local level.

Remember you can seek guidance from the Trust's Governance Department, HR Department, or your staff side representative should you have any queries about this process.

↓

Stage 3

Once concerns are registered they will be assessed, and appropriate action will be taken to review the concerns raised (e.g informal review, internal inquiry, or more formal investigation).

OR

Alternatively you may be directed to the relevant policy to take forward your concerns e.g Grievance policy, Dignity at Work policy if your concerns are related to employment matters, or if appropriate a referral may be made to the Local Counter Fraud Team if your concerns relate directly to potential fraudulent activity.

↓

Stage 4

If initial stages do not resolve the matter, or if this stage is deemed inappropriate, concerns should be raised to a senior manager within your Divisional Management Team structure. You will be asked at this stage if you wish for your identity to be disclosed. Alternatively your concern may be raised anonymously (see section 6.4 of the policy).

↓

Stage 5

A designated manager will be assigned, who may wish to conduct an interview with you or assess appropriate action (e.g informal review, internal inquiry or formal investigation). The aim will be to provide feedback or resolution at each stage. Depending on the complexity and level of information provided may have an impact on the time line to resolve cases.

IF IN DOUBT – RAISE IT

Whistleblowing Procedure for Managers
Flowchart – Internal Stages

Stage 1

When a Whistleblowing concern is raised to you by a staff member:
Register the concern centrally using the electronic Whistleblowing Concerns Form which is available on the intranet and can be submitted directly to the dedicated email address which is:
SWBH-GM-Whistleblowing.nhs.uk

Note: If a member of Medical Staff raises a concern about a colleague they have a duty under their GMC registration to raise this in the first instance with the Medical Director.

↓

Stage 2

Make contact with the employee raising concerns as soon as reasonably practicable to ensure appropriate supportive measures (if appropriate) are in place.

Undertake an initial assessment of the issues and within ten working days, acknowledge receipt and confirm the date when you will be able to provide a formal response.
(It is anticipated that this will normally be within four weeks, but more complex cases may take longer).

Note: For concerns raised that are in respect of potential fraudulent activity these need to be escalated to the Trust's Local Counter Fraud Team, and Safeguarding matters need to be referred to the Trust's Safeguarding Policy/Leads as appropriate.

Remember you can seek guidance from the Trust's Governance Department, or HR Department should you have any queries about this process.

↓

Stage 3

Write to the employee to confirm the outcome of the investigatory enquries within the deadline previously confirmed.

Send a copy of the original whistleblowing notication and outcome report to the Trust's Designated Non-Executive Director for Whistleblowing for recording and monitoring purposes.

Ensure that all identified actions are undertaken or escalate the report and associated recommendations to the relevant Trust manager.

Guidance on Information Required when Raising a Concern under the Whistleblowing Policy and Procedure

Checklist

To assist us in assessing or investigating your concerns, it would be helpful if you could be as clear as possible with the details. As a minimum we need to understand the following:

□ Date(s) of incident(s)

□ Type of incident (see appendix 1 – further information sources for guidance)

Is the type of incident by its nature a protected disclosure by reason of it alleging:

- Criminal offences or a failure to comply with legal obligations
- Fraud, Corruption or malpractice
- Miscarriages of justice
- Dangers to health and safety
- Damage to the environment
- Any attempt to deliberately conceal any of the above

Identify if the concern relates to:

- An act or omission that took place in the past
- Improper conduct occurring in the present, or
- The prospect of likelihood of an act or omission occurring in the future

□ Description of incident(s)/details of concerns

□ Where did it happen?

□ Who has been involved?

□ If possible, explain how you think the matter may be best resolved or start thinking about it in preparation for any meetings you may be required to attend (if you have shared your identity)

If you feel comfortable sharing your identity then please provide us with your name, your work location and contact details

Appendix 4

MANAGERS GUIDE TO WHISTLEBLOWING

Sandwell and West Birmingham Hospitals NHS
NHS Trust

October 2012

For the attention of all Trust Managers

Dear *colleague*

Re: Sandwell and West Birmingham Hospitals NHS Trust's Manager Guide to handling whistleblowing concerns

Sandwell and West Birmingham Hospitals NHS Trust is committed to dealing responsibly, openly and professionally with any genuine concern you or a member of your team may have about wrongdoing, malpractice or a safety risk within the workplace which has the potential to affect you, team members and colleagues, or patients attending Sandwell and West Birmingham NHS Trust itself.

We cannot do this without your help. The simple fact is that in many cases you or another member of your team may suspect something is going wrong long before we *[the Trust Board]* find out about it. The sooner we know, the better we are able to prevent an accident or serious incident occurring.

If something at work is troubling you or a team member, please tell us. While we hope you and your team will feel able to raise such a matter, we recognise that another contact point may be preferred. Alternatively you or a team member may welcome the chance to discuss concerns with someone in confidence first.

For this reason we have *revised* our whistleblowing policy, a copy of the policy can be located on the SWBH intranet site for your reference. The policy has been drawn up in consultation with staff and local trade unions and follows the guidance developed by the Social Partnership Forum an independent whistleblowing charity, Public Concern at Work. The policy commits us to ensuring that staff will suffer no detriment by the Trust as a result of raising a concern about malpractice or wrongdoing at work, even if the concern later proves to be wrong or unfounded. If you or a member of your team wishes to raise a concern in confidence, the policy explains how you can do this.

I do ask you to take a few minutes to read the policy on the intranet. If you are worried about raising a concern about a risk, wrongdoing or malpractice, you can also seek advice from your Union or from Public Concern at Work on 020 7404 6609.

If you are unclear about any aspect of the policy and our arrangements, please feel free to speak with one of the people listed within the policy.

Yours sincerely

Chair/Chief Executive

A Managers Guide to Whistleblowing

This working guide has been developed to help Managers to follow best practice guidelines when reviewing, and handling whistleblowing concerns.

The information provided in this guide follows the guidance produced by the © NHS Social Partnership Forum (inclusive NHS Employers, NHS trade unions and the Department of Health) & Public Concern at Work (independent whistleblowing charity).

Introduction

It is vital that staff in the NHS feel empowered and expected to speak up whenever patient safety may be compromised or errors occur.

The Public Interest Disclosure Act gives employees protection under the law to raise any concern they may have with their employer, whether it is about patient safety, financial malpractice or any other risk.

This guide also supports the NHS Constitution, which incorporates the right of all staff who report wrongdoing to be protected.

To enhance public confidence in the safety and quality of the care they receive, it is important that staff understand the ways through which they can raise a concern.

Specifically this guide explains why whistleblowing matters, what is expected of NHS boards and their executives, and the support you can expect from the Department of Health and Public Concern at Work when raising concerns.

Why does whistleblowing matter?

Over the years there have been a number of high-profile cases involving tragic incidents that have taken place both in, and outside the NHS.

For example extensive inquiries into the baby heart unit at Bristol Royal Infirmary and into the extraordinary behaviour of the GP Dr Harold Shipman raised questions about the protection provided to whistleblowers within the health service.

Investigations into these and other incidents revealed that in some cases staff had concerns about what was happening but were unsure whether or how to raise them, or had raised the issue only to be ignored. In many of those cases the consequences were devastating for patients, families, staff and the organisation itself. This is why getting whistleblowing in healthcare right is vital.

Encouraging staff to raise concerns they may have about malpractice or serious risk as early as possible is essential, and responding appropriately, is integral to achieving this.

Importantly, it will help the Trust to deal with a problem before any damage is ever done.

It is essential that within the Trust, no matter how busy we are that all staff work together to establish the trust and confidence of patients and of one another.

As an organisation we want to encourage a culture to raise concerns as otherwise there is a danger that poor practice will go unchallenged. No-one wants a culture where problems are exposed by secret filming or by endless public inquiries. Whistleblowing is a straightforward

and practical governance tool. It is not a substitute for good risk management, but getting it right reaps benefits beyond simply detecting malpractice. Importantly, whistleblowing deters wrongdoing and raises the bar on standards and quality.

This simple Guide is designed to enhance and improve existing whistleblowing arrangements with a view to give you the confidence and ability to demonstrate to your patients, staff and other stakeholders that high standards of clinical care and governance are at the heart of your daily work.

The Law

The Public Interest Disclosure Act (PIDA) protects the public by providing a remedy for individuals who suffer a detriment by any act or any deliberate failure to act by their employer for raising a genuine concern, whether it be a risk to patients, financial malpractice, or other wrongdoing. The Act's tiered disclosure regime promotes internal and regulatory disclosures, and encourages workplace accountability and self-regulation. Essentially, under PIDA, workers who act honestly and reasonably are given automatic protection for raising a matter internally.

In the NHS an internal disclosure can go up to the highest level and includes going to the responsible Minister at the Department of Health. Protection is also readily available to individuals who make disclosures to prescribed regulators (such as the Care Quality Commission and Monitor).

In certain circumstances, wider disclosures (for example to an MP or the media) may also be protected. A number of additional tests apply when going wider, including:

- Whether it is an exceptionally serious concern
- Whether the matter has already been raised
- Whether there is good reason to believe that the individual will be subject to a detriment by his employer if the matter were raised internally or with the appropriate regulator
- Whether disclosure was reasonable given all the circumstances.

The Act covers all workers including temporary agency staff, persons on training courses and self-employed staff who are working for and supervised by the NHS. It does not cover volunteers.

PIDA also makes it clear that any clause in a contract that prevents an individual from raising a concern that would have been protected under the Act is void.

MANAGERS RESPONSIBILITIES

As a manager it is important that you promote to staff:

- The Whistleblowing Policy
- The value and importance of an open and accountable workplace
- How to handle concerns fairly and professionally
- How they will be protected if they were to raise a genuine concern, and where they can get help or refer a concern
- That confidentiality will be maintained but also carefully manage their expectations about the concerns they are raising
- The options for them as an alternative to line management when raising concerns if the usual channels of communication are inappropriate.

Practical tips for managers when handling whistleblowing concerns

As a manager you can lead by example. Be clear to your staff what sort of behaviour is unacceptable and be a role model to your team. Encourage staff to ask you what is appropriate if they are unsure before – not after – the event. If you find wrongdoing or a potential risk to patient safety, take it seriously and deal with it immediately.

Responding to a concern

• Thank the staff member for telling you, even if they may appear to be mistaken.
• Manage expectations and respect promises of confidentiality.
• Discuss reasonable timeframes for feedback with the member of staff.
• Remember there are different perspectives to every story.
• Determine whether there are grounds for concern and investigate if necessary as soon as possible. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help.

Put your response in writing.

• Always remember that you may have to explain how you have handled the concern.
• Feedback any outcome and/or remedial action you propose to take to the whistleblower but be careful if this could infringe any rights or duties you may owe to other parties.
• Record-keeping – forward a copy of the original concern and a copy of your response to the designated non-executive director for whistleblowing.

Frequently Asked Questions (FAQ's)

What's the difference between a grievance and a whistleblowing concern?

Generally speaking, a whistleblowing concern is about a risk, malpractice or wrongdoing that affects others. It could be something which adversely affects patients, the public, other staff or the organisation itself. A grievance, on the other hand, is a personal complaint about an individual's own employment situation: for example, a staff member may feel aggrieved if they think a management decision has affected them unfairly or that they are not being treated properly. A whistleblowing concern is where an individual raises information as a witness whereas a grievance is where the individual is a complainant.

Open, confidential, anonymous?

Usually, the best way to raise a concern is to do so openly. Openness makes it easier for the Trust to assess the issue, work out how to investigate the matter, understand any motive and get more information. An employee raises a concern confidentially if he or she gives his or her name on the condition that it is not revealed without their consent. An employee raises a concern anonymously if he or she does not give his or her name at all. If this happens, it is best for the Trust to assess the anonymous information as best it can, to establish whether there is substance to the concern and whether it can be addressed. Clearly if no-one knows who provided the information, it is not possible to reassure, protect, or respond to them.

What if the whistleblower has an ulterior motive?

There may be occasions when you are worried that someone has raised a concern with an ulterior motive or, more rarely, maliciously. The Trust's Whistleblowing Policy makes it clear that the Trust cannot give the same assurances and safeguards included in the policy to

someone who is found to have *maliciously* raised a concern that they also *know to be untrue*. Such situations should be handled carefully. The starting point for a Manager is to look at the concern and examine whether there is any substance to it. Every concern raised should be treated as made in good faith, unless it is subsequently found not to be. However, if it is found that the individual has maliciously raised a concern that they know is untrue, disciplinary proceedings may be commenced against that individual.

Case studies

The following case studies give Managers some examples of the types of concerns that may be regarded as whistleblowing matters.

Case study 1: Dealing with a 'flu outbreak

Due to a 'flu outbreak, the number of cleaners in a hospital block with four wards is down 50 per cent one evening. The supervisor of the contract company says that no help is available so they would just have to do their best, but she will get some cover the following evening. The next night, the situation is the same. Two of the cleaners, Harriet and Gordon, say they are not happy about working like this, as it is impossible to keep the ward clean, and they have asked to meet the ward sister that evening with a list of work not done the previous evening. The manager tells the supervisor to let them know that they could be disciplined if they do that.

Question for you to consider – As Managers what do you think Harriet and Gordon should do?

Harriet and Gordon then raised this with their union representative. They were advised to fill in an incident form, which would be forwarded on to the trust's directorates of facilities and risk management.

After this was done, the director of facilities discussed the issues raised with the contract company and as a result the company increased the number of cleaners employed, so as to ensure they had adequate cover for sickness absence.

Case study 2: Qualified to cover?

Ijaz, a newly qualified nurse, was working on a 28-bedded acute medical ward. The first two weeks went well and he had lots of support and development. However, in week three he was left in charge for five days. This was his first time in charge and for two days things went OK. However, after day three the ward got busier and he struggled to cope with staff shortages. Ijaz spoke to the ward manager who said it was a good way for him to learn, and that she, the ward manager, had been thrown in at the deep end when she first qualified. Ijaz decided to carry on but remained unhappy and worried. On day five an elderly patient fell from bed and other things went wrong. He contacted the matron, who said there was nothing she could do as they had reduced staffing levels elsewhere.

Question to consider – As a Managers what do you think Ijaz should do?

Rather than leave this, Ijaz contacted his local trade union representative, who went through his options. He had acted entirely correctly to record his concerns both with the ward manager and matron. Ijaz was also right in recognising his limitations. Not only was he newly qualified, but even an experienced nurse would have struggled to cope in such a situation. Both the ward manager and matron had failed to discharge their professional duties. They should have thoroughly investigated the concerns of the nurse and if they found these to be justified, done everything possible to provide additional staffing and the nurse in question with the appropriate supervision. Their union then took the matter up with senior management, who, following a

brief investigation, agreed to transfer staff from another ward, and to employ additional bank staff.

Case study 3: Flushing it out

Derek was a senior care coordinator in a care home for the elderly. Derek was on duty one day when he found that the carers had forgotten to give some residents their medication, which included tablets for water retention, blood pressure and some heart medication. Derek immediately told the home's manager what had happened. The home's manager took the unused medication and flushed it down the toilet.

Question to consider – As a Manager what do you think Derek should do?

Derek came across another incident where medication was missed and was unsure what to do.

After considering his options, Derek decided to contact the head office to tell them what he had witnessed. The matter was investigated and the home's manager was taken through a disciplinary process. Derek then contacted PCaW because he was worried about being revealed as the whistleblower.

Question to consider – As a Manager what assurances may be given to Derek?

The adviser at PCaW worked through the situation with Derek. As Derek was the sole witness of the manager's actions, it was more than likely the manager would work out that Derek was the source of the concern. PCaW advised Derek to be open with head office and explain his anxieties to them, particularly as they were taking the concern seriously. PCaW reassured Derek that he could ring back if he had any questions or concerns. A couple of months later Derek advised PCaW that the concern had been resolved. He had followed the advice and when he spoke to head office, they had taken his worries about confidentiality seriously and found another way to deal with the situation. Derek was still at the same home. He was relieved no-one had been fired; the manager was still in post but there has been a change in the medicine protocols and in the culture at the home.

Case study 4: A private matter?

Sheila was a paramedic and team leader in an ambulance service. Sheila's trust had contracted out part of the ambulance service to a private company.

Sheila was concerned about staff from the private company who were not properly trained, did not have the required paramedic registration numbers, did not sign in (so there was no way of tracing who had done what job), and had made incorrect diagnoses. On one occasion a team had failed to initially diagnose stroke symptoms and left: another ambulance had to be called out later. Sheila raised her concern with her manager who told her to report it to the local clinical standards team, which she did. She was told it would be looked into further. Sheila then received a call from two directors in the trust who said the matter should be kept internal as it was being investigated by the HR director. This made Sheila uneasy and she was worried that her concerns would not be investigated properly.

Question for you to consider – As a Manager what do you think Sheila should do?

Sheila contacted PCaW and was reassured that she had done the right thing and it would be best to give the trust a chance to look into the matter. PCaW pointed out that to get a response at director level is an achievement and a sign that the issue was being taken seriously. PCaW suggested Sheila see what response she gets – thank the trust for handling the issue and if possible suggest ways forward.

Sheila contacted PCaW again to say that she had met one of the directors who had asked her to be seconded to head office to work alongside them in addressing the issue. Sheila was still unhappy that no interim measures had been put in place to deal with the issue and was frustrated that things were not moving fast enough. PCaW pointed out that when Sheila was stationed at head office she would be better placed to influence what happens.

Sheila later contacted PCaW to say that the private company were no longer going to be used by the trust.

Appendix 5

A STAFF GUIDE TO RAISING WHISTLEBLOWING CONCERNS

Sandwell and West Birmingham Hospitals NHS
NHS Trust

October 2012

For the attention of all staff members

Dear *colleague/name*

Re: Sandwell and West Birmingham Hospitals NHS Trust's Employee Guide to raising whistleblowing concerns

Sandwell and West Birmingham Hospitals NHS Trust is committed to dealing responsibly, openly and professionally with any genuine concern you may have about wrongdoing, malpractice or a safety risk in the workplace affecting you, colleagues, patients or Sandwell and West Birmingham NHS Trust itself.

We cannot do this without your help. The simple fact is that in many cases you or another member of your team may suspect something is going wrong long before we *[the Trust board]* find out about it. The sooner we know, the better we are able to prevent an accident or serious incident occurring.

If something at work is troubling you, please tell us. While we hope you will feel able to raise such a matter with your line manager, we recognise that you may prefer another contact point, or would welcome the chance to discuss your concern with someone in confidence first. For this reason we have *revised* our whistleblowing policy, a copy of which can be located on the SWBH intranet site for your reference. The policy has been drawn up in consultation with staff and local trade unions following the guidance developed by the Social Partnership Forum and the independent whistleblowing charity, Public Concern at Work. It commits the Trust to ensuring that you will suffer no detriment from your employer as a result of honestly raising a genuine concern about malpractice or wrongdoing at work, even if your concern later proves to be wrong or unfounded. If you wish to raise a concern in confidence, the policy explains practically how you can do this.

I do ask you to take a few minutes to read the policy on the intranet. If you are worried about how to raise a concern about a risk, wrongdoing or malpractice, you can also seek advice from your union or from Public Concern at Work on 020 7404 6609.

If you are unclear about any aspect of the policy and our arrangements, please feel free to speak with one of the people listed within the policy.

Yours sincerely

Chair/Chief Executive

A Staff Guide on how to raise whistleblowing concerns within Sandwell & West Birmingham Hospitals NHS Trust

This guide has been developed to help staff to follow best practice guidelines when raising, or considering raising whistleblowing concerns.

The information provided in this guide follows the guidance produced by the © NHS Social Partnership Forum (inclusive NHS Employers, NHS trade unions and the Department of Health) & Public Concern at Work (independent whistleblowing charity).

Introduction
It is vital that you feel empowered to speak up whenever patient safety may be compromised or errors occur.

The Public Interest Disclosure Act gives you protection under the law to raise any concern you may have with the Trust, whether it is about patient safety, financial malpractice or any other risk.

This guide also supports the NHS Constitution, which incorporates the right of all staff who report wrongdoing to be protected.

To enhance public confidence in the safety and quality of the care they receive, it is important that you understand the ways through which you can raise a concern.

Specifically this guide explains why whistleblowing matters, what is expected of NHS boards and their executives, and the support you can expect from the Department of Health, and Public Concern at Work when raising concerns.

Why does whistleblowing matter?

Over the years there have been a number of high-profile cases involving tragic incidents that have taken place both in, and outside the NHS.

For example extensive inquiries into the baby heart unit at Bristol Royal Infirmary and into the extraordinary behaviour of the GP Dr Harold Shipman raised questions about the protection provided to whistleblowers within the health service.

Investigations into these and other incidents revealed that in some cases staff had concerns about what was happening but were unsure whether or how to raise them, or had raised the issue only to be ignored. In many of those cases the consequences were devastating for patients, families, staff and the organisation itself. This is why getting whistleblowing in healthcare right is vital.

Encouraging you to raise concerns you may have about malpractice or serious risk as early as possible is essential, and responding appropriately, is integral to achieving this.

Importantly, it will help the Trust to deal with a problem before any damage is ever done.

It is essential that within the Trust, no matter how busy we all are that we all work together to establish the trust and confidence of patients and of one another.

As an organisation we want to encourage a culture where you feel comfortable to raise concerns as otherwise there is a danger that poor practice will go unchallenged. No-one wants a culture where problems are exposed by secret filming or by endless public inquiries. Importantly, whistleblowing deters wrongdoing and raises the bar on standards and quality.

This simple guide is designed to enhance and improve existing whistleblowing arrangements with a view to give you the confidence and ability to demonstrate to your patients that high standards of clinical care and governance are at the heart of your daily work.

The Law

The Public Interest Disclosure Act (PIDA) protects the public by providing a remedy for individuals who suffer a detriment by any act or any deliberate failure to act by their employer for raising a genuine concern, whether it be a risk to patients, financial malpractice, or other wrongdoing. The Act's tiered disclosure regime promotes internal and regulatory disclosures, and encourages workplace accountability and self-regulation. Essentially, under PIDA, workers who act honestly and reasonably are given automatic protection for raising a matter internally.

In the NHS an internal disclosure can go up to the highest level and includes going to the responsible Minister at the Department of Health. Protection is also readily available to individuals who make disclosures to prescribed regulators (such as the Care Quality Commission and Monitor).

In certain circumstances, wider disclosures (for example to an MP or the media) may also be protected. A number of additional tests apply when going wider, including:

- Whether it is an exceptionally serious concern
- Whether the matter has already been raised
- Whether there is good reason to believe that the individual will be subject to a detriment by his employer if the matter were raised internally or with the appropriate regulator
- Whether disclosure was reasonable given all the circumstances.

The Act covers all workers including temporary agency staff, persons on training courses and self-employed staff who are working for and supervised by the NHS. It does not cover volunteers.

PIDA also makes it clear that any clause in a contract that prevents an individual from raising a concern that would have been protected under the Act is void.

Frequently Asked Questions (FAQ's)

What's the difference between a grievance and a whistleblowing concern?

Generally speaking, a whistleblowing concern is about a risk, malpractice or wrongdoing that affects others. It could be something which adversely affects patients, the public, other staff or the organisation itself. A grievance, on the other hand, is a personal complaint about an individual's own employment situation: for example, a staff member may feel aggrieved if they think a management decision has affected them unfairly or that they are not being treated

properly. A whistleblowing concern is where an individual raises information as a witness whereas a grievance is where the individual is a complainant.

Open, confidential, anonymous?

Usually, the best way to raise a concern is to do so openly. Openness makes it easier for the Trust to assess the issue, work out how to investigate the matter, understand any motive and get more information. You can raise a concern confidentially if you give your name on the condition that it is not revealed without your consent. You can raise a concern anonymously you do not give your name at all. If this happens, it is best for the Trust to assess the anonymous information as best it can, to establish whether there is substance to the concern and whether it can be addressed. Clearly if no-one knows who provided the information, it is not possible to reassure, protect, or respond to you.

Example case studies

The following case studies give examples of the types of concerns that may be regarded as whistleblowing concerns.

Case study 1: Dealing with a 'flu outbreak

Due to a 'flu outbreak, the number of cleaners in a hospital block with four wards is down 50 per cent one evening. The supervisor of the contract company says that no help is available so they would just have to do their best, but she will get some cover the following evening. The next night, the situation is the same. Two of the cleaners, Harriet and Gordon, say they are not happy about working like this, as it is impossible to keep the ward clean, and they have asked to meet the ward sister that evening with a list of work not done the previous evening. The manager tells the supervisor to let them know that they could be disciplined if they do that.

Harriet and Gordon then raised this with their union representative. They were advised to fill in an incident form, which would be forwarded on to the trust's directorates of facilities and risk management.

After this was done, the director of facilities discussed the issues raised with the contract company and as a result the company increased the number of cleaners employed, so as to ensure they had adequate cover for sickness absence.

Case study 2: Qualified to cover?

Ijaz, a newly qualified nurse, was working on a 28-bedded acute medical ward. The first two weeks went well and he had lots of support and development. However, in week three he was left in charge for five days. This was his first time in charge and for two days things went OK. However, after day three the ward got busier and he struggled to cope with staff shortages. Ijaz spoke to the ward manager who said it was a good way for him to learn, and that she, the ward manager, had been thrown in at the deep end when she first qualified. Ijaz decided to carry on but remained unhappy and worried. On day five an elderly patient fell from bed and other things went wrong. He contacted the matron, who said there was nothing she could do as they had reduced staffing levels elsewhere.

