Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 6 February 2014; 1330h

Members

Mr R Samuda	(RSM)	[Chairman]
Ms C Robinson	(CRO)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mr C Ovington	(CO)	[Chief Nurse]
Miss R Barlow	(RB)	[Chief Operating Officer]
Mr T Waite	(TW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]

In attendance

Mr M Hoare	(MH)	[Non Executive Director]
Miss K Dhami	(KD)	[Director of Governance]
Mr M Sharon	(MS)	[Director of Strategy & OD]
Mrs C Rickards	(CR)	[Trust Convenor]

Guests

Mrs L Pascall	(LP)	[Deputy Chief Nurse]
Mr A Tyagi	(AT)	[Group Director – Surgery B]

Secretariat

Mr S Grainger-Lloyd (SGP) [Trust Secretary]

Time	Item	Title	Reference Number	Lead
1330h	**1**	**Apologies**	**Verbal**	**SG-L**
	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**
	2.1	Declarations from Colin Ovington, Tony Waite and Mike Hoare for receipt and acceptance	SWBTB (2/14) 002 (a) SWBTB (2/14) 002 (b) SWBTB (2/14) 002 (c)	SG-L
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 19 December 2013 a true and accurate records of discussions*	**SWBTB (12/13) 266**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (12/13) 266 (a)**	**SG-L**
	5	**Questions from members of the public**	**Verbal**	**Public**
1340h	**6**	**Patient story**	**Presentation**	**LP**
1400h	**7**	**Chair's opening comments and Chief Executive's report**	**SWBTB (2/14) 003** **SWBTB (2/14) 003 (a)**	**RSM/ TL**
1415h	**8**	**Never Events – exceptional item**		
	8.1	Never Event 5 in Ophthalmology	SWBTB (2/14) 004	AT/ RST
	8.2	Never Event control audit	SWBTB (2/14) 005 SWBTB (2/14) 005 (a)	KD

		MATTERS FOR DISCUSSION		
1440h	**9**	**Quarter 3 update on annual plan delivery and year-end risks**	**SWBTB (2/14) 006** **SWBTB (2/14) 006 (a)**	**MS**
1450h	**10**	**Corporate performance dashboard**	**SWBTB (2/14) 007** **SWBTB (2/14) 007 (a)**	**TW**
		Reports back from the Committees and matters of exception		
1455h	**11**	**Update from the meeting of the Quality & Safety Committee on 31 January 2014**	**Verbal**	**GH/ CO**
1500h	11.1	Grade 4 pressure ulcer	SWBTB (2/14) 008	CO
1505h	11.2	Norovirus update	SWBTB (2/14) 009 SWBTB (2/14) 009 (a)	CO
1510h	**12**	**Update from the meeting of the Finance & Investment Committee held on 31 January 2014, minutes from the meeting held on 22 November 2013**	**SWBFI (11/13) 102**	**CR/ TW**
1515h	**13**	**Financial performance report**	**SWBTB (2/14) 010** **SWBTB (2/14) 010 (a)**	**TW**
1520h	**14**	**Transformation Savings Programme 2014/15**	**SWBTB (2/14) 018**	**TW**
1525h	**15**	**Update from the meeting of the Audit & Risk Management Committee held on 30 January 2014, minutes from the meeting held on 25 October 2013**	**SWBAR (10/13) 060**	**GH/ KD**
1530h	**16**	**Data Quality update**	**SWBTB (2/14) 011** **SWBTB (2/14) 011 (a)**	**TL**
1545h	**17**	**To approve interim changes to Standing Orders/Standing Financial Instructions and Scheme of Delegation**	**SWBTB (2/14) 012**	**TW**
		Matters for discussion and approval		
1550h	**18**	**To approve Public Health plans: 2014 - 17**	**SWBTB (2/14) 013** **SWBTB (2/14) 013 (a)**	**RST**
1600h	**19**	**Patients Know Best: our patient experience plans**	**SWBTB (2/14) 014** **SWBTB (2/14) 014 (a)**	**TL**
1610h	**20**	**To discuss the medical education chapter of the emerging integrated education strategy 2014-17**	**SWBTB (2/14) 015** **SWBTB (2/14) 015 (a)**	**MS/ RST**
1620h	**21**	**To note Leadership Development programme**	**SWBTB (2/14) 016** **SWBTB (2/14) 016 (a)**	**MS**
1625h	**22**	**To approve Healthcare Software Systems contract novation**	**SWBTB (2/14) 023** **SWBTB (2/14) 023 (a)**	**TW**
	23	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
	24	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (2/14) 017**	

	24.1	Approach to Grove Lane Site Acquisition	SWBTB (2/14) 019 SWBTB (2/14) 019 (a)
	25	**Foundation Trust application programme: monitoring report**	**SWBTB (2/14) 020**
	26	**Details of next meeting** *The next public Trust Board will be held on 6 March 2014 at **1330h** in the Anne Boardroom, City Hospital*	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REGISTER OF BOARD MEMBERS INTERESTS

Name of Director: **Colin Ovington**.....

My declarations of interests, relevant and material to Sandwell & West Birmingham Hospitals NHS Trust are:

Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies)	None
Ownership of private companies, businesses or consultancies seeking or possibly, likely to seek to be a Contractor to Sandwell and West Birmingham Hospitals NHS Trust	None
Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHSHospitals NHS Trust	None
A position of authority in a charity or voluntary body in health or social care.	None
Any connection with a voluntary or other body contracting for NHS services	None
Other interests regarded as being relevant and/or material	None

Signed.....

Date..23rd January 2014..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REGISTER OF BOARD MEMBERS INTERESTS

Name of Director: TONY WATTS

My declarations of interests, relevant and material to Sandwell & West Birmingham Hospitals NHS Trust are:

Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies)	NONE
Ownership of private companies, businesses or consultancies seeking or possibly, likely to seek to be a Contractor to Sandwell and West Birmingham Hospitals NHS Trust	NONE
Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHSHospitals NHS Trust	NONE
A position of authority in a charity or voluntary body in health or social care.	NONE
Any connection with a voluntary or other body contracting for NHS services	NONE
Other interests regarded as being relevant and/or material	NONE

Signed..... Date 7-1-14

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

REGISTER OF BOARD MEMBERS INTERESTS

Name of Director: Mike Hoare

My declarations of interests, relevant and material to Sandwell & West Birmingham Hospitals NHS Trust are:

Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies)	None
Ownership of private companies, businesses or consultancies seeking or possibly, likely to seek to be a Contractor to Sandwell and West Birmingham Hospitals NHS Trust	None
Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHSHospitals NHS Trust	None
A position of authority in a charity or voluntary body in health or social care.	None
Any connection with a voluntary or other body contracting for NHS services	My wife works for a Local surgery in Redditch
Other interests regarded as being relevant and/or material	None

Signed [ELECTRONIC SIGNATURE] Mike Hoare **Date** 7 January 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Boardroom, Sandwell Hospital **Date** 19 December 2013

Present	**In Attendance**
Mr Richard Samuda [Chair]	Miss Kam Dhami
Ms Clare Robinson	Mr Mike Sharon
Dr Sarindar Sahota OBE	Mrs Linda Pascall
Mrs Gianjeet Hunjan	Mrs Chris Rickards
Ms Olwen Dutton	
Mr Toby Lewis	**Guests**
Mr Robert White	Ms Debbie Mitton [Lead Nurse and Centre Manager, Behcets]
Mr Colin Ovington	Dr Deva Situnayake [Consultant]
Miss Rachel Barlow	Patient
Dr Roger Stedman	Patient's carer

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr Harjinder Kang and Professor Richard Lilford.	
2 Declaration of Interests	**Verbal**
There had been no declarations of interest made since the last meeting and no Board member declared an interest with any item on the agenda of the meeting.	
3 Minutes of the previous meeting	**SWBTB (11/13) 248**
The minutes of the Trust Board meeting held on 28th November 2013 were	

presented for consideration and approval.	
AGREEMENT: The minutes of the last meeting were approved	
4 Update on Actions arising from Previous Meetings	**SWBTB (11/13) 248 (a)**
The Board received the updated actions log. It was noted that there were no actions outstanding or requiring escalation to the Board for resolution. Miss Barlow advised that a policy for handling cancelled operations was being developed and that a further update on addressing the position would be presented at the next Quality & Safety Committee meeting in January 2014. Mr Lewis asked that specifically included an assessment of the Eye Hospital, which had been the apparent source of the enlarged problem some months ago. Ms Robinson highlighted that the handling of a recently publicised complaint about a cancelled outpatient appointment, which needed to be handled sensitively to avoid any further adverse reputational implications on the Trust. Mr Lewis provided the Board with background to the case to which Ms Robinson referred and advised that he was satisfied that the handling of the patient had been appropriate in this instance. Mr Ovington, the newly appointed Chief Nurse, was welcomed to the Trust and to his first meeting of the Board.	
5 Questions from members of the public	**Verbal**
There were no questions.	
6 Patient story	**Presentation**
The Board was addressed by a patient affected by Behcet's disease who outlined the experience of care by the Trust and of the way in which the condition had affected her life. The patient was asked by Mr White whether the network for those suffering with Bechet's disease was useful. He was advised that the support worker was useful and a network was in place locally. Dr Stedman asked for a view as to the effectiveness of communication with the Bechet's team and asked whether there were any suggested improvements to accessing advice. He was advised that easier communication between hospitals would be welcome, including shared access to notes. The patient advised that she carried details of her condition with her at all time in the event that she had to be treated at a location other than the Trust. The patient's carer asked whether the patient's records were accessible to all healthcare trusts. Dr Stedman advised that unfortunately this was not the case and that there were barriers to sharing healthcare records widely. He advised that the wider implementation of a system known as 'Patient Knows Best' was being considered, which would ensure that records could be accessed more widely. Dr	

Situnayake expressed his admiration for the patient and the way in which she handled the complications associated with her condition and remarked that he was pleased at how the patient was progressing. The Board was advised that there was considerable benefit to patients by virtue of having a dedicated centre for treating the disease. The patient and her carer were thanked for their attendance and illuminating experience.	
7 Chair's Opening Comments and Chief Executive's report	**SWBTB (12/13) 250**
Mr Samuda advised that further work on the new hospital project continued, including finalising the financial model. The Board was advised that Mr White's replacement, Mr Tony Waite had been appointed and would commence post in January 2014. It was reported that a new NED designate had been identified and appointed and that a new legal services provider had been appointed. Mr Lewis advised that a Pre-Qualification Questionnaire had been issued for the leadership development programme and returned bids and decisions were expected to be gained in February 2014. He reported that the take up of the influenza jab was in excess of 70% of staff, which he highlighted was a pleasing position. Ms Robinson added her congratulations to this achievement, which was a transformation for the Trust from prior years.	
7.1 Data Quality	**SWBTB (12/13) 250 (a)**
Mr Lewis asked the Board to note the update on work on Data Quality and in particular the kite mark system that would be introduced and the Intensive Support Team work that was due to commence. It was reported that there was an expectation that the testing of performance reported against the clinical quality data indicators that would be assessed by the CQC as part of its intelligent monitoring work would be completed by the internal audit function in the new year. Ms Robinson asked whether the performance reported from the Dr Foster system was regarded as being accurate. She was advised that this was the case and that the Trust had the opportunity to validate the information reported.	
7.2 Integrated Transformation Fund	**SWBTB (12/13) 250 (b)**
Mr Lewis asked the Board to receive and note the update on the integrated transformation fund, now renamed Better Care. He advised that it was likely that the format and availability of the funds might change in future. Ms Dutton noted the importance of this fund and welcomed the evident engagement of Trust leaders to date.	
8 Safety, Quality & Governance	

8.1 Proposals for external support for 'Never Events' assurance	SWBTB (12/13) 251 SWBTB (12/13) 251 (a) SWBTB (12/13) 251 (b)
Dr Stedman advised that an overall assessment of the patient safety culture in the Trust and by area was needed and that a tool had been identified for this purpose, which would be launched at a patient safety summit planned for 13 February 2014. It was reported that this would be used within teams and that the feedback would be collated to provide the overall view of the Trust. In terms of the external support required for this process, it was reported that the NHSLA, through the use of a third party, would conduct a review and provide support. Ms Dutton expressed her support for the work and asked whether the tool would pick up poor practice on an individual basis. Dr Stedman advised that this was the case and that the assessment would take into account aspects such as how individuals could raise safety concerns. Ms Dutton noted that this linked to the application of the whistleblowing policy. Dr Sahota noted that there was variable practice across the Trust and asked how good practice should be shared and bad practice eliminated. Dr Stedman advised that there was some improvement to be gained in terms of sharing practice and that the Trust should strive to foster a learning environment at a local level firstly, due to the nature of the matter. Mr Lewis noted that the work would identify those areas where good practice was in place and that the tactics for peer learning needed to be identified and finalised. Mrs Hunjan asked how the learning would be monitored and that changed habits would be recognised. Mr Lewis advised that the consideration of lessons learned would be considered more widely in January 2014. Ms Robinson noted that the work focussed on cultural change and the link to the transformation plan, which needed to be co-ordinated to avoid a diverse number of change programmes running in parallel. Mr Lewis drew the Board's attention to his expectation, being developed within the executive presently, that the programme structures and nomenclature for 2014-15 would be different; he committed to discuss that with the Board not later than annual plan sign off at our March 2014 meeting. Ms Dutton asked whether one of the measures when looking at the future leadership development plans concerned how the dissemination of learning was to be handled. Mr Sharon advised that this was the case. Ms Dutton underlined the need for knowledge transfer to be delivered as part of the patient safety work. Dr Stedman confirmed that the work would not be run as a separate programme. Ms Robinson asked whether, by engaging the NHSLA as part of the work, current premiums would be affected. Miss Dhami advised that the NHSLA standards would change to being outcomes focussed and that the current discounts would	

be maintained or improved but would not be adversely impacted by the work.	
ACTION: **The Executive to discuss the learning model in development session with the Board** **ACTION:** **Mr Lewis to ensure that the programme model for 2014 onwards be presented as part of Annual Plan finalisation**	
8.2 Abridged action plan in response to the Francis Inquiry and related national reports	**SWBTB (12/13) 252** **SWBTB (12/13) 252 (a)**
Miss Dhami advised that the paper and action plan built on discussions at the November 2013 meeting of the Board, with the report now highlighting the key themes of the action plan. The Chairman advised that an allocation by Non Executive Director to the eight themes in the action plan had been shared in draft, however this would be finalised shortly. Miss Dhami reported that progress with the overarching themes would be presented by rotation and that a detailed action plan underpinned delivery of the themes overall. She asked the Board to review the schedule of updates to the Board which was highlighted to be based on a means of prioritisation. The plans for communication of the plan were also highlighted. The Chairman noted that the Care Quality Commission (CQC) had reviewed the Francis recommendations and asked whether the work proposed in the Trust aligned to that of the CQC. Miss Dhami advised that in terms of key lines of enquiry and reports from the recent inspections, there appeared to be clear synergy. Ms Dutton expressed her support for the themed approach. She commented however, that some of the timescales for the completion of the actions appeared to be overly challenging, particularly that concerning shared learning. The Board agreed with this view. The executive will revisit those timeframes. Ms Robinson reviewing the measures, such as effective complaints handling, asked for the reasons for setting target at a level other than 0% for the linked complaints indicator. Miss Dhami advised that there was a number of reasons for linked or returned complaints to be received. Ms Robinson suggested in this case, that the measure should differentiate the reasons for the complaint being received back. Mr Ovington suggested that the measure of effective complaints handling could be set to be the elimination of all complaints about the complaints process. He also suggested that accountability needed to run through the action plan and that consideration should be given to the means of measuring this. In connection with the theme measures concerning 'accurate, useful and relevant information', Mrs Robinson asked for the reasons behind setting a level of 25% to the reduction in red ratings on an annual basis. Mr White advised that this reflected an aspiration to reduce the severity of ratings over time as a	

consequence of programmes or audit work being delivered, however the improvement trajectory needed to be set once the baseline position had been determined. Ms Robinson suggested that a re-discussion of this target should be undertaken once this assessment had been undertaken. Mr Lewis highlighted the ambition in the eight goals, which reflected a determination to ensure public confidence in organisations within the NHS. He highlighted that no Trust in the West Midlands achieved the Friends & Family Test results nor nursing confidence numbers as set out in this plan. He also drew attention to a style change in this plan, in that one might undertake all the actions but not achieve that ambition and as such required further or indeed fewer actions. This was noted by the Board.	
8.3 Update from the meeting of the Quality & Safety Committee in December 2013 and minutes from the meeting held on 22nd November 2013	**SWBQS (11/13) 164**
Ms Dutton reported that the Committee did not meet formally in December. She reiterated our plan to ensure that Q&S in 2014 focused more of its time on delivery of our long-term Quality goals. Dr Stedman undertook to push harder on the disappointing position with the adverse performance against the mortality review target.	
8.4 Quality Report	**SWBTB (12/13) 253** **SWBTB (12/13) 253 (a)**
The Board was asked to receive and accept the Quality Report. Mr Lewis reported that there was on-going work on a weekly basis to confirm future nursing establishments in medicine, and that Trust-wide we would be publishing our staff-on-duty from February, ahead of the national timeline. Dr Stedman reported that in terms of the CQC outlier alert for maternity, an analysis of the position had been undertaken, which identified that generic sepsis had been reported in some cases, rather than the specific maternity sepsis for which the Trust had been identified as an outlier. A number of other issues were reported to have been identified, such as the inappropriate collection and reporting of data. Ms Robinson suggested that further detail should be included on patient safety walkabouts in future reports. Miss Dhami reported that the outputs from the year and the action plans would be shared with the Quality & Safety Committee in January 2014. She added that the new schedule of visits would be arranged shortly. Mr Lewis added that there would be a major change in 2014 with the removal of the quality report. The integrated dataset would be used, accompanied by a to-be-determined report providing soft intelligence and narrative on quality. Dr Sahota noted that there was an issue with falls at present, which he	

highlighted could be related to access to fall mattresses. Mrs Pascall advised that this was not a common theme and that individual practice in this respect should be investigated. Ms Robinson asked whether the consultant whose story of poor practice had been published in the press recently, remained employed by the Trust. She was advised that this was not the case.	
8.5 Board Assurance Framework – Quarter 1 & 2 update	**SWBTB (12/13) 254** **SWBTB (12/13) 254 (a)**
The Board was asked to note the revised Board Assurance Framework (BAF) which had been updated to complete the information that had not been included in the version presented in November. Miss Dhami noted that the use and construction of the BAF would be developed in the new year to reflect the strategic risks and to link more closely to the operational risk register and programme of audit. It was highlighted that the work would be addressed through the Audit & Risk Management Committee and work of the new internal auditors. The Chairman suggested that the IT investment to deliver change should feature within the BAF and that the occurrence of 'Never Events' should also be reflected. Ms Robinson suggested that the key controls and assurances needed to be more accurately and appropriately populated.	
8.6 Equality & diversity – interim position statement	**SWBTB (12/13) 255** **SWBTB (12/13) 255 (a)**
Mrs Pascall provided an overview of equality and diversity practice in the Trust, including an initial view of compliance with the Equality Act and the Equality Delivery System. It was highlighted that equality and diversity was currently within the remit of the Patient Experience Lead. In terms of the publishing responsibilities, it was highlighted that the Trust was compliant. The Board was advised that in Quarter 4, the Board would be asked to approve a statement of compliance. It was reported that the new Board Committee and Clinical Leadership Executive (CLE) Committee which concerned Public Health would include equality and diversity within their remits. Ms Dutton suggested that some decisions that the Board had been asked to take may not have been done so in the context of an equality and diversity assessment. Mr Ovington noted that the Board's responsibilities in relation to equality and diversity needed to be clarified. It was agreed that this would be included within the business of one of the future Board Development sessions. Dr Sahota noted that the equality implications in relation to procurement also needed to be borne in mind.	

Mrs Pascall noted that the Trust had reasonable information against the protected characteristics of Trust staff however this was to be developed further in future.	
ACTION: Mr Grainger-Payne to include equality and diversity within the business of a future Board Development session	
8.7 EPR procurement	**SWBTB (12/13) 256** **SWBTB (12/13) 256 (a)**
Dr Stedman reported that as part of the HIS restructure, a procurement team had been identified to carry forward the EPR procurement work. The Chairman asked what timeframe applied to the work. He was advised that an 18 month timeframe applied. Ms Robinson suggested that consideration should be given to collaboration and gaining learning from other trusts pursuing a similar programme of work. Ms Dutton highlighted that the value for money aspect of the procurement needed to be incorporated into the work. She was advised that this consideration was in hand.	
9 Finance & Performance Management	
9.1 Monthly Finance Report – Month 8	**SWBTB (12/13) 257** **SWBTB (12/13) 257 (a)**
Mr White advised that in November a surplus had been created meaning an overall year to date higher than planned position had been achieved. It was highlighted that there had been mixed performance across the Clinical Groups, with Medicine & Emergency Care most notably falling below expectations. It was reported that some of the position reflected winter pressure costs and the position was being considered in further detail to understand the further reasons behind the variance. The Board was advised that the detail would be presented at the meeting of the Finance & Investment Committee in January 2014. The Board was asked to note that there was a significant variance in pay in month. Ms Dutton asked whether expenditure on agency staff was influencing the position. She was advised that this was the case and needed to be analysed further to gain a better understanding of the position. Mr Sharon advised that this issue had been discussed at the recent meeting of the Workforce & Organisational Development Committee, where it had been reported that bank pay rates were regularly reviewed yet for some specific staff groups more expensive agency staff needed to be used. Mrs Pascall highlighted the practice of using of dedicated nursing support to some patients needed to be reviewed. Mr Lewis suggested that the controls on medical staffing needed to be tightened given that this spend was a key aspect of the agency expenditure. Mrs Hunjan asked how compliance with the European Working Time Directive (EWTD) was monitored for staff being employed as bank staff internally or elsewhere. Mrs Pascall advised that a monitoring system was in place for staff within the Trust's employment and that	

all bank staff were required to abide by the EWTD. It was noted however that there was a degree of personal flexibility that was difficult to monitor, particularly with those staff who worked external to the Trust. Mrs Hunjan underlined the need for effort to be directed to minimise the risks associated with staff working more hours than the EWTD permitted. Ms Robinson highlighted that the Finance & Investment report needed to be issued monthly as agreed by the Board. She also highlighted that further assurance was needed in terms of the use of bank and agency staff, looking at performance at a more detailed level. Miss Barlow advised that work was currently underway which would provide this view. Ms Dutton noted the link between good leadership and sickness absence, which impacted on the use of bank and agency staff. She was advised that the work underway would identify the reasons for the use of bank and agency staff. Mr Lewis highlighted that the Trust was £135k adrift on pay. He specified several pieces of work over coming weeks as follows: - To understand the £1.2m overspend on medical staffing and decide if controls in place were sufficient (Mr White/Miss Barlow) - To conclude our work on vacancies and turnover (Miss Barlow) - To complete our review of bank pay rates (Deputy Director of Workforce) It was reported that the continuity of service risk rating remained at 4 and that cash remained strong.	
9.2 Monthly Performance Monitoring Report	**SWBTB (12/13) 258** **SWBTB (12/13) 258 (a)**
The Board was asked to receive and accept the monthly performance monitoring report. Performance against the Emergency Care target and the Trust's infection rates was highlighted to be positive. Performance against the ambulance turnaround target was also reported to be good, as was performance against the Imaging targets. Dr Sahota asked what measures were being undertaken to improve the Friends and Family Test results. It was highlighted that the Emergency Care performance compared favourably to other organisations, however Mrs Pascall advised that improvement against the maternity element needed further improvement. Ms Robinson noted that the complaints information appeared anomalous. It was agreed that this needed to reviewed further with a view to reporting back at the next meeting. Mrs Hunjan noted that the forecast projection for a number of areas showed that there was a risk of not achieving some targets and it was agreed that the latest position should be discussed as part of the performance discussion at the next meeting of the Quality & Safety Committee.	
ACTION: Miss Dhami to verify the accuracy complaints information	

included in the corporate performance report	
9.3 Setting annual priorities 2014/15	**SWBTB (12/13) 259** **SWBTB (12/13) 259 (a)**
Mr Sharon presented an overview of the plans to set the Trust's annual priorities in 2014/15, including the process for engaging staff and patients. Mr Sharon advised that the views of the shadow membership were canvassed as part of the Annual General Meeting. Ms Dutton suggested that equalities needed to be considered as part of the process for settling the priorities. Ms Robinson suggested that that the practice adopted by other trust in respect of harm free care should be considered as part of the plans. Mr Lewis advised that a harm index would be developed in the near future, however he expressed reticence of adopting terminology concerning harm free care. It was highlighted that shared learning from complaints needed to be incorporated into to priorities and the use of innovation should be included. Mr Sharon advised that an interim return would be submitted to the Trust Development Authority (TDA) which would be signed by the Chairman and Chief Executive on behalf of the Board. Dr Sahota suggested that there should be a clear focus on addressing 'DNA' rates, however he was advised that this would be addressed through the wider outpatient improvement work.	
10 Update from the Committees	
10.1 Update from the meeting of the Configuration Committee held on 12 December 2013 and minutes from the meeting held on 15 October 2013	**SWBCC (10/13) 008**
The Chairman provided an overview of discussion points from the meeting of the Configuration Committee held on 12 December 2013. The Board was asked to note the potential disconnect between the transformation work and the clinical reconfiguration work. Mr Lewis advised that an assessment as to the clinical and financial feasibility of some reconfiguration schemes would be undertaken and that work would be developed to harmonise the programmes of work. The Board was advised that the assessment criteria for the new hospital procurement bids would be released for comment in the new year.	
10.2 Update from the meeting of the Charitable Funds Committee held on 12 December 2013 and minutes from the meeting held on 9 May 2013	**SWBCF (5/13) 018**
Dr Sahota provided an overview of discussion points from the meeting of the	

Charitable Funds Committee held on 12 December 2013. It was specifically reported that the investment exclusions policy was to be widened to include alcohol and armaments, however the full list of FTSE 350 companies would be reviewed to ensure that the policy be applied as appropriately as possible.	
10.3 Update from the meeting of the Workforce & Assurance Committee held on 16 December 2013 and minutes from the meeting held on 30 September 2013	**SWBWA (9/13) 030**
In Mr Kang's absence, the Chairman provided an overview of discussion points from the meeting of the Workforce & Organisation Development Committee held on 16 December 2013. Mr Lewis noted that the division of work between the CLE subcommittee and that of the Board Workforce & Organisational Development Committee needed to be finalised.	
11 Any Other Business	**Verbal**
In the event that this was Mr White's last meeting he was thanked for his contribution to the work of the Board and years of service to the Trust. The Chairman commented that the integrity of the finance team was a credit to Mr White's leadership.	
Matters for Information	
The Board received the following for information: Midland Metropolitan Hospital Project: Monitoring Report Foundation Trust Application Programme: Monitoring Report	
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 6th February 2014 and would be held in the Boardroom, Sandwell Hospital.	

Signed: …….

Name: ……

Date: ……

Next Meeting: 6 February 2014, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

19 December 2013, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Ms O Dutton (OD), Mrs G Hunjan (GH), Mr T Lewis (TL), Mrs L Pascall (LP), Miss R Barlow (RB), Mr R White (W), Dr R Stedman (RST)

In Attendance: Miss K Dhami (KD), Mr M Sharon (MS), Mrs C Rickards (CR)

Apologies: Mr H Kang (HK), Prof R Lilford (RL)

Secretariat: Mr Simon Grainger-Payne (SGP)

Last Updated: 31 January 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.271	Proposals for external support for 'Never Events' assurance	SWBTB (12/13) 251 SWBTB (12/13) 251 (a) SWBTB (12/13) 251 (b)	19-Dec-13	Discuss the learning model in development session with the Board	Executive	14/02/14	Scheduled for discussion at the February meeting - to be led by Mr Ovington	G
SWBTBACT.272	Proposals for external support for 'Never Events' assurance	SWBTB (12/13) 251 SWBTB (12/13) 251 (a) SWBTB (12/13) 251 (b)	19-Dec-13	Ensure that the programme model for 2014 onwards be presented as part of Annual Plan finalisation	TL	31/03/14		G
SWBTBACT.273	Equality & diversity – interim position statement	SWBTB (12/13) 255 SWBTB (12/13) 255 (a)	19-Dec-13	Include equality and diversity within the business of a future Board Development session	SG-P	30/04/14	Training slot to be agreed with new legal team	G
SWBTBACT.274	Monthly Performance Monitoring Report	SWBTB (12/13) 258 SWBTB (12/13) 258 (a)	19-Dec-13	Verify the accuracy complaints information included in the corporate performance report	KD	31/12/13	Verified as requested	B

KEY:

R	Action highly likely to not be completed as planned or not delivered to agreed timescale.
A	Action potentially will not delivered to original timetable or timing for delivery of action has had to be renegotiated more than once.
Y	Slight delay to delivery of action expected or timing for delivery of action has had to be renegotiated 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

REPORT TO THE PUBLIC TRUST BOARD
Chief Executive's Report – February 2014

The Board today considers a number of pieces of work that are in development by the frontline leadership, clinical groups and the executive. We discuss the shape of the patient experience promises that we want to deliver, as well as beginning to discuss our education plans. Traditionally, a strength for the Trust, and something we want to build upon. The proposed Public Health strategy is submitted for approval - embodying our commitment to regeneration, the wellbeing of our workforce, and our role in the wider community. The timing of this paper comes as we move one step closer to MMH and the regeneration of the Windmill, as we sit firmly in the premier league of NHS providers for flu vaccination (top 10 by percentage, top 20 by volume), and as we deploy, our now NICE endorsed, Nicotine Replacement Therapy service for staff.

1. Our patients

We set out in May to make sure that winter 2013 was better for patients, visitors and staff, than 2012. In June and August we demonstrated marked improvements in very long waits, and compliance with the national standard. In November, December, and in January, we have maintained that success. Importantly, we have seen ambulance turnaround also delivered consistently on both our acute sites, despite knock on pressures supporting other organisations in the Black Country. Colin Ovington can provide a summary of our infection control position when we meet as a Board, but in headline terms, the impact of norovirus has been far, far less than in 2012, and we need to continue vigilance to make sure that we sustain that improvement.

In keeping with our ambitions for excellence, we need now to press ahead with three areas where we can evidence less progress, each of which depend on system collaboration. Those being (a) mental health provision for acutely ill adolescents, (b) readmission rates among adults at Sandwell, and (c) delayed transfers of care in either acute or community beds in both Local Authority areas. The remedy we need is different in each case. We do not yet have an agreed plan for the first. The second is a subject where we know what we believe will work and now need to deploy it. Clarity on the third will be significantly enhanced when we expand our operations-control centre model (which we deployed across our acute bed base in November) across all system beds (which ourselves, the CCG, LAT, and LAs have committed to do by the end of March).

