Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 6 March 2014; 1330h

Members

Mr R Samuda	(RSM)	[Chairman]
Ms C Robinson	(CRO)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[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

Dr A Lock	(AL)	[Consultant - Palliative Medicine]

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**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 6 February 2014 a true and accurate records of discussions*	**SWBTB (3/14) 028**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (3/14) 028 (a)**	**SG-L**
	5	**Questions from members of the public**	**Verbal**	**Public**
1340h	6	**Patient story**	**Presentation**	**CO**
1400h	7	**End of Life Care update**	**Presentation**	**CO**
1420h	8	**Chair's opening comments and Chief Executive's report**	**SWBTB (3/14) 030**	**RSM/ TL**
		MATTERS FOR DISCUSSION AND APPROVAL		
1430h	9	**2014/15 annual corporate plan**	**SWBTB (3/14) 031** **SWBTB (3/14) 031 (a) - SWBTB (3/14) 031 (c)**	**MS**
1450h	10	**Whistleblowing policy**	**SWBTB (3/14) 032** **SWBTB (3/14) 032 (a)**	**KD**

1505h	**11**	**National patient and staff survey results**	**SWBTB (3/14) 033 SWBTB (3/14) 033 (a) - SWBTB (3/14) 033 (c)**	**CO/ MS**
1515h	**12**	**Corporate performance dashboard**	**SWBTB (3/14) 034 SWBTB (3/14) 034 (a)**	**TW**
	12.1	Site differences in performance against rapid access chest pain target	Verbal	RB
	12.2	Unacceptable Emergency Care waits in February	Verbal	RB
1535h	**13**	**Financial performance report – Month 10**	**SWBTB (3/14) 035 SWBTB (3/14) 035 (a)**	**TW**
1545h	**14**	**Board Assurance Framework – Quarter 3 update**	**SWBTB (3/14) 036 SWBTB (3/14) 036 (a)**	**KD**
		REPORTS BACK FROM THE COMMITTEES		
1550h	**15**	**Update from the meeting of the Quality & Safety Committee on 28 February 2014 and minutes of the meeting held on 31 January 2014**	**SWBQS (1/14) 014**	**OD/ CO**
1600h	**16**	**Update from the meeting of the Public Health, Community Development and Equalities Committee held on 27 February 2014**	**Verbal**	**RSM/ TL**
1610h	**17**	**Update from the meeting of the Configuration Committee held on 28 February 2014 and minutes from the meeting held on 12 December 2013**	**SWBCC (12/13) 013**	**RSM/ MS**
	18	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
	19	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (3/14) 038**	
	20	**Foundation Trust application programme: monitoring report**	**SWBTB (3/14) 039**	
	21	**Sustainability update**	**SWBTB (3/14) 040**	
	22	**Details of next meeting** *The next public Trust Board will be held on 3 April 2014 at **1330h** in the Churchvale/Hollyoak Rooms, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Boardroom, Sandwell Hospital **Date** 6 February 2014

Present	**In Attendance**
Mr Richard Samuda [Chair]	Mr Mike Hoare
Ms Clare Robinson	Miss Kam Dhami
Dr Sarindar Sahota OBE	Mr Mike Sharon
Mrs Gianjeet Hunjan	Mrs Chris Rickards
Mr Toby Lewis	
Mr Tony Waite	**Guests**
Mr Colin Ovington	Mr A Tyagi [Group Director, Surgery B]
Miss Rachel Barlow	Patient
Dr Roger Stedman	Patient's wife
	Mrs L Pascall

Secretariat

Mr Simon Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr Harjinder Kang and Ms Olwen Dutton.	
2 Declaration of Interests	**SWBTB (2/14) 002 (a)** **SWBTB (2/14) 002 (b)** **SWBTB (2/14) 002 (c)**
The declarations of interest received from Mr Waite, Mr Ovington and Mr Hoare were presented for receiving and noting. Mr Grainger-Lloyd advised that the contents being incorporated within the wider Register of Interest which would be refreshed in April 2014.	
3 Minutes of the previous meeting	**SWBTB (12/13) 266**

The minutes of the Trust Board meeting held on 19th December 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 (12/13) 266 (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.	
5 Questions from members of the public	**Verbal**
There were no questions.	
6 Patient story	**Presentation**
The Board was addressed by a patient who had experienced an episode of complete blindness following a haemorrhage. It was reported that his treatment had been considered by a number of other provider organisations, before referral to the Birmingham and Midland Eye Centre. Dr Stedman asked the patient whether there were any measures that could make the Eye Centre more welcoming and a safer environment for patients in a similar position. He was advised that the use of coloured flooring or coloured guidelines on the floors would be welcome for partially sighted patients. The Chairman suggested that the appointment letters should provide advice on what was needed should the patients experiencing difficulty with their sight require any assistance on arrival at hospital. Mr Hoare noted that the event would have been stressful and asked what additional support had been provided at this time by other organisations. He was advised that there was little support other than that directly provided by the Trust that had been available. Mr Lewis suggested that this needed to be a matter of interest and deliberation for the Trust in terms of how patients are directed to the systems, processes and organisations that could provide this assistance. Mr Hodgetts asked whether the patient thought that emotional help was needed at this time. The patient's wife advised that although emotional support would have been welcome, practical help would have been better received at the time. Mr Lewis asked whether, in the patient's view, the referrals between hospitals had been handled respectfully and efficiently. The patient relayed an experience at a neighbouring trust which had not been positive. The patient and his wife were thanked for their attendance and illuminating story.	
7 Chair's Opening Comments and Chief Executive's report	**SWBTB (2/14) 003** **SWBTB (2/14) 003 (a)**

The Chairman advised that since the last meeting, much work had been undertaken to support the work to progress the Midland Metropolitan Hospital project. Congratulations were extended the team for progressing the scheme to approval by the Trust Development Authority and its onward transmission to the Department of Health. It was reported that the new blood science facility at Sandwell Hospital had been opened since the last meeting. Good progress was reported to have been made with the plans to replace Prof Lilford as the University of Birmingham's representative, with the recruitment process now being underway. Mr Lewis reported that following the recent Road Traffic Incident involving the Leasowe's facility, it would shortly become operational once more. It was reported that a number of NHS trust Chief Executives had met with Julian le Grande with a view to informing the decisions around the future of Children's services that was being directed for Michael Gove, Secretary of State for Education. The Board was advised that further attention needed to be directed to addressing Delayed Transfers of Care given the significant negative implications that these create. Mr Lewis reported that the Trust was focussing on completing staff appraisals and that a consequences regime would be applied for those not complying. Mr Lewis presented the future plans for car parking, noting the concern that had been raised in the media around the proposals to raise the rates. It was reported that the plans sought to address the current shortage of car parking spaces at the Sandwell site, in addition to adjusting the charging regime for car parking. It was highlighted that for short term stays, the Trust's car parking charges were not an outlier in comparison to the local position, with the charges for longer term stays being lower than many other trusts in the region. The Chairman suggested that charges for patients delayed in clinics needed to be considered. It was suggested that this could be built into the outpatient processes. It was also highlighted that special tickets were issued for patients who were required to attend on a repeated basis. Mr Lewis advised that the equality impact assessment would be considered for disabled parking. Mr Hodgetts asked why there was considerable difference between the main sites and Rowley Regis Hospital. He was advised that the plans to address this might force car parking onto the neighbouring streets of Rowley Regis Hospital or the Trust's overall savings would need to be revised. Mr Hodgetts advised that the local residents were clearly resistant to patients and staff parking in local roads at Rowley Regis Hospital. Mr Sharon advised that the charging on this site partly reflected the lower cost of providing parking at the hospital.	

Ms Robinson asked how the charges compared with other organisations in the region. Mr Lewis reiterated that on a long-stay basis the Trust's position was less expensive and that on an hourly basis the Trust was not out of line with other trusts. Mrs Hunjan asked relative to patients seen, whether there were there more car parking spaces at City Hospital than at Sandwell Hospital. Mr Lewis offered to provide a briefing note to advise when the position had been established, which would also include the impact of adjusting the charges to make them more equitable between the sites.	
ACTION: Mr Lewis to present a briefing note concerning car parking facilities and City and Sandwell Hospitals at the Board meeting in April	
8 Never Events	
8.1 Never Event 5 in Ophthalmology	**SWBTB (2/14) 004** **SWBTB (2/14) 004 (a)**
Dr Stedman provided an overview of the latest Never Event in Ophthalmology and advised that the table top review of the incident had been held. It was reported that the incident had given rise to several points of learning including the consequences of the prolonged transition between the use of paper to electronic systems and the need to reconsider the current practice in respect of the construction of theatre lists. Mr Hodgetts referring to the Never Event, asked why the patient's date of birth had not been checked in this instance. Dr Stedman advised that all of the checks had taken place in advance of the patient's procedure however there had been a disconnect between the information held on the different systems used in the area at the time. Mr Tyagi provided a detailed explanation of the reason behind the error in this respect. Mr Lewis asked what consequences would ensue should a key member of staff not attend team briefs in advance of the procedure. He was advised that the procedures would not progress until all key members were in place and that those not attending the brief without good reason would be subject to a disciplinary procedure. Mr Lewis emphasised the need for a core team to be maintained in team brief and throughout the operating list. Mr Tyagi advised that breaks were inevitable, however any changes taking place during these periods would be clearly communicated and relevant staff would be briefed following the breaks. Dr Stedman advised that there was a greater risk of discontinuity due to dynamics of the team in an Emergency setting. It was highlighted that in this case, multiple team briefs and 'times out' were organised and new members of the team were introduced where needed. Miss Barlow suggested that checks were needed against each and every point of the process and information throughout the transition between the use of paper	

and electronic records. Ms Robinson noted that the incident had been reported quickly and that no harm had been incurred as a result of the Never Event. She suggested that the patient could be empowered as part of the process to ensure that they contributed to the controls. It was also suggested that other checks and validation mechanisms needed to be considered, drawing from practice in other organisations where possible. Mr Tyagi advised that positive patient identification was employed in the area now and that the introduction of a process analogous to barcoding was being considered. Dr Stedman advised that the current consent process needed to be considered particularly. Mrs Hunjan asked where delays to the schedule of procedures were incurred, how they were communicated. Mr Tyagi advised that the patients were not sent for from the ward until the procedure was ready to proceed. He added that the team brief was held regardless of the delay experienced and that there was a degree of flexibility in the theatre lists to allow the session to extend if needed. Dr Sahota suggested that given the previous Never Events in the area, the team should have been more vigilant. Mr Lewis asked what progress had been made with using videoing in the area. Mr Tyagi advised that reflective practice was in place to which all staff in Ophthalmology had been subjected, with the first videoing occurring on 28 February 2014. The Chairman asked what the key points of learning from the Never Event were seen to be. Mr Tyagi advised that there was a need to use positive patient identification; adherence to standard operating procedures; and empowering all members of the team to speak up should they not be confident that the process was adequate or safe.	
8.2 Never Event controls audit	**SWBTB (2/14) 005** **SWBTB (2/14) 005 (a)**
Miss Dhami presented an overview of the assurance against the controls that had been put in place to prevent any reoccurrence of the Never Events. It was highlighted that 17 Never Events had been reported since 2009. The Board was asked to note that a grade and assurance level was applied to reflect the level of assurance against the controls for each Never Event. It was reported that of particular concern was the assurance identified against the use of information leaflets, which included informed consent. The assurance on controls associated with site marking in Ophthalmology was reported to be strong, although targeted follow up work was planned. In terms of additional requirements, it was reported that robust informed consent needed to be in place for patients who were consented on the day of the procedures, such as diagnostics.	

It was noted that the work concluded that the safety culture needed to be improved and that as part of this intent a safety summit was planned for 13 February 2014 and that an external review of patient safety had been commissioned. Dr Stedman provided an overview of the plans and structure of the Patient Safety Summit. Ms Robinson asked in terms of the lens protocol, whether an auditor would observing a procedure and was advised that this was the case. She commented that there as there was an expectation that clinicians would naturally be more cautious when being observed in this manner, the value of this audit was not clear. Mr Lewis noted the value of looking at the work at a speciality and Group level to highlight the hot spots.	
9 Quarter 3 update on annual plan delivery and year-end risks	**SWBTB (2/14) 006** **SWBTB (2/14) 006 (a)**
Mr Sharon presented an overview of progress with the annual plan deliverables and the risks associated with non-delivery of some objectives by the year end. Dr Sahota in connection with working with social care, commented that it was crucial that the processes and influences on local authorities were clearly understood and made as robust as possible. Miss Barlow advised that good progress had been made with engaging social services with joint working and that seven day working was in place. The Chairman noted the concerns over medicine management, noting that this risk had been recognised for some time. Mr Ovington reported that clear focus was being given to this issue now, however he acknowledged that the situation was disappointing at present. Dr Stedman reported that addressing the matter was included within the remit of the ten 'Always Events', which set out a series of key interventions that would be applied to each patient. Mr Ovington added that the security of the medicines storage was a particular concern that needed to be addressed.	
10 Corporate performance dashboard	**SWBTB (2/14) 007** **SWBTB (2/14) 007 (a)**
Mr Waite reported that the areas of concern in terms of performance against key targets were similar from the perspective of the Trust and the Trust development Authority (TDA). These were advised to include Never Events, access targets including Emergency Care, referral to treatment time targets and appraisal rates. Mr Lewis asked whether the cancer patients who had been waiting for treatment in December had been seen. Miss Barlow advised that this was the case and that a root cause analysis had been taken for all breached cases and near misses. It was reported that although there had been a number of breaches to the waiting time targets, there were extreme waits.	

In terms of rapid access chest pain, the Chairman noted that there was a difference between sites and asked for the reasons behind this. Miss Barlow agreed to circulate a note to explain.	
ACTION: Miss Barlow to circulate a note explaining the site difference in terms of rapid access chest pain performance	
11 Update from the meeting of the Quality & Safety Committee on 31 January 2014	**Verbal**
In Ms Dutton's absence, Ms Hunjan presented an overview of the key discussions held at the Quality & Safety Committee on 31 January 2014. It was highlighted that the devolved model of complaints handling was working well. It was reported that that the Quality Impact Assessment process for TSP schemes was underway and that the process was more advanced than at the same period in 2012/13. Miss Dhami advised that the indicators to be used to monitor the delivery of the schemes needed to be agreed. Mr Lewis advised that there was a focus on implementation impact as part of this work and he advised that it was likely that the work would be completed by April 2014. Ms Robinson asked what progress had been made with refreshing the Patient Safety Walkabouts process. Miss Dhami advised that some protected time would be set aside for the Board to consider the process. It was suggested that tracking and gathering the learning points from the walkabouts needed to be harnessed and that this was being included within the Group performance review process.	
11.1 Grade 4 pressure ulcer	**SWBTB (2/14) 008**
Mr Ovington reported that the investigation into the Grade 4 pressure sore remained ongoing and would be presented to the Quality & Safety Committee at its next meeting.	
11.2 Norovirus update	**SWBTB (2/14) 009** **SWBTB (2/14) 009 (a)**
Mr Ovington reported that the Norovirus position was less severe than it had been at the same point during the previous year. It was noted that the handling of the recent outbreak had been efficient and that the feedback from external and internal sources was positive in this respect. Miss Barlow advised that other local hospitals and nursing homes had been affected by Norovirus and she commented that the rapid response to this in the Trust had been pleasing. The Board was advised that a MRSA bacteraemia case had been reported and that a formal update would be presented to the Quality & Safety Committee at its next meeting. The outline of and key learning from the case was presented.	

ACTION: **Mr Ovington to present the detail of the MRSA bacteraemia case at the next meeting of the Quality & Safety Committee**	
12 Update from the meeting of the Finance & Investment Committee held on 31 January 2014 and minutes from the meeting held on 22 November 2013	**SWBTB (11/13) 102**
Ms Robinson presented an overview of the key discussions held at the Quality & Safety Committee on 31 January 2014. It was noted that the focus of the Committee was shifting to be more forward focused and risk-based. Mr Lewis welcomed the news that the contracts database was being populated comprehensively. In terms of the Winter funding award, he highlighted that the funding received had covered the planned work, however the decision had been taken to complete additional work at the expense of the Trust. Mr Lewis asked whether the non-nursing temporary staffing spend position was now clearly understood. He was advised that further work was planned in a programme to address the position which included consideration of medical staff rotas. Mr Waite noted that the Committee had considered a number of specific issues in relation to workforce and suggested that longer term planning for workforce needed to be given focus within the Workforce & OD Committee. Mr Lewis advised that much work had been undertaken to reconcile current workforce positions against budgeted establishments across the Trust.	
13 Monthly Finance Report – Month 9	**SWBTB (2/14) 010** **SWBTB (2/14) 010 (a)**
Mr Waite reported that the year-end forecast surplus had been updated, which showed an improved position which reflected in part that some reserves and provisions had been managed prudently. It was reported that the year-end position was anticipated to be positive, however the two year forecast was being given additional focus at present. It was reported that the need to adhere to the costs savings programmes planned was critical to the future financial viability of the business and an understanding of the impact of the key actions and decisions planned was required. The likelihood that the Capital Resource Limit (CRL) would not be met was highlighted, although the future risks associated with this were reported to be low. Mrs Hunjan noted that there had been a failure to meet the CRL during previous years. Mr Waite advised that priorities would be brought forward where possible and that every effort would be made within the near future to address the position.	
14 Transformation Savings Programme 2014/15	**SWBTB (2/14) 018**

The Board was informed that there was a need to ensure that the schemes identified for 2014/15 were delivered and that the quality impact assessment process should be robust to assess the impact of the schemes. It was noted that there was a degree of reliance on some income generation schemes within the programme.	
15 Update from the meeting of the Audit & Risk Management Committee held on 30 January 2014 and minutes from the meeting held on 25 October 2013	**SWBAR (10/13) 060**
Mrs Hunjan presented an overview of the key discussions held at Audit & Risk Management Committee on 30 January 2014. It was noted that the handover of the Internal Audit work from CW Audit to Baker-Tilly was underway. It was noted that c. 76,000 letters had been issued to patients with an open pathway; not 176,000 as the hard copy report stated. Miss Dhami was asked to circulate the plans for the refresh of the risk management framework.	
ACTION: Miss Dhami to circulate the plans for the refresh of the risk management framework as presented to the Audit & Risk Management Committee	
16 Data Quality update	**SWBTB (2/14) 011** **SWBTB (2/14) 011 (a)**
Mr Lewis reported that there was confidence in meeting the data quality plans by the year-end, however the progress with the work was not as expected at present. It was reported that data quality and information governance training would be combined in future. It was noted that the data quality work was being considered within the Contract Query Notice (CQN) meetings that were held fortnightly.	
17 Changes to the Standing Orders/Standing Financial Instructions and Scheme of Delegation	**SWBTB (2/14) 012**
The Board approved the proposed changes to the Standing Orders/Standing Financial Instructions and Scheme of Delegation, noting that a more comprehensive refresh was planned for later in the year.	
18 Public Health Plan: 2014 - 17	**SWBTB (2/14) 013** **SWBTB (2/14) 013 (a)**
Dr Stedman presented the proposed Public Health Plan: 2014 – 17, which reflected a shift in focus of the Trust to one that promoted a healthy lifestyle in addition to treating illness. It was reported that it was the intention of the plan to	

provide direct attention to the delivery of a number of key actions to promote public health matters and focus on longevity of life. The application of the plans to staff and the wider social responsibility implied were highlighted. The Board was asked to approve the plans, subject to the views of the Public Health, Equality and Community Development Committee. It was agreed that a more detailed discussion, including a trajectory to deliver the strategy should be developed. Mr Lewis suggested that there needed to be a shift to systemic delivery of public health matters, away from a project focussed approach. It was noted that the actions planned were very ambitious, with some being controversial. Mr Hoare noted that there were some targets the delivery of which was heavily influenced by bodies outside of the Trust, including primary care. Mr Lewis agreed that there was a degree of exposure in this respect on some targets. Dr Stedman suggested that there was good opportunity to provide public health promotion as part of key interventions that the Trust already delivered, including maternity care. The Board was asked to comment on the format of the plan. A number of board members commended the format, notwithstanding some drafting issues. Ms Robinson noted that the subject of prevention was topical and should embrace joint working. She suggested that consideration was needed as to whether to include posts or names within the plan, given that at present there was a degree of inconsistency. Mr Lewis advised that this reflected some personal commitment on behalf of some individuals mentioned. The Board approved the plan subject to the views of the Public Health, Equality and Community Development Committee and the development of an implementation strategy.	
19 Patients Know Best: our patient experience plans	**SWBTB (2/14) 014** **SWBTB (2/14) 014 (a)**
Mr Ovington presented the patient experience plan, highlighting that it was a work in progress but focussed on the longer term patient experience. The Chairman noted that there needed to be an effective distillation process to ensure that the key actions and expectations within the plan were made clear. Miss Barlow suggested that the plan should reflect the experience of patients both outside and inside the acute setting and that the messages across the various pathways needed to be consistent. Dr Stedman highlighted the influence of individual behaviour as part of the plans. Mr Hoare agreed that this cultural influence was important to bear in mind. Miss Dhami asked whether patients' views had been taken into account on matters such as meeting and greeting. She was advised that to date the	

involvement of patients had been limited but it was the intention to do so. Dr Stedman noted that there was a patient expectation level that was low in some respect and that every effort should be made to exceed this. Ms Robinson suggested that the application of the promises should apply to staff that were not patient-facing and that the strategy needed to reflect the interaction with governors. Mr Sharon advised that a set of values were in place which set expectations for staff behaviours. Mr Lewis endorsed a plan to move away from 'Customer Care' promises to reflect staff to staff behavioural expectations as well, however the current set of promises would be used as a basis for setting these. Dr Sahota encouraged the strategy to encompass the experience of carers and relatives in addition to patients.	
20 Medical Education chapter of the emerging integrated education strategy 2014 - 17	**SWBTB (2/14) 015** **SWBTB (2/14) 015 (a)**
Dr Stedman presented the Medical Education chapter of the emerging integrated education strategy 2014 – 17, which he highlighted was a work in progress. It was noted that the existing framework for education was essentially sound. The key highlights of the strategy were outlined including the joint and strategic work with the local medical schools. It was reported that simulation training was to become a more significant element of training in future, in addition to retaining more traditional elements. Mr Lewis noted that it was a challenge to set sufficiently ambitious aims while retaining the core delivery of education, meeting statutory requirements and securing the support of the staff responsible for education. Ms Robinson suggested that the articulation of the requirements to support the future ambitions needed to be incorporated.	
21 Leadership Development programme	**SWBTB (2/14) 016** **SWBTB (2/14) 016 (a)**
Mr Sharon outlined the objectives of the leadership development programme, which he highlighted was a compulsory element of the Trust's work. It was highlighted that a development centre would be arranged and the programme would focus on a coaching culture within the organisation. Mr Lewis suggested that evaluation of the impact of the programme needed to be discussed by the Workforce & OD Committee.	
22 Healthcare Software Systems contract novation	**SWBTB (2/14) 023** **SWBTB (2/14) 023 (a)**
The Board considered and approved the novation of the Healthcare Software Systems contract.	
23 Any Other Business	**Verbal**
There was none.	

Matters for Information	
The Board received the following for information: Midland Metropolitan Hospital Project: Monitoring Report and approach to Grove Lane acquisition Foundation Trust Application Programme: Monitoring Report	**SWBTB (2/14) 017** **SWBTB (2/14) 019** **SWBTB (2/14) 019 (a)**
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 March 2014 and would be held in the Anne Gibson Boardroom, City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 6 March 2014, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

6 February 2014, Boardroom @ City Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr T Lewis (TL), Miss R Barlow (RB), Mr T Waite (TW), Dr R Stedman (RST)

In Attendance: Mr M Hoare (MH), Miss K Dhami (KD), Mr M Sharon (MS), Mrs C Rickards (CR), Mr B Hodgetts (BH)

Apologies: Mr H Kang (HK), Ms O Dutton (OD)

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 28 February 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
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	ACTION NOT YET DUE	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-L	30/04/14	ACTION NOT YET DUE Training slot to be arranged for May 2014	G
SWBTBACT.275	Chair's Opening Comments and Chief Executive's report	SWBTB (2/14) 003 SWBTB (2/14) 003 (a)	06-Feb-14	Present a briefing note concerning car parking facilities and City and Sandwell Hospitals at the Board meeting in April	TL	03/04/14	ACTION NOT YET DUE	G
SWBTBACT.276	Corporate performance dashboard	SWBTB (2/14) 007 SWBTB (2/14) 007 (a)	06-Feb-14	Circulate a note explaining the site difference in terms of rapid access chest pain performance	RB	06/03/14	Included as a verbal update on the agenda of the March Trust Board meeting	G
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	Discussed at the February Board Development meeting led by Mr Ovington	B
SWBTBACT.277	Norovirus update	SWBTB (2/14) 009 SWBTB (2/14) 009 (a)	06-Feb-14	Present the detail of the MRSA bacteraemia case at the next meeting of the Quality & Safety Committee	CO	28/02/14	Discussed at the meeting of the Quality & Safety committee held on 28 February 2014	B

SWBTBACT.278	Update from the meeting of the Audit & Risk Management Committee held on 30 January 2014	SWBAR (10/13) 060	06-Feb-14	Circulate the plans for the refresh of the risk management framework as presented to the Audit & Risk Management Committee	KD	06/03/14	Circulated by SG-L	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

CHIEF EXECUTIVE'S REPORT

Report to the Public Trust Board – March 2014

The Board's attention is drawn to several features of the material presented this month, which of course relates to *January's performance*. In addition two national surveys are reported, which show very limited change from 2012 results. It is pleasing to see the very sharp increase in the number of staff, who regard safety as the Trust's top priority. *The 2014-15 local and national planning process for providers* continues and the Board sees the latest submission made to the Trust Development Authority. We are considered a low risk organisation for these submissions. As the Board might expect *we highlight the risks associated for our plan* with changes in education and specialist services commissioning, as well as the on-going failure to reduce the number of patients classified as delayed transfers of care within our system. The former could drive difficult configuration discussions in coming months. The latter is a direct counter to our own plans to operate with fewer beds in 2014-15. Though local partnerships remain strong, delivery is elusive on this issue.

1. Our patients

During February we have been consulting within the organisation on our Care Promises and how we might make them more consistently real across the Trust. This forms the heart of our 2014-15 patient experience plan, which we discussed in February. That plan needs to be seen in the context of the ambitious long term goal for satisfaction agreed when we considered the Francis Report at our December Board to out-perform the rest of NHS West Midlands. During March we need to finalise implementation approaches to some key initiatives within that plan – in particular how we adopt the 'hello my name is' campaign pioneered by Dr. Kate Granger, as well as how we improve information for patients both about what to expect and how to raise concerns. I am encouraged by the initial changes in responsiveness that we are seeing from local complaint devolution.

In January we were very successful in delivering national standards, with our best ever VTE assessment position and continued ED compliance. We achieved the cancer standard that we missed in December, and maintained 18-week compliance. However, ED performance has deteriorated sharply in February as arrival numbers and admission demand has leapt with some changed hourly concentrations. We have had a small number of patients (unacceptably) spend more than 60 minutes awaiting handover from ambulance crews (as opposed to remaining on forecourts in ambulances, which has not occurred). And our waiting list position in elective care is behind the improvement plan we established in October. This means that we will need to treat more people in quarter 1 than we had expected in some specialties.

During our membership events in February, as well as with colleagues internally, we have been developing further ideas about our safety and quality plans for the next three years. One idea which has gained some traction seeks to tackle both the plethora of initiatives problem which can bedevil the NHS and the reality that whilst we do very many things well, most of the time, our complaints, incidents and concerns often focus on variability and inconsistency. Our 10 out of 10 campaign, initially for inpatient care, will seek to tackle that by bringing together a lot of other projects, abolishing a lot of audits that are done at ward level, and giving a clear guarantee about what to expect on admission. We should be ready to launch this work in a planned manner during Q1 2014-

15. It does require change in some ways in how teams work, and will help us to tackle the quality of patient handover that inpatients experience, both between shifts and between professions.

A process is on-going across Birmingham and the Black Country in relation to the right model of acute stroke care. This would see fewer hyper-acute stroke units for the initial onset of the condition. Our teams are participating actively in that review work and we will make initial submissions in mid-March about how we see the service at Sandwell developing. It is important that we are confident that we can meet all the standards involved if we are to propose both continuing and expanding the service that we offer. Transit times are important for stroke and it is crucial that the Black Country is well served. Creating HASUs saves lives.

2. Our colleagues

The national staff survey results are reported to the Board. Our monthly Your Voice polling data is also gathering pace internally as we enter the second round of returns. We will ensure through the Workforce and OD committee of the Board that not only is the data visible, but the rich detail of staff comment is also available to members. It is very evident that we have some outstanding practice in some teams; how they are led, how they communicate, how they problem-solve. It is equally clear that the best of what we do is not done everywhere. To achieve our ambitions that has to change, and we need skills transfer from successful teams to others. We do need to recognise of course that many employees are members of several teams. That should make peer-learning easier, albeit we have work to do to ensure that those working in so many teams have the time to work effectively in each. That work includes, but is not limited to:

Reinforcing existing expectations and best practice around how handover and team brief are undertaken. Our latest Learning Alert will tackle these issues and we agreed at the Clinical Leadership Executive to accelerate the process of recruiting Chief Residents in line with the Future Hospital Commission Report and our own Francis Response intent to hear better from trainee doctors.

Changing how we set aside time and use the time for audit, improvement, research and communication. Board members are aware that we plan to expand the number of set-side half days for these purposes. We will have ten a year (in effect a whole week). From October 2014 these will be Trust-wide and *simultaneous* in all specialties.

Linked to this, but motivated by a wider agenda that we have discussed in the Board, we will from May begin a year's experiment to ensure leaders have the time to look and listen across our sites. Each '*first Friday'* we will prohibit all management meetings and central Trust activities, with the intention that our top leaders (120-150 people) spend time in waiting rooms, corridors, clinics, departments and wards. This is not an auditing exercise and will not be audited. It relies on senior leaders taking responsibility and developing the skills to hear what is working well and what gets in the way. This will complement, but not replace, our formal programmes of safety walkabouts and unannounced in and out of hours inspections. We will review the usefulness of this approach in spring 2015. This summer we will, using that whole peer group, and the views of staff, set some ambitions about the benefits we seek.

3. Our partners

The local CCG continue to review their model of working, as the end of their first year of existence draws near. Building on work that we have done together on district nursing, they envisage much more of their care models and commissioning being undertaken at a very small scale local level, across around 35 'units' gathered around paired practices. I would suggest that we make arrangements in Q1 2014-15 to review with the CCG Governing Body how they envisage that working for various services that our Trust currently offers. Together we need to achieve the benefits of local knowledge and focus without losing the economies of scale of single-style consistent provision. It will be exceptionally important that commissioning moves ever more towards outcome driven purchasing and reduces any tendency to prescribe workforce models unless they can be demonstrated to be consistent with both safety and long-term affordability.

We are pleased that commissioning colleagues have been able to support continuation into 2014-15 of the seven day working arrangements for social workers on acute sites. Other planning decisions for Q1 are not yet finalised. Our local commissioned contract discussions for the new financial year remain highly constructive and I am optimistic that we will reach a conclusion in time, and consistent with, signing our budget book in the weeks ahead.

4. Our regulators

The Board will recall that in Q3 for the first time the CQC issued intelligent monitoring data and graded that against a six point risk scale. We were assessed at 4, with 6 being the best possible performance. In March a renewed data-set will be announced and our initial expectation is of a very similar result. Since we last were assessed our own quality structure and that of the CQC have resolved the elevated risk alert associated with puerperal sepsis, which reflected our enthusiasm for identified sepsis risk.

On February 20th we were assessed for CNST level 3 in our maternity services. I am thrilled to be able to confirm that we expect to be awarded that highest possible metric. This is the latest tribute to sustained improvement in the quality of care in our maternity services. Having spent time at the Sandwell Overview and Scrutiny Committee earlier this month, I am aware how strongly some local people feel about the geography within which they give birth. We continue to support our Halycon Birth Centre in Oldbury for lower risk deliveries. It is however encouraging that the external review confirms the calibre of our risk management arrangements, in particular for higher risk births. The full report will certainly contain scope for further improvement which we will emphasis within normal operational improvement work.

Finally, our day nurseries for the children of staff have completed at extremely rigorous Ofsted inspection. Again the final report is being drafted. But we expect to do very well. The team have worked hard to achieve that, in the context of changes in staff funding and in the case of our City unit a non-purpose built facility. It is a great credit to both the teams and the HR leadership team that they have been so highly praised.

Toby Lewis,
Chief Executive
27th February 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**NTDA Planning Submission: 5th March 2014**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**6 March 2014**

EXECUTIVE SUMMARY:

The Trust is required to submit a **draft** two year plan summary to the TDA on 5 March 2014. The final version is to be submitted to the TDA on 4 April.

The two year summary is split into the following sections:

- Strategic context & direction
- Approach taken to improve quality & safety
- Service capacity and developments
- Delivery of operational performance standards
- Workforce plans
- Financial and investment strategy

The report also outlines the additional submission requirements for 5th March 2014.

REPORT RECOMMENDATION:

The draft two year plan is submitted before the Board meets on 6th March 2014.

The Board is therefore asked to:

- Review the two-year summary at Appendix A and **provide any comments to Mike Sharon by 2pm onTuesday 4th March.**
- Note the requirements for the 5th March submission to the TDA, and subsequent submission deadlines

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	x

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

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

Comments:

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

Aligned to all strategic objective and Trust performance metrics

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

NHS Trust Development Authority (NTDA) Planning Requirements: 2nd Submission (5th March 2014)

1. Introduction

The Trust is required to submit a **draft** two year plan summary to the TDA on 5 March 2014. The **final** version is to be submitted to the TDA on 4 April.

2. Additional submission requirements

In addition to the two year summary plan, the following submissions are also required on 5th March:

Activity planned trajectories
C. difficile planned trajectories
A&E activity trajectories
A detailed finance submission
Workforce trajectories
A Planning checklist

Except for the planning checklist, these are all submitted directly to the TDA via web forms.

The planning checklist is made up of a series of statements against which the Trust, through the signature of the Chief Executive and Chairman, declares compliance or non-compliance.

This checklist is attached at Appendix B

3. Timetable

As the table below highlights, in quarter 1 we have some further submissions to make. Fortunately the work we have undertaken to produce Long Term Financial and Workforce models stands us in good stead to achieve sign off of our plans.

Submission deadline	Content
5th March 2014 (*Full plan 1st draft post contract sign off date of 28/02)*	2 year finance plan 2 year workforce plan 2 year activity plan & *C Difficile* / A&E trajectory 2 year planning checklist 2 year plan summary
4th April 2014 (*Full plan post dispute resolution process with NHSE)*	2 year finance plan 2 year workforce plan 2 year activity plan & *C Difficile* / A&E trajectory 2 year planning checklist 2 year plan summary

4. Recommendation

The draft two year plan is submitted before the Board meets on 6 March.

The Board is therefore asked to:

Review the two-year summary at Appendix A and **provide any comments to Mike Sharon by 2pm on Tuesday 4th March.**
Note the requirements for the 5th March submission to the TDA, and subsequent submission deadlines

Summary of Two Year Plan 2014/15 to 2015/16

NHS Trust…Sandwell & West Birmingham Hospitals NHS Trust

Strategic context & direction	Two year summary
Context of plan delivery in 2013/14 Narrative on two years ahead (14/15 & 15/16) Impact of strategic commissioning intentions and service changes	**Strategic Context and Direction** The Trust serves half a million people. We have the lowest acute mortality in Birmingham. We provide integrated adult and paediatric care to 300k people. We are rated at 2 by the TDA and 4 by the CQC. Our CsRR is 4 – and we have a 10 year LTFM at 3. Over the next three /six years we are investing in leadership, in a new EPR, and in reconfiguration. A new Board and Executive team are 'bedding down' and building on a tradition of partnership strength with some local stakeholders. Tackling a poor acute readmission rate, ensuring seven day care continuity, and improving patient satisfaction into the 80s+ are critical goals for us. 75% of staff think safety is our top priority, and as we make data quality, risk management, and peer learning more transparent that figure will improve further. We want patients to view us an integrated care provider; renowned as the best such in the NHS. **Impact of strategic commissioning intentions and service changes** • SWBH will seek to provide an element of BCF community capability building and care management and enabling • Activity and capacity model agreed with SWBCCG as reasonable strategic financial planning assumptions • MMH supports reduction of 15% in emergency activity • B&BC Shared care record supports integrated care across all providers • Regaining work lost to other providers, notably QE and DGH • The Trust is a specialist eye, cancer, cardiac, haematology and rheumatology centre **Context of Plan Delivery 2013/14** We reduced amenable mortality further, delivered ED standards in midwinter, outperformed our surplus projection and achieved over £20m+ of savings once again. We did this whilst assimilating a new NED, CEO, DOF, and CNO. Our Board is supported by Deloitte in our FT journey. We faced five never events, material data quality issues, had 2 MRSA cases and one grade 4 pressure ulcer. Each are a call to action to improve, and specifically to learn better internally from one team to another – this led our quality self-assessment to be more self critical than other submissions made in January. Our CCG relationships are strong, though that organisation too is changed, and we have sought to find a new partnership around community nursing services. Both relevant LAs have the poorest rating for childrens' services and we are actively engaged in improvement work.