Rather than leave this, Ijaz contacted his local trade union representative, who went through his options. He had acted entirely correctly to record his concerns both with the ward manager and matron. Ijaz was also right in recognising his limitations. Not only was he newly qualified, but even an experienced nurse would have struggled to cope in such a situation. Both the ward manager and matron had failed to discharge their professional duties. They should have thoroughly investigated the concerns of the nurse and if they found these to be justified, done

everything possible to provide additional staffing and the nurse in question with the appropriate supervision. Their union then took the matter up with senior management, who, following a brief investigation, agreed to transfer staff from another ward, and to employ additional bank staff.

Case study 3: Flushing it out

Derek was a senior care coordinator in a care home for the elderly. Derek was on duty one day when he found that the carers had forgotten to give some residents their medication, which included tablets for water retention, blood pressure and some heart medication. Derek immediately told the home's manager what had happened. The home's manager took the unused medication and flushed it down the toilet.

Derek came across another incident where medication was missed and was unsure what to do.

After considering his options, Derek decided to contact the head office to tell them what he had witnessed. The matter was investigated and the home's manager was taken through a disciplinary process. Derek then contacted PCaW because he was worried about being revealed as the whistleblower.

The adviser at PCaW worked through the situation with Derek. As Derek was the sole witness of the manager's actions, it was more than likely the manager would work out that Derek was the source of the concern. PCaW advised Derek to be open with head office and explain his anxieties to them, particularly as they were taking the concern seriously. PCaW reassured Derek that he could ring back if he had any questions or concerns. A couple of months later Derek advised PCaW that the concern had been resolved. He had followed the advice and when he spoke to head office, they had taken his worries about confidentiality seriously and found another way to deal with the situation. Derek was still at the same home. He was relieved no-one had been fired; the manager was still in post but there has been a change in the medicine protocols and in the culture at the home.

Case study 4: A private matter?

Sheila was a paramedic and team leader in an ambulance service. Sheila's trust had contracted out part of the ambulance service to a private company.

Sheila was concerned about staff from the private company who were not properly trained, did not have the required paramedic registration numbers, did not sign in (so there was no way of tracing who had done what job), and had made incorrect diagnoses. On one occasion a team had failed to initially diagnose stroke symptoms and left: another ambulance had to be called out later. Sheila raised her concern with her manager who told her to report it to the local clinical standards team, which she did. She was told it would be looked into further. Sheila then received a call from two directors in the trust who said the matter should be kept internal as it was being investigated by the HR director. This made Sheila uneasy and she was worried that her concerns would not be investigated properly.

Sheila contacted PCaW and was reassured that she had done the right thing and it would be best to give the trust a chance to look into the matter. PCaW pointed out that to get a response at director level is an achievement and a sign that the issue was being taken seriously. PCaW suggested Sheila see what response she gets – thank the trust for handling the issue and if possible suggest ways forward.

Sheila contacted PCaW again to say that she had met one of the directors who had asked her to be seconded to head office to work alongside them in addressing the issue. Sheila was still

unhappy that no interim measures had been put in place to deal with the issue and was frustrated that things were not moving fast enough. PCaW pointed out that when Sheila was stationed at head office she would be better placed to influence what happens.

Sheila later contacted PCaW to say that the private company were no longer going to be used by the trust.

The Trust's commitment to you

Your safety

The board and the chief executive and the unions are committed to the Whistleblowing policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). Provided you are acting in good faith (effectively this means honestly), it does not matter if you are mistaken or if there is an innocent explanation for your concerns. So please do not think we will ask you to prove it. Of course we do not extend this assurance to someone who maliciously raises a matter they know is untrue.

Your confidence

With these assurances, we hope you will raise your concern openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, please say so at the outset. If you ask us not to disclose your identity, we will not do so without your consent unless required by law. You should understand that there may be times when we are unable to resolve a concern without revealing your identity, for example where your personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

Please remember that if you do not tell us who you are it will be much more difficult for us to look into the matter. We will not be able to protect your position or to give you feedback.

Accordingly you should not assume we can provide the assurances we offer in the same way if you report a concern anonymously.

How to raise a concern

If you are unsure about raising a concern at any stage you can get independent advice from your trade union representative or Public Concern at Work (see contact details under Independent advice below). Please remember that you do not need to have firm evidence before raising a concern. However, we do ask that you explain as fully as you can the information or circumstances that gave rise to your concern.

Stage 1, 2, 3

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager or lead clinician. This may be done verbally or in writing.

Stage 4

If you feel unable to raise the matter with your line manager or lead clinician, for whatever reason, please raise the matter with your Divisional Senior Management Team who can quickly be located by dialling "0" on the internal phone system via the IVOR telecommunications system.

Stage 5

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:
Chief Executive, Medical Director, Chief Operating Officer, Chief Nurse, or Deputy Director of Workforce as appropriate

Department of Health

Sandwell and West Birmingham Hospitals NHS Trust recognise its accountability within the NHS. In light of this you can also contact:

1. NHS Counter Fraud Line on **0800 028 40 60** (if your concern is about financial malpractice)

2. Department of Health
   Customer Service Centre
   Department of Health
   Richmond House,
   79 Whitehall
   London
   SW1A 2NS

   Or email to: **dhmail@dh.gsi.gov.uk**

   Or telephone to: 020 7210 4850

3. NHS Midlands and East (Strategic Health Authority) – postal address can be located from the website as appropriate.

How we will handle the matter

Once you have told us of your concern, we will assess it and consider what action may be appropriate. This may involve an informal review, an internal inquiry or a more formal investigation. We will tell you who will be handling the matter, how you can contact them, and what further assistance we may need from you. If you ask, we will write to you summarising your concern and setting out how we propose to handle it and provide a timeframe for feedback. If we have misunderstood the concern or there is any information missing, please let us know.

When you raise the concern it will be helpful to know how you think the matter might best be resolved. If you have any personal interest in the matter, we do ask that you tell us at the outset. If we think your concern falls more properly within our grievance, bullying and harassment or other relevant procedure, we will let you know.

Whenever possible, we will give you feedback on the outcome of any investigation. Please note, however, that we may not be able to tell you about the precise actions we take where this would infringe a duty of confidence we owe to another person. While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly and properly. By using this policy you will help us to achieve this.

Independent advice

If you are unsure whether to use this policy or you want confidential advice at any stage, you may contact your local Trade Union representative, or the independent whistleblowing charity Public Concern at Work (PCaW) on 020 7404 6609, or by email to: **helpline@pcaw.co.uk**.

Their lawyers can talk you through your options and help you raise a concern about malpractice or wrongdoing at work as appropriate.

External contacts

While we hope this policy gives you the reassurance you need to raise your concern internally with us, we recognise that there may be circumstances where you can properly report a concern to an outside body. In fact, we would rather you raised a matter with the appropriate regulator – such as the Care Quality Commission, the Independent Regulator of NHS Foundation Trusts (Monitor), the professional regulator, the Audit Commission or the National Patient Safety Agency – than not at all. Your union or Public Concern at Work will be able to advise you on such an option if you wish.

Monitoring oversight

The board/audit committee is responsible for this policy, and will review cases on an annual basis. The policy will be monitored on a frequent basis (daily/weekly) to review any new cases arising in conjunction with the incident reporting procedures in operation within the Trust.

Who we consulted

This policy has been drawn up in consultation with national best practise and in partnership through consultation arrangements with Trade Union representatives, and information from other professional associations including Public Concern at Work.

Additional information

Whistleblowing

If you are worried that something wrong or dangerous is happening at work, please don't keep it to yourself. Unless you tell us about any concerns you may have about fraud, safety risks including clinical safety, or other wrongdoing, the chances are we won't find out until it's too late. As some of you may be nervous about raising such matters, here are some tips:

- Raise it when it's a concern – we won't ask you to prove it
- Keep it in perspective – there may be an innocent explanation
- It will help us if you can say how you think things can be put right
- Stay calm – you're doing the right thing
- If for whatever reason you are worried about raising it with your manager, please follow the steps shown in the next column.

How to raise a concern about serious malpractice

1. We hope that you will feel able to tell your line manager.

2. If for whatever reason you are uneasy about this or your manager's response doesn't seem right, you can contact your local Trade Union Representatives for advice and guidance.

3. If you want to talk to them in confidence, just say so. If you prefer to put your concerns in writing, this is fine, but please tell us who you are so we can review your concerns further.

4. If you want confidential advice first, you can talk to your local trade union representative, and you may also want to call the independent whistleblowing charity Public Concern at Work on 020 7404 6609.

In Summary

If you have any concerns about the information contained within this working guide or would like to raise any questions about the policy please contact a member of the Workforce/HR department for further guidance.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Audit Letter
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	KPMG LLP
DATE OF MEETING:	25 October 2011

SUMMARY OF KEY POINTS:

The annual audit letter summarises the key issues arising from the work that the Trust's external auditors, KPMG LLP have carried out during 2011-12.

The letter highlights both areas of good performance and provides recommendations designed to help the Trust improve performance in coming years.

The scope of the audit covers use of resources and a review of the financial statements and the Trusts Annual Governance Statement. The audit opinion highlights that the published accounts present a true and fair view of the Trust's financial affairs and that the processes and procedures adopted in producing the accounts were sound.

The letter was presented to the Audit Committee for review on 13 September 12 and after review by the Trust Board will be published on the Trust's website.

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

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to NOTE the letter and key messages contained within

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Financial reporting – The Trust produces annual accounts in accordance with relevant standards and timetables, supported by comprehensive working papers

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

Financial	**X**	
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	**X**	Satisfies the statutory responsibilities and powers of the appointed auditors as set out in the Audit Commission Act 1998
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Audit Committee on 13 September 2012

KPMG

cutting through complexity™

Sandwell and West Birmingham Hospitals NHS Trust

Annual Audit Letter 2011/12

13 September 2012

Contents

The contacts at KPMG in connection with this report are:

Andrew Bostock
Director
KPMG LLP (UK)
Tel: 0121 335 2741
Andrew.Bostock@kpmg.co.uk

Sarah Ann Moore
Manager
KPMG LLP (UK)
Tel: 0121 232 3476
Sarah-Ann.Moore@kpmg.co.uk

Ben Stone
Assistant Manager
KPMG LLP (UK)
Tel: 0121 232 3579
Ben.Stone@kpmg.co.uk

Becky Donnelly
Assistant Manager
KPMG LLP (UK)
Tel: 0121 232 3694
Rebecca.Donnelly@kpmg.co.uk

This report is addressed to Sandwell and West Birmingham Hospitals NHS Trust(the Trust) and has been prepared for the sole use of the Trust. We take no responsibility to any member of staff acting in their individual capacities, or to third parties. The Audit Commission has issued a document entitled Statement of Responsibilities of Auditors and Audited Bodies. This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. We draw your attention to this document.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

If you have any concerns or are dissatisfied with any part of KPMG's work, in the first instance you should contact Andrew Bostock who is the engagement lead to the Trust or Trevor Rees, the national contact partner for all of KPMG's work with the Audit Commission. After this, if you are still dissatisfied with how your complaint has been handled you can access the Audit Commission's complaints procedure. You can contact the Complaints Unit by phone (0844 798 3131), by email (complaints@audit-commission.gov.uk), through the audit commission website (www.audit-commission.gov.uk/aboutus/contactus), by textphone/ minicom (020 7630 0421), or via post to Complaints Unit Manager, Audit Commission, Westward House, Lime Kiln Close, Stoke Gifford, Bristol, BS34 8SR.

Introduction

Background

This Annual Audit Letter (the letter) summarises the key issues arising from our 2011/12 audit at Sandwell and West Birmingham Hospitals NHS Trust (the Trust). Although this letter is addressed to the directors of the Trust, it is also intended to communicate these issues to key external stakeholders, including members of the public. It is the responsibility of the Trust to publish the letter on the Trust's website at http://www.swbh.nhs.uk

In this letter we highlight areas of good performance, and also provide recommendations to help the Trust improve performance. A summary of our key recommendations is provided in Appendix A. We have reported all of the issues in this letter to the Trust throughout the year, and a list of all reports we have issued is provided in Appendix B.

Scope of our audit

The statutory responsibilities and powers of appointed auditors are set out in the Audit Commission Act 1998. Our main responsibility is to carry out an audit that meets the requirements of the Audit Commission's Code of Audit Practice (the Code) which requires us to report on:

Use of Resources (UoR)	We conclude on the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources.
Financial Statements including the Annual Governance Statement	We provide an opinion on the Trust's accounts. That is whether we believe the accounts give a true and fair view of the financial affairs of the Trust and of the income and expenditure recorded during the year. We also confirm that the Trust has complied with the Department of Health requirements in the preparation of the Trust's Annual Governance Statement.

Fees

Our fee for the audit in 2011/12 was £171,361 plus VAT. We have also provided the audit of the Trust's Charitable Funds for a fee of £14,500, and the audit of the Quality Accounts for £12,500 plus VAT. These fees are in line with those highlighted within our audit plan and communicated to the Audit Committee throughout the year.

We have also completed the following pieces of work at the Trust during the year:

Redundancy calculations	Audit testing in respect of Trust's redundancy cost calculations from May 2012 to date. We are completing this work on a time and materials basis using the Audit Commission scale rates. Costs to date total £6,075 plus VAT. Final fee to be confirmed with the Director of Finance and Performance on completion of work.
Payment By Results (PbR)	Review of implementation of PBR data assurance recommendations raised in previous audits. The fee for this work was £5,135 plus VAT but was covered by the PCT and not charged to the Trust.

Headlines

Use of Resources	We concluded that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Our VfM opinion was informed by: • our structured risk based assessment of the Trust's general VfM arrangements; • follow up of our 2010/11 review of Quality and Efficiency Programme (QuEP) arrangements, the results of which were reported to you in our Interim Report in May 2012; • our follow up review of data quality and governance arrangements, and indicator testing, in respect of your Quality Account, for which a separate report was issued to you in June 2012; and • Our work in respect of reviewing the calculation of potential redundancy payments prior to Trust communication with the SHA.
Financial Statements including the Annual Governance Statement	We issued an unqualified opinion on the Trust's accounts on 7 June 2012. This means that we believe the accounts give a true and fair view of the financial affairs of the Trust and of the income and expenditure recorded during the year. We confirmed that the Trust had complied with regularity requirements that in all material respects its expenditure and income have been applied to the purposes intended by Parliament. We also confirmed that the Trust had complied with the Department of Health requirements in the preparation of the Trust's Annual Governance Statement. There were two unadjusted audit differences relating to the treatment of transformation funding from commissioners as provisions. Several minor presentational changes were made by management during the audit.
Recommendations	There were three new recommendations arising from our 2011/12 audit work, although none of these were high risk. These are summarised in Appendix A. The Trust has been effective at implementing agreed audit recommendations from prior years. Of the three recommendations we made in 2010/11, two have been fully implemented and one has been superseded.

Headlines (cont.)

Whole of Government Accounts	We issued an unqualified Group Audit Assurance Certificate to the National Audit Office regarding the Whole of Government accounts submission with two exceptions reported that were above the de minimis limit.
Quality Accounts	The Trust achieved a limited assurance opinion on compliance with the Quality Accounts. Detailed testing of three of the performance indicators included in the quality account highlighted eight recommendations. The three indicators tested were: • VTE assessments • Pressure ulcers • 62 day cancer waiting time referral (follow up of prior year recommendations) We raised six medium priority recommendations and two low priority recommendations arising from our work on the indicators and relevant systems and processes.
Public Interest Reporting	We have a responsibility to consider whether there is a need to issue a public interest report or whether there are any issues which require referral to the Secretary of State. We did not issue any public interest reports in the year.
PbR Data Assurance Follow up	This review followed up on the recommendations arising from: • Our review of year 2009/10 reference costs submission to the Department of Health. • The 2009/10 clinical coding audit of admitted patient core activity (inpatients audits). • The 2009/10 data quality review of outpatient data. The Trust has made satisfactory progress in the implementation of recommendations.

Appendix A

Key recommendations

Recommendations Raised in 2011/12

No.	Risk	Issue, impact and recommendation	Management response/responsible officer/due date
1	2	**Identification and classification of Deferred Income and Accruals** During our audit testing we have identified classification errors in relation to deferred income, accruals and provisions. The Trust should undertake an exercise as part of the closedown process to ensure that all intra-NHS balances that are outside the scope of the agreement of balances exercise are correctly classified. This should include understanding the purpose of the income received, when the associated expenditure is likely to be incurred and whether the Trust has a right to defer the income. An assessment should then be made on the correct treatment and presentation under IAS18 Revenue Recognition and IAS 37 Provisions. Where possible this treatment should be agreed by the counterparty to ensure consistency.	The Trust will build upon the work undertaken to prepare its 11/12 accounts ensuring that these recommendations are put in place so that all intra-NHS balances are correctly classified. A review will be undertaken prior to the interim audit in the final quarter of 12/13 and ahead of the accounts finalisation process. Due Date – February 2013, Responsible Officer – DoF&PM
2	3	**Long term provision of consultancy services** As part of our review of Consultancy costs accounted for as other operating expenditure, we noted payments totalling £138k,000 to one consultant over a 12 month period. There is a risk that self employed consultants could be deemed to be Trust employees by HMRC, rendering the Trust liable for tax and social security contributions for such individuals. Whilst a significant proportion of expenditure in this instance was offset by SHA income, the Trust must ensure that it adheres to fiscal and employment regulations for all staff when such arrangements are entered into. This is of particular importance where a consultant is being paid through their own company, rather than as an individual, as appropriate Social Security payments may not be being made.	The specific case referred to in the recommendations will be reviewed to ensure that any self-employed status is warranted and where this is not the case that changes are made to ensure compliance. A more general review will be undertaken into any other similar arrangements that may require testing and follow-up actions by the responsible managers in those areas. **Specific Case** – Due Date – November 2012, Responsible Officer – DoF& PM supported by Medical Director **General Review** – Due Date – November 2012, Responsible Officer - DoF&PM
3	3	**Formalisation of subletting arrangements** During audit testing performed over fixed assets, it was noted that there is no formal agreement in place for a property sublet from Sandwell PCT. The lease payments of £75,000 were inconsequential in the context of the Trust"s accounts but we note that but no contract or agreement on fee could be provided as audit evidence. The Trust should ensure that formal contracts are drawn up for such arrangements, to protect both the lessee and lessor in case of dispute.	A formal lease is in place, signed as a deed by the PCT. The Trust has countered signed and sealed the document and we await its return from the Landlord's solicitors. This item is complete save for receipt of the final contract which has the seals of both organisations affixed to it. Due Date – September 2012, Responsible Officer – Director of Estates

Key:

High Risk 1 *Medium Risk* 2 *Low Risk* 3

Appendix B

Summary of reports issued

2012

January

February

March

April

May

June

July

August

September

October

November

December

Refreshed Audit Plan (January 2012)	The Audit Plan set out our approach to the audit of the Trust's Use of Resources and Financial Statements (including the Governance Statement).
Audit Report (June 2012)	The Audit Report provides our audit opinion for the year, the Value for Money conclusion, and our Audit Certificate.
Audit Highlights Memorandum (June 2012)	The Audit Highlights Memorandum provides details of the results of our audit for 2011/12 including key issues and recommendations raised as a result of our observations. We also provided the mandatory ISA260 declarations as part of this report.
Annual Audit Letter (September 2012)	This Annual Audit Letter provides a summary of the results of our audit for 2011/12.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Staff Health and Well-being Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Overfield, Chief Nurse (Exec Lead for Workforce)**
AUTHOR:	**Tamsin Radford, Occupational Health Physician**
DATE OF MEETING:	**25 October 2012**

EXECUTIVE SUMMARY:

Sandwell and West Birmingham Hospitals NHS Trust has made good progress with a high level of staff health and wellbeing activity. Trust Staff Health and Wellbeing Services are centred on prevention of both work related and lifestyle ill health issues.

The appointment of the health and Wellbeing facilitator in November 2010 has been the key to development in this area. The Trust has continued to invest in a nationally accredited Occupational Health and Wellbeing service which supports all the health and wellbeing and sickness absence initiatives.

Partnership working with local authorities and charities has enabled a wide range of low or no cost activities and initiatives to be completed. All strategic action plans and aims are undertaken with consultation and partnership working from staff side representatives. Since 2012 Equality and Diversity monitoring is also undertaken.

Quarterly health topics are agreed based on feedback and local and workforce needs assessment and themed initiatives implemented, attached to SMART objectives to assess effectiveness. Topics covered so far in 2012 include “the aging workforce”, “mental health” and “obesity”

.

Results:

- The 2010 National Staff Survey, Health and Wellbeing related questions scored fairly with an average of 20% - this increased to >70% in the 2011 National Staff Survey, along with a drop in work related stress by 20%.

- Sandwell and West Birmingham Trust have been approached by NHS Employers to be used as a “gold standard” example of best practice on its website and associated hub. It will be featured in the Nursing Care and Quality Forum for improvements made within staff health and wellbeing.

- Trust sickness absence levels have maintained a consistent downward trend up until May 2012. It is hoped that the adverse trend since May 2012 is short-term and is the result of the scale of organisational change within the organisation.

REPORT RECOMMENDATION:

The Trust Board is asked to support the on-going investment in health and well-being services and **receive** and **note** this update 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		Patient Experience	
Clinical	**x**	Equality and Diversity		Workforce	x

Comments: Health and Well-being supports a reduction in sickness absence and consequently, both improvements in quality and reduction in sickness absence costs.

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

Trust objective to reduce sickness absence levels.

PREVIOUS CONSIDERATION:

March 2012.

STAFF HEALTH AND WELL-BEING

Trust Board Update – October 2012

1. Introduction

The purpose of this paper is to inform the Trust Board of the actions taken and the progress made in implementing the Staff Health and Well-Being Action Plan. This will include an overview of the work being undertaken with regards to reducing levels of sickness absence.

2. Background

The staff health and well-being strategy aims to team effective sickness absence management with sickness prevention via health and wellbeing promotion and education for all staff. It is an integral part of the Trust's workforce strategy, supports the Trust's wider organization development and compliments the Trust's wider operational plans to develop a high quality and engaged workforce with high levels of attendance.

It aims to ensure that Boorman's recommendations and NICE guidelines are incorporated into the organizational strategies and implemented within the health and Wellbeing action plan. Sickness absence management was transferred to the Health and Wellbeing Committee in September 2011.

The Staff Health and Well-Being Committee is responsible for overseeing the implementation and action plan and reports to the Trust Governance Board through the Trust's Workforce Efficiency Group. All health and wellbeing activity within the Trust is monitored and evaluated via a monthly dashboard report and regular progress reports are provided to the Trust Management Board.

The Chief Nurse (Executive Lead for Workforce) is the Board level champion and the Trust Board has requested a regular update on progress with regards to improving staff health and well-being twice a year. This is the second report and updates on actions / progress from November.

3. Progress to date

Health and Wellbeing

i) Overview

- Sandwell and West Birmingham Trust has made good progress with a high level of staff health and wellbeing activity. Trust Staff Health and Wellbeing Services are centred on prevention of both work related and lifestyle ill health issues.

- The appointment of the health and Wellbeing facilitator in November 2010 has been the key to development in this area. The Trust has continued to invest in a nationally accredited Occupational Health and Wellbeing service which supports all the health and wellbeing and sickness absence initiatives.

- Partnership working with local authorities and charities has enabled a wide range of low or no cost activities and initiatives to be completed. All strategic action plans and aims are

undertaken with consultation and partnership working from staff side representatives. Since 2012 Equality and Diversity monitoring is also undertaken.

- Since the start of 2012, quarterly health topics are agreed based on feedback and local and workforce needs assessment and themed initiatives implemented, attached to SMART objectives to assess effectiveness. Topics covered so far in 2012 include "the aging workforce", "mental health" and "obesity" The sections below provide highlights of activities undertaken.

ii) Mental health initiatives

- In September 2011 the Trust committed to the 'Mindful Employer Scheme' which supports employers in recruiting and retaining staff with mental ill –health problems. More recent developments have seen a briefing sheet for all staff to support employees with stress, anxiety and depression. This compliments ongoing workshops on stress management which are popular with staff.

- The BDMA counselling service has continued and has shown an increase in the number of staff accessing the service in line with greater awareness of the service.

- Staff feedback also highlighted anxiety associated with financial difficulties. Therefore a series of 'Money Management' seminars and Retirement seminars have been attended to full capacity.

- The continued development of the 'Holistic Therapy Service' since November 2011 now allows a comprehensive service to be offered on all three main sites.

iii) Physical health initiatives

- Many low cost physical activity programmes continued to be offered including Zumba, lunchtime walking, Boxercise, 'Bike to Work scheme' running club, yoga classes and circuit training. A more recent initiative has seen the introduction of the Staff Rehabilitation Physical Exercise Programme. This has just been developed in partnership with the on site Gym organization, *Working Well.* This programme offers 6 weeks free gym membership to assist and support staff after illness.

- In 2011, smoking cessation programmes were introduced for staff, providing personalised one to one advice and nicotine replacement therapies.

- Staff health screening events have been introduced looking at smoking and cardiovascular risk in 2011 and blood pressure in 2012.

iv) Communication

- Communication of staff health and wellbeing initiatives has made steady progress. Raising the awareness of events using a monthly Health and Wellbeing Newsletter has been commenced, with cascading to departments via Health & Wellbeing champions, Team Briefing meetings and also using the Trusts Heartbeat magazine.