The Board will discuss a series of disappointing individual incidents of poor care, or rather poor outcomes or experience of care. We do that against a backdrop of returned compliance on VTE assessment and sustained improved MRSA screening. However, we have had a grade four pressure ulcer for the first time in almost two years, our second MRSA bacteraemia of 2013-14, and a fifth Never Event. The never event controls audit was reviewed by the Clinical Leadership Executive and illustrates where our weakest points remain. The externally supported safety summit on February 13th is the latest milestone in the work we approved in December to construct, or spread, a culture of the safest practice. We anticipate proposing in our Annual Plan for 2014-15 a series of always events, which we want to secure for every patient on every admission as part of a 'no-harm index'.

On Monday January 13th, colleagues are aware that a large lorry penetrated the wall of our Leasowes Hospital, after apparently veering to avoid a crash. No patients, passengers, nor staffs

were harmed. We evacuated patients initially to Sandwell and then to a re-opened ward at Rowley Regis. Building work to make good the structure continues during February, and we expect to be able to confirm a re-opening date during March. The efforts of staff, leaders, and partner emergency services, were impressive, and the Chairman and I have extended our thanks to those involved.

2. Our teams

Over coming weeks, there is continued focus on our appraisal rates, as well as on mandatory training compliance, notably safeguarding. Around 2,000 appraisals remain to be done or recorded to take us to our aim of 100% coverage in year. In 2014-15, we want to alter that ambition to distribute appraisals more evenly across the year so that we can be more confident that proper time is being spent on each one.

The Board is aware of considerable focus over the last six months on the accuracy and congruence of our workforce data, and we are now confident that by the start of the new financial year, our vacancy position will be available with much greater accuracy, not just locally but corporately - enabling us to 'red flag' any post that has been unfilled for more than specified period. This is consistent with the Board's ambitions to reduce time-to-hire (in part by cutting the time to decide to re-hire) and our goal to cut our paybill by reducing premiums spent on temporary staffing. The third element of this plan, reducing turnover, notably among recent nursing recruits in some teams, is subject to further review with the workforce committees of the executive and Board.

Unavoidably, our financial plans for 2014-15, which foresee another year of £20m+ savings, will necessitate workforce changes. The JCNC has discussed candidly which parts of the approach to change from this year have worked well, and which merit adaptation. We are all committed to minimising redundancies and recognise that internal redeployment, given our vacancy rates in many roles, should be possible. We will need to ensure collective flexibility by employees and line managers in supporting reasonable adjustments to roles as well as development and support.

We will update orally in the Board meeting on progress with the leadership development tender to support our top 150 leaders over the coming 18 months. There has been an encouraging response from the market and a cross section of clinical leaders has been involved in the evaluation process. A summary of our ambition for this work is included in today's written papers.

3. Our partners

A useful joint meeting of CCG clinical leads, and many medical leaders from within the Trust, has provided a basis for trying to develop joint forward plans, in the challenging territory of the 15-16 Better Care Fund. Challenging because what we do together has to work to curb demand safely, and challenging because the mechanisms used to nationally (re) deploy this money need to be used flexibly to allow organisations like ours to redefine ourselves on an integrated basis. We want to avoid a return to counting care closer to home by location, where the BCF programme is about improving outcome and achieving care integration. We should be encouraged by productive discussions with Sandwell Metropolitan Borough Council around role change, as we look to build on our iCares success, and reduce duplicate assessments undertaken by different personnel simply because budgets are divided across organisations.

We have contributed to the ongoing review of children's services across Birmingham, being led by Julian LeGrande. This has provided a valuable opportunity to reflect with health partners on the role we need to play to ensure services for over 300,000 young people in the city are effective. The outcome of that external process is not known at this time.

4. Our regulators

The Trust Development Authority continues to work with us to sustain improvements in emergency care, and provide oversight of the work on elective access. The Intensive Support Team are working with us to test our 18 week position against good practice elsewhere. Clearly, discussions with the TDA have also covered are re-stated year-end position, which sees an improved non-recurrent surplus, as well as the public approval by the NTDA Board of the outline business case. Should that approval be replicated by DH and HMT then we can proceed to OJEU.

Work continues within our quality and safety regimes on the CQC core dataset, including of course our data quality. After a significant number now of acute site inspections, we have reviewed learning from staff, patients and leaders in other organisations, both in the Clinical Leadership Executive and the CD away day. Of course the new system is not a replacement for our own oversight, walkabouts or inspections, and the intention is to enhance the scale and profile of those systems during Q1. We continue with local CQC colleagues to understand how the regime will work effectively in an integrated care organisation.

5. Feedback direct from our middle managers

The Hot Topics (HT) process kicked off at the start of January. It coincided with the launch of our first video based Learning Alert, which focused on positive patient identification. This innovation was well received and widely viewed, and similar work is planned at roughly monthly intervals. In December, the discussion topic has focused on our Year of Outpatients proposition, and during January the subject has been opportunities and barriers to "seven day" working. From that we have received a sense of what our staff consider to be important on this national agenda:

A need to ensure that we have a joined up approach, in other words that dependencies for weekend services are in place

The key enabler being IT to allow people to work seamlessly across the week and not duplicate information collection

The twin employment challenges of finding a payment and contracts model for weekend working, whilst recognising that this may reduce payments to those presently working overtime

The importance of making use of equipment, but also the cost of increased use on equipment life and fitness

The face to face briefings are also a direct opportunity to take the temperature among those providing frontline leadership in the Trust. Tackling re-admissions and issues of late discharge continue to be explored at Sandwell. In February, we want to use the HT system to explore the plans the Board is discussing around patient experience, and our commitments to change and improve in 2014-15. These emerging plans also feature in today's Board papers as we try and ensure engagement at different of the Trust happens concurrently not always sequentially.

Attached to this briefing is a summary of next year's intended car park charge changes for information. Unavoidably these are always inflation congruent, given the multiples on which we work our machines. We have also sought to bring greater equity between sites and between staff groups.

Toby Lewis
Chief Executive

Facilities 2014/15

Car Parking – charge summary

C***oncessions***

Increase cost from £2.00 to £2.50 each ticket (pack of 4 for £10)

Visitor tariff – City and Sandwell

Uplift visitor charges by 10p each band (10p is the minimum increase due to machine configuration)

	Current tariff	Proposed new tariff
Up to 15 mins	free	free
Up to 1 hour	£2.50	£2.60
Up to 2 hours	£3.50	£3.60
Up to 3 hours	£4.00	£4.10
Up to 4 hours	£4.50	£4.60
Up to 5 hours		
Up to 6 hours	£5.00	£5.10
Up to 7 hours		
Up to 8 hours		
Up to 9 hours		
Up to 10 hours		
Up to 24 hours		

Visitor tariff – Rowley

Uplift charges for up to 6 hours by 50p

	Current tariff	Proposed new tariff
Up to 15 mins	free	free
Up to 6 hours	£2.00	£2.50
Up to 24 hours	£5.00	£5.00

Consultant car park at Sandwell

We will change the consultant/resident only car park at Sandwell to allow all staff access. This is in line with City Hospital where consultants and residents do not have their own car park.

Risks	Benefits
Loss of revenue (circa £10k) Consultants not always be able to park close to the hospital (those arriving from 8.30am onwards) – (nb. no consultant parking at City) Residents would lose priority parking (nb. no priority parking for residents at City)	Staff satisfaction – additional capacity 30-35 spaces

Sandwell and West Birmingham Hospitals NHS
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TRUST BOARD

DOCUMENT TITLE:	A summary report into 'Wrong Implant' Never Event which occurred in the Eye Theatres on 3 January 2014
SPONSOR (EXECUTIVE DIRECTOR):	Roger Stedman, Medical Director
AUTHOR:	Roger Stedman, Medical Director
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

This is, unfortunately, the fifth Never Event to have taken place in the Trust in the last 12 months and the third to have taken place at the Birmingham & Midland Eye Centre.

The paper outlined the facts of the incident, findings including root causes and contributing factors.

Immediate management actions and learning points are also presented in the paper.

REPORT RECOMMENDATION:

The Board is asked to consider this in the context of previously agreed actions, including the Never Event Assurance plan, external review of theatres and the plans for the Patient Safety Summit.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:
Risk Management, incident investigations and Being Open

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

Safe High Quality Care

PREVIOUS CONSIDERATION:

None

A Summary Report into a 'Wrong Implant' never event which occurred in Eye Theatres on 03/01/14

Introduction

This is, unfortunately, the fifth never event to have taken place in the Trust in the last 12 months and the third to have taken place at BMEC. The team have since the first incident of wrong intra-ocular lens implant undertaken a number significant changes to both process, policy and training in the eye operating theatres. They are naturally deeply concerned that despite this a further incident has occurred. This incident prompted an immediate temporary suspension of this type of operating at BMEC in order to take some time to examine why lessons from previous incidents are still not preventing these errors occurring. This temporary suspension was immediately followed by a whole team extraordinary governance meeting in order to exercise effective team learning.

Key facts of the incident

The timeline of the incident starts with a clerical error at the time of booking. The patient was scheduled from a waiting list 'pool', at the time of booking there were two patients with the same surname requiring the same operation on the same eye on the waiting list. The error that occurred was that the wrong patient details were selected from the waiting list pool to be placed on the operating theatre scheduling system to those of the patient that was invited to the operation.

On the day of surgery the error was in fact spotted by a vigilant receptionist when the details of the patient that had arrived on the day did not match those on the theatres system. The system was updated and theatres informed of the change, however this did not occur before a set of operating lists had been printed and distributed with the wrong details on them. A new set of lists were printed - however not all incorrect lists were replaced, including the list being held by the operating surgeon.

The operating list started late for several reasons, there had been an emergency case that morning that had disrupted the morning list and resulted in a number of cancellations. The operating surgeon due to carry out the list had called in sick and so a surgeon was drafted in at the last minute. There was a previously unidentified need for anaesthetic support for the list and so an anaesthetist was also drafted in late. As a result of this a full team brief did not occur - and the surgeon, anaesthetist and at least some of the theatre nurses were unaware of the change in details on the operating list.

When the patient was sent for, all identity checks were carried out correctly against a correct version of the operating list and against the patient's wrist band and paper record. The error occurred because the surgeon used the patient details on the incorrect operating list to access the electronic 'Medisoft' patient record. It is this electronic record that holds the details of the lens implant to be used only and not the paper record. A name check was carried out by the surgeon when the electronic record was used - however it was a verbal check only and because the patient had the same name, and the surgeon had not been made aware of the same name risk, the discrepancy was not picked up.

The error was spotted after the operation at the time the operating notes were being written up and the patient was in recovery. The patient was immediately offered an explanation, apology and corrective surgery - which was carried out on the same operating list under the same local anaesthetic.

Immediate actions following incident

The incident was immediately recognised as a never event, appropriately reported and escalated.

The patient received appropriate communication and apology in line with the 'being open' policy.

Following a detailed risk assessment routine cataract surgery was suspended for three working days whilst a thorough investigation was conducted and an extraordinary team learning event organised - which took place on 08/01/2014.

A full table top review took place on 07/01/2014 chaired by the medical director.

Investigation findings

Root cause:

- failure to carry out adequate identity check when accessing electronic patient record

Contributory factors:

- failure to carry out adequate team brief
- late list change and failure to remove incorrect operating list from circulation
- inadequate integration of IT systems - both theatre scheduling, and medisoft

Key lessons

1) Operating lists are not a reliable source of identification
2) There is organisation wide risk associated with multiple patient records - paper and electronic - additional vigilance required when accessing
3) Team brief is mandatory and should include the whole team

Actions arising

1) Intra-ocular lens strength to be recorded in paper record and checked against this at time of selection
2) Medisoft functionality to be reviewed with respect to integration with theatre systems and PAS
3) Audit of all actions arising from previous never events
4) Task and finish group to be set up to look at ways to reduce late changes in operating lists
5) Learning alert to be produced on the theme of team brief and de-brief

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**'Never Events': Controls Audit**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami – Director of Governance**
AUTHOR:	**Allison Binns, Assistant Director of Governance**
DATE OF MEETING:	**6 February 2014**

EXECUTIVE SUMMARY:

Given the continued occurrence of 'Never Events' at the Trust, assurance on processes to aid prevention was requested.

Audits, across mostly surgical specialties, were undertaken between October and December 2013 and the attached report details the results and recommendations made.

The audit results were variable with only the ophthalmic lens protocol audit achieving 100% compliance however, there were some good results from individual specialties within the overall audits.

Whilst some assurance has been gained, the appetite for safety requires some focussed attention if we are to prevent a further Never Event.

REPORT RECOMMENDATION:

The Trust Board is asked to **RECEIVE** and **ACCEPT** the audit results and findings and the proposed actions.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

High Quality Care

PREVIOUS CONSIDERATION:

Executive Group and Clinical Leadership Executive on 28 January 2014

'Never Events': Controls Audit

1. Introduction

In September 2013 a report was presented to the Trust Board identifying the level of assurance from the controls in place to prevent recurrence of the **14** 'Never Event's that had happened since 2009 (the national inception of NEs). Through the clinical audits undertaken, positive assurance was gained in some areas, however, low compliance and poor audit results were found in others. Consequently, in October 2013 targeted audits were requested and developed to undertake reassessment of those practices causing concern.

2. Outcomes

Where the audit was on a Trust-wide (surgical) basis the compliance has been aggregated for the Trust as a whole and results are available at **Appendix 1**. Results for the targeted audits are broken down further in **Appendix 2**. *Table 1* shows the assurance grading that has been applied to each control measure.

Table 1

Grade / Assurance level							
4	**High**	Good compliance	3	**High/Medium**	Reasonable compliance	2 **Medium**	Average compliance
1	**Low**	Poor/no compliance					

	Audit	Methodology	Intended Outcome	Success measure	Audit Results	Assurance Level
1.	**Surgical site marking**	Each of the targeted specialities (x10) will review the healthcare records of 40 procedures undertaken within the previous 3 months to identify if the surgical site was marked appropriately. A standard data collection proforma will be used. The audit will be carried out retrospectively and take data from both the theatre care plan and the WHO checklist	All patients undergoing surgery where the surgery is site specific will have the site marked (this excludes where only one organ exists or the operation is bilateral).	100% of all eligible cases are marked and the WHO surgical checklist and Theatre care plan correlate.	**Trust compliance: 91%** (n=351)	**4**

	Audit	Methodology	Intended Outcome	Success measure	Audit Results	Assurance Level
2.	**Swab / instrument count**	Each of the targeted specialities (x10) will review the healthcare records of 40 procedures undertaken within the previous 3 months to identify if the swab and instrument counts were documented as correct (excluding Maternity). A standard data collection proforma will be used. The audit will be carried out retrospectively and take data from both the theatre care plan and the WHO checklist.	All patients undergoing surgery will have no unintended foreign objects left following completion of surgery.	100% of all eligible cases are documented and the WHO surgical checklist and Theatre care plan correlate.	**Trust compliance: 91.5%** (n=351)	**4**
3.	**Maternity swab/ instrument count**	Maternity will review 40 sets of healthcare records for instrumental deliveries, C-sections and normal deliveries undertaken with the previous 3 months.	No woman following birth will have an unintended retained foreign object.	100% of cases have a documented swab count either through use of WHO checklist or healthcare records as appropriate.	**Overall compliance: 94%** (n=62)	**4**
4.	**Guide wire count**	This audit is specific to Breast Surgery and will review all cases over a 4 week period. Data is already recorded for this and a review of the records will check that documentation of guide wire removal has taken place	No patient will have a retained guide wire after their surgical procedure.	100% of eligible cases will be documented as having the guide wire removed following surgery.	**Compliance: 90%** (n=31)	**4**
5.	**Use of information leaflets**	This is included within the monthly consent audit undertaken by each specialty. The audit review is particularly looking to see if leaflets are provided to patients pre-operatively and that this information is documented on the consent form. 20 sets of	As part of the consent for surgery/procedure process all patients are provided with written information pre-operatively to support their decision making.	It is documented on the consent form that patients were provided with written information pre-operatively in all cases.	**Trust compliance**: **27.8%** (n=252)	**1**

	Audit	Methodology	Intended Outcome	Success measure	Audit Results	Assurance Level
		healthcare records per specialty (x2) will be reviewed over 2 months.				
6.	**Consent**	This is a monthly audit already in progress and undertaken by each specialty. Each month 20 sets of notes are reviewed. The audit review particularly looks at the completion of the consent form and who undertook the consent. This audit is particularly concerned with **when** the consent form was signed, which is already an integral question.	Consent for all eligible procedures is undertaken prior to the day of surgery/procedure (this excludes direct access surgery and procedures)	All eligible patients are being consented for their procedure prior to the day of surgery.	**Trust compliance: 74.2%** (n=267)	**2**
7.	**Amended interventional WHO checklist**	Re-audit of a randomised records review to ensure that the modified checklist is used and correctly completed on each occasion.	No unintentional harm to patients undergoing critical care interventional procedures within the department environment.	All WHO checklists for interventional procedures fully completed in CCS	No audit undertaken (see note below)	**1**
8.	**Lens protocol**	A re-audit of four randomly selected Eye theatre lists in November 2013 which will observe compliance with the Protocol for the selection and management of implantable lenses. A total of 16 procedures will be observed by an independent auditor to measure compliance with the agreed lens checking processes.	No patient will have a wrong intraocular lens implanted	100% of cases audited adhere to the protocol for the selection and management of implantable lenses	100% (n=13)	**4**
9.	**Nasogastric tube insertions**	A Trust wide re-audit which will review the documentation in the healthcare records of all NGT insertions undertaken in October	No patients will have an incorrectly inserted nasogastric feeding tube.	100% of nasogastric tube insertions will be documented in the	**Trust Compliance:** Insertions **81%** (n=31)	**3**

	Audit	Methodology	Intended Outcome	Success measure	Audit Results	Assurance Level
		2013. The audit will also survey 50 nurses and 50 doctors to assess knowledge of the NG insertion processes and identify any further training needs.		Trust NGT Checklist. 100% of staff involved with nasogastric tube position checks will have been assessed as competent through theoretical and practical learning.	**Training:** Nurses 65% (n=54) Doctors 80% (n=40)	
10	**Pre-printed dental chart**	The Oral and Maxillofacial surgeons have met to discuss the use of pre-printed dental charts in the prevention of another Never Event within their service. They have advised that this is used more in community dentistry and that their Society has provided guidance. They have been asked to review this guidance and implement the changes necessary by the end of October 2013 to ensure a further incident doesn't happen. These changes will then be audited in January 2014.			Audit results will be available in February 2014.	
11	**Theatre Visitor Policy**	The Theatre Visitor policy to be shared across appropriate Clinical Groups and reviewed to ensure that the standards within are appropriate for each Theatre complex. It will then be introduced and audited for compliance.			Policy in place in all theatres. Audit taking place currently and results available in March 2014.	

NB: As a priority, the Group Director for Surgery will ensure that the required compliance audit for use of the WHO checklist for interventional procedures in the CCS is completed by the end of February.

3. Good Practices and concerns

	Audit	Good practices and concerns
1.	**Surgical site marking**	Any compliance of less than the Trust compliance was considered as an outlier. The specialties who met the target of 100% of cases were Breast and ENT. The specialty which gave concern was Urology who only reviewed 8 cases of which 2 required a side marking (although their compliance was relatively high at 75%). General and Colorectal Surgery reviewed 41 cases of which 5 required a side marking (their compliance was relatively high at 80%).

	Audit	Good practices and concerns
2.	**Swab / instrument count**	Specialties meeting the 100% target were gynaecology and ophthalmology. The outlier of most concern was Urology who only reviewed 8 cases, although others failed to achieve the target.
3.	**Maternity swab/ instrument count**	The audit for instrumental deliveries was changed during the audit as the Directorate felt practice was safer and best practice to have two signatures.
4.	**Guide wire count**	Although not part of the audit vascular reviewed their practice with regard to guide wires during Radio Frequency Ablation of varicose veins. They are introducing the documenting of removal of the guide wire in the theatre care plan following agreement on 7 January and will audit this in February
5.	**Use of information leaflets**	Overall poor compliance was seen across all specialties with Breast (66.7%), Maternity (62.5%) and Urology/Vascular (74.3%) all showing these given as documented on the consent form in over 50% of cases, although numbers were small in both Breast and Maternity. Additionally the audit asked if it was documented elsewhere in the healthcare records that an information leaflet was provided. This was only marginally recovered by T&O who documented it elsewhere in 35.5% of cases.
6.	**Consent**	This refers to elective admissions only. Only one specialty met the target of 100% compliance – Ophthalmology. Areas of concern are General Surgery (0%), T&O (17.6%), Plastics (57.7%) and Breast (55.5%). The audit also looked to see if there was opportunity for consent to have been taken prior to admission; areas of continued concern are Breast, General Surgery and Plastics. All other areas recognised that this could have occurred and that their compliance could greatly improve.
7.	**Amended interventional WHO checklist**	Despite efforts of the Group Director, no audit was undertaken.
8.	**Lens protocol**	Although positive assurance was gained from the audit results, following another Never Event in January 2014, the Lens protocol will require amendment.

	Audit	Good practices and concerns
9.	Nasogastric tube insertions	Neither target was met; however the audit results are an improvement on previous year's results. Encouragingly there was 100% use of pH paper to test for positioning and no liquids or feeds were introduced until confirmation of the correct tube positioning was obtained. Documentation remains an issue
10	Pre-printed dental chart	Auditable standards being identified and audit currently on-going.
11	Theatre Visitor Policy	Ophthalmology have had no visitors into theatres since they introduced their visitor protocol. As and when they do the standards within their protocol will be audited. An approved policy is now in place and all theatres are currently auditing this.

4. Proposed actions in response to audit findings

Follow-up work arising from the audit findings is listed below. This will be assigned to designated individuals within the appropriate Directorates and a plan developed to address the issues identified. The overall plan will be presented to the Patient Safety Committee on 7 February for approval. The PSC will monitor progress thereafter.

a)	Urology to undertake a retrospective audit of swab and instrument counts of 40 sets of notes within the next 4 weeks.
b)	Ophthalmology to undertake a further audit of site marking across all areas where interventions occur commencing in February 2014.
c)	Ophthalmology undertakes a consent audit for patients undergoing outpatient procedures.
d)	Revision of the Ophthalmology Lens protocol to define where biometry confirmation is taken from (1 source preferably HCR) and that the biometry checks are done independently rather than two people together.
e)	Purchase and use of a stamp for theatres (care plan) for use in surgery using guide wires until this can be added into the next theatre care plan print (e.g. guide wire removed Yes ☐ No ☐)

f)	Maternity require swab and instrument counts to be documented on the WHO checklist and maternity theatre care plan rather than either for instrumental deliveries and C sections which are carried out in theatres.
g)	All specialties to review the available leaflets provided by EIDO, through CONNECT. Processes to be put in place to improve the provision of information and its documentation for each specialty.
h)	All specialties to ensure that they have a robust method of taking consent prior to procedure day except in direct access cases.
i)	Improvement in numbers of nurses in 'high risk' areas having completed training for NGT insertion.
j)	Critical care to either adopt use of the NGT check list or to ensure the insertion information is documented within the HCR.
k)	Review of the full 'Never Events' list and commission audits where appropriate.

5. Conclusion

The results of the audits undertaken have shown that there is variable practice across the Trust in process which has contributed towards the Never Events experienced over recent years. In addition, the participation in the process of gaining assurance from these results has proved challenging in some specialties. This reflects on the appetite for patient safety from both a monitoring and improvement perspective.

This does not mean that practices are necessarily unsafe, but it does show that evidence of such practices is not consistently of a high standard. Documentation is often the only evidence that processes have been followed and that safety is central to patient care. This reflects a safety culture that is reactive, responding mostly when an incident has occurred.

Re-audits of these areas are unlikely to show an improving picture without first addressing the safety climate of the Trust and taking steps to transform it.

6. Recommendations

The Clinical Leadership Executive (CLE) is asked to **DISCUSS** the audit results and findings and **APPROVE** the proposed actions.

Allison Binns
Assistant Director of Governance

Penny Holtom
Clinical Effectiveness Facilitator

Appendix 1

Surgical Site Marking / Swab & Instrument Count Audit

1. Audit Sample – Specialties Breakdown

		SURGICAL SITE MARKING				SWAB & INSTRUMENT COUNT	
Specialties	**Audit sample**	**Operations involving a side**	**1a) Is it documented on the theatre care plan that operation was marked?**	**1b) Documented on WHO checklist that the surgical site was marked?**	**Compliant (1a & 1b)**	**2) Instruments, swab and sharps count - WHO checklist documentation**	**3) Instruments, swab and sharps count - Theatre care plan**
Breast	40	Yes = 39 (98%)	***n=39*** Yes = 39 (100%)	***n=39*** Yes = 32(82%) No = 7 (18%)	***n=78*** Yes = 71 (91%)	***n=40*** Yes = 36 (90%) No = 4 (10%)	***n=40*** Yes = 35 (88%) No = 5 (13%)
ENT	72	Yes = 28 (39%)	***n = 28*** Yes = 28 (100%)	***n = 28*** Yes = 28 (100%)	***n = 56*** Yes = 56 (100%)	***n = 72*** Yes = 69 (96%) No = 3 (4%)	***n = 72*** Yes = 68 (94%) No = 4 (6%)
General / Colorectal	41	Yes = 5 (12%)	***n=5*** Yes = 3 (60%) No = 2 (40%)	***n=5*** Yes = 5 (100%)	***n=10*** Yes = 8 (80%)	***n=41*** Yes = 33 (80%) No = 8 (20%)	***n=41*** Yes = 35 (85%) No = 6 (15%)
Gynae Oncology	28	Yes = 1 (4%)	***n=1*** Yes = 0 No = 1 (100%)	***n=1*** Yes = 1 (100%) No = 0	***n=2*** Yes = 1 (50%)	***n=28*** Yes = 26 (93%) No = 2 (7%)	***n=28*** Yes = 25 (89%) No = 3 (11%)
Gynaecology	20	Yes = 1 (5%)	***n=1*** Yes = 1 (100%) No = 0	***n=1*** Yes = 1 (100%) No = 0	***n=2*** Yes = 2 (100%)	***n=20*** Yes = 20 (100%)	***n=20*** Yes = 20 (100%)
Ophthalmology	40	Yes = 40 (100%)	***n=40*** Yes = 27 (68%) No = 13 (33%)	***n=40*** Yes = 40 (100%)	***n=80*** Yes = 67 (84%)	***n=40*** Yes = 40 (100%)	***n=40*** Yes = 40 (100%)
Plastics	42	Yes = 40 (95%)	***n=40*** Yes =38 (95%) No =2 (5%)	***n=40*** Yes = 40 (100%)	***n=80*** Yes = 78 (98%)	***n=42*** Yes = 40 (95%) No = 2 (5%)	***n=42*** Yes = 41(98%) No = 1 (2%)

		SURGICAL SITE MARKING				SWAB & INSTRUMENT COUNT	
Specialties	**Audit sample**	**Operations involving a side**	**1a) Is it documented on the theatre care plan that operation was marked?**	**1b) Documented on WHO checklist that the surgical site was marked?**	**Compliant (1a & 1b)**	**2) Instruments, swab and sharps count - WHO checklist documentation**	**3) Instruments, swab and sharps count - Theatre care plan**
T&O	40	Yes = 40 (100%)	***n=40*** Yes =37 (93%) No = 3 (8%)	***n=40*** Yes =35 (88%) No = 5 (13%)	***n=80*** Yes =72 (90%)	***n=40*** Yes = 36 (90%) No = 4 (10%)	***n=40*** Yes = 36 (90%) No = 4 (10%)
Urology	8	Yes = 2 (25%)	***n=2*** Yes = 1 (50%) No = 1 (50%)	***n=2*** Yes = 2 (100%)	***n=4*** Yes = 3 (75%)	***n=8*** Yes = 7 (88%) No = 1 (13%)	***n=8*** Yes = 2 (25%) No = 6 (75%)
Vascular	20	Yes =19 (95%)	***n=19*** Yes = 18 (95%) No = 1 (5%)	***n=19*** Yes = 16 (84%) No = 3 (16%)	***n=38*** Yes = 34 (89%)	***n=20*** Yes = 20 (100%)	***n=20*** Yes = 19 (95%) No =1 (5%)

2. Timing of Consent (n=349)

Specialty	Number Elective Admissions	Number Emergency Admissions	Elective Admissions signed prior to Admission	% Opportunity to take consent prior to Admission
Breast	**18/18**	**0**	**10/18 55.5%**	**2/8 25%**
ENT & Audiology	**60/62 96.8%**	**2/62 3.2%**	**57/60 95%**	**3/3 100%**
General Surgery	**11/20 55%**	**9/20 45%**	**0/11 0%**	**1/11 9.1%**
Gynaecology	**32/40 80%**	**8/40 20%**	**25/32 78.1%**	**6/7 85.7%**
Maternity & Perinatal	**16/50 32%**	**34/50 68%**	**15/16 93.8%**	**1/1 100%**

Specialty	Number Elective Admissions	Number Emergency Admissions	Elective Admissions signed prior to Admission	% Opportunity to take consent prior to Admission
Ophthalmology	52/58 89.7%	6/58 10.3%	52/52 100%	N/A
Plastics	26/26 100%	0	15/26 57.7%	3/11 27.3%
T&O	17/40 42.5%	23/40 57.5%	3/17 17.6%	11/14 78.6%
Urology / Vascular	35/35 100%	0	21/35 60%	0
Trust	267/349 76.5%	82/349 23.5%	198/267 74.2%	27/69 39.1%

Appendix 2

1. Maternity Site Marking / SWAB & Instrument Count Audit

Total audit sample	62
Number of Instrumental Deliveries	24
Number of C-Section Deliveries	18
Number of Normal deliveries	20

1) Instrumental deliveries (n=24)

18/11/13: Process agreed that 2 signatures would be captured on the Instrumental proforma with immediate effect. This was following concerns that the signature of only the operator was insufficient evidence of a complete swab and instrument count having been undertaken

Location Performed	Delivery Room	17
	Theatre	7

a) Delivery Room Instrumental deliveries (n=17)

Agreed process is that instrumental proforma should be signed by 2 staff members who have checked swab & instrument count

	Yes	**No**
Documented on instrumental proforma + signed twice	15	2
Compliant	15 (88%)	2 (12%)

2 non-compliant cases were undertaken by the same Registrar and the instrumental proforma had only been signed once on the instrumental proforma rather than twice. The Registrar has been alerted and is aware of the need for 2 signatures.

b) Theatre Instrumental deliveries (n=7)

Agreed process is that swab & instrument count should be documented on both WHO checklist & maternity theatre care plan

	Yes	**No**
Documented on WHO checklist	6	1
Documented on Maternity Theatre Care Plan	6	1
Compliant	5 (71%)	2 (29%)

The 2 cases which were non-compliant 1 had been documented on WHO checklist only and 1 on maternity theatre care plan only

2) C-Section Deliveries (n=18)

Agreed process is that swab & instrument count should be documented on either WHO checklist or maternity theatre care plan where there is space for 2 individual signatures

Location performed	Theatre	18	
		Yes	**No**
	Documented on WHO checklist	15	3
	Documented on maternity theatre plan	13	5
	Compliant	18 (100%)	0 (0%)

3) Normal Deliveries (n=20)

Location Performed	Delivery Room	19
	Theatre	1 (3° Tear)

a) Normal Deliveries in delivery room (n=19)

Agreed process is for swab & instrument count to be documented on instrumental proforma or in yellow birth notes where there is space for 2 individual signatures

	Yes	**No**	**N/A**
Documented in yellow birth notes	19	0	0
Documented on instrumental proforma	3	0	16
Compliant	19 (100%)	0 (0%)	

b) Normal Deliveries in Theatre (n=1)

Agreed process is for it to be documented on both WHO checklist and in instrumental proforma

Documented on WHO checklist	Yes
Documented on Maternity Theatre Care Plan	Yes
Documented in yellow birth notes	Yes
Documented on instrumental proforma	N/A
Compliant	1 (100%)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2013/14 – Q3 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon – Director of Strategy and OD**
AUTHOR:	**Mike Sharon – Director of Strategy and OD**
DATE OF MEETING:	**6 February 2014**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for Q3.