	Narrative on 2 Years Ahead (2014/15 and 2015/16) In Q4 15-16 we will reach financial close on MMH and will have agreed an EPR replacement FBC. By then outpatient transfer into community settings will be advanced in line with our RCRH trajectories. Equally advanced will be our integrated care provision in support of the BCF. Preparing for those second year goals, will be of equal importance to the Board in 14-15 as the immediate drive to secure sustained improvement in readmissions, harm free care, employee morale, mandate standards, and another £20m+ cost reduction plan. SWBH is well placed for the new NHS, but only if we galvanise the talents of our 7500 employees.
Approach taken to improve quality and safety	**Two year summary**
Approach to quality improvement & methodology used	Our ambition is to provide the safest, highest quality care possible. To achieve this ambition we will wholeheartedly adopt the lessons from the Francis and Berwick reports. This means that our approach will deliver: • An organisation that continuously learns from the best in the world, from our patients and from our experience • A strong patient voice from ward to board, driving our key discussions and our key actions • Over 7,000 staff living our values every day • A leadership cadre with the values and improvement science skills effectively to put quality of care and patient safety as their highest priority • A completely open and transparent way of doing business underpinned by confidence in the quality of our data and using data intelligently We have already decided to make a significant investment in leadership development over the next two years because delivering ever higher quality and safety while meeting our financial challenges requires extraordinary talent, extraordinarily well led. Our patient experience strategy has been developed to ensure that we deliver on our nine Care Promises that will deliver significantly improved patient satisfaction. Our Francis ambition on satisfaction is to be over three years the best in the West Midlands. We also have a Quality and Safety Strategy (2012-2016) which provides an overarching framework for quality governance across the Trust. This defines, at a high-level, the improvements in the quality of care we intend to achieve over a 4 year period. Our specific long-term quality goals are currently being reviewed. The Trust's Quality & Safety Committee (a sub-committee of the Trust Board) provides assurance on the delivery of

	the Trust's long term quality goals as set out in the Quality & Safety strategy. It also monitors and provides assurance to the Board that clinical services are appropriately delivered, in terms of quality, effectiveness and safety. Where quality and performance falls below acceptable standards, ensures that action is taken to bring it back in line with expectations, and to promote improvement and excellence. Sitting underneath the Trust's Clinical Leadership Executive (CLE) are 3 sub-committees focused on quality: • Patient Safety Committee • Clinical Effectiveness Committee • Patient and Staff Experience Committee (chaired by the CEO) • In addition we have a Risk Management Committee
Key improvements to be delivered over next two years across five CQC domains of quality NB. Consistent with Trust's published Quality Account	The priorities identified in our current Quality Account and current Annual Plan are: • Reducing preventable deaths • Reducing readmissions • Improving emergency department waiting times • Improving our Friends and Family test score • Becoming a Health Promoting hospital • Reducing the number of complaints per 1000 episodes of care • Improving VTE assessment rates Most of these priorities will be continued into 2014/15 and 2015/16 During Q1 we will introduce a new programme called 10/10. In effect a right every time pledge for inpatients. **Our proposed standards to prevent harm:** • We will use Positive patient identification using three unique identifiers • We will assess every patient for their risk of developing a pressure ulcer and put in place the appropriate preventative measures • We will assess every patient for their risk of falling and ensure that the correct preventive measures are in place • We will assess every patient for the risk of developing venous thrombo-embolism and ensure the correct

	prophylaxis is prescribed where appropriate • We will ensure every patient has a base line set of observations carried out by a registered nurse including at least one record of height and weight • Every patient will have their medicines checked and reconciled against a definitive list and have any allergies clearly documented on their prescription chart • Every patient will have their mental capacity assessed and where required referral for further assessment • Every patient will have their pain assessed against a visual analogue scale and offered analgesia if required • Every patient will be screened for MRSA and give decolonisation treatment if required • Every patient will have their nutrition and fluid needs assessed and given access to appropriate nutritional advice **Proposed CQUIN targets for 2014/15:** • Safety thermometer ➢ Pressure sore prevention ➢ Blood clot prevention ➢ Falls – inked to sedation and blood pressure medicine • Sepsis • Referral time to treatment for therapy services • Friends and family test • Dementia • Pain • Speed up sending letters to GPs after an outpatient appointment • Letters to GPs after an inpatient discharge • Safeguarding referral patterns
Service capacity & developments	**Two year summary**
Summary of service capacity & developments over next 2 years	The Trust has a long term activity and capacity model (underpins our LTFM) which includes the configuration of the new hospital and residual service models at City, Sandwell and community locations as part of our health economy wide *Right Care Right Here* vision.

	The model is based on activity and efficiency assumptions on a year by year trajectory (in line with our LTFM). Our capacity and service development plans for the next 2 years aim to meet these trajectories and as such key features include: • Shift from acute bed capacity to intermediate care and other community services • A focus on outpatient transformation in 2014/15 to include new pathways that deliver improved patient experience, reduced follow up appointments, alternatives to face to face consultant contacts and care closer to home • New community based models of care for Long Term Conditions delivered in partnership with primary care colleagues • Greater integration of acute and community services along care pathways • Growth in our community services to support the transfer of activity from acute care, admission avoidance, greater integration with primary care • Increased day case rates We will continue our programme of the last 5 years of service reconfiguration to ensure safe high quality sustainable clinical services. This is likely to include inpatient cardiology reconfiguration with consolidation on one site.
Delivery of operational performance standards	**Two year summary**
Summary of how the Trust will meet operational performance standards over next two years, including contractual and national targets and standards	The Trust has in 2013-14 performed well on national standards. We have identified some in-year and prior year discrepancies in performance. This suggests some frailty in systems and in data quality. A taskforce is supporting the Board on data quality, against a plan agreed with commissioners, and aligned with our new Internal Auditor. This group, chaired by the Chief Executive, has introduced a data quality kite-mark, new sign-off standards for data, a new mandatory training programme for all employees and the visible publication of key data within the Trust on large public view television screens. Together this package is a strategy to ensure our data is highly accurate. The areas of deviation in 13-14 saw us: Not deliver VTE assessment at 95% every month, though we are YTD compliant. We believe that our technology-enabled mitigation (deployed since January) provides a secure forward plan. Have increased on-the-day cancelled operations. New practices have been deployed during February and

	we believe that by Q2 14-15 these will be embedded and robust. Our goal is to achieve 0.5% or better. Miss the 62-day cancer standard for one month (December). This is highly unusual and we believe that our standard control regime will enable delivery consistently. We also identified longstanding mixed sex non-compliance in a specified number of departments. From March 2014 our data for this standard will flow directly from our PAS system. The areas of potential small-scale non-compliance will remain critical care (beyond 12 hours at level 1) on occasion. Performance on this element has transformed in year. But pressures remain. And some front door and coronary care unit pressures – the former associated with flow choices to preserve safety and the latter a consequence of poor estate design. We expect to remain within national standards on a quarterly basis. Diagnostic compliance is being achieved. Pressures and demands mount as patterns of referral change. We are working through a specific project to try and achieve five week compliance to provide a measure of headroom on our current arrangements. The Trust remains RTT compliant. In 2013-14 we have surmounted the longstanding reporting issues faced by non-admitted patients. The IST are reviewing with us in Q4 our new arrangements. We project continued Trust compliance through 2014-15 and specialty compliance from the end of Q2. A specific plan for those specialties is going to be managed alongside commissioners through Q1. In eleven months, the Trust has achieved 95% compliance five times. Our ambulance turnaround position is consistently averaging below 30 minutes. Yet we still have over 45 minute turnarounds (there remain some data issues within that) and our emergency care resilience (and ability to deliver on both sites) is not yet demonstrated. We have a cogent care model which we introduced in May 2013. Our forward plans are more of the same, augmented by a whole community bed control centre run from the Trust. This will give us improved capability to tackle the 5% of our medical bed base consistently occupied by patients who are 'labelled' delayed transfer of care. We have strong seven-day provision already and are working through the priorities to improve further.
Workforce plans	**Two year summary**
Summary of two year workforce plans including proposed changes, quality impact, staff engagement and support	**PROPOSED CHANGES** Overall WTE reduction of circa 250 posts per annum (2014/15 and 2015/16): • Increasing our substantive nurses in post (funded through converting temporary staffing spend)

	• Reduction in support roles and management / administrative roles Significant reduction in temporary staffing pay spend (primarily agency costs) as: • We improve our 'time to hire' for recruitment • Strengthen controls on when additional staff are required • Introduce an 'in-house' medical staffing bank • Re-job plan our medical teams to ensure capacity and fit • Address medical ward nursing staff turnover **STAFF ENGAGEMENT AND SUPPORT** • Trust's overall level of staff engagement showing an improving trend and in line with national average (3.67 to 3.73) • Significant increase in NHS staff friends and family test from 3.53 to 3.71 • Trust is ranked as in best 20% of Trusts for 9 of the 28 key findings including those qualities required for effective change management i.e. • Satisfaction with the quality of care delivered • Work pressure felt by staff • Well structured appraisal • Staff suffering from work related stress • Good communication between senior management and staff • Trust –wide decision day to input to annual priorities for 2014/15 prior to annual business plan being agreed • Monthly staff surveys 'Your Voice' introduced in September 2013 at team level to measure staff engagement levels 'real time' and improve working lives • Trust's staff engagement methodology 'Listening into Action' well established and monthly CEO 'hot-topics' introduce key change programmes for discussion and staff feedback • Well established organisational change management policy, processes and track record of successfully delivering large scale change (service re-configuration, workforce reduction programmes) • Staff Health and Wellbeing Programme and support mechanisms for career advice, coping with change, counselling etc. • Healthy employee relations climate

NHS Trust Development Authority
Planning checklist: Quality and workforce
CIH Domains: Safe, Effective, Caring, Responsive to people's needs, Well-led

Most of the following requirements for assurance in the checklist apply to all Trusts, others to specific types of Trusts e.g. Acute Trusts. The note in brackets indicates whether it applies to all or only some e.g. "where applicable").

Please provide for each individual requirement:

confirmation that requirements are in place (yes/no)
a Trust assurance statement against each of the individual requirements (no more than 1 -2 paragraphs) either to support your confirmation of compliance (including how you could further evidence that if necessary, e.g. by referencing web links, key documents) or, in the case of non-compliance describe the mitigating actions/plan/timeline in place to achieve compliance.

Please also indicate against any requirements where you may benefit from support/signposting to best practice/linkages with other Trusts and any areas within the checklist where you are demonstrating good practice you are willing to share

Name of NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
1.	**Context** All NHS Trusts need to make demonstrable progress towards reducing avoidable deaths in our hospitals. This requires all NHS Trusts to have robust systems to identify and escalate deteriorating patients, in particular at weekend and out of hours, as well as robust governance systems of mortality surveillance and review. **(All)** **Trusts to confirm the following are in place:**			
	1.1 An early warning system is in place (e.g. NEWS) with evidence that this is linked to clinically appropriate procedures/pathways for escalation of care in deteriorating patients, at all times	Yes	Resuscitation Lead is the clinical lead in the Trust. Adopted NEWS in Nov 13 but the	Can Trust assure appropriate EWS for specialities e.g. children and

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			Trust has had early warning systems charts for the past 10 years. The NEWS observation chart is used for all acute adult inpatients. The Obs Chart includes the SIRS trigger tool linking to appropriate clinical escalation pathways. This includes the adjusted trigger points required for localisation in Maternity and Paediatrics The Trust will also be implementing an electronic early warning system called VitalPACs over the next year. This will include deployment in both Maternity and Paediatric areas. Both the Current NEWS system and the planned VitalPacs are linked to escalation procedures that trigger graded response from Clinical teams, Critical Care Outreach and Emergency Medical Response team	maternity?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	1.2 All deaths in hospital are reviewed using a screening template to identify any evidence of sub-optimal care	Yes	The Trust has implemented an electronic Mortality Review System which allows senior doctors to view clinical notes online and carry out the review. Preventable deaths are identified, reported on the incident reporting system.	
	1.3 All deaths where aspects of care were judged to be suboptimal should undergo a thorough review by a multi- disciplinary team, including Doctors (Consultants/GPs and junior doctors), Nurses, Pharmacists/other AHPs as appropriate with outcomes reported to a Mortality Review Committee (or equivalent) and any further action taken e.g. case note reviews, which should take into account national guidance	Yes	It is agreed with the CCGs that at least 80% of inpatient deaths must be reviewed by a senior doctor within 42 working days of a patient's death. All reviews which flag up that care was potential sub-optimal are flagged on the incident reporting system and further investigation and multi-disciplinary review is carried out including where necessary a full TTR.	Rated green: Further assurance required that all deaths where care was suboptimal are subject to MDT review
	1.14 A Trust wide Mortality Review Group (or equivalent – a multi-disciplinary team including consultants, junior doctors, nurses etc) chaired by the Medical Director monitors mortality to identify and consider emerging themes of reviews. The Trust should have defined processes to evaluate risk-adjusted mortality rates across specialities in order to compare rates with peer organisations. Actions are taken to embed learning, triangulated with other quality measures (eg complaints, adverse incidents and patient feedback); and findings are reported to public Board meetings	Yes	The Mortality & Quality Alerts Committee meets monthly, chaired by the Medical Director, and reviews many aspects of mortality & morbidity. SSIs are reported at the Public Board. Mortality review rates are	How is learning embedded?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			monitored through the Assurance and Accountability Framework. A Mortality report is fed back to Clinical Group and Directorate Governance forums where learning is shared as part of mortality and morbidity review.	
2.	**Context** All Trusts should have an open and transparent culture in which serious incidents are routinely reported, investigated and learned from **(All)** **Trusts to confirm the following are in place:**			
	2.1 The Trust has systems in place to ensure reporting, investigation, closure rates and learning of all Serious Incidents, Never Events, CAS (Central Alerting System) Alerts, and the National Reporting and Learning System, in line with national requirements (SIRI Policy 2010, Never Events Policy Framework 2012, National Patient Safety Warning System, Care Quality Commission (CQC), 2009/10, Core Standards C1b: Safety Notices)**.** There should be regular reports to the Trust public Board	No	High level information is currently provided in the Quality Report that is presented monthly to the Board. From February 2014 KPIs for the requirements stated will be included in the refreshed Integrated Quality, Performance and Finance report (the Quality Report will be discontinued). Organisation wide learning is variable and actions are in place to strengthen this. A patient safety summit is being held in February 2014, as a launch platform for increasing awareness. An external review of theatre safety has been	What is the timescale for this? Has this been risk rated?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			commissioned. New approaches are being introduced to share learning across the organisation e.g. issuing 'Learning Alerts' via video messages. The Patient Safety Summit launched on 13 Feb 14. A safety culture exercise commenced here and is being rolled out. The first learning alert video was sent to all Trust mobiles and via the intranet in Jan 14. KPIs are incorporated into the dashboard already. Reports of non- closure of alerts and incidents are reported through the Patient Safety Committee and with the CCG. Escalation processes have been refined.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	2.2 The Trust should have systems in place to ensure active use of the patient safety thermometer with regular reporting to the Trust public Board	Yes	Monthly data collection established and regularly reported in the quality report to date and will be included in the Assurance and Accountability Framework. Feedback from the monthly assessment is discussed with the matrons and senior nursing team and followed through to individual wards any immediate actions are taken as a result of the round of feedback.	How are lessons learned implemented?
	2.3 Trusts should have processes in place to enable staff to raise concerns safely through clear and accessible policies and procedures	Yes	Incident reporting is accessible to all staff and a whistle blowing policy exists. This policy is currently being reviewed and following approval in January will be subject to a comprehensive launch campaign. Lessons are implemented at the service level and for serious incidents monitored through the corporate risk team.	How are lessons learned implemented?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
3.	**Context** The importance of ensuring safe staffing is critical. All Trusts need to ensure a robust approach to workforce planning, sign off, monitoring and reporting that ensures sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services. Whilst there are specific expectations set out *in the National Quality Board's Safe Staffing 'How To Guide' for Nursing, Midwifery and care staff*, Trust Boards should assure themselves that the whole clinical staff is sufficient to deliver safe care. ***(All)*** **Trusts to confirm the following are in place:** **Workforce Planning:**			
	3.1 A workforce planning process is in place that supports the Trust IBP's Clinical Strategy and LTFM	Yes	The Trust has a workforce planning process that supports the annual workforce plan submission and the workforce chapter of the IBP. All directorates are required to identify workforce changes as part of annual and cost improvement planning. The Trust has a Board approved Workforce Strategy. Workforce planning is overseen by the Workforce Committee of the Trust's Clinical Leadership Executive and the Workforce Assurance Committee of the Board.	Red rag rate for work force plan, what risk to quality and safety? **(CUT & PASTE ERROR)**
	3.2 A Board-approved workforce plan for the period 2014-16 developed by a multi-disciplinary team (using benchmarked workforce metrics and ensuring triangulation with finance and activity). This should take into account relevant workforce guidance for specific staff groups, such as the National Quality Board guidance on safe staffing,	Yes	The Trust has developed a workforce plan for the period that is reflected in the supporting Submissions to the TDA. This has been developed as part of the new	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	and should be underpinned through the use of evidence based tools such as Safer Nursing Care Tool, or Birth Rate Plus		hospital approvals process and has been approved by the Board.	
	3.3 Quality Impact Assessment processes should be conducted on Cost Improvement Plans and their currency maintained in year in line with National Quality Board Guidance on CIPs, published June 2012.	Yes	QIA process established and reported during 2013/14. QIA to be undertaken on 2014/15 and 2015/16 savings plans. QIAs are managed and monitored through the use of the TPRS-electronic transformation planning reporting system. Cyclical reports are sent to the clinical / group director responsible for the TSP (transformation savings plan) and when completed are referred to the Med Director / Chief Nurse for sign off or rejection.	
3b	**Workforce Plan Sign Off**			
	3.4 The workforce plan, including the impact of any cost improvement plan on workforce should be signed off by the Medical and Nurse Directors prior to full Board approval	Yes	Completed for 2013/14. Work in progress for 2014/15	
3c	**Workforce in-year monitoring and reporting:**			
	3.5 Policies and systems such as e-rostering and staffing escalation policies should be in place to support those with responsibility for staffing decisions on a shift-to-shift basis	Yes	E-rostering in place for wards and role. Internal polices minimum staffing policy in place for nursing. An e.roster system is in use in the	More narrative required re escalation, and shift to shift staffing decisions.

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			majority of inpatient wards.The system produces a roster as per agree thresholds to deliver safe and effective care.The roster is authorised by the ward matron who also has responsibility for monitoring on a shift by shift basis that safe staffing levels are met and for taking corrective action if there is a risk that they may not be met. The Clinical Group nursing leadership team also have access and receive monthly reports regarding the predicted and actual use. In addition to the agreed level threshold, in practice the e.roster system is supported by an operational policy and an annual leave policy. Running in tandem with these policies and systems there is a safe minimal level staffing policy which again defines the number of staff required on duty to deliver safe care.and the escalation process to be applied when these levels are not met.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	3.6.1 Boards should receive monthly updates on the staffing profile using agreed workforce KPIs. Actual versus planned nursing and midwifery should be published.	Yes	HR Dashboard reported to the Workforce Assurance Committee. Key workforce KPI's also included within Performance Report. Workforce metrics are monitored through the AAF and IFQP.	
	3.6.2 In addition, in the case of Nursing, Midwifery and care staff, in line with the National Quality Board's Safe Staffing 'How To Guide', Boards should receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. The Government's response to Robert Francis adds that from April 2014 and by June 2014 at the latest, NHS Trusts should publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing should be published every month.	No	Nursing and midwifery staffing reports received at board and monthly data in the performance reports. Plans are underway to have public facing information on each ward about the number of staff on duty and the ratio of patients to registered nurses by February 2014. This activity along with e-rostering data will then feed the board with the relevant information and triangulated with data about the quality of care.	
	3.7 Every six months, the Trust board will undertake a detailed review of staffing using evidence based tools. The first of these will take place in June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools	No	Not currently in place. Plan being drawn up over the next month.	Plan in place with timescale
	3.8 The Trust should have a register of risks against the workforce plan, underpinned by a reliable system for monitoring CIP schemes in-year assessing the quality impact in line with NQB	No	A risk register for the workforce plan will developed by March. All CIP schemes are quality impact	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	Guidance on CIPs.		assessed by the Chief Nurse and Medical director. The Trust has agreed not to develop a separate set of metrics for measuring the quality impact of CIPs. Therefore the any adverse quality impact of CIPs is identified through the routine integrated performance reporting system.	
	3.9 All Trusts should display information about the number and grade of nurses, midwives and care staff on duty for each shift in all clinical areas. Compliance with NICE Guidance once issued will be expected.	No	Plans are underway to have public facing information on each ward about the number of staff on duty and the ratio of patients to registered nurses by February 2014.	Plan in place with timescale
4.	**Context** All Trusts should continue to support reductions in Healthcare Associated Infections through a robust strategy for infection prevention and control, underpinned by the Health and Social Care Act: Code of Practice on the prevention and control of infections **(All)** **Trusts to confirm the following are in place:**			
	4.1 Full compliance with the Health and Social Care Act: Code of Practice on the prevention and control of infections	Yes	Detailed monitoring is well established and reported at the Infection prevention and Control Advisory Committee.	
	4.2 Confirm there is a Director of Infection Prevention and Control (DIPC) accountable directly to the CEO	Yes	The Chief Nurse has this title and portfolio of work.	
	4.3 Confirm an IP&C multidisciplinary team including agreed provision for data management support	Yes	A well established team exists with identified ICD, ICN's and data management and antimicrobial pharmacist posts.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	4.4 A robust Root Cause Analysis and Post Infection Review programme in line with national requirements; SI reporting for outbreaks and deaths associated with HCAIs and formal review of CDI 30 day mortality	Yes	Fully compliant with RCA's being completed along with colleagues from commissioning and primary care. Formal process with table top review for all deaths at 30 days where C diff is the causative factor on part 1 of the death certificate are undertaken.	Clarification required that the Trust has a formal review of 30/7 C.diff mortality
	4.5 An established antimicrobial stewardship programme that meets all of the recommendations contained in the national DH ARHAI guidance (section 2.4 and its sub- sections)	Yes	Antimicrobial stewardship well established with leadership from within the infection control team.	
5.	**Context** All Trusts should have a proactive approach to optimising the use of medicines to support high quality care **(All)** **Trusts to confirm the following are in place:**			
	5.0 There is a named lead Director with Trust-wide responsibility for medicines optimisation	Yes	The Medical Director, Dr Roger Stedman, is the lead director.	
	5.1 The Trust has a medicines optimisation strategy informed by tools such as the NTDA medicines optimisation framework and the Royal Pharmaceutical Society's 'Principles for medicines optimisation'	No	The Trust has completed the NTDA Medicines Optimisation Assessment and reviewed the pharmacy service against the RPS professional standards for Hospital Pharmacy and a medicines optimisation strategy will be developed based around these. Anticipate the strategy will be completed by year end and fully implemented across the Trust by	Amber: Request estimated dates for completion of the strategy and implementation

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			1/4/15.	
	5.2 The Trust has a robust mechanism to identify, monitor and reduce harm from medication errors (e.g. medication safety thermometer)	Yes	The Trust has a Medication Safety Group which considers issues around medicines safety, including clinical incident reports, important adverse drug reactions, litigation and complaints. It also commissions audits related to prescribing, dispensing, administering and storage of drugs, reviews report findings and draws up action plans to address areas of issue as required. The group monitors medication incidents using information form governance systems. The review process is being revised. Implementation date for revised monitoring processes is September 2014	Does this group monitor medication incidents and monitor actions/outcomes?
	5.3 The Trust has a development plan to implement the recommendations of the national 5-year strategy for antimicrobial resistance	Yes	There is a multidisciplinary Antibiotic Management Group (AMG). The AMG has a work plan in place to deliver key antimicrobial stewardship initiatives; both the strategy and	Amber: Request estimated dates of plan completion and implementation. Does this plan include liaison with

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			AMG work plan address the points mentioned in the DH AMR 5 year plan. The AMG work plan currently incorporates the relevant activities as ongoing tasks, without completion dates as they don't really apply. A document addressing the DH 5 year AMR plan 'activities', whether or not they apply to SWBH, and if so, how we are tackling them, has been produced by the AMG team. The Trust is developing links with CCG pharmacy lead for antimicrobial prescribing to extend learning from hospital prescribing measures to primary care. The Trust is also contributing to development of NetFormulary for GPs in primary care.	primary care colleagues?
6.	**Context** To support improved outcomes and quality of life in treatable conditions such as stroke and heart disease, all Trusts should ensure full participation in all national clinical audits for the services that they provide **(Where applicable)**			

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	Trusts to confirm the following are in place:			
	6.1 Trusts are actively taking part in all relevant clinical audits as listed in the HQIP list (www.hqip.org.uk/2013-2014-quality-accounts- list/) and also audits specified by NHS England Specialised Commissioning where appropriate. The Trust publishes the results and the participation rates, with regular reporting to the Trust's public Board	Yes	As reported in our Quality Account for 2012/13 the Trust participated in 97% of national clinical audits and 100% national confidential enquiries which it was eligible to participate in. High level audit information is reported to the Board each month in the Quality Report. KPIs are in development to monitor compliance. These will be included in the revised Integrated Quality, Performance and Finance Report. Participation rates are available through a link on the Trust website.	
	6.2 The Trust will publish activity, clinical quality measures and survival rates from national clinical audits for every consultant practising in the ten specialties identified by NHSE for publication and include any subsequent additions to ensure the Board receives audit reports and action plans.	Yes	This information is available through a link on the Trust website.	
7.	**Context** - NICE Quality Standards can be used to evaluate and review services to support improved outcomes **(Where applicable)**			

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	All Trusts should use NICE quality standards to self-assess relevant services they provide, eg Dementia, to support their understanding of areas for improvement	Yes	The implementation of relevant NICE Guidance (Including Quality Standards) is managed through the Trust's policy for the implementation of national clinical guidance. The policy requires baseline assessments (self-assessments) against key recommendations or standards to be conducted by the relevant service leads and any areas of non-compliance identified and appropriate actions determined. The Trusts NICE Implementation Group monitors the completion of baseline assessments and reviews the compliance reported.	What process in place for monitoring this?
8.	**Context** The move towards an NHS staffed with senior decision makers 24/7 is critical in supporting the provision of high quality services **(All)** **Trusts to confirm the following are in place:**			
	As set out by NHS England, on 7-day working, local contracts for 2014/15 should include an Action Plan to deliver the	No	The Trust has implemented a number of development for 7 day	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	clinical standards within the Service Development and Improvement Plan Section		working this year. The partnership Urgent Care Board has agreed to take on the partnership programme approach for 7 day service development. Contract rounds in process and action plan to be included.	
9.	**Context** - Treating mental and physical health conditions in a coordinated way, and with equal priority, is essential to supporting recovery. Yet people with mental health problems have worse outcomes for their physical healthcare, and those with physical conditions often have mental health needs that go unrecognised. NHS England's objective is to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole. **(Where applicable)**			
	The NHS Mandate sets out the need to ensure measurable improvement by March 2015, towards achieving true parity of esteem where everyone has timely access to evidence based services, Trusts should aim to support delivery of the necessary improvements in 14/15 in agreement with Commissioners with reference to the Government's soon to be published Action Plan, 'Priorities for change in mental health care and support' and Mental Health Crisis Care Concordat	No	Will consider action plan when published and ensure local plan developed to achieve recommendations.	
10.	**Context** Getting to know patients and managing their journey through the system effectively can make all the difference in ensuring they are cared for safely **Trusts to confirm the following are in place:**			
	Every patient should have a named consultant and named nurse responsible for their care while they are in hospital, with their name above their bed ***(Where applicable)***	No	A corporate template has been introduced above each bed however this is not being consistently implemented. This will	What is the timescale for this?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			be reinforced through staff communications during February 2014. However, we have further work to do on what this role means in practice, so that staff and patients understand the role in the same way. This will be part of our 10/10 campaign in the spring.	
11.	**<u>Context</u>** It is important to have effective systems in place to collect, measure and respond to patients, relatives and carer feedback to ensure they are equal partners in care, treated with dignity and understand what is going to happen to them and why at each stage of their treatment **(All)** **Trusts to confirm the following are in place:**			
	11.1 Trusts should have clear plans in place to meet national CQUINs response rates for the Friends and Family test (FFT) in all areas required by the national guidance on FFT. The FFT already applies to Acute in-patient, A and E and maternity services and Trusts should have plans in place where applicable to roll out in Mental Health services by the end of December 2014 in line with national guidance. The Trust can provide evidence that it is using the learning from FFT to drive improvement in the quality of patient care **(Where applicable)**	Yes	This CQUIN is established in our programme of work with increasing trends in performance across all areas. Multiple methods are used to collect information and our efforts continue to ensure that this is grown and sustained in the coming year. FFT response rates and scores are monitored through the Assurance and Accountability Framework. Results and learning are discussed in the Group Performance reviews to ensure learning and actions are picked up	How are lessons learned implemented?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			A new Patient experience Group of our Clinical Leadership Executive provides a focus for all activities designed to address improved patient experience	
	11.2 Trusts should have a clear approach to listening and responding to patients including; effective ways of gathering real time information and responding to feedback with regular reports to the Board. Trusts to use the TDA patient experience measurement framework, to be published in the 2014 Accountability Framework, which will enable Trust Boards to view data and benchmark performance against other NHS Trusts.	Yes	A new Patient Experience Group has been established in the latter part of 2013 chaired by the Chief Executive to ensure that patient experience is identified as a key priority. Patient stories are brought to the board to ensure that Board members are sighted on the lived experiences of patients. Complaints are managed in a structured manner and themes and data relating to complaints is reported to the Board. A number of local initiatives across the trust have been established. Assurance and Accountability framework is in development and planned implementation February 2014. We collect real time patient feedback on meridian system and have invested in iPads used at	More detail required on the use of RT feedback to improve services

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			ward level to help with data collection. The results are available to frontline staff in real time via a portal. The system also actions detractor responses as an automatic email to the ward or department.	
	11.3 The Board should prioritise the use of patient stories. It should develop strong partnerships with local healthwatch organisations **(All)**	Yes	Patient stories are brought to the board to ensure that Board members are sighted on the lived experiences of patients. There is only minimal involvement of Health watch to date and will be part of our growing patient involvement and experience priorities for 2014.	
12.	**Context** An independent review into the Liverpool Care Pathway concluded in July 2013 that the pathway should be phased out and the forthcoming recommendations of the Leadership Alliance for the Care of Dying People adopted to support improved care of the dying. **(Where applicable)** **Trusts to confirm the following are in place:**			
	12.1 A Board member should have the responsibility for dealing with complaints about an end of life pathway and an independent assessor on complaints should be made available if families request one.	Yes	The Chief Nurse has Board responsibility Requests for independent assessment by families will be met on all occasions and in some circumstances may also	Narrative not quite clear

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			be instigated by the Chief Nurse.	
	12.2 Trusts should be able to demonstrate they have plans in place to consider and implement where necessary, the forthcoming recommendations of the Leadership Alliance for Dying People, including the need to ensure that the LCP is replaced no later than July 2014 with an end of life care plan for each patient that is in line with the recommendations	Yes	The Trust has initiated action plans to deal with the 44 recommendations. LCP is not used in the Trust - a Supportive Care pathway is in place and widely used.	
	Context and Requirement *Trusts must prepare plans which ensure compliance with all of the rights and pledges conferred by the NHS Constitution. Where current performance is below the standard required a robust recovery plan with improvement trajectory must be prepared and submitted. Please confirm compliance with this expectation in relation to the specific requirements below and where not compliant provide details of recovery plans in place*			
13.	Maintain delivery of Referral to Treatment 18 week maximum waiting time standards of: **13.1** 90% within 18 weeks for admitted patients; **13.2** 95% within 18 weeks for non-admitted patients; **13.3** 92% within 18 weeks for incomplete non-emergency pathways (yet to start treatment)	Yes	Trust level compliance. Recovery plans in place at specialty level with trajectory for activity / performance standards.	
14.	Zero tolerance of any referral to treatment waits of more than 52 weeks	No	52 week breaches currently reported as the tail end of the historical validation process is completed. From 14/15 no breaches forecast.	Trust non-complaint for reasons that are well understood.
15.	Maintain and improve on reductions in waiting times for diagnostic tests and do not exceed more than 1% of patients waiting longer than 6 weeks	Yes	Direct access pathways in cardiology and orthopaedics introduced in 13/14. Local	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			development plan for those areas with breaches.	
16.	At least 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival in accident and emergency	Yes	Compliant in November and December. Recovery plan submitted in Q2/3 13/14.	
17.	No patient should wait longer than 12 hours on a trolley in accident and emergency	Yes	Complaint performance since May 2013	
18.	Sufficient capacity is in place to deliver the following cancer waiting time standards: **18.1** maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%; **18.2** maximum two week wait for first outpatient appointments for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%; **18.3** maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers – 96%; **18.4** maximum 31 day wait for subsequent treatment where that treatment is surgery – 94%; **18.5** maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%; **18.6** maximum 31 day wait for subsequent treatment where that treatment is a course of radiotherapy – 94%; **18.7** maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer -85%;	Yes	Compliance with standards. Demand and capacity profiling to be completed for next year.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	18.8 maximum 62 day wait from referral from an NHS Screening service to first definitive treatment for all cancers – 90%; **18.9** maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set.			
19.	75% of Category A emergency responses arrive on scene within 8 minutes (target to be met for both Red 1 and Red 2 calls separately)	N/A	This is the West Midlands Ambulance Service (WMAS)	
20.	95% of Category A emergency responses arrive on scene within 19 minutes	N/A	This is the West Midlands Ambulance Service (WMAS)	
21.	All handovers between an ambulance and A&E Department take place within 15 minutes and crews are ready to accept new calls within a further 15 minutes	No	Latest data shows 89.1% of ambulance to A&E handovers taking place within 15 minutes. This shows significant improvement from Sept 2013 (79.5%). Our Urgent Care Board continues to focus on this area of performance.	Good description. Actions in place.
22.	The Trust has published a declaration of compliance with mixed sex accommodation requirements and any breaches are minimised	No	Revised policy to be ratified and a new compliance statement to follow in Q4. A Majority of breaches reported related to critical care.	Policy in development and actions in place.
23.	All patients who have operations cancelled on or after the day of admission (including day of surgery) for non-clinical reasons are offered another binding date within 28 days, or the patient's treatment is funded at the time and hospital of the patient's choice	Yes	Performance standard. Local process and policy in place.	
24.	There is zero tolerance of an urgent operation being cancelled for the second time	Yes	Local process and policy in place.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
25.	95% of patients under adult mental illness specialties on the Care Programme Approach are followed up within 7 days of discharge from psychiatric inpatient care	N/A		
26.	The NHS Trust is preparing for full roll-out of the access to psychological therapies programme by 2014/15 and for the recovery rate to reach 50%.	N/A		
27.	The Trust has plans in place to deliver a zero tolerance approach to MRSA infections	Yes	The trust has robust plans in place for zero tolerance to any hospital acquired infections and continues to monitor MRSA bloodstream infections and screening rates for MRSA. All are reported via the Infection Prevention and Control Advisory Committee and the Annual report.	
28.	The Trust has plans in place to deliver the agreed *Clostridium difficile* trajectory	Yes	The trust has robust plans in place for zero tolerance to any hospital acquired infections and continues to monitor Clostridium Difficile rates and is currently performing well against expectations All cases are reported via the Infection Prevention and Control Advisory Committee and the Annual report.	
29.	The Trust is preparing for a potential move to paperless referrals in the NHS by March 2015	Yes	The Trust has an agreed informatics strategy which will migrate the organisation from a paper to a paper light operating model. A key step in that transition	

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			is the use of electronic data exchange between secondary and primary care. The Trust has already proven the ability to transmit clinical letters to primary care and this infrastructure can be extended to support paperless referrals that can be received from primary or via choose and book.	
30.	The Trust will use the NHS number as the primary identifier in 2014/15 to facilitate national data collection	Yes	The Trust uses the NHS number as the primary identifier. The Trust has a single PAS in all acute and feeds other downstream EPR systems – this is linked to the spine and thus contains NHS numbers, and patients can be identified/searched by the NHS number alone if needs be. The Trust Community services use a different PAS which uses the NHS number as its Primary identifier and thus all documentation produced also contains the NHS number.	
31.	The Trust will ensure its data on the Secondary Uses Service is complete and of the required quality	Yes	Data is signed off by COO as being accurate and reflective of the Trust. The Trust has a focus on developing assurance processes for the data quality of reporting	

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			standards which will be delivered with a new kite mark score of data quality.	
32.	All NHS Trusts who provide community services should have systems in place to fully collect all data fields contained in the Community Information Data Set (CIDS). Where this is not the case please provide an update on progress in implementing the CIDS including as a minimum your current data capture completeness and date when you expect to have a fully populated and compliant IT System	Yes	All Clinical data is entered into SystmOne for community services. This enters data on a patient by patient basis and captures all mandatory data fields required for CIDS. SystmOne was implemented in community over 3 years ago and has been modified by the system provider to capture the CIDS data.	
33.	The Trust will comply with data collections that have been approved by the Information Standards Board, including the Systemic Anti-Cancer Therapy dataset and Cancer Outcomes and Services dataset	Yes	E-prescribing project in progress. CIS Healthcare are on site building up the chemotherapy e-prescribing system. Go live date remains 1st April 2014. Initial clinical regimens will be haematology Lymphoma regimens rather than Gynae as originally planned. (Gynae will be delayed due to the Consultant being on leave early April). The Trust is aiming to meet the October 2014 national target, though we continue to signal that	Please describe progress of e-prescribing project.