- There is also a dedicated page on the Trusts intranet with instant access to over two-hundred health and wellbeing resources.

- Staff engagement via 'Hot Topics' monthly team brief and 'Survey Monkey' have given feedback that staff value the Health and Wellbeing initiatives that are offered throughout the Trust and have suggested areas for development.

v) Results

- Results of these actions are shown in employees' perceptions of the. The 2010 National Staff Survey, Health and Wellbeing related questions scored fairly with an average of 20% - this increased to >70% in the 2011 National Staff Survey, along with a drop in work related stress by 20%.

- Sandwell and West Birmingham Trust have been approached by NHS Employers to be used as a "gold standard" example of best practice on its website and associated hub. It will be featured in the Nursing Care and Quality Forum for improvements made within staff health and wellbeing.

4. Sickness Absence

Trust sickness absence levels for the last two years have demonstrated a consistent downward trend. During this period SWBH has benchmarked positively when compared to equivalent Trusts within the West Midlands.

The Health and Wellbeing Committee oversees the implementation of the Trust's sickness absence management action plan. Initiatives over the last year include, the:

- introduction of revised Sickness Absence Management and Stress at Work policies;
- provision of management workshops to support the effective management of stress;
- on-going sickness absence management training workshops.;
- case management review of long-term sickness absence cases (3 months or greater) to ensure effective management;
- review of departmental sickness absence hot spots.

In May 2012 the Trust's sickness absence levels started to move away from the positive downward trend identified above.

Given the sudden change it is likely that the contributory factors relate to the adverse impact of the significant amount of change currently on-going within the organization ie: Trust Transformation Plan, Bed Reconfiguration and Workforce Implications Programme. All of these factors make it hard during the transition phase to ensure both continuity of sickness absence management and positive levels of staff motivation and engagement.

Actions to improve the situation include:

- An increase in the number of staff counseling sessions available via BDMA.

- A review of the workforce implications aspect of the 2012/13 TSP to streamline the redundancy approval process and ensure a more timely process.

- Implementation of a revised ward management structure. The increase in management capacity is designed, in addition to improving clinical quality indicators, to support improvements in workforce performance targets, including sickness absence management.

- Review of sickness absence performance information provided to divisional managers to assist them to target management resources more effectively/ identify emerging hotspot areas.

- To scope the feasibility of an electronic solution to track all activity associate with sickness absence to facilitate the provision of targeted information/reminders and consequently more responsive management action.

- Targeted support from Human Resources Department to 'hot spot areas' to ensure effective management measures are in place.

- Development of an sickness absence audit programme to assess compliance with policy requirements.

- Roll-out of the sickness absence reporting model adopted within the Medicine Division i.e: nurses to report to the Head of Nursing or nominated matron.

- Targeted health and well-being initiatives based on trend analysis of reasons for sickness absence.

- Promotion of good practice of departments who have succeeded in significantly reducing sickness absence levels.

- Commencement of a 'Self Care Skills at Work Course' to address short-term sickness absence in the workplace. The course is designed to equip individuals with high levels of sickness absence with the skills and confidence to manage their ill-health whilst remaining in the workplace.

5. Key Actions and Issues

Whilst in his original report Boorman found that Trusts moving from average to high levels of staff health and wellbeing showed an associated drop in absenteeism there is not yet robust evidence that supports this.

Future actions will be increasingly focused on the use of sickness absence data to inform the development of future actions and wellbeing developments. This will also include consideration from a diversity perspective to ensure where possible, that well-being provisions meet the needs of all diversity strands.

Threats to the Health and wellbeing program include the reliance on free resources which are reducing in line with cost savings across all organization. Researching the cost effectiveness of investment in Health and Wellbeing to support future business cases is therefore a key priority therefore for 2013.

6. Conclusion

Good progress is being made implementing the Staff Health and Well-Being Strategy supported by a detailed sickness absence management action plan. It is essential that the factors affecting staff attendance and well-being continue to maintain a high profile within the organization, particularly given the scale of the Trust's Transformation agenda.

7. Recommendations

The Trust Board is asked to support the on-going investment in health and well-being services and **receive** and **note** this update report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – September 2012
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	25 October 2012

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the period to 30th September 2012.

Measured against the DoH target, the Trust generated an actual surplus of £552,000 during September against a planned surplus of £423,000. For the purposes of its statutory accounts, the in month surplus was slightly higher at £581,000.

REPORT RECOMMENDATION:

The Trust Board is requested to NOTE the contents of the report, NOTE any actions taken to ensure that the Trust remains on target to achieve its planned financial position and NOTE the proposed changes to the capital programme.

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

Accept	Approve the recommendation	Discuss
x		

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

Financial	x	Environmental		Communications & Media	
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 12/13 OfE, key Strategies & Programmes)

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 16 October 2012 and Finance & Performance Management Committee on 19 October 2012.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2012

EXECUTIVE SUMMARY

• For the month of September 2012, the Trust delivered a "bottom line" surplus of £552,000 compared to a planned surplus of £423,000 (as measured against the DoH performance target).

• For the year to date, the Trust has produced a surplus of £1,174,000 compared with a planned surplus of £908,000 so generating an positive variance from plan of £266,000.

• The planned surplus continues to rise significantly in the latter part of the year and towards the year end.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 135 below planned levels. After taking account of the impact of agency staff, WTE's were 56 below plan. Total pay expenditure for the month, inclusive of agency costs, is £335,000 below the planned level.

• The month-end cash balance was approximately £21m 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	129	266	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	95	215	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	335	483	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(321)	(2,106)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	56	37	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	20,949	20,949	>= 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	908	1,174
Capital Resource Limit	7,485	1,971
External Financing Limit	---	20,949
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at September 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	Forecast Outturn £000's
Income from Activities	382,515	32,620	32,606	(14)	192,070	193,668	1,598	385,465
Other Income	38,186	3,196	3,291	95	19,285	19,525	240	38,386
Operating Expenses	(394,082)	(33,493)	(33,479)	14	(199,047)	(200,670)	(1,623)	(397,272)
EBITDA	26,619	2,323	2,418	95	12,308	12,523	215	26,579
Interest Receivable	100	8	13	5	50	72	22	140
Depreciation & Amortisation	(14,738)	(1,228)	(1,228)	0	(7,369)	(7,369)	0	(14,738)
PDC Dividend	(5,594)	(466)	(466)	0	(2,797)	(2,797)	0	(5,594)
Interest Payable	(2,157)	(185)	(156)	29	(1,110)	(1,081)	29	(2,157)
Net Surplus/(Deficit)	**4,230**	**452**	**581**	**129**	**1,082**	**1,348**	**266**	**4,230**
IFRS/Impairment/Donated Asset Related Adjustments	(353)	(29)	(29)	0	(174)	(174)	0	(353)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,877**	423	552	129	**908**	**1,174**	**266**	**3,877**

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.

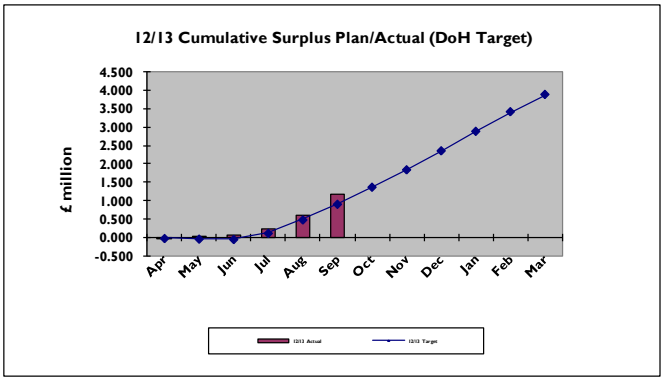
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2012

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Net bottom-line performance delivered an actual surplus of £552,000 in September against a planned surplus of £423,000. The resultant £129,000 positive variance moves the year to date position to £266,000 above targeted levels.



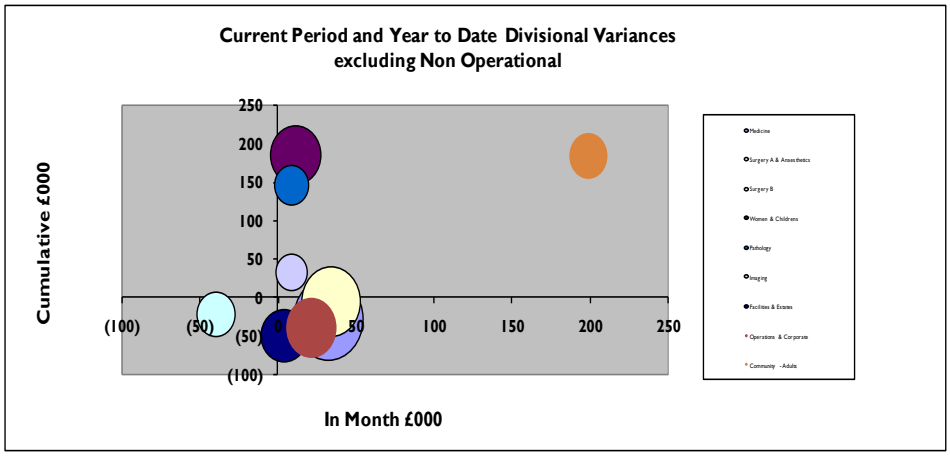
Divisional Performance

• For September, there are again no major variances from plan among operational divisions with only Surgery B posting a small in month deficit (representing less than 1% of the division's in month turnover).

• Performance in non operational areas reflects a cautious view of a number of uncertain items, including patient related SLA income which will need to be reviewed in conjunction with commissioners.

• SLA performance which is based on fully costed information for August shows an ongoing significant overall positive variation from plan particularly within Women & Children's Services (primarily obstetrics), Medicine (although a significant element of this relates to high cost drugs for which there is an equivalent higher level of expenditure) and some smaller variations in other areas.

• There are no material year to date adverse variances from plan although Medicine, Surgery A, Surgery B, Facilities and Corporate Services all have relatively small adverse variances.



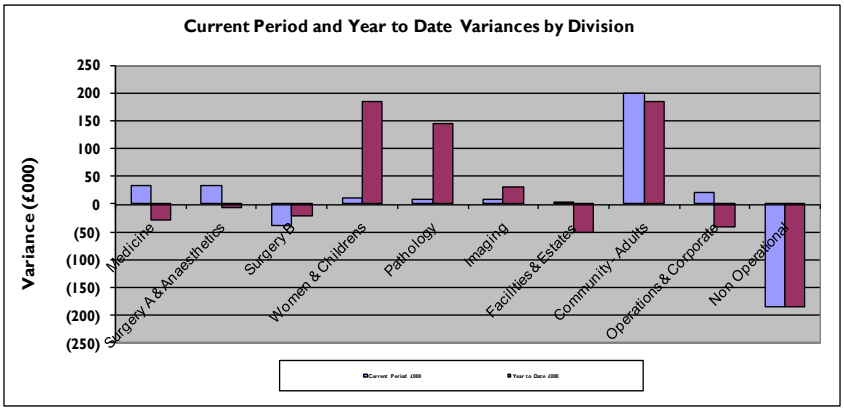
The tables adjacent and below show small adverse year to date variance for although Medicine, Surgery A, Surgery B, Facilities and Corporate Services.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

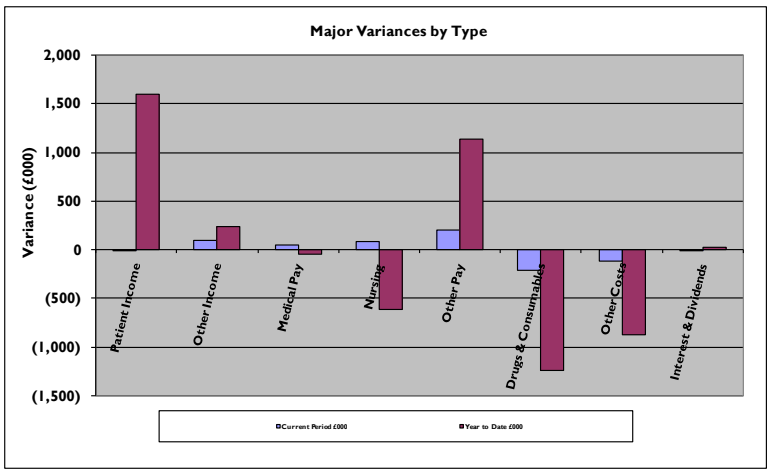
Financial Performance Report – September 2012

Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	33	(29)
Surgery A & Anaesthetics	34	(6)
Surgery B	(39)	(22)
Women & Childrens	12	185
Pathology	9	145
Imaging	9	32
Facilities & Estates	4	(50)
Community - Adults	199	184
Operations & Corporate	21	(40)
Non Operational	(186)	(185)



For September, patient related SLA income again shows a positive variation from plan although this is offset by a worsening in the performance of ICR income which, in turn, is primarily the result of an increase in the nationally set level of doubtful debt provision which is required. Overall pay expenditure is below planned levels particularly with the scientific, therapeutic & technical and management pay groups at £183k and £105k lower than plan respectively. Overall non pay expenditure is £321,000 higher than plan in month, largely in respect of medical consumables , postage, printing & stationery and hotel services costs.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	(14)	1,598
Other Income	95	240
Medical Pay	49	(46)
Nursing	83	(608)
Other Pay	203	1,137
Drugs & Consumables	(208)	(1,234)
Other Costs	(113)	(872)
Interest & Dividends	5	22



Sandwell and West Birmingham Hospitals NHS
NHS Trust

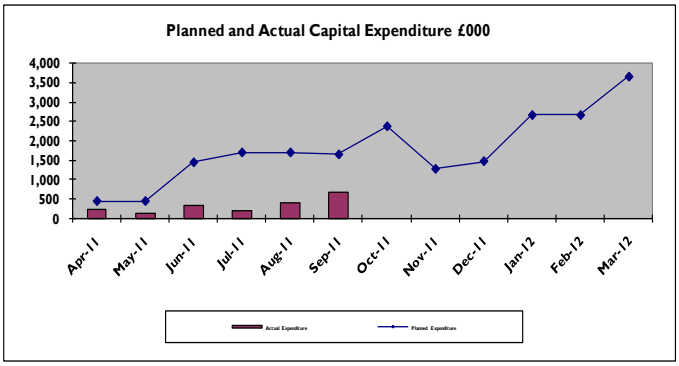
Financial Performance Report – September 2012

Capital Expenditure

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

• Although in month expenditure is significantly higher than that for previous months, the year to date actual spend remains significantly lower than planned levels although this is primarily the result of delays in the acquisition of Grove Lane land.

• For the year to date, actual expenditure is almost £2m primarily related to balances on brought forward schemes, capitalised salaries, estates rationalisation. statutory standards and medical equipment.



Capital Expenditure Continued

• A review of expected land acquisition costs has been undertaken along with a more general assessment of the progress of other schemes included in the capital programme. As a result of this review, a number of amendments are proposed to the capital programme for the year:

- a decrease in the plan for land acquisition from £5m to £3m covering £1.8m purchase costs, £0.5m demolition and safety and a £0.7m contingency
- an increase of £450k in the statutory standards programme
- switching £235k from mammography to ultrasound machines
- an additional £177k for medical equipment (£23k for and EMG Machine and £154k for an ICP-MS Analyser)
- an agreed allocation of £900k towards stroke reconfiguration as part of 12/13 works.

Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 56 below plan compared with 89 above for August. Excluding the impact of agency staff, wte numbers are around 135 below plan. Actual wte's have fallen by 141 compared with August, of this 59 wtes relates to bank and 18 wtes to agency.

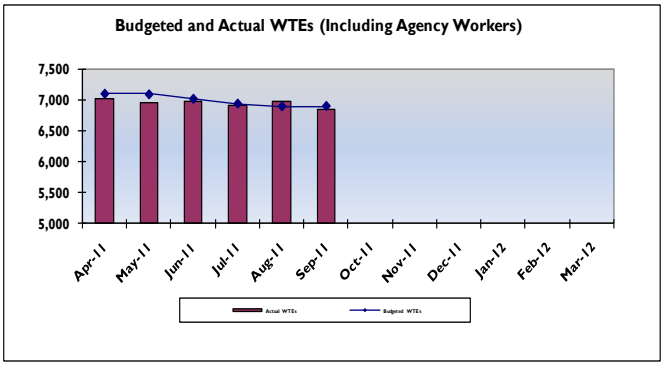
• Total pay costs (including agency workers) are £335,000 lower than budgeted levels for the month , particularly within the scientific, therapeutic & technical and management pay groups.

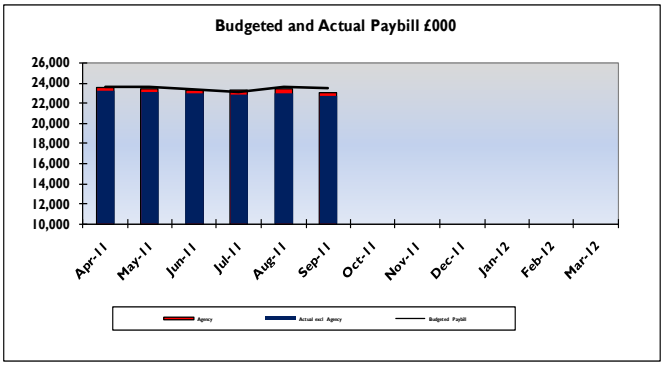
• Expenditure for agency staff in September was £415,000 compared with £525,000 in August, an average of £526,000 for 2011/12 and an September 2011 spend of £459,000. The biggest single group accounting for agency expenditure remains medical staffing.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2012





Pay Variance by Pay Group

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

Analysis of Total Pay Costs by Staff Group

	Year to Date to September					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	37,507	35,980		1,573	37,553	(46)
Management	7,712	7,112		0	7,112	600
Administration & Estates	15,502	14,508	651	227	15,386	116
Healthcare Assistants & Support Staff	15,548	14,439	1,251	4	15,694	(146)
Nursing and Midwifery	42,675	41,005	1,846	433	43,283	(608)
Scientific, Therapeutic & Technical	21,833	20,931		311	21,242	591
Other Pay	(147)	(123)			(123)	(24)
Total Pay Costs	140,630	133,852	3,747	2,548	140,147	483

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

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

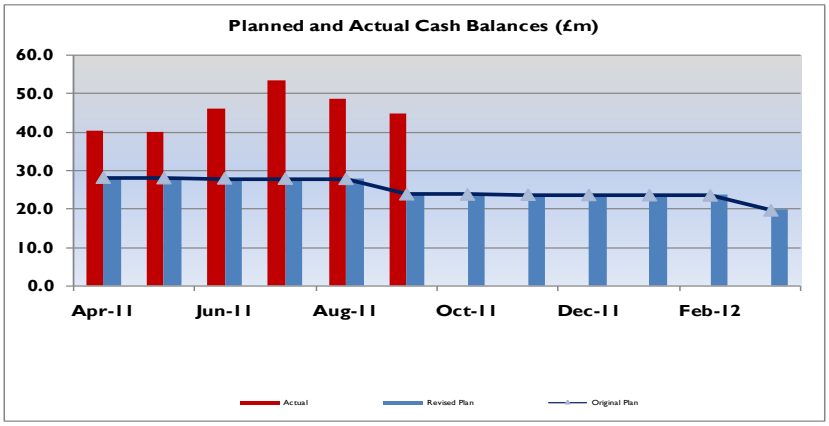
• Cash balances at 30th September are approximately £44.9m which is around £10.4m higher than at 31st March and £3.9m lower than in August, primarily the result of the payment in month of the half yearly PDC dividend of £2.8m and repayment of a further instalment of the capital expenditure loan of £1m.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2012

Sandwell & West Birmingham Hospitals NHS Trust STATEMENT OF FINANCIAL POSITION 2012/2013				
		Opening Balance as at 1st April 2012 £000	Balance as at end September 2012 £000	Forecast at 31st March 2013 £000
Non Current Assets	Intangible Assets	1,075	1,020	1,125
	Tangible Assets	227,072	221,593	228,882
	Investments	0	0	0
	Receivables	865	865	950
Current Assets	Inventories	4,065	3,987	4,050
	Receivables and Accrued Income	14,446	14,225	13,500
	Investments	0	0	0
	Cash	34,465	44,893	26,134
Current Liabilities	Payables and Accrued Expenditure	(33,751)	(39,989)	(31,337)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(1,166)	(1,166)	(1,221)
	Provisions	(15,649)	(14,145)	(10,389)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	(5,000)	(4,000)	(3,000)
	Borrowings	(29,995)	(29,508)	(28,969)
	Provisions	(2,532)	(2,532)	(1,600)
		191,895	193,243	196,125
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231
	Revaluation Reserve	41,228	41,228	41,228
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(18,622)	(17,274)	(14,392)
		191,895	193,243	196,125



Cash Forecast

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

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2012

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT September 2012

ACTUAL/FORECAST	Sep-12 £000s	Oct-12 £000s	Nov-12 £000s	Dec-12 £000s	Jan-13 £000s	Feb-13 £000s	Mar-13 £000s	Apr-13 £000s	May-13 £000s	Jun-13 £000s	Jul-13 £000s	Aug-13 £000s	Sep-13 £000s
Receipts													
SLAs: Black Country Cluster	**17,736**	17,165	17,165	17,165	17,165	17,165	17,165	16,993	16,993	16,993	16,993	16,993	16,993
Birmingham & Solihull Cluster	**11,329**	11,341	11,341	11,341	11,341	11,341	11,341	11,228	11,228	11,228	11,228	11,228	11,228
Other Clusters	**629**	629	629	629	629	629	629	623	623	623	623	623	623
Pan Birmingham LSCG	**1,944**	1,944	1,944	1,944	1,944	1,944	1,944	1,925	1,925	1,925	1,925	1,925	1,925
Education & Training		4,347			4,347			4,300	0	0	4,300	0	0
Loans													
Other Receipts	**3,003**	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900
Total Receipts	**34,641**	38,326	33,979	33,979	38,326	33,979	33,979	37,968	33,668	33,668	37,968	33,668	33,668
Payments													
Payroll	**13,965**	13,220	13,215	13,215	13,215	13,215	13,214	13,068	13,068	13,068	13,068	13,068	13,068
Tax, NI and Pensions	**9,255**	9,559	9,556	9,556	9,556	9,556	19,110	9,455	9,455	9,455	9,455	9,455	9,455
Non Pay - NHS	**2,621**	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Non Pay - Trade	**7,376**	7,541	6,814	5,361	8,995	8,314	9,527	8,000	7,500	7,500	7,500	7,500	7,500
Non Pay - Capital	**751**	1,750	2,375	1,275	1,475	4,165	4,588	1,750	1,750	500	500	500	500
PDC Dividend	**2,797**						2,797						2,700
Repayment of Loans	**1,000**						1,000						1,000
Interest	**30**						25						20
BTC Unitary Charge	**387**	416	416	416	416	416	832	430	430	430	430	430	430
Other Payments	**376**	175	175	175	175	175	175	175	175	175	175	175	175
Total Payments	**38,558**	35,161	35,051	32,498	36,332	38,341	53,768	35,378	34,878	33,628	33,628	33,628	37,348
Cash Brought Forward	**48,810**	44,893	48,058	46,986	48,467	50,461	46,099	26,310	28,901	27,691	27,732	32,073	32,114
Net Receipts/(Payments)	**(3,917)**	3,165	(1,072)	1,481	1,994	(4,362)	(19,789)	2,591	(1,209)	41	4,341	41	(3,679)
Cash Carried Forward	**44,893**	48,058	46,986	48,467	50,461	46,099	26,310	28,901	27,691	27,732	32,073	32,114	28,434

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

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	5.9%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	101.7%	5
Net Return After Financing	Surplus after dividends over average assets employed	1.8%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.6%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	24.6	3
Overall Rating			**3.0**

Risk Ratings

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

• 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. This changes the Liquid Ratio score from 1 to 3.

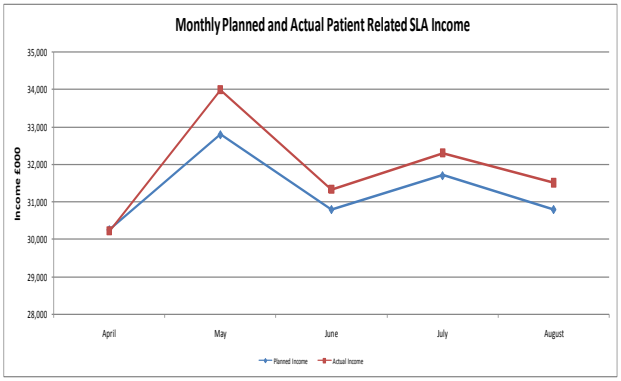
•I&E Surplus Margin continues to be lower than would normally be expected due to relatively low levels of surplus being delivered in the first half of 2012/13 (surpluses are profiled towards the latter part of the year). In month performance rather than year to date would generate a score of 3.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2012

Performance Against Service Level Agreement Target

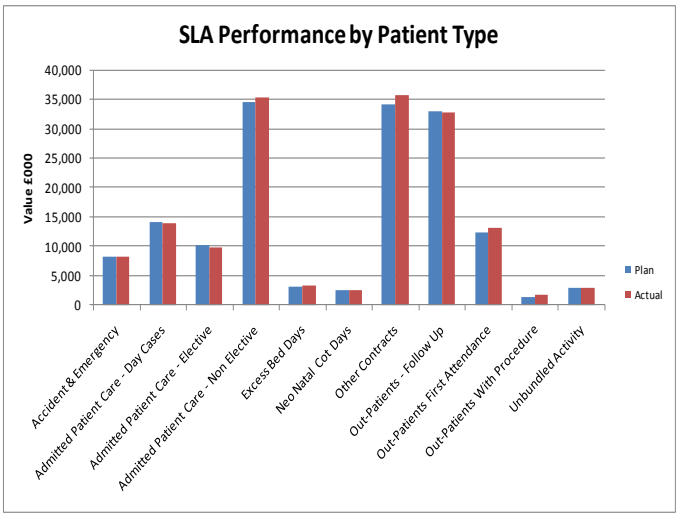
•The adjacent graph and table shows an overview of financial performance against the Trust's Service Level Agreements with Commissioners.
• Fully costed data is only available one month in arrears and this data therefore only covers the period April – August. For the purpose of financial reporting for the current period, a prudent estimate is made of SLA income. This adjustment together with the aforementioned timing difference does not permit a direct comparison with performance incorporated within the main financial statements.
•The adjacent graph and table show the extent of the overall over performance against the planned financial position.