A summary has been provided of key actions currently rated amber or red which are at risk of not being completed by year end.

The overall status for the 120 actions included within the annual plan is as follows:

RAG	Description	Q3
5	**Action complete**	**19**
4	**Progressing as planned**	**63**
3	**Some delay but expect to be completed as planned**	**30**
2	**Significant delay - unlikely to be completed as planned**	**7**
1	**Action not yet due to start**	**1**

REPORT RECOMMENDATION:

To discuss progress against achievement of the key activities outlined in the Trust Annual Plan for Q3.

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:

October 2013 (Q2 update)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Q3 Annual Plan Monitoring Report

1. Introduction

The Trust's internal Annual Plan (2013/14) was structured around the Trust's strategic objectives and informed by the NTDA annual planning process. Five key areas of focus emerged which underpin all developments and priorities for 2013/14.

This report outlines progress against a list of actions included within the 13/14 annual plan, focusing on those that are currently delayed and are at risk of not being completed by Q4.

2. Q3 position

The status of the 120 actions included within the 13/14 annual plan is illustrated below:

RAG	Description	Q1	Q2	Q3
5	**Action complete**	**9**	**9**	**19**
4	**Progressing as planned**	**79**	**83**	**63**
3	**Some delay but expect to be completed as planned**	**30**	**25**	**30**
2	**Significant delay - unlikely to be completed as planned**	**2**	**3**	**7**
1	**Action not yet due to start**	**1**	**1**	**1**

A number of the actions that are currently rated as 'progressing as planned' are long-term quality goals from the Trust's Quality and Safety Strategy. These actions are ongoing, with specific targets being met for 2013/14. Some other actions progressing as planned refer to year end targets which are expected to be met but cannot be shown as completed until year end.

Some of the actions facing delay (rated amber) are on track to be completed by year end. Those which are at risk of further delay, and therefore non-completion by Q4, are included in the table below. Mitigations have been provided which outline the work being done to address these risks.

3. Main Year end risks

Objective	Exec Lead	Q3 RAG	Complete by 13/14?	Carried forward to 14/15?	Risks to delivery	Mitigation
Improvements to the way we provide care for emergency and acutely unwell patients	COO	3	No	Yes	• Below target performance earlier in 13/14 • Current Trust performance: YTD 94.56% unlikely to recover year performance. • Ensuring continued engagement of social care in Birmingham and Sandwell • Capacity and flow through community social care and health beds • Recruitment of ED consultants and middle grade vacancies	• Significant improvement seen in Q3, with performance above 95% in November and December showing signs of sustainability of initiatives implemented throughout the year. • 7 day working programme with social services in development phase – sustainable model to be agreed into next year. • Operations hub to be implemented for community beds. • Recruitment campaign internationally and nationally continues.
Improve standards for safe storage of medicine	COO	3	No	Yes	Trajectory not currently being hit Number of incidents relating to safe storage	Weekly audits and action tracking
Reduction in link complaints	DG	3	No	Yes	Number not reducing	This is variable and complainant centred. Part of the devolution plan is to offer more meetings in the first place which will have the effect of reducing Link complaints.
Improve the proportion of complaints responded to within set time limits	DG	3	No	Yes	Minor delays within new model of complaints handling process.	New process embedding into the organisation. Working with groups and directorates to iron out these challenges. Downward trend reported in CPR.
Attain national mean for emergency re-admissions	COO	3	No	Yes	• Current underperformance against goal. • Coding errors	• Prediction tool implemented to predict risk of readmissions • Project manager appointed to support

					• 7 day working and engagement of health and social care system in readmission taskforce • Below national mean for 30 day non-elective readmissions (13.85% v 14.25%) • Above national mean for 30 day elective readmissions (7.57% v 6.72%) • Above national mean for 2 day non-elective readmissions (3.08% 2.81%) • Above national mean for 2 day elective readmissions (1.21% v 1.06%)	taskforce; key work streams include coding, discharge plans and communications, • GP and social care representative invited to join group and participate in audit • Re-run readmission statistics in Q4
Consistently achieve national A&E targets	COO	3	No	Yes	• Below target performance earlier in 13/14 • Current Trust performance: YTD 94.56% unlikely to recover year performance. • Ensuring continued engagement of social care in Birmingham and Sandwell • Capacity and flow through community social care and health beds • Recruitment of ED consultants and middle grade vacancies	• Significant improvement seen in Q3, with performance above 95% in November and December showing signs of sustainability of initiatives implemented throughout the year. • 7 day working programme with social services in development phase – sustainable model to be agreed into next year. • Operations hub to be implemented for community beds. • Recruitment campaign internationally and nationally continues.
Waiting times in at least 90% of specialities will be as good as neighbours	COO	3	No	Yes	Waiting times for a majority of specialities are competitive in comparison to neighbours. Exceptions include cardiology, ENT, vascular surgery	Cardiology turn around project to improve operational standards including key access in train. Trajectories for all specialities requiring decrease in waiting times monitored though elective access meetings.
Make progress with MMH	NHPD	3	No	Yes	TDA Board approved MMH financial model	Pursue DH/HMT approval and respond promptly to queries

					DH and HMT approval to come	
Undertake external assurance review of estates compliance issues CQC outcomes 10 & 11	DE	3	Yes	No	Procurement of external assurance delayed	Procurement process initiated, review planned to be completed by 31st March
Improve performance in national staff survey	DSOD	3	No	Yes	Mixed results in 2013 Staff survey	Improved communications through all media Your voice Devolution of decision making
Compliance with all QGAF domains	DG	3	No	Yes	Last self-assessment indicated significant gaps in assurance	Continued development of Trust committee structure, Board governance, group governance processes, performance management systems and risk management systems
Replacement of maternity system	CII	3	Yes	No	Supplier delay	This is scheduled for go live at the end of March.
Reduce rate of written complaints per 1000 episodes by 5%	DG	2	No	Yes	Will not meet original target of 5% reduction	Improvement expected as locally complaints are managed at source.
Develop a new service model for Frail Elderly	COO	2	No	Yes	• New service model will not be in place by year end as additional consultant posts required to deliver revised action plan • Recruitment key to expand on work. • Clinical strategy and delivery plan to be agreed at Winter 2013 Programme Board in January.	• EIST provided critical recommendations on our services which have been presented to clinicians/AHPs/nursing involved in older adults' care • Action plan devised for care of older adults • In process of writing combined JDs for geriatric and acute medicine to provide older adult consultant leadership from the front door. This will be included in 14/15 annual plan.

Strengthen partnership working with social care through introduction of a joint partnership protocol with Birmingham Social Care	COO	2	No	Yes	Social service slow to commit to new way of working. Joint location achieved in August.	Team working under joint health and social service protocol started in September
Submit FT application in line with revised TFA milestones	DSOD	2	No	Yes	• No current formal timeline agreed with TDA • CQC have not confirmed date of CIH visit which is key milestone in FT application	• IBP being re- developed whilst waiting for confirmation of FT timeline • Board coaching continues as part of Board Development Plan • FT Development Committee engaging with clinical and corporate groups ahead of the CIH visit • Most key operational performance metrics continue to improve • Clinical Group governance baseline audit
Attain 10% better than the national mean for sickness absence rates	COO	2	No	Yes	Overall sickness absence levels have started to decrease but levels of absence in nursing and midwifery staff groups remaining higher than the acute benchmark groups in the West Midlands.	• Sickness absence is being closely managed at Group level with support from HR and Occupational Health Depts. • Focus on long-term sickness management and reducing overall absence timescales. • Monthly case conference review of all long-term sickness absence cases, now includes all nursing and midwifery absences of greater than 1 months duration. • Sickness cases with a duration of 9 month plus are subject to a table top review. Information from the TTR is shared with relevant stakeholders.

4. Recommendations

The Board is asked to:

Accept the progress against the overall action plan for 2013/14.

Discuss the year end risks and agree any actions required to ensure successful delivery.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – December 2013.

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 Committee, Clinical Leadership Executive and Finance & Investment Committee (on alternate months)

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST INTEGRATED PERFORMANCE CORPORATE DASHBOARD - DECEMBER 2013

EXECUTIVE SUMMARY

External Assessment Frameworks

Performance against metrics contained within the NHS TDA Accountability Framework:

Metrics aligned to Access, Outcomes and Quality Governance are reflected in the External Assessment Framework section of this report. Expected performance thresholds, as identified by the NHS Trust Development Authority, for a number of metrics, are now incorporated in the report, with actual Trust performance RAG rated accordingly.

Access Metrics:

Emergency Care - the Trust's improved 4-hour wait performance during November (95.2%) continued through December (95.4%), meeting the operational threshold of 95.0% for both months. Performance exceeding 95.0% has not been achieved for both of these months since 2009. During November and December 2013 there was a total of 38594 attendances, 4112 (11.9%) higher, than the corresponding period during 2012.

Referral to Treatment / **Diagnostic Waits -** the Trust met each of the 3 High-Level RTT pathway thresholds during the month, although 12 Treatment Functions (8 Surgery A and 4 Medicine) are beneath the operational performance threshold. The number of patients waiting more than 6-weeks for a diagnostic test / investigation at the end of December was 107, equivalent to 1.56% of all patients waiting, compared with an operational threshold of 1.0% or less.

Outcome Metrics:

Infection Control - The number of cases of C Diff reported during the month increased to 4, with number for the year to date increasing to 31, both values remain within the respective thresholds. Reported cases of MSSA and E. Coli for the year to date also remain within operational thresholds, although the rate per 100,000 bed days of MSSA Bacteraemias slightly exceeded the threshold in month.

Emergency Readmissions - the overall rate for the period (quarter) for which complete data is available is 13.59%, similar to the previous quarter's data (13.49%), which exceeds the NTDA target of <11.0%. Specific actions focused on improving readmission rates are being identified and monitored through the Readmissions Task Force.

Mortality - both the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital level Mortality Indicator (SHMI) for the most recent 12-month cumulative period for which data is available, remain below 100 for the Trust.

During the month (December) there were 7 **Open Serious Incidents Requiring Investigation and 9 Open Central Alerting System** (CAS) Reports identified.

Quality Governance:

A total of 4 **Mixed Sex Accommodation** breaches were reported during the month of December comprising; Coronary Care Sandwell (2) and Critical Care City (2).

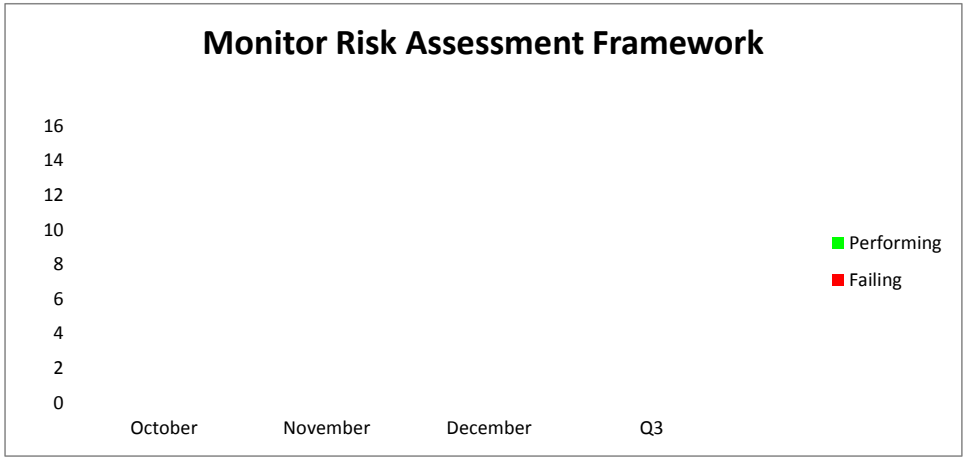
Sickness Absence - the overall rate of sickness absence remains fairly stable at 4.25% for the year to date. The range by Group for the year to date is 3.24% - 5.17%.

PDR Compliance is currently 82.7%, with 6193 staff reported as having received a PDR within the most recent 12-months. Data by Directorate of PDR numbers needing to be performed by the end of March is currently being displayed as a screensaver within the Trust, as a measure to improve compliance rates. **Medical Appraisal** compliance has improved steadily during recent months to 89% as at end of December.

Performance against metrics contained within the Monitor Risk Assessment Framework

Monitor introduced its ***Risk Assessment Framework*** for NHS Foundation Trusts with effect from 1 October 2013, which replaces its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The metrics are identified within the Access, Outcomes and Quality Governance categories of this report. The Access and Outcome metrics used by Monitor have thresholds identified and weightings attributed.

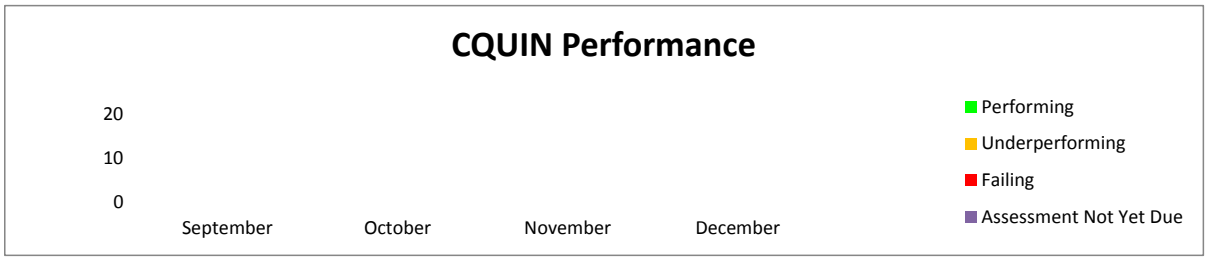
Access and Outcome metrics are formally monitored quarterly. A potential governance concern is triggered by; an aggregate weighted score is 4.0 or more, **or** by failing the same indicator for at least 3 consecutive quarters **or** by breaching the A&E waiting times target in two quarters over any four-quarter period and in any additional quarter over the subsequent three quarters.



During the month of December the Trust met / is projected to meet the required thresholds for each of the Access and Outcomes indicators, other than the 62-day Cancer GP Referral to Treatment target. The threshold for achievement is 85.0%, with provisional data currently indicating 83.0% compliance. This would attract an overall weighted score for the month of 1.0, an AMBER / GREEN Governance Rating. For Quarter 3, underperformance against the Emergency Care 4-hour wait target (94.36%) would similarly attract a weighted score of 1.0, with an AMBER / GREEN Governance Rating. The Trust is projected to meet the 62-day cancer target for the quarter due to better performance during October and November.

A comprehensive report produced by the Trust's Cancer Services Manager identifies a number of actions designed to reduce cancer breach numbers, such as; review of specialty treatment pathways, review of the current escalation policy for potential breaches, more frequent patient tracking as they progress along

CQUIN



CQUIN - A summary of the current performance against the various acute, community and specialised CQUIN schemes is reflected in the table above. Of the 20 summary schemes,17 are performing, with either year to date targets being met or progress in accordance with plan, 2 schemes are currently failing, with the remaining scheme, Annual Staff Survey, not yet due for assessment.

Of note is the improved performance against the **Dementia** (Find, Assess and Refer) CQUIN scheme during the month of December. Compliance exceeded 90% for each of the 3 components for the first month during the year. An increased frequency of audit is to continue to ensure compliance is maintained. Achievement of this CQUIN requires all 3 components to be met at 90% or more, for 3 consecutive months.

The December audit of wards against the CQUIN **Medicines Management** (Storage) criteria identified a rate of 59% of wards, fully (100%) compliant, with each of 6 aspects of the scheme. Although an improvement on the previous audit (46%), much work is required to ensure all wards are fully compliant. Prior to the final Quarter 4 audit, a 'formal' interim audit is scheduled, as well as weekly audits in all non-compliant areas, until such time that a sustained level of full compliance is demonstrable. This fundamental requirement is being escalated through the Trust's organisational structure.

The expansion during the year of the **Friends and Family Test** to Maternity services required a 30% response rate at the end of October 2013, which the Trust failed to meet, with a further (final) milestone of 65% response rate by end March 2014. Currently (December) the response rate is 7.00%, having reduced from a more promising rate of 12.30% for November. Measures taken to date to improve compliance are the introduction of sms texting and pre-stampted post cards for return to the Trust. As a further measure, the feasibility of using anonymised responses in the Community via i-pads is being explored.

Clinical Quality & Outcomes

Stroke Care - improvement is seen across a number of stroke care related metrics during December. Particularly noticeable is an increase in the percentage of patients admitted to an Acute Stroke Unit within 4-hours of arrival and the proportion of patients with TIA treated within the identified thresholds.Data for December also identifes improvement in the percentage of patients receiving thrombolysis within 60 minutes of admission.

A total of 4 **Falls** Requiring Serious Incident Investgation were recorded during the month. All are subject to Table Top Reviews to ascertain whether they were avoidable / non-avoidable.

Fractured Neck of Femur - the percentage of patients receiving an operation within 24 hours of admission improved from November, but at 75.0% was lower than previous months. High numbers of admissions were experienced during the month, and additional trauma lists were created. The Group / Directorate at other measures which may deal with peaks in demand.

Patient Experience

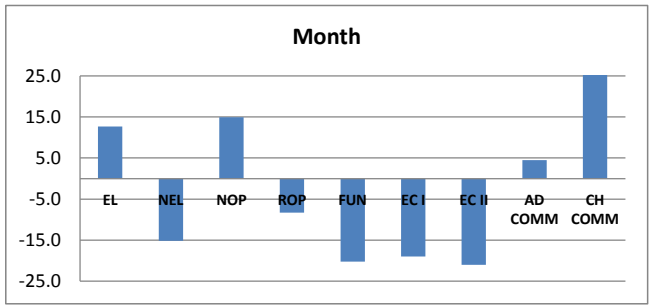
The percentage of **Imaging Requests** from Emergency Care for MRI reported within 24-hours reduced to 81% during December. The absence of key members of reporting staff contributed adversely. Engagement of locum cover is projected to improve performance during January.

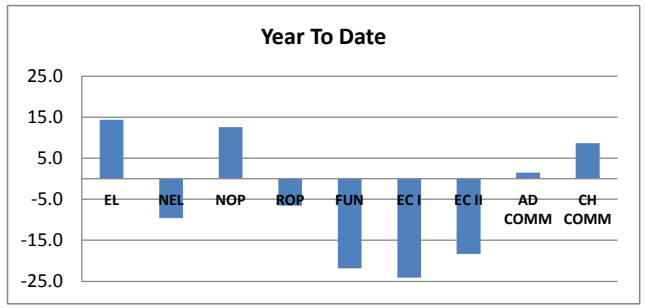
Cancelled Operations - the overall number and proportion of cancelled operations remains relatively stable, although numbers by specialty are quite variable. The proportion of patients experiencing multiple cancellations is not reducing. There were no breaches of the 28-day guarantee following cancellation, reported during the month. A separate meeting led by the Chief Operating Officer with bed holding Clinical Groups is to be held to determine specific reasons for cancellation and identify actions necessary to improve.

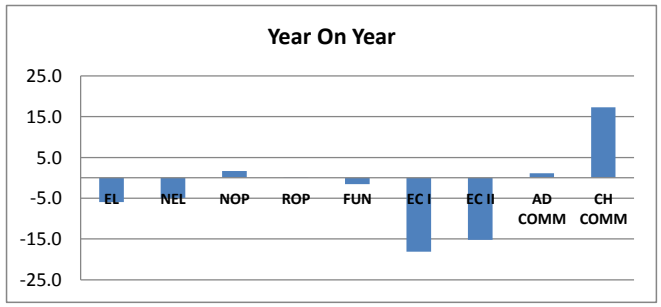
Rapid Access Chest Pain - performance reduced to 90.9% during the month of November, influenced by site specific performance of 81.8% at City. Validation of the data is to take place to ensure only appropriate referrals (those received within 24 hours of decision to refer) are included in the data.

Activity & Contractual

Activity - Variance expressed as a percentage between actual activity and planned (contracted) activity is reflected for the month and year to date in the graphs below. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time. High level Elective activity continues to exceed the plan for the month (+12.6%) and year to date (+14.4%), although remains (-6.0%) less than that delivered during the corresponding period last year. Non-Elective activity is currently 9.6% less than the plan for the year to date, and 4.9% less than the corresponding period last year. Overperformance against the New Outpatient activity plan for the year to date (+12.5%) and an underperformance against the Review OP activity plan for the year to date (-6.6%), gives a Follow Up:New OP Ratio of 2.22 for the year to date, significantly less than the ratio derived from plan (2.70), and that for the same period last year (2.25). Type I and Type II Emergency Care activity to date remains significantly less than plan and for the corresponding period in 2012 / 2013. Adult Community and Child Community activity is currently exceeding plans forthe year to date by 1.5% and 8.6% respectively.







DECEMBER 2013	EXTERNAL ASSESSMENT FRAMEWORKS - TDA ACCOUNTABILITY FRAMEWORK & MONITOR RISK ASSSESSMENT FRAMEWORK

Exec Lead	KPI Source	Data Source	Category / Indicator			August	September	October	November		December		To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Access Metrics			Trust	Trust	Trust	S'well	City	S'well	City	Trust	YTD	13/14						
RB	B*	1	Cancer	2 weeks	%	95.5 ▲	93.9 ▼	95.8 ▲	→		→		96.7 ▲	94.8	=>93	=>93	No variation		Any variation	●	94.8	94.7
	B*			2 weeks (Breast Symptomatic)	%	96.6 ▲	97.8 ▲	93.6 ▼	→		→		97.3 ▲	95.8	=>93	=>93	No variation		Any variation	●	95.8	95.9
	B*			31 Day (diagnosis to treatment)	%	100 ■	99.4 ▼	100 ▲	→		→		97.5 ▼	99.0	=>96	=>96	No variation		Any variation	●	99.5	99.5
	B*			31 Day (second/subsequent treatment - surgery)	%	100 ■	99.0 ▼	100 ▲	→		→		96.3 ▼	98.4	=>94	=>94	No variation		Any variation	●	100.0	99.2
	B*			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		→		100 ■	100	=>98	=>98	No variation		Any variation	●	99.2	99.8
	B*			31 Day (second/subsequent treat - radiotherapy)	%	n/a	n/a	n/a	→		→		100 ■	100	=>94	=>94	No variation		Any variation	●	100	100
	B*			62 Day (urgent GP referral to treatment)	%	85.3 ▼	85.2 ▼	88.0 ▲	→		→		85.4 ▼	87.5	=>85	=>85	No variation		Any variation	●	86.9	87.1
	B*			62 Day (referral to treat from screening)	%	100 ▲	93.8 ▼	96.3 ▲	→		→		98.0 ▲	98.0	=>90	=>90	No variation		Any variation	●	98.5	96.9
	A*			62 Day (referral to treat from hosp specialist)	%	94.1 ■	92.0 ▼	100 ▲	→		→		97.3 ▼	90.5	=>85	=>85	No variation		Any variation	●	91.6	93.2
RB	B*	2	Emergency Care 4-hour waits		%	95.5 ■	94.7 ■	92.6 ▼	94.9 ▲	95.3 ■	95.6 ■	95.2 ▼	95.4 ▲	94.5	=>95	=>95	=>95		<95	●	95.38	92.54
RB	B*	2	Referral To Treatment	Admitted Care (RTT <18 weeks)	%	92.3 ▼	90.1 ▼	91.8 ▲	→		→		92.4 ▲	92.4*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
	B*			Non-Admitted Care (RTT <18 weeks)	%	96.6 ▼	95.1 ▼	96.2 ▲	→		→		96.9 ▲	96.9*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
	B*			Incomplete Pathway (RTT <18 weeks)	%	92.2 ▼	92.6 ▲	93.8 ▲	→		→		93.8 ■	93.0 ▼	93.0*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
				Treatment Functions Underperforming	No.	7 ▲	11 ▼	10 ▲	→		→		13 ▼	12 ▲	12*	0	0	0 / month	1 - 6 / month	>6 / month	●	10 (Q4)	11 (Q4)
	A			Waits >52 weeks	No.	29 ▲	20 ▲	66 ▼	→		→		36 ▲	12 ▲	12*	0	0	<0		>0	●		
RB	A*	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.61 ▼	0.42 ▲	0.44 ▼	→		→		0.85 ▼	1.56 ■	1.56*	<1.0	<1.0	<1.0	1.0 - 5.0	>5.0	●	0.99	0.88
RB	A	2	Cancelled Operations	28 day breaches	No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
	A	2		No. of second or subsequent urgent operations cancelled	No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	0	0	0	<0		>0	●		0
			Outcome Metrics																			
LP	B*	4	Infection Control	C. Difficile (DH Reportable)	No.	3 ■	4 ▼	2 ▲	1 ■	2 ▼	2 ▼	2 ■	4 ▼	31	36	46	No variation		Any variation	●	95	37
	A*			MRSA Bacteraemia	No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	No variation		Any variation	●	2	1
	A			MSSA Bacteraemia (rate per 100,000 bed days)	No.	0.0 ▲	4.8 ▼	17.6 ■	→		→		4.5 ■	9.5 ■	6.2	=<9.02	=<9.02	No variation		Any variation	●		
	A			E Coli Bacteraemia (rate per 100,000 bed days)	No.	24.0 ▼	4.82 ▲	30.7 ▼	→		→		35.9 ▼	19.0 ▲	19.1	=<94.9	=<94.9	No variation		Any variation	●		
RB	A	6	Emergency Readmissions (CCS Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Elective or Non-Elective Admission	%	→	9.05	→	→		→		→	9.06	9.06*							
	A			Following an initial Elective Admission	%	→	3.43 Jan'13 - Mar'13	→	→		→		→	4.06 Apr'13 - Jun'13	4.06*							
	A			Following an initial Non-Elective Admission	%	→	13.49	→	→		→		→	13.69	13.69*	10.9	10.9	No variation		Any variation	● ●		
RS		3	Mortality Reviews within 42 working days		%	81 ▼	78 ■	86 ■	→		→			86*	80	80	No variation		Any variation	●	66.9	
RS	A	6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate	HSMR	88.4 Jun'12 to May'13	92.2 Jul'12 to Jun'13	92.7 Aug'12 to Jul'13	→		→		93.2 Sep'12 to Aug'13	93.6 Oct'12 to Sep'13	93.6	100	100	No variation		Any variation	●	88.9	90.5
				Peer (SHA) HSMR	HSMR	97.5	101.9	101.7	→		→		101.4	100.9	100.9							
				Peer (National) HSMR - Quarterly	HSMR	→	98.1	→	→		→		→	96.4	96.4							
	A	19		SHMI	SHMI	98.1 Jun'12 - May'13	97.2 Jul'12- Jun'13	97.8 Aug'12- Jul'13	→		→		98.1 Sep'12- Aug'13	97.8 Oct'12- Sep'13	97.8	100	100	No variation		Any variation	●	96.8	95.9
RS	A	12	Obstetrics	Caesarean Section Rate — Elective and Non-Elective	%	25.5 ▲	26.3 ▼	23.6 ■	→		→		25.2 ■	20.6 ■	24.8	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	A			Elective	%	10.7	8.8	10.9	→		→		10.3	11.0	11.1							
	A			Non-Elective	%	14.8	17.4	12.7	→		→		14.9	9.6	13.7							
	A			Maternal Deaths	No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	0	0	0	No variation		Any variation	●		
LP	A*	8	Patient Safety Thermometer - Harm Free Care		%	93.0 ▼	93.0 ■	94.0 ▲	→		→		93.7 ▼	94.5 ▲	94.5*	=>92	=>92	=>92		<92	●		