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			a minority of regimes may take up to six months longer to implement (see CEO correspondence to LAT etc autumn 2013) At this point the Trust will roll out a system upgrade and introduce scheduling within the system which will improve patient experience and provide granular evidence for audit and service redesign In order to ensure that this is aim is achieved the System Administrator and Senior Pharmacist Technical Services will be trained as Prince2 practitioners to keep the implementation on track.	
34.	**Context** All Trusts need to ensure their complaints system is carried out in line with national guidance and that they are working towards implementation of the recommendations of the Clwyd/Hart review relevant to them to support improved handling of complaints **(All)** **Trusts to confirm the following are in place:**			
	34.1 Their complaints service meets national requirements set out in The Local Authorities and NHS Complaints (England) Regulations 2009 and NHS Constitution	Yes	A devolved model of complaint investigation and management was	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			introduced last November to ensure consistent and robust compliance with the national regulations, particularly around the timeliness of responses, improvements in practice directly arising from complaints and wider organisational learning. KPIs have been set for monthly monitoring and assurance purposes, with a formal evaluation of the new arrangements in March 2014.	
	34.2 A Quarterly Complaints report is produced for the Board evidencing the learning from complaints, setting out the number, type and theme of complaints and compliance against national requirements	Yes	High level complaint information is provided within the monthly Quality Report as well as progress against the KPIs in the monthly performance report. Action plans, where appropriate, are devised and implemented at service level and also monitored by the	How are lessons learned implemented?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			directorate/group. During Q1 we plan to integrate complaint, incident, and other signal reporting. So that localised patterns reported through different channels are aggregated.	
	34.3 Evidence of implementation of the Clwyd/Hart review	Yes	Changes to process will be shared with the CCG (or QSC) at the monthly review meetings. Staff training is in place for staff who manage complaints. The emphasis on training and within recently updated patient information is to try and resolve concerns at the local level. Staff respond to complainants following investigation of concerns rather than a corporate complaints process. Staff are encouraged to contact complainants, clarify issues and to meet as the first line of resolution. Web page updated with easier to use complaints form, a new 'raising your concerns form' developed. Introduction of a revised complainants feedback	More narrative required

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			form.	
35.	**Context** All Trusts need to have in place effective child and adult safeguarding procedures which support inter-agency working **(All)** **Trusts to confirm the following are in place:**			
	35.1 Trusts need to have systems in place on child and adult safeguarding that adhere to statutory guidance and are in line with the NHS England guidance, *Safeguarding Vulnerable People in the Reformed NHS, Accountability and Assurance Framework*	Yes	Children's Services' Performance Accountability Board has requested an assurance report from Sandwell and West Birmingham Hospitals NHS Trust (SWBHT) in relation to supervision arrangements as detailed below: an audit of what supervisions are being carried out with front line staff; how the arising management actions from staff supervision are captured; and how the arising management actions from staff supervision are implemented **SUMMARY FINDINGS** Supervision is offered to all health visitors every 12 weeks The families discussed at supervision are the most	Not sure the narrative assures compliance

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			vulnerable on a practitioners case load This ensures that practitioners are supported in dealing with their most complex cases. Compliance to practice standards and supervisees view of the supervisory process is monitored through the audit process, 100 % of records audited had a completed care plan an increase of 6% from 2012 audit 70% of care plans were found to be robust or of quality (defined by time frames/ review dates and reference to Every Child Matters) 66% of the care plans reflected the most up to date care delivered, as documented on paper and electronically. This significant drop demonstrates the difficulty In duplicating data in both records. This reinforces the concept of Sandwell health visiting service becoming paper free/ paper light 67.5% of the Health Care	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			Needs Analysis (HCNA) on the child reference card corresponded with the care plan, a drop of 4.5% 84.5% of the children had been seen within the last six months and increase of 0.5% A Supervision Report is prepared annually with key recommendations and actions identified with timescales for completion detailed The Health Visiting service had an article accepted in the Nursing Times 'Using supervision to protect vulnerable families'; the article was double-blind peer reviewed and published in November 2013. The article provides a summary of the current HV supervision model and has been cited by NHS England as best practice across the region. **School Health Nursing** The service was in the process of recruiting to supervisory lead posts	

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			to mirror the HV supervisory arrangements. This is no longer being progressed due to the contract for this service ceasing at the end of March 2014. Staffs currently receive supervision from team leaders and the Trust Named Nurses. **Midwives** Supervision for safeguarding issues for midwives is provided as required by the named midwife, with a proposed development for group supervision going forward. **Monitoring arrangements** Audit action plans are monitored at the Children's Safeguarding Committee reporting to the overarching Trust Safeguarding Committee, chaired by the Deputy Chief Nurse, and reporting on to the monthly executive-led Clinical Effectiveness Committee. Executive leadership sits with the Chief Nurse. Identified	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			clinical/named and designated professional staff are in post and an additional Safeguarding Children's lead is currently being recruited. The current policy is under review as part of the natural review process, this includes a review of training. Systems are in place however work is underway to embed and test the robustness; There are two safeguarding boards because of the geographical dimensions of the trust catchment area and arrangements are different for each. We are working to gain assurance from external agencies about their systems of work. This is one of our key areas of work for 2014/15.	
	35.2 The Trust is taking into account the recommendations of the Report of the Children and Young People's Outcomes Forum	Yes	Training event held with the Women's and Children's group on the outcomes framework A self-assessment against the outcomes framework was undertaken in May 2013 and a local action plan put in place for the actions which relate to the Trust	Not sure the narrative assures compliance

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			Work has been established with the trust to ensure that safeguarding is a key priority during 2013/14 and moving into 2014/15 there are a number of areas of good practice however, teenage pregnancy, youth work and transition to adult services for children with long term conditions, and adolescent care remain within our immediate focus.	
	35.3 Trusts must demonstrate they are compliant with the Winterbourne Concordat https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213217/Concordat.pdf	Yes	There are a wide range of initiatives which are embedded which include training for staff, identification of patients with a learning disability on our electronic systems, pathways of referral for specialist advice and support which is expected within 24 hours of admission. There is evidence of reasonable adjustments made e.g. carers being allowed into anaesthetic rooms. We have active member of both Birmingham and Sandwell Safeguarding Adult's Boards and the respective subgroups The Chief Nurse executive director	Narrative does not assure compliance

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			for safeguarding and care for vulnerable adults We have put in place specific training regarding care of the person with a Learning Disability this training has involved people with a LD, and we have planned for more training delivered this way. Changing our lives, advocacy group which includes people with an LD are involved in audits of the trust. They also chair the 'Healthcare for All' group looking at improving and maintaining high quality care within SWBH. Deprivation of liberty responsibility is delegated to adult safeguarding team, policy in place and training delivered within safeguarding adult's mandatory training and additional ward based training. SWBH process of DoLs requests recognised by both DoLs supervisory bodies as of a high standard with the highest number of appropriate requests in Birmingham. Whistleblowing policy discussed in	

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			safeguarding training with one scenario specifically designed with a member of staff as a perpetrator of abuse and the process to follow. Communication boxes available and range of easy read information as well as liaison nurse support. Disclosure and Barring Service processes in place. We have a working group re challenging behaviour which is in its infancy. Challenging behaviours is included in out dementia training; areas which identify challenging behaviour will phone safeguarding team for advice. Extreme challenging behaviour which involves the use of security for support is always recorded as an incident. We have access to a liaison nurse, employed by the Black Country mental health trust with funding from Sandwell LA, she will help and support with any patient.	
36.	**Context** By recognising that every patient has different needs and circumstances, we can best meet those needs and improve			

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	outcomes by delivering a personal form of care, using and supporting the diverse talents and experiences of our workforce. **(All)** **Trusts to confirm the following are in place:**			
	All organisations should be using the Equality Delivery System (EDS2) toolkit to provide assurance that the organisation is working effectively in this context	Yes	The Trust has a comprehensive programme around Equality and Diversity and a very detailed assessment against version 1EDS. This is being mapped to the version 2 tool kit and once completed will be submitted to Healthwatch for assessment during 2014.	
37.	**Context** The strong evidence from the Keogh Reviews is that a common theme was poor Governance. All Trusts should regularly assess the robustness of their quality governance processes using Monitor's Quality Governance Framework, and, once introduced, the new joint assessment framework being developed by the Care Quality Commission, Monitor and NHS TDA. **(All)** **Trusts to confirm the following are in place**:			
	All Trusts will need firm plans to take action to strengthen their governance and leadership in response to the new joint assessment framework being developed by the Care Quality Commission, Monitor and NHS TDA. Until the new framework is available, all Trusts should evaluate their governance arrangements against Monitor's Quality Governance Framework (QGAF).	Yes	The Trust in 2013/14 undertook a self-assessment against the QGAF, a view which was validated by Deloitte and provided a quality score of 5.5. Further work has been undertaken since, to introduce and embed measures which would improve the Trust's score against the QGAF. Further work is planned in early 2014 to reassess the position against the	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			QGAF and identify any areas of further development needed.	
38.	**Context** *There is strong evidence that where staff are well supported and where their well-being is a priority for their organisation, there is a significant and positive impact on outcomes for patients and service users (All)* **Trusts to confirm the following are in place:**			
	38.1 All Trusts should have a process in place for gathering, analysing, reporting to the Board and acting on staff feedback. This should include the national staff survey but all Trusts should have more frequent local surveys in place covering all staff groups. Examples include the cultural barometer approach being tested in some Trusts, listening into action work, and tools such as the medical engagement scale.	Yes	Trust was a pioneer of Listening into Action. Since August 2013 we have introduced monthly staff polling. Results are reported to the Clinical Leadership Executive and the workforce Assurance Committee of the Board. Our 'Your Voice' survey polls 2500 people every month and we act on the results. The Chairman undertakes monthly staff walkabouts. The Chief Executive undertakes open briefing sessions monthly, as well as using media such as open Twitter chats.	
	38.2 Working with Health Education England, Trusts should have a process in place for regularly considering the feedback from medical and non-medical trainees such as the GMC National Training Survey	Yes	Feedback from Medical Trainees such as the GMC Survey and JEST feedback is looked at by the Postgraduate Clinical Tutors who then discuss the feedback with	What is in place for non-medical trainees?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			College Tutors and other relevant people within the specialty. If there are `red flags' then action plans are developed to rectify problems. Trainee feedback is regularly discussed at the Educational Committees and is also part of the rolling programme of meetings that the Postgraduate Tutors and Associate Medical Director have with the College Tutors. **Reg and Non registered Nurses** Written evaluation is collected at the end of all training provided. Trainee feedback is regularly reviewed by the Clinical Practice team and future training is planned taking into account the needs of the learners. Clinical MOT taught sessions are reviewed annually to ensure content reflects what is required by trainees as well as that of the organisation. Preceptorship feedback is evaluated monthly and taught sessions have been added in response to the need of the new	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			registrants. Clinical skills that are taught which include, male catheterisation, cannulation, phlebotomy, IV therapy are always accompanied by competencies that the learner must complete in their clinical area. Successful completion of competencies identifies that training has been effective. **Pre Reg Students** There are two major inputs: Students evaluations for each placement Via the ECQ returns Also 3rd year students as part of the National Student Survey which is being undertaken via the University at this time. There are also various Groups/ meetings that we attend with the Universities where students are part of the group (Course management meeting is one such as an example) For most of the other AHP's/ HCPC	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			it is via Course Tutor feedback/ Partnership meeting and Student Evaluations/ Feedback)	
	38.3 The Trust has arrangements to ensure all staff have appraisals and continuing professional development plans, with regular reports to the Board	Yes	PDR Policy in place for non-medical staff. Appraisal Policy for medical staff. Appraisal compliance data reported as part of the Performance Dashboard and HR Dashboard. PDR compliance is also monitored through the Assurance and Accountability Framework.	
	38.4 The Trust is compliant with the organisational and governance requirements of medical revalidation, and is preparing for nursing revalidation. The Board is assured that doctors are being appraised, and are receiving appropriate training and professional development to enable them to continue to improve the care that they deliver to patients.	Yes	The Trust has established a robust structure to manage Medical Revalidation. An IT system (PReP) has been purchased to assist with the medical appraisal process and the revalidation implementation process has been overseen by a Medical Revalidation Implementation Group chaired by the Medical Director. Regarding Nurse revalidation, we will respond to NMC consultation on revalidation.	What is planned for nurse revalidation?
39.	**Context** Trusts should ensure they fulfil their obligations in relation to the auditing and publication of Quality Accounts **(All) Trusts to confirm the following are in place:**			

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	Trusts can evidence a process for actively engaging patients and the public in identifying priorities for the Quality Account and that these are published in line with national requirements. There is evidence of independent auditing and liaison with CCGs and Health and Well Being Boards	Yes	The Trust has many patient involvement events to define the priorities. The Quality Account is sent to CCGs and Patient Groups for comment. The Quality Account was audited by KPMG for compliance with national guidance and accuracy of reporting.	
40.	**Context** All Trusts need to have robust Information Governance processes that comply with national guidance **(All)** **Trusts to confirm the following are in place:**			
	Trusts need to have a framework in place to ensure a minimum of level 2 compliance across all applicable requirements of the HSCIC Information Governance Toolkit and compliance with the Caldicott 2 review	Yes	The Trust is on track to declare compliance at level 2 for the Toolkit. There are no obvious areas of concern at present. Areas which may not be complaint or evidence is not easily available will have targeted actions to ensure compliance is achieved by the set timeframe.	
41.	**Context** *The Boards and leadership of Trusts need to be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement* ***(All)*** **Trusts to confirm the following are in place:**			
	41.1 The Trust has a quality dashboard/integrated performance report that assures the Board that services are Safe, Effective, Caring, Responsive and Well Led -	Yes	The Trust has produced a monthly integrated corporate performance report, inclusive of a wide range of quality and safety metrics, for the Board, for a number of years. In addition a separate monthly	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			Quality Report is produced, considered by the Trust's Quality and Safety Committee, which focuses on Patient Safety, Clinical Effectiveness and Patient Experience. During Quarter 4 (2013 / 2014), the 2 reports are to be integrated into a single report, which will go to the Board, with supporting narrative provided by relevant Executive leads.	
	41.2 Trusts should have a Board Director responsible for Quality Information	Yes	The Exec lead Tony Waite, Director of Finance.	
42.	**Context** No NHS organisation, however big, small or remote, should be an island unto itself. All Trusts need to ensure they take steps to guard against professional, academic and managerial isolation. One of the clear themes to emerge from NHS Trusts facing difficulties this year has been that they often act in isolation, and seldom have a satisfactory engagement programme which connects them to their patients, their staff, their stakeholders and their communities. **(All)** **Trusts to confirm the following are in place:**			
	42.1 Every healthy NHS Trust Board should have a planned strategy on engagement that they should risk rate and update on a regular basis. This year we would like NHS Trusts to develop a broad engagement strategy that should include plans to report on engagement with: **42.1A** Patients and carers **42.1B** Staff; **42.1C** Stakeholders; and, **42.1D** Communities	Yes	The Board has approved an engagement strategy that encompasses the public, communities, staff, and membership. A new Public Health and Communities Committee of the Board has been set up. This engagement strategy will be	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			reviewed in summer 2014.	
	42.2 All Trusts should be able to demonstrate active participation in local Clinical Networks, Clinical Senates and Academic Health Science Networks. Trusts should also be part of the planned patient safety collaboratives being developed by NHSE following the Government's response to Robert Francis	Yes	The Trust participates actively in local clinical networks. Each clinical speciality has a lead and engages in the networks by speciality. The Associate Director for Innovation attends the Academic Health Science networks. The Group Director for Women's and Child health attends the Clinical Senates. SWBH Chief Executive is the representative on the oversight and scrutiny committee for Clinical Networks region wide, as the Trust hosts the WM Quality Review service.	
	42.3 Providers should actively release staff to support improvement across the wider NHS, including Chief Inspector of Hospital inspections, peer review, and education and training activities, and those of the Royal Colleges.	Yes	Staff have been encouraged to enrol of CIH visits though the Trust's intranet. The Trust hosts the West Midlands Quality Review Service – a local peer review service Postgraduate and undergraduate clinical tutors are actively engaged with Colleges	

Planning checklist: Finance

Name of NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	Trust plans must comply with the financial elements of the TDA planning guidance. Please confirm compliance in relation to the specific requirements below:			
1.	The financial plan is consistent with the latest financial trajectory agreed with the NTDA. This may take the form of an LTFM with a view to either achieving FT status or being part of a transaction or a recovery plan.	Yes	This is the case.	
2.	The Trust is planning for a surplus / deficit in 2014/15 and 2015/16 in line with its LTFM / transaction / recovery plan	Yes	This is the case.	
3.	In 2014/15 and 2015/16, on an exception basis, any Trust planning for breakeven or a deficit is in formal recovery	Yes	Noted The Trust plan is consistent with the LTFM submission of a recurrent surplus of £4.5m (1.1%) reduced non-recurrently by £1.4m to £3.2m.	Trust plan is not delivering 1% surplus as per guidance. TDA to discuss & progress this with new CFO.
4.	If each of 2014/15 and 2015/16 the Trust is planning for minimum of 0.5% of turnover as a contingency fund	Yes	This is the case.	
5.	In 2014/15 the Trust is planning for cost uplifts in acute service prices of 2.5% and non-acute service prices of	Yes	The Trust plans to comply with these financial planning assumptions.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	2.2%. Both acute and non-acute services cost uplifts will be offset by an efficiency factor of 4%. In addition to the 2.5% cost uplift for acute services, prices within tariff will have an additional cost uplift that averages 0.3% applied at HRG sub chapter level to reflect the change in the cost of CNST contributions.			
6.	The Trust is planning to deliver all the CQUIN schemes agreed in the contract for 2014/15. The maximum CQUIN that can be earned is 2.5% of annual contract outturn excluding any income for high cost drugs and devices. The Trust has plans to meet national and local CQUIN goals in 2014/15 in full with regular monitoring systems in place. One fifth of the CQUIN schemes will be for achievement of national improvement goals, as follows: • Friends & Family Test • Improving dementia and delirium care • Improving diagnosis in Mental Health • Improvement against the NHS Safety Thermometer Please refer to NHS England CQUIN guidance for further details.	Yes	The Trust always agrees it CQUIN schemes in conjunction with commissioners as part of a clinically led process. This is supported corporately ensuring that national mandated requirements are followed.	
7.	The Trust will implement the National Tariff for	Yes	The Trust will implement the national	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	2014/15, including local variations and modifications in a manner that ensures consistency with 'Enforcing the National Tariff' guidance from Monitor		tariff and will pursue and agree local variations and modifications.	
8.	The Trust is a full partner in ensuring retained funds from the application of the marginal rate rule are invested transparently and effectively in appropriate demand management and improved discharge schemes. This approach is also expected to apply to funds retained for emergency readmissions	Yes	Arrangements for reinvestment are reviewed at contract settlement date and the Trust is a full partner in this.	
9.	As part of the 2013/14 planning process NHS Trusts captured any legacy commitments that have been agreed prior to 2013/14 that impact in this year and beyond. This process needs to continue and the Trusts should have identified any legacy commitments that are unwinding over more than one year and ensure they are properly reflected in the operational and strategic plans	Yes	Noted. If by legacy it is referring to past 'hosting' arrangements then when the contract is agreed at the end of February 2014, it is expected that these will be in place.	
10.	The financial plan allows for the delivery of all operational standards and contractual terms from commissioners in accordance with the Standard National Contract and no local arrangements are in place unless they have been agreed by all parties	Yes	Local arrangements are only put in place if agreed by the parties affected by the modifications.	
11.	The NHS Standard contract will be used with all	Yes	The Trust will use the contract with	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	NHS commissioners and includes details of activity plans and how that activity is priced. The NHS Trust has applied the guidance on local variations and modifications to tariff as per the final tariff guidance		modifications based on contract flexibilities applied where appropriate.	
12.	There is a clear articulation of an in year risk management strategy in each contract including the process by which action will be identified, the roles and responsibilities of NHS Trusts and the financial consequences of the risk management approach	Yes	This is executed through set contract monitoring meetings involving clinical, operational and financial colleagues from both Trust and CCGs.	
13.	The Trust is not planning for any mandatory fines to be applied	Yes	The Trust expect fines where ambulance turnaround times are concerned as was the case in 13/14, but will be expecting to agree tripartite improvement plans.	
14.	The Trust is engaged with commissioners on the outcomes expected for the £1.1 billion investment of resources in social care as a section 256 agreement in 2014/15	Yes	Regular planning discussion take place at CEO and Executive Director level on outcomes to be achieved in 2014/15 including implementing of 7 day working for social care	
15.	If the Trust is likely to be affected by the use of the Integrated Transformation Fund then it has been fully engaged from the outset by CCGs and Local Authorities in developing a shared view of the future shape of services. CCGs and Local Authorities have also worked with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services	Yes	This is the case.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
16.	The Trusts capital plans will be an update on the plans agreed in 2013/14. The update will need to reflect any changes in overall strategy or affordability since the previous plan submissions	Yes	Any change to 14/15 capital planning submissions will only include self-financed slippage.	
17.	Access to PDC financing for operational or capital purposes will be severely restricted and should only be considered as a final option if loan financing is unaffordable and where all health economy solutions have been exhausted. Where PDC is included in NHS Trust plans it should not be assumed that this will be available and all cases will be scrutinised during the planning process and will then need to be supported by the NTDA and presented to the Independent Trust Financing Facility	Yes	Noted. Only PDC against discrete pre-agreed allocations will be included, e.g. maternity and any further tech fund/dementia funding.	
18.	The Trust has triangulated activity, finance and workforce and the results demonstrate consistency	Yes	As submitted to the TDA as part of our 10 year plans.	
19.	A financial strategy has been developed which ensures financial health over the next five years and that delivers the required productivity gains, efficiency and improved taxpayer value	Yes	As submitted to the TDA as part of our 10 year plans.	
20.	Financial plans deliver the statutory financial duties of the Trust	Yes		
21.	The Trust is in active discussions with its commissioners regarding which services will remain commissioner requested services in line with the Monitor guidance	Yes	The Trust is working through the 14/15 contract negotiations.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
22.	Financial planning forms have been signed off by the Director of Finance prior to submission	Yes		

Planning checklist: Quality Innovation Productivity and Prevention (QIPP)

Name of NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
1.	A firm foundation and detailed project plans agreed with stakeholders are essential to delivery of QIPP. Please confirm compliance in relation to the specific requirements below:			We need some narrative in this section to allow us to judge both compliance, and to better understand the QIPP process in the local health economy – **SEE TEMPLATE SUBMISSION FOR UPDATE ON QIPP**
	1.1 QIPP schemes are based on evidence which demonstrates the possible range of improvement against a benchmarked position	Yes	In most cases benchmarks are sought especially where NICE guidance is present.	
	1.2 QIPP plans have progressed from high level ambitions to detailed pieces of service and clinical pathway redesign	Yes	Moves to cease outpatient activity via email/telephone consultant based advice complemented with pathology support being one example.	
	1.3 the service and clinical pathway redesign work underpinning the QIPP plans has been led by both primary and secondary care clinicians	Yes		
	1.4 QIPP plans that involve unscheduled care are developed in sufficient detail to focus on a particular group of patients or conditions	Yes	Alternatives to hospital care are being development, e.g. QiPP plans with commissioners for say vaccine preventable admissions	
2.	The Trust has considered consultation requirements associated with the QIPP plans and has a consultation plan if appropriate which outlines stakeholders and planned timescales	Yes	The Trust will meet consultation requirements. None are active at present.	
3.	Testing of assumptions increases the likelihood			

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	of successful delivery of planned changes. Please confirm compliance in relation to the specific requirements below:			
	3.1 tests of changes on a pilot basis have been carried out to provide assurance of the expected impact of the schemes	Yes	The Trust has been running RCRH (right care, right here) pilots as part of its new hospital development and these are evaluated.	
	3.2 the Trust has assured itself that there is a direct causal link between each proposed QIPP action and the expected impact for the NHS Trust	Yes	The QiPP actions are jointly agreed as part of LDP negotiations, consequently the anticipated impact is taken into account.	
	3.3 the Trust has assured itself that the QIPP plan distinguishes appropriately between full year and part year effects	Yes	The Trust's plan is its Transformation Plan (CIP and pathway redesign) which each year distinguishes between PYE&FYE.	
	3.4 the Trust and commissioners have assured themselves that the skills required to deliver the new pathways are available in the required staff group and the correct location	Yes	The JCCG (joint clinical commissioning group) discussed (Jan'14) workstream projects and the planned clinical, project and contracting support put in place.	
	3.5 QIPP schemes have a realistic start date		See comment below.	
	3.6 Please state how much confidence each party has in the delivery of the QIPP schemes		This is too generic a question. Only QiPP schemes with a workable degree of success are being pursued.	
4.	The success of each QIPP scheme must be measurable. A set of Key Performance Indicators and milestones has been jointly agreed that will measure the outcomes of each scheme	Yes	The QiPP schemes for 14/15 continue in development, but once secured there are specific measurement points and milestones.	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
5.	Appropriate arrangements are in place to monitor delivery of QIPP plans against KPIs and milestones	Yes	The QiPP schemes are identified at the time of contract sign-off (Feb '14) and then monitored at monthly contract reviews.	
6.	The Trust and commissioners have run an integrated business process for 2014/15 and 2015/16 including planning and contracting, with the outcome of detailed contract amendments at Healthcare Resource Group level	Yes	The Trust and commissioners have an agreed multi-year model as supported by an activity and capacity model relevant to the MMH development.	
7.	Appropriate access to commissioner headroom/non recurrent resources has been discussed. For example, to cover non-recurring costs associated with the change such as redundancies / pump priming costs /stranded fixed costs for a limited period of time	Yes	Each party has shared its forward planning assumptions which refers to operating framework expectations regarding commissioner headroom and preparations for the BCF funding movements.	
8.	A robust shared approach to risk management is required to support QIPP delivery in 2014/15. Please confirm compliance in relation to the specific requirements below:			
	8.1 consideration has been given to whether QIPP schemes would support a gain share approach, for example, pass through drug costs;	Yes	The principle of gain share has been present in our RCRH partnership arrangements for some time, e.g. the shift of outpatients to community contacts with gain share.	
	8.2 an approach to in year risk delivery has been agreed;	Yes	There are sophisticated risk sharing arrangements in place for maternity tariffs and elective referral mechanism behaviour	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	8.3 the detail of the risk sharing agreements is linked to the level of detail in the plan and the level of confidence in all parties around delivery;	Yes	These agreements support contract execution.	
	8.4 the approach to risk sharing has taken into consideration the baseline planned activity and price;	Yes	The current and future contracts hold this approach.	
	8.5 the Trust and commissioners have agreed an exit strategy if a component of the QIPP plan does not deliver the expected outcomes;	Yes	Bound in the principles associated with the transitional financial framework which supports RCRH planning trajectories.	
	8.6 the consequences of the agreed exit strategy are clearly outlined for each party	Yes	The consequences are understood in terms of the impact on each main party and implications for not right-sizing activity for MMH. In the short term, each party will hold contingencies.	

Planning checklist: Innovation

Name of NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	In line with the recommendations in Innovation Health and Wealth, each NHS Trust needs to: secure the benefits of greater access to innovative treatments in improving patient outcomes; achieve its savings potential from improved procurement; and adopt best practice through its participation in the local Academic Health Science Network. The specific expectations for each element are set out below, subject to the updated national strategy to be published in January 2014			
1.	The NHS Trust has a systematic approach to implementation of NICE approved technologies including: • automatic inclusion of positive NICE Technology Appraisals in local formularies in a planned way that supports safe and clinically appropriate practice • publication of local formularies in line with the best practice guidance from NICE • demonstrable improvements in the uptake and utility of NICE Technology Appraised products tracked through the Innovation Scorecard	Partial compliance	Relevant positive NICE Technology Appraisals are included in the local formulary in a planned way. The Clinical Effectiveness Department informs the Chair and Secretary to the D&TC of the publication by NICE of TA Guidance. The relevant lead clinicians are requested to provide a baseline assessment of compliance and to identify the plans for implementation. If clinically appropriate, the Lead Clinician(s) make	Thorough answer but do the Trust plan to implement the score card?

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	• support to overcome the system barriers to implementation of NICE Technology Appraisal guidance and other guidelines though the NICE Implementation Collaborative		an application to the D&TC for the technology to be added to the formulary. The Formulary is published on the Intranet and is accessible from the Trusts internet homepage. The Innovation Scorecard has not been used up to now to monitor the uptake of NICE Technology Appraisals. Following discussion of the latest submission of local information for the scorecard with the Secretary to the Drug and Therapeutics Committee, information can be provided and will be reviewed on a more frequent basis. The latest version of the Innovation Scorecard will be reviewed at the next meeting of the Trust NICE Implementation Group to be held on 9th January 2014. Any gaps in information or uptake will be identified and monitored going forward. All new NICE approvals are considered by the local health economy drugs and therapeutics committee. They are introduced to the formulary if they represent a clinical improvement and/or cost improvement on the current offering within the formulary. It is not felt that the innovation score card adds	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			value to this process.	
2.	The NHS Trust is tracking its progress on implementing the relevant high impact innovations previously published in Innovation Health and Wealth, in order to secure the benefits for local patients and services	Yes	Three High impact innovations are being monitored in line with the Trusts performance management framework. Progress is being monitored and is on track against milestones. The three high impact innovations the Trust has selected to pursue are: Intraoperative goal directed fluid therapy - is in use during high risk surgical procedures or with high risk patients Digital First – We have significantly increased the use of virtual clinics, telephone consultation, e-mail advice and guidance and are rolling out a program of Tele-health consultation in Diabetes Dementia carer Support - On admission there is a screening question to assess need of carers and trigger to initiate referral on for social assessment /support. In hospital and Sandwell community patients are screened for possible dementia and referred on for	Narrative required

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			support to them and family. Respite care is supported as part of EOL care for patients with dementia via bungalows project (Sandwell)	
3.	The NHS Trust has its own plan to implement Better Procurement, Better Value, Better Care: a procurement development programme to support the NHS to save £1.5 billion to £2 billion through improved procurement whilst supporting economic growth by building its commercial relationships and procurement information	No	The Trust employs a range of systems, relationships and procurement routes to maximise efficiency through procurement initiatives. It is a paid-up member of H.T.E. (Health Trust Europe) collaborative procurement Hub as complemented by a material level of purchasing via NHSSC. It has implemented Materials Management to maximise clinical time on wards & depts leading to barcode ordering and delivery back to ward. It maintains minimum stocking levels and is expanding use of catalogue based ordering through GHX. All ordering is automated via Oracle with notifications linked to email. Plans to enhance KPI monitoring are in place and a shared service is provided to a local NHS Foundation Trust as provided by SWBH. Use of managed services is in place to maximise price, quality and support. All of these measures would meet many features of BP-BV-BC, but we have taken a strict interpretation of the	Thorough answer

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
			question. In refreshing the procurement strategy in 14/15, we plan to incorporate the development plan, with many of its features already met.	
4.	In support of its procurement strategy, the NHS Trust has a Board-approved plan for the implementation of GS1 coding, in line with the NHS Standard Contract 2014/15	No	Use of GS1 is not fully rolled out within the NHS. Officers are attending sessions in March with a view to implementation in accordance with prescribed timelines.	Good explanation
5.	The NHS Trust has its own specific plan for research including: • engagement with the National Institute for Health Research (including the Clinical Research Networks), Academic Health Science Networks and other initiatives such as the Collaborations for Applied Health Research and Care; • promoting further participation by NHS patients in research funded by both commercial and non- commercial organisations to improve patient outcomes and contribute to economic growth; ensuring payment of treatment costs for NHS patients taking part in research funded by Government and Research Charity partner organisations	Yes	The Trust plan for research is detailed in the Research & Development (R&D) Strategy 2012-15. The Trust has full engagement with the National Institute for Health Research through the regional Clinical Research Networks, is a partner organisation in the West Midlands Academic Health Science Network and the Birmingham Collaborations for Applied Health Research and Care. As part of the Trusts Strategic Objectives for R&D there is aim to treble the number of patients participating in research studies over the next three years and to increase the number of Commercial studies delivered. The Trust only participates in research studies for which funding of treatment costs has been identified.	Narrative required (see left)
6.	The NHS Trust is preparing to update its own approach to innovation based on the refreshed national	Yes	The Trust held a Transformation & Innovation Workshop on the 8th November 2013. The outputs from this	Narrative required (see left)

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	strategy, to be published in January 2014		workshop and the refreshed national strategy will be used to inform the future Transformation Programme. In January/early February 2014 further meetings / mini-workshops will be held with key stakeholders to design the Transformation Programme in detail.	

Planning checklist: Sustainability

Name of NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	Trusts plans must demonstrate a clear trajectory towards clinical and financial sustainability, enabling progression to NHS Foundation Trust status. Where the current organisational configuration is not considered to be sustainable, plans should be consistent with the transition to another sustainable organisational form. The fundamental requirements for FT status as set out in Monitor's Guide for Applicants remain consistent: centred on high quality services; sound strategic and business planning; and strong governance and leadership. In line with the recommendations of the Mid Staffordshire Inquiry, the quality of services will be given priority at all times. The estimated trajectories to FT status will be dependent on the outcome of the Chief Inspector of Hospital inspections and compliance with the other conditions required for FT status. The TDA is asking each NHS Trust to submit an Integrated Business Plan and Long Term Financial			

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	Model, recognising that each NHS Trust will be at a different stage of its journey towards clinical and financial sustainability. The level of robustness of the plans will help to identify the stage of the NHS Trust in that journey, and the next steps needed			
	In the light of the above, the checklist below asks for a high level confirmation of progress towards a sustainable organisational form. Further details are set out in the letter from the TDA, Monitor and CQC issued on 25 November 2013			
1.	The NHS Trust Board plans to:	Yes	The Trust has developed an IBP and LTFM that demonstrates a sustainable independent future.	
	1.1 pursue a standalone FT application			
	1.2 pursue an alternative organisational form (specify which).	N/A		
2.	The move to a sustainable organisational form will be achieved within the period of the Trust's five year plan (specify which period within the five years)	Yes	Subject to receiving approval for its new hospital plans, the current planned trajectory is for the Trust to undergo a CIH visit in Q1 2014 and to progress through the TDA phase of the assessment process by the end of summer 2014.	
3.	The NHS Trust Board is on track to produce its five year plan by 20 June 2014, including an Integrated Business Plan and Long Term Financial Model	Yes	LTFM has already been submitted for new hospital approval. This will be updated, as will the previous IBP by June 2014.	The Trust has a 10 year LTFM in place.
4.	The Integrated Business Plan of the NHS Trust will set	Yes	The IBP will set out how the Trust addresses both its short term and long	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (31st January 2014)
	out plans to manage the key challenges that are currently barriers to clinical and financial sustainability		term challenges.	
5.	The five year plan will include a Long Term Financial Model, consistent with commissioning intentions, that meets the Monitor requirements for financial sustainability	Yes	The Trust's LTFM has been submitted to the TDA as part of its MMH business case planning. This required a letter of commissioner support regarding alignment and the LTFM shows implied efficiency being met. The current LTFM base case and mitigated downside demonstrate the Trust's ability to meet Monitor requirements for financial sustainability.	10 year.
6.	For NHS Trust Boards pursuing an alternative organisational form, the five year plan will set out how the NHS Trust will progress through the Gateway review process of the TDA (specify current Gateway)	N/A		
7.	The development plans to be prepared by the NHS Trust in discussion with the TDA will include the key elements of support needed to achieve clinical and financial sustainability	Yes	The Trust will bring an open and objective approach to analysing its strengths and its challenges as we construct our development plans and identify any support required from the TDA.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Whistleblowing Policy
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	6th March 2014

EXECUTIVE SUMMARY:

The importance of fostering an effective and positive whistleblowing environment within the Trust has been underlined clearly within the report by Robert Francis QC and subsequent publications. It is recognised however, that the creation of this environment represents a real cultural shift in the way in which whistleblowing is dealt with in the Trust.

It is important that an open and honest culture among all levels of the Trust's workforce is developed, from the Board downwards, including the creation of robust mechanisms of support for those reporting concerns. In addition, measures will need to be taken to publish organisational learning from the issues raised to demonstrate the positive impact that can be gained from the adoption of a robust whistleblowing culture.

The Board will recall that it last reviewed the Whistleblowing Policy in October 2012, however since then the policy has been revised to more clearly encourage staff to raise concerns without fear of repercussion and to clarify the various means by which concerns can be raised in addition to the use of the whistleblowing route. A version of the revised policy is attached for comment.

REPORT RECOMMENDATION:

The Trust Board is asked to comment on the proposed policy.

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

Comments:

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

The development of a positive whistleblowing culture is recognised as a national priority, particularly given the profile of the issue as part of the 'Francis' report.

PREVIOUS CONSIDERATION:

Trust Board in October 2012 and Quality & Safety Committee in February 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DRAFT

WHISTLEBLOWING POLICY

Policy author	Kam Dhami, Director of Governance
Accountable Executive Lead	Kam Dhami, Director of Governance
Approving body	Trust Board
Policy reference	SWBH/XXX/NNN [Assigned by Trust policy-Co-ordinator]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1 – All employees

2 – Name of group

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

POLICY APPROVAL DATE:
Month and Year

POLICY IMPLEMENTATION DATE:
Month and Year

DATE POLICY TO BE REVIEWED:

Month and Year

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)

WHISTLEBLOWING POLICY

KEY POINTS

1. If you have a concern about a possible danger, professional misconduct or financial malpractice, please use this policy so we can look into it

2. The policy applies to all employees, bank staff, agency workers, secondees, trainees, students, contractors, volunteers and external bodies working within the Trust

3. This Policy does not replace the Trust's existing policies and procedures regarding incident reporting, grievances, reporting cases of potential fraud or corruption, or complaints, nor does it replace the normal lines of communication between employees and their managers

4. Employees who raise a concern through the whistleblowing process are protected against victimisation by legislation and against any reprisal by the Trust

5. You are encouraged to raise concerns openly, however you may also feel the need to raise them in confidence or anonymously

6. You should consider raising your concerns with your line manager in the first instance, or if you do not feel confident to do so, then you may raise your concerns with the relevant director of the service or with the nominated Executive Directors with responsibility for whistleblowing

7. The Chief Executive and the Non Executive Director whistleblowing lead may be approached if you feel the matter is sufficiently serious or that other means of raising your concern have been exhausted

8. While you are encouraged to raise your concerns internally, we recognise that there may be circumstances where you would wish to report your concerns to an outside body (Prescribed Body)

9. An internal helpline is in place which you may access if you wish to seek general advice on how to raise a concern

10. If in doubt, report it!

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

1. INTRODUCTION

1.1 All of us at one time or another have concerns about what is happening at work. Usually these are easily resolved. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or the Trust itself, it can be difficult to know what to do.

1.2 You may be worried about raising such an issue and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. You may have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

1.3 Sandwell and West Birmingham Hospitals NHS Trust (hereafter the Trust) has introduced the Whistleblowing Policy to enable you to raise concerns that you may have at an early stage and in the right way. We would rather that you raised the matter when it is just a concern instead of waiting for proof.

1.4 If you have a reasonable suspicion that malpractice is occurring, has occurred or is likely to occur, please use this Policy to let us know so that we can look into it.

1.5 This Policy supports our values, in particular "caring and compassionate" and "open and accountable", as well as our Customer Care Promises.

1.6 If you are aggrieved about your employment or how you have been treated please refer to the Grievance & Disputes Policy and the Dignity at Work Policy. If you have a concern about financial misconduct or fraud, please see our Counter Fraud, Bribery and Corruption Policy.

1.7 It is acknowledged that there are a number of avenues by which employees can and should raise concerns, for example by completing an incident form for a specific incident (available on the Intranet), via a safeguarding adult/child route, reporting cases of potential fraud or corruption to the Local Counter Fraud Specialist or via the PREVENT route. These routes should be used where appropriate however this Policy provides processes for you to follow in the event that you feel there are no other routes available, or if you believe that you concerns have not been addressed. Further advice can be sought as set out in Section 6.