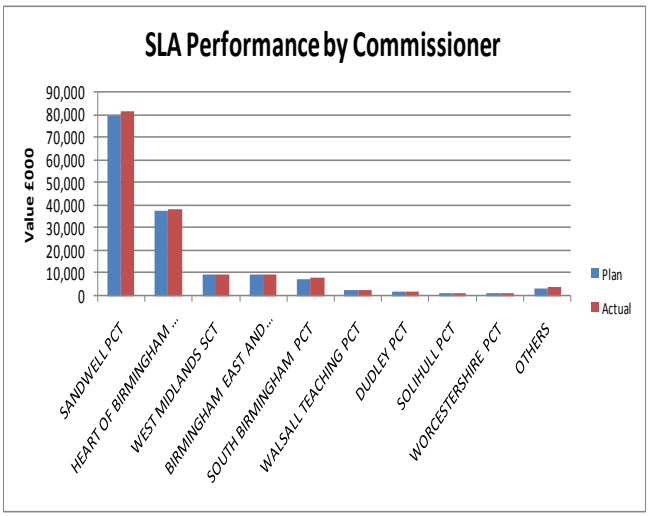


Month	Planned Income £000	Actual Income £000	Variance £000
April	30,262	30,222	(40)
May	32,796	33,998	1,202
June	30,801	31,337	536
July	31,704	32,307	603
August	30,801	31,508	707
Total	**156,364**	**159,372**	**3,008**

Performance by Activity Type and Commissioner

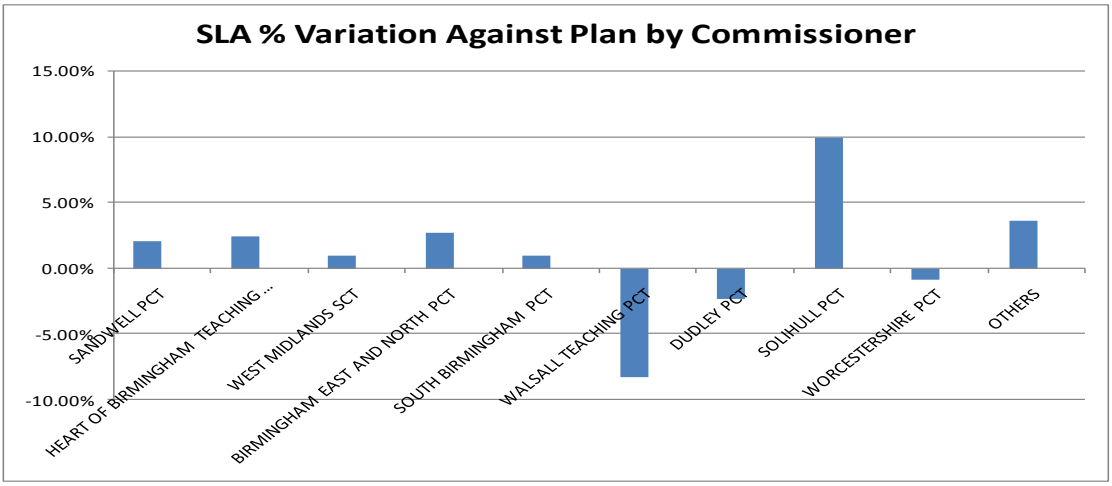
• The following graphs show performance by activity type and commissioner comparing planned and actual financial values for the year to date and the percentage variance from plan for each type of activity and commissioner.

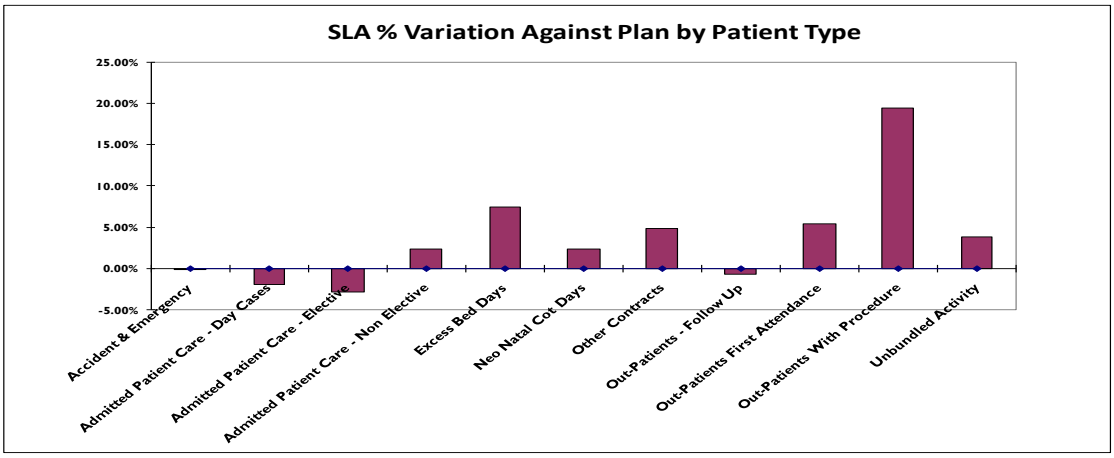




Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2012



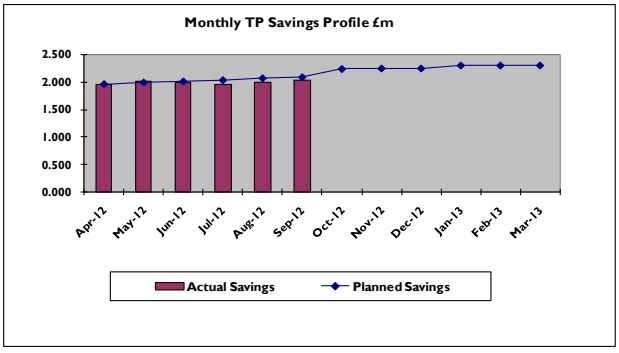


Transformation Programme

•The adjacent table shows actual progress against the Trust's Transformation Programme for 2012/13, inclusive of RCRH related changes.

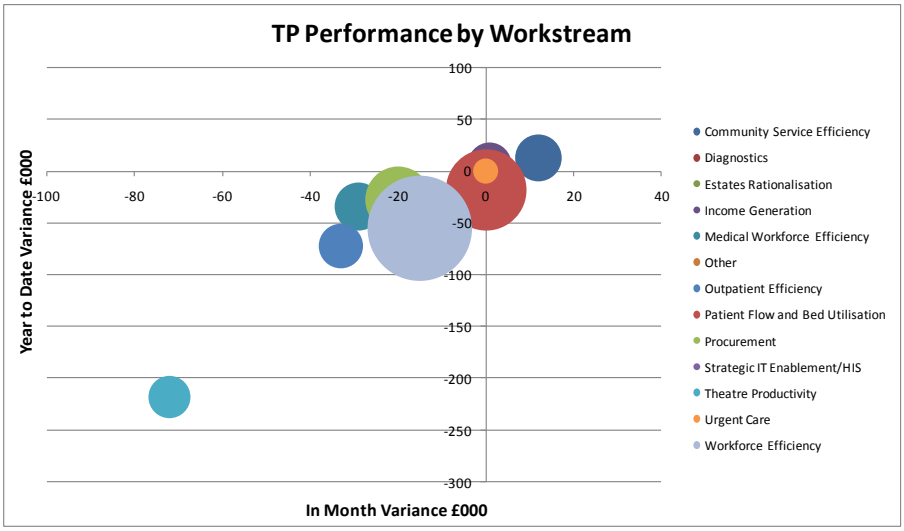
• At 30th September, actual savings were £198,000 or 1.6% lower than planned levels although the full year effect is maintained at the level of the initial plan.

• The forecast outturn for the programme remains in line with the original plan and the full year recurrent effect of the programme remains in excess of the 2012/13 requirement.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2012



Transformation Programme

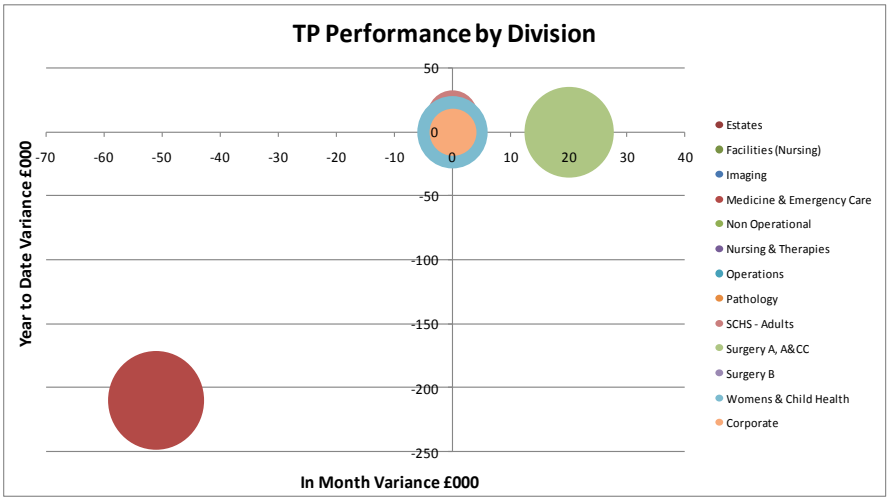
•The adjacent chart shows in month and year to date performance of the Transformation Programme by workstream.

• At September, 5 workstreams have an adverse year to date variance against plan although the majority of these are fairly negligible. The largest adverse variance of (£92,000) relates to workforce efficiency.

Transformation Programme

•At the end of September, only Medicine & Emergency Care is reporting a deficit against plan.

• Mitigating strategies remain in place for the position to date with a detailed assessment of risk management and actions planned as part of the ongoing performance management regime for Medicine and Surgery. The Performance Management Board will continue to recommend appropriate actions to the F&PMC sub-committee of the Board



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2012

External Focus

• The latest report from the IMF suggests that the global economic recovery is weakening and identified a considerable risk that further deterioration in the economic outlook would occur. One of the biggest downgrades was to the UK economy, which the IMF expects to shrink by 0.4% this year compared with a forecast of 0.2% growth in July. Next year, the IMF predicts that the UK economy should grow by 1.1%, a reduction from its previous forecast of 1.4%.

• The MPC this month voted unanimously to keep interest rates at 0.5% and leave the quantitative easing programme at £375bn. At the same time, it noted that inflation, which dropped to 2.5% in August, would fall back more slowly than previously anticipated.

• Meanwhile, a Kings Fund survey of NHS Directors of Finance suggested that the NHS could get worse in 2013. A BBC survey at the same time identified that 60% of people expected that services would have to be cut.

• A total of 27 of the 45 managers who took part in the survey believed that there was now a high or very high risk that NHS would not meet its savings targets of £20bn by 2015. 19 expected care to worsen over the next few year.

• In response to the survey, Lord Howe, the Health Minister, maintained that the NHS was on track to achieve its savings target.

Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £552,000 during September against a planned surplus of £423,000. For the purposes of its statutory accounts, the in month surplus was higher at £581,000. This represents a further increase on the surplus delivered in previous months and reflects the profiling of the Trust's financial plan and particularly the impact of the TSP in the later months of the year.

• The £552,000 surplus in September is £129,000 better than planned for the month.

• For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £1,174,000 which is £266,000 better than the planned position.

• In month capital expenditure is £666,000 which remains lower than plan. The main reason for the variance from plan is the later than planned acquisition of land in Grove Lane. Amendments to the capital programme have been recommended to take into account an updated position regarding Grove Lane land acquisition and a more general review of progress on capital schemes.

•At 30th September, cash balances are approximately £21m higher than the cash plan and around £10.4m greater than the balance held at 31st March.

• Performance for most divisions in month has been in line with or better than plan and there are no material adverse year to date positions. Nevertheless, monitoring of divisional performance continues with action being taken as necessary to rectify any potential and/or actual variances. . This is particularly the case where the Medicine Division is concerned given the anticipated pressures reported to the Committee last month. The Division will be reporting to the committee in November. Monitoring of the performance of the Transformation Programme will continue to be a key component of this.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2012

Recommendations

The Trust Board is asked to:

i. **NOTE the contents of the report;**

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

iii. **APPROVE the variations to the capital programme outlined in the capital section of this 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:	25 October 2012

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – September 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 16 October 2012 and Finance & Performance Management Committee on 19 October 2012.

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

SUCCESSES AND EXCEPTIONS

Note	Patient Safety
	SUCCESSES
a	**Stroke Care** - performance against the target for patients who spent at least 90% of their hospital stay on a Stroke Unit continues to be maintained above the 80% threshold. Provisional data for September for **TIA** (High Risk) Treatment (within 24 hours of initial presentation) indicates overall performance of 60.0%, comprising 50.0% Sandwell and 71.4% City.
b	**Infection Control** - The number of C Diff cases reported during the month of September was 2 compared with a trajectory for the month of 5. Year to date cases total 16, well within the trajectory for the period of 30. The number of cases of MRSA Bacteraemia reported for the year to date remains 1, with no cases reported during September.
d	**VTE (Venous Thromboembolism) Risk Assessment** - early data for September indicates performance of 90.1%, just above the required threshold of 90.0%.
	Appropriate use of Warfarin - this CQUIN requires a quarterly audit of patients admitted taking warfarin with an International Normalised Ratio (INR) above 5.0 whose dosage has been adjusted or reviewed prior to the next warfarin dose. Systems are now established to monitor performance and report. the Trust was fully compliant with audit requirements during Q1.
	Safety Thermometer (Acute Services) - this CQUIN requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre. Data collection systems have been established and data submitted for each month year to date.
	Use of Antibiotics - Antimicrobial Stewardship - requires a quarterly self-assessment audit of prescribing of antibiotics in agreed specialities. A baseline compliance score of 60 has been established. An improvement trajectory / action plan to an end of year target of 80 is identified. Other requirements of this CQUIN; Prescribing Audit and Snapshot of Antibiotic Prescribing are also being met.
	Reducing avoidable pressure ulcers for all (Acute) inpatients - target is the continued provision of data through audit (as part of Safety Thermometer). Compliant to date.
	Nutrition and Weight Management (Acute Services) - this CQUIN is to reduce avoidable hospital acquired weight loss in elderly care and stroke patients. The requirement is to provide data through audit, for both Acute and Community services, across an extended (from original) scope of patients, with the intention that the process is fully integrated with the Safety Thermometer audit in Quarter 4 and demonstrate that 95% of patients receive harm-free care. Compliant each month to date.
	Ensuring Safe Surgery (WHO Checklist) - To take measures to ensure 100% compliance with SHA defined areas (theatres) and improvement trajectory for other (non-SHA defined) areas following Q1 baseline assessment. Performance in Theatres during September is 99.8%, performance in non-Theatre areas (Endoscopy, Radiology, Pain Management and Cardiology) is 100%.
	Stroke Discharge - comprises 4 components, a) CT Scan within 24 hours of arrival (95%), b) Swallow Screen completed within 4 hours of presentation (70%), c) Prescription / Administration to eligible patients within 24 hours of presentation of anti-platelet agents (90%), d) Commencement of anti-coagulation / Management Plan in place on discharge (60%). a) is assessed quarterly. b), c) and d) have had a Q1 baseline assessment and an improvement trajectory has been determined. The first component (CT Scans within 24 hours of arrival) continues to be met for the period to date.
	Safety Thermometer (Community IP Services - Henderson and Leasowes) - this CQUIN requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre. Submission of data for 3 consecutive months within the quarter triggers payment for the period Quarters 2 - 4 inclusive. Data has been collected and submitted for each month year to date.
	Reducing avoidable pressure ulcers (Community IP Services - Henderson & Leasowes) - target is the continued provision of data through audit (as part of Safety Thermometer). Compliant to date.
	Nutrition and Weight Management (Community Services - Henderson & Leasowes) - this CQUIN is to reduce avoidable hospital acquired weight loss in elderly care and stroke patients. The requirement is to provide data through audit, for both Acute and Community services, across an extended (from original) scope of patients, with the intention that the process is fully integrated with the Safety Thermometer audit in Quarter 4 and demonstrate that 95% of patients receive harm-free care. Compliant each month year to date.
	EXCEPTIONS
c	**MRSA Screening** - the percentage of Elective and Non-Elective MRSA Screens reduced slightly during September. The improvement trajectory set earlier in the year, leading to a target screen rate of 85%, is not being met for Elective cases.
e	**PDR** (12-month rolling) compliance improved slightly to 65.6%. Overall **Mandatory Training** compliance at the end of September also improved slightly to 83.3%. The improvement trajectory for end October is 90%.
	Effectiveness Of Care
	SUCCESSES
f	**Dementia Risk Assessment (Acute Services)** - comprises 3 elements, a) Assessment (by screening question) of all emergency admissions aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories. A system to gather, report and record data has been established. Requirements for each month year to date have been met.
	Dementia Risk Assessment (Community Services) - comprises 3 elements, a) Assessment (by screening question) of all new patients to District Nursing caseload (wef April 2012) aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories. Requirements for each reported month year to date have been met.
h	Each year ***Dr Foster*** rebases its calculation of the relative risk of mortality, the impact of which is seen in the most recent 12-month cumulative mortality data As a consequence the **Hospital Standardised Mortality Rate** (HSMR) of the Trust, and its SHA (Peer) has increased to 96.4 and 101.3 respectively, for the 12-month cumulative period stated. The HSMR of the Trust following rebasing remains below 100 and within 95% statistical confidence limits. The Peer (National) HSMR is 97.0. The report also includes the most recent data for the **Summary Hospital-level Mortality Indicator** (SHMI) for 12-month cumulative periods, which for the Trust is 99.1.
i	Provisional data for September indicates that 80.0% of patients with a **Fractured Neck of Femur** received an operation within 24 hours of admission, and as such has been maintained above the 70% performance threshold. Year to date performance has improved to 71.7%.
	EXCEPTIONS
g	**Mortality Review** - the trajectory for August is to review 64% of all qualifying (adult) deaths within hospital within 42 days of death, with an end year end (March 2012) target of 80%. An action plan to improve performance is currently being implemented.
	Patient Experience
	SUCCESSES
k	**Imaging Reporting Times** - data on the percentage of Imaging Requests from A&E, by modality, reported within 24 hours is reported, which shows an increase (improvement) from the previous month. An end December target of 90% (national standard) has been identified for each modality with an interim 70% trajectory for the end of October.
m	**Mixed Sex Accommodation** - No breaches have been recorded for the 6 months year to date.
n	**Improve responsiveness to personal needs of patients (Acute Services)** - this CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The average composite score during the period September - November (66.6%) defines the baseline, against which an improvement of 5% is required during Quarter 4. Performance during the first 3 months has met the performance trajectory. Quarterly (in house) surveys are to be undertaken.

Net Promoter Score (Acute Services) - the target is to deliver a 10 point improvement (by Q4) in the Net Promoter Score from a minimum survey size of 10% of inpatients. The month of April determined the baseline score of 55 with most recent performance of 60 during August meeting the trajectory of 58.

n (cont'd)

End Of Life Care (EOL) - To improve the percentage of patients receiving effective EOL care from the integrated SWBH NHST palliative care team including dying in their place of choice, and reduce the variation in use by ward of the supportive care pathway by patients known to palliative care. Q1 baseline established and end of year target of 53% identified. Performance during August was 57% (trajectory 47%).

Alcohol Screening - screen all defined (EAU, MAU and Cardiology, Endocrinology and Gastroenterology Outpatients) patients aged 16 and over and offer brief intervention. I.T. Data system expanded to capture Cardiology and Endocrinology data. Q1 baseline established, audit periods and improvement trajectory to 80% determined.

Smoking During Pregnancy - comprises 2 elements, a) 80% eligible maternity staff to complete locally agreed training in delivering brief stop smoking advice by Q4 and improvement trajectory following baseline assessment of patient smoking status, checking and recording at booking, or first midwife contact. During Q1, 34% of eligible staff were trained. Smoking status baseline data awaited.

Improve responsiveness to personal needs of patients (Community IP Services - Henderson and Leasowes) - this CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The proposal is to maintain a score of 90 each quarter. the aggregated score for August for Henderson and Leasowes is 95.5.

Every Contact Counts (Community Services - new patients to District Nursing caseload (wef April)) - comprises 3 elements, a) Staff completing locally agreed training in delivering brief advice as required to implement the Making Every Contact Count (MECC) ambition, b) Delivery of advice, c) Referrals to any lifestyle service from contacts. Requires a baseline and improvement trajectory. Data capture system now implemented with baseline data being captured. The Training component of this CQUIN is being met.

Smoking Cessation (Community Services - new patients to District Nursing caseload (wef April)) - comprises 3 elements, a) Number of patients with smoking status recorded, b) Number of patients given brief stop smoking advice, c) Number of patients referred to the Stop Smoking Service. Requires a baseline and improvement trajectory. Data capture system now implemented with baseline data being captured.

Clinical Quality Dashboards (Specialised Services) - CQUIN is to implement and demonstrate routine use of clinical quality dashboards for specialised services (Cardiology, Paediatric Intensive Care and Neonatal Services). Required progress is on track.

Neonatology (Specialised Services) - **Increase effective use of hypothermia treatment** - CQUIN is for pathway for therapeutic hypothermia to be utilised for all babies meeting criteria (excluding those born at home). Q1 baseline assessment completed and submitted to commissioners.

Neonatology (Specialised Services) - **Discharge Planning / Family Experience and Confidence** - CQUIN is for 95% of babies transitioned / discharged from neonatal care by 44 weeks corrected gestation. Baseline assessment completed and submitted to commissioners.

HIV (Specialised Services - Ensure therapy is optimised) -Number of patients failing therapy (as measured by a detectable viral load) who are stabilised quickly and regain an undetectable viral load. Required progress is on track.

EXCEPTIONS

j **Accident & Emergency -** performance during September against the 4-hour maximum wait target improved slightly to 93.9%, but remains below the 95.0% operational threshold for the year to date. The Trust met 2 of the 5 **Clinical Quality Indicators** during the month, 1 in each of the 2 groupings, timeliness and patient impact.

l **Ambulance Turnaround -** the indicators within the report reflect those contained in the Quality section of the Trust's 2012 / 2013 contract with its commissioners, which focus on Clinical Handovers (% in <15 mins), Average Turnaround (mins : secs) and the number of ambulances turned around in excess of 60 minutes. Performance against each of the 3 components deteriorated during the month.

o **Net Promoter Score (Community IP Services - Henderson and Leasowes)** - the target is to maintain the baseline score of 75, from a minimum survey size of 10% of inpatients. During the month of August this was not achieved, with a reported score of 71.

Transformation Plan

SUCCESSES

p

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

	Month				Year to Date			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%
IP Elective	672	842	-170	-20.2	5269	5464	-195	-3.6
Day case	4213	3604	609	16.9	25639	23379	2260	9.7
IPE plus DC	4885	4446	439	9.9	30908	28843	2065	7.2
IP Non-Elective	4618	4546	72	1.6	28445	27679	766	2.8
OP New	13605	11353	2252	19.8	83913	72065	11848	16.4
OP Review	30151	33563	-3412	-10.2	193260	214949	-21689	-10.1
OP Review:New	2.22	2.96	-0.74	-25.0	2.30	2.98	-0.68	-22.8
AE Type I	13076	14464	-1388	-9.6	89185	88902	283	0.3
AE Type II	1973	3074	-1101	-35.8	14386	18895	-4509	-23.9
Adult Community	47984	41488	6496	15.7	231562	205733	25829	12.6
Child Community	10284	11835	-1551	-13.1	62155	66458	-4303	-6.5

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

	2011 / 12	2012 / 13	Variance	%
IP Elective	5425	5269	-156	-2.9
Day case	26562	25639	-923	-3.5
IPE plus DC	31987	30908	-1079	-3.4
IP Non-Elective	26837	28445	1608	6.0
OP New	79418	83913	4495	5.7
OP Review	209649	193260	-16389	-7.8
OP Review:New	2.64	2.30	-0.34	-12.8
AE Type I	88892	89185	293	0.3
AE Type II	19170	14386	-4784	-25.0
Adult Community	198447	231562	33115	16.7
Child Community	58444	62155	3711	6.3

Overall Elective activity for the month and year to date remains in excess of the plan by 9.9% and 7.2% for the periods respectively. Non Elective activity exceeded the plan for the month by 1.6%, and exceeds the plan for year to date by 2.8%. Month and year to date New and Review Outpatient performance is such that the Follow Up : New Outpatient Ratio for the year to date improved (reduced) to 2.30 which compares favourably with a ratio derived from plan of 2.98. A&E Type I activity (+0.3%) is essentially on plan for the year to date although Type II (BMEC) activity (-23.9%) remains well below plan. Adult Community activity is currently 12.6% above plan for the year to date. Child Community activity is 6.5% below plan. Activity for the period to date is compared with the corresponding period last year in the table opposite.