Exec Lead	KPI Source	Data Source	Category / Indicator				August	September	October	November			December			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Outcome Metrics (Cont'd)				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
KD	A	14	Medication Errors causing serious harm			No.	0 →	0 →	0 →	→		0 →	→		0 →	0	0	0	No variation		Any variation	●		
KD	A		Open Serious Incidents Requiring Investigation (SIRI)			No.	8 ▲	6 ▲	9 ▼	→		6 ▲	→		7 ▼	7*	0	0	No variation		Any variation	●		2
KD	A		Never Events - in month			No.	1 →	0 →	0 →	→		2 →	→		0 →	4	0	0	No variation		Any variation	●		2
KD	A		Open Central Alert System (CAS) Alerts			No.	6 →	8 ▼	7 ▲	→		6 ▲	→		9 ▼	9*	0	0	No variation		Any variation	●		10
RS	A*	3	VTE Risk Assessment			%	94.4 →	95.1 →	95.0 ▼	→		94.2 →	→		95.5 →	95.5*	95	95	=>90		<90	●	92.4	90.8
RS	A	3	WHO Safer Surgery Checklist	Audit - 3 sections		%	99.2 ▼	99.6 ▲	99.5 ▼	→		99.7 ▲	→		99.8 ▲	99.8*	100	100	=>98		<98	●		
RS		3		Audit - 3 sections and brief		%	89.5 ▼	91.6 ▲	91.7 ▲	→		94.5 ▲	→		97.2 →	97.2*	100	100	=>95		<95	●		
RS		3		Audit - 3 sections, brief and debrief		%	76.3 ▲	78.4 ▲	80.2 ▲	→		85.9 →	→		86.1 →	86.1*	100	100	=>85		<85	●		
RB	C	11	Data Quality	Data Completeness Community Services		%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50	=>50		<50	●		>50
LP	C	8	Access to healthcare for people with Learning Disability (full compliance)			Y / N	Y →	Y →	Y →	→		Y →	→		Y →	Yes	Full	Full	Y		N	●	N	Y
			Quality Governance																					
RB	A	2	Mixed Sex Accommodation Breaches	As percentage of completed FCEs		%	0.00 →	0.06 ▼	0.13 ▼	→		0.07 ▲	→		0.03 ▲	0.08	0.0	0.0	0.00		>0.00	●		
RB	A*	2		Numerical		No.	0 →	7 ▼	17 ▼	→		9 ▲	→		4 ▲	87	0	0	0		>0	●		
RB				Chargeable Days		No.	0 →	13 ▼	29 ▼	→		17 ▲	→		7 ▲	168	0	0	0		>0	●		
LP	B	8	Patient Satisfaction (Friends & Family)	Response Rate	Inpatient Wards	%	31.4	18.7	29.2	→		31.4	→		29.0	29.0*								
LP	B				Emergency Care Department	%	5.3	11.6	21.1	→		17.1	→		15.0	15.0*								
LP	B*				IP Wards plus Emergency Care Department	%	10.7	13.4	23.4	→		21.0	→		19.0	19.0*								
LP	B			Score	Inpatient Wards	No.	67	72	71	→		70	→		73	73*								
LP	B				Emergency Care Department	No.	50	51	46	→		47	→		44	44*								
LP	B*				IP Wards plus Emergency Care Department	No.	60	58	54	→		56	→		57	57*								
RB	B	7	Sickness Absence	Long Term (> 28 days)		%	2.78 ▼	2.79 ▼	2.78 ▲	→		2.67 ▲	→		2.62 ▲	2.72	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
RB	B			Short Term (<28 days)		%	1.33 ▲	1.49 ▼	1.54 ▼	→		1.56 ▼	→		1.47 ▲	1.53	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
RB	B			Total		%	4.11 ▲	4.28 ▼	4.32 ▼	→		4.23 ▲	→		4.10 ▲	4.25	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
RB	A	7	Staff Appraisal	PDRs (12-month rolling)		No. (%)	5779 (78.8) ■	5887 (79.6) ▲	5925 (79.7) ▲	→		5975 (79.9) ▲	→		6193 (82.7) ▲	6193 (82.7)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS	A	14		Medical Appraisal and Revalidation		%	81	81	84	→		87	→		89	89*	No. Only	No. Only						77
LP	A		Nursing Staff	Registered Nurses as percentage of Nurses		%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
LP	A			Nurse : Bed Ratio		Ratio	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
MS	B		Staff Turnover	All Staff (Excluding Medical & Dental) - rolling 12 months		%	11.01 →	11.07 →	10.90 →	→		10.90 →	→		10.87 →	10.87	2.7 - 18.8	2.7 - 18.8	2.7 - 18.8		<2.7 or >18.8			

(* Indicators assessed by NHS TDA as part of Summer Report)

DECEMBER 2013	CQUINs

Exec Lead	KPI Source	Data Source	Indicator					August	September	October	November			December			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
								Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	D	3	VTE	Risk Assessment		224	%	94.4 ■	95.1 ■	95.0 ▼	→		94.2 ■	→		95.5 ■	95.5*	95	95	=>90		<90	●	92.4	90.8
RS	D	5		Root Cause Analysis		224	%	→	100 ■	→	→		→	→			100	100	100	100		<100	●		
LP	D	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers	ACUTE	224	%	4 ■	5 ▼	4 ▲	→		1 ▲	→			62	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
LP	D				COMMUNITY	224	%	0 ■	0 ■	1 ▼	→		1 ■	→		0 ▲	4						●		
LP	D	8	Dementia	Find, Investigate and Refer		269	%	0 of 3 met	2 of 3 met	2 of 3 met	→		1 of 3 met	→		3 of 3 met	3 of 3 met	90% (F, I and R) for 3 consec. months		No variation		Any variation	●		
LP	D			Clinical Leadership		45		→	→	→	→			→			Identified	In Place	In Place	No variation		Any variation	●		
LP	D			Supporting Carers of People with Dementia		135		Survey Undertaken	Survey Undertaken	Survey Undertaken	→		Survey Undertaken	→		Survey Undertaken	Survey Undertaken	Monthly Audit		No variation		Any variation	●		
LP	D	8	Friends & Family Test	Phased Data Collection Expansion - Maternity		137	%	→	→	9.04	→		12.30	→		7.00	7.00	30	65				● ●		
LP	D			Increased Response Rate (Emergency Care plus All Wards)		175	%	10.7	13.4	23.4	→		21.0	→		19.0	19.0	17	>20				●		
LP	D			Improve Performance on Staff FFT		137	Score	→	→	→	Autumn Annual Staff Survey			Autumn Annual Staff Survey				Improvement from 12/13							
RB	D	20	Safe Storage of Medicines			1105	%	→	46 ■	→	→		→	→		59 ■	59	75	90	No variation		Any variation	● ●		
LP	D	8	Dementia Patient Stmulation			1138		→	Progress Delayed	On Track	→		On Track	→		On Track	On Track	Compliance		No variation		Any variation	●		
RS	D	9	Use of Pain Care Bundles			1138	%	On Track	On Track	Base identifie d	→		Base identified	→		On Trajectory	On Trajectory	Improvement Trajectory agreed		No variation		Any variation	●		
RS	D	4	Use of Sepsis Care Bundles			1105	%	On Track	On Track	On Track	Baseline Sept. - November		Base identified				Base identified	5% improvement trajectory		No variation		Any variation	●		
LP	D	11	Community Risk Assessment & Advice			1105	%	→	Base identified	On Track	→		On Trajectory	→		On Trajectory	On Trajectory	10% improvement trajectory		No variation		Any variation	●		
RS	D	8	Recording DNAR Decisions			1105	%	→	95 Base	→	→		→	→		→	95 (Base)	Improvement on Q2 base by Q4		No variation		Any variation	●		
RS	D	Oct-13	Specialised Commissioners (Quarterly Returns)	Clinical Quality Dashboards		60		→	Compliant	→	→		→	→		Compliant	Compliant	Compliance		No variation		Any variation	●		
RS	D	22		Behcets Highly Specialised Service		60		→	On Track	→	→		→	→		On Track	Compliant	Compliance		No variation		Any variation	●		
RS	D	12		HIV - Communication with GPs		180		→	Compliant	→	→		→	→		Compliant	Compliant	Compliance		No variation		Any variation	●		
RS	D	12		Neonatal - Retinopathy Of Prematurity (Screening)		180		→	Compliant	→	→		→	→		Compliant	Compliant	Compliance		No variation		Any variation	●		

Exec Lead	KPI Source	Data Source	Indicator				August	September	October	November			December			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	D	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	91.5 ▼	94.6 ▲	90.5 ▼	→		92.3 ▲	→		88.5 ▼	91.4	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	D			Pts admitted to Acute Stroke Unit within 4 hrs		%	76.3 ■	72.1 ▼	68.1 ▼	→		69.2 ▲	→		80.8 ▲	75.1	90	90	No Variation	0 - 2% Variation	>2% Variation	●	68.7	59.1
	D			Pts receiving CT Scan within 24 hrs of presentation		%	96.0 ▲	98.1 ▲	95.7 ▼	→		100.0 ■	→		97.9 ■	94.2	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	D			Pts receiving CT Scan within 1 hr of presentation		%	71.1 ▼	71.7 ▼	68.1 ▼	→		73.1 ▲	→		78.7 ▲	70.1	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	D			Admission to Thrombolysis Time (% within 60 mins)		%	67.0 ▲	0.0 ▼	0.0 no pts	→		50.0 ▲	→			25.0	85	85	=>85		<85	● ● ●		
	D			Admission to Thrombolysis Time (% over 90 mins)		%	33.0 ■	100.0 ▼	0.0 no pts	→		50.0 ▲	→			40.0	0	0	0		>0	● ●		
	D			Stroke Admissions - Swallowing assessments (<24h)		%	100.0 ■	100.0 ■	100.0 ■	→		100.0 ■	→		100.0 ■	98.3	100	100	=>98		<98	●		
	D			TIA (High Risk) Treatment <24 h from initial presentation		%	72.0 ▼	75.9 ▲	65.5 ▼	→		56.3 ■	→		70.0 ■	71.1	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	D			TIA (Low Risk) Treatment <7 days from initial presentation		%	92.5 ▲	87.9 ▲	81.1 ▼	→		84.9 ▲	→		100.0 ▲	87.0	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RB		3	Infection Control	MRSA Screening - Elective	Patient Not Matched	%	217 ▼	253 ▲	250 ▼	Numerator = 3523	Denominator = 1553	227 ▼	Numerator = 3209	Denominator = 1129	221 ▼	284*	89	90	No variation		Any variation	●		138.9
					Best Practice - Patient Matched	%	76 ▼	90 ▲	82 ▼	Numerator = 1137	Denominator = 1553	73 ■	Numerator = 996	Denominator = 1129	88 ■	88*	78	80	No variation		Any variation	●		59.5
				MRSA Screening - Non Elective	Patient Not Matched	%	87 ■	88 ▲	90 ▲	Numerator = 2176	Denominator = 2372	92 ▲	Numerator = 2125	Denominator = 2391	89 ▼	89*	89	90	No variation		Any variation	●		76.8
					Best Practice - Patient Matched	%	77.3 ▲	91 ▲	92 ▲	Numerator = 2176	Denominator = 2355	92 ▲	Numerator = 2125	Denominator = 2281	93 ▲	93*	78	80	No variation		Any variation	●		64.9
LP		14	Falls Requiring Serious Incident Investigation			No	0 ■	1 ■	7 ▼	→		2 ▲	→		4 ▼	24	0	0	No variation		Any variation	● ●		22
LP		8	Grade 3 or 4 pressure ulcers - avoidable			No	1 ■	0 ■	0 ■	→		0 ■	→		1 ■	7	0	0	No variation		Any variation	●		
LP		8	High Impact Nursing Actions	Inpatient Falls reduction	Acute	No	54 ■	53 ▲	59 ■	→		30 ■	→			409	440	660	=<55/m		>55/m	●		737
					Community	No	10 ▼	11 ▼	12 ▼	→		15 ■	→			88	96	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	0 ■	0 ■	0 ■	→		1 ▼	→		0 ■	3	36	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU		%	9.5 ▼	11.0 ■	12.1 ■	→		12.4 ▼	→			10.3	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
				Adjusted Perinatal Mortality Rate (per 1000 babies)		/1000	5.9 ■	12.2 ■	12.2 ■	→		16.3 ▼	→			16.3*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
	D			Early Booking (Completed Assessment <12+6 weeks)	National Definition	%	110.0 ▼	137.0 ▲	178.0 ▲	→		158.0 ▼	→			158.0*	=>90	=>90	=>90	75-89	<75	●	76.0	78.0
	D				SWBH Early Booking (Bookings > Births)	%	78.0 ▼	70.0 ■	81.0 ■	→		83.5 ▲	→			83.5*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
LP		2	Infant Health & Inequalities	Maternal Smoking Rates		%	→	7.83 ▲	→	→		→	→		8.12 ▼	8.4	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
				Breast Feeding Initiation Rates		%	→	76.7 ▼	→	→		→	→		76.4 ▼	76.7	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6
RB		3	Hip Fractures	Operation <24 hours of admission		%	85.7 ■	81.8 ▼	89.5 ▲	→		70.6 ■	→		75.0 ▲	75.0*	83.0	85.0	No Variation	0 - 2% Variation	>2% Variation	●	66.4	76.7
RB	D	3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	92 ▼	93 ■	93 ■	→		92 ▼	→		92 ■	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES		%	6.7 ▲	7.1 ▼	6.8 ▲	→		9.2 ▼	→		7.2 ▲	7.2	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	4:34 ▲	5:05 ▼	5:45 ▼	→		4:46 ▲	→		4:48 ▼	5:04	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	16 ▲	16 ■	20 ▼	→		17 ▲	→		17 ■	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)		mins	42 ▲	41 ▲	48 ▼	→		43 ▲	→		42 ▲	46	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	5.75 ▲	5.44 ▲	6.16 ▼	→		6.09 ▲	→		6.37 ▼	6.62	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate		%	3.35 ▲	3.44 ▼	3.47 ▼	→		2.96 ▲	→		3.16 ▼	3.65	=<5.0	=<5.0	=<5.0		>5.0	●	4.83	4.67
	D		Emergency Care Trolley Waits >12 hours			No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	0		>0	●		
RB	D	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes		%	85.1 ▲	84.9 ■	87.7 ■	90.3 ▲	89.2 ▼	89.7 ▲	89.1 ▼	89.3 ▲	89.2 ▼	89.2*	=>85	=>85	=>85		<85	●		71.3
	D			Average Turnaround Time		m : s	27:57 ▼	28:46 ▼	29:02 ▼	26:30 ■	27:21 ▲	26:59 ▲	26:27 ▲	28:25 ▼	27:19 ▼	27:19*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	D			30 - 60 minutes	All Journeys	No.	1333 ▲	1301 ▲	1505 ▼	498 ▲	755 ▲	1253 ▲	513 ▼	872 ▼	1385 ▼	12253	0	0	0		0	● ● ●		22089
	D				Hospital Fines (WMAS report)	No.	252 ▲	123 ▲	290 ▼	57 ▲	65 ▲	122 ▲	58 ▼	101 ▼	159 ▼	2353	0	0	0		0	● ● ●		
	D			In Excess of 60 minutes	All Journeys	No.	32 ▼	50 ▼	71 ▼	4 ▲	1 ▲	5 ▲	4 ■	14 ▼	18 ▼	369	0	0	0		0	● ● ●	1256	2354
	D				Hospital Fines (WMAS report)	No.	21 ▼	16 ▲	54 ▼	1 ▲	1 ▲	2 ▲	1 ■	9 ▼	10 ▼	213	0	0	0		0	● ● ●		

Exec Lead	KPI Source	Data Source	Indicator			August	September	October	November		December		To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	S'well	City	Trust	YTD	13/14						
RB		21	Reporting Times of Imaging Requests from Emergency Care - % **reported within 24 hours / next day**	Plain Radiography	%	99 ■	98 ▼	99 ▲	→		→		100 ▲	99 ▼	99*	90	90	No variation		Any variation	●		99
				Ultrasound	%	100 ■	100 ■	100 ■	→		→		100 ■	100 ■	100*	90	90	No variation		Any variation	●		100
				MRI	%	84 ▲	65 ▼	100 ■	→		→		93 ▼	81 ■	81*	90	90	No variation		Any variation	●		84
				CT	%	99 ■	99 ■	99 ■	→		→		100 ▲	99 ▼	99*	90	90	No variation		Any variation	●		99
KD	D	14	Complaints	No. of Complaints Received formal and link)	No.	94	86	65	→		→		82	65	713	No. Only	No. Only					834	724
				No. of Active Complaints in the System (formal and link)	No.	254	238	201	→		→		201	190	190*	No. Only	No. Only						
				No. of First Formal Complaints received / 1000 episodes of care	No.	0.88	0.52	0.36	→		→		0.45	0.40	0.40*	No. Only	No. Only						
				No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%	97 ▲	76 ▼	97 ▲	→		→		99 ▲	98 ▼	98*	100	100	100		<100	●		
				No. of responses which have exceeded their original agreed response date (% of total active complaints)	%	25 ▲	22 ▲	33 ▼	→		→		29 ▲	20 ▲	20*	0	0	0		>0	● ●		
				No. of responses sent out	No.	73	78	109	→		→		59	79	79*	No. Only	No. Only						
				Oldest' complaint currently in system	Days	147	150	107	→		→		174	91	91*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.	11250	13181	13978	→		→		12590	10032	110920	No. Only	No. Only					111793	150454
				Average Length of Queue	mins	0.22 ▲	0.39 ▼	0.27 ▲	→		→		0.24 ▲	0.20 ▲	0.24*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins	17.2 ▼	17.3 ▼	13.0 ▲	→		→		7.2 ■	8.3 ▼	8.26*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.	67671	70460	76416	→		→		73295	71451	646573	No. Only	No. Only					849502	901987
				Calls Answered	%	91.2	91.0	90.5	→		→		91.2	89.4	90.8	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%	70.6	72.0	71.3	→		→		70.2	57.4	67.7	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%	83.4	84.1	83.5	→		→		82.6	72.6	80.6	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs	13.8	12.9	13.1	→		→		14.1	22.0	22.0*	No. Only	No. Only					25	18
				Longest Ring Time	Secs	280	433	341	→		→		476	526	526*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days	3.5 ■	4.0 ▼	3.6 ▲	4.3 ▼	3.4 ▼			3.8 ▼		3.7	4.3	4.3	No Variation	0 - 5% Variation	>5% Variation	●	4.2	3.8
				Day of Surgery (IP Elective Surgery)	%	92.7 ▼	94.9 ▲	94.4 ▼	91.9 ▼	95.7 ▲	94.3 ▲	97.0 ▲	94.1 ▼	95.9 ▲	94.3	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%	83.9 ▲	83.7 ▼	83.7 ▼	79.0 ■	83.4 ▼	83.1 ■	83.0 ▼	81.8 ▼	83.1 ▲	84.4	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.	740	754	786	→		→		774	770	770*								
RB		2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.8 ■	1.4 ■	1.3 ▲	2.2 ▼	0.8 ■	2.2 ■	1.0 ▼	1.3 ■	1.4 ▼	1.0	<0.8	<0.8	<0.8	0.8 - 1.0	>1.0	●	0.6	0.7
	D			28 day breaches	No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
	D			No. of second or susequent urgent operations cancelled	No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	0	0	0	<0		>0	●		0
				Sitrep Declared Late Cancellations	No.	36 ▲	66 ▼	64 ▲	38 ▼	26 ▲	33 ▲	27 ▼	64 ■	60 ▲	442	240	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	9 ▼	10 ▼	7 ▲	4 ▼	1 ▲	2 ▲	5 ▼	5 ▲	7 ▼	7*	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%	18.6 ▼	13.6 ▲	12.4 ▲	→		→		13.3 ▼	13.3 ■	13.3*	3.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	5.3 ▲	5.6 ▼	5.7 ▼	→		→		5.5 ▲	5.4 ▲	5.4*	3.7	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty — Door To Balloon Time (90 mins)	%	100.0 ■	90.9 ▼	76.9 ■	→		→		75.0 (S) ▼		85.6	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
				Primary Angioplasty — Call To Balloon Time (150 mins)	%	100.0 ▲	95.0 ▼	100.0 ▲	→		→		85.7 (S) ▼		92.5	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain	%	100 ■	100 ■	96.4 ■	→		→		90.9 ■		97.4	100	100	=>98	96.0 - 97.9	<96	●	99.1	95.7
RB		12	GU Medicine	Patients offered app't within 48 hrs	%	100 ■	100 ■	100 ■	→		→		100 ■	100 ■	100	=>98	=>98	=>98	95-98	<95	●	100	100

Exec Lead	KPI Source	Data Source	Indicator			August	September	October	November			December			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
MS	D	7	Staff in Post	Establishment	wte	7008	7139	7188	→		7252	→			7252*								
				Staff In Post (contracted)	wte	6496	6528	6545	→		6626	→		6632	6632*								
				Staff In Post (headcount)	no.	7484	7502	7527	→		7610	→		7617	7617*								
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		1.15	→		1.15	1.15*								
				Variance (Establishment - Staff In Post)	wte	512	611	643	→		626	→			626*								
				Qualified Nursing Variance (FIMS)	wte	181	236	177	→		199	→			199*								
				Posts Advertised in Month (NHS Jobs)	wte	178	105	158	→		146	→		139	139*								
			Induction		%	95 ▲	86 ▼	95	→		83	→			83*	100	100	=>85		<85			91.3
RB	D	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5779 (78.8) ■	5887 (79.6) ▲	5925 (79.7) ▲	→		5975 (79.9) ▲	→		6193 (82.7) ▲	6193 (82.7)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS		14		Medical Appraisal and Revalidation	%	81	81	84	→		87	→		89	89*	No. Only	No. Only						77
MS		3		Mandatory Training Compliance	%	86.4 ▼	86.1 ▼	85.2 ▼	→		86.6 ▲	→		86.6 ■	86.6	100	100	=>95	90 - 95	<90	● ●	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	2.78 ▼	2.79 ▼	2.78 ▲	→		2.67 ▲	→		2.62 ▲	2.72	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.33 ▲	1.49 ▼	1.54 ▼	→		1.56 ▼	→		1.47 ▲	1.53	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.11 ▲	4.28 ▼	4.32 ▼	→		4.23 ▲	→		4.10 ▲	4.25	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	78.0	75.9	75.0	→		76.0	→		71.2	75.3	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	5463 ▼	5265 ▲	5258 ▲	→		5172 ▲	→		4302 ▲	44876	35235	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	56396	60463
				Nurse Agency Shifts covered	No.	1533 ▲	1585 ▼	2481 ▼	→		2617 ▼	→		2472 ▲	20250	2872	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	6948	12874

DECEMBER 2013 | **ACTIVITY & CONTRACTUAL**

Exec Lead	KPI Source	Data Source	Indicator			August	September	October	November			December			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB		2	Spells	Elective IP	No.	640 ▼	726 ▲	764 ▼	→		802 ▲	→		648 ▼	6491	7618	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	3804 ▼	4062 ▲	4452 ▼	→		4141 ▼	→		3645 ▲	37686	30197	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	4444 ▼	4788 ▲	5216 ▼	→		4943 ▼	→		4293 ▲	44177	37815	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4537 ▲	4402 ▼	4742 ▲	→		4562 ▼	→		4642 ▼	41105	45039	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	12948 ▼	14415 ▲	15991 ▼	→		14642 ▼	→		12949 ▲	130496	114136	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	29244 ▼	30313 ▲	32500 ▼	→		30360 ▼	→		27239 ▲	289406	308420	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	12180 ▼	12006 ▼	12201 ▼	5296 ▲	6464 ▲	11760 ▲	5431 ▲	6455 ▲	11886 ▲	112203	139248	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	2061 ▲	2189 ▲	1944 ▼	→	1847 ▲	1847 ▲	→	1778 ▼	1778 ▼	18051	21364	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	19883 ▲	20026 ▲	20120 ▲	7976 ▲	11104 ▲	19080 ▲	8233 ▲	11281 ▲	19514 ▲	181592	157169	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	46370 ▲	45642 ▲	49810 ■	→		46207 ■	→			374907	369391	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	12147 ■	14855 ■	17857 ▲	→		17407 ▲	→			123760	113070	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
			Contract	Improvement Notices	No.	0 ■	0 ■	1 ■	→		0 ■	→		0 ■	0*	0	0				●		
RB	D	2	Delayed Transfers of Care	Acute	%	3.7 ■	3.9 ▼	3.6 ▲	1.6 ▲	3.9 ■	2.6 ■	2.5 ▼	4.2 ▼	3.2 ▼	3.2	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
				Pt's Social Care Delay	No.	9 ▼	14 ▼	9 ▲	3 ■	7 ▼	10 ▼	3 ■	5 ▲	8 ▲	8*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	11 ■	7 ■	10 ■	4 ■	5 ■	9 ■	5 ■	5 ■	10 ■	10*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.26 ▼	2.10 ▲	2.03 ▲	2.19 ▲	2.00 ▼	2.07 ▼	2.31 ■	2.02 ▼	2.10 ▼	2.22	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	13.9 ▼	12.4 ▲	12.9 ▼	→		12.2 ▲	→		12.7 ▼	11.7	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	11.9 ▲	12.4 ▼	12.6 ▼	→		12.5 ▲	→		13.5 ▼	10.5	10.0	10.0	No variation		Any variation	●	11.9	10.3

LEGEND

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

INDICATORS WHICH COMPRISE THE PERFORMANCE ASSESSMENT FRAMEWORKS	
A	TDA Accountability Framework
B	TDA Accountability Framework and Monitor Risk Assessment Frameowk
C	Monitor Risk Assessment Framework
D	Local & Contract (inc. CQUIN)

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**

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:	Grade Four Pressure Ulcer
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Colin Ovington – Chief Nurse
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

A patient in the community has developed a grade four pressure ulcer; the patient has been a paraplegic since 2003 following an accident and was under the care of Orthopaedic Hospital Oswestry for pressure ulcers. The patient who has full capacity has been self-caring for many years and communicated with spinal unit when required. Since this time the patient suffered with pressure ulcers til October 2012. A grade two ulcer developed in November 2012, but despite treatment and advice, the patient refused to use pressure relieving equipment, and slept on the sofa. Consequently the pressure ulcer has deteriorated to become a grade four sore. The patient is currently an inpatient at another trust.

The information surrounding the incident has been taken from Systemone community electronic records and more information will be required from the hand held nursing notes to give insight to the documented evidence of assessments undertaken and the frequency of reviews undertaken by the registered nurses. The District Nursing team leader is awaiting a reply from the relatives to gain entry to the home to obtain the hand held Nursing records in order to fully complete a Root Cause Analysis.

It is planned that the incident will be reviewed on the 17th February.

REPORT RECOMMENDATION:

The Board is requested to receive and accept the report.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Improve quality and standards of care

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Norovirus update
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington (Chief Nurse)
AUTHOR:	Rebecca Evans (Head of Infection Prevention & Control)
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

During January 2014 we had four wards where patients were suffering from symptoms of winter vomiting disease. Only one ward (Lyndon 3) was classified as an outbreak. The outbreak lasted nine days and all key actions identified in the attached report were completed. This was managed very well by all staff, daily outbreak meetings were held at 0900h every morning to assess the previous 24 hour period, agree immediate actions and to allow for planning of operational activity. Communications were central to our campaign, which included a live radio interview to ensure that the wider community were informed and their support required to contain the infection requested.

REPORT RECOMMENDATION:

The Board is asked to note the update on Norovirus activity in the Trust during January 2014 and the containment and control measures undertaken.

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

Comments:

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

CQC standard C4a which relates to the Hygiene Code

PREVIOUS CONSIDERATION:

Considered by the infection control team

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report into Outbreak and increased incidence of Diarrhoea and Vomiting (D43, L3, L5, P3) for the period January 2014

SWBH site	Cross site
Clinical Group	Medicine, Trauma & Orthopaedics
Speciality	As above
Wards/Department	D43, L3, L5, P3
SI Number	00067
Report compiled by	Rebecca Evans – Head of Infection Prevention and Control Nursing Services

Infection Prevention and Control Service
Pathology Group
City Hospital
Dudley Road
Birmingham
B18 7QH

1.0 Summary

The following report outlines a summary of actions following an increase in the number of patients with symptoms of diarrhoea and or vomiting on 4 wards at SWBH during January 2014. A total number of 28 patients were affected and 11 staff member on 4 wards (3 Sandwell site, 1 City site). Of the 4 wards affected one ward (L3) was closed to admissions and discharges. Of the remaining 3 wards, only bays were closed to admission and discharges on 2 wards (P3, D43) and one bay was kept under observation (L5). Norovirus was detected in the stool specimens of 2 patients from L3 and D43.

	Key Actions	**Completed**
1	Clinical Group Notified	Yes
2	Outbreak/PII meeting convened	Yes
3	SUI notified on STEIS (as appropriate – Risk Management)	Yes
4	Action plan implemented	Yes

2.0 Introduction

During January 2014 the Infection Prevention and Control Service (IPCS) identified an increase in the number of patients presenting with clinical symptoms of diarrhoea and or vomiting on 4 wards at SWBH. In addition to this staff members were reporting symptoms of diarrhoea and or vomiting from both the affected wards and other clinical areas and disciplines.

Any key issues or actions identified were addressed (see Action Plan Appendix 1)

Please see table below outlining summary of wards and bays affected.

Hospital	**Sandwell**	**Sandwell**	**Sandwell**	**City**	**Total**
Ward affected	L3	L5	P3	D43	4
Ward closed	Yes	No	No	No	1
Bay(s) closed	Yes	No	Yes	Yes	3
Bay(s) affected	1, 2 & 5	2	2	1 & 3	-
Under observation		Under observation			1
Number of patients affected	13	4	2	9	28
Number of staff affected	8	-	-	3	11
Causative organism	Norovirus	None identified	None identified	Norovirus	-
Total number of days ward/bay(s)closed	9	0	2	2	13
Accumulative bed days lost	147	0	2	2	151

3.0 Definitions

Terminology	Definition
Major Outbreak	A major outbreak can be characterised by either clinical signs affecting a significant number of people or the ability of an organism to cause serious infection or spread. This may involve one individual or any situation presenting unusual features, whether in terms of scale, complexity, or potential threat to the health of the population. If numbers reach a point where significant Trust internal business is affected or an outbreak is large enough within the community to warrant multiple admissions requiring extraordinary measures, then a major incident will be invoked and appropriate procedures followed as per the Major Incident Plan.
Minor Outbreak	A minor outbreak may be more difficult to define but can be characterised as similar clinical symptoms or identification of related micro organisms affecting a group of people in a particular area over a period of days or weeks. Dependent upon the nature and extent of the outbreak it may be upgraded to a major outbreak. In some cases e.g. *Clostridium difficile* and norovirus, specific definitions exist as to what constitutes an outbreak or period of unusually increased incidence
Outbreak	The sudden, unexpected occurrence of a communicable disease in a given population
Period of Increased Incidence	Period of increased incidence (PII), usually relates to cases of *Clostridium difficile* is defined as 2 or more new cases (occurring more than 48hrs after admission, not relapses in a 28 day period on a ward or department.

4.0 Responsibilities undertaken by SWBH

4.1 Infection prevention and control outbreak measures put in place to contain transmission as per Outbreak policy
4.2 External agencies, Risk Management notified
4.3 Outbreak Control meeting convened and chaired at 9.00hrs by Director of Infection Prevention and Control daily to monitor progress and agree key actions. Attendees included healthcare professionals both internal and external to the organisation
4.4 Actions were circulated to all attendees as part of the minutes

5.0 Issues identified

5.1 In addition to information banner usually displayed an additional poster was put on all ward/departmental doors and entrance requesting visitors with symptoms of diarrhoea and/or vomiting to refrain from visiting to contain transmission
5.2 Agreed that there was a need to ensure effective means of communication across the organisation
5.3 Advised to keep fire doors in centre of affected wards closed to help contain transmission and reduce movement
5.4 Visitor restrictions agreed and put in place on affected wards and bays
5.5 Patients given access to free telephone and TV on affected ward
5.6 All staff affected were referred to Occupational Health and Wellbeing. Samples requested from symptomatic staff

6.0 Actions taken

As part of the management and control of any outbreak a series of actions were taken to reduce transmission and prevent further acquisition.