2. OTHER POLICIES TO WHICH THIS POLICY REFERS

2.1 Incident Reporting Policy (ORG/050)

2.2 Grievance and Disputes policy (HR/007)

2.3 Counter Fraud, Bribery and Corruption Policy (Finance/01)

3. PURPOSE AND SCOPE

3.1 The aims of the Whistleblowing Policy are to:

a. ensure that all those who work for us and with us understand how to raise a concern about a possible danger, professional misconduct or financial malpractice, and encourages them to do so;

b. Demonstrate the Trust's commitment to openness and accountability; and

c. Locally clarify the responsibilities of the Trust and its employees as required under The Public Interest Disclosure Act 1998 (PIDA).

3.2 The types of concerns that can be raised via this Policy are:

Malpractice, unsafe practice or ill treatment of a patient / service user. Repeated ill treatment of a patient / service user, despite a previous report having been made. A suspected fraud, such as embezzlement. A criminal offence is, had been, or is likely to be committed. Disregard for legislation, e.g. health and safety legislation. Damage to the Trust and/or its property A miscarriage of justice. Suspected conflict of business interests. Deliberate concealment of any of the above. *This list is examples only and does not constitute a complete list.*

3.3 This Policy applies to all employees, bank staff, agency workers, secondees, trainees, students, contractors, volunteers and external bodies working within the Trust, all of whom are referred to under the collective term "employees" for the purposes of this Policy.

3.4 This Policy does not replace normal lines of communication between employees and their managers so that matters of concern may still be dealt with through normal management / advisory channels (see Section 8).

4. TERMS AND DEFINITIONS

Whistleblowing concern	Reasonable and honest suspicion an employee has about fraud, a possible danger or other serious risk that threatens patients, colleagues, the public or the organisation's own reputation.
Whistleblowing	When an employee reports suspected wrongdoing at work, which they reasonably believe is in the public interest.
Employee	Someone who works in or for the Trust.
Open whistleblowing	Where the employee openly raises the whistleblowing concern and does not request confidentiality.
Confidentiality	Where the employee's name is known but will not be disclosed without their consent, unless required by law.

Helpline	Independent service offering confidential advice to an employee on whether and how they can raise a whistleblowing concern internally or externally.
External hotline	External reporting facility that passes reports back to a senior or designated officer in the Trust.
External disclosure	Raising a whistleblowing concern externally with a regulator or independent supervisory body, or as appropriate the police, MPs or the media.
Anonymity	Where the employee does not identify himself or herself at any stage to anyone.
The Public Interest Disclosure Act 1998 (PIDA)	The Act protects employees by providing a remedy if they suffer a workplace reprisal for raising a concern which they believe to be genuine.
Protected disclosure	For an employee's disclosure to be protected by PIDA, it must be a 'protected disclosure'. The employee must: Make sure the information is of a 'qualifying' nature' Make the disclosure in good faith, which means with honest intent and without malice. Reasonably believe that the information is substantially true. Reasonably believe that they are making the disclosure to the right 'specified person'.
Prescribed body	A 'prescribed body' is one that is identified under PIDA as able to receive concerns about organisations. Most regulators, such as the Care Quality Commission, are prescribed bodies. Employees can raise their concerns with a prescribed body, such as the CQC, or any other body, if the concern is relevant to that body. Such disclosures are protected under PIDA, where the whistleblower meets the criteria for disclosure. They must also reasonably believe that the matter is substantially true and relevant to the regulator. There is more information about this on the Public Concern at Work website.

5. GENERAL PRINCIPLES

5.1 Protection of staff

5.1.1 Employees who raise a concern about possible malpractice are protected in two ways. Firstly, statutory protection against victimisation is provided by the Public Interest Disclosure Act 1998 (the Act). Secondly, the Trust undertakes to not take reprisal against people who raise genuine concerns, and also guarantees where possible, anonymity.

5.1.2 It is imperative that users of this Policy understand that the commencement of an investigation does not presume guilt and that the reporting of concerns should not, accordingly, be delayed

5.2 Statutory protection

5.2.1 The Act encourages people to raise concerns about malpractice in the workplace, and requires employers to respond by addressing the message, not acting against the messenger. It does this by preventing an employer taking disciplinary action against, or victimising, a member of staff who genuinely raises a concern.

5.2.2 In addition to employees, the Act covers trainees, agency staff, contractors, home workers, and every professional in the NHS.

5.2.3 A disclosure in good faith to a manager or the employer will be "protected" (i.e. any reprisals taken by the employer will be unlawful) if the whistleblower has a reasonable suspicion that the alleged malpractice has occurred, is occurring or is likely to occur.

5.2.4 The Act also protects disclosures made in good faith to outside bodies where the whistleblower has a reasonable belief that their allegation(s) are substantially true.

5.3 Freedom from reprisal

5.3.1 The Trust Board and Chief Executive and the staff unions are committed to this Policy. If you raise a genuine concern under the Whistleblowing Policy, you will not be at risk of losing your job or suffering any detriment (such as reprisal or victimisation).

5.3.2 Providing you have a reasonable belief that the concern you are raising is in the public interest it does not matter if you are mistaken or if there is an innocent explanation for your concerns. So please do not think we will ask you to prove it. Of course, we do not extend this assurance to someone who maliciously raises a matter they know is untrue.

5.4 Confidentiality

5.4.1 It is hoped that employees will feel able to raise their concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If you would prefer to raise your concern in confidence, then so say from the outset.

5.4.2 In these circumstances we will not disclose your identify without your consent, unless required by law. If a situation arises where the Trust is not able to resolve the concern without revealing your identity (for instance because evidence is needed in a court of law, or the Trust's Disciplinary Policy is used), we will discuss with you whether and/or how the matter can best proceed.

5.4.3 Whilst pursuing the aim of openness, it is imperative that confidentiality is maintained and employees are reminded that raising a concern, even where warranted, does not give a person the right to disclose confidential information gained through their employment, e.g. that relates to treatment of patients, personal details about colleagues, the business of the Trust or is covered by the Data Protection Act.

NB: This does not preclude the raising of concerns, for example, about the treatment of patients.

5.5 Anonymity

5.5.1 The Trust appreciates that some employees may wish to raise their concern anonymously and in these circumstances we will look into the matter. Please remember that if you do not tell us who you are it may be more difficult for us to do this if we are unable to discuss the matter with you. Also, we will not be able to protect your position or to give you feedback. Accordingly you should not assume we can provide the assurance we offer in the same way if you report a concern anonymously.

6. INDEPENDENT ADVICE ON WHISTLEBLOWING

6.1 If you are unsure whether to use this Policy and want to gain some confidential advice please contact:

a. Internally

The HR Department, the Trust Secretary or Assistant Director of Governance via a dedicated Helpline.
A local trade union representative

b. Externally

The following can talk you through your options and help you to raise a concern about malpractice or wrongdoing at work.

Public Concern at Work on 0207 4046609 or helpline@pcaw.co.uk
National Whistleblowing Helpline on 0800 724725 or enquiries@wbhelpline.org.uk or www.helpline.org.uk
The Department for Business, Enterprise and Regulatory Reform at http://www.berr.gov.uk/

7. WAYS TO RAISE A CONCERN

7.1 There are various ways by which you can raise issues that are causing you concern at work or find answers to a query. These include, but are not limited to, the following:

With your line manager
Through your trade union representative
At your team meeting / briefing
Via an incident report, if the issue relates to a specific incident

Additional mechanisms to raise a concern can be found in **Appendix 1**.

7.2 Many issues can be investigated and resolved without the need to resort to the formal elements of this Policy, as the Trust is committed to ensuring that the Trust is as risk-free as possible, for both staff and its patients.

7.3 If you feel that your concern has not been resolved after raising it via one or more of the mechanisms listed in **Appendix 1**, or consider it to fall under the scope of the Whistleblowing Policy (see 4.1.1 and 4.1.2 above) then you may wish to move onto the formal elements of the Policy set out below.

8. HOW TO RAISE A WHISTLEBLOWING CONCERN

8.1 Preferably, any concern that you have must be personally observed or experienced. If a friend or colleague tells you about wrongdoing you must encourage them to report it.

8.2 Please remember that you do not need to have firm evidence before raising a concern. However, we do ask that you explain as fully as you can the information or circumstances that gave rise to your concern.

8.3 If you want to raise the matter confidentially, please say so at the outset so that appropriate arrangements can be made.

8.4 All concerns will be given full and sympathetic consideration. People will be treated with respect and understanding and it will be recognised that raising a concern within the auspices of this Policy can be a difficult experience.

8.5 The stages for raising and escalating whistleblowing concerns are described below and set out in diagrammatic form in **Appendix 2**.

8.6 It is possible to take one step at a time and only go as far as necessary to have your concern properly addressed. There may be occasions, however, where there is good reason to take two or more steps at a time.

8.7 You can raise concerns verbally or in writing at any stage of the process below.

Step One

8.8 If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, giving the nature of your concern and the reasons for it.

8.9 In cases of suspected fraud or other corruption these should be raised with the Trust's Local Counter Fraud Specialist and/or Director of Finance and Performance Management.

8.10 If an individual does not feel confident in raising the issue with their line manager in the first instance, **Step two** of the process may be invoked.

Step Two

8.11 If you feel unable to raise the matter with your line manager, for whatever reason, or you do not feel this is appropriate or Step One has not worked then please contact the relevant Director of the service. Or if you feel unable to do this, raise the matter with the:

Director of Governance; or
Director of Organisational Development (when appointed)

8.12 These people have been given special responsibility and training in dealing with whistleblowing concerns.

Step Three

8.13 If Steps One and Two have been followed and you still have concerns, or if you feel that the matter is too serious and you cannot discuss it with any of the above people, please contact the Chief Executive or Non-Executive Director Whistleblowing Lead

Step Four

8.14 While we hope that this Policy gives you the reassurance you need to raise your concern internally with us (Steps One, Two and Three), we recognise that there may be circumstances where you can properly report a concern to an outside body (Step Four). In fact, we would rather you raised a matter with the appropriate Prescribed Body than not at all. Public Concern at Work or your trade union will be able to advice you on such an option if you wish.

The following section provides further information on raising a concern externally and details of the prescribed regulatory bodies and independent sources of advice are available on the Intranet.

8.15 The Trust has commissioned a commercial to receive whistleblowing concerns which you can use to report your concern, anonymously if you wish. This information will be passed back, in confidence, to an Executive Director to forward on to the most appropriate person for action.

9. RAISING A CONCERN EXTERNALLY

9.1 You may wish to raise your concern externally with a 'Prescribed Body' if:

a. You have exhausted all the internal reporting procedures and remain dissatisfied with the outcome.
b. You feel your concern is so serious that it cannot be discussed with any of the people mentioned in Steps One, Two and Three (section 9).
c. You want independent external advice, at any stage
d. You feel unable to raise the concern internally from the outset because you think it will be covered up or you will be treated unfairly if you complain.

9.2 Healthcare concerns can be raised externally to:

The Care Quality Commission on 03000 616161, enquiries@CQC.org.uk or CQC National Correspondence, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA.

A full list of the 'Prescribed Bodies' for raising concerns externally, regarding fraud, data protection and health and safety for example, can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/222517/dg_177605.pdf

9.3 In certain circumstances, wider disclosure, for example to the police, an MP or the media, may also be protected under the Public Interest Disclosure Act 1998. A number of additional tests will apply when wider disclosures are made.

9.4 Firstly, the employee must:

a. Make the disclosure in good faith;
b. Reasonably believe that the information, and any allegation contained in it, are substantially true; and
c. Not act for personal gain.

9.5 In addition, one or more of the following conditions must be met:

a. Whether there is good reason to believe that the individual who raised the concern would suffer a detriment by their employer or any of its staff, if the matter was raised internally or with the appropriate 'Prescribed Body';
b. In the absence of an appropriate 'Prescribed Body or Person', the employee reasonably believes that disclosure to the employer would result in destruction or concealment of information about the wrongdoing;
c. The employee has previously disclosed substantially the same information to his/her employer or to a 'Prescribed Body or Person'.

9.6 Employees are encouraged to follow the process outlined in the Policy before involving outside agencies and before considering any course of action involving the media.

10. HOW WE WILL HANDLE YOUR CONCERN

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

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

10.3 Whenever possible, we will give you feedback on the outcome of any investigation. Please note, however, that we may not be able to tell you about the precise actions we take where this would infringe a duty of confidence we owe to another person.

10.4 While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly and properly. By using this Policy you will help us to achieve this.

10.5 Where action is not considered practicable or appropriate, we will provide a prompt and through explanation of the reasons for this, and may also provide information regarding what further action is available within the Trust policies, where appropriate. Where any required

action will involve taking disciplinary action or other action against a third party, this will remain confidential to that third party.

10.6 In recognition that raising a concern can be a difficult experience for some employees, the Occupational Health Department will provide confidential support and access to a staff counselling service. Employees are also reminded that trade union representatives may be able to provide support to them.

10.7 The Non-Executive Director Whistleblowing Lead for the Trust (contacted via the Trust Secretary on 0121 507 4994 or 07896 425196) will ensure your concern is handled in accordance with this Policy. The Lead will be informed each time a concern is raised and may be contacted directly in the event that you believe your concern is not being handled in accordance with this Policy.

10.8 If at any stage you experience reprisal, harassment or victimisation for raising a genuine concern please contact the Chief Executive on his mobile telephone (number available through IVOR) or email.

11. ROLES AND RESPONSIBILITIES

11.1 It is the responsibility of all employees to raise concerns in accordance with this Policy. Proof of wrong doing is not required, merely a reasonably held concern.

11.2 Line managers should ensure that concerns brought to them by employees are taken seriously and properly investigated. They should do everything in their power to ensure that the person raising the concern is not victimised are treated detrimentally due to their actions under this Policy.

11.3 Line managers are also responsible for ensuring that concerns are addressed through the appropriate structure and process, and should provide advice and support to employees when required.

11.4 It is the responsibility of all employees to familiarise themselves with and to understand this Policy.

11.5 The Director of Governance is the Executive Lead and author of this Policy who is responsible for ensuring this policy is implemented effectively.

11.6 The Non-Executive Director Whistleblowing Lead will seek assurance that the Policy is working effectively and that issues raised are being dealt with in an appropriate and timely manner.

12. AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

12.1 The Audit and Risk Committee will receive an anonymous and confidential report of all concerns raised under this Policy twice a year. The report will provide assurance that the Policy is working effectively and that issues raised are being dealt with in an appropriate and timely manner.

The report will also provide assurance that individuals raising concerns under this Policy are protected from detrimental treatment, dismissal or other disadvantage as a result of raising their concern.

12.2 The Director of Governance will complete the report for the Audit and Risk Committee and the Workforce Delivery Committee will review any lessons learned from anonymised cases.

12.3 Key performance indicators that will be used to monitor effectiveness of this Policy are:

a. Response times for providing the outcome of the investigation of the concerns.
b. Evidence of actions to address the concerns have been completed
c. Employee satisfaction indicators
d. Number of concerns escalated to the Chief Executive or Non-Executive Director

13. AWARENESS AND TRAINING

13.1 Awareness of this existence of this Policy will be made via the usual Trust communication mechanisms; these consist of Hot Topics team briefing, Heartbeat and the Staff Bulletin.

13.2 Individual managers will be responsible for making employees aware of the processes and procedures set down in this Policy.

13.3 Training will be provided for line managers in responding to and investigating whistleblowing concerns. These will be a co-production between Management and the local trade unions.

14. EQUALITY AND DIVERSITY

14.1 As part of its development, this Policy and its impact on equality have been reviewed in line with the Trust's Equality and Diversity Policy. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on service users and people employed by the Trust on the grounds of race, sex, disability, sexual orientation or religious belief.

14.2 This Policy was reviewed and no detriment identified.

15. REVIEW

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

16. REFERENCE DOCUMENTS AND BIBLIOGRAPHY

16.1 See **Appendix 3**

17. FURTHER ENQUIRIES

17.1 Further information about this Policy can be obtained from the Trust Secretary or Assistant Director of Governance.

Appendix 1

Raising a concern at work

The Trust has various ways by which you can raise issues that are causing you concern or find answers to a query. These include, but are not limited to, the following:

With your line manager

At your team meeting / briefing

Refer to the relevant Trust document on the Intranet e.g. Trust Policy, Clinical Guideline, Care Pathway, Standing Financial Instructions or Orders

Through your trade union representative

With a relevant person in the Trust e.g. if the issue relates to risk management via the Risk Team, or if it relates to Safeguarding, the named nurse for Safeguarding or the Safeguarding Adult Lead

Carry out a risk assessment

Send a letter to 'Your Right to be Heard'

With your local Staff Ambassador

With your Health and Safety Representative

During handover

Via an Incident report, if the issue relates to a specific incident

With the Local Security Management Specialist

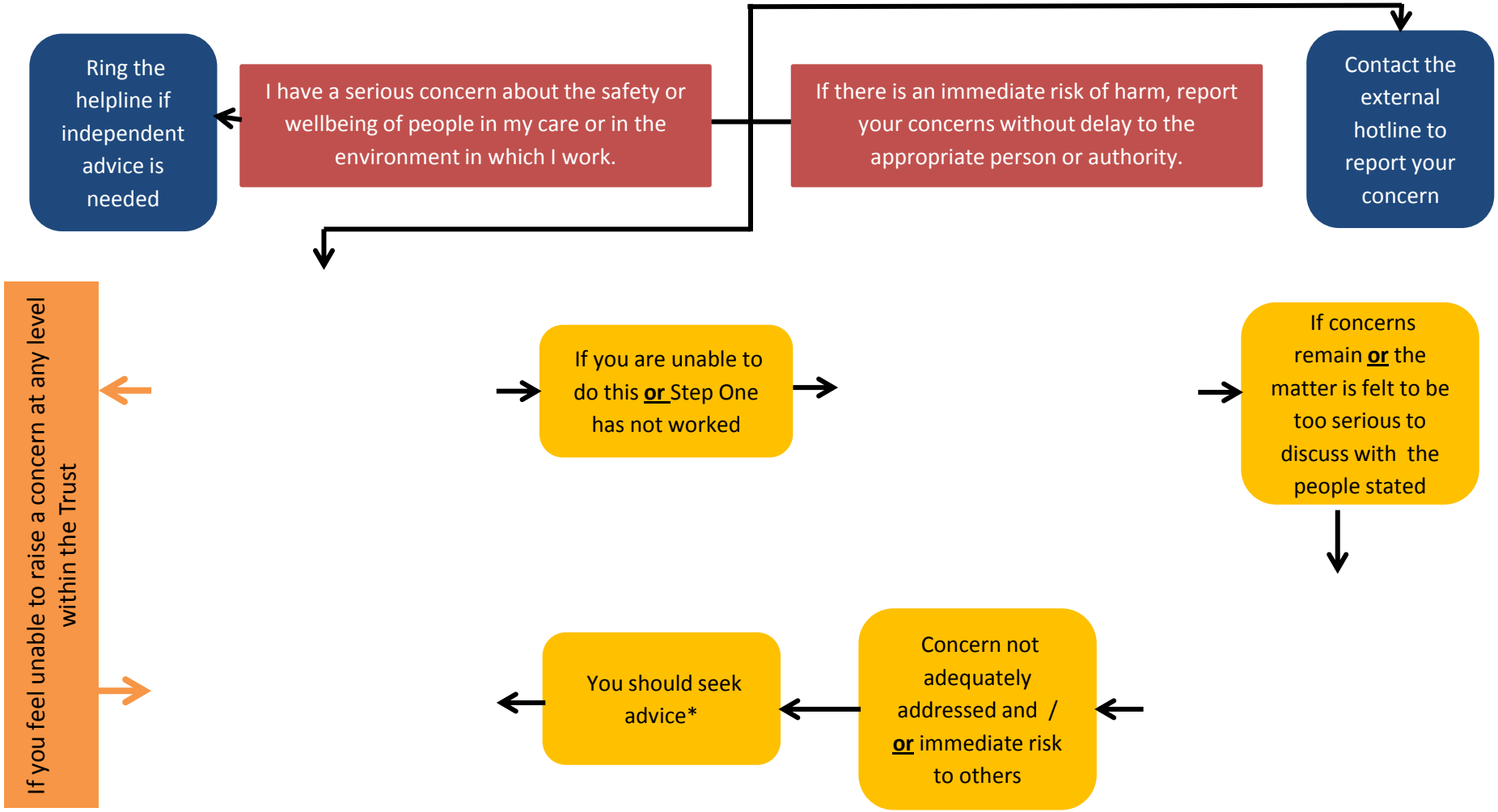
With a local Harassment Advisor

Whistleblowing Policy

Appendix 2

Stages for raising and escalating serious concerns

This flowchart should be read in conjunction with the whole policy



* Independent, confidential advice is available from your professional body, trade union or Public Concern at Work. Students can also speak to their university, tutor, lecturer or mentor.

Appendix 3

Further Information

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

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

National Advisory organisations contact information:

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

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

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

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

NHS Protect
Weston House, 246 High Holborn, London WC1V 7EX.
Tel: 020 7895 4500

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

Professional regulator contact information:

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

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

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

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

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

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

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

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

Trade Unions contact information:

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

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

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

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

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

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

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

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

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

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

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	National survey results: patients and staff
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington, Chief Nurse and Mike Sharon, Director of Strategy & OD
AUTHOR:	Quality Health, Picker Institute and Gayna Deakin, Deputy Director - Workforce
DATE OF MEETING:	6 March 2014

EXECUTIVE SUMMARY:

The Trust Board is asked to receive two national surveys, which show very limited change from 2012 results. In terms of the staff survey, it is pleasing to see the very sharp increase in the number of staff, who regard safety as the Trust's top priority.

The Board is also asked to note the latest results from the internally run staff polling process, 'Your Voice'. It is proposed that 'Your Voice' be developed further to ensure that the actions being taken to address areas of improvement identified, act as the key route to achieving better staff engagement.

REPORT RECOMMENDATION:

The Trust Board is requested to RECEIVE the surveys.

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

Comments:

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

Aligned to the patient experience plans presented at the Trust Board in February 2014

PREVIOUS CONSIDERATION:

Considered annually

Sandwell and West Birmingham Hospitals NHS Trust

2013 National Inpatient Survey
Core Survey Results

Survey results

This report sets out the results from the 2013 National Inpatient Survey, ordered in exactly the same way as the core survey questionnaire sent to patients.

Reading the columns of figures

The results are shown firstly in absolute numbers then as percentage responses. The first two columns show the results for the Trust from the 2012 survey (2012); the second two columns show the results for the Trust from the 2013 survey (2013); and the third two columns show the results from all the Trusts where Quality Health undertook the survey in 2013 (ALL).

The purpose of presenting the figures in this way is to give direct, at-a-glance, comparisons between the Trust's performance in 2012 and 2013; and between the Trust and other Trusts in the Quality Health database.

Conventions

The percentages are calculated after excluding those patients that did not answer that particular question. All percentages are rounded to the nearest whole number. When added together, the percentages for all answers to a particular question may not total 100% because of this rounding.

The 'Missing' figures show the number of patients who did not reply to that particular question. In some cases, the 'Missing' figure is quite high because it includes patients who did not answer that question or group of questions because it was not applicable to their circumstances (e.g. Q2).

On some questions there are also some figures which are italicised. These figures have been recalculated to exclude responses where the question was not applicable to the patient's circumstances. For example, questions such as Q14 about using same bathroom or shower area as patients of the opposite sex, where both those not answering (Missing) and those saying they did not use a bathroom or shower are excluded.

Changes made to the data

There are a number of questions which are 'routed' (i.e. where patients are directed to a subsequent question depending on their answer to the lead question). Sometimes there are conflicts in the answers that patients give to these questions and the data is corrected to account for this. For example, if option 2 in question 1 is ticked and the patient goes on to answer question 2 etc., then any data between question 1 and question 5 (where the patient was directed) will be deleted as the patient should not have answered these questions.

ADMISSION TO HOSPITAL

		Total	2012	Total	2013	Total	All
Q01 :	**Was your most recent hospital stay planned in advance or an emergency?**						
	Emergency or urgent	184	65%	176	66%	10370	62%
	Waiting list or planned in advance	88	31%	79	30%	5899	35%
	Something else	12	4%	12	4%	510	3%
	Missing	19		10		639	

THE ACCIDENT & EMERGENCY DEPARTMENT

		Total	2012	Total	2013	Total	All
Q02 :	**When you arrived at the hospital, did you go to the A&E Department (the Emergency Department / Casualty / Medical or Surgical Admissions unit)?**						
	Yes	182	93%	173	93%	9318	87%
	No	13	7%	14	7%	1401	13%
	Missing	108		90		6699	
Q03 :	**While you were in the A&E Department how much information about your condition or treatment was given to you?**						
	Not enough	30	16%	31	18%	1286	14%
	Right amount	124	67%	119	70%	5948	65%
	Too much	3	2%	3	2%	31	0%
	I was not given any information about my treatment or condition	12	7%	3	2%	745	8%
	Don't know / can't remember	15	8%	13	8%	1107	12%
	Missing	119		108		8301	
Q04 :	**Were you given enough privacy when being examined or treated in the A&E Department?**						
	Yes, definitely	141	75%	125	73%	6873	75%
	Yes, to some extent	32	17%	37	22%	1677	18%
	No	7	4%	5	3%	202	2%
	Don't know / can't remember	7	4%	5	3%	466	5%
	Missing	116		105		8200	

WAITING LIST OR PLANNED ADMISSION

		Total	2012	Total	2013	Total	All
Q05 :	**When you were referred to see a specialist, were you offered a choice of hospital for your first hospital appointment?**						
	Yes	38	23%	28	21%	2155	26%
	No, but I would have liked a choice	28	17%	24	18%	798	10%
	No, but I did not mind	90	54%	68	52%	5018	60%
	Don't know / can't remember	12	7%	11	8%	418	5%
	Missing	135		146		9029	
Q06 :	**How do you feel about the length of time you were on the waiting list before your admission to hospital?**						
	I was admitted as soon as I thought was necessary	124	78%	99	78%	6157	78%
	I should have been admitted a bit sooner	18	11%	17	13%	1147	14%
	I should have been admitted a lot sooner	16	10%	11	9%	631	8%
	Missing	145		150		9483	
Q07 :	**Was your admission date changed by the hospital?**						
	No	134	85%	109	83%	6688	82%
	Yes, once	17	11%	19	14%	1187	15%
	Yes, 2 or 3 times	5	3%	3	2%	230	3%
	Yes, 4 times or more	1	1%	1	1%	27	0%
	Missing	146		145		9286	
Q08 :	**In your opinion, had the specialist you saw in the hospital been given all of the necessary information about your condition or illness from the person who referred you?**						
	Yes definitely	0	0%	100	76%	6493	78%
	Yes to some extent	0	0%	24	18%	1215	15%
	No	0	0%	4	3%	288	3%
	Don't know / can't remember	0	0%	4	3%	316	4%
	Missing	0		145		9106	

ALL TYPES OF ADMISSION

Q09 : From the time you arrived at the hospital did you feel that you had to wait a long time to get to a bed on a ward?	Total 2012	2012	Total 2013	2013	Total All	All
Yes, definitely	48	16%	45	16%	2092	12%
Yes, to some extent	60	20%	65	24%	3377	20%
No	192	64%	163	60%	11600	68%
Missing	3		4		349	

THE HOSPITAL & WARD	Total	2012	Total	2013	Total	All
Q10 : While in the hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?						
Yes	64	21%	57	21%	3481	20%
No	219	73%	196	72%	12762	75%
Don't know / can't remember	18	6%	19	7%	859	5%
Missing	2		5		316	
Q11 : When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?						
Yes	47	16%	49	18%	1598	9%
No	253	84%	226	82%	15536	91%
Missing	3		2		284	
Q12 : During your stay in the hospital, how many wards did you stay in?						
1	176	59%	155	57%	10368	61%
2	97	33%	95	35%	5166	30%
3 or more	19	6%	16	6%	1358	8%
Don't know / can't remember	6	2%	5	2%	216	1%
Missing	5		6		310	
Q13 : After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?						
Yes	9	8%	19	18%	397	6%
No	109	92%	89	82%	6027	94%
Missing	185		169		10994	
Q14 : While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?						
Yes	*28*	*10%*	*31*	*12%*	*1857*	*12%*
Yes, because it had special bathing equipment that I needed	*0*	*0%*	*3*	*1%*	*160*	*1%*
No	*241*	*85%*	*203*	*81%*	*13303*	*82%*
I did not use a bathroom or shower	12	4%	19	7%	896	5%
Don't know / can't remember	*14*	*5%*	*15*	*6%*	*825*	*5%*
Missing	8		6		377	
Q15 : Were you ever bothered by noise at night from other patients?						
Yes	106	36%	107	39%	6420	38%
No	191	64%	168	61%	10600	62%
Missing	6		2		398	
Q16 : Were you ever bothered by noise at night from hospital staff?						
Yes	56	19%	47	17%	3383	20%
No	242	81%	226	83%	13616	80%
Missing	5		4		419	

THE HOSPITAL & WARD

		Total	2012	Total	2013	Total	All
Q17 :	**In your opinion, how clean was the hospital room or ward that you were in?**						
	Very clean	168	56%	161	58%	12070	70%
	Fairly clean	123	41%	108	39%	4610	27%
	Not very clean	6	2%	5	2%	370	2%
	Not at all clean	3	1%	2	1%	73	0%
	Missing	3		1		295	
Q18 :	**How clean were the toilets and bathrooms that you used in the hospital?**						
	Very clean	*156*	*55%*	*131*	*49%*	*10526*	*64%*
	Fairly clean	*111*	*39%*	*115*	*43%*	*5148*	*31%*
	Not very clean	*14*	*5%*	*19*	*7%*	*697*	*4%*
	Not at all clean	*5*	*2%*	*1*	*0%*	*166*	*1%*
	I did not use a toilet or bathroom	15	5%	10	4%	576	3%
	Missing	2		1		305	
Q19 :	**Did you feel threatened during your stay in hospital by other patients or visitors?**						
	Yes	11	4%	7	3%	584	3%
	No	290	96%	266	97%	16527	97%
	Missing	2		4		307	
Q20 :	**Were hand-wash gels available for patients and visitors to use?**						
	Yes	285	95%	254	93%	15923	93%
	Yes, but they were empty	5	2%	7	3%	239	1%
	I did not see any hand-wash gels	7	2%	6	2%	366	2%
	Don't know / can't remember	4	1%	7	3%	614	4%
	Missing	2		3		276	
Q21 :	**How would you rate the hospital food?**						
	Very good	*61*	*21%*	*65*	*25%*	*3572*	*22%*
	Good	*108*	*37%*	*92*	*35%*	*6014*	*37%*
	Fair	*85*	*29%*	*79*	*30%*	*4643*	*28%*
	Poor	*36*	*12%*	*27*	*10%*	*2172*	*13%*
	I did not have any hospital food	9	3%	11	4%	667	4%
	Missing	4		3		350	
Q22 :	**Were you offered a choice of food?**						
	Yes, always	219	73%	190	71%	13580	81%
	Yes, sometimes	57	19%	56	21%	2370	14%
	No	23	8%	21	8%	861	5%
	Missing	4		10		607	

THE HOSPITAL & WARD	Total	2012	Total	2013	Total	All
Q23 : Did you get enough help from staff to eat your meals?						
Yes, always	*62*	*54%*	*49*	*52%*	*3086*	*65%*
Yes, sometimes	*35*	*30%*	*24*	*26%*	*862*	*18%*
No	*18*	*16%*	*21*	*22%*	*823*	*17%*
I did not need help to eat meals	182	61%	177	65%	12010	72%
Missing	6		6		637	

DOCTORS

		Total	2012	Total	2013	Total	All
Q24 :	**When you had important questions to ask a doctor, did you always get answers that you could understand?**						
	Yes, always	*184*	*69%*	*160*	*64%*	*10555*	*69%*
	Yes, sometimes	*70*	*26%*	*74*	*30%*	*3952*	*26%*
	No	*13*	*5%*	*16*	*6%*	*802*	*5%*
	I had no need to ask	31	10%	21	8%	1748	10%
	Missing	5		6		361	
Q25 :	**Did you have confidence and trust in the doctors treating you?**						
	Yes, always	241	80%	215	79%	13807	81%
	Yes, sometimes	47	16%	52	19%	2704	16%
	No	12	4%	6	2%	550	3%
	Missing	3		4		357	
Q26 :	**Did the doctors talk in front of you as if you weren't there?**						
	Yes, often	23	8%	31	11%	863	5%
	Yes, sometimes	51	18%	63	23%	3262	19%
	No	215	74%	182	66%	12907	76%
	Missing	14		1		386	

NURSES

		Total	2012	Total	2013	Total	All
Q27 :	**When you had important questions to ask a nurse, did you get answers that you could understand?**						
	Yes, always	*173*	*67%*	*159*	*67%*	*10623*	*70%*
	Yes, sometimes	*71*	*27%*	*70*	*29%*	*3968*	*26%*
	No	*16*	*6%*	*10*	*4%*	*617*	*4%*
	I had no need to ask	40	13%	36	13%	1911	11%
	Missing	3		2		299	
Q28 :	**Did you have confidence and trust in the nurses treating you?**						
	Yes, always	220	74%	200	73%	13341	78%
	Yes, sometimes	64	21%	65	24%	3357	20%
	No	15	5%	10	4%	449	3%
	Missing	4		2		271	
Q29 :	**Did nurses talk in front of you as if you weren't there?**						
	Yes, often	29	10%	23	8%	682	4%
	Yes, sometimes	41	14%	50	18%	2501	15%
	No	227	76%	203	74%	13883	81%
	Missing	6		1		352	
Q30 :	**In your opinion, were there enough nurses on duty to care for you in hospital?**						
	There were always or nearly always enough nurses	186	62%	166	60%	10181	60%
	There were sometimes enough nurses	79	27%	82	30%	5037	29%
	There were rarely or never enough nurses	33	11%	27	10%	1869	11%
	Missing	5		2		331	

YOUR CARE & TREATMENT

		Total	2012	Total	2013	Total	All
Q31 :	**Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?**						
	Yes, often	29	10%	21	8%	1163	7%
	Yes, sometimes	69	23%	75	27%	4125	24%
	No	201	67%	179	65%	11786	69%
	Missing	4		2		344	
Q32 :	**Were you involved as much as you wanted to be in decisions about your care and treatment?**						
	Yes, definitely	170	57%	144	53%	9699	57%
	Yes, to some extent	85	28%	97	36%	5725	34%
	No	44	15%	31	11%	1573	9%
	Missing	4		5		421	
Q33 :	**How much information about your condition or treatment was given to you?**						
	Not enough	59	20%	47	17%	3320	19%
	The right amount	239	80%	223	82%	13613	80%
	Too much	2	1%	1	0%	123	1%
	Missing	3		6		362	
Q34 :	**Did you find someone on the hospital staff to talk to about your worries and fears?**						
	Yes, definitely	*70*	*36%*	*54*	*32%*	*4284*	*41%*
	Yes, to some extent	*68*	*35%*	*65*	*38%*	*3823*	*36%*
	No	*57*	*29%*	*51*	*30%*	*2414*	*23%*
	I had no worries or fears	103	35%	102	38%	6502	38%
	Missing	5		5		395	
Q35 :	**Do you feel you got enough emotional support from hospital staff during your stay?**						
	Yes, always	*129*	*61%*	*97*	*52%*	*6388*	*59%*
	Yes, sometimes	*47*	*22%*	*60*	*32%*	*3052*	*28%*
	No	*37*	*17%*	*29*	*16%*	*1463*	*13%*
	I did not need any emotional support	86	29%	87	32%	6169	36%
	Missing	4		4		346	
Q36 :	**Were you given enough privacy when discussing your condition or treatment?**						
	Yes, always	218	72%	192	71%	13039	77%
	Yes, sometimes	64	21%	68	25%	2976	17%
	No	19	6%	10	4%	1020	6%
	Missing	2		7		383	

YOUR CARE & TREATMENT

		Total	2012	Total	2013	Total	All
Q37 :	**Were you given enough privacy when being examined or treated?**						
	Yes, always	267	88%	234	87%	15578	91%
	Yes, sometimes	26	9%	32	12%	1348	8%
	No	9	3%	2	1%	201	1%
	Missing	1		9		291	
Q38 :	**Were you ever in any pain?**						
	Yes	206	69%	164	62%	10653	63%
	No	91	31%	99	38%	6220	37%
	Missing	6		14		545	
Q39 :	**Do you think the hospital staff did everything they could to help control your pain?**						
	Yes, definitely	128	61%	103	64%	7533	71%
	Yes, to some extent	59	28%	48	30%	2417	23%
	No	22	11%	10	6%	602	6%
	Missing	94		116		6866	
Q40 :	**How many minutes after you used the call button did it usually take before you got the help you needed?**						
	0 minutes / right away	*35*	*20%*	*19*	*15%*	*1450*	*14%*
	1-2 minutes	*54*	*31%*	*38*	*30%*	*3915*	*38%*
	3-5 minutes	*51*	*29%*	*42*	*33%*	*3112*	*30%*
	More than 5 minutes	*28*	*16%*	*26*	*20%*	*1748*	*17%*
	I never got help when I used the call button	*7*	*4%*	*3*	*2%*	*122*	*1%*
	I never used the call button	119	40%	133	51%	6410	38%
	Missing	9		16		661	

OPERATIONS & PROCEDURES

		Total	2012	Total	2013	Total	All
Q41 :	**During your stay in the hospital, did you have an operation or procedure?**						
	Yes	180	61%	162	62%	10316	61%
	No	113	39%	99	38%	6575	39%
	Missing	10		16		527	
Q42 :	**Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?**						
	Yes, completely	*139*	*77%*	*127*	*80%*	*8217*	*82%*
	Yes, to some extent	*32*	*18%*	*28*	*18%*	*1426*	*14%*
	No	*10*	*6%*	*4*	*3%*	*327*	*3%*
	I did not want an explanation	2	1%	2	1%	224	2%
	Missing	120		116		7224	
Q43 :	**Beforehand, did a member of staff explain what would be done during the operation or procedure?**						
	Yes, completely	*136*	*76%*	*128*	*80%*	*7542*	*76%*
	Yes, to some extent	*32*	*18%*	*24*	*15%*	*1963*	*20%*
	No	*10*	*6%*	*8*	*5%*	*447*	*4%*
	I did not want an explanation	7	4%	2	1%	270	3%
	Missing	118		115		7196	
Q44 :	**Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?**						
	Yes, completely	*116*	*71%*	*107*	*79%*	*6877*	*78%*
	Yes, to some extent	*36*	*22%*	*24*	*18%*	*1651*	*19%*
	No	*11*	*7%*	*4*	*3%*	*300*	*3%*
	I did not ask any questions	23	12%	27	17%	1382	14%
	Missing	117		115		7208	
Q45 :	**Beforehand, were you told how you could expect to feel after you had the operation or procedure**						
	Yes, completely	107	58%	91	58%	5821	57%
	Yes, to some extent	39	21%	43	27%	2868	28%
	No	37	20%	24	15%	1445	14%
	Missing	120		119		7284	
Q46 :	**Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?**						
	Yes	165	91%	129	82%	8523	85%
	No	17	9%	28	18%	1551	15%
	Missing	121		120		7344	