EXCEPTIONS

q **Sickness Absence** - overall Sickness Absence increase slightly during September to 4.19% (4.10% during August). The current trajectory is <3.25%.

Key Access Targets

SUCCESSES

r **Cancer** - All high level Cancer Waiting times targets were met within the month of August and continue to be met for the year to date. Early indications are that the 62-day urgent GP referral to treatment target of 85% is unlikely to be met for the month of September.

v **Cardiology** - the Primary Angioplasty call to balloon target of =>80% patients within 150 minutes continues to be met. Rapid Access Chest Pain performance is also in excess of the operational threshold for the period identified.

w **GUM Medicine** - for each month year to date 100% of patients have been offered an appointment within 48 hours of contacting the service.

EXCEPTIONS

s **Referral to Treatment Time** - All high level Admitted (90%), Non-Admitted (95%) and Incomplete (92%) Pathway targets were met during the month of September. Speciality specific exceptions were Trauma and Orthopaedics (72.6% Admitted and 86.3% Incomplete) and Plastic Surgery (85.6% Admitted and 90.5% Incomplete). **Diagnostic Waits** (patients waiting greater than 6 weeks for a diagnostic test / investigation) increased to 1.47% during the month, highest numbers were within Endoscopy.

t During the month (September) **Delayed Transfers of Care** increased to 3.6%, although at 3.2% for the year to date, remain within a target of <3.5%.

u **Cancelled Operations** - the overall number and proportion of cancelled operations increased during the month of September. There was also 1 breach of the 28-day guarantee, the first during the year to date.

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

Exec Lead	PATIENT SAFETY						May	June	July	August			September			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
RS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	93.9 ▲	94.1 ▲	85.1 ▼	→		88.9 ▲	→		84.1 ▼	89.6	83	83	a	No Variation	0 - 2% Variation	>2% Variation	●	72.8	85.9
	K			Pts admitted to Acute Stroke Unit within 4 hrs		%	72.2 ▼	73.1 ▲	65.3 ▼	→		68.7 ▲	→		57.9 ▼	70.5	90	90		No Variation	0 - 2% Variation	>2% Variation	● ●		68.7
	K			Pts receiving CT Scan within 24 hrs of arrival		%	100 ■	92.3 ■	94.0 ▲	→		93.8 ▼	→		100 ■	95.9	100	100		No Variation	0 - 2% Variation	>2% Variation	●		100
	K			Pts receiving CT Scan within 1 hr of arrival		%	61.1 ▼	58.3 ▼	51.3 ▼	→		53.1 ▲	→		62.5 ▲	59.4	50	50		No Variation	0 - 2% Variation	>2% Variation	●		37.5
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	50.0 ■	100 ■	57.1 ■	66.7 ▼	100 ■	80.0 ■	50.0 ■	71.4 ▼	60.0 ▼	66.7	60	60		No Variation	0 - 2% Variation	>2% Variation	●	46.15	53.2
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	48.2 ▼	47.4 ▼	58.3 ■	86.7 ■	80.0 ▲	82.5 ■	83.3 ▼	84.2 ▲	83.9 ▲	65.1	60	60		No Variation	0 - 2% Variation	>2% Variation	●		30.4
R0	A	4	Infection Control	C. Difficile (DH Reportable)		No.	2 ▲	1 ▲	2 ▼	2 ▼	4 ■	6 ■	1 ▲	1 ■	2 ■	16	30	57	b	No variation		Any variation	●	120	95
	K			C. Difficile (Best Practice Numbers)		No.	6 ▲	5 ▲	7 ▼	4 ▼	8 ■	12 ■	2 ▲	2 ■	4 ■	41	48	95					●	120	95
	A			MRSA Bacteraemia		No.	0 ■	1 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	1	2		No variation		Any variation	●	5	2
				MSSA Bacteraemia		No.	6	4	0	0	1	1	1	0	1	13	No. Only	No. Only						22	12
				E Coli Bacteraemia		No.	3	5	3	1	2	3	3	3	6	23	No. Only	No. Only						73	50
	F	3		MRSA Screening (Elective)		%	42.2 ▲	42.9 ▲	42.1 ■	Numerator = 1046	Denominator = 2650	39.5 ▼	Numerator = 965	Denominator = 2494	38.7 ▼	38.7*	55	85	c	No variation		Any variation	● ●	40.3	40.6
	F			MRSA Screening (Non-Elective)		%	68.6 ▼	68.7 ▲	68.2 ▼	Numerator = 1341	Denominator = 1941	69.1 ▲	Numerator = 1255	Denominator = 1898	66.1 ▼	66.1*	55	85		No variation		Any variation	●	18.9	26.0
RS	A	3	Acute CQUIN	VTE Risk Assessment (Adult IP)	396	%	92.9 ▲	91.0 ▼	90.3 ▼	→		87.2 ■	→		90.1 ■	90.1*	90	90	d	=>90		<90	●	92.3	92.4
RB	K	20		Appropriate Use of Warfarin	372		→	Compliant	→	→		→	→			Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Safety Thermometer	396	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→		Data Submitted	Data Submitted	Monthly data collection			No variation		Any variation	●		
RB	H	20		Antibiotic Use	743	Score	→	60 Base	→	Quarterly Audit			→			60 Base		80		No variation		Any variation	●		
RO	D	8		Reducing Avoidable Pressure Ulcers	372	No.	Compliant	Compliant	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Nutrition and Weight Management	743		→	Q1 Base Audit Complete	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit			No variation		Any variation	●		
RS	H	9		Safe Surgery - Operating Theatres	743	%	→	→	→	→		99.7 ■	→		99.8 ■	99.7	99	100		No variation		Any variation	●		
				Safe Surgery - Other Areas		%	→	→	→	→		99.6 ■	→		100 ▲	100	98	98		No variation		Any variation	●		
RS	H	10		Stroke Care	743	%	→	Met Q1 req's	→	→		→	→			Met Q1 req's	Comply	Comply		No variation		Any variation	●		
RO	H	11	Community CQUIN	Safety Thermometer	88	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→			Data Submitted	Monthly data collection			No variation		Any variation	●		
RO	D			Reducing Avoidable Pressure Ulcers	176		Compliant	Compliant	Compliant	→		Compliant	→			Compliant	Comply with audit			No variation		Any variation	●		
RO	H			Nutrition and Weight Management	176		→	Q1 Base Audit Complete	Compliant	→		Compliant	→			Compliant	Comply with audit			No variation		Any variation	●		
KD	F	14	Never Events - in month			No.	0 ■	0 ■	1 ■	→		0 ■	→		1 ■	1*	0	0		No variation		Any variation	●		
	F		Open Serious Incidents Requiring Investigation (SIRI)			No.	7	9	10	→		4	→		2	2*	No. Only	No. Only							
	F		Open Central Alert System (CAS) Alerts			No.	19	17	14	→		9	→		10	10*	No. Only	No. Only							
DS	D		100% Compliance WHO Surgical Checklist			Y / N	N ■	N ■	N ■	→		N ■	→		N ■	No	Y	Y		Y		N	●		N
RO	D		Falls Resukting In Severe Injury or Death			No	0 ■	1 ■	1 ■	→		2 ▼	→		6 ▼	6*	0	0		No variation		Any variation	●		
RO		8	High Impact Nursing Actions	Inpatient Falls reduction		%	59 ▲	60 ▼	79 ▼	→		62 ▲	→			334	171	684		=<57/m		>57/m	●	1024	763
				Nutritional Assessment (MUST)		%	96 ▼	94 ▼	85 ■	→		90 ■	→		91 ▲	91*	90	90		=>90		<90	●		89.0
				Fluid Balance Chart Completion		%	99	100	98	→		94.0	→		97.0	97*									100

Exec Lead						May	June	July	August			September			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
PATIENT SAFETY (Continued)																								
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	3 ▼	0 ▲	0 ■	→		1 ▼	→		0 ▲	4	24	48		=<2	3 - 4	>4	●	9	7
				Admissions to Neonatal ICU	%	9.9 ■	10.4 ■	10.5 ▼	→		8.7 ■	→			10.1	=<10	=<10		=<10	10.0-12.0	>12.0	●	7.2	10.7
				Adjusted Perinatal Mortality Rate (per 1000 babies)	/1000	2.0 ▲	7.6 ▼	7.6 ■	→		7.1 ▲	→			7.1*	<8.0	<8.0		<8	8.1 - 10.0	>10	●	6.5	11.9*
				Caesarean Section Rate	%	24.1 ▼	19.8 ▲	23.9 ▼	→		27.1 ■	→		21.4 ■	23.5	<25.0	<25.0		=<25.0	25-28	>28.0	●	23.6	22.2
	H			Early Booking (Completed Assessment <12+6 weeks)	%	80 ▲	79 ▼	84 ▲	→			→			84*	=>90	=>90		=>90	75-89	<75	● ●		76.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates	%	→	10.4 ▼	→	→		→	→		9.5 ▲	9.9	<11.5	<11.5		<11.5	11.5 - 12.5	>12.5	●	11.9	9.8
				Breast Feeding Initiation Rates	%	→	71.9 ▼	→	→		→	→		72.8 ▲	72.3	>63.0	>63.0		>63.0	61-63	<61.0	●	65.6	73.0
RO	H	12	Number of Health Visitors in Post		No.				→			→					83.5							
RB		5	Cervical Cytology	Diagnostic Report Turnaround	Days	<9 days ■	<9 days ■	<9 days ■	→		<9 days ■	→		<9 days ■	<9 days	<9 days	<9 days		<9 days	9-12 days	>12 days	●	<9 days	<9 days
RO		7	Learning & Development	PDRs (12-month rolling)	No. (%)	5390 (72.9) ▲	5166 (69.9) ▼	4805 (65.0) ▼	→		4836 (65.4) ▲	→		4904 (65.6) ▲	4904 (65.6)	7389 (100)	7389 (100)	e	0-15% variation	15 - 25% variation	>25% variation	● ●	4635	5348
RS				Medical Appraisal and Revalidation	%	78	69	71	→		79	→		84	84	No. Only	No. Only							
RO	K	3		Mandatory Training Compliance	%	77.8 ■	78.9 ▲	79.4 ■	→		80.8 ■	→		83.3 ■	83.3	100	100		=>90	85 - 89	<85	● ●	86.8	71.9
EFFECTIVENESS OF CARE																								
RO	H	8	Acute CQUIN	Dementia	396	%	Met Q1 req's	Met Q1 req's	Meeing Q2 req's	→		Meeing Q2 req's	→		Meeing Q2 req's	Meeing Q2 req's	70	90	f	No variation		Any variation	●		
RS	H	3		Mortality Review	743	%	69.0 ▼	70.6 ▲	61.1 ■	→		58.7 ▼	→			58.7*	64	80	g	No variation		Any variation	●		66.9
RO	H	11	Community CQUIN	Dementia	44	%	Met Q1 req's	Met Q1 req's	Meeing Q2 req's	→		Meeing Q2 req's	→			Meeing Q2 req's	70	90	f	No variation		Any variation	●		
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	92.3 Mar'11 to Feb'12	90.5 Apr'11 to Mar'12	89.7 May'11 to Apr'12	→		88.3 Jun'11 to May'12	→		96.4 Jul'11 to Jun'12	96.4			h						
				Peer (SHA) HSMR		HSMR	97.4	95.8	94.9	→		93.3	→		101.3	101.3									
				Peer (National) HSMR - Quarterly		HSMR	→	90.5	→	→		→	→		97.0	97.0									
	D	19		SHMI		SHMI	101.3 Nov'10 - Oct'11	99.8 Dec'10 - Nov'11	99.1 Jan'11 - Dec'11	→		99.1 Jan'11 - Dec'11	→		99.1 Jan'11 - Dec'11	99.1									
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	164 ▼	117 ■	139 ■	→		141 ▼	→		132 ▲	830	731	1463		No Variation	0 - 5% Variation	>5% Variation	●		1463
				Following initial Elective Admission		%	1.43 ▼	1.15 ■	1.26 ■	→		1.34 ▼	→		1.30 ▲	1.31	1.15	1.15		No Variation	0 - 5% Variation	>5% Variation	●		1.15
				Following initial Non-Elective Admission		No.	682 ▼	612 ▲	710 ▼	→		644 ▲	→		567 ■	3837	3421	6842		No Variation	0 - 5% Variation	>5% Variation	●		6842
				Following initial Non-Elective Admission		%	5.94 ▲	6.03 ▼	6.41 ▼	→		6.13 ■	→		5.59 ■	6.06	5.38	5.38		No Variation	0 - 5% Variation	>5% Variation	●		5.38
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	56.3 ▼	62.5 ▲	80.0 ■	→		76.2 ▼	→		80.0 ▲	71.7	70.0	70.0	i	No Variation	0 - 2% Variation	>2% Variation	●	64.7 (Q4)	66.4
RB		3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	95 ▲	94 ▼	95 ▲	→		95 ■	→		95 ■	95	90	90		>/=90	89.0-89.9	<89	●	94.5	95
		3		Maternity HES		%	6.2 ▼	6.1 ▲	6.4 ▼	→		6.3 ▲	→		6.2 ▲	6.2	<15	<15		=<15	16-30	>30	●	5.4	6.0
	G	11		Data Completeness Community Services		%	No Data	No Data	No Data	→		No Data	→		No Data	No Data	=>50	=>50		=>50		<50	● ● ●		
	H	2		SUS Altered Data		%				→			→												
PATIENT EXPERIENCE																								
RB	A	2	A&E 4-hour waits	4-hour waits		%	95.7 ▲	94.3 ■	94.5 ■	94.3 ■	92.4 ▼	93.4 ▼	95.7 ■	92.4 ■	93.9 ▲	94.52	=>95	=>95	j	=>95		<95	● ●	96.99	95.38
	D	3	A&E Timeliness	Total Time in Department (95th centile)		h : m	3 : 59 ■	4 : 41 ■	4 : 34 ▲	→		4 : 37 ▼	→		4 : 58 ▼	4:36	=<4hrs	=<4hrs		=<4hrs		=<4hrs	● ●		3 : 59
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	15 ■	17 ■	17 ■	→		18 ▼	→		18 ■	17	<15	<15		<15		<15	● ●		21
	D			Time to treatment in department (median)		mins	62 ▲	67 ▼	66 ▲	→		60 ■	→		53 ▲	62	=<60	=<60		=<60		>60	●		59
	D		A&E Patient Impact	Unplanned re-attendance rate		%	7.94 ▼	8.38 ▼	8.26 ▲	→		8.25 ▲	→		7.88 ▲	8.04	=<5.0	=<5.0		=<5.0		>5.0	● ● ●		8.66
	D			Left Department without being seen rate		%	4.91 ▼	5.57 ■	5.26 ▲	→		4.91 ■	→		4.23 ▲	4.96	=<5.0	=<5.0		=<5.0		>5.0	●		4.83
RB		21	Reporting Times of Imaging Requests from ED - **pecentage reported within 24 hours / next day**	Plain Radiography		%	7	4	11	→		14	→		33	33*		90	k						
				Ultrasound		%	100	100	97	→		100	→		100	100*		90							
				MRI		%	71	62	82	→		60	→		71	71*		90							
				CT		%	97	98	98	→		98	→		99	99*		90							

Exec Lead			PATIENT EXPERIENCE (Continued)				May	June	July	August			September			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
	H			Clinical Handovers completed within 15 minutes		%				74.5 ■	83.2 ■	79.4 ■	73.5 ▼	80.7 ▼	77.6 ▼	78.5	=>85	=>85		=>85		<85	● ●		18:41
RB	H	18	Ambulance Turnaround	Average Turnaround Time		m : s	30:56 ▲	32:14 ▼	32:44 ▼	33:49 ▲	31:39 ▼	32:37 ▲	33:50 ▼	32:34 ▼	33.07 ▼	32:08	=<30:00	=<30:00	l	=<30:00		>30:00	●		29:23
	H			In Excess of 60 minutes		No.	122 ▼	131 ▼	166 ▼	70 ▲	79 ▼	149 ▲	84 ▼	79 ■	163 ▼	837	0	0		0		>0	● ● ●		1256
RB	B	2	Mixed Sex Accommodation (Total Number of Breaches)			%	0.00 ■	0.00 ■	0.00 ■	→		0.00 ■	→		0.00 ■	0.00	0.0	0.0	m	0.00	0.00 - 0.50	>0.50	●		0.07
KD	F	14	Complaints	First Formal Complaints Received		No.	51	61	62	→		79	→		56	369	No. Only	No. Only							834
RO	H	8	Acute CQUIN	Personal Needs	396	%	69.4 ▲	67.9 ▲	→	→		→	→		→	67.9	67.6	71.6	n	No variation		Any variation	●		
RO	H	8		Net Promoter	372	No.	57 ■	58 ▲	58 ■	→		60 ▲	→			60	59	65		No variation		Any variation	●		
RO	H	8		End of Life Care	372	%	48 ▲	47 ▼	55 ▲	→		57 ▲	→			57	47	53		No variation		Any variation	●		
RB	H	10		Every Contact Counts - Alcohol	372	%	→	55 Base	→	Quarterly Audit			→			55 Base		80					●		
RO	H	12		Every Contact Counts - Smoking	372	%	→			→			→												
RO	H	11	Community CQUIN	Pt. (Community) Exp'ce - Personal Needs	44	Score	→	→	91 ■	→		95.5 ▲	→			95.5	90	90		No variation		Any variation	●		
RO	H	11		Net Promoter	88	No	→	75 Base	91 (H'son) & 80 (L'wes)	→		71 ■	→			71	75	75	o	No variation		Any variation	●		
RO	H	11		Every Contact Counts	132	%	→	→	→	→		Base data being captured	→		Base data being captured	Base data being captured			n				●		
RO	H	11		Smoking Cessation	132	%	→	→	→	→		Base data being captured	→		Base data being captured	Base data being captured							●		
RS	H		Specialised Commissioners	Clinical Quality Dashboards	49		→	Q1 Data Submitted	→	Quarterly Assessment / Data Submission			→			Q1 Data Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	13		Neonatal - Hypothermia Treatment	73	%	→	Q1 Data Submitted	→	Quarterly Assessment / Data Submission			→			Q1 Data Submitted	Derive Base	Derive Base		No variation		Any variation	●		
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	Q1 Data Submitted	→	Quarterly Assessment / Data Submission			→			Q1 Data Submitted	Derive Base	Derive Base		Met		Not Met	●		
RS	H	12		HIV - Optmum Therapy	147	%	→	Q1 Data Submitted	→	Quarterly Assessment / Data Submission			→			Q1 Data Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RB		15	Elective Access Contact Centre	Number of Calls Received		No.	13128	11426	12755	→		12090	→		11492	71270	No. Only	No. Only						137824	111793
				Average Length of Queue		mins	0.35 ■	0.36 ▼	0.34 ▲	→		0.29 ▲	→		0.39 ▼	0.39*	<1.0	<1.0		<1.0	1.0-2.0	>2.0	●	0	0.21
				Maximum Length of Queue		mins	18.5 ▼	7.2 ■	12.4 ■	→		9.1 ▲	→		13.2 ▼	13.2*	<6.0	<6.0		<6.0	6.0-12.0	>12.0	● ●	6.3	10
			Telephone Exchange	Number of Calls Received		No.	75443	71289	74174	→		75331	→		70935	436993	No. Only	No. Only						909301	849502
				Calls Answered		%	92.6	91.0	92.4	→		89.8	→		90.7	91.5	No. Only	No. Only						90.5	90.2
				Answered within 15 seconds		%	57.9	51.1	57.0	→		54.6	→		64.4	57.0	No. Only	No. Only						52.4	52.5
				Answered within 30 seconds		%	73.7	67.2	72.9	→		70.1	→		77.1	72.3	No. Only	No. Only						68.4	68.1
				Average Ring Time		Secs	20.6	25.0	21.6	→		25.3	→		19.5	19.5*	No. Only	No. Only						21.2	25
				Longest Ring Time		Secs	940	462	780	→		1173	→		734	734*	No. Only	No. Only						731	718
TRANSFORMATION PLAN																									
RB		2	Spells	Elective IP		No.	917 ▼	848 ▲	1113 ■	→		1034 ▼	→		672 ■	5269	5464	10981	p	No Variation	0 - 2% Variation	>2% Variation		11748	10610
				Elective DC		No.	5003 ▲	3899 ▼	4278 ▲	→		4017 ▼	→		4213 ▲	25639	23379	46983		No Variation	0 - 2% Variation	>2% Variation		53959	53685
				Total Elective		No.	5920 ▲	4747 ▼	5391 ▼	→		5051 ▼	→		4885 ▲	30908	28843	57964		No Variation	0 - 2% Variation	>2% Variation	●	65707	64295
				Non-Elective - Short Stay		No.	635 ▲	536 ▼	602 ▲	→		580 ▲	→		479 ■	3413	3110	6416		No Variation	0 - 2% Variation	>2% Variation		16460	13918
				Non-Elective - Other		No.	4243 ■	4182 ▲	4335 ▲	→		4152 ▲	→		4139 ▼	25032	24569	50689		No Variation	0 - 2% Variation	>2% Variation		42540	41757
				Total Non-Elective		No.	4878 ■	4718 ▼	4937 ▲	→		4732 ▲	→		4618 ▼	28445	27679	57105		No Variation	0 - 2% Variation	>2% Variation	●	59000	55675
			Outpatient Attendances	New		No.	15663 ▲	12428 ▼	15147 ▲	→		13634 ▼	→		13605 ▲	83913	72065	144072		No Variation	0 - 2% Variation	>2% Variation	●	163493	159051
				Review		No.	35673 ▼	28797 ▼	33831 ▲	→		31369 ▼	→		30151 ▲	193260	214949	430846		No Variation	0 - 2% Variation	>2% Variation	●	440812	421494
			A/E Attendances	Type I (Sandwell & City Main Units)		No.	15951 ■	15317 ▼	15819 ▲	6530 ▲	7763 ▼	14293 ▼	5942 ■	7134 ■	13076 ■	89185	88902	175107		No Variation	0 - 2% Variation	>2% Variation	●	181494	177201
				Type II (BMEC)		No.	2777 ▼	2293 ▼	2359 ▲	→	2143 ▼	2143 ▼	→	1973 ▼	1973 ▼	14386	18895	37217		No Variation	0 - 2% Variation	>2% Variation	● ● ●	36756	36362
		16	Community	Adult - Aggregation of 18 Individual Service Lines		No.	48473 ▲	44182 ▼	49385 ▲	→		47984 ▼	→			231562	205733	492472		No Variation	0 - 2% Variation	>2% Variation	●	461797	493163
				Children - Aggregation of 4 Individual Service Lines		No.	15902 ▼	11471 ■	12909 ▲	→		10284 ▼	→			62155	66458	158876		No Variation	0 - 2% Variation	>2% Variation	●	102773	143400