6.1 Patients

Patients were cohort nursed by virtue of closing designated bays and or isolated in a single sideroom as appropriate
Enteric precautions advised and correct use of personal protective equipment e.g. aprons and glove
Mobile hand wash stations were deployed to affected bays to facilitate hand decontamination
Hand hygiene emphasised for all patient contact (washing with soap and water first, followed by 70% isopropyl alcohol gel/rub) for staff and visitors.
Samples of stool (samples of faeces) and vomit were sent for examination in the laboratory to determine a causative organism
Patient admission check list instigated for early identification of symptomatic patients
Patients given access to free telephone and TV on affected ward

6.2 Decontamination of the environment

Environmental cleaning (using **"**Chlor-Clean®") on the affected wards for all vertical and horizontal surfaces, touch points
Increased cleaning of toilet/sanitary areas.
Increased cleaning of patient's bed space and equipment

6.3 Staff

Any symptomatic staff were advised to contact Occupational Health and Wellbeing
Samples of stool (samples of faeces) and vomit were requested to be sent for examination in the laboratory to determine a causative organism
Symptomatic staff restricted from working until asymptomatic for 48hrs and taking normal diet.
Hand hygiene as above reiterated.
Staff only allowed to visit the affected wards if absolutely necessary**.**
Use of personal protective equipment (gloves and aprons) reiterated.
Supplies of laundry, soap, hand towels etc. to be kept in good supply at all times.
Staff movement from affected to unaffected areas prohibited until affected ward/s declared non-infectious where possible.
Only essential maintenance should be undertaken on affected wards (e.g. bedpan repairs).
Matrons undertook to ensure all nursing staff (including bank staff) were cohorted to the effected wards and bay to reduce transmission.
Medical students not allowed onto affected wards unless deemed necessary by Undergraduate tutor.

6.4 Visiting

Visitor check list instigated Organisation wide to identify and potentially symptomatic visitors to reduce transmission
Visiting restricted on affected areas

6.5 General Communication

Infection Prevention and Control pull up banners erected outside closed wards to reinforce the message that the area is closed and only essential staff to enter.
Bay closure posters placed on all affected bay doors
Daily email sent to DIPC (Director of Infection Prevention and Control) for communication to all mailboxes
Throughout the day infection prevention and control liaised with clinical teams, capacity management, facilities, laboratory staff etc.,)

6.6 Documentation.

To ensure each ward affected was reviewed and monitored, additional specific documentation was implemented to include:-

Use of red outbreak folders.
Implementation of stool charts for all affected patients to monitor patients clinical condition
Outbreak monitoring sheets implemented to identify ongoing status of all affected patients.

Appendix 1

SWBTB (2/14) 009 (a)

Action Plan following Outbreak of Diarrhoea and or Vomiting SWBH January 2014

Aim

The aim of this action plan is to identify;-

To clearly define any issues identified, lessons learnt and action taken

Status	
Dark Green	Complete (all completed tasks to date have not been included in this action plan)
Light Green	On track
Amber	Some delay but expected to complete as planned
Red	Significant delay
White	Not yet commenced

NO.	ISSUES IENTIFIED AND ACTION REQUIRED	WHO BY	Completed	PROGRESS	EVIDENCE	RATING
1	In addition to information banner currently in displayed to display designated poster on all ward/departmental doors and entrance requested visitors with symptom to refrain from visiting to contain transmission	Rebecca Evans	Completed	New A4 posters designed, laminated and displayed on all ward/departmental doors and entrances to the hospital sites to include Leasowes, Rowley Regis Hospitals	Posters displayed	Green
2	Need to ensure effective means of communication across the organisation	Rebecca Evans /Colin Ovington	Completed	Email template agreed with Colin Ovington. Agreed IPCT to send email to Colin daily during outbreaks/ward closures for circulation via all mailboxes	Email	Green
3	Advised to keep fire doors in centre of affected wards closed to help contain transmission and reduce movement	Clinical Groups	Completed	A4 poster developed with agreement from Colin Ovington for display on internal ward fire doors during outbreaks Posters delivered to all wards and department for insertion into outbreak folders	Posters	
4	Free patient TV and phone on affected wards	Steve Clarke	Completed	All patients on affected wards were offered free TV and phone		Green

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Investment Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 22 November 2013; 0800 – 1000h

Present	In attendance	Secretariat
Ms Clare Robinson	Mr Chris Archer	Mr Simon Grainger-Payne
Mr Richard Samuda [Part]	Mr Tony Wharram	
Mr Harjinder Kang		
Mr Robert White		
Ms Rachel Barlow		
Mr Mike Sharon		

Minutes	Paper Reference
1 Apologies for Absence	**Verbal**
Apologies for absence were received from Mr Richard Samuda. It was noted that Mr Harding would now attend the Quality & Safety Committee to reflect the revised terms of reference for the Committee.	
2 Minutes from the previous meeting	**SWBFI (9/13) 089**
The minutes of the meeting held on 20 September 2013 were accepted as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held	
3 Matters arising from previous meeting	**SWBFI (9/13) 089 (a)**
The Committee was asked to receive and note the action tracker. It was suggested that further information in terms of the measures used to judge the performance of Social Services was needed at a future meeting. Miss Barlow advised that analysis was in place to analyse the pathways that resulted in delayed transfers of care. It was reported that a joint team was being created which would inform the creation of a Social Services performance dashboard. It was agreed that harmonisation of the stroke services performance data should	

be verified by the Quality & Safety Committee.	
ACTION: **Miss Barlow to present an update on the monitoring of Social Services performance at the next meeting**	
3.1 Assessment of the operational impact of using bank and agency staff	**Verbal**
Miss Barlow advised that to use bank staff was significantly cheaper than agency, particularly for out of hours provision. It was highlighted that bank pay rates had not been increased for a significant period and anecdotally rates were lower than those of some other organisations. It was agreed that the matter could be considered by the Workforce & OD Committee.	
ACTION: **Mr Grainger-Payne to add an item to the agenda of the next Workforce & OD Committee to ensure that the use of temporary staff is discussed**	
3.2 Financial implications of current staff turnover and time to hire position	**Verbal**
Mr White reported that a reconciliation exercise between budgets and the Electronic Staff Record was underway, being led by Workforce. In the Medicine & Emergency Care Group, it was noted that there was difficulty with recruiting into key posts, despite job fairs and recruitment initiatives, due to competition across the patch. Miss Robinson asked what plans were being put in place to make the Trust more attractive to join. Miss Barlow advised that various incentive schemes were being considered. Mr Kang suggested that the Workforce & OD Committee could consider some of the fundamental issues about how recruitment is framed. Mr Kang asked whether medical staff were used on the Trust bank, noting that pay costs could be reduced through this measure. He was advised that this was rare. Miss Barlow agreed to circulate a separate report on this matter prior to the next meeting. It was noted that the time to recruit remained unacceptably protracted at present.	
ACTION: **Miss Barlow to circulate a report into the use of medical bank staff prior to the next meeting**	
3.3 Financial liability associated with the double running of Pathology analysers	**Verbal**
Miss Barlow advised that a detailed review had been undertaken during the changeover between the new analysers. It was noted that there was some waste in terms of reagents and some other costs that had been incurred, which reflected embedding issues and overtime that had not been anticipated as part of the original business case. It was agreed that the lessons learned would be incorporated into the post project review and would be disseminated to other areas where possible.	
3.4 Progress with the contracts database	**Verbal**

Mr White advised that a live exercise was underway to trawl the organisation to identify contracts in place across the Trust and record the value and end dates of each. It was reported that a central portal may be needed to manage the contracts more robustly and in a more harmonised way. It was highlighted that in response to the Francis recommendations, within Service Level Agreements, reference needed to be made to public service values and the NHS Constitution. Mr White reported that the standard terms and conditions advised at present that the Trust traded under standard NHS terms. Ms Robinson suggested that the requirements of the Francis recommendations should be built into the NHS standard terms and conditions. It was agreed that a further update should be provided at the January 2014 meeting.	
ACTION: **Mr White to provide a further update on the progress with populating the contracts database at the next meeting**	
3.5 Update on the approach to seven day working	**SWBFI (11/13) 091** **SWBFI (11/13) 091 (a)**
The Committee was asked to receive and note the update. Mr Sharon advised that the creation of the Midland Metropolitan Hospital (MMH) would assist with addressing some of the challenges of seven day working. He advised that work had been undertaken to identify services that should run on a 24 hour basis and those needed to run seven days per week as part of these plans. Ms Robinson suggested that the seven day working concept was designed to improve the care for patients and asked how seven day working considerations could be built into transformation initiatives that were currently being developed. Mr White advised that the application of this to the most appropriate services needed to be borne in mind and that at present, much work was already underway to embrace seven day working in critical areas. Ms Robinson highlighted that the Christmas break impacted on trusts' operations and in particularly the winter pressures being generated in the early part of the New Year as a result of catching up on elective work postponed during the festive period. She asked what work was being undertaken to plan for these pressures. Mr Sharon reported that these considerations were built into the winter plans submitted to the Trust Development Authority recently, where a capacity plan had been developed to cope with the anticipated demand. Mr Sharon reported that elective inpatients represented a small proportion of the total number of patients treated. Mr Kang asked if there was a significant alteration in capacity over Christmas. Mr Sharon advised that there was a small reduction.	
4 Future operation of the Committee to include risks and forward plan of business	**Verbal**
Ms Robinson highlighted that the remit of the Committee included the consideration of the Trust's key financial risks. She proposed that the Board Assurance Framework (BAF) be considered to identify the most significant risks that the Committee should be reviewing. It was suggested that this approach be	

taken in the other Board Committees. Mr White advised that the current Board Assurance Framework lent itself to a mapping exercise between the risks and the various scrutiny bodies in place. It was agreed that this should be raised to the Board at the meeting on 28 November 2013.	
5 Novation of the Pathology contract	**SWBFI (11/13) 092** **SWBFI (11/13) 092 (a)**
Mr Wharram reported that in 2011, the Trust signed a contract for the supply for reagents and analysers to support MRSA testing. Since then the approach to testing had changed and therefore the costs were not being recovered for the analysers supplied, therefore the organisation from which the Trust leased the machines, Cephaid, was requesting redress. It was reported that work was being taken to seek an acceptable way forward on the matter. Mr White provided an update on the background to the reasons behind the change in the testing approach. It was noted that legal advice had been taken on the position, which suggested that the breach may not be material. Mr Kang asked how the new relationship proposed with GenMed would operate, including the benefits. Mr Wharram reported that there was an expectation that GenMed would take on the liability for buying material from Cephaid though an existing Service Level Agreement. Ms Robinson asked whether legal advice and the dispute had been received in writing. She was advised that this was the case and that this would be made clear to the Board when it was asked to agree the proposal for novation of the contract. Ms Robinson suggested that there needed to be work undertaken to determine if there were any other contracts in place which would provide similar risks. She was advised that this would be captured through the current organisational trawl. Ms Robinson asked how the lessons learned would be captured and disseminated. Mr White advised that the learning would be shared with key managers but also training would be delivered in terms of the rules set out in the Standing Orders and Standing Financial Instructions. It was agreed that an update on the review of Pathology contracts would be presented at the next meeting. Ms Robinson asked whether the impact of issues such as this impacted on transformation plans. Miss Barlow advised that a clear understanding of this would be gained following the organisational trawl and in particular those contracts that might prevent savings being delivered because of the inflexible contractual terms. The Committee agreed to recommend the novation of the contract to the Trust board at its forthcoming meeting.	
ACTION: Mr White to provide an update on the Trust's Pathology contracts at the next meeting	
6 Procurement – embedded contract pricing	**SWBFI (11/13) 093**

	SWBFI (11/13) 093 (a)
The Committee was asked to receive and accept the update.	
7 Trust financial management	
7.1 2013/14 Month 7 financial position, forecast forward income position and compliance with the Better Payment Practice Code	**SWBFI (11/13) 095** **SWBFI (11/13) 095 (a)** **SWBFI (11/13) 095 (b)**
Mr White reported that a higher than planned surplus had been generated during the month, due largely to injury cost recovery income received during the period and a recasting of the Public Dividend Capital payments. It was highlighted that a revised end of year financial forecast might need to be presented to the TDA. In terms of the winter pressure funding available from the Clinical Commissioning Group (CCG), it was highlighted that this had been badged against specific initiatives and that this needed to be factored into any revised forecast that needed to be communicated. Ms Robinson suggested that the parameters of the revised end of year forecast needed to be presented at the next meeting. The Committee was asked to note the influences on the performance against the Better Payment Practice code, which were highlighted to concern primarily a need to improve payment of agency and energy bills. Ms Robinson asked how the financial position of the Medicine Group appeared favourable given the earlier reported issues. She was advised that this reflected support that had been provided from central reserves for funding of supernumery posts and for difficult to recruit posts. Miss Barlow advised that during the period there had been a high level of Delayed Transfers of Care during the period. Mr Sharon reported that against the Monitor Risk Assessment Framework, the Trust was performing well. He also highlighted that total WTEs were above plan, yet pay costs were below expectation. Mr White advised that pay budgets had been adjusted in month to recognise the operational pressures. Mr Archer reported that budgets may be flexed on a monthly basis to reflect matters such as the incurring of costs associated with high costs drugs, for which the Trust would be reimbursed. Mr White advised that guidance would be developed in terms of the appropriate justification for the adjustment of budgets. The movement of reserves to handle environmental issues were discussed.	
ACTION: Mr White to present the likely end of year forecast and the influences on this at the next meeting	
7.2 Non-pay variability	**Verbal**
Mr Archer highlighted that one of the key influences on the non-pay budget was the harmonisation of reporting to the position reported to the TDA for technical	

reasons on a monthly basis. Ms Robinson agreed that visibility of this harmonisation was needed. Mr White encouraged a pragmatic approach to be taken regarding the reserve release process that reflected operational practice. Mr Archer advised that budgets were adjusted to reflect in year Board decisions for instance. Mr White highlighted that the 'bottom line' was consistent between the internal reports and those issued to the TDA. It was highlighted that drugs and medical consumables and environmental works at Grove Lane also generated a degree of non-pay variability.	
7.3 LTFM outputs and assumptions	**SWBFI (11/13) 094** **SWBFI (11/13) 094 (a)**
Mr Samuda joined the meeting for this item. Mr White presented the ten year financial model and the associated risk ratings to allow the MMH project to proceed. The assumptions were highlighted, including the receipt of £100m of Public Dividend Capital and tapering relief. Mr White outlined the calculations used to assess that the Trust's estates costs did not exceed 12.5% of the annual normalised income. It was highlighted that the model as it was currently constructed, would deliver a satisfactory risk rating of 3 and an acceptable level of surplus for the lifetime of the model. Ms Robinson asked how the transfer of community services into the Trust had assisted with the position. Mr White suggested that as an integrated care provider this had little significance in the overall consideration. Ms Robinson asked who had scrutinised the plan. Mr White reported that KPMG had been asked to verify the document and a draft report had been prepared summarising their findings. It was suggested that the internal team responsible for preparing the report should be congratulated. Noting the historical financial position, it was suggested that further work be undertaken to remove all the unusual variances and contributions to provide a clearer view of the underlying position. It was suggested that this could be considered as part of the Due Diligence process. Mr Archer advised that a view had been prepared beforehand which could be drawn upon and that the underlying position was intrinsic to the model. He drew the Committee's attention to some of the key major influences that might affect the underlying position. Mr Kang asked in terms of downside modelling, whether the elements were weighted by probability. Mr Sharon advised that the values were set based on scale and probability. Mr White advised that the downside mitigated case produced a better surplus in the later years as the model. It was highlighted that this reflected that there was a need to achieve further savings during these year to improve the efficiency and retain a risk rating of 3 during the period. In terms of appendix 3, concerning the transformational savings trajectory, it was noted that the magnitude of efficiency was significant. Ms Robinson asked if the	

transformation schemes received were consistent with this trajectory. Mr White advised that the trajectory presented a worst case position, however the schemes received to date appeared to support the required savings. Ms Robinson asked in terms of the assumptions made, that the source of these should be included where possible. It was agreed that the challenges and key deliverables that supported the LTFM results should be considered by the Board in due course. It was noted that the reference to being able to afford a larger scheme reflected that additional commissioning support would be needed but also recognised a degree of flexibility with the model.	
7.4 Going Concern update	**SWBFI (11/13) 096** **SWBFI (11/13) 096 (a)** **SWBFI (11/13) 096 (b)**
It was agreed that the Committee should receive and note the report.	
7.5 Financial risks to the organisation	**Verbal**
It was agreed that there were no further risks that needed to be considered at present.	
8 Transformation Plan	
8.1 TSP delivery report 2013/14	**SWBFI (11/13) 097** **SWBFI (11/13) 097 (a)** **SWBFI (11/13) 097 (b)**
It was agreed that the Committee should receive and note the report. Mr Archer reported that although the Estates Directorate appeared to be significantly adrift from the target, however non-recurrent mitigations had been identified.	
8.2 Progress update	**Verbal**
Miss Barlow reported that work had begun to consider a range of transformation innovations and external support had been secured to assist with preparing the forward plan for the Trust, concentrating in particular on outpatients, theatres and long term condition management. It was agreed that Miss Barlow should meet Ms Robinson and Mr Kang and present a formal proposal at the next meeting.	
ACTION: Miss Barlow to meet with Ms Robinson and Mr Kang to discuss the contents of the transformation plan **ACTION: Miss Barlow to present the detail of the Transformation Plan at the next meeting**	
9 Service Line Reporting update	**SWBFI (11/13) 101** **SWBFI (11/13) 101 (a)**

The Committee received and noted the report. Ms Robinson agreed that the future plans for Service Line Reporting should be considered in more detail at the next meeting, alongside the Transformation Plan. Mr Archer noted that the report had been restructured to reflect the new Clinical Group structure.	
ACTION: Mr White to present the future plans for Service Line Reporting at the next meeting	
10 Matters for information	
10.1 Corporate quality & performance dashboard	**SWBFI (11/13) 098** **SWBFI (11/13) 098 (a)**
The Committee received and noted the report.	
10.2 Monitor Risk Assessment Framework	**SWBFI (11/13) 100** **SWBFI (11/13) 100 (a)**
The Committee received and noted the report.	
11 Matters to highlight to the Board	**Verbal**
It was agreed that there were several matters raised during the meeting that should be raised to the Board at its next meeting.	
12 Meeting effectiveness feedback	**Verbal**
It was agreed that the meeting had been productive and the chairing of the meeting had been effective, including noting the matters that were appropriate while dedicating time to matters of importance. It was suggested that consideration to matters arising may be needed at future meetings.	
13 Any Other Business	**Verbal**
It was noted that the meeting would be Mr White's last meeting.	
14 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 31 January 2013 at 0800h in the D29 (Corporate Suite) meeting room at City Hospital.	

Signed: ……

Name: ……

Date: ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – P09 December 2013
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer / Robert White
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust, clinical groups and corporate directorates for the period to 31st December 2013.

The Trust's Monitor continuity of service risk rating for the year to December is 4 which is satisfactory ("no evident concerns").

Measured against the DH target, the Trust generated an actual surplus of £846,000 during December against a planned surplus of £598,000. The year-end surplus has been revised upwards to £6,736,000 which includes a review of the movement in one-off items such as the provision for the costs of redundancy. The forecast year end Continuity of Service rating using the TDA methodology rises to 4.

The cash balance of £43.2m is £3.4m higher than plan for 31st December.

REPORT RECOMMENDATION:

The Trust Board is requested to RECEIVE the contents of the report and ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

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

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

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

Good use of Resources (under 12/13 OfE, key Strategies & Programmes)

PREVIOUS CONSIDERATION:

Draft report considered by Performance Management Committee.
This report to be considered at Finance & Investment Committee.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2013

EXECUTIVE SUMMARY

• For the month of December 2013, the Trust delivered a "bottom line" surplus of £846,000 compared to a planned surplus of £598,000 (as measured against the DoH performance target). Actual in month performance is consistent with the year end revised surplus.

• For the year to date, the Trust has produced a surplus of £4,247,000 compared with a planned surplus of £3,671,000 so generating a favourable variance from plan of £576,000, above the Trust's year to date target of £4,600,000. A review of the forecast position has revised the Trust's outturn surplus to £6,736,000. Using the TDA Continuity of Service risk rating, the forecast score has moved from 3 up to 4.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 215 below planned levels. After taking account of the impact of agency staff, WTE's were 34 above plan. Total pay expenditure for the month, inclusive of agency costs, is £277,000 below the planned level (£416,000 year to date), which includes some year to date adjustments.

• The month-end cash balance was £43.2m. Year to date spend on capital is £6.3m.

•The forecast year end I&E position includes an estimate of impairments to fixed assets. This is treated as a technical adjustment and does not affect delivery against the revised DH target surplus of £6.7m.

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	248	576	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	96	98	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	277	416	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(234)	(2,456)	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	(34.0)	(74.3)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	3,420	3,420	>= Plan	>=95% of plan	<95% of plan
Note: positive variances are favourable, negative variances unfavourable					

Performance Against Key Financial Targets		
	Year to Date	
Target	Plan	Actual
	£000	£000
Income and Expenditure	3,671	4,247
Capital Resource Limit	15,305	15,305
External Financing Limit	---	3,420
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at December 2013	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	393,035	33,033	32,909	(124)	294,842	296,386	1,544	392,463
Other Income	40,124	3,713	3,890	177	29,938	30,532	594	40,932
Operating Expenses	(407,437)	(34,696)	(34,653)	43	(305,576)	(307,616)	(2,040)	(405,631)
EBITDA	25,722	2,050	2,146	96	19,204	19,302	98	27,764
Interest Receivable	100	8	9	1	75	98	23	125
Impairment of Fixed Assets	0	0	0	0	0	0	0	(2,500)
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(855)	(734)	121	(10,163)	(10,042)	121	(13,962)
PDC Dividend	(5,027)	(419)	(391)	28	(3,771)	(3,462)	309	(4,767)
Interest Payable	(2,232)	(186)	(184)	2	(1,674)	(1,649)	25	(2,424)
Net Surplus/(Deficit)	**4,601**	**598**	**846**	**248**	**3,671**	**4,247**	**576**	**4,236**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	2,500
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,601**	**598**	**846**	**248**	**3,671**	**4,247**	**576**	**6,736**

The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. Some 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 – December 2013

Overall Performance against Plan

The overall performance of the Trust against the DoH planned position is shown in the graph. Net bottom-line performance delivered an actual surplus of £846,000 in December against a planned surplus of £598,000. The resultant £248,000 favourable variance results in a year to date return on income of 2.3%, exceeding the plan of a 1.1% return.

The Trust's forecast is now a surplus of £6.7m.

Performance of Clinical Groups / Corporate Areas

•Medicine costs for waiting list initiatives and queue busting sessions continue to overspend alongside additional capacity costs.

•Women & Child Health reflects fewer births than plan resulting in lost income.

•Community & Therapies is facing demand for wheelchairs and continence products that exceeds the block contract income.

•Imaging direct access is overperforming.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**	**Budget £000**
Medicine	(79)	(1,225)	103,534
Surgery A	(9)	(40)	62,291
Women & Child Health	(193)	(279)	50,554
Surgery B	(12)	(9)	25,850
Community & Therapies	42	(133)	27,628
Pathology	15	(15)	19,973
Imaging	16	311	17,930
Corporate	2	334	86,868
Central	316	1,147	17,408

•Corporate directorates continue to underspend on management costs.

•The Central position reflects contingency release and will continue to do so for the remainder of the year where not directed towards specific agreed pressures.

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The Trust-wide in-month favourable variance of £248,000 shows net under performance on patient income, principally A&E and maternity.

Medical pay includes waiting list initiatives and use of locums in a number of specialties in Medicine & Emergency Care.

Nursing continues to be reliant on signficiant agency support to cover vacancies. Health care assistants are being used to support additional capacity and acuity. Management and therapies staffing continue to underspend.

Hotel services are overspending across the Trust.

The Trust benefits from a revised calculation of its dividend; depreciation costs are low due to the slow start to the capital programme.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(124)	1,544
Other Income	177	594
Medical Pay	(111)	(1,259)
Nursing	184	941
Other Pay	204	734
Drugs & Consumables	6	(1,432)
Other Costs	(240)	(1,024)
Interest & Dividends	152	478

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Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are 34 above plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 215 below plan.

• Total pay costs (including agency workers) are £277,000 below budgeted levels for the month, which includes central support for the staffing position.

•Overspends on healthcare assistants and medical staff continue which are partly offset by underspending management and scientific staff budgets.

•Gross expenditure for agency staff in December was £948,000 which shows no improvement on the previous two months.

Analysis of Total Pay Costs by Staff Group

	Year to Date to December					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	57,532	55,825	0	2,966	58,791	(1,259)
Management	11,581	10,528	0	0	10,528	1,053
Administration & Estates	23,938	21,580	1,775	964	24,319	(381)
Healthcare Assistants & Support Staff	23,797	21,477	3,105	846	25,078	(1,281)
Nursing and Midwifery	68,702	61,662	3,160	3,089	67,761	941
Scientific, Therapeutic & Technical	32,796	31,413	0	280	31,693	1,103
Other Pay / Technical Adjustment	256	16	(150)	(350)	16	240
Total Pay Costs	218,602	202,501	7,890	7,795	218,186	416

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Balance Sheet

•Cash balances at 31st December stood at £43.2m, £3.0m higher than the planned figure. The forecast cash flow for the next twelve months is shown overleaf.

•The forecast balance sheet assumes impairment in the value of tangible assets also reflected in the I&E statement and the revised forecast I&E surplus of £6.7m.

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STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013	Balance as at end December 2013	Forecast at 31st March 2014
		£000	£000	£000
Non Current Assets	Intangible Assets	924	750	874
	Tangible Assets	216,669	213,150	220,477
	Investments	0		
	Receivables	1,048	701	700
Current Assets	Inventories	3,604	3,520	3,600
	Receivables and Accrued Income	10,432	20,866	12,300
	Investments	0	0	
	Cash	42,448	43,166	37,944
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(49,707)	(46,361)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(1,037)	(1,029)
	Provisions	(10,355)	(8,573)	(7,654)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	(3,000)	(2,000)	(1,000)
	Borrowings	(29,263)	(28,227)	(27,884)
	Provisions	(3,168)	(3,233)	(3,262)
		183,385	187,376	186,705
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	162,139
	Revaluation Reserve	34,356	33,659	28,909
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(20,260)	(15,572)	(13,401)
		183,385	187,376	186,705

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT December 2013

ACTUAL/FORECAST	Jan-14 £000s	Feb-14 £000s	Mar-14 £000s	Apr-14 £000s	May-14 £000s	Jun-14 £000s	Jul-14 £000s	Aug-14 £000s	Sep-14 £000s	Oct-14 £000s	Nov-14 £000s	Dec-14 £000s
Receipts												
SLAs: SWB CCG	20,700	20,700	20,700	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978
Associates	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600
Other NHS income	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100
Specialised Service (LAT)	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400
Education & Training	4,750			4,700	0	0	4,700	0	0	4,700	0	0
Loans												
Other Receipts	2,400	2,400	2,400	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800
Total Receipts	39,950	35,200	35,200	39,578	34,878	34,878	39,578	34,878	34,878	39,578	34,878	34,878
Payments												
Payroll	13,700	13,700	13,700	14,200	14,200	14,200	14,200	14,200	14,200	14,200	14,200	14,200
Tax, NI and Pensions	9,400	9,400	9,400	9,550	9,550	9,550	9,550	9,550	9,550	9,550	9,550	9,550
Non Pay - NHS	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Non Pay - Trade	8,540	8,540	9,324	7,825	7,825	7,825	7,825	7,825	7,825	7,825	7,825	7,825
Non Pay - Capital	1,750	1,750	3,900	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308
PDC Dividend			2,253						2,750			
Repayment of Loans			1,000						1,500			
Interest			15	0	0	15	0	0	15	0	0	15
BTC Unitary Charge	844	428	428	225	225	225	225	225	225	225	225	225
Other Payments	500	500	500	92	92	92	92	92	92	92	92	92
Total Payments	36,734	36,318	42,520	35,200	35,200	35,215	35,200	35,200	39,465	35,200	35,200	35,215
Cash Brought Forward	43,166	46,382	45,264	37,944	42,322	42,000	41,663	46,041	45,719	41,132	45,509	45,187
Net Receipts/(Payments)	3,216	(1,118)	(7,320)	4,378	(322)	(337)	4,378	(322)	(4,587)	4,378	(322)	(337)
Cash Carried Forward	46,382	45,264	37,944	42,322	42,000	41,663	46,041	45,719	41,132	45,509	45,187	44,850

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Capital Expenditure

• Year to date capital expenditure is £6.3m, mainly on blood sciences, statutory standards and estates rationalisation. Spending has begun on the medical equipment programme, "Winter Must Be Better" and "Dementia Friendly Environment" programmes of ward works and on the HIS programme.

•A review of the programme has been undertaken to accommodate the bringing forward of expenditure in relation to Grove Lane within a pre-existing agreed overall sum. There remains a risk of capital programme (and thus capital resource limit) underspend. The programme is under review to appropriately manage the programme taking one year with another.

Continuity of Service Risk Rating

•The previous Monitor Financial Risk Rating has now been retired and has been replaced by the new Continuity of Service Risk Rating. The new financial risk rating position is shown below (out of 4). Revised threshold for liquidity have been published by Monitor which are now reflected in the rating below.

•The in month score of 4 reflects the improved I&E position and increased current assets.

•The forecast year end score, using the TDA methodology, increases from 3 to 4.

Financial Risk Analysis

1) Financial Risk Ratings	Financial Metric	Current Year to Date			Forecast Outturn		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
2) Continuity of Service Rating							
Liquidity Ratio (days)	Working Capital Balance	(2,848)	2,715	5,563	(7,235)	(6,800)	435
	Annual Operating Expenses	302,757	308,361	5,604	403,753	405,606	1,853
	Liquidity Ratio Days	(2.5)	2.4	4.9	(6.5)	(6.0)	0.4
	Liquidity Ratio Metric	3	4	1	3	3	0
Capital Servicing Capacity (times)	Revenue Available for Debt Service	20,458	19,320	(1,138)	26,989	27,589	600
	Annual Debt Service	6,857	6,943	86	9,815	10,070	255
	Capital Servicing Capacity (times)	3.0	2.8	(0.2)	5.4	2.7	(2.7)
	Capital Servicing Capacity metric	4	4	0	4	4	0
Continuity of Services Rating	**Continuity of Services Rating for Trust**	4	4	1	4	4	0

Transformation Programme

•Progress against 2013/14 TSPs is reported separately.

•Governance arrangements for reviewing the deliverability and quality impact assessments of future year's TSP programmes is being updated in preparation for presentation to the Quality and Safety committee.

•The Clinical Leadership Executive has reviewed the position on QIA and EIA status with efforts to complete this work continuing as part of 2014/15 preparations.

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Performance Against Service Level Agreement Target

•Performance for April to November is ahead of plan overall , including pass through high cost drugs and direct access imaging and pathology work for GPs. A&E activity is below plan as is the number of births.

•Commissioners have raised a number of queries on the performance to date which are being discussed in the context securing respective financial stability and retention of resources for local services. Dialogue has also begun about plans for 2014/15.