OPERATIONS & PROCEDURES

		Total	2012	Total	2013	Total	All
Q47 :	**Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?**						
	Yes, completely	140	84%	108	85%	7184	85%
	Yes, to some extent	17	10%	17	13%	936	11%
	No	9	5%	2	2%	309	4%
	Missing	137		150		8989	
Q48 :	**After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?**						
	Yes, completely	119	65%	108	68%	6915	68%
	Yes, to some extent	40	22%	33	21%	2235	22%
	No	25	14%	18	11%	959	9%
	Missing	119		118		7309	

LEAVING HOSPITAL

		Total	2012	Total	2013	Total	All
Q49 :	**Did you feel you were involved in decisions about your discharge from hospital?**						
	Yes, definitely	*149*	*52%*	*129*	*49%*	*9015*	*55%*
	Yes, to some extent	*87*	*31%*	*88*	*33%*	*4941*	*30%*
	No	*49*	*17%*	*46*	*17%*	*2483*	*15%*
	I did not want to be involved	12	4%	7	3%	590	3%
	Missing	6		7		389	
Q50 :	**Were you given enough notice about when you were going to be discharged?**						
	Yes, definitely	176	59%	150	55%	9357	55%
	Yes, to some extent	80	27%	84	31%	5550	33%
	No	42	14%	37	14%	2126	12%
	Missing	5		6		385	
Q51 :	**On the day you left the hospital, was your discharge delayed for any reason?**						
	Yes	100	34%	92	34%	6928	41%
	No	196	66%	178	66%	9913	59%
	Missing	7		7		577	
Q52 :	**What was the main reason for the delay?**						
	I had to wait for medicines	58	64%	59	69%	4064	62%
	I had to wait to see the doctor	12	13%	7	8%	856	13%
	I had to wait for an ambulance	11	12%	3	3%	644	10%
	Something else	10	11%	17	20%	949	15%
	Missing	212		191		10905	
Q53 :	**How long was the delay**						
	Up to 1 hour	16	16%	14	16%	1046	15%
	Longer than 1 hour but no longer than 2 hours	26	26%	29	33%	1932	28%
	Longer than 2 hours but no longer than 4 hours	38	38%	21	24%	2289	34%
	Longer than 4 hours	20	20%	25	28%	1546	23%
	Missing	203		188		10605	
Q54 :	**Before you left the hospital, were you given any written or printed information about what you should or should not do after leaving hospital?**						
	Yes	201	70%	187	71%	11569	69%
	No	87	30%	77	29%	5285	31%
	Missing	15		13		564	

LEAVING HOSPITAL

		Total	2012	Total	2013	Total	All
Q55 :	**Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?**						
	Yes, completely	*182*	*75%*	*154*	*72%*	*9489*	*75%*
	Yes, to some extent	*41*	*17%*	*49*	*23%*	*2094*	*17%*
	No	*20*	*8%*	*11*	*5%*	*1049*	*8%*
	I did not need an explanation	28	10%	26	10%	2005	12%
	I had no medicines	19	7%	25	9%	1973	12%
	Missing	13		12		808	
Q56 :	**Did a member of staff tell you about medication side effects to watch for when you went home?**						
	Yes, completely	*89*	*41%*	*69*	*36%*	*4238*	*39%*
	Yes, to some extent	*39*	*18%*	*36*	*19%*	*2091*	*19%*
	No	*88*	*41%*	*86*	*45%*	*4475*	*41%*
	I did not need an explanation	56	21%	48	20%	3663	25%
	Missing	31		38		2951	
Q57 :	**Were you told how to take your medication in a way you could understand?**						
	Yes, definitely	*162*	*76%*	*144*	*72%*	*8494*	*76%*
	Yes, to some extent	*31*	*15%*	*39*	*20%*	*1729*	*15%*
	No	*19*	*9%*	*16*	*8%*	*1025*	*9%*
	I did not need to be told how to take my medication	60	22%	40	17%	3236	22%
	Missing	31		38		2934	
Q58 :	**Were you given clear written or printed information about your medicines?**						
	Yes, completely	*162*	*71%*	*141*	*67%*	*8343*	*70%*
	Yes, to some extent	*31*	*14%*	*41*	*19%*	*1824*	*15%*
	No	*26*	*11%*	*22*	*10%*	*1404*	*12%*
	I did not need this	46	17%	27	11%	2568	18%
	Don't know / can't remember	*8*	*4%*	*7*	*3%*	*348*	*3%*
	Missing	30		39		2931	
Q59 :	**Did a member of staff tell you about any danger signals you should watch for after you went home?**						
	Yes, completely	*87*	*40%*	*81*	*39%*	*5309*	*43%*
	Yes, to some extent	*49*	*23%*	*48*	*23%*	*2641*	*21%*
	No	*81*	*37%*	*77*	*37%*	*4407*	*36%*
	It was not necessary	74	25%	58	22%	4243	26%
	Missing	12		13		818	

LEAVING HOSPITAL

		Total	2012	Total	2013	Total	All
Q60 :	**Did hospital staff take your family or home situation, into account when planning your discharge?**						
	Yes, completely	*111*	*53%*	*94*	*46%*	*7197*	*60%*
	Yes, to some extent	*42*	*20%*	*55*	*27%*	*2416*	*20%*
	No	*55*	*26%*	*47*	*23%*	*1986*	*16%*
	It was not necessary	82	28%	63	24%	4627	28%
	Don't know / can't remember	*3*	*1%*	*7*	*3%*	*470*	*4%*
	Missing	10		11		722	
Q61 :	**Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?**						
	Yes, definitely	*107*	*48%*	*85*	*42%*	*5990*	*51%*
	Yes, to some extent	*47*	*21%*	*48*	*24%*	*2545*	*22%*
	No	*70*	*31%*	*68*	*34%*	*3170*	*27%*
	No family or friends were involved	32	11%	21	8%	1948	12%
	My family or friends did not want or need information	40	14%	40	15%	2911	18%
	Missing	7		15		854	
Q62 :	**Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?**						
	Yes	193	66%	173	66%	11921	72%
	No	72	25%	65	25%	3354	20%
	Don't know / can't remember	28	10%	25	10%	1343	8%
	Missing	10		14		800	
Q63 :	**Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?**						
	Yes	*80*	*73%*	*47*	*65%*	*4187*	*83%*
	No, but I would have liked them to	*30*	*27%*	*25*	*35%*	*841*	*17%*
	No, it was not necessary to discuss it	183	62%	192	73%	11577	70%
	Missing	10		13		813	
Q64 :	**Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)**						
	Yes	*132*	*80%*	*117*	*81%*	*7657*	*86%*
	No, but I would have liked them to	*32*	*20%*	*28*	*19%*	*1211*	*14%*
	No, it was not necessary to discuss it	129	44%	117	45%	7701	46%
	Missing	10		15		849	
Q65 :	**Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?**						
	Yes, I received copies	205	70%	182	69%	9579	58%
	No, I did not receive copies	61	21%	59	22%	5482	33%
	Not sure / don't know	25	9%	24	9%	1528	9%
	Missing	12		12		829	

LEAVING HOSPITAL

		Total	2012	Total	2013	Total	All
Q66 :	**Were the letters written in a way that you could understand?**						
	Yes, definitely	151	74%	122	68%	7110	75%
	Yes, to some extent	41	20%	50	28%	2057	22%
	No	8	4%	5	3%	237	3%
	Not sure / don't know	3	1%	2	1%	73	1%
	Missing	100		98		7941	

OVERALL

		Total	2012	Total	2013	Total	All
Q67 :	**Overall, did you feel you were treated with respect and dignity while you were in the hospital?**						
	Yes, always	239	80%	206	76%	13673	81%
	Yes, sometimes	48	16%	57	21%	2642	16%
	No	12	4%	8	3%	478	3%
	Missing	4		6		625	
Q68 :	**Overall, the rating of your experience was?**						
	0 - I had a very poor experience	*3*	*1%*	*1*	*0%*	*130*	*1%*
	1	*3*	*1%*	*3*	*1%*	*135*	*1%*
	2	*5*	*2%*	*2*	*1%*	*195*	*1%*
	3	*3*	*1%*	*3*	*1%*	*277*	*2%*
	4	*13*	*5%*	*4*	*2%*	*361*	*2%*
	5	*18*	*6%*	*19*	*7%*	*775*	*5%*
	6	*21*	*7%*	*16*	*6%*	*811*	*5%*
	7	*29*	*10%*	*34*	*13%*	*1734*	*11%*
	8	*63*	*22%*	*58*	*23%*	*3802*	*24%*
	9	*58*	*20%*	*48*	*19%*	*3440*	*21%*
	10 - I had a very good experience	*72*	*25%*	*66*	*26%*	*4472*	*28%*
	Ambiguous response	2	1%	0	0%	0	0%
	Missing	13		23		1286	
Q69 :	**During your hospital stay, were you ever asked to give your views on the quality of your care?**						
	Yes	54	18%	69	26%	2920	17%
	No	216	73%	174	64%	11930	71%
	Don't know / can't remember	25	8%	27	10%	1899	11%
	Missing	8		7		669	
Q70 :	**Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?**						
	Yes	44	15%	49	18%	3364	20%
	No	192	68%	174	65%	10034	60%
	Not sure / don't know	48	17%	44	16%	3266	20%
	Missing	19		10		754	

ABOUT YOU

		Total	2012	Total	2013	Total	All
Q71 :	**Who was the main person or people that filled in this questionnaire?**						
	The patient (named on the front of the envelope)	204	70%	201	78%	14073	85%
	A friend or relative of the patient	35	12%	20	8%	1006	6%
	Both patient and friend/relative together	47	16%	33	13%	1479	9%
	The patient with the help of a health professional	5	2%	5	2%	74	0%
	Missing	12		18		786	
Q72 :	**Are you male or female?**						
	Male	129	44%	142	53%	7877	47%
	Female	164	56%	125	47%	8845	53%
	Missing	10		10		696	
Q73 :	**Age**						
	16-24	8	3%	8	3%	439	3%
	25-34	14	5%	15	6%	629	4%
	35-44	24	8%	21	8%	959	6%
	45-54	35	12%	30	11%	1910	12%
	55-64	53	18%	39	15%	2823	17%
	65-74	73	25%	60	23%	4220	25%
	75-84	60	20%	74	28%	3866	23%
	85+	28	9%	19	7%	1734	10%
	Missing	8		11		838	

ABOUT YOU

		Total	2012	Total	2013	Total	All
Q74 :	**Do you have any of the following long standing conditions?**						
	Deafness or severe hearing impairment	49	16%	43	16%	2401	14%
	Missing	254		234		15017	
	Blindness or partially sighted	17	6%	16	6%	842	5%
	Missing	286		261		16576	
	A long-standing physical condition	79	26%	72	26%	4692	27%
	Missing	224		205		12726	
	A learning disability	6	2%	9	3%	298	2%
	Missing	297		268		17120	
	A mental health condition	13	4%	24	9%	937	5%
	Missing	290		253		16481	
	A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease, or epilepsy	86	28%	83	30%	5203	30%
	Missing	217		194		12215	
	No, I do not have a long-standing condition	93	31%	90	32%	5925	34%
	Missing	210		187		11493	

ABOUT YOU

		Total	2012	Total	2013	Total	All
Q75 :	**Does this condition(s) cause you difficulty with any of the following?**						
	Everyday activities that people your age can usually do	111	59%	98	57%	5782	56%
	Missing	77		73		4600	
	At work, in education, or training	24	13%	28	16%	1380	13%
	Missing	164		143		9002	
	Access to buildings, streets, or vehicles	57	30%	53	31%	2948	28%
	Missing	131		118		7434	
	Reading or writing	34	18%	30	18%	1375	13%
	Missing	154		141		9007	
	People's attitudes to you because of your condition	27	14%	26	15%	1270	12%
	Missing	161		145		9112	
	Communicating, mixing with others, or socialising	45	24%	39	23%	2160	21%
	Missing	143		132		8222	
	Any other activity	29	15%	26	15%	1699	16%
	Missing	159		145		8683	
	No difficulty with any of these	42	22%	40	23%	2745	26%
	Missing	146		131		7637	

ABOUT YOU

		Total	2012	Total	2013	Total	All
Q76 :	**What is your ethnic group?**						
	White - English / Welsh / Scottish / Northern Irish / British	207	73%	188	74%	14955	93%
	Irish	4	1%	7	3%	179	1%
	Gypsy or Irish Traveller	0	0%	0	0%	10	0%
	Any other White background	4	1%	4	2%	246	2%
	White and Black Caribbean	0	0%	1	0%	29	0%
	White and Black African	0	0%	1	0%	14	0%
	White and Asian	0	0%	1	0%	36	0%
	Any other Mixed / multiple ethnic background	1	0%	0	0%	20	0%
	Indian	31	11%	21	8%	218	1%
	Pakistani	11	4%	6	2%	97	1%
	Bangladeshi	2	1%	2	1%	28	0%
	Chinese	1	0%	1	0%	29	0%
	Any other Asian background	3	1%	3	1%	66	0%
	African	4	1%	4	2%	82	1%
	Caribbean	10	4%	14	5%	111	1%
	Any other Black / African / Caribbean background	1	0%	1	0%	13	0%
	Arab	1	0%	0	0%	16	0%
	Any other ethnic group	2	1%	1	0%	15	0%
	Missing	21		22		1254	
Q77 :	**What is your religion?**						
	No religion	16	6%	24	9%	2438	15%
	Buddhist	1	0%	2	1%	57	0%
	Christian (including Church of England, Catholic, Protestant and other Christian denominations)	204	73%	187	74%	12542	78%
	Hindu	6	2%	9	4%	164	1%
	Jewish	1	0%	1	0%	94	1%
	Muslim	23	8%	13	5%	226	1%
	Sikh	25	9%	12	5%	52	0%
	Other	2	1%	1	0%	215	1%
	I would prefer not to say	2	1%	4	2%	255	2%
	Missing	23		24		1375	
Q78 :	**Which of the following best describes how you think of yourself?**						
	Heterosexual / straight	235	92%	210	91%	14556	95%
	Gay / lesbian	2	1%	1	0%	108	1%
	Bisexual	0	0%	0	0%	65	0%
	Other	2	1%	1	0%	86	1%
	I would prefer not to say	16	6%	18	8%	573	4%
	Missing	48		47		2030	

SWBTB (3/14) 033 (b)

2013 National NHS staff survey

Brief summary of results from Sandwell And West Birmingham Hospitals NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2013 national NHS staff survey conducted in Sandwell And West Birmingham Hospitals NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 28 Key Findings.

These sections of the report have been structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus two additional themes:

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

- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

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

- Additional theme: Staff satisfaction

- Additional theme: Equality and diversity

Please note that the NHS pledges were amended in 2013, however the report has been structured around 4 of the pledges which have been maintained since 2009. For more information regarding this please see the “Making Sense of Your Staff Survey Data” document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2013 survey results for Sandwell And West Birmingham Hospitals NHS Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q12a - 12d and the weighted score for Key Finding 24. The percentages for Q12a – Q12d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

The Q12d score is related to CQUIN payments for Acute trusts participating in the National NHS Staff Survey. 2013/2014 guidance on CQUIN payments can be found via the following link https://www.supply2health.nhs.uk/eContracts/Documents/cquin-guidance.pdf.

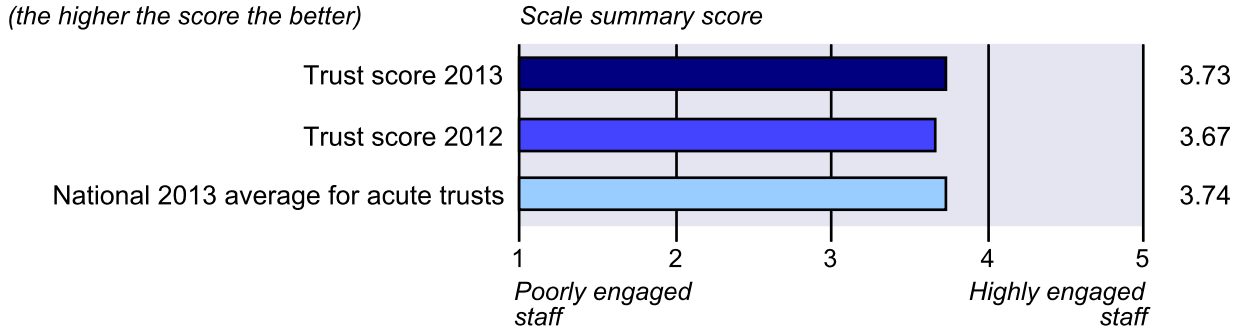
Q12a, Q12c and Q12d feed into Key Finding 24 “Staff recommendation of the trust as a place to work or receive treatment”.

		Your Trust in 2013	Average (median) for acute trusts	Your Trust in 2012
Q12a	"Care of patients / service users is my organisation's top priority"	75	68	60
Q12b	"My organisation acts on concerns raised by patients / service users"	74	71	64
Q12c	"I would recommend my organisation as a place to work"	59	59	50
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	59	64	57
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.71	3.68	3.52

2. Overall indicator of staff engagement for Sandwell And West Birmingham Hospitals NHS Trust

The figure below shows how Sandwell And West Birmingham Hospitals NHS Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.73 was average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 22, 24 and 25. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 22); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 24); and the extent to which they feel motivated and engaged with their work (Key Finding 25).

The table below shows how Sandwell And West Birmingham Hospitals NHS Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2012 survey.

	Change since 2012 survey	Ranking, compared with all acute trusts
OVERALL STAFF ENGAGEMENT	• No change	• Average
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	• Average
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	✓ Increase (better than 12)	• Average
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	! Lowest (worst) 20%

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2013 Key Findings for Sandwell And West Birmingham Hospitals NHS Trust

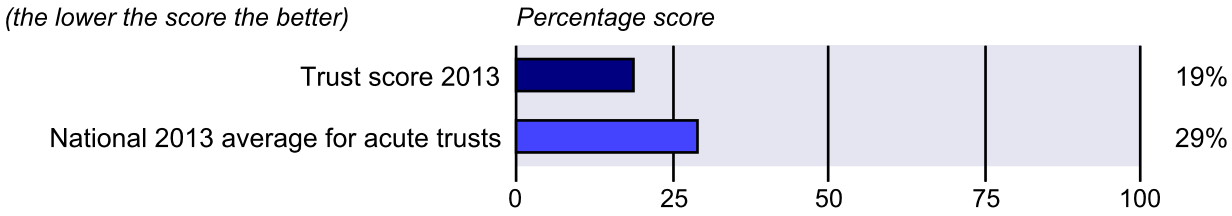
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which Sandwell And West Birmingham Hospitals NHS Trust compares most favourably with other acute trusts in England.

TOP FIVE RANKING SCORES

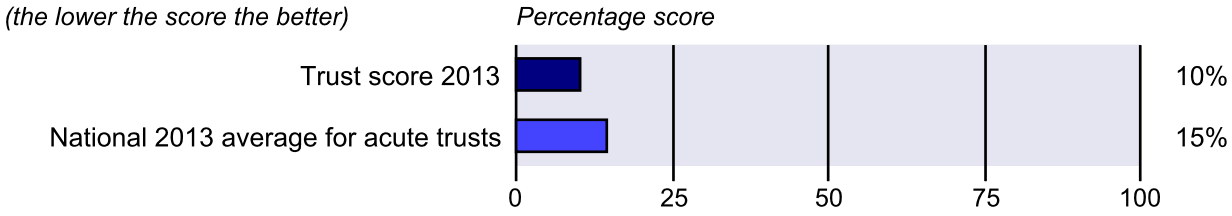
✓KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



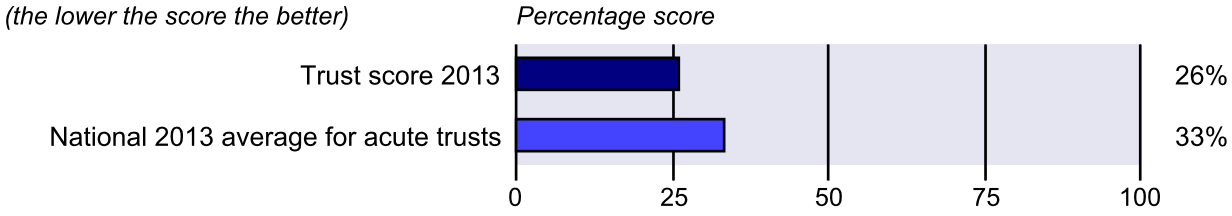
✓KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



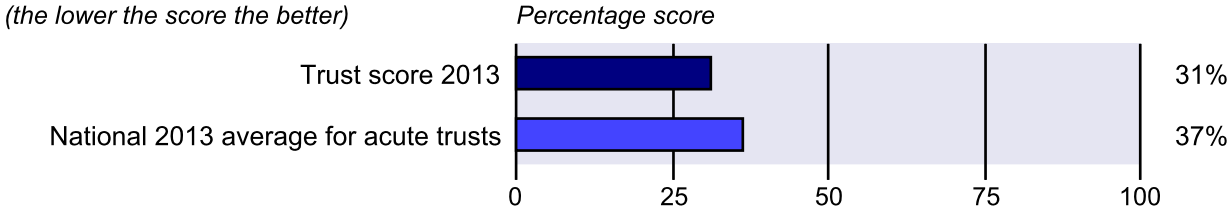
✓KF13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



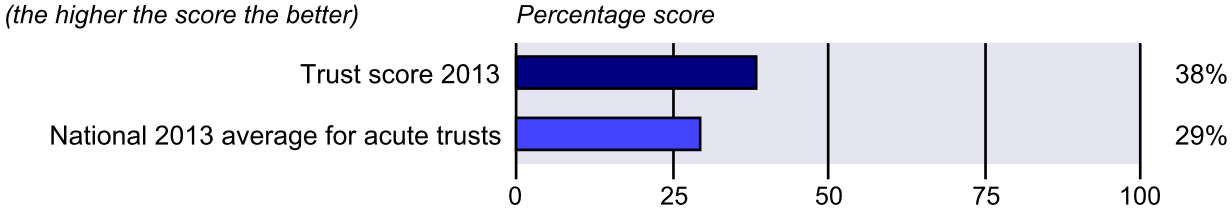
✓KF11. Percentage of staff suffering work-related stress in last 12 months

(the lower the score the better)



✓KF21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)

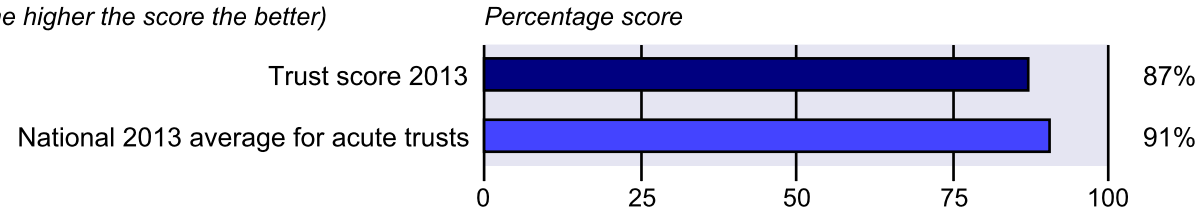


This page highlights the five Key Findings for which Sandwell And West Birmingham Hospitals NHS Trust compares least favourably with other acute trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

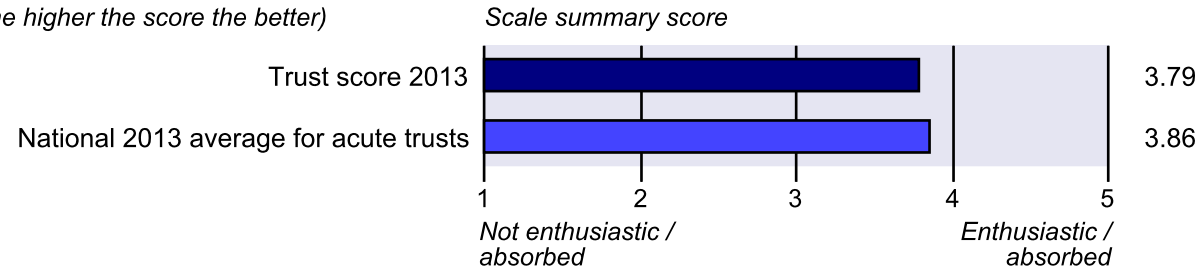
! KF2. Percentage of staff agreeing that their role makes a difference to patients

(the higher the score the better)



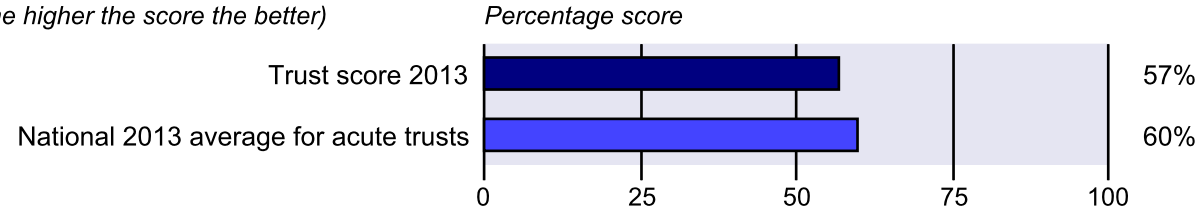
! KF25. Staff motivation at work

(the higher the score the better)



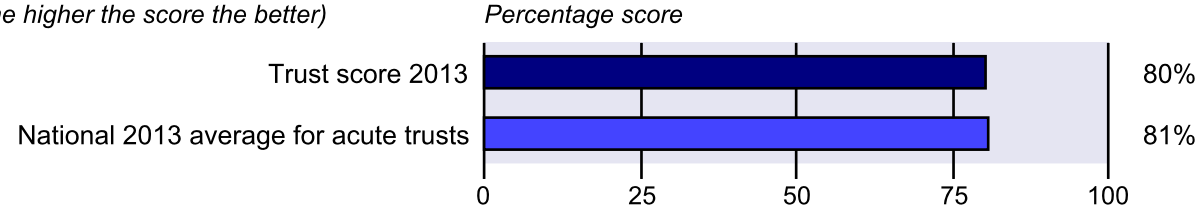
! KF12. Percentage of staff saying hand washing materials are always available

(the higher the score the better)



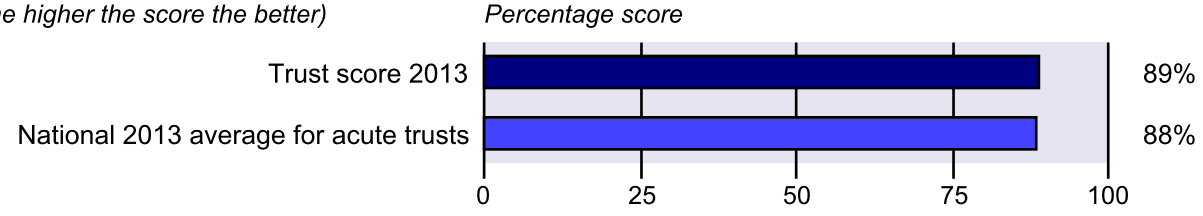
! KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



! KF27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

(the higher the score the better)



For each of the 28 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 141 (the bottom ranking score). Sandwell And West Birmingham Hospitals NHS Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 141. Further details about this can be found in the document ***Making sense of your staff survey data***.

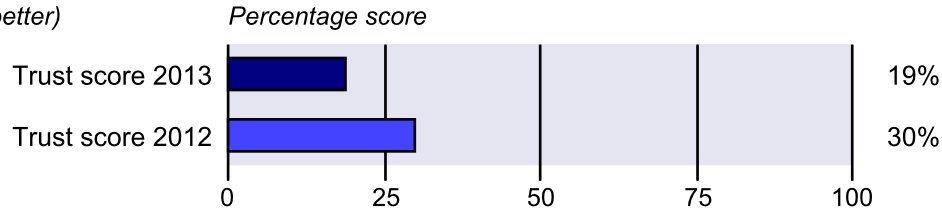
3.2 Largest Local Changes since the 2012 Survey

This page highlights the four Key Findings where staff experiences have improved the most at Sandwell And West Birmingham Hospitals NHS Trust since the 2012 survey.

WHERE STAFF EXPERIENCE HAS IMPROVED

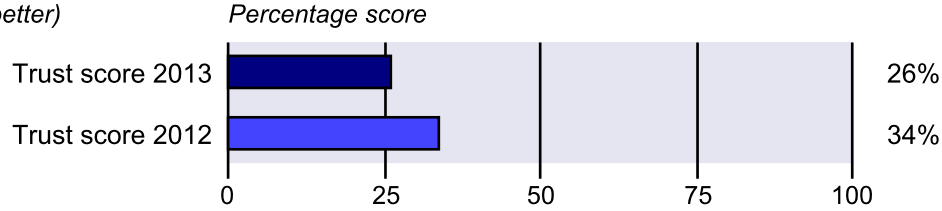
✓KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



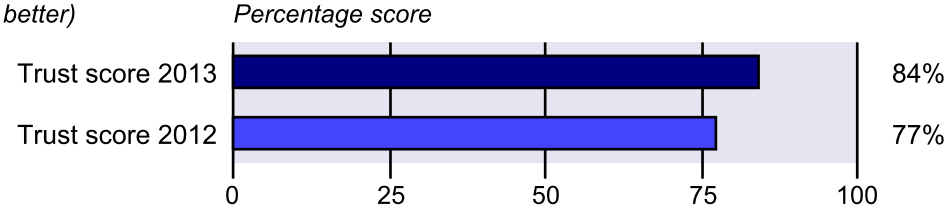
✓KF13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



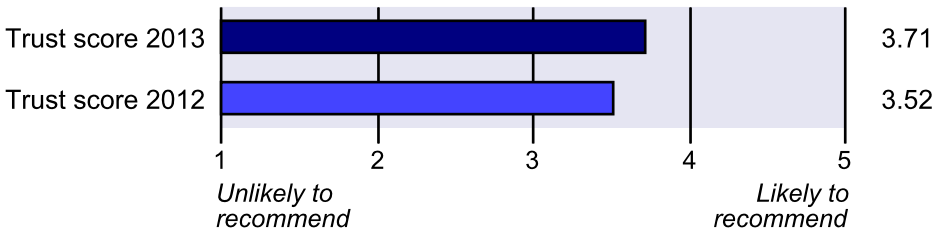
✓KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



✓KF24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have improved the most. Rather, the extent of 10-11 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.2. Summary of all Key Findings for Sandwell And West Birmingham Hospitals NHS Trust

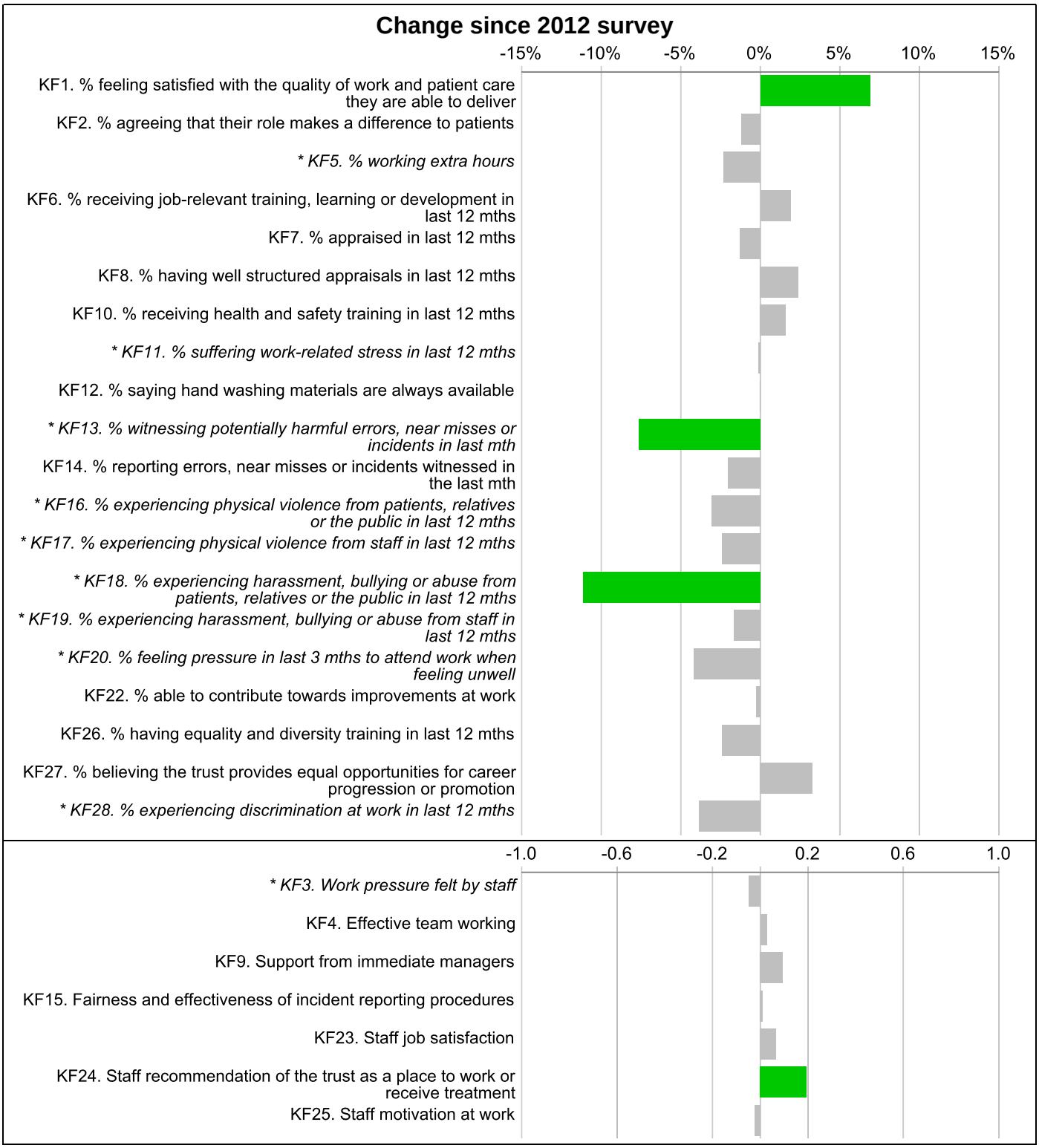
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2012 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2012 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2012 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for Sandwell And West Birmingham Hospitals NHS Trust

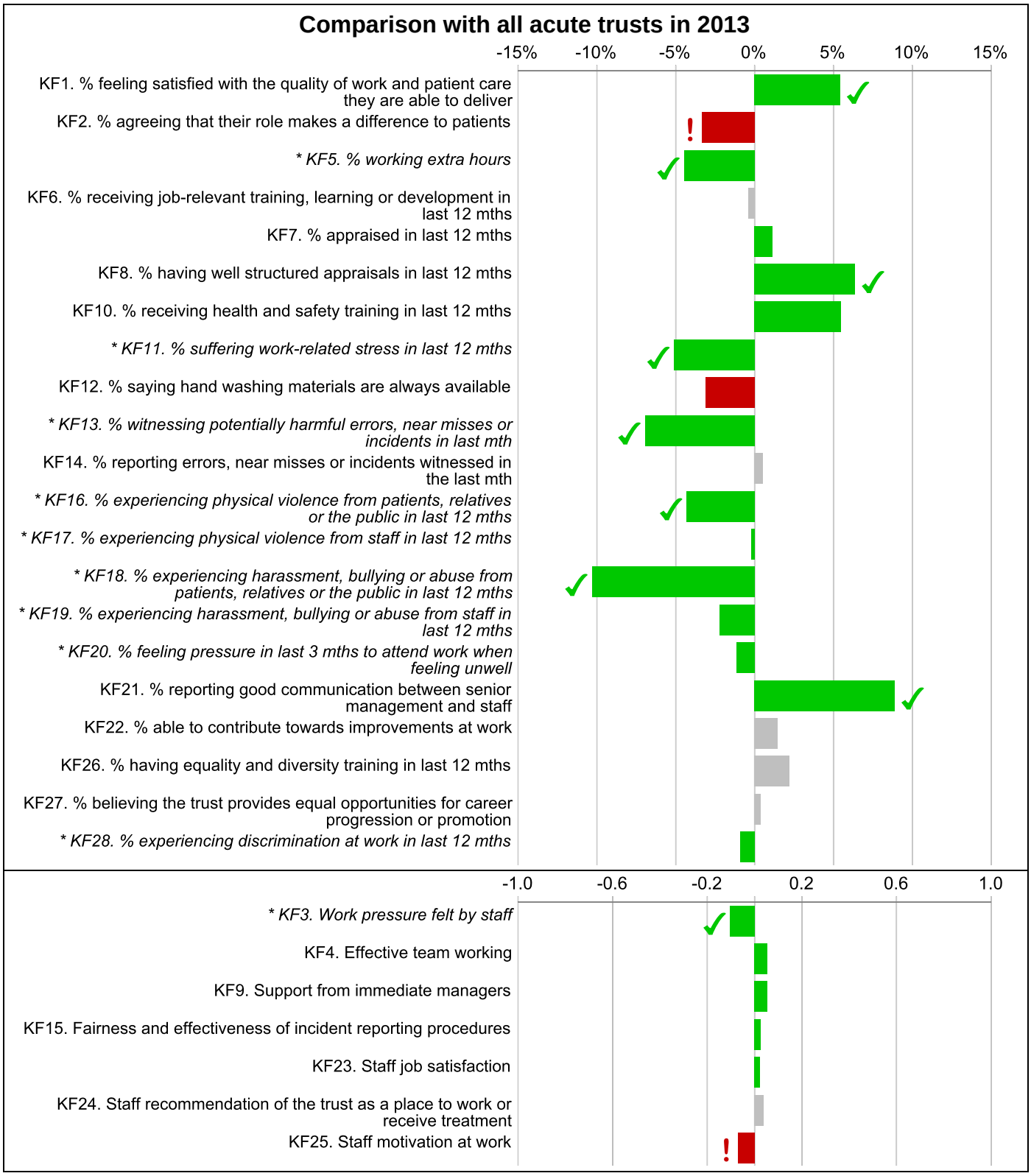
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than avearge. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Sandwell And West Birmingham Hospitals NHS Trust

KEY

✓ Green = Positive finding, e.g. in the best 20% of acute trusts, better than average, better than 2012.