Exec Lead			TRANSFORMATION PLAN (Continued)			May	June	July	August			September			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13								
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.28 ■	2.32 ■	2.23 ▲	2.93 ▼	2.06 ▼	2.30 ■	2.70 ▲	2.03 ▲	2.22 ▲	2.30	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	●	2.70	2.65
				DNA Rate - New Referrals	%	10.7 ▲	11.9 ▼	11.8 ▲	→		12.6 ▼	→		11.9 ▲	11.2	10.0	10.0		No variation		Any variation	● ●	13.1	11.8
				DNA Rate - Reviews	%	9.7 ■	10.6 ■	11.4 ▼	→		10.9 ▲	→		11.0 ▼	10.3	10.0	10.0		No variation		Any variation	●	11.9	10.5
RB		2	Patient Flow	Average Length of Stay	Days	4.0 ▲	3.9 ▲	3.4 ▲	4.0 ▼	3.2 ■	3.5 ▼				3.8	4.3	4.3		No Variation	0 - 5% Variation	>5% Variation	●	4.3	4.2
				Day of Surgery (IP Elective Surgery)	%	91.6 ▲	90.6 ▼	92.4 ▲	89.6 ▼	92.7 ■	91.6 ▼	88.4 ▼	85.3 ▼	86.5 ▼	91.0	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	●	88.7	89.5
				Daycase Rate - All Procedures	%	83.2 ▼	80.7 ▼	78.3 ■	82.7 ▼	75.6 ▲	78.4 ▲	87.3 ▲	83.3 ■	85.0 ■	82.2	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	●	81.5	82.7
RO		7	Sickness Absence	Long Term (> 28 days)	%	3.51 ▼	3.33 ▲	3.26 ▲	→		3.34 ▼	→		3.28 ▲	3.29 (Q2)	<2.20	<2.20	q	<2.20	2.20-2.55	>2.55		3.12	2.95
				Short Term (<28 days)	%	0.99 ▼	0.90 ▲	0.90 ■	→		0.76 ▲	→		0.91 ▼	0.86 (Q2)	<1.05	<1.05		<1.05	1.05-1.20	>1.20		1.05	0.95
	D			Total	%	4.50 ▼	4.23 ▲	4.16 ▲	→		4.10 ▲	→		4.19 ▼	4.15 (Q2)	<3.25	<3.25		<3.25	3.25-3.75	>3.75	● ●	4.17	3.90
RO		17	Bank & Agency Use	Nurse Bank Fill Rate	%	90.6	85.7	89.1	→		86.9	→		87.0	87.5	No. Only	No. Only						86.2	87.2
				Nurse Bank Shifts covered	No.	4462 ▼	4684 ▼	4893 ▼	→		5385 ▼	→		4922 ▲	28797	23490	46980		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	54952	56396
				Nurse Agency Shifts covered	No.	569 ▲	577 ▼	491 ▲	→		674 ▼	→		481 ▲	3447	1915	3830		0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	4550	6948
KEY ACCESS TARGETS																								
RB	A	1	Cancer	2 weeks	%	94.8 ▲	94.0 ▼	95.6 ▲	→		94.4 ▼	→			94.7	=>93	=>93	r	No variation		Any variation	●	94.5	94.8
	A			2 weeks (Breast Symptomatic)	%	98.7 ▲	93.0 ▼	100 ▲	→		98.0 ▼	→			97.1	=>93	=>93		No variation		Any variation	●	94.7	95.8
	A			31 Day (diagnosis to treatment)	%	100 ▲	100 ■	100 ■	→		98.8 ▼	→			99.6	=>96	=>96		No variation		Any variation	●	99.7	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	100 ▲	100 ■	100 ■	→		97.8 ▼	→			99.4	=>94	=>94		No variation		Any variation	●	99.5	100.0
	A			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>98	=>98		No variation		Any variation	●	100	99.2
	A			31 Day (second/subsequent treat - radiotherapy)	%	n/a	100 ■	n/a	→		100 ■	→			100	=>94	=>94		No variation		Any variation	●	100	100
	A			62 Day (urgent GP referral to treatment)	%	86.7 ▲	86.0 ▼	86.4 ▲	→		93.7 ▲	→			87.9	=>85	=>85		No variation		Any variation	●	88.0	86.9
	A			62 Day (referral to treat from screening)	%	100 ■	100 ■	90.0 ▼	→		92.9 ▲	→			98.0	=>90	=>90		No variation		Any variation	●	99.2	98.5
	H			62 Day (referral to treat from hosp specialist)	%	90.5 ▼	97.1 ▲	84.4 ■	→		97.9 ■	→			93.3	=>85	=>85		No variation		Any variation	●	95.6	91.6
RB	A	2	RTT 18-Weeks	Admitted Care (RTT <18 weeks)	%	93.9 ▼	93.6 ▼	94.3 ▲	→		95.3 ▲	→		93.3 ▼	93.3*	=>90.0	=>90.0	s	=>90.0	85-90	<85.0	●	92.7	93.2
	A			Non-Admitted Care (RTT <18 weeks)	%	99.4 ▲	96.7 ▼	99.0 ▲	→		98.5 ▼	→		96.5 ▼	96.5*	=>95.0	=>95.0		=>95.0	90 - 95	=<90.0	●	96.7	97.5
	A			Incomplete Pathway (RTT <18 weeks)	%	97.1 ▲	97.4 ▲	97.5 ▲	→		97.7 ▲	→		97.0 ▼	97.0*	=>92.0	=>92.0		=>95.0	87 - 92	=<87.0	●		97.2
	E			Treatment Functions Underperforming	No.	4 ■	3 ▲	4 ▼	→		3 ▲	→		4 ▼	4*	0	0		0 / month	1 - 6 / month	>6 / month	●		10 (Q4)
	H			Audiology D.A Patients seen in <18 weeks	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	100	100		100		<100	●		100
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.67 ■	0.62 ▲	0.26 ▲	→		0.97 ▼	→		1.47 ■	1.47*	<1.0	<1.0		<1.0	1.0 - 5.0	>5.0	●		0.99
RB	C	2	Delayed Transfers of Care	Acute	%	4.4 ▼	2.7 ■	2.6 ▲	2.5 ■	2.6 ▲	2.5 ▲	2.8 ▼	4.3 ■	3.6 ■	3.2	<3.5	<3.5	t	<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
				Pt's Social Care Delay	No.	19 ■	10 ■	3 ▲	4 ▼	7 ▼	11 ▼	8 ▼	3 ▲	11 ■	11*	<18	<18		No Variation	0 - 10% Variation	>10% Variation		23	13
				Pt.'s NHS & NHS plus S.C. Delay	No.	7 ■	13 ■	4 ■	2 ■	6 ▼	8 ▼	2 ■	8 ■	10 ■	10*	<10	<10		No Variation	0 - 10% Variation	>10% Variation		22	20
RB	H	2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.4 ▼	0.6 ▼	0.7 ▼	0.4 ▲	0.3 ■	0.4 ▲	0.5 ▼	0.9 ■	0.7 ▼	0.5	<0.8	<0.8	u	<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
	H			28 day breaches	No.	0 ■	0 ■	0 ■	→		0 ■	→		1 ■	1	1	3		3 or less	4 - 6	>6	●	1	1
				Sitrep Declared Late Cancellations by Speciality	No.	27 ▼	27 ■	34 ■	8 ▲	9 ■	17 ■	9 ■	25 ■	34 ■	151	160	320		0-5% variation	5 - 15% variation	>15% variation	●	500	363
RB		10	Cardiology	Primary Angioplasty (<150 mins)	%	95.2 ▼	88.2 ▼	100 ▲	88.9 ▼	100 ■	92.3 ▼				94.5	=>80	=>80	v	=>80	75-79	<75	●	90.7	88.4
				Rapid Access Chest Pain	%	98.3 ▲	100 ▲	93.6 ■	100 ■	89.5 ▼	96.0 ▲	100 ■	94.7 ▲	97.7 ■	97.0	=>98	=>98		=>98	96 - 97.9	<96	●	100.0	99.1
RB		12	GUM 48 Hours	Patients offered app't within 48 hrs	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	=>98	=>98	w	=>98	95-98	<95	●	100.0	100
RO	G	8	Access to healthcare for people with Learning Disability (full compliance)		Y / N	N ■	Y ■	Y ■	→		Y ■	→		Y ■	Yes	Full	Full		Y		N	●		N

KEYS AND SUMMARY PERFORMANCE AGAINST INDICATORS WHICH COMPRISE NATIONAL PERFORMANCE FRAMEWORKS

NHS PERFORMANCE FRAMEWORK	May	June	July	August		September	
Performing	17	17	17	→	16	→	14
Underperforming	2	2	2	→	2	→	3
Failing	0	0	0	→	1	→	2
No Data	0	0	0	→	0	→	0
Average weighted Score	2.86	2.86	2.86	→	2.64	→	2.46

MONITOR COMPLIANCE FRAMEWORK	May	June		August		September	
Performing	14	14	14	→	14	→	13
Underperforming	1	1	1	→	1	→	2
No Data	1	1	1	→	1	→	1
Overall Governance Rating	1.5	2.0	2.0	→	2.0	→	3.0

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

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

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Mike Harding, Head of Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	25 October 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 (September):
There were 5 areas of underperformance during the month of September; A&E 4-hour waits (93.90%), RTT Delivery in all specialities, Diagnostic Waits (1.47% greater than 6 weeks) and Delayed Transfers of Care which have increased slightly to 3.6%. Additionally, indications are that the 62-day urgent GP Referral to Treatment Cancer target, the threshold for which is 85%, is unlikely to be met, with actual performance of c.75% for the month. The overall average weighted score for service performance has reduced to 2.46. CQC Registration Status remains Unconditional. As such for the month of September the Trust attracts a **PERFORMING** classification.

Service Performance (Quarter 2):
The overall score of 2.64 for the Quarter is influenced by 3 areas of underperformance; A&E 4-hour waits, RTT delivery in all specialities and VTE Assessments, with data for the latter indicating performance of 89.54%, marginally below the 90.00% threshold. The Trust attracts a **PERFORMING** classification.

Financial Performance (September):
The weighted overall score remains 2.93 with underperformance reported in 2 areas; Better Payment Practice Code (Value) and Creditor Days. The classification for the month of September remains **PERFORMING.**

Foundation Trust Compliance Summary report (September):
Within the Service Performance element of the Risk Rating for the month of September the Trust underperformed against the A&E 4-hour wait target and is currently unable to report its performance against the 'Data Completeness Community Services Indicator'. Additionally, as stated above the 62-day urgent GP Referral to Treatment Cancer target is also unlikely to be met. The overall score for the month has increased to 3.0, which attracts an **AMBER / RED** Governance Rating.

Performance for Quarter 2 (score 2.0) is influenced by underperformance against A&E 4-hour waits and inability to report against the 'Data Completeness Community Services Indicator', the Governance Rating remains **AMBER / RED.**

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 16 October 2012 and Finance & Performance Management Committee on 19 October 2012.

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

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Performance Thresholds: Score 2	Performance Thresholds: Underperforming (Score 0)	Quarter 1 2012/13	Score	Weight x Score	July 2012/13	Score	Weight x Score	August 2012/13	Score	Weight x Score	September 2012/13	Score	Weight x Score	Quarter 2 2012/13	Score	Weight x Score
A/E Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	95.14%	3	3.00	94.45%	2	2.00	93.40%	0	0.00	93.90%	0	0.00	93.91%	0	0.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	3	3.00	1	3	3.00	1	3	3.00	1	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	6	3	3.00	2	3	3.00	6	3	3.00	2	3	3.00	10	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	93.8%	3	3.00	94.3%	3	3.00	95.3%	3	3.00	93.3%	3	3.00	94.3%	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	98.4%	3	3.00	99.0%	3	3.00	98.5%	3	3.00	96.5%	3	3.00	98.0%	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	97.1%	3	3.00	97.5%	3	3.00	97.7%	3	3.00	97.0%	3	3.00	97.4%	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	11	2	2.00	4	2	2.00	3	2	2.00	4	2	2.00	11	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	0.87%	3	3.00	0.26%	3	3.00	0.97%	3	3.00	1.47%	2	2.00	0.90%	3	3.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	94.5%	3	1.50	95.6%	3	1.50	94.4%	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%	96.2%	3	1.50	100.0%	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%	99.8%	3	0.75	100.0%	3	0.75	98.8%	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%	99.7%	3	0.75	100.0%	3	0.75	97.8%	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	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	n/a	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%	86.4%	3	1.50	86.4%	3	1.50	93.7%	3	1.50	<80.0%*	0	0.00	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	100.0%	3	1.50	90.0%	3	1.50	92.9%	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%	2	2.00	2.60%	3	3.00	2.50%	3	3.00	3.60%	2	2.00	<3.50%	3	3.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.13%	3	3.00	90.29%	3	3.00	87.20%	2	2.00	90.10%	3	3.00	89.54%	2	2.00
Sum (all weightings)	**14.00**																		
Average Score (Integrated Performance Measures)							**2.86**			**2.86**			**2.64**	* projected		**2.46**	* projected		**2.64**

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**			**Performing**

Overall Quality of Service Rating

							Performing			**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 TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

Financial Indicators				SCORING			2012 / 2013			2012 / 2013			2012 / 2013		
Criteria	**Metric**	**Weight (%)**		**3**	**2**	**1**	**July**	**Score**	**Weight x Score**	**August**	**Score**	**Weight x Score**	**September**	**Score**	**Weight x Score**
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	**0.06%**	**3**	**0.6**	**0.15%**	**3**	**0.6**	**0.28%**	**3**	**0.6**
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	**5.53%**	**3**	**0.15**	**5.70%**	**3**	**0.15**	**5.85%**	**3**	**0.15**
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	**6.29%**	**3**	**0.15**	**6.27%**	**3**	**0.15**	**6.27%**	**3**	**0.15**
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	**0.92%**	**3**	**0.15**	**0.91%**	**3**	**0.15**	**0.91%**	**3**	**0.15**
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	**6.29%**	**3**	**0.15**	**6.27%**	**3**	**0.15**	**6.27%**	**3**	**0.15**
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	**96.00%**	**3**	**0.075**	**94.00%**	**2**	**0.05**	**91.00%**	**2**	**0.05**
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	**91.00%**	**2**	**0.05**	**95.00%**	**3**	**0.075**	**95.00%**	**3**	**0.075**
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	**1.07**	**3**	**0.15**	**1.10**	**3**	**0.15**	**1.10**	**3**	**0.15**
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	**10.45**	**3**	**0.15**	**11.44**	**3**	**0.15**	**12.99**	**3**	**0.15**
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	**42.83**	**2**	**0.1**	**38.26**	**2**	**0.1**	**36.87**	**2**	**0.1**
						Weighted Overall Score			**2.93**			**2.93**			**2.93**

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Provider Management Regime return – September 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:	25 October 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 September 2012 are as follows:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	A
Financial Risk Rating (Assign number as per SOM guidance)	G
Contractual Position (RAG as per SOM guidance)	A

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.

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
September 12

NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each

TFA Progress

Sep-12

Sandwell & West Birmingham Hospitals NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Comments where milestones are not delivered or where a risk to delivery has been identified
1	Draft IBP and LTFM submitted	Aug-11	Fully achieved in time	
2	Assess and challenge IBP/LTFM	Sep-11	Fully achieved in time	
3	HDD stage 1	Dec-11	Fully achieved in time	
4	8 week public engagement completed	Mar-12	Fully achieved in time	
5	First cut Quality Governance self-assessment	May-12	Fully achieved in time	
6	BGAF process	Sep-12	Fully achieved in time	
7	Submit IBP/LTFM to SHA for review	Sep-12	Fully achieved in time	
8	Final cut Quality Governance self-assessment	Sep-12	Fully achieved in time	
9	Submission of key FT application documentation for review	Sep-12	Fully achieved in time	
10	External validation of final Quality Governance sef-assessment	Oct-12	On track to deliver	
11	FT readiness review with SHA	Oct-12	On track to deliver	
12	Final IBP/LTFM - SHA submission	Nov-12	On track to deliver	
13	BGAF validation	Nov-12	On track to deliver	
14	Board able to certify compliance with IG toolkit	Dec-12	On track to deliver	
15	SHA approval review	Dec-12	On track to deliver	
16	HDD Stage 2	Dec-12	On track to deliver	
17	SHA FT quality assessment	Jan-13	On track to deliver	
18	Final submission of all key outstanding documentation to SHA	Jan-13	On track to deliver	
19	Final SHA Board to Board	Feb-13	On track to deliver	
20	Submission of FT application to DH	Mar-13	On track to deliver	

Note - Revised TFA now agreed with SHA / DH

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

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

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, 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 SOM guidance)	A
Financial Risk Rating (Assign number as per SOM guidance)	G
Contractual Position (RAG as per SOM guidance)	A

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

Governance Declarations

NHS Trusts 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:		Print Name:	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:	Chairman	

Signed by:		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 :	

GOVERNANCE RISK RATINGS

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

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Current Data: Jul 12	Current Data: Aug-12	Current Data: Sep-12	Current Data: Qtr to Sep-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	No	No	No	No	No	No	Action plan exists to achieve compliance. Will be compliant by the month of October 2012.
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		No	No	No	No	No	No	No	As above
			Patients dying at home / care home	50%		No	No	Yes	Yes	Yes	Yes	Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	Yes	Yes	Yes	Yes	Yes	Status changed June 2012
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	August 2012 performance confirmed from National Cancer Waiting Times system report. September performance projected.
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes	No	No	August 2012 performance confirmed from National Cancer Waiting Times system report. September performance projected, indications are that the 62-day Urgent GP Referral to Treatment target will not be met.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	August 2012 performance confirmed from National Cancer Waiting Times system report. September performance projected.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	As above
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	Yes	No	No	No	No	Performance in September was 93.9%. Departments are in Trust's special measures regime in order to resolve issues. External reviews by SHA and independent expert completed. Action plan being further refined.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3j	Category A call – emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	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	No	No	No	
				TOTAL		**1.5**	**1.5**	**1.0**	**2.0**	**2.0**	**3.0**	**3.0**	

RAG RATING :

GREEN	**= Score of 1 or under**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score of 4 or above**

Overriding Rules - Nature and Duration of Override at SHA's Discretion

i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective	No	No	No	No	No		No	
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No		No	
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No		No	
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	No	No	No	No	No		No	
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No		No	
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter	No	No	No	No	No		No	Entry of n/a triggers a 'Yes' in final column, and an override. Conditional formatting has not been set up correctly, hence entry of 'No'.
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	Yes	Yes	Yes	Yes	Yes		Yes	
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.	Yes	Yes	Yes	Yes	Yes		Yes	
		Number of Overrides Triggered	***2.0***	***2.0***	***2.0***	***2.0***	***2.0***	***0.0***	***2.0***	

FINANCIAL RISK RATING

Sandwell & West Birmingham Hospitals NHS Trust

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

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Comments where target not achieved
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	5	4	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	3	2	3	Reflects in year profiling of surplus.
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	Includes effect of assumed working capital facility
Weighted Average		**100%**						**3.0**	**3.1**	**3.0**	**3.2**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

Max Rating	Rule	
3	Plan not submitted on time	No
3	Plan not submitted complete and correct	No
2	PDC dividend not paid in full	No
2	One Financial Criterion at "1"	
3	One Financial Criterion at "2"	
1	Two Financial Criteria at "1"	
2	Two Financial Criteria at "2"	

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Sandwell & West Birmingham Hospitals NHS Trust

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

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	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	No	No	No	
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No	No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No	No	No	
9	Capital expenditure < 75% of plan for the year to date	Yes	No	Yes	Yes	Yes	Yes	Yes	

CONTRACTUAL DATA

Sandwell & West Birmingham Hospitals NHS Trust

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

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
Might the dispute require SHA intervention or arbitration?	No	No	No	No	No	No	No	
Are the parties already in arbitration?	No	No	No	No	No	No	No	
Have any performance notices been issued?	No	No	Yes	Yes	Yes	Yes	Yes	3 Performance Notices were received in June, all of which relate to performance during April. The 3 areas were; A&E Timeliness, 18-weeks Admitted Care RTT and 6-week Diagnostic Waits. RTT performance at specialty level (T&O and Plastic Surgery) remains below required thresholds for Admitted Patient Care and Incomplete Patient Care. A&E Clinical Indicator performance during September was such that performance thresholds were met for 2 of the 5 indicators, 1 in each of the Timeliness and Patient Impact groupings. Diagnostic Waits for September was 1.47%.
Have any penalties been applied?	No	No	Yes	Yes	Yes	Yes	Yes	

QUALITY

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

	Criteria	Unit	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Comments on Performance in Month
1	SHMI - latest data	Ratio	101.3	99.8	99.7	99.7	99.7	99.7	99.7	99.8	99.1	99.1	99.1	99.1	SHMI data relates to period January 2011 - December 2011 which continues to be the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	92.2	93.3	90.8	92.9	92.4	92.6	92.4	92.9	91	90.3	87.2	90.1	
3a	Elective MRSA Screening	%	42.2	41.6	42.5	40.2	39.4	40.8	38.1	39.9	40.7	42	39.5	38.7	Data represents actual screens matched to specific patients requiring screens. An improvement trajectory leading to a 85% March 2013 target has been set. Review of recording methods and matching of screens to patients who require screens is under review and will be complete within the next reporting period
3b	Non Elective MRSA Screening	%	68.3	66.5	54.2	50.5	58.7	61.7	70.3	64.1	66.3	68	69.1	66.1	Data represents actual screens matched to specific patients requiring screens. An improvement trajectory leading to a 85% March 2013 target has been set. The Trust will review the target and trajectory and report
4	Single Sex Accommodation Breaches	Number	0	0	0	0	8	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number			8	8	8	2	8	7	9	10	4	2	
6	"Never Events" in month	Number			1	1	1	1	0	0	0	1	0	1	Incorrect tooth extraction. WHO checklist used. Correct tooth removed subsequently. More robust use of Imaging facilities being ensured to prevent reoccurrence
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number			10	14	19	23	20	19	17	14	9	10	6 alerts are overdue for completion and 2 will be signed off in October 2012.
9	RED rated areas on your maternity dashboard?	Number	1	4	4	4	4	4	2	1	2	4	3	3	Midwifery Staff Vacancies (9.0%), Midwifery Staff Sickness Absence (5.5%) and Deliveries during month of 564 exceeding upper threshold of 550.
10	Falls resulting in severe injury or death	Number	3	1	4	2	6	2	3	0	1	1	2	6	
11	Grade 3 or 4 pressure ulcers	Number	2	0	5	14	5	7	12	4	1	3	0	0	
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.83% in September (3553 records compliant of 3559 total). All list and individual checklists are checked for completeness by senior staff at the end of the session and then entered onto a data base
13	Formal complaints received	Number	77	67	51	59	69	72	60	51	61	62	79	56	
14	Agency as a % of Employee Benefit Expenditure	%	1.8	1.3	1.5	1.7	1.8	2.5	1.7	1.4	1.9	1.9	2.24	1.8	
15	Sickness absence rate	%	4.19	4.43	4.28	4.34	4.39	4.13	4.06	4.51	4.23	4.16	4.1	4.18	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%					78	72	74	78	69	71	79	84	These figures indicate the percentage of Consultant Appraisals that were completed at that time without reference to completed PDPs which are seen as a more dynamic document.

Board Statements

dwell & West Birmingham Hospitals NHS T

September 12

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), the 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.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	Yes
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**John Adler**	**25/10/2012**
Chair		**Richard Samuda**	**25/10/2012**

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) 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. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries.
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (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. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.

Notes

Ref	Indicator	Details
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. 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. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist 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. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2012/13 – Q2 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon – Director of Strategy and OD**
AUTHOR:	**Neetu Sharma – Head of Strategic Planning**
DATE OF MEETING:	**30 August 2012**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for Q2.

REPORT RECOMMENDATION:

To discuss progress against achievement of the key activities outlined in the Trust Annual Plan for Q2.

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:

Relates to all annual priorities

PREVIOUS CONSIDERATION:

None

Trust Board - 25th October 2012

Annual Plan – Quarter 2 Update

1.0 Introduction

The purpose of this report is to provide an update on delivery of each of the key priorities identified in the 2012/13 Annual Plan.

2.0 Delivery against Priorities

This report provides a summary of progress against each of the five Trust priority areas for the year as well as the sections of the Annual Plan that were required by the SHA. This report therefore covers the following summary themes:

- Delivering the Quality priorities set out in our quality account and annual plan
- Workforce Plans
- Progressing towards becoming a Foundation Trust
- Achieving key access targets
- Right Care Right Here
- Service Developments (other than RCRH)
- Sustainability
- Delivering the Transformation Plan

It provides a summarised analysis of progress and informs the Board where more detailed reporting of individual objectives takes place.

Of the eight summary themes; three are GREEN, four are AMBER and one (Right Care Right Here delivery) is RED.

3.0 Recommendations

The Board is asked to:

- Accept progress against delivery of each of the key priorities identified in the 2012/13 Annual Plan.
- Consider the key issues outlined for the attention of the Board for each key priority area.