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Key risks

•Discussions with commissioners are under way to understand and manage the key risks and uncertainties in the contractual position for the year. This includes referral trends, activity levels, particularly in A&E, maternity, direct access work and pass through drugs, contract penalties including ambulance turnaround time and delivery of targets such as CQUIN. The intention is to secure respective financial stability and retention of resources for local services.

•Winter plans are being brought into action in conjunction with commissioners. Capacity continues to be run at a premium cost within Medicine.

•Premium rate waiting list and queue busting work is being undertaken in a number of specialties.

•The year end surplus has been revised upwards to £6.7m which reflects the movement in balance sheet items including provisions.

External Focus

•The Department of Health has confirmed its intention to charge visitors and migrants who use the NHS. The changes include an extension of charges for primary care services, such as prescriptions, though GP and nurse consultations will remain free. Charging will be introduced in accident and emergency departments. Overseas visitors will be charged more for taxpayer-subsidised services, such as optical and dental care, and there will be a new system for identifying and recording patients who should be charged for NHS services.

•National Tariff and associated planning guidance has been issued for 2014/15. The Trust has submitted its initial financial and workforce plans to the Trust Development Authority which reflect the planning assumptions in the Long Term Plan approved by Trust Board in November 2013.

•National assumptions include a tariff deflator of 1.5% for acute services supporting a 4.0% efficiency requirement. This allows for 1.5% impact of pay awards and increments and a contribution to expected investments in quality and safety.

Recommendations

The Finance & Performance Management Committee is asked to:

i. RECEIVE the contents of the report; and

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

Tony Waite

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
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TRUST BOARD

DOCUMENT TITLE:	Transformation Savings Programme 2014/15
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mngt
AUTHOR:	Tony Waite, Director of Finance and Performance Mngt
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

This report is intended to update the Board as to progress in the development of savings proposals necessary & sufficient to meet the trust's forward service & financial plans.

The trust is required to approve & submit to the TDA its Operating Plan for the two years 2014-16 by the beginning of March 2014. This plan is required to set out those savings proposals and to confirm that they have been reviewed and confirmed by the Medical & Nursing Directors for their impact on safety, quality & equality.

TSP summary	2014/15		2015/16	
	£m	%	£m	%
Target savings	20.6		19.9	
Directorate savings proposals	18.8	91%	13.8	69%
Central savings proposals	2.4	12%	6.3	32%
	21.2		20.1	
Final QIA signed	15.4	73%	8.2	41%
Memo - savings reported to TDA	20.8		20.0	

Work is progressing to secure necessary confidence in the savings proposals consistent with a robust Operating Plan as follows:

- Confirmation of target savings requirement as income contracts, cost pressures and necessary investments to secure service standards are concluded
- Confirmation of month on month profile of savings realisation having regard to firm operational implementation milestones
- Challenge & confirm scope for acceleration of 2015/16 savings delivery
- Relentless pursuit of further savings proposals to mitigate delivery risk
- Completion of outstanding QIA reviews

The detail behind this summary has been considered by the Quality & Safety and Finance & Investment Committees.

REPORT RECOMMENDATION:

The Trust Board is asked to DISCUSS the report and relevant feedback from board committees.

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	
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:

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 Committee, Clinical Leadership Executive, Quality & Safety Committee and Finance & Investment Committee

Sandwell and West Birmingham Hospitals NHS
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MINUTES

Audit Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 22 October 2013

Members Present		In Attendance		Guests
Mrs G Hunjan	[Chair]	Mrs S-A Moore		Miss R Barlow
Dr S Sahota		Mr R Chidlow		Mr P Finch
Mr H Kang		Mrs R Chaudary		
Ms O Dutton		Mr P Capener		
		Mr D Ferguson		
		Ms S Mallinson		
		Miss K Dhami		
		Mr T Wharram		
Secretariat		Mr T Lewis	[Part]	
Mr S Grainger-Payne		Mr R Samuda	[Part]	

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Ms Clare Robinson, Mr Andy Bostock, Mr Glen Palethorpe and Mr Robert White. Mrs Hunjan thanked Mrs Moore for her support during her time in post as the Trust's key link with External Audit and wished her well. She welcomed her replacement Mr Robert Chidlow and also Mrs Shauna Mallinson from Baker-Tilly which had been recently appointed to succeed CW Audit as internal auditors.	
2 Minutes of the previous meeting	**SWBAR (5/13) 043** **SWBAR (6/13) 044**
The minutes of the meetings held on 9 May & 6 June 2013 were approved as a true and accurate reflection of discussions held.	

Minutes	Paper Reference
AGREEMENT: The minutes of the meetings held on 9 May & 6 June 2013 were approved as an accurate record	
3 Matters arising	**SWBAR (5/13) 043 (a)**
The Audit Committee received and noted the updated actions log.	
3.1 Salary overpayment recovery rate and trends by Group	**SWBAR (10/13) 046** **SWBAR (10/13) 046 (a)**
Mr Wharram presented the report for receiving and noting. He advised that although the value of the overpayments was relatively low as a proportion of the overall payroll transactions, the position remained unacceptable. He advised that the key reason for the overpayments concerned the failure of managers to update staff information in a timely manner. The Committee was asked to note that the distribution of such cases was spread across the Trust. In terms of addressing the issues, it was highlighted that the requirement to complete the changes forms was reinforced though mandatory training and other sources of information. It was reported that the Director of Finance & Performance Management wrote personally to the areas in which the overpayments originated. Mr Kang asked whether any overpayments were not pursued because of their relative low value. Mr Wharram advised that this was not generally the case, however the most problematic issues lay with long standing cases. He advised that the immediate recovery plans were executed through payroll. Miss Dhami asked whether the issue was prevalent in medical staff as anecdotally this had been raised previously. She was advised that this was not a particular issue pertaining to medical staffing. Ms Dutton asked whether overpayments featured prominently in the Trust's risk register. She was advised that this was not the case unless there was a problem in a specific issue. Mrs Hunjan asked whether the trends had reduced from 2012/13. Mr Wharram advised that overall the trend had reduced year on year, however overall the pattern was random across the Trust. Mrs Hunjan suggested that there was little reason why managers should not complete the appropriate paperwork for leavers of staff changing hours and asked whether the impact of the communication from the Director of Finance was seen to have improved the position. Mr Wharram reiterating the random spread of the cases, advised that there appeared no specific impact of the Finance Director's letters issued.	
4 Local Security Management Specialist workplan	**SWBAR (10/13) 047** **SWBAR (10/13) 047 (a)**

Minutes	Paper Reference
	SWBAR (10/13) 047 (a)
Mr Finch joined the meeting and provided an overview of the Local Security Management Specialist workplan. He advised that as from April 2013, the way in which the security was audited had changed and was based on an assessment against a number of standards. The Committee noted that the grading against these was predominantly amber given that an assessment of the effectiveness against each standard needed to be made which could not yet be judged. Mr Finch advised that the self-assessment had been submitted to NHS Protect and that compared to other local organisations, the Trust's position was positive. The Committee was advised that a revised security management strategy needed to be developed and would be taken forward when the new Chief Nurse commenced in post. Mrs Hunjan asked how feedback against the standards would be gained. Mr Finch advised that in due course the Trust would be inspected against the standards. In terms of the number of assaults in the Trust, it was reported that these had risen, which it was suggested reflected better reporting of incidents. The majority of assaults were noted to be classified as being clinical as opposed to deliberate. Ms Dutton noted that abuse of staff by relatives was prevalent and asked if the new guidance expected by NHS Protect would encompass the way in which this should be handled. Mr Finch advised that all front line Trust staff were required to undertake conflict resolution training to handle these issues and de-escalate situations. In terms of violence compared to other local organisation, it was reported that the Trust's position was average. Mr Finch advised that staff on staff assaults was within the responsibility of the Workforce directorate to handle and report. Mrs Hunjan asked in terms of risk assessments, how this linked into the annual audit plan and the overall assurances provided. Mr Finch advised that his input was provided though the Risk Management Group and other key action groups addressing specific risks in the Trust. Mr Capener reported that there was a separation between the working of Internal Audit and the security function. Mr Finch advised that there was an indirect link between the asset risks work between the two functions. Dr Sahota noted that a number of actions within the plans that were due for completion by March 2014 and asked by when all actions would be at green status. Mr Finch advised that it was likely to take 3-4 years to complete all actions, although he envisaged good progress would be made by the start of 2014/15. Miss Dhami advised that progress would be monitored through the Executive-led committees, such as the newly	

Minutes	Paper Reference
formed Risk Management Committee. Mrs Hunjan asked that any matters of exceptional concern be presented to the Audit & Risk Management Committee, however she expressed her contentment with the day to day monitoring resting with the Executive.	
5 Data Quality matters	
5.1 Data quality for national targets and plans for the next six months	**SWBAR (10/13) 056** **SWBAR (10/13) 056 (a)** **SWBAR (10/13) 056 (a)**
Mr Lewis and Mr Samuda joined the meeting for this item. Mr Wharram presented an overview of the plans to review data quality against national targets. In terms of the Internal Audit review of data quality, Mr Capener reported that a range of national targets had been tested. Against most, it was reported that significant or full assurance had been provided. Against two indicators, A & E waiting times and same sex accommodation breaches it was reported that only moderate assurance could be provided. In respect of the former, Mr Capener advised that a process was not in place to validate the accuracy of data from Malin Health and therefore third party assistance was being sought. It was noted that the issue concerning the incorrect inclusion of some also BMEC attendances needed to be clarified. Mr Lewis asked whether an assessment had been undertaken against best practice. He was advised that national guidance had been used as a basis for the assessment. In response to Mr Lewis' advice that there was a plan to restate the performance against the Accident & Emergency target for Quarter 2, Mr Capener suggested that it would be useful to understand the reasons for this. Miss Barlow advised that a resubmission would be made to the CCG and TDA. In terms of breaches to the same sex accommodation guidance, it was highlighted that there had been incomplete submissions from some areas. Dr Sahota noted that returns had not been received from 19 out of 32 wards and asked how this would be addressed. Miss Barlow advised that an electronic solution would be implemented which would improve the robustness of the returns process. Mr Lewis noted that overall significant assurance had been provided against the DTOC assessment and asked how this could be the case given that no written audit trail was in place. Mr Capener advised that although the audit trail could not be evidenced, he was comfortable that a satisfactory process was in place. It was noted that there was no policy document in place that covered handing of Delayed Transfers of Care. In terms of cancer waits, Mr Lewis noted that a reconciliation process was	

Minutes	Paper Reference
not in place to provide assurance that all referrals received had been added to Lorenzo. He asked how assurances had been gained on information after treatment had started. Mrs Chaudary advised that the scope of the audit had not extended to review information at this level. Regarding the review of the data quality of the VTE assessment information, Ms Dutton observed that the CQUIN target was 95% however the internal target was 100%. It was reported that the MRSA element of the review covered MRSA reporting rather than screening. Mr Lewis noted that significant assurance had been provided against the diagnostic waits indictor. He observed however, that he would have been expected to have seen an issue concerning reoffering diagnostic appointments to patients following a 'Did Not Attend'. Mr Samuda suggested that the overall conclusion of the review should cover the culture and custom & practice in respect of national guidance to assess data quality. Mrs Hunjan asked for an overall view as to current adherence with national guidance. Mr Capener advised that there appeared to be a departure with national guidance in some areas at present, however there was an expectation that greater focus would be directed to this given the higher priority directed to data quality nationally. It was agreed that there remained a number of further questions that needed to be concluded as a result of the report and therefore Mr Lewis suggested that he should meet with Internal Audit separately to discuss the matter further. On this basis, it was agreed that the recommendations from the Internal Audit work on Data Quality could not be accepted.	
5.2 18 weeks – open pathway update	**Presentation**
Miss Barlow reminded the Committee of the background to the validation work on the 18 weeks data quality programme. The validation work was reported to have been undertaken in a number of phases, the first covering referrals pre-1 April 2012 with phase two relating to referrals from 1 April 2012 – 31 December 2012. It was reported that the work had identified that there were several thousand pathways that could be closed down without writing to patients to notify them of the issue, however there was a cohort of individuals to which this did not apply and therefore a letter had been issued to them providing an invitation to contact the Trust if they felt it was necessary. Miss Barlow advised that in the event that a response had not been received, in a number of instances the pathway had been closed. It was highlighted that a number of patients had called into the Trust as a result of the letters and a small number of patients were invited into the Trust for	

Minutes	Paper Reference
an appointment. In terms of phase two, it was reported that the majority of patients' pathways were noted to have been stopped appropriately, with only a small proportion still needing to be validated by the end of October. It was highlighted that there was little likelihood that significant number of patients would need to be seen by the Trust as a result of this work. Mr Capener asked where patients had needed to be seen, whether any serious clinical risks had been identified. He was advised that this was not the case as the majority related to minor procedures. Miss Barlow reported that a number of 52-week waiting time breaches had been identified and that all of these patients would undergo a clinical risk assessment. She advised however, that it was unlikely that in any case, that a significant clinical risk would be identified. Miss Barlow outlined a number of lessons learned from the situation. She advised that the data quality issue had been identified some time before 2012 when it was appropriately escalated and therefore processes around this that had prevented the matter being reported in a timely way needed to be clarified. In terms of the validation process, it was suggested that the statistical sampling method used initially had proved to be inappropriate and caused delays and therefore should the matter reoccur then a more appropriate validation method would need to be chosen initially. She added that consideration of external support to validate the pathways might need to be given in future as would the use of dedicated resources, such as a turnaround director. Mr Lewis advised that the future handling of data quality issues would be discussed at the next Trust Board meeting, which he advised would pick up the most appropriate escalation processes. Dr Sahota suggested that those patients experiencing a protracted waiting time may have returned to GPs and as such he asked whether these cases had been identified. Miss Barlow advised that the position had been triangulated to complaints received during the period and it appeared that there were no obvious links. She advised that the local CCG had been appraised of the position and would be provided with a list of patient affected. Mr Capener asked what impact was expected in terms of the relationship with the CCG. Mr Lewis advised that the Trust had been candid with the CCG and acknowledged that there was a degree of dissatisfaction in terms of 52 week breaches that would need to be managed. Miss Barlow advised that much work would be directed to ensuring that a robust process was in place going forward, including the use of a	

Minutes	Paper Reference
monitoring dashboard. It was highlighted that recovery plans were being put into place to address issues of poor performance against the 18 week obligation in some specialities. The effectiveness of processes was reported to be being given clear focus, including through the support of the Department of Health's Intensive Support Team, the implementation of 18 week tracking resources and additional resources in the HIS team. Ms Dutton suggested that performance against the national indicators needed to be monitored to ensure that the issue was not repeated. Mrs Hunjan noted that had the information identified by the national waiting time 'ready reckoner' have been acted upon the issue may have been addressed sooner. Mrs Hunjan asked where the 18 weeks dashboard would be monitored. She was advised that this would be reviewed primarily at an Executive level, however it would also be presented to the Quality & Safety Committee periodically.	
6 Risk Management and Governance matters	
6.1 Terms of Reference	**SWBAR (10/13) 048** **SWBAR (10/13) 048 (a)**
Miss Dhami advised that the terms of reference for the Audit & Risk Management Committee had been considered and approved by the Board previously and now incorporated risk management responsibilities that had previously been within the remit of the Quality & Safety Committee. It was noted that with regard to the aspect of the terms of reference relating to External Audit, that the responsibilities should not include an external review of internal audit. Mrs Moore suggested that consideration should be given to placing the consideration of the Quality Account report to the Quality & Safety Committee. Mrs Hunjan noted that in terms of the membership of the Committee that this should reflect that all Non Executive Directors were members. She also highlighted some further typographical errors which would need to be corrected for the final version.	
ACTION: Mr Grainger-Payne to amend the terms of reference for the Audit & Risk Management Committee in line with the suggestions made at the meeting	
7 External Audit Matters	
7.1 External Audit progress report	**SWBAR (10/13) 049**
Mrs Moore provided a summary of progress since the last meeting. She	

Minutes	Paper Reference
presented the Annual Audit Letter and the opinion in respect of the Quality Account. It was reported that a debrief of the annual accounts process had been undertaken and the Committee was asked to note the key points that had arisen from this. The Committee was advised that an onsite audit of the Charitable Funds accounts had commenced for reporting in December 2013 and that the external/internal audit protocol had been set. It was agreed that this would be considered annually by the Audit Committee. The opinion on the auditable section of the annual report was considered and the matters raised were noted. Mrs Hunjan noted the IT requirements in respect of the audit that were raised. Mrs Moore advised that work would be undertaken jointly with the Trust to improve the position in respect of this in future.	
7.2 Annual Audit letter	**SWBAR (10/13) 050**
Mrs Moore asked the Committee to note the scope of the work of External Audit covered during 2012/13, the final audit fee for the work undertaken and confirmation of independence. Mr Grainger-Payne was asked to arrange for the Annual Audit Letter to be published.	
ACTION: Mr Grainger-Payne to arrange for the Annual Audit Letter to be published	
7.3 Review of Quality Account	**SWBAR (10/13) 051**
The Committee received and noted the External Audit review of the Quality Account.	
8 Internal Audit matters	
8.1 Internal Audit progress report and recommendation tracking	**SWBAR (10/13) 057** **SWBAR (10/13) 057 (a)** **SWBAR (10/13) 057 (b)**
Mr Capener highlighted that the majority of the work of Internal Audit since the Committee had last met concerned the data quality audit. Mrs Hunjan noted that a number of responses were outstanding in respect of the Internal Audit review of data quality and suggested that these should be expedited where possible. In terms of the review of the Board Assurance Framework (BAF) and risk management, Mrs Hunjan asked how this would be covered. She was advised that these aspects of the programme would be completed in January 2014.	

Minutes	Paper Reference
Regarding the non-medical recruitment review, Mr Capener advised that there were a number of influences that had been identified that were apparently preventing a speedy recruitment process, including managers not complying with due process and the process by which vacancy approval forms are completed. Mr Kang asked whether there was a standard process in the NHS for recruitment. He was advised that this was not the case, although Mr Capener suggested that a comparison of the processes in other trusts would be beneficial. Dr Sahota noted that some action was planned to implement a method of transferring CRB checks between organisations when an individual moved jobs, however it appeared little progress had been made to date.	
8.2 Counter Fraud progress report	**SWBAR (10/13) 059** **SWBAR (10/13) 059 (a)** **SWBAR (10/13) 059 (b)**
Mr Ferguson presented the self-assessment against the NHS Protect standards which he advised had been submitted in July 2013. It was noted that the Trust had not been chosen for full inspection against the standards at present, although there was a possibility that a partial inspection would be conducted. The Counter Fraud progress report was considered. It was reported that the Counter Fraud and Corruption policy had been updated and published. The Committee was advised that the work during the period had included prevention and recovery of overpayments to some staff leaving the Trust. Cases brought forward from the previous year were reviewed.	
8.3 Revised arrangements for provision of business risk and audit services	**SWBAR (10/13) 055** **SWBAR (10/13) 055 (a)** **SWBAR (10/13) 055 (b)**
Ms Mallinson advised that plans were in place to assume the responsibility for audit and business risk services by Baker Tilly from April 2014. The Committee was asked to note the suggested areas of support on offer from Baker-Tilly. The internal audit charter was considered, which it was highlighted provided an opportunity to develop a set of KPIs against which the delivery of services from Internal Audit could be monitored.	
9 Feedback from the Trust Board Committees	
Miss Dhami advised that there had been a decision taken not to include the minutes of the Board Committees as had been the tradition and that	

Minutes	Paper Reference
discussions would be held to agree the relationships between the Audit & Risk Management Committee and other Committees. Mrs Hunjan advised that there was a need to ensure that matters raised at the other Committees were fed into the discussions at the Audit Committee when necessary. It was suggested that the current Committee summary proforma should include matters to raise to the Audit & Risk Management Committee. Mrs Moore suggested by including the Board Committee chairs in the membership of the Audit & Risk Management Committee this was embracing the integrated governance agenda.	
9.1 Finance & Investment Committee	**SWBAR (10/13) 052**
The Committee was asked to receive and note the update from the meeting of the Finance & Investment Committee held on 20 September 2013.	
9.2 Quality & Safety Committee	**SWBAR (10/13) 053**
The Committee was asked to receive and note the update from the meeting of the Quality & Safety Committee held on 20 September 2013.	
9.3 Workforce & Organisational Development Committee	**SWBAR (10/13) 058**
The Committee was asked to receive and note the minutes from the meeting of the Workforce & Organisational Development Committee held on 29 July 2013.	
9.4 Charitable Funds Committee	**SWBAR (10/13) 054**
The Committee was asked to receive and note the update from the meeting of the Charitable Funds Committee held on 9 May 2013.	
10 Any Other Business	**Verbal**
Mrs Hunjan thanked those present for their input and attendance.	
11 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 30 January 2013 at 1400h in the Anne Gibson Boardroom, City Hospital	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Third update on Data Quality
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Toby Lewis, Chief Executive
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

The summary provides Board members with progress information on actions, which are being overseen by a small group of directors on a fortnightly basis. Two non-executive directors also attend that meeting.

It remains the case that I would expect us to complete our plan by 31 March 2014 albeit some actions are off track currently.

REPORT RECOMMENDATION:

The Board is invited to NOTE to report, which is primarily for information.

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	X	Workforce	

Comments:

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

None specifically

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Data Quality Improvement Update 3

Report to the Trust Board on 6 February 2014

Context

1. This is well known from prior meetings of the Board. We identified concerns, initially arising from 18-week issues in 2012-13. This concern was reflected in my statement of Internal Control, issued with the accounts for that year. The challenge was exemplified by subsequent issues with single sex, cancelled operations, and ED data. The Contract Query Notice served on the Trust in Q3 further emphasised the need for change. We agreed to a two-phase approach, which stabilised national indicator reporting, before systematically examining other key data flows.

Project control

2. The work is supported through the TSO and facilitated through a fortnightly group, which includes myself, the director of finance, COO, director of governance and IT director. Baker Tilly and the CCG attend. The meeting on February 4 is expected to endorse a single document Gantt charting our deliverables. This will be the basis for standard reporting over the next eight weeks.

Delivered

3. We have an agreed kite-marking model to underpin our reporting cycle from April. Over the next three weeks we will undertake an initial assessment of data quality for our KPIs. No other provider working to our CCG has any form of DQ metric in their Board visible reporting.
4. A standard set of data quality metrics at departmental level will commence tracking through the Operational Management Committee. This is intended to drive greater focus on front-line data entry to reduce duplicate note creation and missing NHS numbers, as well as delayed clinic cash up.
5. We have a single sign-off system in place for Unify returns through the COO. It is clear from the draft report on MSA misreporting that the sign off process is one that has in the past been too distributed.

In delivery

6. On time, we agreed an audit cycle for the CQC dataset, which is due its second national issue in early March. The audit is however presently delayed and we will discuss with BT on Tuesday 4th how that can be recovered.
7. We have a draft set of SOPs for all indicators bar the diagnostic wait. These are expected to be signed off when the DQ group next meets. They will then be

shared with the delivery chain for signed compliance statements from employees.

8. Audits are ongoing of cancelled operations, MSA, cancer waits and DTOCs. MRSA, c-diff and VTE are due in March. A full suite of audits will come therefore to the Audit and Risk Management Committee in April.
9. Revised information governance training will be implemented from early April in the Trust, with a parallel emphasis on data quality. This will provide general awareness, supported by the specific 18 week training rolled out in early 2013.
10. The Intensive Support Team are on-site with us, working on 18-week delivery to an agreed scope signed off by the COO.

In delay

11. Work is progressing with other parties to try and resolve two boundary issues:
    Creating a clear inter-organisational agreement in respect of cancer data flow. This impacts SWBH both as a tertiary provider and a secondary supplier. There is, to date, no evidence of delays in care, simply of unclear boundaries about counting.
    The Trust houses two GP urgent care services, which are under contract to the CCG. The services are not able to provide the CCG or us with the assurances we need about patient specific data. Discussions are now being handled directly by Andy Williams and Rachel Barlow. Resolution in February is essential.

12. I remain, a priori, concerned about our diagnostic wait data. The delivery system for these services is unavoidably spread Trust-wide and does not derive from a single computer system. Access policy rules about notice periods, DNA handling, triage categories, are susceptible to variability. Rachel Barlow will present a single access policy on these issues by February 14. This will then be distributed to teams, and audited for application from week beginning March 10. For us to be assured about 14-15 data it is essential that new habits commence from mid March, in so far as they need to.

What will be 'left' at April 1?

13. From the start of the new fiscal year we will be operating with:
    i. A single director signing unify returns, with line control over the information function, and a separate director providing independent DQ scrutiny of reports
    ii. A scorecard for data quality, and a kite-marked public Board reporting system – together with our High Vis approach to data inside SWBH
    iii. Written SOPs, supporting a revised access policy across all national indicators. Wherever feasible, for example on MSA, we are replacing paper returns with IT enabled returns.
    iv. Our standard mandatory training will cover data quality as well as information governance.
    v. A new internal audit function specifically tasked with providing insight for senior management into gaps and errors.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Proposed amendments to the Standing Financial Instructions, Standing Orders and Scheme of Delegation
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance & Performance Management
AUTHOR:	Simon Grainger-Lloyd, Trust Secretary
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

The Audit & Risk Management Committee at its meeting on 30 January 2014, received an amended version of the Trust's standing financial instructions, standing orders and scheme of delegation, which had been changed to reflect the new suite of Board Committees, the change in nomenclature of the Trust's major clinical areas from 'Divisions' to 'Groups' and the associated change of titles used for the members of the Groups' triumvirates.

The Committee supported the interim changes therefore the Board is asked to approve the same, with the intention that it receives a more comprehensively reviewed version later in the year.

A full copy of the amended standing financial instructions, standing orders and scheme of delegation is available from the Trust Secretary.

REPORT RECOMMENDATION:

The Board is asked to approve the interim changes to the standing financial instructions, standing orders and scheme of delegation.

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:

None specifically

PREVIOUS CONSIDERATION:

Audit & Risk Management Committee on 30 January 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	2014-15 patient experience plan (draft): Patients Know Best
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Linda Pascall, Deputy CNO [and others]
DATE OF MEETING:	6 February 2014

EXECUTIVE SUMMARY:

This short document proposes that ***our patient experience efforts should focus on living out our nine longstanding promises***. These embody great care. The plan proposes initial ideas on what actions or behaviours we need to take. The steering group recognise that these are too inpatient and adult focused presently, and we are using the 'Hot Topics' system in February to engage all employees in developing further ideas. This plan supports the Francis goals endorsed by the Trust Board at its December meeting. The financial impact is contained in annual plan.

REPORT RECOMMENDATION:

The Board is asked to comment on the direction of travel and highlight any specific pledges it wishes to see included. We expect to return to the Board quarterly with updates on delivery.

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Patient experience is one of the key quality dimensions which runs through the operation of the Trust

PREVIOUS CONSIDERATION:

Discussed in CLE and by all clinical groups through CLE sub-committee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Second draft

Patients Know Best

Our plan to improve patients' experiences of care in our system

Contents

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Introduction by our Chief Executive & Chairman

This plan is grounded in an important belief: That our patients know best. That does not suggest that they can advise on treatment choice nor are experts on service configuration. In different ways they buy that specialist skill from us. But they have knowledge that we do not, because they know themselves better than we can. They are witness to the healthcare we provide and participate in the care we propose.

Time and again, whether in national enquiries into error, or local evaluations of our incidents or complaints, it is evident that our patients tell us far more than we choose to hear. And that if we heard and acted on what we hear, we would provide better and safer services.

Our ability to hear and act is composed of three things:

1. The behaviour of individuals – the quality of our people.
2. The systematic way in which we make sure that what we hear is handed over from shift to shift, clinician to clinician, porter to nurse, therapist to pharmacist, trainee to GP – our quality of teamwork.
3. Our organisation has to learn from what works well and is appreciated by patients, as well as where we err, and need to do better – the quality of our culture.

This plan is about patient satisfaction. It does matter to us whether we meet expectation, made up of every single interaction and communication. Yet the plan is also part of our safety campaign. because there is not a single study of safety in healthcare published in any reputable journal that does not suggest that the patient's voice matters, and matters far more than we tend to assume.

We extend that idea to hear too the carer's voice and understand better the continuity of care offered by family and friends. That continuity is something we need in what we do, and as care delivery becomes sometimes fragmented we need to find new ways to create it.

As it happens, 'Patient Knows Best' is an IT system we are piloting in some of our specialties. We are keen to see if we can give data and knowledge back to the patient who gave it to us, rather than securing someone's case notes in our own password protected place. That idea, of course demands a paradigm shift in how the NHS works with patients. That shift is one that this plan will contribute to. If we all make sense of how we can contribute to delivering the ideas described within it. Some

parts of our Trust do this already and do it better than other parts. Our plan builds on that variation and seeks to reduce it massively. We want the best of SWBH now to be what we do consistently across SWBH in the near future.

At SWBH we are passionate about our services and care deeply about the quality of care our service users, their carer's and families receive. We know that we don't always get it right but it is our intention, with the help of this strategy, to implement a culture where we continually listen and learn from patient, staff and carer feedback so that we work together to achieve sustainable service improvement.

We recognise that staff are our biggest asset and in order to deliver a good patient experience, we need to ensure a good staff experience. We know that all staff whatever their role or position within the organisation have a responsibility to work within a way that ensures that 'the patients voice is heard at every level of the organisation.'

The patient experience and staff engagement is not an end in itself; it is a tool for delivering high quality patient centred services. We expect staff to let us know when they feel unable to do this, either due to personal circumstances, lack of resources or inadequate systems and processes.

1. Our Approach

In keeping with a simple philosophy that patients know best, our strategy is shaped around the 9 promises that every member of our organisation makes to patients in our care. Put simply, by working to keep our promises we will be doing the best we can to ensure the best experience possible. These promises were developed some time ago, and have the strong and evident support of both staff and patients. Our view is that re-describing the ambitions behind our promises would delay us – and the real task is consistent implementation.

In striving to provide excellence in patient and carer experiences the Trust will seek to benchmark its performance with other NHS organisations, aiming always to be amongst the best. To achieve excellence, the Trust will learn from best practice in health care or commercial organisations. Our formal response to the Francis enquiry sets out a series of ambitious goals both for our culture and for our patients. We want to achieve the best level of patient satisfaction of any provider of NHS care in the west midlands.