! Red = Negative finding, e.g. in the worst 20% of acute trusts, worse than average, worse than 2012.

'Change since 2012 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2012 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2012 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.

	Change since 2012 survey	Ranking, compared with all acute trusts in 2013
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	✓ Increase (better than 12)	✓ Highest (best) 20%
KF2. % agreeing that their role makes a difference to patients	• No change	! Lowest (worst) 20%
* *KF3. Work pressure felt by staff*	• No change	✓ Lowest (best) 20%
KF4. Effective team working	• No change	✓ Above (better than) average
* *KF5. % working extra hours*	• No change	✓ Lowest (best) 20%
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	• No change	• Average
KF7. % appraised in last 12 mths	• No change	✓ Above (better than) average
KF8. % having well structured appraisals in last 12 mths	• No change	✓ Highest (best) 20%
KF9. Support from immediate managers	• No change	✓ Above (better than) average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	• No change	✓ Above (better than) average
* *KF11. % suffering work-related stress in last 12 mths*	• No change	✓ Lowest (best) 20%
Infection control and hygiene		
KF12. % saying hand washing materials are always available	• No change	! Below (worse than) average
Errors and incidents		
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	✓ Decrease (better than 12)	✓ Lowest (best) 20%
KF14. % reporting errors, near misses or incidents witnessed in the last mth	• No change	• Average
KF15. Fairness and effectiveness of incident reporting procedures	• No change	✓ Above (better than) average

3.3. Summary of all Key Findings for Sandwell And West Birmingham Hospitals NHS Trust (cont)

	Change since 2012 survey	Ranking, compared with all acute trusts in 2013
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Lowest (best) 20%
* *KF17. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	✓ Decrease (better than 12)	✓ Lowest (best) 20%
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Below (better than) average
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	✓ Below (better than) average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	--	✓ Highest (best) 20%
KF22. % able to contribute towards improvements at work	• No change	• Average
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	• No change	✓ Above (better than) average
KF24. Staff recommendation of the trust as a place to work or receive treatment	✓ Increase (better than 12)	• Average
KF25. Staff motivation at work	• No change	! Lowest (worst) 20%
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	• No change	• Average
KF27. % believing the trust provides equal opportunities for career progression or promotion	• No change	• Average
* *KF28. % experiencing discrimination at work in last 12 mths*	• No change	✓ Below (better than) average

4. Key Findings for Sandwell And West Birmingham Hospitals NHS Trust

315 staff at Sandwell And West Birmingham Hospitals NHS Trust took part in this survey. This is a response rate of 37%[1] which is in the lowest 20% of acute trusts in England, and compares with a response rate of 49% in this trust in the 2012 survey.

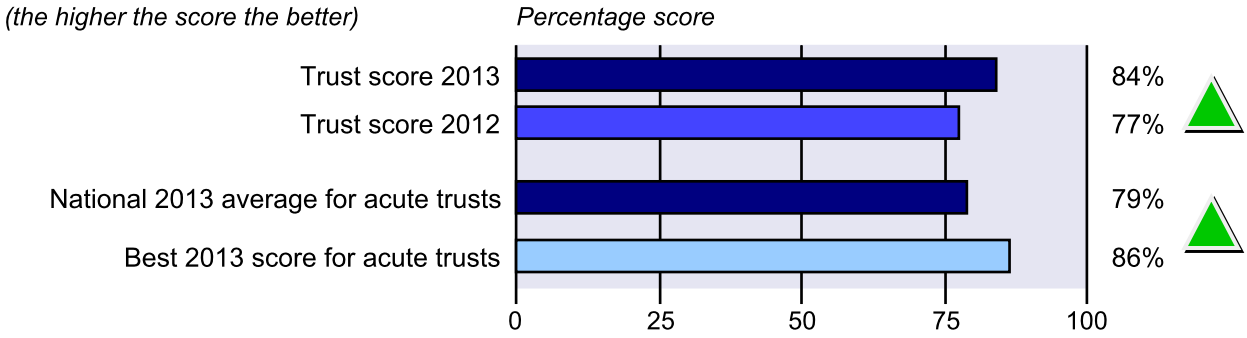
This section presents each of the 28 Key Findings, using data from the trust's 2013 survey, and compares these to other acute trusts in England and to the trust's performance in the 2012 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the two additional themes of staff satisfaction and equality and diversity.

Positive findings are indicated with a green arrow (e.g. where the trust is in the best 20% of trusts, or where the score has improved since 2012). Negative findings are highlighted with a red arrow (e.g. where the trust's score is in the worst 20% of trusts, or where the score is not as good as 2012). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

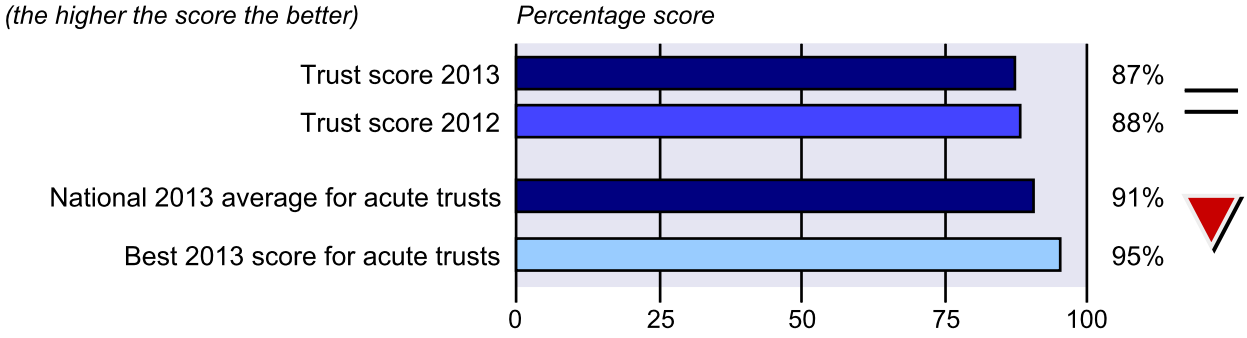
KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients

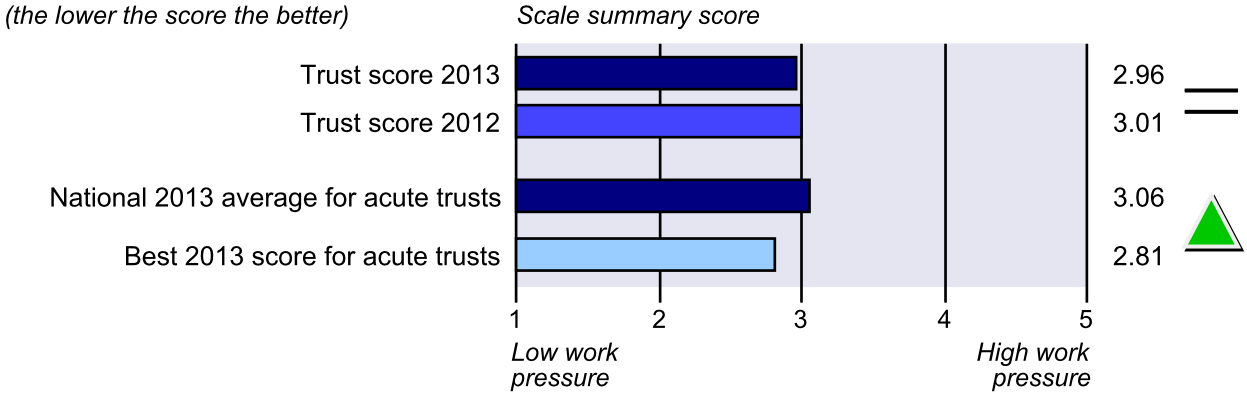
(the higher the score the better)



[1]At the time of sampling, 7382 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 842 staff. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

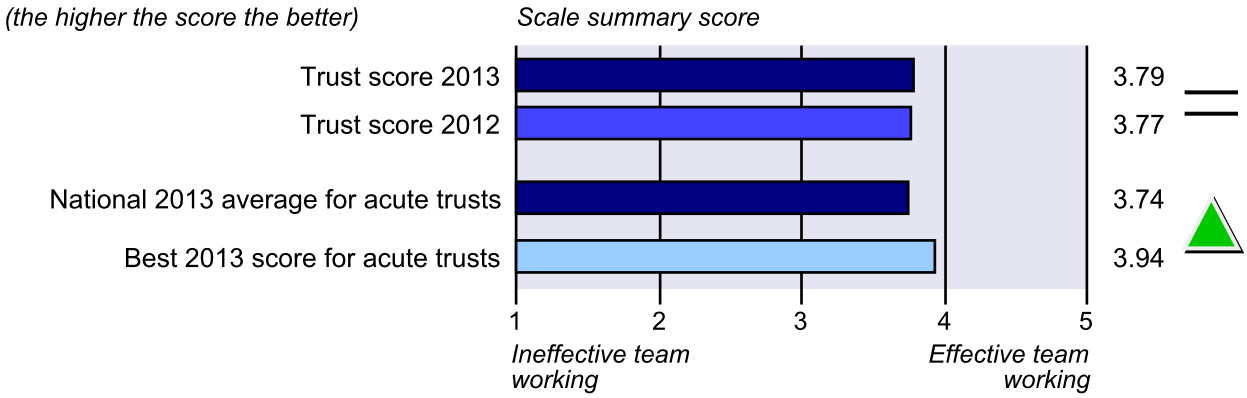
KEY FINDING 3. Work pressure felt by staff

(the lower the score the better)



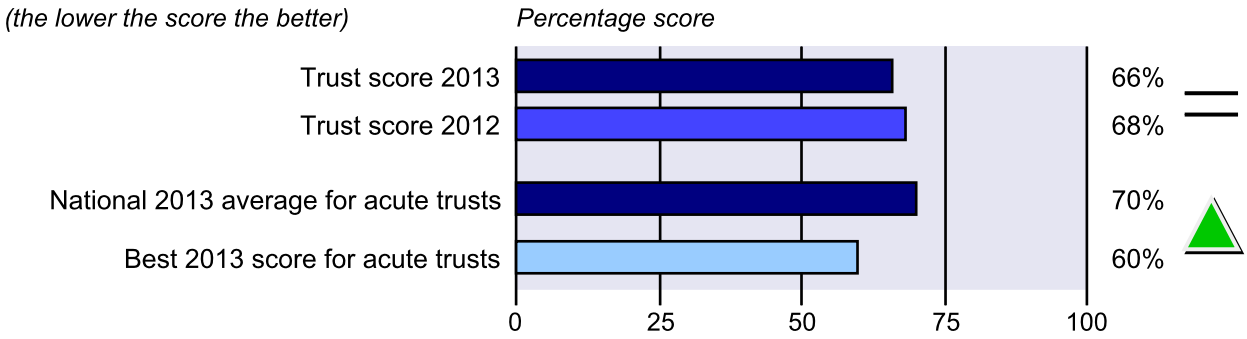
KEY FINDING 4. Effective team working

(the higher the score the better)



KEY FINDING 5. Percentage of staff working extra hours

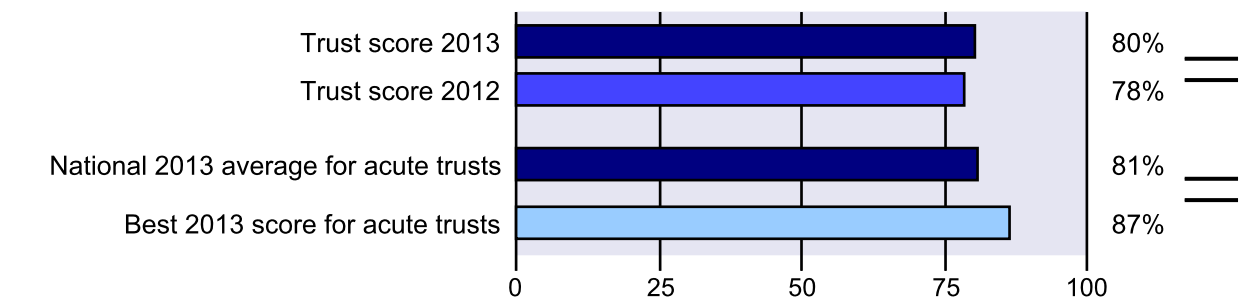
(the lower the score the better)



STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

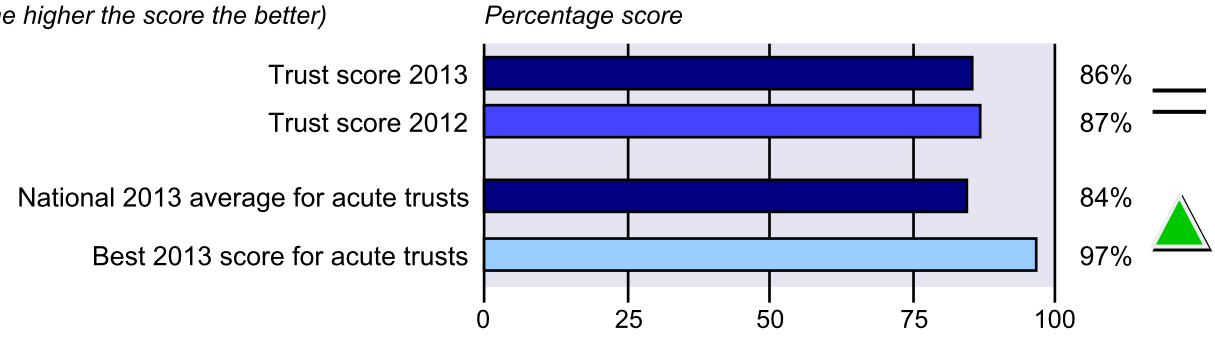
KEY FINDING 6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



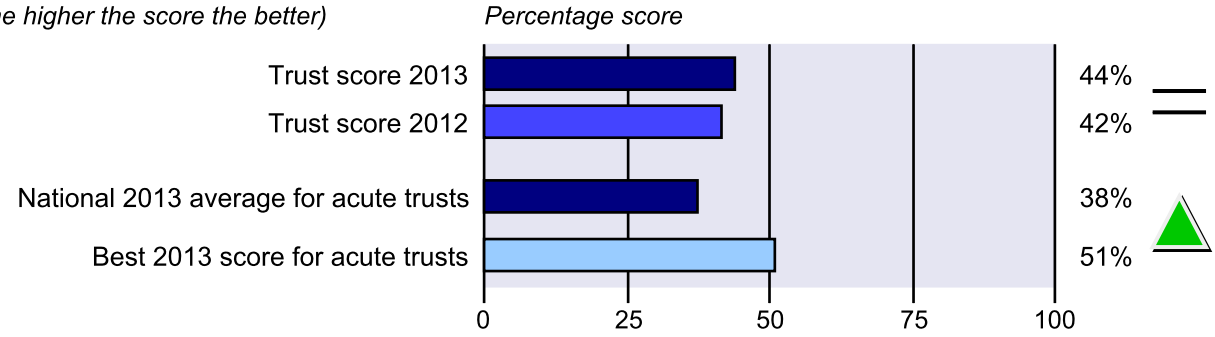
KEY FINDING 7. Percentage of staff appraised in last 12 months

(the higher the score the better)



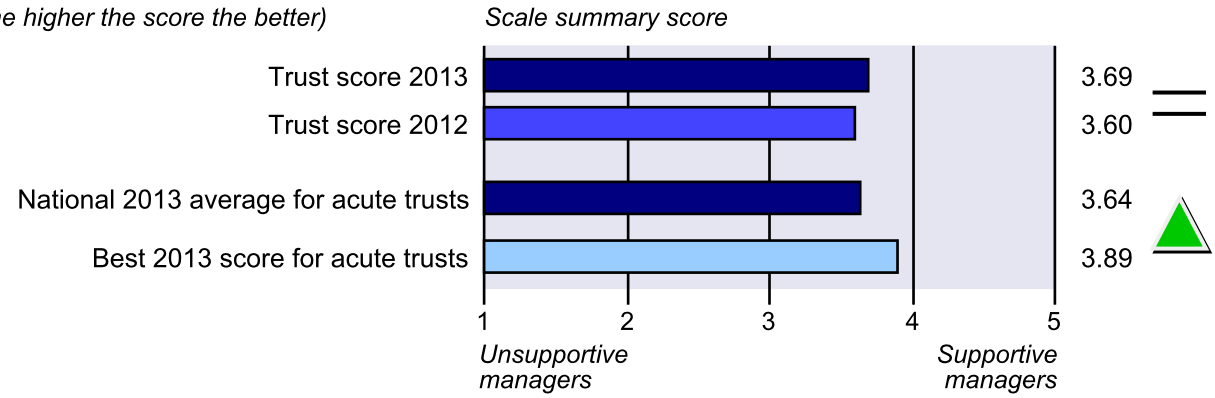
KEY FINDING 8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better)



KEY FINDING 9. Support from immediate managers

(the higher the score the better)

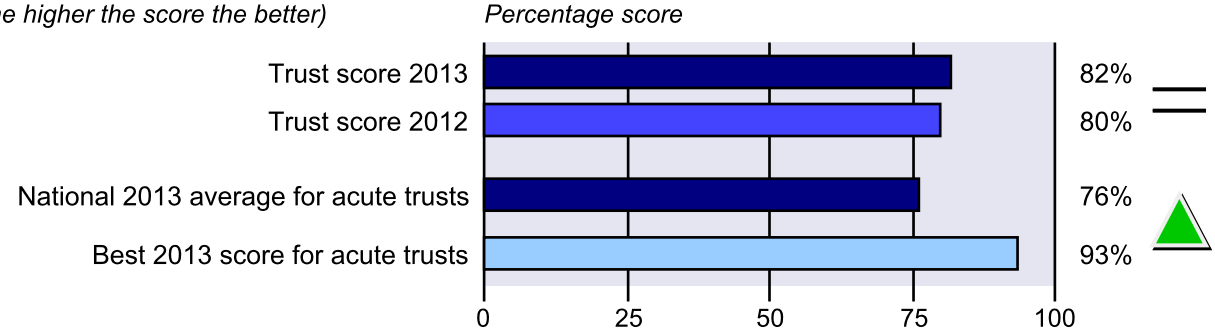


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Occupational health and safety

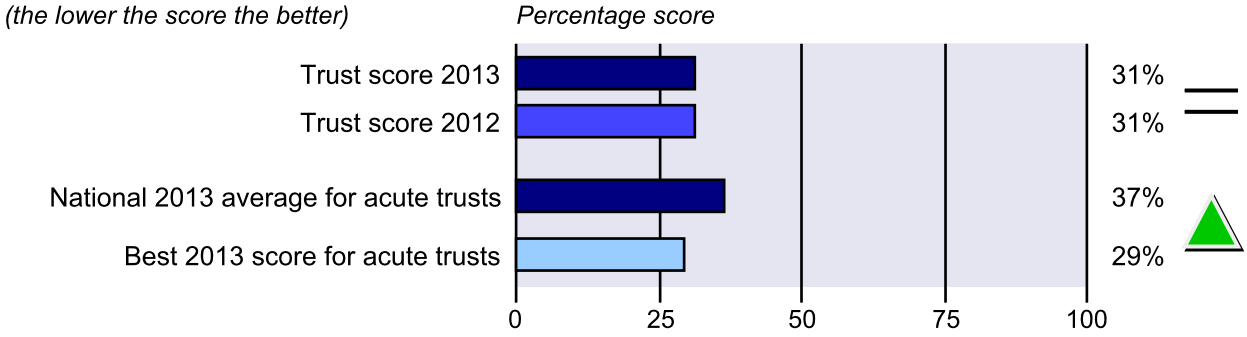
KEY FINDING 10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better)



KEY FINDING 11. Percentage of staff suffering work-related stress in last 12 months

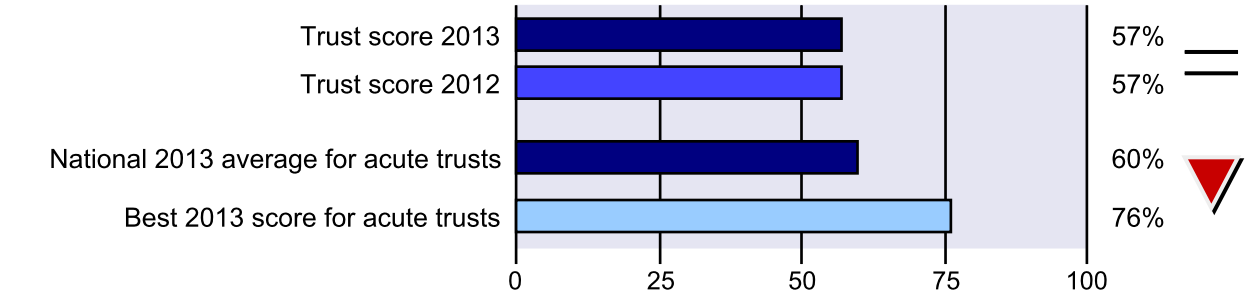
(the lower the score the better)



Infection control and hygiene

KEY FINDING 12. Percentage of staff saying hand washing materials are always available

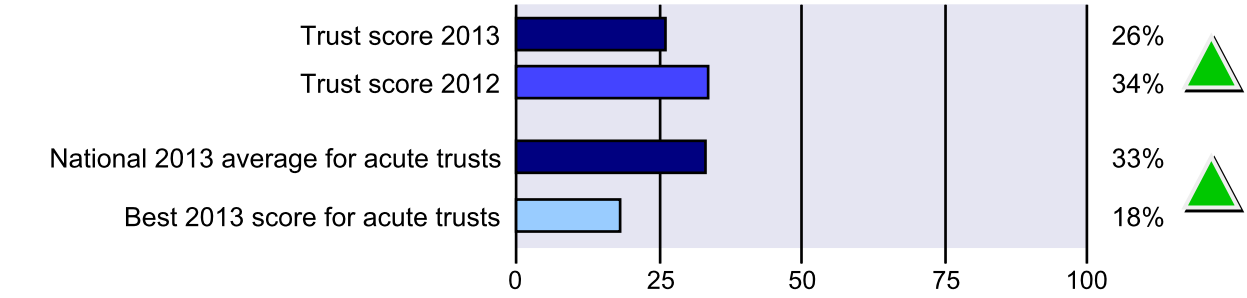
(the higher the score the better)



Errors and incidents

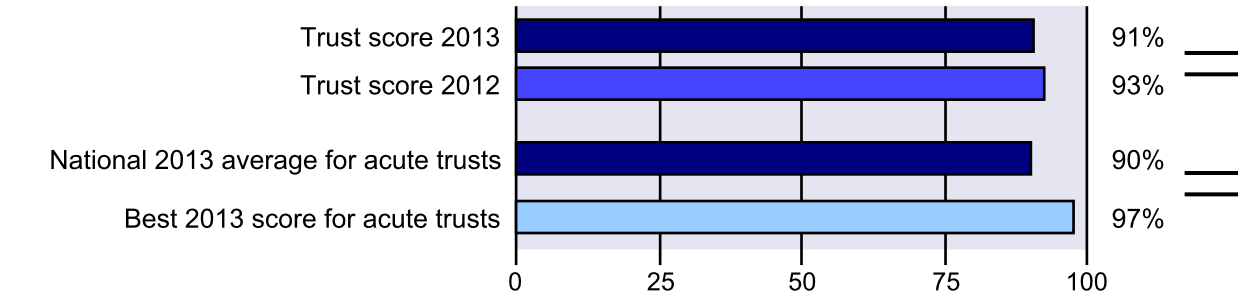
KEY FINDING 13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



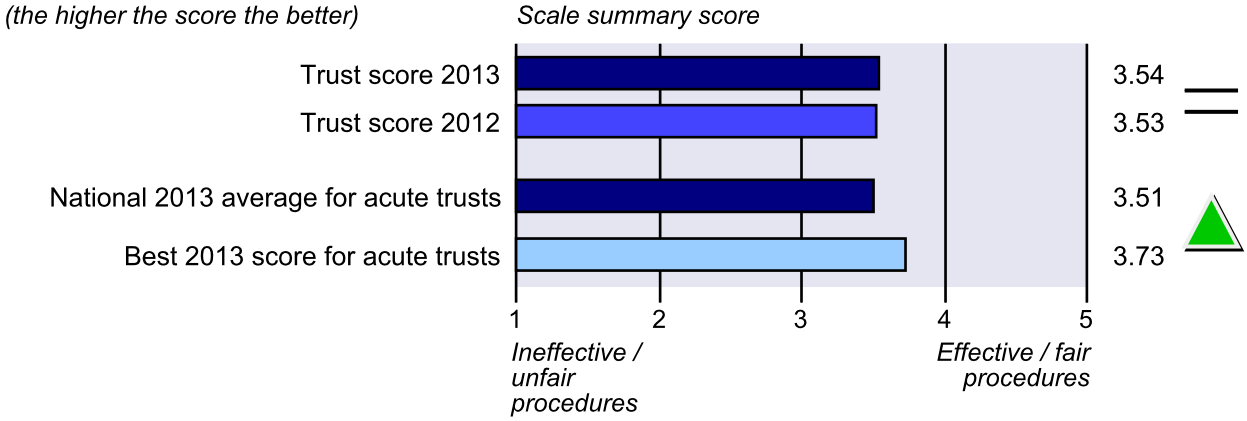
KEY FINDING 14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



KEY FINDING 15. Fairness and effectiveness of incident reporting procedures

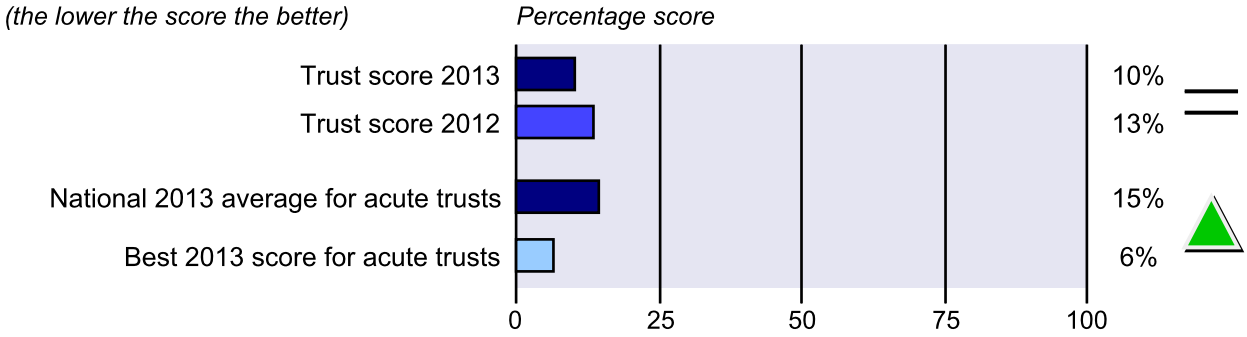
(the higher the score the better)



Violence and harassment

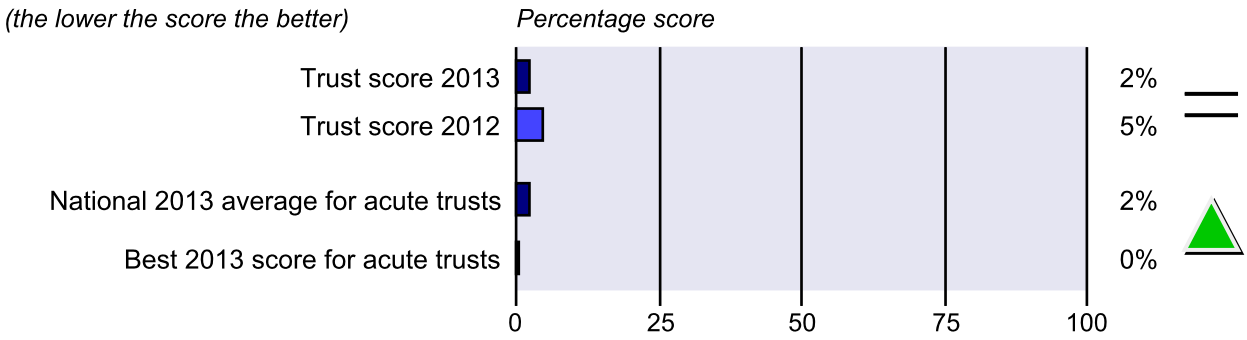
KEY FINDING 16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



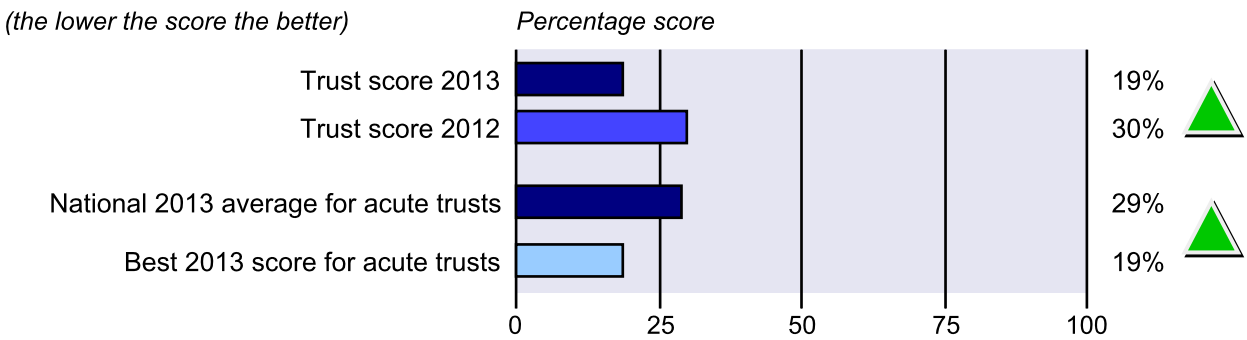
KEY FINDING 17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



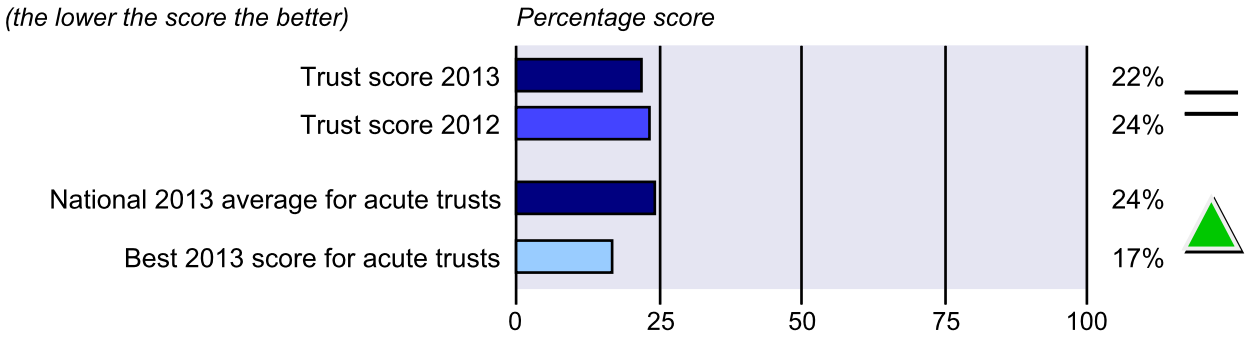
KEY FINDING 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



KEY FINDING 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

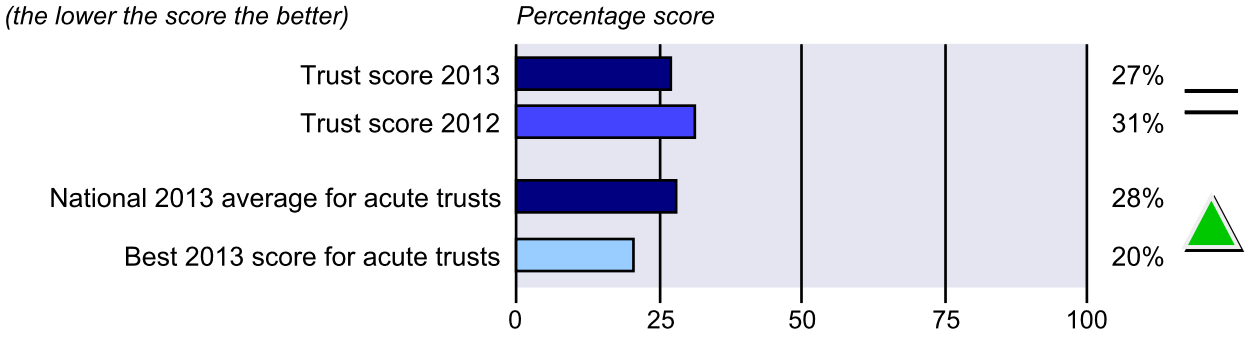
(the lower the score the better)



Health and well-being

KEY FINDING 20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

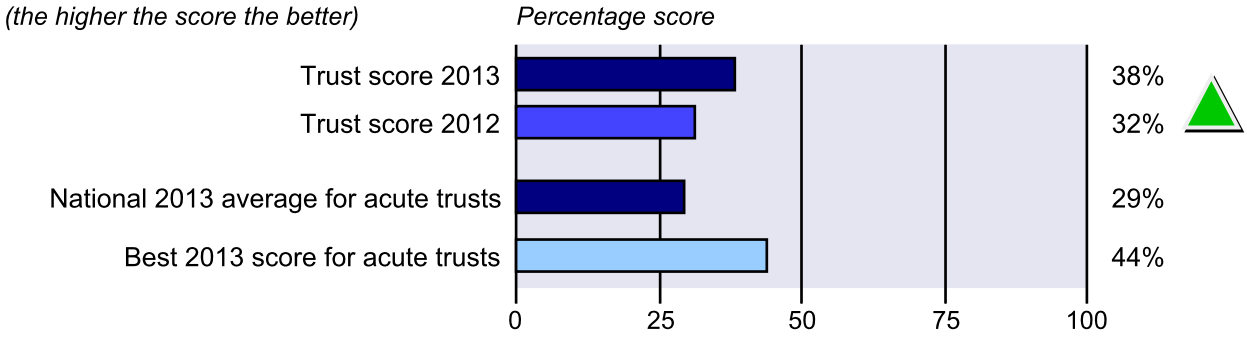
(the lower the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

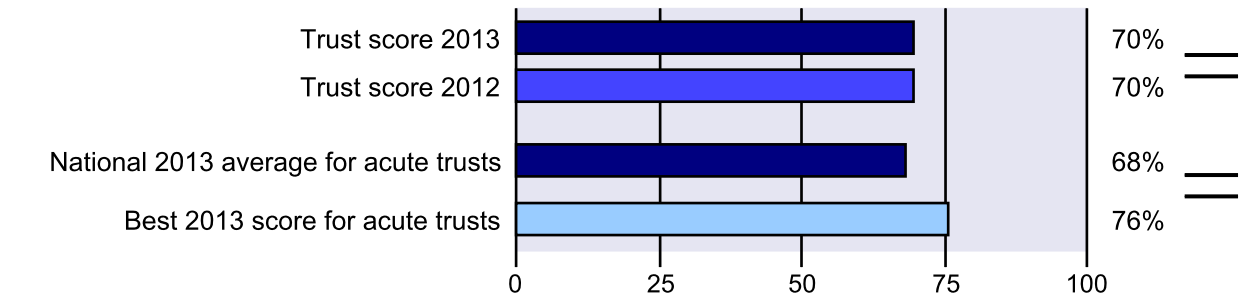
KEY FINDING 21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 22. Percentage of staff able to contribute towards improvements at work

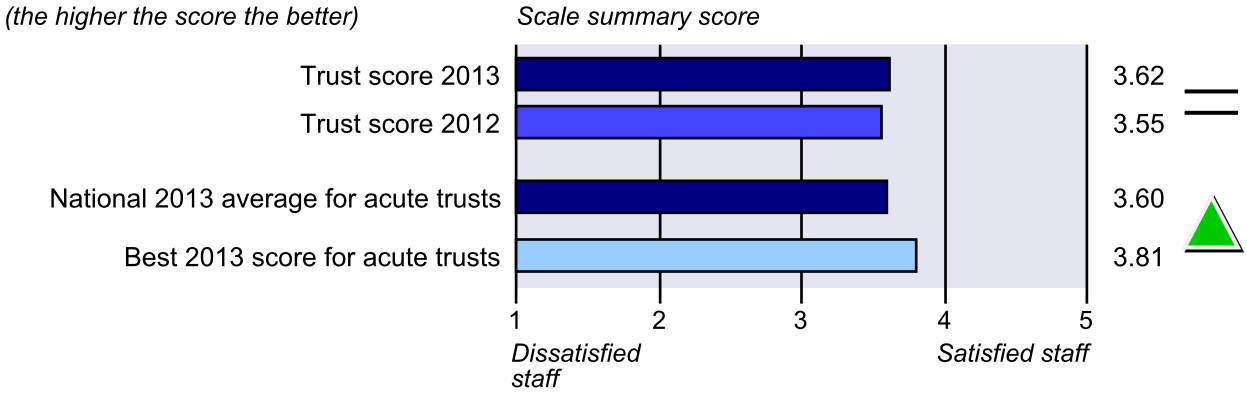
(the higher the score the better)



ADDITIONAL THEME: Staff satisfaction

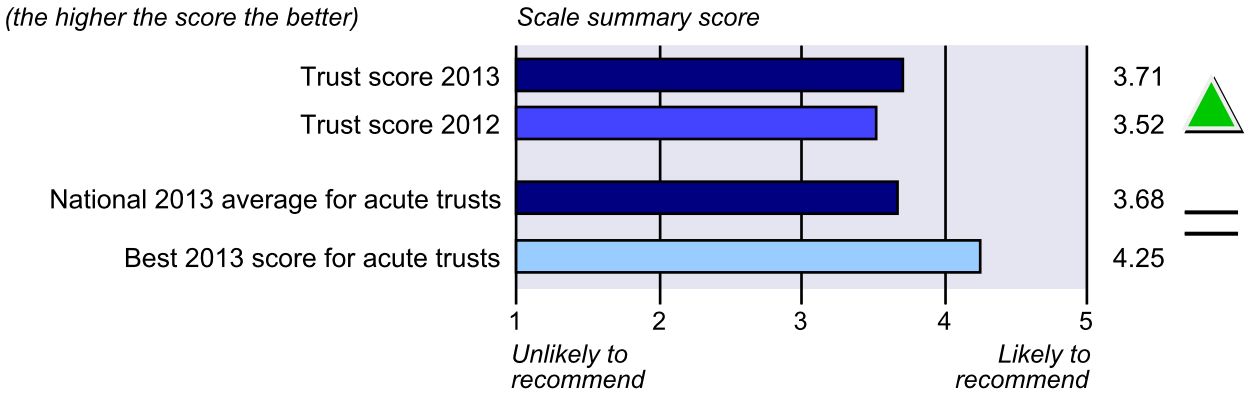
KEY FINDING 23. Staff job satisfaction

(the higher the score the better)