Update Against Key Priorities – Q2	
Key Priority Area	**Delivering Quality priorities set out in our quality account and annual plan**
Executive Lead	Chief Nurse/ Director of Governance/ Medical Director
Summary of position	• Stroke standards continue to be variable but are generally showing an improvement trend. • Safer surgery compliance is now consistently above 98%. • CQUiNs are all on target for end of year achievement. • Infection control targets are being achieved with the exception of MRSA screening target. • Safety thermometer is currently registering 95% harm free care. • ED progress is slow but the main 'building blocks' are now in place. • T&O action group now in place. • Pressure damage rates continue to reduce.
Key issues to flag to the attention of the Board	• Structure to support ED revised to create greater Executive/Directorate communication/action. • MRSA screening rates – action plans in development and data cleansing.
Current Reporting Process	All of the above are included in Quality Report, which goes to Governance Board/Q&S and Trust Board.
RAG rating – Q2	**4**

Update Against Key Priorities – Q2	
Key Priority Area	**Workforce Plans**
Executive Lead	Chief Nurse/ Director of Strategy and Organisational Development
Summary of position	• Workforce reduction programme on target. • Bank/agency reduction negatively affected by pause in bed closure plans and winter pressures. • Medical agency not reducing – mainly ED and Surgery B. • Workforce efficiency programme delivering against plan. • HR dashboard established. • Workforce assurance tool (SHA) being reviewed for possible use. • Workforce plans include some new roles/ways of working. • Leadership framework in place. • Sickness absence not on trajectory. • On track NHSLA standards (workforce).
Key issues to flag to the attention of the Board	• Sickness absence not reducing as planned. Action plan revised. • Delays with other plans affecting delivery in some cases. • Workforce assurance tool gives some useful data – reviewing how best to use this. • More focus required on leadership/succession/talent spotting.
Current Reporting Process	• Workforce and medical efficiency programme reported as part of Transformation Programme reports. • HR dashboard reported to F&PC. • Sickness absence, mandatory training, PDR information on Performance Report.
RAG rating – Q2	**3**

Update Against Key Priorities – Q2	
Key Priority Area	**Progressing towards becoming a Foundation Trust**
Executive Lead	Mike Sharon, Director of Strategy and Organisational Development
Summary of position	A revised Tripartite Formal Agreement has been agreed and signed by the Trust, SHA and DH. In the last quarter the Trust has completed the following stages of the FT application: • Board Governance Memorandum self-assessment. • Two Board self- assessments against the Monitor Quality Governance domains (both have been independently verified). • SHA and external assessments of the Board and sub-committees of the Board and interviews with Board Members. • A 'mock' Board to Board session with the external support that has been engaged to provide Board development support. • FT readiness meeting with the SHA. • Submission of two drafts of the IBP/LTFM and supporting documentation to the SHA for review. We will now commence production of the 8th draft of the IBP. This is planned for submission to the SHA at the end of November 2012. HDD stage 2 is planned to commence in December 2012, and a final quality governance self-assessment and independent validation will need to be prepared ahead of the end of January 2013 deadline of submission of all outstanding FT application documentation to the SHA. The SHA Quality and Safety visit is planned for the 15th January 2013.
Key issues to flag to the attention of the Board	Following the SHA readiness review meeting, a number of areas for action were identified which will require resolution. A revised draft of the IBP and LTFM will need to be produced and submitted to the SHA at the end of November 2012 incorporating any specific feedback from the SHA. The SHA have specified that detailed 2 year TSP's and outline for a further 3 years will be required for the November submission. The integrated Development Plan sets a number of challenging timescales for the Trust.
Current Reporting Process	FT Programme Director's Report to the Trust Board.
RAG rating – Q2	**3**

Update Against Key Priorities – Q2 Template	
Key Priority Area	**Achieving key access targets**
Executive Lead	Chief Operating Officer
Summary of position	• Overall good performance with the exception of ED performance and 18 weeks at specialty level (Plastics and Orthopaedics): o ED 94.52% YTD; o September performance 18 weeks: orthopaedics admitted: 72.62 % and Plastics 85.61%. • Sustained improvements in Delayed Transfers of Care (3.2%YTD) and continued delivery of Cancer targets. • Stroke: Variable performance in Stroke and TIA services. Reconfiguration business case approved and on track for implementation in Q4. • Cancer – Trust may miss 62 day target for September.
Key issues to flag to the attention of the Board	**Emergency Department Performance:** Both main ED's were placed into special measures in Q2. Performance deteriorated particularly on the City site. Special measures plan in place and overseen by EDAT chaired by CEO. Primary focus has been safety due to incident trend, which was the primary trigger for special measures. External assessments completed by SHA and experts in emergency medicine. Key Issues include clinical leadership, effective team working/ communication, a comprehensive approach to local governance and a lack of systems and processes. Despite some progress against the above issues the above remain of concern and ED Performance remains a risk at the end of Q2. A key leadership appointment has recently been made to the new role of a Clinical Director for Emergency Care. The post holder starts in October. An initial view of focus areas for improving performance includes: assessment and triage system review, standardising practice and pathways, developing clinical leadership and effective team working and revising escalation procedures. A report on ED performance and quality will be submitted to the October Trust Board. Capacity planning: bed (reduction) programme put on hold. Non-elective activity over performing YTD causing pressure. **Working with partner organisations to respond to pressures both in ED attendances and admissions.** 18 weeks**:** Trajectory for improvement for T&O and plastics and investment

	to support additional backlog capacity agreed. Reconfiguration of orthopaedics to Sandwell completed in Q2. Cancer: Delays in the treatment pathway may mean that the Trust misses the 62 day target for September
Current Reporting Process	Performance reporting is via PMB to Trust Board. The Trust Board receives a monthly update on performance. Exceptional reporting on areas of risk are via individual agenda items e.g. ED updates and Stroke Reconfiguration Business Case.
RAG rating – Q2	**3**

Update Against Key Priorities – Q2	
Key Priority Area	**Right Care Right Here**
Executive Lead	Director of Strategy and Organisational Development
Summary of position	**RCRH Programme:** Management of the Programme is now embedded within the CCG structure and a Partnership event in September confirmed on-going commitment to the Partnership and the Programme. A new Programme meeting structure was agreed at the Partnership Board meeting in October. Within this meeting structure there will be a group focusing on pathway redesign including implementation. **Implementation of Redesigned Care Pathways:** As part of the LDP agreement for 2012/13 it was agreed to progress implementation of the approved RCRH redesigned care pathways (as part of QIPP). Recent CCG prioritisation events have confirmed this as a priority for the CCG. There has been a delay in taking this work forward whilst the CCG structure has been appointed to but rapid progress is now expected in terms of agreeing implementation plans and timescales (during quarter 3) and then starting to implement the pathways (during quarter 4). **QIPP Savings:** Of the £10million income reduction related to QIPP Savings and agreed as part of the LDP, only high-level plans have been identified with activity reductions equating to circa £6.3million. Activity monitoring suggests at month 5, an underperformance against the high level plans of circa £800k mainly due to higher levels of non-elective (emergency) admissions than planned. Some of the QIPP savings are expected to come from implementation of the approved RCRH redesigned care pathways (these mostly impact on outpatient activity).
Key issues to flag to the attention of the Board	• Delay in implementing the approved RCRH redesigned care pathways whilst CCG structure appointed to and CCG priorities confirmed. Rapid progress now expected. • QIPP saving activity reductions only identified at a high level and to the value of £6.3million against the LDP agreement of £10 million. This creates a potential gap for the 2013/14 LDP.
Current Reporting Process	Monthly RCRH Implementation Board meeting with monthly progress report to Trust Board.
RAG rating – Q2	**2**

Update Against Key Priorities – Q2 Template	
Key Priority Area	**Service Developments (other than RCRH)**
Executive Lead	Director of Strategy and Organisational Development
Summary of position	Clinical Service Reconfigurations: • **Vascular Surgery** – transfer of inpatient service to UHBFT completed 10/9/12. • **Stroke and Transient Ischaemic Attack (TIA) Services** – implementation plan in progress & on track to implement from end of February 2013. Returns submitted to Network as part of SHA Strategic Review of Stroke Services. • **Orthopaedic Inpatient Services** – transfer to Sandwell Hospital completed 24/8/12. • **Development of an Emergency Assessment Unit (EAU) at City Hospital** – the development of an EAU at City is no longer a service development for 2012/13. • **Pathology** - The Blood Sciences Laboratory phase 1 work is on track for completion by end of January 2013 and within budget. The LTS study of our and Dudley Group of Hospitals Pathology Laboratories is on going with a final report due in December 2012. The tendering of direct access work is expected to start at end of October 2012. We are currently carrying out an option appraisal of whether to bid for the work, whether we need a partner and if so, should it be another NHS lab or a private provider. Major Capital Redevelopments: • **Endoscopy Unit Upgrade –** This project is on track. Phase 1, (Endoscopy washers and decontamination) will be operational by the end of March 2013. Phase 2, (the Endoscopy unit works) will commence on 1st April 2013 (in line with the Capital Programme). Expansion of Specialist Services: • **National Behçet's Syndrome Centre** – The Centre has been established with clinics starting slightly ahead of plan (and the other 2 national centres). Most of the staff have been recruited with recruitment for the Consultant Ophthalmologist post on-going. To date the clinics have been held within the BMEC outpatient department but the plan is to transfer the clinics to a dedicated area within the Clinical Research Facility (adjacent to BMEC) by the end of November. • **Gynae-Oncology Service** - work is on-going within the speciality to develop pathways with referring units, rollout the Survivorship Programme, identify any further opportunities to convert open surgery to minimal access surgery, develop an outpatient ascetic drainage service and explore an 'at home service'. An External Peer

	Review visit is taking place on 29th October 2012. In addition the specialty is developing a 5 year Clinical Strategy which will be presented to the Executive team for sign off in January 2013. <u>Expansion of our Community Services:</u> • **Health Visiting Service** - Additional 15wte training posts. We are on track to increase Heath Visitor numbers by 15 wte additional posts in 2012/13. We have extensively re-shaped the way we train Health Visitors with 16 due to qualify 2013. In addition a recent care plan audit showed improvements in all of our Health Visiting teams; a Health Visitor Service Rapid Appraisal was undertaken by the SHA in August and the resulting Integrated Development Plan will be produced by the end of October; we are undertaking two pilots to improve outcomes, one with pregnant women suffering domestic abuse and one with children and families with social and emotional attachment issues.
Key issues to flag to the attention of the Board	**Clinical Service Reconfigurations:** • SHA Strategic Review of Stroke Services on-going with aim of having a preferred configuration of Stroke Services across the SHA by end of March 2013.
Current Reporting Process	**Clinical Service Reconfigurations:** Reported Quarterly to Clinical Services Reconfiguration Programme Board, quarterly progress report to Trust Board and specific project updates/Business Cases to Trust Board at key milestones. **Major Capital Redevelopments:** Progress reported to Strategic Investment and Review Group (SIRG). **Expansion of Specialist Services:** Divisional Performance Reviews (by exception). **Expansion of our Community Services:** Directorate Meetings & Divisional Performance Reviews (by exception).
RAG rating – Q2	**Clinical Service Reconfigurations: 3** **Major Capital Redevelopments: 4** **Expansion of Specialist Services: 4** **Expansion of our Community Services: 4**

Update Against Key Priorities – Q2	
Key Priority Area	**Sustainability**
Executive Lead	Director of Estates/New Hospital Project Director
Summary of position	**Carbon emissions reduction in line with the Carbon Trust Carbon Management Plan (CMP)** • The CMP document and baseline is currently being revised to account for organisational changes and to take into account the proposed timeframes for the new hospital. • The revised document states that the Trust will reduce carbon emissions 15% by 2016/17 (from the 20011/12 baseline). It lists a number of projects that will help progress the Trust towards achieving this target. • Current and planned projects in the pipeline include air conditioning controls, energy efficient lighting and controls, steam trap repair work, insulation jackets, and on-going staff engagement work. **Target reduction of 5% for total site energy consumed per 100m3 heated volume (i.e. reduction to 925kWh per 100m3)** • New steam boiler planned for March 2013 with an economiser at Sandwell Hospital that is estimated to save 5% on gas consumption during the summer months (i.e. April-Sept). • Site rationalisation work is also in progress to reduce energy consumption from buildings (see below). **Site rationalisation / agile work implementation as part of Estates TSP** • Rationalisation work progressing with D29 (the Corporate Suite) completed, with D22 and D29 to follow. • The rationalisation / agile working environment will greatly reduce the Trust's energy consumption and help us towards our carbon management target of 15% reduction in carbon emissions by 20156/17 (from 2011/12 levels).
Key issues to flag to the attention of the Board	To note that the energy (and carbon) savings from the site rationalisation / agile working programme will be heavily impacted by any changes to the planned areas for closure and also the timeframes.
Current Reporting Process	Sustainability progress is reported to the Trust Board on a quarterly basis with regards to recently implemented and planned/future projects.
RAG rating – Q2	**4**

Update Against Key Priorities – Q2	
Key Priority Area	**Delivering the Transformation Plan**
Executive Lead	Chief Operating Officer
Summary of position	**Developing an expert level Transformation Support Office (TSO) function within the Trust to improve capacity and capability to deliver large-scale change.** • Work streams established and reporting structures embedded. • Each work stream is supported by an executive director and clinical sponsor (the latter where appropriate). • A Transformation Plan Reporting System is well developed and includes integrated project, quality and financial information. • KMT advising and supporting development of TSO as part of commissioned work. • KMT contracted until end of financial year. TSO team development programme in progress. **Recruitment to key posts: Associate Director Transformation, Chief Informatics Officer, Medical Director** • AD for Transformation vacancy is mitigated by advisory support. • Recruitment on track to be completed in October. • Medical Director appointed and interim Chief Informatics Officer in post. Both post holders are members of the Transformation Plan Steering Group. **Delivery of workforce plan related to all transformation projects.** • Workforce plan identified for each project. • Transformation Plan Reporting System project function developed to track workforce element for each TSP. This is to be implemented in Q3 to strengthen workforce planning for TSPs. • A review of workforce processes related to redundancy planning and approval has taken place to inform a LEAN approach to this element of workforce planning. This was facilitated by KMT. **Impact on other organisations (e.g. primary and community care) to enable change to be identified and delivered, e.g. decommissioning and commissioning of pathway changes to reduce acute hospital activity.** • Some good progress in joint working with Sandwell social services through community work stream. Work plan now being rolled out to Birmingham equivalent stakeholders. • Decommissioning plans at service level are light for outpatients and are a potential block to progress in this an area of decommissioning. This is an area of focus for the Out Patients work stream.

	IT strategy and plan to identify key enablers to projects. • A high-level gap analysis has been completed to inform the alignment of the HIS strategy and the Transformation Plan.
Key issues to flag to the attention of the Board	• As a relatively new way of working in a 5 year approach to Transformation, the capacity and capability of teams to apply and deliver transformational thinking to future planning. This will be addressed through organisational development plan encompassing transformation. This work is currently in a planning phase and linked with the overall organisational development agenda. • Clinical engagement – the development of the clinical sponsor roles has been successful and a significant area of progress from previous approaches to leading change programmes. This now needs to be emulated throughout the Trust in key leadership capability. In part this is relate to point 1. The LIA sponsorship group now includes Transformation Plan engagement. LIA champions have been aligned to Transformation work streams. • Impacts of external commissioning structure changes: Uncertainty on how to work with incoming CCG as they go through a rapid development and establishment phase. The Trust is working with key CCG leaders through the RCRH Programme Board and local forums to establish infrastructure to support transformation plan. • Over performance in non-elective activity has impacted on the delivery of the bed programme.
Current Reporting Process	Transformation Plan Programme update: via TPSG to Trust Board monthly Transformation Plan financial update: via F&PC to Trust Board monthly.
RAG rating – Q2	**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Transformation Plan Status Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow, Chief Operating Officer**
AUTHOR:	**Paul Crabtree, Interim Associate Director of Transformation**
DATE OF MEETING:	**25 October 2012**

EXECUTIVE SUMMARY:

Development of FY13/14 & 14/15 TSPs:

- Workshops help for all clinical workstreams
- Process in place to review al QIAs and EIAs
- Exec sign off meetings underway

Theatres Workstream:

- 3 key projects underway
    1. Centralised booking. Engagement event held on 15th Oct
    2. Scheduling – Project started with "deep dive" review of data and stakeholder review
    3. Pre-Operative Assessment – Benchmark visit to Bristol held and Engagement event planned for 18th Oct.
- T&O identified to pilot all 3 projects

Patient Flow Workstream:

- Daily Discharge Planning meeting now running as part of Phase 1.
    - Daily conference calls held with wards at 10:30 & 14:30
    - Call focus is "named patents ready for discharge" – Not "beds"
- Transport project making good progress towards discharges by 12:00
- TTO project with "near patent pharmacy" live on L2 with roll out plan in place for other wards.

Community:

- Rehab workstream - Visual patient control whiteboards being established (eBMS not currently possible due to IT restrictions).
- Integrated Teams project went live on 1st Oct.

Urgent Care:

- Rapid Initial Assessment in ED model went live on 1st Oct – Trial in place for 4 weeks.

Cardiologist of the Week, within MAU, now live at City since September.

Outpatients:

- Deep Dive + and Exec Task Force on-going with directorates.
- Next phase projects currently being prioritised within steering group
- Patient focussed pathway project now being prepared for roll out with targeted directorates

Transformation Associate Director recruitment: successful candidate appointed

REPORT RECOMMENDATION:

The Board is asked to receive and note the update.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

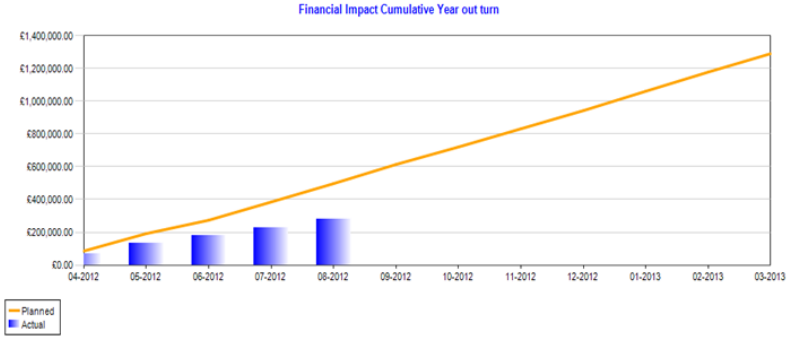
Delivery of the Transformation Plan

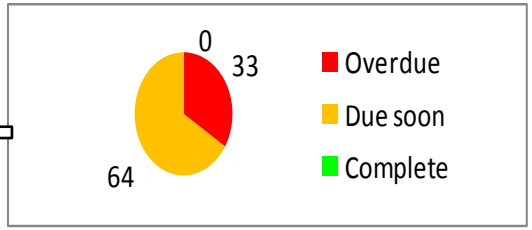
PREVIOUS CONSIDERATION:

Trust Management Board on 16 October 2012

Workstream: Theatres

Financial status





Major milestones impacting on savings

Milestone status

RAG	Milestone(s)	Impact	Actions
1	Theatre productivity savings	Replacement scheme identified	Delays in finance support. workforce & costing calculations awaited (21.8.2012).

Next steps

Continued engagement and communication with T&O team (pilot for all projects)
Deep Dive across T&O
Benchmarking across other Trusts (Bristol)

Risks / Issues / Escalation

1. Appropriate Capacity to meet demand in theatres
2. Team flexibility to support changing theatre sessions to maximise efficiency
3. Centralised booking timescales/resource practicalities
4. Monies for additional resource for divisions
5. Location of centralised booking team

Workstream: Theatres

Delivery status

THEATRES WORKSTREAM

•Centralised Booking

- Engagement event will be held on the 15th Oct. Aim of event is to communicate CB process and develop SOP's
- Business case for pilot (T&O) will be submitted to SIRG on 1st Oct
- Working groups being held
- JD,s have been banded
- T&O has been identified and scoped for CB pilot

• Scheduling

•Deep dive commenced in T&O, this includes data collection, stakeholder interview and observations

•T&O has been identified as Scheduling Pilot

•Workout date organised for 7th Nov

• Pre-operative Assessment

- Visit to Bristol on the 5th Oct – lessons learnt and will be discussed re implementation
- Nursing documentation with Medical illustration piloted in T&O
- Rotas being devised to support one stop shop
- Engagement and consultation event for stakeholders being organised 18th Oct
- Clinical templates being devised
- EDTA pilot in T&O (Dec 12)

Patient Flow - Daily Discharge Review

What: A mechanism within the organisation that drives discharges (so supports flow)

How & Who: 4 Stage Pilot

1. Information to wards based on eBMS – send update by 10.00
2. Wards to send through position by 10.00–checked against eBMS
1. 1:1 coaching with Matrons – use of eBMS
2. **10.30 & 14.30 Conference Calls**

Progress:

3rd Oct: Medical Wards SGH (L4, P4, P5, P3) plus transport

8th Oct: plus Surgery Wards (N2, P2, L2, N3, L3) and (D21& D25) plus SGH bed management

All wards joining both calls – principle of first on, first off.

Longest call so far 23 minutes – status understood for 11 wards

Currency: Named patients for discharge i.e. NOT BEDS

Patient Flow - Daily Discharge Review: The script

10.30

1. Did the Board Round happen?
2. Was everyone there you expected to be there?
3. Are you looking at eBMS? It shows that you have XX patients with an EDD for today – talk me through them? (inc. TTOs & transport status)
4. How many of these patients do you want to report as a) confirmed and b) potential to the 12.00 capacity meeting?

14.30: the really important bit!!!!

1. At 10.30 you had XX confirmed and YY potential – updated position on each

1. Any additional patients identified via the ward round?

2. Updated position for the 16.00 capacity meeting ..XX confirmed and YY potential

3. **How is tomorrow looking?** eBMS shows that you have XX patients with an EDD for tomorrow – are any of these confirmed? If so, TTOs completed and transport booked, if required?

Patient Flow - The intended development

Phase One:

Calls happening following the script & using eBMS, - focus on EDDs, Pharmacy & Transport KPIs,

Emphasis on morning discharges – 40% by 12noon

Next 2 weeks

A number of people to sit alongside VC to help shape who should lead this meeting

Phase Two:

Phase 1+ internal waits (imaging, path, echo, orthotics etc.)

Emphasis on broader internal waits - need to define "wait"

Next 2 weeks

Meeting with Imaging to discuss – undertake ward audit to prioritise areas

Phase Three:

Phases 1& 2 + community and social care

Emphasis on wider system communication

In development

Separate community acute daily review as part of community workstream – need to agree how it all fits together

Want to get to City Site early November – dependent on others getting involved

Patient Flow -

Transport

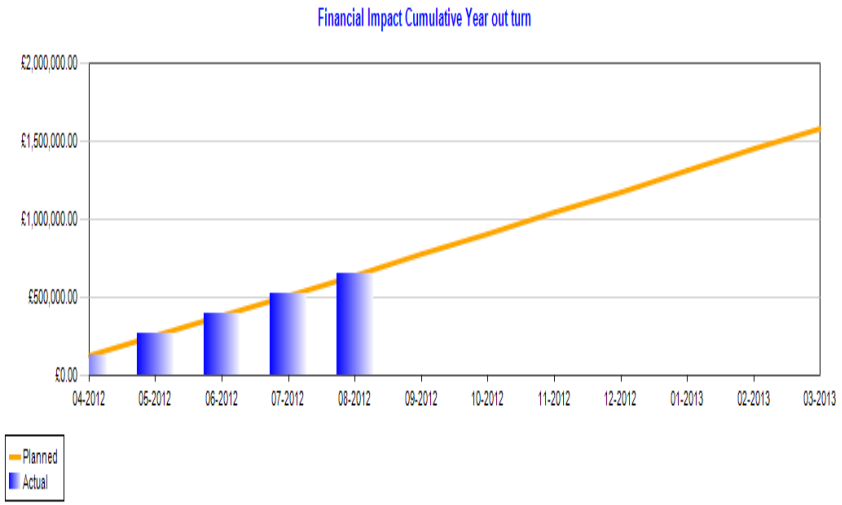
- Patients are pre-booked into morning slots
  - SGH 15 slots before 12noon.
- Access visits – part of OT assessment
- Operational Changes
  - Rostering:
    - 08.00-20.00 Control Centre,
    - 08.00-22.00 Crews
  - Single Phone Number
- Checklist – patient ready
- November Onwards – implement at City

Pharmacy

- Near patient pharmacy
  - 8th October GO LIVE – Lyndon 2
- "Dear all just to say that the staff on Lyndon 2 have commented how everyone has worked really well today to ensure TTOs are promptly written up and staff have commented how helpful it is to have Hilal there to dispense - they have managed to get patients discharged within 40 minutes which is great - thank you :-) This really does make lives easier lets keep it up.
- Roll-out Plan
  - 15th October : Lyndon 4
  - Newton 3 & Priory 5
  - Priory 2 & Priory 3
  - Lyndon 3, Priory 4 & Newton 4

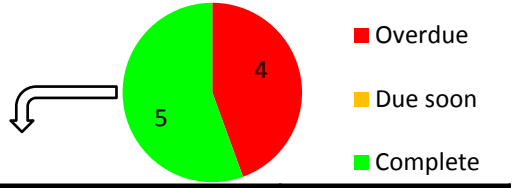
Workstream: COMMUNITY

Financial status



Milestone status

Major milestones impacting savings



RAG	Milestone(s)	Impact	Actions
	Not cross cutting – Division are aware and working to correct		
	CROSS CUTTI NG		

Next steps

- Work with staff on Henderson and Leasowes to develop a visual whiteboard to aid discharge
- Introduce a daily community/acute update to feed into acute capacity meeting
- Develop relationships formed with STAR and Rapid Response at Sandwell
- Understand pathways into above services and how they can feed into daily community/acute update

Risks / Issues / Escalation

- Pace of demand for change from other work programmes – community workstream is a key enabler to savings from UC, Beds and OPD in acute
- Complexities around introduction of SPA
- Vascular Repatriation – Receiving a few queries relating to community beds and delayed discharges
- Unmet need for complex stroke care
- ESD target remains a problem discussion with Commissioners planned

Workstream: Community

Delivery status

1. Rehab Workstream

Plans to introduce a visual patient status whiteboard to support nurse handover and Discharge Board Review meetings (introduction of eBMS on units currently on hold due to logistics)

Interface between Community & Acute - Meetings have been held to determine what needs to be communicated on a daily basis. Next steps:

- Agree on model and information flows
- Explore how we will use forum to sign post patients into other community services

The re admissions audit work is defined - needs to go to Governance meeting (scheduled for November)

Meeting held with Optimal Ward Project Nurse to share knowledge and learning to aid planning of roll out

Audit undertaken at Leasowes to review stock levels to prepare for Productive Community Ward

2. Integrated Teams

New model of working went live on 1st October (Team called ICARES)

Review of some of the processes underway to iron out a few issues that have arisen this week

Visited STAR and Rapid Response to discuss how they could feed into community/acute update meeting

Meeting held with Sandwell Housing Team re pilot to assist people to leave hospital

Pilot of single referral form ended – feedback being prepared, then form will be reviewed