2. The Promises

1. I WILL make you feel welcome
2. I WILL make time to listen to you
3. I WILL be polite, courteous and respectful
4. I WILL keep you informed and explain what is happening
5. I WILL admit to mistakes and do all I can to put them right
6. I WILL value your point of view
7. I WILL be caring and kind
8. I WILL keep you involved
9. I WILL go the extra mile

3. The Importance of getting Patient Experience Right

We want to ensure patients and their carers receive the very best experience possible. This is important for several reasons:

It is everyone's constitutional right, as identified in the NHS constitution 2010
Good patient experience is definitely linked to better outcomes
It instils local and national confidence in the Trust, reinforcing our reputation as we move into new fields of care as an integrated provider
It will help to retain and recruit staff, as an organisation with a sense of wellbeing is a place people want to work in

The national agenda is focussed on improving patient and carer experience clearly identified by a number of recently published documents and guidance. The latter can be summarised thus:

Give patients, carers and colleagues the same respect you would want for yourself or a member of your family
Patients, their families and carers feeling informed, being involved and being given options
Staff who listen and spend time with their patient
Being treated as a person and not a number
The value of support services
Consistent efficient processes

We believe that delivering our promises 24/7 will deliver these recommendations

4. How do we know what patients think?

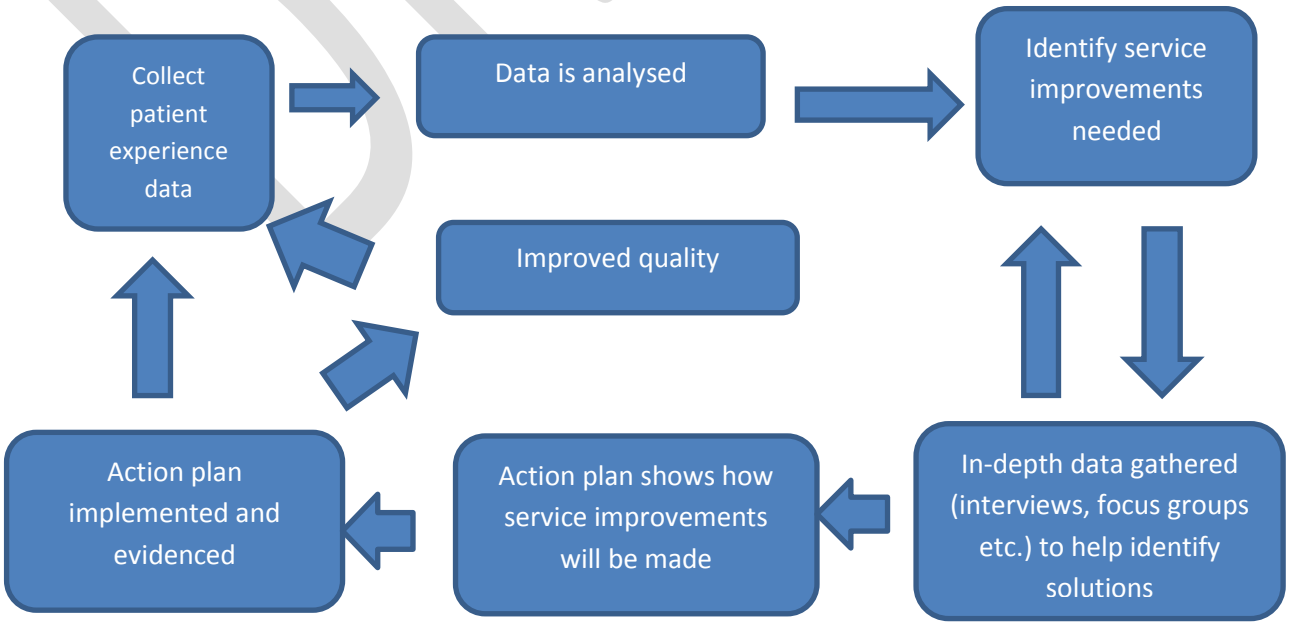
There are key factors to be taken into consideration in order to get the most meaningful patient experience 'data' – both quantitative and qualitative.

For example, we need to:

Ensure the data is service and locality specific
Collect it in 'real time' or 'near time' wherever possible
Make it an on-going basis as part of everyday service delivery
Select quantitative methods are used to identify themes and trends
Use qualitative methods for more in-depth research into patient experience
Be certain that the means of feedback are accessible to patients in terms of the method and language used
Make sure that data is shared with staff to help involve them in identifying solutions

Patient experience data needs to be analysed rigorously and the actions arising should be informed by other data, such as complaints, serious incidents and PALS and by staff feedback.

The Patient Experience Cycle:



Measuring progress towards excellent patient and carer experience

National surveys

The Trust regularly participates in national surveys:

- Annual inpatient survey
- Cancer patient survey
- Maternity services survey
- Children and Young People Survey
- Accident and Emergency Departments Surveys
- Experience of Neonatal care

The Trust benchmarks its performance against the top 20% of Trusts. Where performance has not reached the required standard improvement plans are agreed and monitored through our Clinical Groups and tracked in our new monthly Patient & Staff Experience Committee.

Patient Experience Trackers

Currently 'Meridian' real-time patient trackers and SMS system are used across the Trust in all adult inpatient clinical services, maternity and emergency departments. Language translations and pictorial easy read versions of the survey are also made available. Feedback from these surveys is used by wards and departments to monitor patient experience. Results are accessible through the Trust results portal and can be monitored by Senior Nurses, Managers and Executive Directors.

Results will inform the monthly performance scorecard, and will play a key role in the Autonomy and Accountability Framework, that we will use to determine the freedoms accrued by groups, directorates and wards.

Family and Friends Test (FFT) - Net Promoter Methodology

The Trust participates in the national Friends and Family test programme and has used the net promoter score generated by this to drive improvements in its services.

NHS Choices

NHS Choices website provides the Trust with valuable reflections from patients and their carers. These are used to provide feedback to clinical services whether positive or negative. The Trust also uses the comment section to ask contributors to make contact with the Trust so that concerns not raised elsewhere can be resolved wherever possible.

During the next two months, this portal and others, will feature on the Trust's intranet site front-page, and then our internet site as well, so that real-time patient opinion will be visible to everyone who works for us.

Complaints, Patient Advice and Liaison (PALS)

Complaints and concerns provide valuable feedback to the Trust about patient and carer experiences. Themes from complaints are triangulated with other sources of patient experience feedback. We have more to do to make that triangulation evident and visible.

Comment Cards

Comment cards are available throughout the Trust, and in 2014-16 will be especially important in supporting our Outpatient Change work.

Patient Stories

Every month a real life patient story is shared with Trust Board to accentuate good practice and learn from where we didn't meet expectations so we can put it right. The Board agreed earlier this year that by October 2015 story-telling needed to become an evident feature of other layers of the management system.

5. Changing the Culture

Life would be simple if all we needed to make this happen was to produce a list, but we recognise that it's not as simple as that.

To achieve what we want we need a culture that ensures patients are truly at the heart of all we do and that this becomes our norm i.e. 'the way we do things around here!'

This requires a number of changes in values, behaviour and culture within the organisation.

This requires:

- Raising staff awareness of their responsibility for ensuring that delivering a good experience is everyone's business
- Communicating a clear vision and understanding of the factors that impact on the patient experience
- Meeting patient's expectations and paying attention to detail
- Concentrating our efforts into turning potential damaging experiences into positive ones by using more local resolution of issues
- Ensuring that all staff are trained, confident and empowered to resolve problems immediately or escalate to the appropriate person as soon as possible
- Developing a culture of pride in the service delivered and in the staff who deliver it
- Developing a culture that does not accept poor communication and behaviour from any member of the organisation

If it easy to do the right thing, people will do. If it is noticed when we do the right thing, then that will send a reinforcing message. In modern healthcare we have lots of checklists and operating procedures. Most of the time following those norms will help deliver the best possible experience. Occasionally, we need to step outside those norms; to break the rules. That means we need a local culture of autonomy that stresses the right of everyone in our Trust to do the right thing.

6. How will we know Patient Knows Best is successful

There will be a range of measures identified later in the strategy, but essentially if we deliver on our promises what we should see is:

- Patients receiving treatment/services in a comfortable, caring and safe environment, delivered in a calm and reassuring way
- Having information to make choices, to feel confident and in control
- Being involved in discussions, listened to and being treated with honest, respect and dignity

As an organisation that places the patient at its centre, we want to be clear that we learn from the experiences and the received wisdom of others to continuously improve the care we provide. In December 2013

the Trust Board endorsed the following objectives distilled from the Robert Francis QC recommendations following investigations into serious deficits in care at Mid Staffs Hospitals.

Continuously improving the quality of care provided: our overarching aims

Creating the right culture with values that put patients first	Our patient promises are consistently delivered across all our services and our staff report that ours is a safe organisation in which they would choose to be treated, within a health and social care system that is integrated	**Getting fundamental standards right**	Through an accountability framework ensure fundamental standards are delivered in a standardised way, reducing variability in practice. Through a culture and behaviour which strives for best practice, service development improvement plans will be in place to ensure best practice.
Effective complaints handling	All feedback from patients, whether it is concerns voiced on the ward at the time, or complaints made once they are back home, will make a difference. These will be taken seriously and lessons learned.	**Medical education and training**	Hearing the voice of doctors in training at every level of the organisation for improving the learning from complaints and incidents, ensuring they have the knowledge, skills and attitudes that equip them as champions for safety throughout their career.
Openness, transparency and candour	Everyone working in the Trust will be honest, open and truthful in all their dealings with patients and the public. Organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	**Compassionate, caring and committed nursing**	Patients can be confident of receiving the highest quality, knowledge based care, delivered consistently with compassion by caring and competent nurses.
Caring for the elderly	A culture where older patients are valued and listened to and are treated with compassion, dignity and respect.	**Accurate, useful and relevant information**	Ensuring a culture where the quality of data is viewed as important by all staff providing as well as those using data with a known framework and assurance systems in place for delivering accuracy

A detailed action plan has been developed to deliver these objectives and they are reflected in the 9 promises.

7. What we aim to do – Our Promises in action – all the time

I will make you feel welcome

We intend to improve patient experience from first contact

How will we do this?

We will:

Greet patients with a smile and "good morning/afternoon" and remember to make eye contact – a smile is useless if you're looking away!
Take into account patient's needs, they may be hard of hearing or may not speak English

Let patients and carers know what will happen throughout their journey and have a named nurse/doctor as link for their care
Tell patients, their carer/family when they can expect to be discharged from hospital to enable them to make the necessary arrangements and give patients a copy of their discharge letter and letters to GPs

Recruit volunteers to work in ward/clinic areas, both supporting care and offering an independent view of how we are doing
Have floor-walkers in key parts of our buildings, who approach visitors and ask if they need any help

I will make time to listen to you

We intend to ensure that when we communicate with patients and their families/carer's that they are involved, informed and responded to.

How will we do this?

We will:

Provide one contact telephone number for patients to call the appointments team, as well as booths to provide video feedback on site
Provide interactive information on the Trust website about its services and how to access services or get advice

Engage with patients and carers when developing services so that their needs are taken into account
Ensure that patient/carers are aware of other healthcare services they can access

Give patients information about how to get to the hospitals and work with the county council and transport services to improve access to all Trust sites by public transport

Introduce on-site hotline phone services so that patients or their relatives can raise concerns during their time with us. This would trigger an immediate graded response.

I will keep you involved

We will improve communication with patients

How will we do this?

We will:

Provide information for patients and users in different formats to meet their needs, for example easy read versions or large print

Provide more patient information on the Trust website, and in various formats within our sites

Give patients/users information about ward or department routines, and give them a mechanism to work differently with those if those routines do not suit their needs

Make sure hospital signage provides easy way-finding for patients and visitors

Answer all phone calls within thirty seconds and provide a back-up systems if no-one gets back to you

Make sure that patients are given information about the side effects of their medication before they leave the hospital, clinic or pharmacy

Use the 'You said – We did' posters to communicate to patients and visitors what actions have been taken as a result of patient experience feedback

Ensure all appraisals seek positive evidence of excellence in 'customer care' as a pre-requisite to higher levels of assessment

I will be caring and kind

Patient's physical comfort needs will be met

How will we do this?

We will

Deliver timely inpatient care, meeting our core standards ten times out of ten

Make sure that patients feel that staff have done all they can to help control pain

Provide patients with good food and nutrition

Provide and promote information about, and access to different forms of spiritual or pastoral support and the chaplaincy team

Make sure that there is someone available to talk to patients, their carer's or family should they have any worries or fears

Work with the voluntary sector to provide additional access to emotional support for patients and their carers as appropriate

I will be polite, courteous and respectful

We will:

Respect the needs of patients and recognise their individuality

How will we do this?

We will:

Use the basic form ‘hello, my name is xxxx’ consistently Trustwide

Ask patients how they wish to be addressed and use this

Ensure that privacy and dignity is considered at all times, and in particular when discussing condition or treatment

Respect and recognise the cultural, religious or diversity needs of patients

Ask patients or carer’s about specific needs or disability so that reasonable adjustments can be made

I will keep you informed and explain what is happening

We will improve engagement of patients and carers

How will we do this?

We will:

Involve patients, as much as they want to be, in decisions about their care and treatment

Engage with, and involve, the diverse community of users of Trust services when developing services or facilities so that service developments are informed by and respond to patient feedback

Use patient experience boards, the website and ‘You said – We did’ posters to communicate actions taken as a result of feedback from users.

Provide information and discuss end of life care with patients and their families as necessary and involve them in decisions about a preferred place to die

I will admit to mistakes and do all I can to put them right

How will we do this?

We will:

Say sorry when we have, might have, or are perceived to have, provided sub-optimal care. This will involve acting on behalf of the

Trust as a whole, and taking responsibility for the sum of all our efforts.

Develop 'being open' advocates throughout the Trust who would be able to support staff with talking to patients and relatives when needed to ensure we are consistent, open and supportive across the whole organisation, recognising it takes courage and staff may need support

Develop leaflets i.e. SAFE IN OUR CARE/information across a number of mediums to set the expectations, make them aware that we realise mistakes happen but we do not try to cover them up an do learn from them, encourage patients and carers to ask for information and to know that we will keep them informed of all events good and bad in an open and honest way

Develop a reflection of 'The last 24 hours' at handover/boardround where information about incidents/mistakes/good practice are highlighted and shared with the MDT again, promoting, developing and enhancing the blame free culture so it doesn't just become a nursing specific programme

Daily conversation with patients on the ward, the nurse in charge/matron would speak to each patient and/or their carers seeking out concerns and updating 'the last 24 hours' ensuring that information good and bad is proactively shared and admitted openly

Close loop in complaints procedure routinely follow up every complaint with a telephone call/written to assess if people are satisfied with the complaint handling

I will value your point of view

How will we do this?

We will:

Engage with patients and carer's when developing services so that their needs are taken into account
Tell patients and carer's what they can expect to happen along a patient pathway, especially in an outpatient setting

Make sure patients and carers have understood what we have said to them

Listen to patients and answer their questions in a way they can understand

I will go the extra mile

How will we do this?

We will:

Assist patients when they telephone through the wrong department in error i.e. establishing which specialty/clinic they require and putting them through to that extension rather than passing them around

Employees will be supported to volunteer to continue working after their shift ends to finish caring for a dying patient and family. Likewise a midwife volunteering to remain on shift to conclude the delivery of a mother she/he has been caring for.

Allow a patient, newly returned from theatre to speak to a close relative (who was desperately worried about them) on the hospital phone to reassure them that he was ok

Spend time with patients, explaining the reasons for the hospital processes that affect them and which they may not necessarily understand i.e. visiting hours and no visiting at lunch time

Thinking holistically about the patient's needs i.e. making sure they have the necessary items for self-care without having to be asked i.e. toothbrush, slippers etc.

Volunteer to direct or personally escort patients/visitors to their destination when they are struggling to find the department they need

Support visitors accompanied by young babies, by offering them a private space to breast feed, heated baby milk and/or baby food, checking they have sufficient nappies etc. without having to be asked

Be willing to 'bend the rules' when necessary (i.e. allowing visitors to come onto a ward outside of visiting hours i.e. when very elderly and have to arrive on public transport and can't time their arrival)

Acknowledge patients that you know when you see them sitting in an out-patient queue and offering to find out how long they will have to wait

Wash out soiled laundry items for patients to prevent them from having to use hospital gowns (which no-one likes having to wear)

How will we know if we are succeeding?

We will not know if we are succeeding by tracking many more things and auditing routinely. Instead, we will focus on capturing on what patients think: At every contact, in every department. That data will be shared and will be visible. It will be used to understand better what works. And to promote, reward and invest in those teams who are succeeding in getting the highest levels of patient satisfaction.

The data will be mined to understand equality and access issues. And to ensure suitable focus on care of those who are dying with our support either at home or on a ward.

We will also ask patients to name and nominate staff, who have helped them. And ask staff to highlight exceptional practice. This will drive a culture of saying 'thank you', as well as creating chances to learn.

Patient support groups, including Healthwatch, will be asked to conduct feedback visits. This will give us an independent eye on how we are doing.

We will maintain our current programme of Board walkabout visits. We intend to introduce mock CQC style visit teams in Q1 2014-15 and 'meetings free days' in which all senior managers are expected to spend time in patient-facing services, either helping with care or listening to patients.

In summary though, this is a not a plan to create a scorecard that is 'sometimes amber-green'. This is a campaign where success will be judged by what people feel about us and say about us. At a macro-level we want a 25% improvement in satisfaction with what we do, without losing the support of those who already support our success. We cannot do that if poor experiences occur, without apology and without learning. Every service is as strong as the poorest moment in someone's care; be it before getting to hospital, in waiting for a health visitor to come or in trying to get through on the phone. Patients know best can only work in a Trust where everyone matters.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Draft Medical Education Strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Steadman (Medical Director) and Mike Sharon (Director of Strategy & OD)**
AUTHOR:	**Deva Situnayake (Associate Medical Director)**
DATE OF MEETING:	**6 February 2014**

EXECUTIVE SUMMARY:

This draft document is a component of the Trust's emerging Education strategy. It is brought to the Board at this stage to allow a specific discussion of a significant component of our Educational effort and because there are changes in the national and local arrangements for delivery and funding of medical education that merit discussion.

The paper sets out the current processes and structures that the Trust has developed and put in place and proposed further actions to support the delivery of high quality undergraduate and postgraduate medical education and training.

REPORT RECOMMENDATION:

The Board is requested to discuss the proposed strategy.

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Delivery of high quality medical education supports the delivery of high quality care and effective use of resources

PREVIOUS CONSIDERATION:

None

Medical Education Strategy
SWBHT

2014 – 2017

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1.0 Executive summary

1.1 This document sets out first to describe the current processes and structures that the Trust has developed and put in place to support the delivery of high quality undergraduate and postgraduate education and training.

1.2 The National and local strategic context is considered driven by the following factors; Health Education England, the developing local relationships including the Aston University International Medical School concept and potentially Aston Health Partners, the emergent autonomy and accountability framework, the developing educational governance process and the arrangements for delivery and quality assurance.

1.3 These local and National drivers provide the rationale for some important proposals for change in our Education strategy that should provide the basis for discussion at Clinical Leadership Executive and the Trust Board.

2.0 Introduction

2.1 Within an acute hospital setting as individuals move from learner to practitioner the separation between undergraduate and postgraduate medical education becomes artificial. Our goal for both undergraduate and postgraduate medical and nursing training must be to equip individuals with the necessary skills and habits to participate in the delivery of high quality and reliable healthcare in the future. Increasingly this will require a reliance on high performance teamwork and the skills to participate effectively in a continuous quality improvement process.

2.2 At both undergraduate and postgraduate level the acquisition of explicit core competencies, both personal, technical, knowledge and skill based will be required. These competencies have been defined in 'tomorrows doctors' (http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors.asp - skiptoNav) and the 5 domains of the Medical Leadership Competency Framework (http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf.)

2.3 As they progress through our hospital system it is our goal to connect individual students and doctors with the right learning opportunities and teachers (including state of the art training facilities) to continuously develop these capabilities such that they are fit for

practice and for purpose as an effective healthcare practitioner and will meet the needs of future healthcare system providers.

2.4 Our final goal is to ensure that the organisation has systems in place to continuously appraise and assure the quality of its education, its teachers and trainers so that the considerable resources invested by the Trust, University and Local Education and Training Board are used and managed effectively.

3.0 Strategic context

3.1 There are a number of significant strategic factors at both National and local level that need to be addressed in a review of the Trusts Education strategy. This will ensure that the Trust can effectively meet the standards identified for an effective education and service provider, whilst delivering the capacity required for our local context in undergraduate and postgraduate training. These include;

3.2 National / Regional

Health Education England and LETB high level goals

Preparing for expansion of GP training and a reduction in specialist trainees
The potential Introduction of National Licensing exams for undergraduates
A changing workforce strategy including a potential expansion of Physicians associates and enhanced nursing roles driven by a need to reconcile the competing demands of capacity, cost and anticipated changes in future workforce
A requirement for enhanced Quality Assurance and VFM for both undergraduate and postgraduate education and training programmes
The shape of training report and implications

3.3 Local

A need to ensure the efficient and cost effective use of our educational resources through the delivery of education as a service line (including those resources identified within the job plans of our consultant clinical teachers)

The potential challenge to educational capacity, quality assurance and governance posed by the Trusts developing relationship with Aston University and the International Medical School concept (a potential intake of an additional 40 - 50 international medical students

per year from 2018) including aspects that relate to widening of participation in health and the prevention agenda through links with our local community and schools.

Delivering an effective leadership programme to support workforce, education and leadership development which is team based, inclusive and where appropriate integrates our offering for our students, trainees, nursing and paramedical, consultant and management staff.

4.0 National framework for Medical Education

4.1 Health Education England (HEE) oversees postgraduate and undergraduate training in England. HEE will be the legal entity that hosts LETBs (Local education training boards.) The role of HEE will be to focus on what needs to be delivered and agree national objectives, overseeing the planning and development of the healthcare and public health workforce. LETB's will focus on how this will be delivered.

4.2 HEE overarching aim is to ensure the health workforce has the skills, behaviours and training, available in the right numbers, to support the delivery of excellent healthcare and health improvement

4.3 The national functions of HEE include:

Providing national leadership on planning the healthcare and public health workforce
Appointing and supporting the development of LETBs
Promoting high quality education and training that is responsive to the changing needs of patients and local communities, including responsibility for ensuring the effective delivery of important national functions such as medical trainee recruitment
Allocating and accounting for NHS education and training resources and the outcomes achieved.
Ensuring security of supply of the health and public workforce.

5.0 Local framework for Medical Education:

5.1 LETBs are provider led providing greater accountability for all providers to plan and develop their workforce, professionally informed and underpinned by strong academic links, and being responsive to the needs of patients and the public.

Objectives of LETBs will be:
Security of supply – ensuring people with the right skills are in the right place at the right time.
Responsiveness to patient need and changing service models.
High quality education and training that supports safe, high quality care and greater flexibility
Value for money.
Widening participation amongst our local schools and educational institutions.
The LETB will engage with the Trust on workforce planning, education and training and our educational management structure needs to support this process.

6.0 Framework within SWBHT (Organisational roles and responsibilities)

6.1 Current Arrangement:

6.2 Head of Academy and deputy: Oversee and coordinate undergraduate education. They are jointly accountable to the Birmingham Medical School and the Trust currently through the Associate Medical Director and Medical Director.

6.3 Postgraduate Clinical Tutors: 2 Tutors who oversee and coordinate postgraduate education. They are currently jointly accountable to the Health Education West Midlands (HEWM, formerly West Midlands Deanery) and the Trust through one of the Associate Medical Directors and Medical Director. They are all extensively supported by Management and Administrative Teams at the Education Centres at the both sites.

6.4 College Tutors (within each specialty): Oversee and coordinate speciality training. They are accountable to the Royal Colleges, to HEWM and to the Trust (through Heads of School, the Postgraduate Clinical Tutors and their own Group Directors)

6.5 Educational Supervisors: Responsible for overseeing individual trainees' education and development. They are accountable to the College Tutor and / or Postgraduate Clinical Tutor.

6.6 Clinical Supervisors: Every trainee is assigned a clinical supervisor who oversees the trainee's clinical work. They should be readily available, frequently observe the trainee, teach on the job with developmental conversations, provide regular feedback and provide rapid response to issues as they arise.

6.7 Senior Academy Teacher (Clinical Lead) for undergraduate teaching attached to each clinical directorate who is responsible for overseeing the teaching programmes for each of the three clinical years in those specialities, this allows vertical integration of teaching within each directorate to maximise learning opportunities for students with least interruption to provision of clinical care

6.8 Senior Academy Tutors allocated to each firm of year 3 and year 4 students to allow assessment of student progress through their learning objectives and provide continuity during their time on placement, which can be in many different clinical areas.

6.9 Academy Teachers (other consultant teachers) provide teaching within tutorials but also within their normal clinical environment. The balance of teaching in year 3 is mainly tutorial and ward based, in year 4 the students are more integrated within the clinical service (clinics and theatre) and year 5 will focus the students much more on acquiring the skills required to undertake the role of a foundation 1 doctor.

The University of Birmingham has a well developed, structured undergraduate curriculum that has recently been refreshed.

7.0 Integration of Medical Education in Trust governance structure

7.1 Currently Medical Education reports to the Trust's Clinical Leadership Executive through its education sub-committee. A bi-annual has traditionally been provided to the Trust Board

7.2 In order to ensure that Medical Education is delivered to a high Quality and within a framework of Patient Safety, it is essential that the organisation and delivery of medical education is embedded within the Trust's Vision and Governance structures including:

The Trust's 3-5 year strategy (including engagement with the Aston International Medical School and Aston Health Partners concept)
The Trust's 5 priorities
Right Care, Right Here (including the support for increasing numbers of medical students and Trainees in the community)
The evolution of the Trust's Transformation Plan
The evolution of the Trust's Reconfiguration Plans
Student and Trainee involvement in leadership development,Audit and understanding of Incident Reporting

7.3 For these reasons it is recommended that;

The inclusion of education (and research) should become core business for the specialities, directorates and groups.
Quality and delivery of the educational domain should become a key component in the emerging Autonomy and Accountability framework.
Educational representation at undergraduate and postgraduate level should be incorporated into the key business of the directorates and clinical groups
Education should remain a key agenda item of the Trust's Clinical Leadership Executive, reporting to Trust Board

8.0 Medical education structure

8.1 Appendix 1 describes the current structure for Medical Education with the Trust's Medical Education committee reporting to the Clinical Leadership Executive. With the potential to develop Medical Education as a 'service line', the attendance at Clinical Leadership Executive would become both mandatory and necessary.

8.2 Through this structure all Undergraduate and Postgraduate education and training should be delivered in accordance with the GMC guide: Tomorrows Doctors 2009 and the GMC: Good medical Practice 2013.
It should address the various aspects of training such as:
Patient Safety
Quality assurance, review and evaluation
Equality, Diversity and Opportunity

Design and delivery of the curriculum (including potentially addressing the planning, capacity and potential differences in emphasis and phasing between Birmingham and Aston Medical schools)
Support and development of students, teachers and local faculty
Educational resources and capacity (including the modelling and building of hospital and community capacity for teaching and support)

9.0 Delivery of UG training programmes

9.1 The Trust hosts students from the University of Birmingham Medical School covering all three of their clinical years of training (Years 3, 4 and 5). The Trust has a long-standing high reputation for the quality of teaching delivered to these students and this may in part contribute to the popularity of the applications for the foundation training posts. Although there used to be separate teaching programmes at Sandwell and City sites, through the introduction of a single teaching academy at the Trust and service reconfiguration, most teaching programmes are now integrated for all years across both sites. This change has progressed in parallel with the University 2014 curriculum review which has seen a change in teaching programmes for year 3 (introduced 2011) year 4 (introduced 2012) and year 5 (introduced August 2013). These changes have not seen any reduction in the number of students offered placement at SWBHT but have required an innovative approach to teaching delivery to be taken.

9.2 The current student provision in the Trust (5599 student weeks per year - equivalent to about 180 students present at any one time during September through to April for all years) generates a SIFT income of just under £4,000,000.

9.3 As a local and major player with established track record in delivery of high quality undergraduate and postgraduate medical education it has also been proposed that SWBHT / MMH become a lead strategic partner in a new 'Aston International Medical School concept. This initiative, which aims to recruit the first clinical students in 2018. is based on attracting students from all over the world with a target number of 100 per intake (including 20 subsidized places), recruiting the first graduates in 2016 with subsequent clinical curriculum delivery by 2018. The non sponsored students would either be full fee paying international students or UK students who would also pay the full 'international' fees (ratio 70:30). If supported this would result in an additional cohort of between 30-50 medical students engaging with their teaching and learning within the Trust in parallel with those from the University of Birmingham.

10.0 Delivery of PG training programmes

10.1 The total number of postgraduate trainees at the trust are currently 394 and these are supported by 2 clinical tutors, 18 specialty college tutors and approximately 200 educational supervisors. The roles are recognised within the consultant job plans with the role of clinical tutors receiving 2-2.5PAs, College Tutors 0.5 – 1.0 PAs and Educational supervisors 0.25 – 0.5 PAs

10.2 Training programmes should include:

Induction: This will include Deanery e-induction, Corporate / Trust induction and Specialty / local induction

Compliance with mandatory training: In addition to the training covered in the deanery e-induction, additional areas should be assessed for compliance: Safe guarding, Harassment and Bullying, Information Governance and Conflict resolution, Equality and Diversity.

Structured programmes to ensure competence in foundation (Yr 1 and 2) and at the specialty level.

Appropriately trained educational and clinical supervisors (in line with the recently published GMC Accreditation of Trainers) with formal recognition and remuneration for their roles according to the trust Job Planning policy and managed through effective annual appraisal and job planning systems built within the current PReP system for appraisal.

Support made available to trainers through job planning to enable them to fulfil other aspects of their training roles such as assisting with college examinations and deanery / trust led interviews.

Clear and robust systems in place to support 'doctors in difficulty'

11.0 Quality assurance of training programmes

11.1 Quality assurance of the undergraduate programme

Changes in the curriculum and its method of delivery in the Trust are communicated to Academy staff via a 3 monthly Academy committee meeting with regular email updates from the HoA to Senior Academy Tutors. The latter meet regularly with their student group to identify any concerns in progress through their learning outcomes, allowing early identification in any areas of concern in the programme delivery at the Trust.

11.2 There are several mechanisms in place for assessment of the quality of the UG programme.

The College of Medical and Dental Sciences undertake a 3 year Quality Assurance Assessment visit (QAA) of the teaching delivered at all parent Teaching Academies. This involves a review of all programmes delivered in the Trust, interviews with the Head of Academy, administrative staff, Senior Academy Tutors and Teachers, students and hospital management. The report of the visit highlights areas of good practice, areas where improvement can be made and any risk to patient care identified.

The HoA has an annual meeting with the vice-Dean of Medical Education at the College, which involves presentation of the risk register for teaching at the Trust.

Student evaluation at the end of each placement in the form of College collated reports from students is sent to the HoA who reviews all areas of good practice and concern in any of the teaching areas. The latter are addressed through the senior Academy Teachers of the clinical area of concern and this evaluation is disseminated to all relevant teachers.