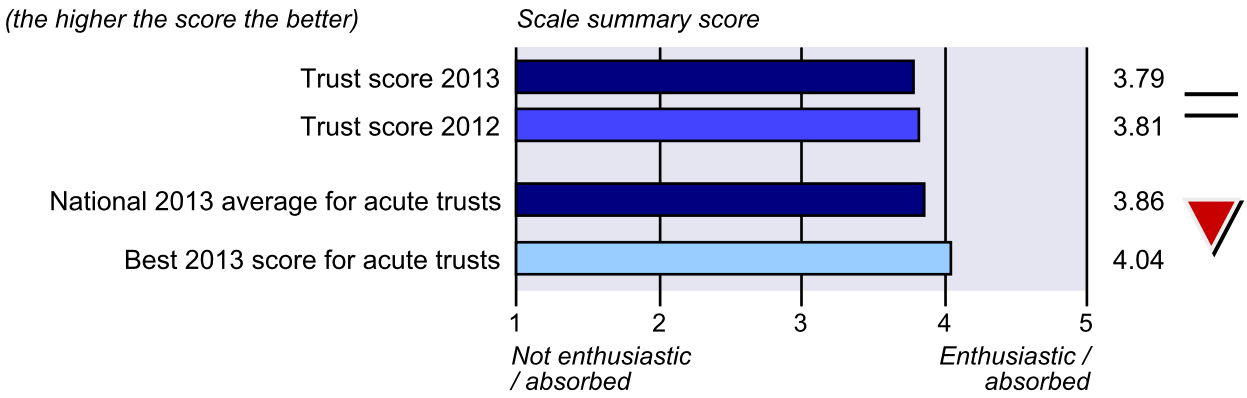
KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



KEY FINDING 25. Staff motivation at work

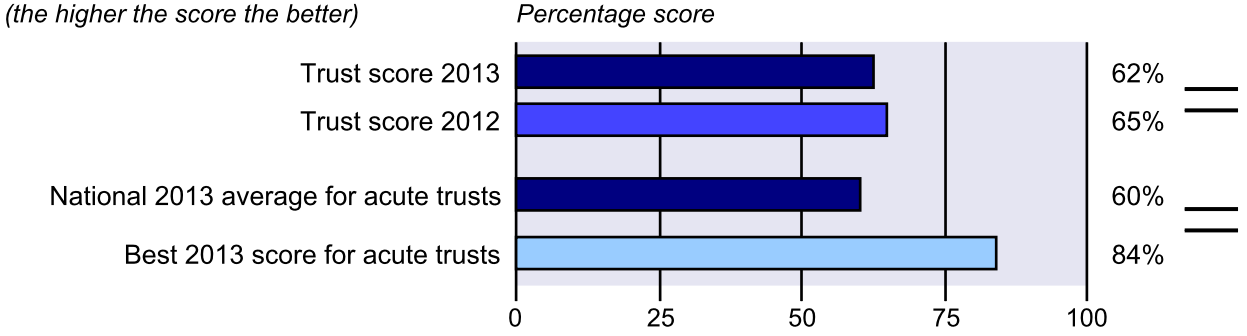
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

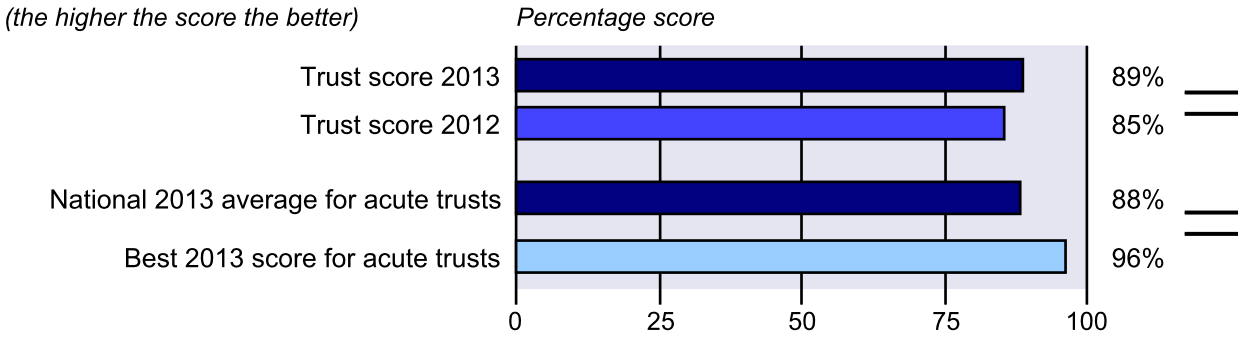
KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



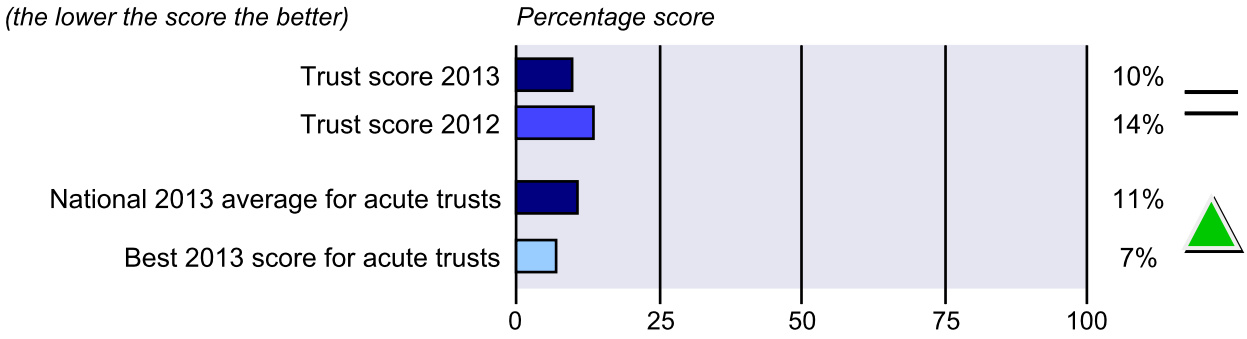
KEY FINDING 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

(the higher the score the better)



KEY FINDING 28. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)



'Your Voice'
Monthly Staff Polling Results

1. Introduction

There is now quite a body of evidence which links high levels of staff engagement to higher levels of care and better patient outcomes. Employee Voice is one of the four enablers for engagement identified by David MacLeod's 2009 report 'Engaging for Success'.

In September 2013, the Trust launched 'Your Voice', a new monthly SWBH on-line staff survey asking colleagues in every area of the Trust for their views at least quarterly to provide regular, team level feedback that we can act on and measure.

Its purpose is to measure and drive levels of staff engagement in the Trust. It also asks people what we can do to make them feel more positive about working for the Trust and for ideas to improve services for patients.

The data gives team, directorate and group leaders and managers staff feedback about levels of engagement for their areas and qualitative data about what staff say needs improving and how. Teams then meet with staff to communicate the results and agree what actions to take as a result.

2. Response Rates

Response rates for the first 3 months starting from September 2013 were between 16% and 26%. We had a break in December, so the groups which participated in the survey in September were surveyed for a second time in January 2014, when response rates fell from 18% to 14%.

Response rates are best in those areas with more access to email, like the corporate areas and community teams, which work with laptops – the best response rate to date is 76% by Community Respiratory.

In Facilities, we provided IT access and organised drop-in sessions supported by IT staff and achieved a 58% response rate in Patient Transport. The IT team is looking at a solution for ward areas by offering the survey on iPads which are used for patient surveys.

3. Results

Your Voice uses the same 9 questions which are used to measure staff engagement by the annual National Staff Survey. The questions measure levels of motivation, advocacy and involvement. The overall engagement score is an average of the score for these three.

The Trust's staff engagement score derived from the National Staff Survey rose from 3.66 in 2012 to 3.73 in 2013. This compares to a national average for 2013 of 3.74. In 2012 the best score achieved by an acute trust was 3.97 and the worst was 3.30. At the moment 'Your Voice' appears to be under report our engagement levels in comparison to the results we get from the National Staff Survey.

The encouraging thing about the January results is that where groups and teams had responded to the issues raised in the survey we saw engagement levels improve.

Surgery A, which reviewed the results and planned a number of communication initiatives, at group level saw the biggest improvement in its score.

Women & Child Health have the best group engagement score to date. You only really see the variation when you get down to team, and to some extent directorate level, which is why response rates are important, because we need a minimum of 11 responses in order to get results for individual teams.

'Your Voice' – League Table by Group

Group	Total Responses	Response Rate	Disengaged	Neutral	Engaged	Overall score	Change	Ranking
Women & Child Health	111	11%	6%	28%	66%	3.79	+0.05	1
Medicine & Emergency Care	139	11%	8%	31%	61%	3.73		2
Imaging	57	19%	8%	30%	62%	3.72	-0.01	=3
Surgery B	69	18%	3%	37%	60%	3.72	+0.06	=3
Community & Therapies	174	28%	8%	32%	60%	3.71		5
Corporate Group	484	26%	11%	35%	54%	3.56		6
Surgery A	124	13%	11%	36%	52%	3.55	+0.48	7
Pathology	54	17%	17%	39%	43%	3.31		8

Directorates from Imaging are at either end of the Directorates league table. The term Imaging Management is misleading as this group is really made up of admin and nursing support staff.

'Your Voice' – League Table by Directorate

Directorate	Response Rate	Disengaged	Neutral	Engaged	Overall score	Ranking
Nuclear Medicine	**57%**	**9%**	**20%**	**71%**	**3.91**	**1**
Maternity & Perinatal Medicine	**4%**	**6%**	**27%**	**67%**	**3.86**	**2**
Paediatrics	**18%**	**3%**	**24%**	**72%**	**3.85**	**3**
Diagnostic Radiology	**14%**	**5%**	**25%**	**70%**	**3.83**	**4**
Community Children	**16%**	**8%**	**25%**	**67%**	**3.80**	**5**
Directorate C- Surgery A	**8%**	**7%**	**27%**	**66%**	**3.76**	**6**
ENT/Audiology/Oral Surgery	**37%**	**3%**	**39%**	**58%**	**3.70**	**=7**
Ophthalmology	**10%**	**3%**	**36%**	**61%**	**3.70**	**=7**
Chief Executive, Strategy, Governance & Communications	**58%**	**9%**	**33%**	**59%**	**3.68**	**=9**
Directorate B - Surgery A	**10%**	**7%**	**35%**	**57%**	**3.68**	**=9**
Estates & New Hospital Project	**29%**	**12%**	**33%**	**56%**	**3.63**	**11**
Directorate A - Surgery A	**11%**	**15%**	**31%**	**53%**	**3.59**	**12**
Corporate Nursing & Facilities	**20%**	**11%**	**32%**	**57%**	**3.57**	**13**
Operations	**22%**	**9%**	**40%**	**52%**	**3.56**	**14**
Finance	**27%**	**9%**	**42%**	**49%**	**3.51**	**15**
Gynaecology, Gynae-Oncology & GUM	**18%**	**5%**	**47%**	**48%**	**3.50**	**=16**
Workforce	**51%**	**14%**	**34%**	**52%**	**3.50**	**=16**
Medical Director	**36%**	**12%**	**38%**	**51%**	**3.47**	**18**
Directorate D - Surgery A	**17%**	**12%**	**43%**	**45%**	**3.44**	**19**
Group Management - Surgery A	**42%**	**16%**	**37%**	**46%**	**3.41**	**20**
Group Management - Imaging	**26%**	**14%**	**40%**	**46%**	**3.33**	**21**

'Your Voice' League Table by Team

Group	Team	Response Rate	Disengaged	Neutral	Engaged	Over all score	Change	Ranking
Corporate Group	Learning & Development	56%	0%	22%	78%	4.06		1
Corporate Group	Ward Services, Sandwell	9%	1%	19%	81%	4.05		2
Women & Child Health	Community Children's Therapies	43%	0%	23%	77%	4.04	+ 0.18	3
Community & Therapies	Physiotherapy	26%	1%	23%	76%	3.99		4
Imaging	Nuclear Medicine	57%	9%	20%	71%	3.91	-0.05	5
Corporate Group	Occupational Health	68%	4%	28%	68%	3.89		6
Corporate Group	Facilities Administration	48%	7%	16%	77%	3.86		7
Women & Child Health	Paediatric Administration	57%	5%	26%	69%	3.85	+0.11	8
Women & Child Health	Health Visiting	9%	13%	22%	65%	3.82	-0.02	9
Women & Child Health	Community Paediatric Nursing	54%	3%	28%	69%	3.79	New Jan 14	10
Community & Therapies	ICARES	36%	6%	33%	61%	3.76		11
Corporate Group	Catering, Sandwell	23%	10%	21%	69%	3.75		12
Community & Therapies	MSK, Foot Health and COS	30%	6%	31%	63%	3.71		= 13
Surgery B	Newborn Hearing Screeners	34%	5%	33%	63%	3.71	New Jan 14	= 13
Surgery B	Hearing Services	46%	5%	35%	59%	3.70	+0.36	15
Corporate Group	Estates	27%	15%	23%	62%	3.67		16
Corporate Group	Pharmacy	23%	6%	45%	50%	3.63		17
Community & Therapies	Community Respiratory	76%	13%	38%	50%	3.62		=18
Community & Therapies	District Nursing	17%	14%	32%	54%	3.62		=18
Corporate Group	Elective Access	40%	6%	40%	54%	3.56		20
Corporate Group	Ward Services, City	8%	17%	30%	53%	3.50		21
Women & Child Health	School Nursing	32%	15%	32%	54%	3.48	Sept 13 score	22
Corporate Group	Corporate Nursing	31%	10%	43%	47%	3.42		=23
Pathology	Microbiology	21%	15%	34%	51%	3.42		=23
Medicine & Emergency Care	Medical Secretaries	21%	14%	34%	52%	3.42		=23
Surgery A	Medical	45%	17%	35%	48%	3.41	+0.55	26

Group	Team	Response Rate	Disengaged	Neutral	Engaged	Over all score	Change	Ranking
	Secretaries							
Corporate Group	Patient Transport	58%	14%	37%	49%	3.40		27
Surgery A	Surgery A Doctors	21%	18%	37%	46%	3.38	+0.46	28
Corporate Group	Operational Finance	54%	12%	45%	43%	3.37		=29
Imaging	Radiology Admin	61%	12%	44%	44%	3.37	Sept 13 score	=29
Imaging	Imaging Nursing	30%	16%	45%	39%	3.30	Sept 13 score	31
Corporate Group	Catering, City	26%	10%	48%	42%	3.28		32
Corporate Group	Human Resources	69%	21%	37%	43%	3.26		33
Surgery A	Critical Care Services, City	17%	5%	67%	29%	3.22	Sept 13 score	34
Pathology	Haematology	31%	21%	38%	41%	3.19		35
Surgery A	Medical Staff Anaesthetics	30%	18%	50%	32%	3.13	+0.05	36
Community & Therapies	Management Teams	71%	24%	35%	41%	3.08		37

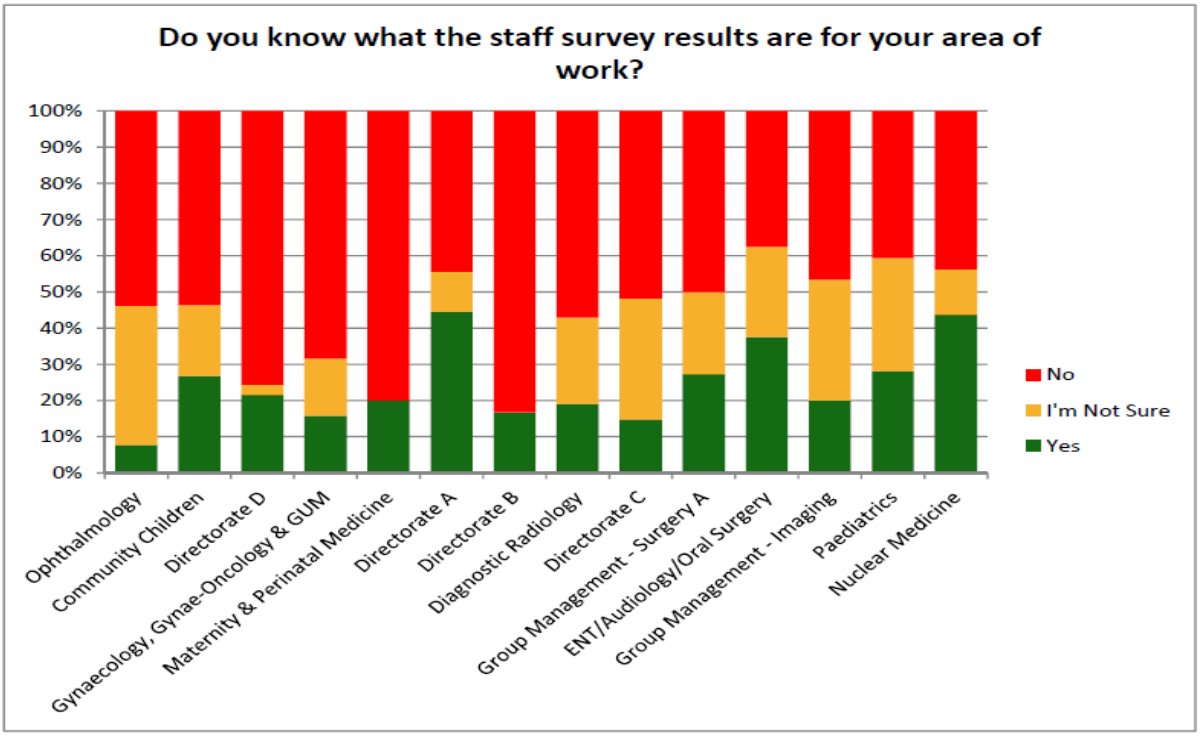
4. Actions

The January results indicated that we need to get better both at telling people about the results of Your Voice and about changes that are happening as a result.

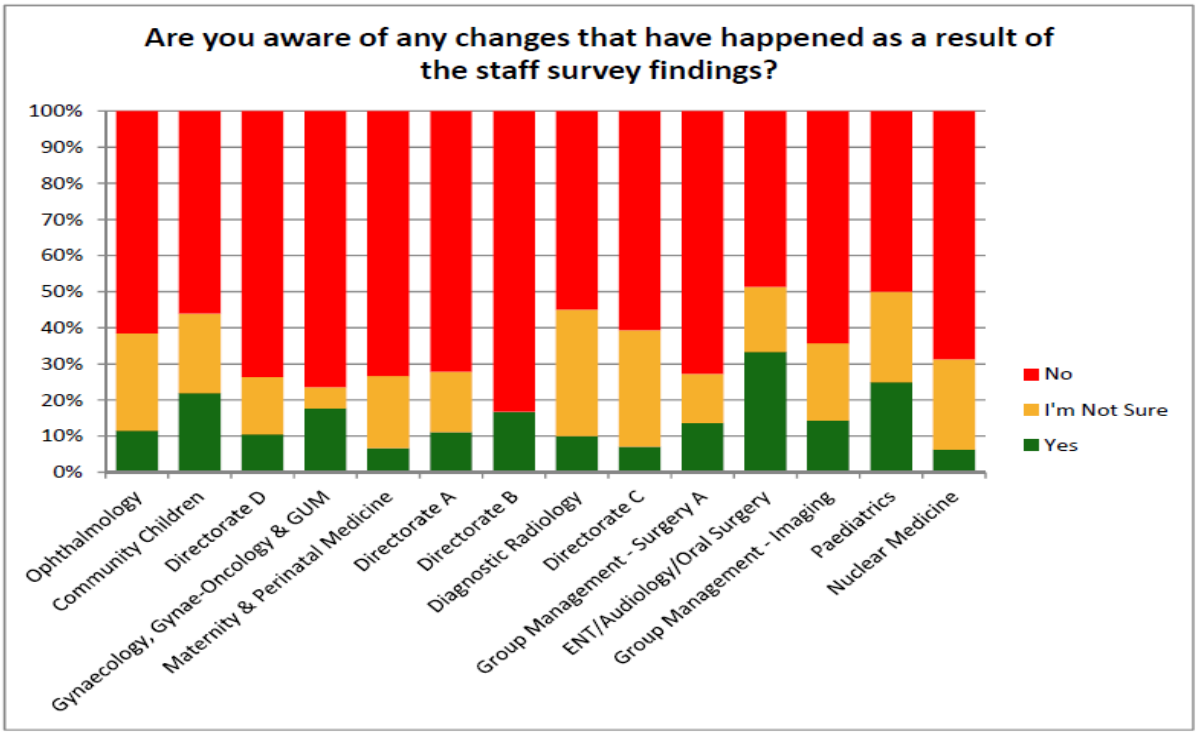
As a result we are now sending the results and comments not only to the group management team, but also to directorates and teams, who should then be responsible for cascading the results to their teams.

We have also introduced a discussion and actions template, which asks groups to explain how the results have been communicated, who is responsible for looking at actions and what those actions are.

All the league tables and management reports we get from Quality Health are published on Connect and we will soon be adding action templates with a brief summary from every group.



The team which achieved the best result for awareness of changes as a result of Your Voice was Hearing Services. They linked their actions directly to comments made by staff in the free text questions and communicated these actions both via email and face to face at team meetings.



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 March 2014 (Report prepared 21 February 2014)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2013 – January 2014.

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 and Quality & Safety Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST INTEGRATED PERFORMANCE CORPORATE DASHBOARD - JANUARY 2014

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:

Cancer Waits - performance (confirmation of provisional position reported last month) against the 62-day GP referral to Treatment target reduced to 83.7% (12 breaches of 73.5 patients treated) during the month of December, falling below the operational threshold of 85.0%, influenced by performance in Gynaecology, Lower GI, Lung and Urology. Performance for the year to date remains above 85.0%, at 87.0%. Performance against all other cancer targets met / exceeded the respective operational thresholds.

Emergency Care - the Trust continued to meet the 4-hour wait operational threshold of 95% during January with performance of 95.4%, further improving year to date performance to 94.6%. Performance as at 17 February 2014 for the month of February was 93.5% and 94.7% for the quarter.

Outcome Metrics:

Infection Control - The number of cases of C Diff reported during the month was 2, with 33 for the year to date, compared with a trajectory of 40 for the period. Reported cases of MSSA and E. Coli for the year to date continue to remain within operational thresholds.

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 (January) there was 1 **Never Event** reported in Ophthalmology, 6 **Open Serious Incidents Requiring Investigation** (SIRIs) and 9 **Open Central Alert System** (CAS) Alerts, 7 of which remain outstanding for closure.

WHO Safer Surgery Checklist - compliance against the 2 of the 3 reported components of the checklist reduced during the month of December. Compliance where all 3 sections of the checklist were completed and a brief undertaken reduced to 90.2%, and where all 3 sections of the checklist were completed with both brief and debrief undertaken reduced to 74.4%. The main specialties influencing the reduced performance were; General Surgery, Trauma & Orthopaedic Surgery and Maternity & Perinatal Medicine.

Quality Governance:

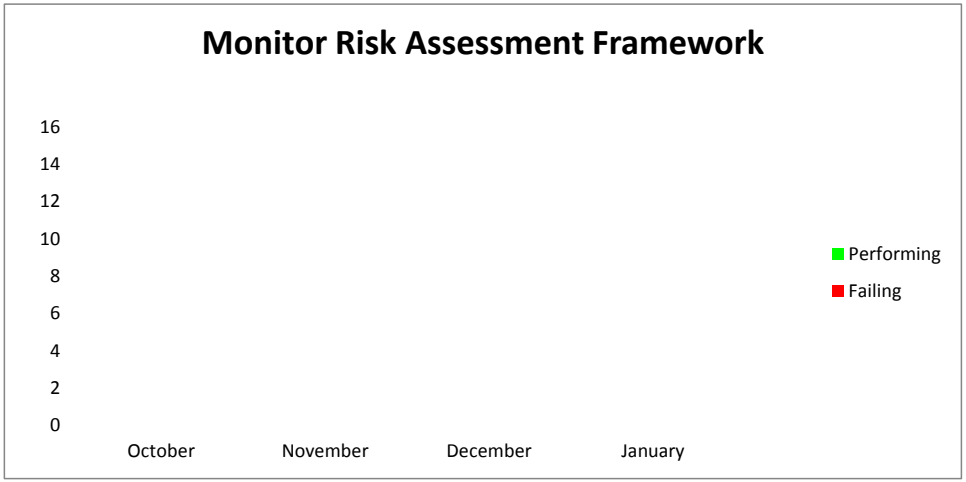
A total of 6 **Mixed Sex Accommodation** breaches were reported during the month of January comprising; Coronary Care Sandwell (3) and Critical Care Sandwell (3).

PDR Compliance further improved to 84.8% overall, with improvement evident in the majority of Groups. However there remain approximately 1800 who are due a PDR prior to the end of March. During the course of the last 4 weeks the total number of staff due to receive a PDR prior to the end of March has reduced by c.500, although remains at c.1800 (data as at 7 February 2014).

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 January the Trust met / is projected (Cancer) to meet the required thresholds for each of the Access and Outcomes indicators. This would attract an overall weighted score for the month of 0.0 with a GREEN Governance Rating.

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,16 are performing, with either year to date targets being met or progress in accordance with plan, 1 scheme underperforming and 2 schemes currently failing, with the remaining scheme, Annual Staff Survey, not yet due for assessment.

Dementia (Find, Assess and Refer) CQUIN scheme - exceeded 90% for each of the 3 components for the second consecutive month. Achievement of this CQUIN requires all 3 components to be met at 90% or more, for 3 consecutive months.

Friends and Family Test to Maternity - as highlighted previously this scheme is currently failing, with a response rate of 8.00% during January, showing no demonstrable improvement from December. The final milestone for this scheme is a 65% response rate by end March 2014.

Medicines Management (Storage) - a further audit of performance is currently being undertaken, with results to date on 12 wards. 9 of the 12 wards audited are fully compliant, equivalent to 75%. Much work is remains to ensure all wards are fully compliant. Any non-compliant wards remain subject to on-going audits until full and sustained compliance is demonstrable.

Use of Pain Care Bundles - there are 2 elements to this CQUIN relative to specific patient groups; documentation of pain scores and administration of analgesia (as appropriate) within specified time periods. Underperformance against the second component of the scheme is recorded during January when compared with baseline and December performance, falling beneath the improvement trajectory. A range of focused actions centred around education and training, designed to heighten awareness have been identified by the scheme lead, and are being taken forward in conjunction with the Nursing Directorate.

Use of Sepsis Care Bundles - the scheme comprises 3 elements; the percentage of patients with triggers of sepsis who are screened with the sepsis tool, of these patients the percentage who have the sepsis bundle commenced and finally those patients where the bundle is fully deployed within 1 hour. Preliminary data indicates a reduction in performance in the first and third element from the baseline position. The formal CQUIN assessment period is Quarter 4. This report will be updated as further data for the quarter becomes available.

Clinical Quality & Outcomes

MRSA Screening - both Elective and Non Elective screening rates remain stable at 87% and 94% respectively. There remains some variation in rates at Group level essentially for Elective patients within the Medicine Group for which performance during January is reported as 50% (96 of 192 eligible patients).

Fractured Neck of Femur - the percentage of patients receiving an operation within 24 hours of admission during January was 66.7% (16 of 24 patients). A higher than average number of patients were admitted during the month, with peaks in activity experienced. Work looking at likely Demand and Capacity required, is on-going within the Group.

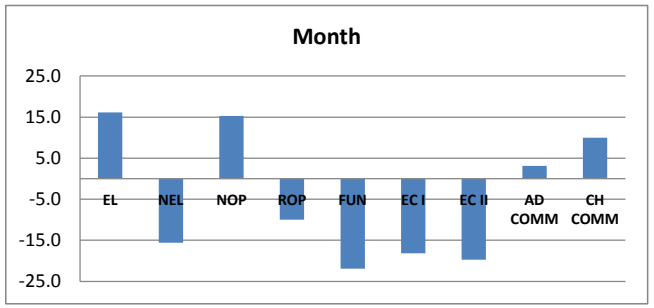
Patient Experience

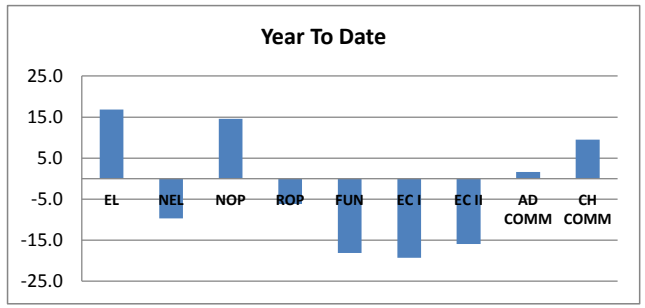
The percentage of **Imaging Requests** from Emergency Care for MRI reported within 24-hours further reduced to 77% during January. A 13% increase in overall demand for MRI has been experienced during the year with mobile facilities being used to support this. New consultant radiology staff due to commence in April should lead to an improvement in this request turnaround time.

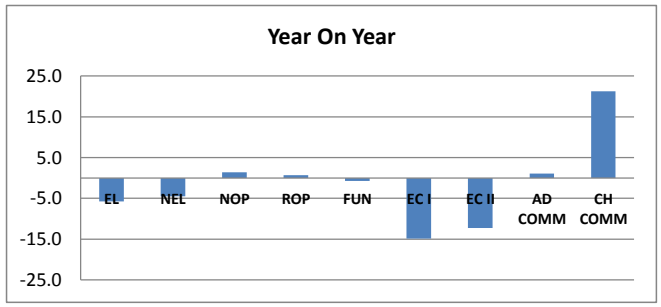
Cancelled Operations - SitRep declared late cancellations increased to 1.7% (1.4% December) and 84 (60 December) during the month of January. Of the 80 cancellations 34 were in Ophthalmology and 20 were in Trauma and Orthopaedic Surgery. The Trust is committed to reduce the number of cancelled operations, with a Task and Finish Group set up to focus on this issue. There were no breaches of the 28-day guarantee following cancellation, reported during the month.

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 year to date BY 16.8%, although remains (5.7%) less than that delivered during the corresponding period last year. Non-Elective activity is currently 9.7% less than the plan for the year to date, and 4.5% less than the corresponding period last year. Overperformance against the New Outpatient activity plan for the year to date (+14.6%) and an underperformance against the Review OP activity plan for the year to date (6.2%), gives a Follow Up:New OP Ratio of 2.22 for the year to date, significantly less than the ratio derived from plan (2.71), and that for the same period last year (2.24). 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 1.6% and 9.5% respectively.







JANUARY 2014	EXTERNAL ASSESSMENT FRAMEWORKS - TDA ACCOUNTABILITY FRAMEWORK & MONITOR RISK ASSSESSMENT FRAMEWORK

Exec Lead	KPI Source	Data Source	Category / Indicator				September	October	November	December			January			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	Trust	S'well	City	Trust		YTD	13/14						
RB	B*	1	Cancer	2 weeks		%	93.9 ▼	95.8 ▲	96.7 ▲	→		97.0 ▲	→			95.0	=>93	=>93	No variation		Any variation	●	94.8	94.7
	B*			2 weeks (Breast Symptomatic)		%	97.8 ▲	93.6 ▼	97.3 ▲	→		97.0 ▼	→			95.8	=>93	=>93	No variation		Any variation	●	95.8	95.9
	B*			31 Day (diagnosis to treatment)		%	99.4 ▼	100 ▲	97.5 ▼	→		98.8 ▼	→			99.0	=>96	=>96	No variation		Any variation	●	99.5	99.5
	B*			31 Day (second/subsequent treatment - surgery)		%	99.0 ▼	100 ▲	96.3 ▼	→		98.1 ▲	→			98.3	=>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	100 ■	→		n/a	→			100	=>94	=>94	No variation		Any variation	●	100	100
	B*			62 Day (urgent GP referral to treatment)		%	85.2 ▼	88.0 ▲	85.4 ▼	→		83.7 ■	→			87.0	=>85	=>85	No variation		Any variation	●	86.9	87.1
	B*			62 Day (referral to treat from screening)		%	93.8 ▼	96.3 ▲	98.0 ▲	→		100 ▲	→			98.2	=>90	=>90	No variation		Any variation	●	98.5	96.9
	A*			62 Day (referral to treat from hosp specialist)		%	92.0 ▼	100 ▲	97.3 ▼	→		100 ▲	→			91.6	=>85	=>85	No variation		Any variation	●	91.6	93.2
RB	B*	2	Emergency Care 4-hour waits			%	94.7 ■	92.6 ▼	95.2 ■	95.6 ■	95.2 ▼	95.4 ▲	96.2 ▲	94.7 ■	95.4 ■	94.6	=>95	=>95	=>95		<95	●	95.38	92.54
RB	B*	2	Referral To Treatment	Admitted Care (RTT <18 weeks)		%	90.1 ▼	91.8 ▲	90.9 ▼	→		92.4 ▲	→		90.1 ▼	90.1*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
	B*			Non-Admitted Care (RTT <18 weeks)		%	95.1 ▼	96.2 ▲	96.2 ■	→		96.9 ▲	→		97.0 ▲	97.0*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
	B*			Incomplete Pathway (RTT <18 weeks)		%	92.6 ▲	93.8 ▲	93.8 ■	→		93.0 ▼	→		92.9 ▼	92.9*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
				Treatment Functions Underperforming		No.	11 ▼	10 ▲	13 ▼	→		12 ▲	→		13 ▼	13*	0	0	0 / month	1 - 6 / month	>6 / month	●	10 (Q4)	11 (Q4)
	A			Waits >52 weeks		No.	20 ▲	66 ▼	36 ▲	→		12 ▲	→		3 ▲	3*	0	0	<0		>0	●		
RB	A*	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks		%	0.42 ▲	0.44 ▼	0.85 ▼	→		1.56 ■	→		1.44 ▲	1.44*	<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 ■	12	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																					
CO	B*	4	Infection Control	C. Difficile (DH Reportable)		No.	4 ▼	2 ▲	3 ▼	2 ▼	2 ■	4 ▼	0 ▲	2 ■	2 ▲	33	40	46	No variation		Any variation	●	95	37
	A*			MRSA Bacteraemia		No.	0 ■	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.	4.8 ▼	17.6 ■	4.5 ■	→		9.5 ■	→		4.4 ■	6.0	=<9.02	=<9.02	No variation		Any variation	●		
	A			E Coli Bacteraemia (rate per 100,000 bed days)		No.	4.82 ▲	30.7 ▼	35.9 ▼	→		19.0 ▲	→		35.1 ▼	20.8	=<94.9	=<94.9	No variation		Any variation	●		
RB	A	6	Emergency Readmissions (all Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Elective or Non-Elective Admission		%	9.05 Jan'13 - Mar'13	→	→	→		9.06 Apr'13 - Jun'13	→		→	9.06*								
	A			Following an initial Elective Admission		%	3.43	→	→	→		4.06	→		→	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			%	78 ■	86 ■	87 ▲	→			→			87*	80	80	No variation		Any variation	●	66.9	
RS	A	6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	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	→		92.5 Nov'12 to Oct'13	92.5	100	100	No variation		Any variation	●	88.9	90.5
				Peer (SHA) HSMR		HSMR	101.9	101.7	101.4	→		100.9	→		101.5	101.5								
				Peer (National) HSMR - Quarterly		HSMR	98.1	→	→	→		96.4	→		→	96.4								
	A	19		SHMI		SHMI	97.2 Jul'12-Jun'13	97.8 Aug'12-Jul'13	98.1 Sep'12-Aug'13	→		97.8 Oct'12-Sep'13	→		99.2 Nov'12-Oct'13	99.2	100	100	No variation		Any variation	●	96.8	95.9
RS	A	12	Obstetrics	Caesarean Section Rate	Elective and Non-Elective	%	26.3 ▼	23.6 ■	25.2 ■	→		20.6 ■	→		27.7 ■	25.0	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	A				Elective	%	8.8	10.9	10.3	→		11.0	→		11.5	11.1								
	A				Non-Elective	%	17.4	12.7	14.9	→		9.6	→		16.2	13.9								
	A			Maternal Deaths		No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	No variation		Any variation	●		
CO	A*	8	Patient Safety Thermometer - Harm Free Care			%	93.0 ■	94.0 ▲	93.7 ▼	→		94.5 ▲	→		94.0 ▼	94.0*	=>92	=>92	=>92		<92	●		