Urgent Care Workstream

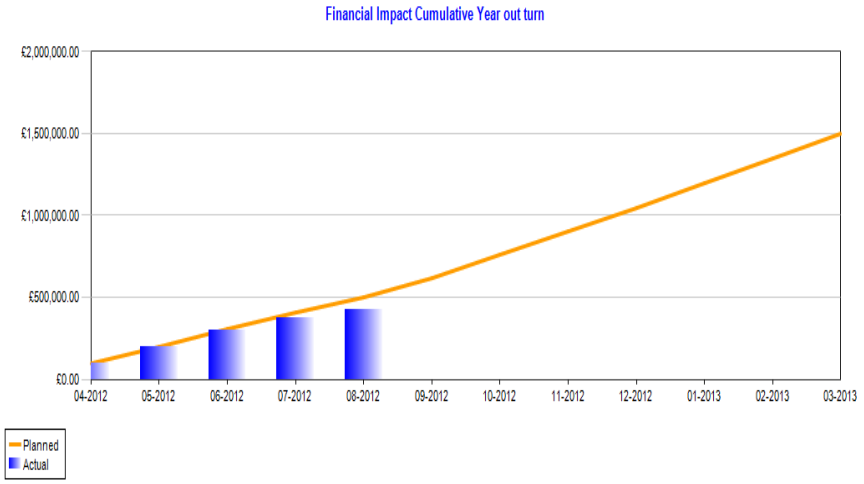
- **Rapid Initial Assessment within ED**
  - Went 'live' within City ED, 1st October. Operates Mon- Fri 1-4pm. Trial for 4 weeks
  - Operates as MDT approach to ambulance borne patients (consultant, Senior nurse and HCA). Undertake brief assessment and initiate any critical investigations and interventions
  - Proposed benefit, shorter transit time for patients through ED, reduce un-necessary investigations – dashboard being developed to capture key activity
  - ***Issues***
    - Not doing a full work up of patients but a management plan for junior staff
    - Team working
    - Identifying areas to undertake early investigations when there are capacity issues e.g. bloods
    - Pilot at Sandwell delayed due to nursing vacancies *(proposed start date, end of Nov.)*

- **General Surgical In-Reach Pathways within ED**
  - Abscess pathway delayed due to core processes being established between ED and General Surgery e.g. checklists for ED nursing staff to identify appropriate patients for RSO
  - Proposed go 'live' end of October

- '**Cardiologist of the Week**' within MAU, City - Went live in September
  - 'Newly' identified patients are being reviewed in a more timely manner
  - ***Issues***
    - Process issues around cardiology 'accepted' patients being reviewed and managed

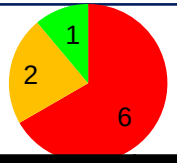
Work stream: Outpatients

Financial status



Milestone status

Major milestones impacting savings



Overdue
Due soon
Complete

RAG	Milestone(s)	Impact	Actions
	Divisional delays in translating PA reduction to job plans	£72K miss on august TSP target	Manage through Divisional leads at COO

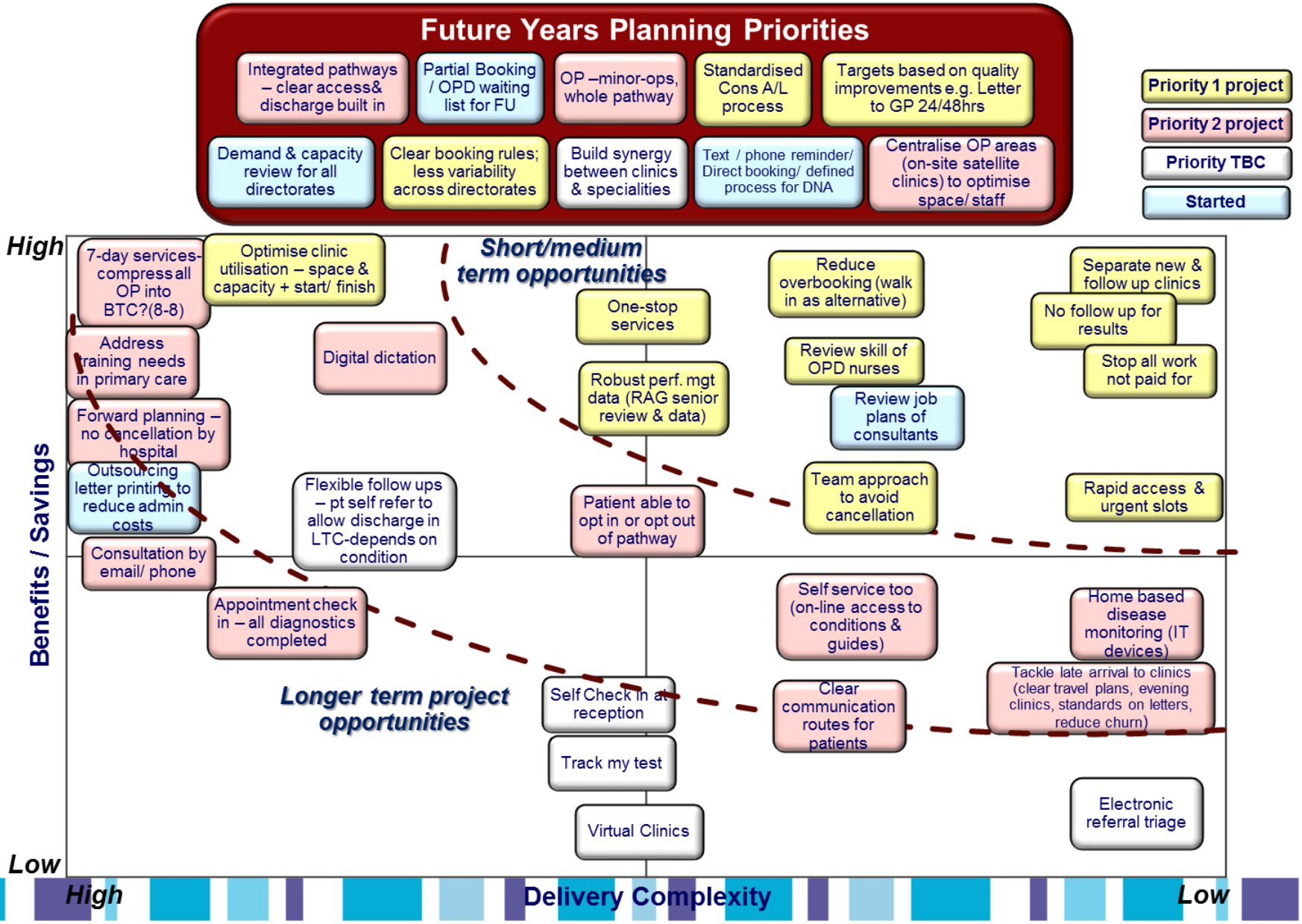
Next steps

- Patient journey and clinical pathway focus presented at consultant conference- some consultant leads identified- TSO will engage with consultant leads. Need TPSG approval for Directorate Transformation teams and staff release to work on transformation.
- Currently re-scoping OP project- see prioritisation matrix
- Three directorates have completed Deep Dive plus and exec task force review- T&O, Cardiology, Urology. Next are Gastro, geriatrics and respiratory
- Develop OP project wall fro medicine and establish transparency with OP project work at speciality level
- Future years planning event on 1st October with Divisional representation- see slide.

Risks / Issues / Escalation

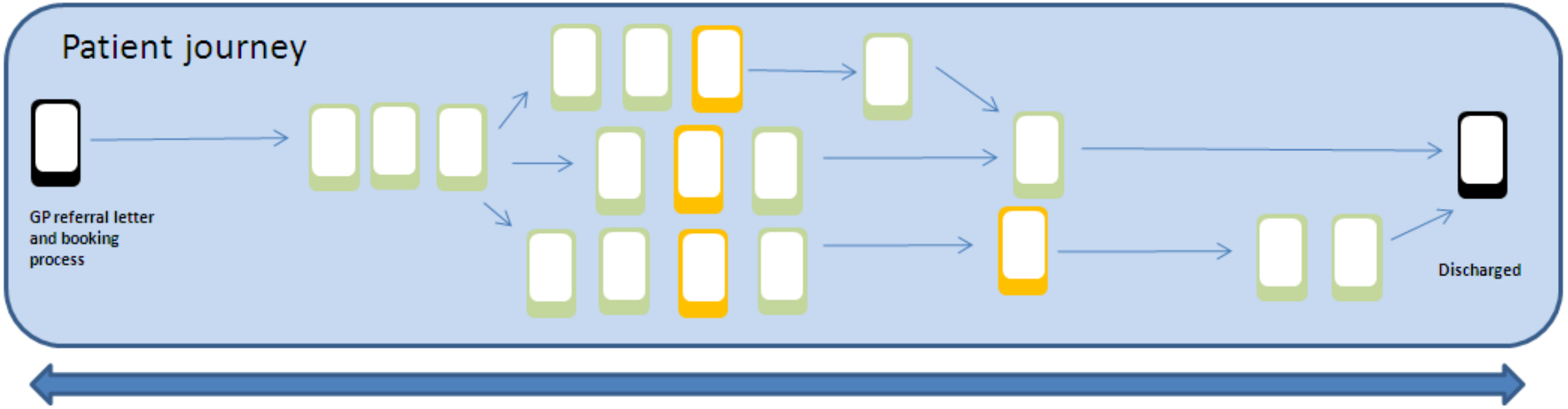
- Exec not always available to support Exec Task Force meeting
- Lack of engagement with consultant body with OP project.
- Lack of clarity on how much outpatient activity the CCGs will agree to provide in primary care
- Speed of decommissioning will not meet TSP savings trajectory
- Resource implications within divisions which may result in a delay in the decommission of clinics or failure to progress projects
- Specialities do not have a clear strategy for OP activities

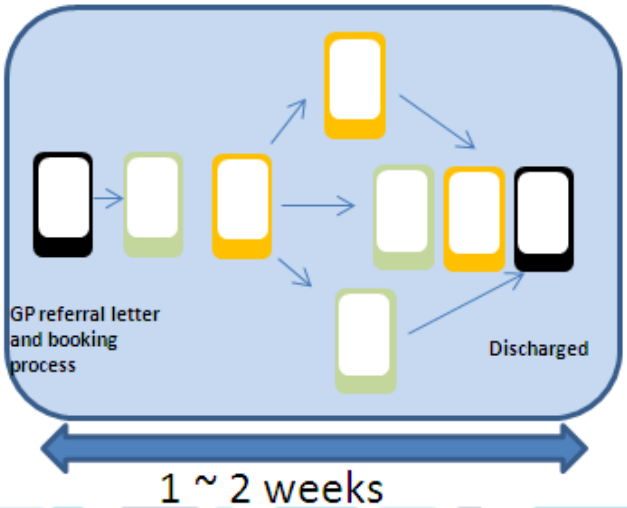
Work stream: Outpatients



Work stream: Outpatients

OP transformation plan- transform the patient journey





For patients requiring acute services- taking out the unnecessary waiting times and waste in the patient journey. Addressing many known issues and implementing solutions as well as problem solving as we go. Ensuring we have clearly defined and used best practice clinical pathways.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	'Right Care, Right Here' Progress Report
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	25 October 2012

EXECUTIVE SUMMARY:

The paper provides a progress report on the work of the 'Right Care, Right Here' Programme as at October 2012.

REPORT RECOMMENDATION:

The Trust Board is asked to ACCEPT the progress made with the 'Right Care, Right Here' Programme.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Supports strategic objective: Care Closer to Home
Supports 2012/13 Annual Priority: Progressing the 'Right Care, Right Here' vision of service change

PREVIOUS CONSIDERATION:

Routine monthly report to the Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT OCTOBER 2012

Introduction

This brief paper provides a progress report for the Trust Board on the work of the Programme as at the 15th October 2012. It provides an update with regard to progress with the Right Care Right Here (RCRH) Programme and the QIPP (Quality Innovation Productivity and Prevention) Schemes. The work of the RCRH Programme and involvement of the Trust in this is discussed on a monthly basis at the Trust's Right Care Right Here Implementation Board meetings.

Transfer of Activity: QIPP Schemes

The LDP agreement for 2012/13 has set a target for the cessation of and transfer out of acute activity into community or primary care worth £10 million of acute SWBH income. The schemes that will deliver this reduction in acute activity will be identified as QIPP schemes. It has been agreed that this activity and income reduction will be delivered through a range of schemes falling into three broad headings:

- Schemes identified within our Transformation Plan that result in a reduction in acute activity and/or transfer of acute activity to community or primary care.
- Schemes identified by the Sandwell and West Birmingham Clinical Commissioning Group (the CCG) to reduce the demand for acute care.
- Implementation of the approved RCRH care pathways.

Work continues to translate these schemes into a detailed schedule with clear agreement between ourselves and the CCG about how and when they should be implemented and arrangements to monitor progress. To date a schedule of acute activity reductions/transfers has been identified equating to £6.3 million income reduction. This has been discussed with the CCG. There is therefore a shortfall of acute activity reductions/transfers equating to £3.7million needs to be discussed with the CCG in order to identify additional schemes and creates a potential gap for the 2013/14 LDP.

The activity reductions (for the £6.3million) have now been applied to the contracts and monitoring for the period April – end of August (month 1-5) shows that against these activity lines there is an over-performance on activity (and under performance on QIPP savings) of circa £800K primarily as a result of over-performance of non-elective admissions (i.e. emergencies). There have been discussions with the CCG about the implications of the increased demand for emergency admissions and what is required to support this over the winter period. In addition the CCG are currently undertaking a risk stratification exercise to identify patients that are at risk of frequent emergency admissions to hospital in order to put in place clinical management plans for clinical alternatives to hospital admission where clinically appropriate.

The CCG have recently undertaken a further prioritisation exercise to identify key areas for service redesign for the remainder of 2012/13. These priorities include implementation of a

number of QIPP schemes including redesigned care pathways. Joint working groups and implementation plans for the prioritised, approved RCRH care pathways will now be set up.

A coherent programme of communication and engagement with clinical staff, patients and the public will be essential to successful delivery.

RCRH Partnership

As reported last month participants at a health economy event held on 13th September to review progress with the RCRH Partnership, strongly supported the continuation of the partnership and the redesign programme, the further development of the Activity and Capacity model, the ambition for a new hospital; in Smethwick.

The RCRH Partnership Board at its meeting in October agreed a number of priorities and recommendations from the above event including:

- The aims of RCRH should be integrated into partner core business objectives and that the delivery mechanism would be via existing partner structures.
- To embed RCRH priorities and targets into job descriptions and personal objectives across partners.
- The RCRH Partnership Board would continue to be chaired by and independent person and that the partnership will collectively fund this post and business support for the Partnership Board and sub committee.
- The RCRH Partnership Board will meet quarterly with a supporting Partnership Executive that will meet monthly and have the following subgroups:
    - Finance and Performance
    - Implementation of Pathways and Redesign
    - Communications and Engagement
    - Regeneration.

Work is underway to identify membership from partners of the above meeting structure with the first meeting of the Partnership Executive expected to take place in November.

RCRH Activity and Capacity Model

As previously reported the Trust continues to base its plans on version 5.7 of the Activity and Capacity model but a full revision of the RCRH Activity and Capacity model is desired. This full revision is expected to be lead by the Finance and Performance subgroup of the RCRH meeting structure.

The Partnership Board received a presentation from the Commissioning Support Unit (CSU) for Birmingham Solihull and the Black Country for developing a model that would incorporate non acute activity. This was welcomed and the CSU agreed to undertake further scooping work and produce a revised proposal.

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
15th October 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**25 October 2012**

EXECUTIVE SUMMARY:

The report gives an update on:

- Milestone status
- Activities this period
- Activities next period
- Issues for resolution and risks in next period

REPORT RECOMMENDATION:

To review the planned activities and issues that require resolution as part of the FT Programme

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		x

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

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

Comments:

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

'Becoming an effective organisation' and 'Achieving FT Status'

PREVIOUS CONSIDERATION:

FT Programme Board on 25 October 2012

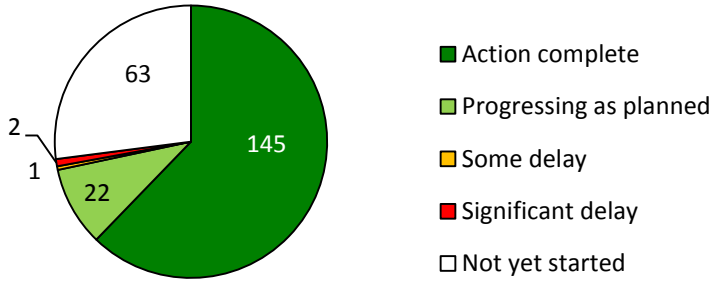
Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Monitoring Status Report

Amber

Milestone status

Milestone Deliverables



Milestone	Lead	End Date	RAG	Planned Actions
Revise base case with fully signed off TSP's for 13/14 and 14/15	RW	07/09/12	2	The TSP annex to the IBP has been produced and submitted to the SHA. This explains the process of completing the IBP for the November Trust Board having taken account of the TSP finalisation process which finishes at the end of October.
Review consequences of revision of TSP's.	RW	07/09/12		The TSP annex to the IBP has been produced and submitted to the SHA. This explains the process of completing the IBP for the November Trust Board having taken account of the TSP finalisation process which finishes at the end of October.

Issues for Resolution/Risks for Next Period

- Finalise TSPs and downside mitigations

Activities Last Period

- 7th draft IBP/LTFM submitted to SHA
- Supporting strategies and annexes submitted to SHA
- Mock Board to Board undertaken
- SHA FT readiness meeting held
- Updated assets register and protected assets compiled
- SHA Board observations held
- Deloitte independent validation of Quality Governance self assessment
- BGAF evidence compilation completed and sent to Finnamore
- Presentations to staff on IBP/LTFM content commenced

Planned Next Period

- 8th draft IBP/LTFM prepared to incorporate SHA feedback on draft 0.7
- Finalise downside modelling and mitigation strategies
- Finalise TSPs
- Submission of 8th draft IBP/LTFM and supporting documentation to SHA (30/11/12)
- BGAF/SHA Board 1:1 meetings
- BGAF - formal independent assessment of BGM completed
- HDD 2 preparation
- Continue programme of raising staff awareness of FT issues
- Commence appointment of election advisors
- Updated Constitution and Governance Rationale
- Commence development of Monitor Board self-certification statements for review/agreement in December 2012

SWTB (10/12) 246

To: CEO Forum Members
CC: Jenni Ord – Chairs' Forum
Ref: AC/RG-N

3rd October 2012

Dear Colleagues

Chief Executives' Forum

I am delighted to be undertaking the role as Chairman of the CEO forum for the next six months and I look forward to working in partnership with all members on our shared strategic system priorities.

At our September meeting we discussed and agreed the following:

If there was to emerge significant issues with the development of the final business case for the Central Care Records programme then the project leads Nick Dunaway & Dr Masood Nazir have an opportunity to escalate and have a discussion with the relevant organisation's CEO. The final business case is expected to be reported to the forum in November.

We endorsed the approach for the Frail Elderly Governance for delivery and the Acute Paediatrics Review scoping proposals. I take this opportunity to thank both Tracy Taylor and Sarah-Jane Marsh for their leadership and commitment in progressing these strategic reviews to date.

It's important that we proactively communicate developments back to our respective organisations; this was specifically highlighted by the Chairs' September quarterly forum. A Compact update report is attached for you to share with your senior management teams and Boards – this was recently presented to the September BSOL Cluster Board meeting.

Refresh Compact

I will be Chairing a meeting with a cross section of representatives drawn from the CEO forum to develop a process to refresh our partnership Compact (*including tor CEO & Chairs' forum*). In addition there will be an opportunity for all partners to participate in an on-line survey. An update will be provided at the next meeting.

Future Meetings

We will be contacting your organisations to host future meetings at their venues. A draft agenda for our October meeting is attached. Please contact ravy.gabrria-nivas@nhs.net for any items that you wish to add to forthcoming meetings.

I will be arranging to meet with you on an individual basis over the next couple of months, in the interim feel free to contact me direct if you wish to have a discussion about any item relating to the forum andrew.coward@nhs.net; I look forward to seeing you all on 16th October.

Yours sincerely

Andrew D. Coward

Dr Andrew Coward
Chairman CEO Forum

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Sustainable Development Management Plan Update
SPONSORING DIRECTOR:	Graham Seager – Director of Estates/New Hospital Project Director
AUTHOR:	Francesca Silcocks / Rob Banks
DATE OF MEETING:	25 October 2012

SUMMARY OF KEY POINTS:

The purpose of this paper is to update the Trust Board on progress with regards to sustainability.

KEY POINTS:
Reporting progress on:

- HSJ Awards - Good Corporate Citizenship
- Sustainability Event – 13th Sept 2012 (summary)
- Carbon Management Plan (CMP) – new baseline
  - Energy efficient lighting
  - Estates Rationalisation
- Carbon management software
- Carbon Reduction Commitment (CRC)
- Waste Recycling Management

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

Approval	Receipt and Noting	Discussion
	✓	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to:

- Note the current progress in relation to Sustainability against key points

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

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)
NHS LA standards	
CQC Essential Standards of Quality b& safety	Regulation 11

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

Financial	**x**	Cost efficiencies through sustainability projects as developed through Carbon Management Plan, Sustainability Events and Sustainability Champions and Supporters (increased awareness), Waste Recycling Scheme, etc
Business and market share		
Clinical		
Workforce	**X**	Promotion and link to Health and Wellbeing projects, Potential for reduction in staff sickness levels, Training for Sustainability Champions
Environmental	**X**	Reduction in SWBH carbon emissions baseline and improved environmental performance
Legal & Policy	**X**	Compliance with Climate Change Bill 2008, NHS Good Corporate Citizen targets, Carbon Reduction Commitment (CRC), European Union Emissions Trading Scheme (EU ETS), Sustainability and Environmental Policy
Equality and Diversity		
Patient Experience	**X**	Provide patients with options for public transport
Communications & Media		
Risks		Non-compliance with: Climate Change Bill 2008, Government carbon and sustainability legislation, NHS Good Corporate Citizen, Staff morale and engagement, Carbon emission reductions affected, Missed cost saving and efficiency opportunities, Potential increase in CRC allowances (i.e. carbon 'tax') EU ETS

PREVIOUS CONSIDERATION:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SUSTAINABILITY UPDATE

TRUST BOARD – 25 OCTOBER 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. HSJ Awards 2012

The Trust has been shortlisted for the HSJ Awards under the Good Corporate Citizenship category for work on progressing the Carbon Management Plan and general Sustainability efforts. The results will be announced in the November ceremony.

3. Sustainability Garden Party Event – Thursday 13th September 2012

The Trust held a 'Sustainability Garden Party' event on the afternoon of Thursday 13th September (12-30pm) in a marquee at City Hospital. The purpose of the event was to engage staff in energy efficiency, reducing waste and recycling more, reducing printing and paper use, active and sustainable travel, health and wellbeing.

The event went very well and positive feedback was received from staff and stall holders. The following stands were present to help engage staff: Sustainability Champions, Health and Wellbeing, Ricoh, Watt Bikes, WRAP (Love Food Hate Waste campaign), EDF Energy and Mytime Health.

4. Carbon Management Plan (CMP)

The Trust has revised the previous CMP document (written in 2010) so that it is aligned with the Transforming Community Services programme and the timeline for the new Hospital.

This document is currently being reviewed and is awaiting verification from the Carbon Trust. The revised carbon target will be a 15% reduction in carbon by 2016/17 (from the 2011/12 baseline). Work is already well underway to progress the Trust towards this ambitious target.

4.1. Energy Efficient Lighting

Lighting surveys have been carried out and a proposal submitted to the Trust for energy efficient lighting and controls work in the Estates department, Sheldon Block and the Libraries at City and Sandwell Hospitals. The Trust is currently reviewing this proposal and is looking into undertaking pilot projects, focusing on those areas that have higher energy savings and the shortest payback periods.

4.2. Estates Rationalisation

The estates rationalisation programme is underway and will greatly reduce energy consumption and therefore carbon emissions. It is estimated that the Trust will save around 244 tonnes of carbon each year (or 895,000 kWh in gas and electricity consumption) if the planned estates rationalisation programme for City and Sandwell goes ahead.

5. Carbon Management Software

The Trust is in the process of implementing basic carbon management software that will store all carbon-related data (i.e. data on energy, water, waste and transport/travel) in a secure and reliable system. It will also aid reporting for the Carbon Management Plan, Carbon Reduction Commitment (CRC), EU Emissions Trading Scheme (ETS), and other internal monitoring and feedback.

6. Carbon Reduction Commitment (CRC)

The Trust continues to collate energy data on a monthly basis for CRC reporting. The next report will be due in July 2013. The carbon management software that will be implemented over the next few months will aid this process and help collate the 'Evidence Pack' and report required by the Environment Agency.

7. Waste Recycling Management

The recycling scheme (for paper, cardboard and plastics) at City Hospital continues to run well, with a further 20 paper and 20 plastic large silo bins recently procured to cope with the recycling demands of the Trust. This will help the Trust save carbon emissions and also costs.

The recycling scheme is being rolled out alongside the Estates rationalisation programme and it is hoped that the new Corporate Suite (D29) will set an exemplar case for the Trust.

8. Next Steps

- Continued work on the revised Carbon Management Plan (CMP)
- Continue with waste reduction and recycling initiatives across the Trust
- Collection of carbon footprint data in carbon management software once implemented
- Utilise carbon data to monitor, action and inform staff of progress against targets
- Annual CRC reporting
- Regular communications to staff

9. Recommendations

The Trust Board is asked to:

- Note the current progress in relation to HSJ Award (Good Corporate Citizenship), Carbon Management Plan, carbon management software, Carbon Reduction Commitment (CRC), waste management
- Continue supporting on-going sustainability projects

Rob Banks
HEAD OF ESTATES