The Academy administrative team, including Clinical Teaching Fellows, meet monthly to review progress of the teaching programmes, while the year 3 student firm leads have 4 weekly meetings with the HoA during their placement to identify areas of concern in the programme.

11.3 Quality assurance of the postgraduate programme

The process for the Quality assurance of Post Graduate training programmes is innovative and based on a rolling programme of ‘Local ‘RAG’ interviews with college tutors with input from Associate MD, Clinical Tutors and College Tutors (see Appendix 2: Trust’s Internal Reporting Mechanisms following QA Visits). Through this process each speciality area is assessed against the GMCs core domains for quality and a comprehensive appraisal of the educational ‘hotspots’ is derived with oversight of key actions.

11.4 A suite of Tools is required for effective quality assurance:

Appraisal / Revalidation feedback focused on Educational competencies.
JEST feedback from individual student placements.
Annual GMC trainee and Trainers survey results.
Database of education personnel qualifications.
Ensuring TTT, E&D and Appraisal databases are compliant with current GMC requirements – Mechanisms introduced to support the collection of this data through the Trusts PReP system for appraisal and revalidation to enable monitoring.
Annual RAG reviews with college and speciality leads, assessing performance of speciality leads against GMC domains for their speciality
Deanery QA Review visits.
Biannual LEP report submission to Health Education West Midland

12.0 Funding streams for medical education

12.1 Current funding streams for medical education include, MADEL and SIFT. The SIFT income of just under £4,000,000 is embedded within the Trust. The MADEL budget is £11.4 Million. These budgets are not currently ring-fenced and there is lack of clarity in how funds are matched to educational provision – this is typically true across the NHS, but we aim to achieve better than that.

12.2 Two goals have been defined for the future;

Achieving a clear and transparent reporting system, required to ensure that sufficient funding is available to support, develop and deliver quality education.

An effective process is required to identify time allocated to teaching and training linked to defined programmed activities (PA's) within consultant job plans

12.3 Both of these goals could be facilitated through the recognition of the education domain as a 'service line' in the Trust's emerging service line management structure.

13.0 Current Strengths

13.1 Undergraduate: To continue to provide high quality teaching in a rapidly changing clinical environment we have looked at ways to support traditional ward based teaching. This has been achieved through the development of simulation programmes primarily for year 3 students. This allows them to see the whole patient pathway with teaching provided in a controlled environment (currently ward D47 Sheldon Block). We have also developed a new programme of clinical examination skills teaching which has ensured a consistent approach to basic clinical skills for all students. These approaches have been acknowledged and commended by the students and University.

13.2 Undergraduate teaching has been further supported by the development of 4 Clinical Teaching Fellows (CT2 grade) posts along with an F2 post to support ward based and simulation based teaching.

13.3 If the development of the Aston International Medical School proceeds it will require the building of capacity to support additional student numbers. Through examination of the developing curricula and its phasing it will be necessary to build capacity in all aspects of the undergraduate teaching programme to support both Birmingham and Aston Students. Ideally this should be delivered in an integrated way without compromising the experience of either group.

13.4 Delivering the capacity for enhanced medical student teaching will also require access to patients in all locations of care. Provision will need to be aligned to the shifting locations and systems of delivery for acute and chronic care.

13.5 Teaching will need to adapt and become integrated in these new patterns of service delivery;

'One stop', solution shop approaches to out patient care
specialised services
'Integrated and community based systems' for chronic care and LTC management
24/7 and 7 day delivery of acute care, increasingly adopting a 'single site' pattern across our Acute care facilities.

13.6 Postgraduate: The Trust has a track record of excellence in postgraduate education delivery which includes;

An excellent reputation for post graduate education as one of the most popular destinations for foundation training.
An engaged and supportive consultant body which in the large part is enthusiastic about Teaching and Training and supportive of the Education Centres.
A robust support process for doctors in difficulty, including excellent collaboration between Medical Staffing, Occupational Health and the Clinical Tutors – who meet regularly to discuss any doctors in difficulty.
A strong Educational administrative support team on both sites.
Close collaboration between the 2 Clinical Tutors with consolidation of roles.
The Development and delivery of multidisciplinary simulation (incorporating human factors training) in the trust incorporating a new simulation suite.
A strong Foundation trainee screening process whereby all incoming F1 Trainees are 'interviewed' 3-4 months before commencing employment in order to ensure base competency levels are met.

14.0 Future Challenges

14.1 Undergraduate training:

The main weaknesses revolve around competing pressures on clinical staff for providing clinical care against honouring teaching commitments in tutorials or being able to effectively engage students in clinics whilst continuing to provide high quality clinical care to the patients.

The complexity of the teaching programmes, at times require students to gain clinical experience on different sites as a consequence of service redesign across our two sites. Maintaining contact with their Senior Academy Tutors can present challenges.

Likely changes in SIFT funding (which will change to funding based on placement number of students rather than a combination of placement number and historical fee for facilities) should lead to an overall increase in income to the Trust as long as student numbers can be maintained.

The challenges to governance, capacity, quality and operational delivery associated with delivery of the undergraduate curriculum from 2018 for students enrolled in The Aston International Medical School should it be supported.

Failure to continue to provide high quality undergraduate education is likely to lead to a reduction in quality of applicants to undertake foundation training posts at SWBHT with a potential fall in quality of care.

Changes to clinical service that do not align with the requirement for delivery of undergraduate education programmes or with inadequate investment will lead to reductions in student numbers as it will not be possible to continue to provide teaching to the current number of students without investment in facilities and staff to support teaching. This will lead to a fall in income equivalent to £34,000 per student per year allocated to the Trust.

Too much emphasis on clinical activities within job planning and not enough time within SPA time for Academy Teachers to either have students within clinic or attend lists, or have time to provide tutorials, will lead to a reduction in quality of teaching and ultimately a fall in student numbers. The increased requirement for examination to be conducted on Trust site and an increase in the number of stations per exam will also be a challenge to provide for if there is not flexibility within job plans and also willingness from colleagues to be involved.

The challenge posed by reducing number of acute beds, the changing nature of the in-patient population (increasingly complex cases) will require a shift from traditional models of learning toward an increased capacity in simulation and planned educational interventions

14.2 Post Graduate Training:

The impact of **Service Reconfiguration** and redesign on (particularly daytime) training and educational opportunities within specialities and clinical teams.

In recent years there have been reconfigurations in Surgery, T&O, O&G, Paediatrics / Neonatology and Stroke Medicine. These have posed considerable challenges in order to ensure (a) that service delivery by Trainees is maintained at both sites (e.g., on-call rotas) and (b) Training opportunities are not limited for Trainees who principally work on one or other site.

The impact of **consolidation of specialised services** on the Trust's portfolio of training opportunities (for example the movement of Vascular Surgery services to UHB in 2012).

The impact of a **shift in outpatient provision to community settings:** this has not happened to date on a major scale but has taken place in some specialties, e.g., Diabetes; this will have an impact on the provision of training to Trainees who have traditionally been hospital-based.

Workforce implications (including financial constraints within the health service):There have been **reductions in the number of Training posts** in recent years and this is likely to continue, most particularly in Surgery (especially T&O) which can have implications on Service delivery (maintenance of rotas) and therefore Training opportunities.

'Vacant' posts at Consultant and Middle Grade level, e.g., in recent years at SWBH in Radiology, Cardiology, Emergency and Acute Medicine: this has significant implications in terms of workload for the smaller number of Trainees in posts and Training provision by the smaller than planned numbers of Consultants (can result in lower levels of engagement / enthusiasm).

'Vacant' posts in the Education Centres

U**ncertainty about future Funding streams** for postgraduate education (MADEL)

Delivering **Trainee revalidation** (a major administrative exercise).

Achieving the requirements for the **GMC Accreditation of trainers** to ensure consistent quality of supervision (another major administrative exercise).

15.0 Supporting Structure(s)

Medical education manager

15.1 To support the Clinical Tutors and Undergraduate Academy in translating the strategy from Health Education West Midlands by developing, managing and delivering a range of high quality and cost effective educational services within the Trust to specifications required by Health Education West Midlands, associated Medical Schools and the Trust's strategic and operational framework.

This will include management responsibility for monitoring performance and achieving targets set for service delivery for Medical Education.

To analyse and evaluate activity and performance in order to continually improve the quality of Medical Education in all service areas.
Influence the Trust's service developments by ensuring that Medical Education is considered in relation to directorate, corporate, regional and national projects.
Will have strategic and management responsibility for both staff and facilities in the Medical Education Centre.
Uphold the Trust's commitment to deliver safe, high quality care and an excellent patient experience through utilising best people management practice. .

15.2 Administrative support – there should be a planned review of administration support and the skill mix of posts allocated to support both the delivery of educational programmes and examinations

15.2 Clinical – there should be clinical support ie nursing / PAMs to ensure appropriate and relevant support is available in regard to the delivery of clinical educational programmes and undergrad/postgraduate examinations

15.3 Accommodation – there should be regular review against agreed benchmarks to ensure adequate and appropriate facilities are provided to house both the administrative Team and provide relevant teaching space in which to deliver both postgraduate and undergraduate training, including lectures, small group teaching and clinical skills training, together with the ability to develop and deliver simulation training

15.4 IT – the capability of future IT systems including business intelligence software, electronic medical records systems and in house IT support should include an assessment of capability to deliver in the educational domain

16.0 Future proposals for medical education

16.1 The preparation of a Medical Education strategy has presented an opportunity for discussion and debate around the strategic, operational, governance and business aspects of what is a core and valued activity within the Trust.

16.2 The current document should enable a thorough appraisal of the Trusts fitness for purpose in delivering in this domain as we move forward with the challenges that face the health service locally and nationally. Education should now be seen as a core element of the emerging autonomy and accountability framework within directorates and clinical groups.

16.3 Medical Education should be seen as one 'chapter' in a book that describes the Trusts approach to education, learning and development and should integrate with those for leadership development, nursing, management and professions allied to medicine. Economies of scale and improvements in culture can come from a move toward a less 'siloist' approach to Education in general.

16.4 The Trust should consider Introducing the role of Director of Medical Education with overall responsibility for Undergraduate and Postgraduate Medical Education. From a Postgraduate perspective this person could be supported by a Tutor responsible exclusively for Foundation Trainees (who in turn has administrative and managerial support) and a Tutor responsible for Specialty Trainees (with similar administrative and managerial support). The two Tutors would be separately responsible for the organisation and delivery of Education and Training, the QA processes (including Deanery Visits) for Foundation / Specialty Trainees respectively.

16.5 The Trust should consider defining medical education as a service line so as to facilitate the work required with directorates and divisions to match the delivery of educational capacity and resource against demand within the agreed resources.

16.6 Trust should prioritise the development of specialty faculty groups consisting of educational supervisors. Faculty groups would be responsible for

- Supporting educational and clinical supervisors
- Monitoring performance of trainees within their specialty
- Providing feedback to supervisors on the performance of their trainees
- Partake in the annual review of competency progression (ARCP) assessment.
- Monitoring quality assurance processes within their specialty.

Faculty groups would be chaired by the college tutor and report to the clinical tutors.

16.7 The Identification within job planning of time for clinical staff to undertake and develop their roles and capabilities as Senior Academy Tutors and Teachers is important. This will develop our capacity for the level of student support that is required in future and provide the time for staff to develop and provide clinical teaching in innovative ways.

16.8 The Trust should use the Learning and Education Committee of CLE to oversee thecurrent RAG reporting process as a starting point.

16.9 The Trust should explore the use of technology to support its Educational Facilities including use of hardware such as i-pads, establishing an e-learning library of teaching

sessions delivered and video conferencing facilities, widening access to these e- resources. This could potentially link to developments with Aston University and the Trusts widening participation programme with local schools and colleges.

16.10 The Trust should maintain and commit investment to the further development of simulation based programmes for clinical examination skills, patient pathways and for the management of common acute presentations thus permitting models of teaching to align with future service needs and the delivery of reliable healthcare to mitigate the effects of service reconfiguration and the shift of care to community settings

16.11 The changes in the undergraduate curriculum and the health service provide an opportunity to review the provision of undergraduate teaching. This is particularly to bring teaching in-line with the requirements of foundation doctor training and guidance set out in the GMC publication Tomorrows Doctors 2009. The Academy has already integrated year 4 into a single cohort of students working across both sites. The new year 5 programme was introduced in July 2013 and the paediatrics and O&G course components are already integrated with the clinical service.

16.12 The placement of year 5 students (48 in total for 2 x 15 week placements) will also require an integrated programme across the acute care specialties which maps to the learning outcomes now focussed on acute presentations that they will meet as foundation doctors. Our experience in simulation training, development of foundation simulation facilities and requirement of the GMC to increase simulation and team based training provide the ideal opportunity for us to integrate simulation scenarios within the clinical placement programme. This is currently being developed and will enhance the clinical placement components of the programme. Such a focus will better prepare the students for life as an FY1 doctor. Developing capacity in this way will also support planning for a potential increase In student numbers with Aston International Medical School

16,13 Whilst the decision to support the Aston International Medical School concept will be made elsewhere it should be noted that building and strengthening academic links with Aston, supported by investment in teaching and research posts would enable the Trust to develop our strengths in basic and clinical science through joint academic appointments and would potentially provide strength to Birmingham in areas that have traditionally been weaker, also enabling recruitment of higher calibre teaching and research fellows.

16.14 Associated links to Aston Business School and facilities could also provide the Trust and its student, leadership and management community with a defined ‘leadership brand’ and access to knowledge and skills transfer in order to build our capability in leadership.

16.15 Opportunities might also emerge for capital investment in building stock to support educational and research facilities, leveraging the opportunities and challenges in the MMH design brief. The retention of the education building at Sandwell is understood to provide the intended hub of our offer.

16.16 From a Postgraduate perspective the Trust should support the development **of Faculty Groups** to support Clinical and College Tutors in areas such as preparation of Teaching Programmes, involvement in Validation and Assessment of Trainees (ARCP), contribution to Internal Quality Assurance processes, etc.

16.17 The synergies and interrelationships with nurse training and development, access to simulation training and support infrastructure will require further discussion as future models for healthcare provision increasingly blur the boundaries between medical and nursing roles.

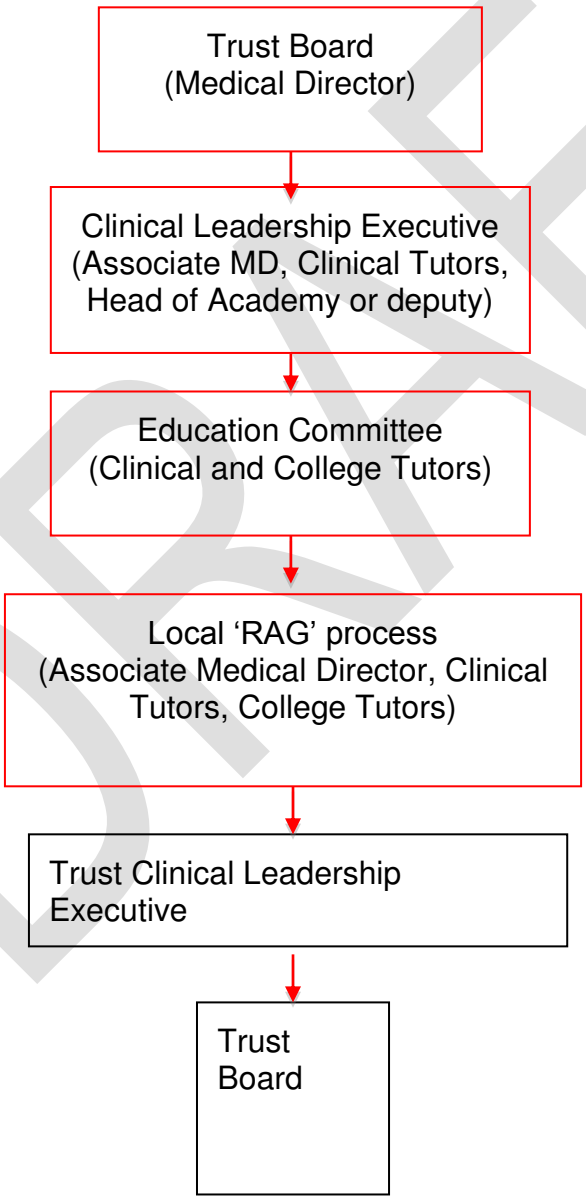
17.0 Recommendations

The Trust Board is asked to discuss the proposed medical educational strategy and the proposals recommended within it.

Contributors: RD Situnayake, J Chilvers, S Singhal, D Carruthers, K Wheatley & the staff of the education centres

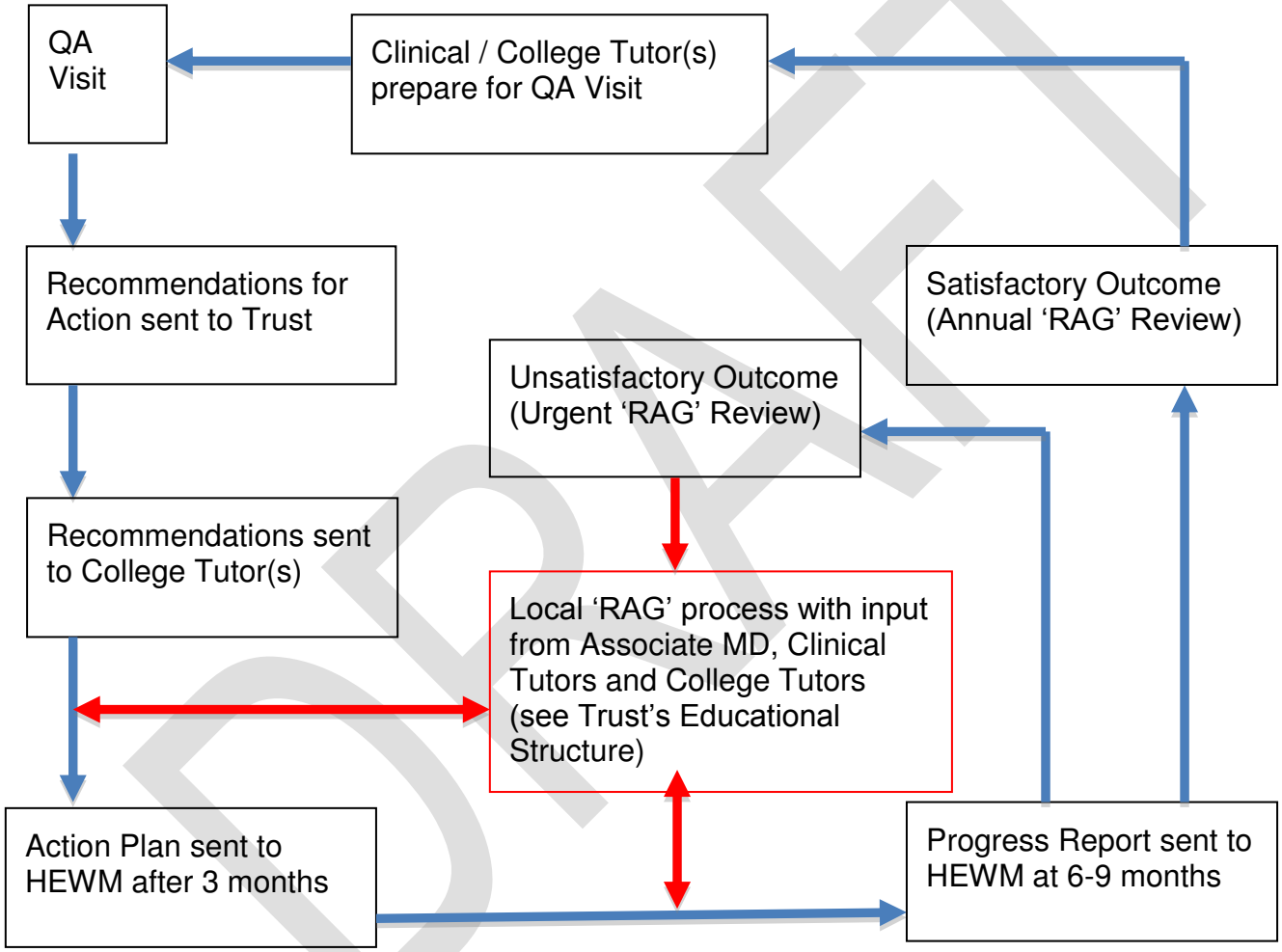
18.0 Appendix 1:

Trust's Postgraduate Educational Structure



19.0 Appendix 2:

Trust's Internal Reporting Mechanisms following QA Visits (SWBH)



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Enhanced Leadership Development**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon – Director of Strategy & OD**
AUTHOR:	**Mike Sharon – Director of Strategy & OD/Jim Pollitt – Head of Learning Development**
DATE OF MEETING:	**6 February 2014**

EXECUTIVE SUMMARY:

The purpose of this paper is to update the Board on the progress of the Trust's procurement of enhanced Leadership Development support.

Objectives to be met are:

The high level objectives to be met via the provision of this procurement are:

- A recognised SWBH leadership brand;
- Improved capability to deliver transformational change within the NHS/Healthcare environment;
- Improved patient outcomes and experience through cultural change and continuous improvement;
- Supporting the development of an integrated approach to talent management;
- Recognition of the Trust as an employer of choice where new and potential employees know they will be developed to be excellent leaders.

The objectives will be achieved via the following:

1. **Development centres**
2. **A development programme**
3. **Consultant and senior level junior doctor 'Introduction to Leadership' programme to include**

REPORT RECOMMENDATION:

The Trust Board is asked to **ACCEPT** progress made in the enhanced leadership support procurement.

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

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

Improved Leadership affects all Trust risks and objectives

PREVIOUS CONSIDERATION:
Discussed in seminar in November

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report for the Public Trust Board
Thursday 6th February 2014

Tender for support for enhanced Leadership Development

Introduction

The purpose of this paper is to update the Board on the progress of the Trust's procurement of enhanced Leadership Development support

Update

The Trust commenced this procurement via an accelerated OJEU procedure in December 2013. This has progressed as planned. It is expected that a final decision will be made within the next week.

The brief

The brief given to bidders includes the following:

We want to be renowned as the best integrated care organisation in the NHS. That means we need to deliver care in partnership, in different locations, using technology better, reorganising services around the patient not the disease or diseases they have. Between now and 2020 we need to cut our cost base by 5% per year. In 2014 we are reorganising outpatients. In 2016 we implement a new IT system. In 2018 we relocate many acute services. By 2020 we want to deliver outcome indices that are the best in the west midlands.

From April 2014 our decision devolution project will start. Clinical directorates will take much of the role of current Groups. Groups will take much of the role of the Executive. The Executive will focus on a three year transformation project. The Board will guard our long term workforce, quality and financial models, and our delivery against them. At each tier we have work to do to create genuinely multi-professional leadership models. And to ensure that we can see pace and accountability being enhanced not inhibited by greater autonomy.

So we want to create a recognisable model of leadership that is adopted by our leading 150 people. This is about shared beliefs but also shared habits of how we do things. That homogeneity must not stifle innovation. But it needs to enhance our ability to implement consistently. Making the best of what we do at SWBH, what we do at SWBH.

Starting with a major development event on March 31 and April 1 we want to kick off eighteen months of intense reflection, learning and development.

The high level objectives to be met via the provision of this procurement are:

- A recognised SWBH leadership brand;
- Improved capability to deliver transformational change within the NHS/Healthcare environment;
- Improved patient outcomes and experience through cultural change and continuous improvement;
- Supporting the development of an integrated approach to talent management;
- Recognition of the Trust as an employer of choice where new and potential employees know they will be developed to be excellent leaders.

1. **Development centres**
   - As a minimum they need to include:
   - 360 degree feedback;
   - Personality profiling;
   - Feedback/coaching;
   - Personal development planning;
   - Talent management training;
   - Developing in-house coaching capability

2. **A development programme** (accreditable) to address the development needs identified from the development centres. This must also include the introduction and setting up of an internal coaching faculty and the development of Action learning Sets

3. **Consultant and senior level junior doctor 'Introduction to Leadership' programme to include**

   1. Effective Team Leadership (including clinicians' roles and responsibilities).
   2. Running productive meetings.
   3. Understanding and managing conflict.
   4. Initiating and leading quality improvement work (including understanding risk; diagnostics; root-cause analysis; and improvement methodology).
   5. Objective setting and delivery.
   6. Service Line Management.

<u>Conclusion</u>

The Board is asked to ACCEPT progress on the Leadership procurement.

Mike Sharon
Director of Strategy & OD
January 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**HSS Contract Novation**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite, Director of Finance & Performance Management**
AUTHOR:	**Fiona Sanders, Interim CIO**
DATE OF MEETING:	**30th January 2014**

EXECUTIVE SUMMARY:

The Board is asked to review the attached briefing paper on the novation of the contract between Healthcare Software Systems (HSS) to Healthcare Software Solutions (New HSS).

The novation and consent to change control has been completed in line with the National Framework Agreement.

REPORT RECOMMENDATION:

The Trust Board is asked to review and sign the novation and consent to change control and apply the common seal.

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

Comments:

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

Not applicable

PREVIOUS CONSIDERATION:

Not applicable

Trust Board: HSS Contract Novation

Date: 30th January 2014
Version: 1.0
Authors: Fiona Sanders (Interim CIO)

1. HSS Contract Novation

The Trust's Radiology Information System, CRIS is provided by Healthcare Software Systems (HSS), one of the leading UK suppliers of Radiology Information Systems. HSS is a wholly-owned subsidiary of the Wellbeing Software Group (WSG).

The Trust has been advised by HSS that negotiations are at an advanced stage for the sale of the entire issued share capital of WSG to the existing HSS management team and their backers through New Street Square Bidco Limited. The new company will be known as Healthcare Software Solutions and will continue to be known as HSS.

As part of the proposed sale to the management team of HSS and their backers, HSS have advised the Trust that they wish to be released and discharged from the Contract as from the time immediately prior to completion of the buyout and that the contract responsibilities are transferred to Healthcare Software Solutions (New HSS). New HSS undertakes to perform the Contract and be bound by the terms of the Contract in place of HSS.

On the 28th January 2014, the Trust were advised by NHS Supply Chain that the novation of contract from **Healthcare Software Systems** to **Healthcare Software Solutions** has now been formally completed and that this has been done in due process in line with the National Framework agreement. Subject to the Trust's agreement, **Healthcare Software Solutions** will now take over all contractual obligations previously held by **Healthcare Software Systems**.

The Trust's levels of service and terms and conditions of contract will remain unchanged and the organisation will still be referred to as **HSS**.

In order for the novation to be formally completed and for the Trust's contract to be novated to the control of the new organisation and service provided in line the Trust's contract NHS Supply Chain require that the Trust complete, sign and apply the common seal to the novation documentation issued by **HSS**.

2. Action required

This paper is presented to the Trust Board for information.

The Trust Board is requested to:

i) Review the Novation and Consent to Change Control,
ii) Sign the document and apply the common seal.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Midland Metropolitan Hospital Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager Director of Estates/New Hospital Project Director**
AUTHOR:	**Graham Seager Director of Estates/New Hospital Project Director**
DATE OF MEETING:	**6 February 2014**

EXECUTIVE SUMMARY:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital Status Report
February 2014

Activities Last Period

- Approval process with NHSTDA concluded- Approved
- Architectural refresh finalised
- Further engagement with DH
- Vacant possession of Grove Lane site achieved
- Demolition of contaminated/ unsafe structures in progress

Planned Next Period

- Progress Grove Lane site demolition plan
- Agree PF2 commercial documentation with HMT
- Initiate bidders for pre market engagement
- Agree final approval process

Issues for Resolution/Risks for Next Period

Final approvals before agreement advertise scheme in OJEU

REPORT RECOMMENDATION:

Discuss and accept status 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		**x**

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

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

Comments:

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

21st Century Facilities

PREVIOUS CONSIDERATION:

Routine monthly update

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Midland Metropolitan Hospital – Approach to Grove Lane Site Acquisition**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis – Chief Executive**
AUTHOR:	**Graham Seager - New Hospital Project Director**
DATE OF MEETING:	**6 February 2014**

EXECUTIVE SUMMARY:

This report has been prepared to report the use of Trust Emergency Powers in respect of making GVD3 for land acquisition (Plot 61 – see attached map) on Grove Lane site.

REPORT RECOMMENDATION:

The Board is asked to note the use of the Board's emergency Powers

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

21st Century Facilities - New Hospital Project

PREVIOUS CONSIDERATION:

Trust Board – GDV dated 5th July 2011 and GVD No 2. dated 31st May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital – Approach to Grove Lane Site Acquisition

REPORT TO THE TRUST BOARD ON 6 FEBRUARY 2014

1.0 INTRODUCTION AND BACKGROUND

As the Board is aware, the Secretary of State approved the acquisition of the Grove Lane site, required for the new Midland Metropolitan Hospital through the use of compulsory purchase powers in January 2011. The decision to confirm the order followed a public inquiry.

In view of the position relating to the approval of the Outline Business Case for the project at that time, the Trust Board decided to proceed with acquisition through General Vesting Declarations (GVD) in two stages:

"GVD No. 1" was made by the Trust on 5 July 2011, and

"GVD No. 2" was subsequently made by the Trust on 31st May 2012.

In approving the making of GVD No. 2 (Trust Board April 2012) it was noted that Plot 61 was not included within the GVD, but that a further GVD may need to be made for that plot.

It has been agreed through Trusts emergency powers, to make GVD No.3 for Plot 61 and specify a vesting period of 28 days from which date title together with the right to possession of the land will pass to the Trust.

In accordance with Standing Order 5.2 the decision to approve the making of the GVD and the use of the Trust's seal was recommended to be undertaken as an urgent decision by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair is now being reported to the next formal meeting of the Trust Board in public session.

Graham Seager
Project Director

SWBTB (2/14) 019 (b)

N

Plots in possession of SWBH

GVD 1

GVD 2

rev	description	date
rev A	GVD 1 current position	13 Jan 12
original by		23.11.11

project
Right Care Right Here
Midland Metropolitan Hospital

drawing
Grove Lane
Land Acquisition Plan

Sandwell & West Birmingham Hospitals NHS Trust

PA-2344-CPO-8-A10
A1 SHEET
25/09/2009

FT Programme Monitoring Status Report

Activities This Month

- Clinical Group Governance audit progressed
- IBP chapters redeveloped
- First meeting of the FT Development Committee
- Clinical strategy redeveloped
- TDA Board MMH approval

Planned Next Month

- Clinical Group Governance Audit presented to CLE
- Continued development of IBP
- Deloitte Board feedback
- Quality & Safety event for members (20.02.14)
- DH MMH approval

Issues for Resolution/Risks for Next Month

- Confirmation required from CQC as to date of CIH visit
- Continue to make progress on A&E target in line with rectification plan to NTDA
- MMH approval