Exec Lead	KPI Source	Data Source	Category / Indicator				September	October	November	December			January			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.	6 ▲	9 ▼	6 ▲	→		7 ▼	→		6 ▲	6*	0	0	No variation		Any variation	●		2
KD	A		Never Events - in month			No.	0 ■	0 ■	2 ■	→		0 ■	→		1 ■	5	0	0	No variation		Any variation	●		2
KD	A		Open Central Alert System (CAS) Alerts			No.	8 ▼	7 ▲	6 ▲	→		9 ▼	→		9 ■	9*	0	0	No variation		Any variation	●		10
RS	A*	3	VTE Risk Assessment			%	95.1 ■	95.0 ▼	94.2 ■	→		95.5 ■	→		97.6 ▲	97.6*	95	95	=>90		<90	●	92.4	90.8
RS	A	3	WHO Safer Surgery Checklist	Audit - 3 sections		%	99.6 ▲	99.5 ▼	99.7 ▲	→		99.8 ▲	→		99.8 ■	99.8*	100	100	=>98		<98	●		
RS		3		Audit - 3 sections and brief		%	91.6 ▲	91.7 ▲	94.5 ▲	→		97.2 ■	→		90.2 ■	90.2*	100	100	=>95		<95	●		
RS		3		Audit - 3 sections, brief and debrief		%	78.4 ▲	80.2 ▲	85.9 ■	→		86.1 ■	→		74.4 ■	74.4*	100	100	=>85		<85	●		
RB	C	11	Data Quality	Data Completeness Community Services		%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50	=>50		<50	●		>50
CO	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		%	0.06 ■	0.13 ▼	0.07 ▲	→		0.03 ▲	→		0.05 ▼	0.07	0.0	0.0	0.00		>0.00	●		
RB	A*	2		Numerical		No.	7 ■	17 ▼	9 ▲	→		4 ▲	→		6 ▼	93	0	0	0		>0	●		
RB				Chargeable Days		No.	13 ■	29 ▼	17 ▲	→		7 ▲	→		10 ▼	178	0	0	0		>0	●		
CO	B	8	Patient Satisfaction (Friends & Family)	Response Rate	Inpatient Wards	%	18.7	29.2	31.4	→		29.0	→		31.0	31.0*								
CO	B				Emergency Care Department	%	11.6	21.1	17.1	→		15.0	→		15.0	15.0*								
CO	B*				IP Wards plus Emergency Care Department	%	13.4	23.4	21.0	→		19.0	→		19.0	19.0*								
CO	B			Score	Inpatient Wards	No.	72	71	70	→		73	→		71	71*								
CO	B				Emergency Care Department	No.	51	46	47	→		44	→		47	47*								
CO	B*				IP Wards plus Emergency Care Department	No.	58	54	56	→		57	→		57	57*								
RB	B	7	Sickness Absence	Long Term (> 28 days)		%	2.79 ▼	2.78 ▲	2.67 ▲	→		2.62 ▲	→		2.52 ▲	2.71	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
RB	B			Short Term (<28 days)		%	1.49 ▼	1.54 ▼	1.56 ▼	→		1.47 ▲	→		1.94 ▼	1.59	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
RB	B			Total		%	4.28 ▼	4.32 ▼	4.23 ▲	→		4.10 ▲	→		4.46 ▼	4.29	<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. (%)	5887 (79.6) ▲	5925 (79.7) ▲	5975 (79.9) ▲	→		6193 (82.7) ▲	→		6337 (84.8) ▲	6337 (84.8)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS	A	14		Medical Appraisal and Revalidation		%	81	84	87	→		89	→		91	91*	No. Only	No. Only						77
CO	A		Nursing Staff	Registered Nurses as percentage of Nurses		%	→	→		Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
CO	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		%	11.07 ■	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)

JANUARY 2014	CQUINs

Exec Lead	KPI Source	Data Source	Indicator					September	October	November	December			January			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	%	95.1 ■	95.0 ▼	94.2 ■	→		95.5 ■	→		97.6 ▲	97.6*	95	95	=>90		<90	●	92.4	90.8
RS	D	5		Root Cause Analysis		224	%	100 ■	→	→	→			→		→	100	100	100	100		<100	●		
CO	D	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers	ACUTE	224	%	5 ▼	4 ▲	1 ▲	→		0 ▲	→			62	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
CO	D				COMMUNITY	224	%	0 ■	1 ▼	1 ■	→		0 ▲	→		3 ■	7						●		
CO	D	8	Dementia	Find, Investigate and Refer		269	%	2 of 3 met	2 of 3 met	1 of 3 met	→		3 of 3 met	→		3 of 3 met	3 of 3 met	90% (F, I and R) for 3 consec. months		No variation		Any variation	●		
CO	D			Clinical Leadership		45		→	→	→	→			→			Identified	In Place	In Place	No variation		Any variation	●		
CO	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	●		
CO	D	8	Friends & Family Test	Phased Data Collection Expansion - Maternity		137	%	→	9.04	12.30	→		7.00	→		8.00	8.00	30	65				● ●		
CO	D			Increased Response Rate (Emergency Care plus All Wards)		175	%	13.4	23.4	21.0	→		19.0	→		19.0	19.0	17	>20				●		
CO	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	● ●		
CO	D	8	Dementia Patient Stmulation			1138		Progress Delayed	On Track	On Track	→		On Track	→		On Track	On Track	Compliance		No variation		Any variation	●		
RS	D	9	Use of Pain Care Bundles			1138	%	On Track	Base identified	Base identified	→		On Trajectory	→		Off Trajectory	Off Trajectory	Improvement Trajectory agreed		No variation		Any variation	●		
RS	D	4	Use of Sepsis Care Bundles			1105	%	On Track	On Track	Base identified			→			Off Trajectory	Off Trajectory	5% improvement trajectory		No variation		Any variation	●		
CO	D	11	Community Risk Assessment & Advice			1105	%	Base identified	On Track	On Trajectory	→		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					September	October	November	December			January			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	%	94.6 ▲	90.5 ▼	92.3 ▲	→		88.5 ▼	→		88.5 ■	91.1	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	D					Pts admitted to Acute Stroke Unit within 4 hrs	%	72.1 ▼	68.1 ▼	69.2 ▲	→		80.8 ▲	→		77.8 ▼	75.3	90	90	No Variation	0 - 2% Variation	>2% Variation	●	68.7	59.1
	D					Pts receiving CT Scan within 24 hrs of presentation	%	98.1 ▲	95.7 ▼	100.0 ■	→		97.9 ■	→		100.0 ■	94.8	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	D					Pts receiving CT Scan within 1 hr of presentation	%	71.7 ▼	68.1 ▼	73.1 ▲	→		78.7 ▲	→		77.8 ▼	70.9	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	D					Admission to Thrombolysis Time (% within 60 mins)	%	0.0 ▼	0.0 no pts	50.0 ▲	→		50.0 ■	→		66.7 ▲	33.3	85	85	=>85		<85	● ● ●		
	D					Admission to Thrombolysis Time (% over 90 mins)	%	100.0 ▼	0.0 no pts	50.0 ▲	→		0.0 ■	→		0.0 ■	29.7	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	%	75.9 ▲	65.5 ▼	56.3 ■	→		70.0 ■	→		72.2 ▲	71.2	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	D					TIA (Low Risk) Treatment <7 days from initial presentation	%	87.9 ▲	81.1 ▼	84.9 ▲	→		100.0 ▲	→		78.6 ▼	86.0	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RB		3	Infection Control	MRSA Screening - Elective	Patient Not Matched		%	253 ▲	250 ▼	227 ▼	Numerator = 3209	Denominator = 1452	221 ▼	Numerator = 4060	Denominator = 1345	302 ▲	302*	89	90	No variation		Any variation	●		138.9
					Best Practice - Patient Matched		%	90 ▲	82 ▼	73 ■	Numerator = 1043	Denominator = 1452	88 ■	Numerator = 1167	Denominator = 1345	87 ▼	87*	78	80	No variation		Any variation	●		59.5
				MRSA Screening - Non Elective	Patient Not Matched		%	88 ▲	90 ▲	92 ▲	Numerator = 2125	Denominator = 2391	89 ▼	Numerator = 2257	Denominator = 2506	90 ▲	90*	89	90	No variation		Any variation	●		76.8
					Best Practice - Patient Matched		%	91 ▲	92 ▲	92 ▲	Numerator = 2125	Denominator = 2281	93 ▲	Numerator = 2257	Denominator = 2403	94 ▲	94*	78	80	No variation		Any variation	●		64.9
CO		14	Falls Requiring Serious Incident Investigation				No	1 ■	7 ▼	2 ▲	→		4 ▼	→		2 ▲	26	0	0	No variation		Any variation	● ●		22
CO		8	Grade 3 or 4 pressure ulcers - avoidable				No	0 ■	0 ■	0 ■	→		1 ■	→			7	0	0	No variation		Any variation	●		
CO		8	High Impact Nursing Actions	Inpatient Falls reduction	Acute		No	53 ▲	59 ■	30 ■	→		47 ▼	→		63 ▼	519	550	660	=<55/m		>55/m	●		737
CO					Community		No	11 ▼	12 ▼	15 ■	→		6 ■	→		9 ▼	110	120	144	=<12/m		>12/m	●		
RS		3	Obstetrics			Post Partum Haemorrhage (>2000 ml)	No.	0 ■	0 ■	1 ▼	→		0 ■	→		0 ■	3	40	48	=<2	3 - 4	>4	●	7	10
						Admissions to Neonatal ICU	%	11.0 ■	12.1 ■	12.4 ▼	→		8.3 ■	→			10.1	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
						Adjusted Perinatal Mortality Rate (per 1000 babies)	/1000	12.2 ■	12.2 ■	16.3 ▼	→		2.2 ■	→			2.2*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
	D			Early Booking (Completed Assessment <12+6 weeks)	National Definition		%	137.0 ▲	178.0 ▲	158.0 ▼	→		152.0 ▼	→			152.0*	=>90	=>90	=>90	75-89	<75	●	76.0	78.0
	D				SWBH Early Booking (Bookings > Births)		%	70.0 ■	81.0 ■	83.5 ▲	→		84.5 ▲	→			84.5*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
CO		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
CO						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	%	81.8 ▼	89.5 ▲	70.6 ■	→		75.0 ▲	→		66.7 ▼	72.3	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)	%	93 ■	93 ■	92 ▼	→		92 ■	→		92 ■	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3				Maternity HES	%	7.1 ▼	6.8 ▲	9.2 ▼	→		7.2 ▲	→		8.5 ▼	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	5:05 ▼	5:45 ▼	4:46 ▲	→		4:48 ▼	→		4:38 ▲	5:02	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D					Time to Initial Assessment (=<15 mins)(95th centile)	mins	16 ■	20 ▼	17 ▲	→		17 ■	→		17 ■	17	=<15	=<15	<15		<15	●	21	17
	D					Time to treatment in department (median)	mins	41 ▲	48 ▼	43 ▲	→		42 ▲	→		45 ▼	46	=<60	=<60	=<60		>60	●	59	58
	D			Emergency Care Patient Impact		Unplanned re-attendance rate	%	5.44 ▲	6.16 ▼	6.09 ▲	→		6.37 ▼	→		5.74 ▲	6.53	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D					Left Department without being seen rate	%	3.44 ▼	3.47 ▼	2.96 ▲	→		3.16 ▼	→		2.73 ▲	3.55	=<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	%	84.9 ■	87.7 ■	89.7 ▲	89.1 ▼	89.3 ▲	89.2 ▼	89.6 ▲	89.8 ▲	89.7 ▲	89.7*	=>85	=>85	=>85		<85	●		71.3
	D					Average Turnaround Time	m : s	28:46 ▼	29:02 ▼	26:59 ▲	26:27 ▲	28:25 ▼	27:19 ▼	26:17 ▲	27:46 ▲	26:59 ▲	26:59*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	D			30 - 60 minutes	All Journeys		No.	1301 ▲	1505 ▼	1253 ▲	513 ▼	872 ▼	1385 ▼	491 ▲	751 ▲	1242 ▲	13495	0	0	0		0	● ● ●		22089
	D				Hospital Fines (WMAS report)		No.	123 ▲	290 ▼	122 ▲	58 ▼	101 ▼	159 ▼	49 ▲	78 ▲	127 ▲	2480	0	0	0		0	● ● ●		
	D			In Excess of 60 minutes	All Journeys		No.	50 ▼	71 ▼	5 ▲	4 ■	14 ▼	18 ▼	1 ▲	6 ▲	7 ▲	376	0	0	0		0	● ● ●	1256	2354
	D				Hospital Fines (WMAS report)		No.	16 ▲	54 ▼	2 ▲	1 ■	9 ▼	10 ▼	0 ■	1 ▲	1 ▲	214	0	0	0		0	● ● ●		

JANUARY 2014	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator				September	October	November	December			January			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		21	Reporting Times of Imaging Requests from Emergency Care - % **reported within 24 hours / next day**	Plain Radiography	%		98 ▼	99 ▲	100 ▲	→		99 ▼	→		100 ▲	100*	90	90	No variation		Any variation	●		99
				Ultrasound	%		100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100*	90	90	No variation		Any variation	●		100
				MRI	%		65 ▼	100 ■	93 ▼	→		81 ■	→		77 ▼	77*	90	90	No variation		Any variation	● ●		84
				CT	%		99 ■	99 ■	100 ▲	→		99 ▼	→		99 ■	99*	90	90	No variation		Any variation	●		99
KD	D	14	Complaints	No. of Complaints Received formal and link)	No.		86	65	82	→		65	→		75	788	No. Only	No. Only					834	724
				No. of Active Complaints in the System (formal and link)	No.		238	201	201	→		190	→		188	188*	No. Only	No. Only						
				No. of First Formal Complaints received / 1000 episodes of care	No.		0.52	0.36	0.45	→		0.40	→		0.46	0.46*	No. Only	No. Only						
				No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%		76 ▼	97 ▲	99 ▲	→		98 ▼	→		97 ▼	97*	100	100	100		<100	●		
				No. of responses which have exceeded their original agreed response date (% of total active complaints)	%		22 ▲	33 ▼	29 ▲	→		20 ▲	→		35 ▼	35*	0	0	0		>0	● ●		
				No. of responses sent out	No.		78	109	59	→		79	→		81	81*	No. Only	No. Only						
				Oldest' complaint currently in system	Days		150	107	174	→		91	→		112	112*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.		13181	13978	12590	→		10032	→		13318	124238	No. Only	No. Only					111793	150454
				Average Length of Queue	mins		0.39 ▼	0.27 ▲	0.24 ▲	→		0.20 ▲	→		0.25 ▼	0.25*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins		17.3 ▼	13.0 ▲	7.2 ■	→		8.3 ▼	→		12.3 ■	12.3*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.		70460	76416	73295	→		71451	→		80266	726839	No. Only	No. Only					849502	901987
				Calls Answered	%		91.0	90.5	91.2	→		89.4	→		90.8	90.8	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%		72.0	71.3	70.2	→		57.4	→		60.9	67.0	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%		84.1	83.5	82.6	→		72.6	→		75.5	80.1	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs		12.9	13.1	14.1	→		22.0	→		19.7	19.7*	No. Only	No. Only					25	18
				Longest Ring Time	Secs		433	341	476	→		526	→		492	492*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days		4.0 ▼	3.6 ▲	3.8 ▼	4.4 ▼	3.3 ▲	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)	%		94.9 ▲	94.4 ▼	94.1 ▼	94.3 ▲	97.0 ▲	95.9 ▲	96.7 ▲	96.1 ▼	96.3 ▲	94.4	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%		83.7 ▼	83.7 ▼	81.8 ▼	83.1 ■	83.0 ▼	83.1 ▲	83.5 ▲	84.7 ▲	84.3 ▲	84.6	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.		754	786	774	→		770	→		783	783*								
RB		2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%		1.4 ■	1.3 ▲	1.3 ■	2.2 ■	1.0 ▼	1.4 ▼	1.6 ▲	1.7 ■	1.7 ▼	1.1	<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.		66 ▼	64 ▲	64 ■	33 ▲	27 ▼	60 ▲	27 ▲	57 ▼	84 ▼	526	267	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.		10 ▼	7 ▲	5 ▲	2 ▲	5 ▼	7 ▼	8 ▼	5 ■	13 ▼	13	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%		13.6 ▲	12.4 ▲	13.3 ▼	→		13.3 ■	→		12.7 ▲	12.7*	2.5	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%		5.6 ▼	5.7 ▼	5.5 ▲	→		5.4 ▲	→		7.9 ▼	7.9*	3.5	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty	Door To Balloon Time (90 mins)	%	90.9 ▼	76.9 ■	75.0 (S) ▼	→			→			85.6	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
					Call To Balloon Time (150 mins)	%	95.0 ▼	100.0 ▲	85.7 (S) ▼	→			→			92.5	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain		%	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			September	October	November	December			January			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	7139	7188	7252	→		7204	→			7204*								
				Staff In Post (contracted)	wte	6528	6545	6626	→		6632	→		6612	6612*								
				Staff In Post (headcount)	no.	7502	7527	7610	→		7617	→		7589	7589*								
				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	611	643	626	→		572	→			572*								
				Qualified Nursing Variance (FIMS)	wte	236	177	199	→		211	→			211*								
				Posts Advertised in Month (NHS Jobs)	wte	105	158	146	→		139	→		91	91*								
			Induction		%	86 ▼	98 ▲	95 ▼	→		94 ▼	→			94*	100	100	=>85		<85			91.3
RB	D	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5887 (79.6) ▲	5925 (79.7) ▲	5975 (79.9) ▲	→		6193 (82.7) ▲	→		6337 (84.8) ▲	6337 (84.8)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS		14		Medical Appraisal and Revalidation	%	81	84	87	→		89	→		91	91*	No. Only	No. Only						77
MS		3		Mandatory Training Compliance	%	86.1 ▼	85.2 ▼	86.6 ▲	→		86.6 ■	→		86.3 ▼	86.3	100	100	=>95	90 - 95	<90	● ●	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	2.79 ▼	2.78 ▲	2.67 ▲	→		2.62 ▲	→		2.52 ▲	2.71	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.49 ▼	1.54 ▼	1.56 ▼	→		1.47 ▲	→		1.94 ▼	1.59	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.28 ▼	4.32 ▼	4.23 ▲	→		4.10 ▲	→		4.46 ▼	4.29	<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	%	75.9	75.0	76.0	→		71.2	→		73..0	75.1	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	5265 ▲	5260 ▲	5191 ▲	→		4347 ▲	→		4880 ▲	49823	39150	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	56396	60463
				Nurse Agency Shifts covered	No.	1608 ▼	2494 ▼	2646 ▼	→		2593 ▲	→		3063 ▼	23509	3192	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	6948	12874

JANUARY 2014	ACTIVITY & CONTRACTUAL

Exec Lead	KPI Source	Data Source	Indicator			September	October	November	December			January			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.	726 ▲	764 ▼	802 ▲	→		648 ▼	→		725 ▼	7195	8499	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4062 ▲	4452 ▼	4141 ▼	→		3645 ▲	→		4356 ▲	42096	33690	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	4788 ▲	5216 ▼	4943 ▼	→		4293 ▲	→		5081 ▲	49291	42189	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4402 ▼	4742 ▲	4562 ▼	→		4642 ▼	→		4738 ▼	45735	50651	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	14415 ▲	15991 ▼	14642 ▼	→		12949 ▲	→		15327 ▲	145976	127431	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	30313 ▲	32500 ▼	30360 ▼	→		27239 ▲	→		33655 ▼	324491	345808	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	12006 ▼	12201 ▼	11760 ▲	5431 ▲	6455 ▲	11886 ▲	5796 ▲	6706 ▼	12502 ▲	124705	154523	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	2189 ▲	1944 ▼	1847 ▲	→	1778 ▼	1778 ▼	→	1882 ▲	1882 ▲	19932	23707	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	20026 ▲	20120 ▲	19080 ▲	8233 ▲	11281 ▲	19514 ▲	8345 ▲	11493 ▲	19838 ▲	201430	173853	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	45642 ▲	49810 ■	46207 ■	→		40222 ▼	→			415129	408405	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	14855 ■	17857 ▲	17407 ▲	→		13173 ▼	→			136933	125048	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
			Contract	Improvement Notices	No.	0 ■	1 ■	0 ■	→		0 ■	→		0 ■	0*	0	0				●		
RB	D	2	Delayed Transfers of Care	Acute	%	3.9 ▼	3.6 ▲	2.6 ■	2.5 ▼	4.2 ▼	3.2 ▼	2.8 ▼	3.6 ▲	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.	14 ▼	9 ▲	10 ▼	3 ■	5 ▲	8 ▲	3 ■	4 ▼	7 ▼	7*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	7 ■	10 ■	9 ■	5 ■	5 ■	10 ■	6 ■	7 ■	13 ■	13*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.10 ▲	2.03 ▲	2.07 ▼	2.31 ■	2.02 ▼	2.10 ▼	2.21 ■	2.19 ▼	2.20 ▼	2.22	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	12.4 ▲	12.9 ▼	12.2 ▲	→		12.7 ▼	→		12.5 ▲	11.7	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	12.4 ▼	12.6 ▼	12.5 ▲	→		13.5 ▼	→		12.4 ▲	10.4	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:	Financial Performance Report – January 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	6th March 2014

EXECUTIVE SUMMARY:

Key messages:

- Headline financial performance in line with delivery of revised plan target
- Headline delivery reliant on central resources to cover significant over spending in clinical groups
- Capex forecast risks CRL undershoot

Key actions:

Secure plan delivery - close out contract value for year with SWB CCG, review & confirm forecast expenditure positions, confirm balance sheet provisions

Ensure robust financial plans consistent with effective financial management at devolved level

Confirm capex forecast & ensure any slippage secured in 2014/15 financial plan CRL submission

Key numbers:

- Forecast surplus £6.7m being in line with revised plan declared to TDA
- In month surplus £892k being £357k better than plan after £500k release of provisions
- Year to date surplus £5.1m being £0.9m better than plan after £1.0m release of provisions

- Forecast over spending across clinical groups £4.5m [£2.6m after planned reserve vs. £1.5m to date]
- Capex £14.3m [66% of annual programme] remaining to be spent in two months

- Capex to date £7.3m [34% of annual programme]
- Cash balance of £45.2m is £5.1m higher than plan as at 31st January.

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
PREVIOUS CONSIDERATION:
Considered by Finance & Investment Committee members, the Performance Management Committee and Clinical Leadership Executive

Sandwell and West Birmingham Hospitals NHS

NHS Trust

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EXECUTIVE SUMMARY

• For the month of January 2014, the Trust delivered a "bottom line" surplus of £892,000 compared to a planned surplus of £535,000 (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 £5,131,000 compared with a planned surplus of £4,206,000 so generating a favourable variance from plan of £925,000. 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 is now 4.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 234 below planned levels. After taking account of the impact of agency staff, WTE's were 46 above plan. Total pay expenditure for the month, inclusive of agency costs, is £716,000 below the planned level (£1,130,000 year to date), which includes release of non-recurrent provisions to improve the position.

• The month-end cash balance was £45.2m. Year to date spend on capital is £7.3m.

•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	357	925	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	234	307	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	716	1,130	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(148)	(2,624)	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	(46.3)	(71.5)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	5,126	5,126	>= 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 £000	Actual £000
Income and Expenditure	4,206	5,131
Capital Resource Limit	17,005	17,005
External Financing Limit	---	5,126
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at January 2014	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	393,498	33,283	33,204	(79)	328,126	329,588	1,462	395,746
Other Income	40,761	3,906	3,651	(255)	33,845	34,184	339	42,303
Operating Expenses	(408,427)	(34,884)	(34,316)	568	(340,379)	(341,873)	(1,494)	(411,240)
EBITDA	25,832	2,305	2,539	234	21,592	21,899	307	26,809
Interest Receivable	100	8	10	2	83	108	25	131
Impairment of Fixed Assets	0	0	0	0	0	0	0	(2,500)
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(1,164)	(1,116)	48	(11,326)	(11,158)	168	(13,390)
PDC Dividend	(5,027)	(419)	(398)	21	(4,190)	(3,860)	330	(4,616)
Interest Payable	(2,344)	(195)	(143)	52	(1,953)	(1,858)	95	(2,198)
Net Surplus/(Deficit)	**4,599**	**535**	**892**	**357**	**4,206**	**5,131**	**925**	**4,236**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	2,500
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,599**	**535**	**892**	**357**	**4,206**	**5,131**	**925**	**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.

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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 £892,000 in January against a planned surplus of £535,000. The resultant £357,000 favourable variance results in a year to date return on income of 1.4%, 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 performed within budget for the month reflecting additional funding for winter capacity.

•Women & Child health performed within budget as income loss was matched by lower non-pay spend.

•Surgery A saw income drop in month for emergencies.

•Community & Therapies continues to see pressures on demand for wheelchairs and continence products that exceed block contract income.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**	**Forecast Variance £000**
Medicine	(5)	(1,225)	(2,481)
Surgery A	(70)	(109)	(746)
Women & Child Health	(0)	(279)	(889)
Surgery B	28	19	(503)
Community & Therapies	(57)	(191)	(482)
Pathology	2	(14)	2
Imaging	(60)	251	555
Corporate	(159)	172	489
Central	555	1,685	5,270

•Corporate directorates continue to underspend on management costs.

•The Central position reflects release of provisions to support the general position.

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The Trust-wide in-month favourable variance is £357,000.

Underperformance on NHS contract income (A&E, maternity, emergency admissions) is reduced by the improvement on injury fund income. R&D income has been adjusted against year to date spend in the month.

Medical pay shows an improvement in month. The nursing and other pay position is improved by release of provisions.

Year to date pass through drugs are overspending (met by income) and internal drugs are underspent.

Hotel services are overspending across the Trust.

Financing costs are below plan.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(79)	1,462
Other Income	(255)	339
Medical Pay	76	(1,184)
Nursing	53	993
Other Pay	587	1,321
Drugs & Consumables	(28)	(1,463)
Other Costs	(120)	(1,161)
Interest & Dividends	123	618

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Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are 46 above plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 234 below plan.

• Total pay costs (including agency workers) are £716,000 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 January was £968,000 which shows no improvement on the previous two months.

Analysis of Total Pay Costs by Staff Group

	Year to Date to January					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	63,988	61,980	0	3,192	65,172	(1,184)
Management	12,898	11,702	0	0	11,702	1,196
Administration & Estates	26,774	23,996	1,986	1,085	27,067	(293)
Healthcare Assistants & Support Staff	26,532	23,236	3,446	939	27,621	(1,089)
Nursing and Midwifery	76,445	68,422	3,495	3,535	75,452	993
Scientific, Therapeutic & Technical	36,456	34,878	0	361	35,239	1,217
Other Pay / Technical Adjustment	308	18	0	0	18	290
Total Pay Costs	243,401	224,232	8,927	9,112	242,271	1,130

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Balance Sheet

•Cash balances at 31st January stood at £45.2m, £5.1m 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.

STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013	Balance as at end January 2014	Forecast at 31st March 2014
		£000	£000	£000
Non Current Assets	Intangible Assets	924	525	874
	Tangible Assets	216,669	215,237	220,477
	Investments	0		
	Receivables	1,048	966	700
Current Assets	Inventories	3,604	3,470	3,600
	Receivables and Accrued Income	10,432	23,355	12,300
	Investments	0	0	
	Cash	42,448	45,189	37,944
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(52,703)	(46,361)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(861)	(1,029)
	Provisions	(10,355)	(8,209)	(7,654)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	(3,000)	(2,000)	(1,000)
	Borrowings	(29,263)	(28,306)	(27,884)
	Provisions	(3,168)	(2,789)	(3,262)
		183,385	191,872	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)	(11,075)	(13,401)
		183,385	191,872	186,705

CASH FLOW

12 MONTH ROLLING FORECAST AT January 2014

ACTUAL/FORECAST	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	Jan-15 £000s
Receipts												
SLAs: SWB CCG	20,650	20,650	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978
Associates	6,760	6,760	6,760	6,760	6,760	6,760	6,760	6,760	6,760	6,760	6,760	6,760
Other NHS income	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Specialised Service (LAT)	3,970	3,970	3,970	3,970	3,970	3,970	3,970	3,970	3,970	3,970	3,970	3,970
Education & Training			4,700	0	0	4,700	0	0	4,700	0	0	4,700
Loans												
Other Receipts	2,500	2,500	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800
Total Receipts	34,880	34,880	39,208	34,508	34,508	39,208	34,508	34,508	39,208	34,508	34,508	39,208
Payments												
Payroll	13,815	13,815	13,680	13,680	13,680	13,680	13,680	13,680	13,680	13,680	13,680	13,680
Tax, NI and Pensions	9,920	9,920	10,070	10,070	10,070	10,070	10,070	10,070	10,070	10,070	10,070	10,070
Non Pay - NHS	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100
Non Pay - Trade	6,200	7,787	7,725	7,725	7,725	7,725	7,725	7,725	7,725	7,725	7,725	7,725
Non Pay - Capital	4,000	6,507	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308
PDC Dividend		2,740						2,750				
Repayment of Loans		1,000						1,500				
Interest		6	0	0	6	0	0	6	0	0	6	0
BTC Unitary Charge	435	435	225	225	225	225	225	225	225	225	225	225
Other Payments	500	500	92	92	92	92	92	92	92	92	92	92
Total Payments	36,970	44,810	35,200	35,200	35,206	35,200	35,200	39,456	35,200	35,200	35,206	35,200
Cash Brought Forward	45,106	43,016	33,086	37,094	36,402	35,704	39,712	39,020	34,072	38,079	37,387	36,689
Net Receipts/(Payments)	(2,090)	(9,930)	4,008	(692)	(698)	4,008	(692)	(4,948)	4,008	(692)	(698)	4,008
Cash Carried Forward	43,016	33,086	37,094	36,402	35,704	39,712	39,020	34,072	38,079	37,387	36,689	40,697

Sandwell and West Birmingham Hospitals NHS
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Capital Expenditure

• Year to date capital expenditure is £7.3m, 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 year end score, using the TDA methodology, shows as 4.

	Financial Metric	2012/13 Full Year Accounts	Current Year to Date	Forecast Outturn
			Actual	Forecast
		£000s	£000s	£000s
Continuity of Service Rating				
Liquidity Ratio (days)	Working Capital Balance	(3,726)	4,770	(6,800)
	Annual Operating Expenses	405,995	341,873	411,240
	Liquidity Ratio Days	(3.3)	4.2	(6.0)
	Liquidity Ratio Metric	**3**	**4**	**3**
Capital Servicing Capacity (times)	Revenue Available for Debt Service	26,928	22,007	26,940
	Annual Debt Service	10,296	8,242	9,843
	Capital Servicing Capacity (times)	**2.6**	**2.7**	**2.7**
	Capital Servicing Capacity metric	**4**	**4**	**4**
Continuity of Services Rating	**Continuity of Services Rating for Trust**	**4**	**4**	**4**

Transformation Programme

•Progress against 2013/14 TSPs is reported separately.

•Continued emphasis is being place on identification of full year TSP for 2014/15. A review of timings of schemes has been undertaken in order to ensure the programme is able to be delivered in full in the year.

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Performance Against Service Level Agreement Target

•Performance for April to December 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 continues about plans for 2014/15.

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Key risks

•Dialogue with commissioners about the likely year end income position is proceeding with the intention of securing respective financial stability and retention of resources for local services.

•Winter plans are continuing 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 Nuffield Trust has published "The Francis Report One Year On". The report says that financial pressures and a complex regulatory environment are making it difficult for the NHS to deliver the patient-centred culture envisaged by Robert Francis. The Trust said senior NHS staff believed the report had added impetus to their efforts to place quality of care as their top priority, despite the difficult financial conditions. However, NHS leaders warned meeting financial goals and ensuring safe staffing levels would only get more difficult in the future. The Health Secretary, Jeremy Hunt says that the 'Francis effect' has changed the NHS for the better. He said the changes included more doctors and nurses, hospitals being put on the road to recovery and direct feedback from patients changing the way hospitals work.

•The Public Accounts Committee has been told that many maternity services are running at a loss or are at best breaking even. The Committee report "Maternity Services in England" said the Department of Health had not demonstrated its maternity policy was affordable and had limited assurance the new pathway tariff would provide sufficient income to implement its policy. While stakeholders believed more could be delivered for less money, through midwife-led centres, the tariff framework was restricting their development. A thorough costing exercise should be launched, the committee said. The report said a further 2,300 midwives are needed to keep pace with the current birth rate despite an overall rise in their numbers recently. It added that the clinical negligence bill for maternity services was too high.

•The HFMA has published revised clinical costing standards. The 2014/15 standards set out recommended best practice to support the production of patient- and service user-level costs in acute and mental health organisations. Key changes in the acute standards include providing more detailed guidance on allocating costs with new standards covering the allocation of the costs of wards, theatres and medical staffing.

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
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 3 update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Trust Secretary**
DATE OF MEETING:	**6 March 2014**

EXECUTIVE SUMMARY:

The Quarter 3 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities is attached.

Work remains planned as part of the wider risk management framework reinvigoration to develop the BAF into a tool that may be more strategically used in future. This work has commenced and the 2014/15 BAF will reflect these changes.

REPORT RECOMMENDATION:

The Board is asked to receive and accept the updated Board Assurance Framework and measures in place to address the gaps in control & assurance where relevant

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

Routine quarterly update

BOARD ASSURANCE FRAMEWORK 2013/14 – QUARTER 3 UPDATE

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Provide the detail of the annual priority 2013/14 to which this entry relates	*Which member of the Executive Group is responsible for the delivery of the annual priority?*	*Which Board or Committee considers a report discussing the risk and its management?*	*What factors could prevent the priority being achieved?*	*What controls or systems do we have in place to assist in securing the delivery of the priority and managing the associated risks?*	*Provide examples of recent initiatives or reports considered by the Board and/or Committee where delivery of the priorities is discussed AND where can the Board gain evidence that the controls and systems are effective to manage the risks and secure delivery of the priority?*	*What gaps in systems, controls and assurance have been identified?*	*What actions are planned and what progress has been made to address the gaps identified?*	*When will the action be completed?*	*Which standard/ aim/ target does the risk relate to or in which other document is the risk reported?*	*Before the actions to address the gaps in control & assurance have been taken , what risk severity score applies?*	*After the actions to address the gaps in control & assurance have been taken, what risk severity score applies ?*
STRATEGIC OBJECTIVE 1:		**SAFE, HIGH QUALITY CARE**									
Deliver Year 2 of the Quality & Safety strategy	MD	Quality & Safety Committee	Lack of clarity about the standards to be achieved in the Q&S Strategy Lifespan Objective (Dec 12)- many remain TBC. The level of risk varies between quality goal.	A structure of clinically led committees is in place to oversee the quality and safety agenda from all aspects of the organisation. The Q&S Board Committee is the principal mechanism of	Performance is measured and reported against plan. Action plans are agreed and completion of actions is reviewed at the committees review cycle.	Changes in systems and reporting hierarchies have led to some lack of clarity in reporting responsibilities. Additional committees have been set up for which the TOR and membership is still under	Clear communication of expectations, TOR & membership.	By end Q4	Risk management, Quality & Safety, PH development committee, patient safety committee, clinical Effectiveness	**16**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				board level scrutiny of quality and safety issues of concern and debate are escalated to Trust board. The Trust is also scrutinised by the CCG at the CQRM		development eg Public Health, community Development & Equality committee					
Deliver all CQUINs	MD/CN	Mortality, VTE, Sepsis, MQuAC Quality & safety Committee	Non achievement of CQUINs. This can be due to lack of focus on the achievement of patient safety measurements e.g. VTE, sepsis six, think alcohol, Mortality reviews	Significant resources are going into supporting clinicians to carry out data recording and developing computer-aided systems to reduce bureaucracy.	Quarterly CQUIN confirm & challenge meeting with execs	No framework yet in place for the meetings and CQUINs at different stages of development.	Ensure frameworks are developed and action plans are rigorously followed up.	By end Q4	National CQUIN and local contract agreements	**12**	**12**
Improve emergency readmission rates	COO	Readmission Taskforce, Quality and Safety Committee, Trust Board	Readmission rates remain high Risk of not having whole system engagement	Readmission Taskforce in place with supporting programme	Readmission activity Audit	Not yet working with primary care	Inviting to be members of taskforce	Review End Q4		**16**	**12**
STRATEGIC OBJECTIVE 2: ACCESSIBLE & RESPONSIVE CARE											
Consistently achieve the national A & E targets	COO	Winter will be better 2013 programme group Urgent Care Board,	Underperformance Sustained delivery of new ways of working Engagement of social services and	Winter 2013 programme and Urgent Care Board improvement	Urgent care scorecard Delivery of programme	Not yet fully recruited into key positions	Recruitment campaign in place nationally and internationally	December – Q4		**20**	**16**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
		Quality and Safety Committee, Trust Board	community bed capacity Recruitment of ED medical staff, ward nurses	programme agreed. Programme governance in place. Monitor and escalate KPI from score card Establish control centre Escalation of issues and risks at executive level to partner organisations. Weekly Urgent Care meeting with partners at chief officer level including social services.		Sustaining reduced level of DTOC	Weekly calls at chief officer / Director level with social services. Establishing community and social care operational hub to better utilise bed and effective community flow				

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Waiting times in at least 90% of specialities will be at least as good as neighbours	COO	OMC Transformation	Difficulty in accessing data Capacity to recover 18 week position post validation for some non admitted specialities will dominate improvement trajectory / profile .	Improvement plan at speciality level to achieve maximum 6 week standard for March 2014. OP will be a major transformation work stream next 2 years and will prioritise at specialty level a further improvement trajectory. Cardiology in turnaround programme to support improvements. Benchmarking against local partners	OP score card Patient survey Review of benchmarked information	The Trust has been identified as being not 100% competitive	Year of out patients programme planned for 2014 with a focus on improving the experience of the out patient services.	Q4		**20**	**16**
Deliver Year 1 of the Dementia Strategy and support to carers	CN	Quality and Safety	Environmental works not being completed by deadline of 31st March 2014. Delay in recruitment of Activity co-ordinators and use of DTRS	Project team continues to negotiate with Group directors and contractors timescales. Staff have been booked as agency staff to increase	2 weekly environmental meetings	N/A	N/A	By end of Quarter 4	DH conditions on environmental monies received. CQUIN agreements	**15**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			software. Non-achievement of quality and CQUIN standard of 90% in 3 consecutive months of the memory screening tool. Survey of carers developed and distributed to wards - poor uptake and return.	activity and DTRS delivered to MFFD ward for use. Waiting EBMS icon All adults to be asked memory screening question On-going raising awareness of carer survey	Weekly audit instead of monthly Confirm and challenge meetings with CN						
Increase the range of alternative models to face to face contact	COO	Clinical Group review	Lack of engagement of multi professional team including those across organisations. Lack of robust of IT systems to facilitate change Resistance to change Lack of leadership capacity and capability to deliver changes	Review of District Nursing teams for 2014 with an new MDT approach to providing care across localities. New technology to support contact with patients in homes (with health and social care) . Readmissions taskforce redesign: new professionals and contacts designed	Review/ reporting of development programmes eg pace setting board, readmissions taskforce. The new Clinical Group of Community and therapies was established in October. This group needs time to establish but will be pivotal	There is not a programme approach to managing long terms conditions	Programme approach to long terms conditions – will be established for transformation theme in 2014.	Review Q4		**16**	**12**

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				as part of discharge pathway eg psychologist for long term respiratory patients	to leading this objective.						
Pilot the process of developing GP letters with a view to providing patients and GPs with clinical letters within two working days	COO	Elective access meeting	Management of the backlog of letters Management of change and acceptance of technology	Digital dictation and electronic sign off process tested with good outcomes OP standard agreed.	Specialty level score card developed.	The digital dictation system needs full roll out	Schedule roll out in 2014 as part of Year of Out Patients	Q4		16	9
Develop comprehensive marketing plans for at least three services	DSOD		Failure to develop comprehensive marketing plans for at least three services resulting in the inability to actively promote and target services to particular audiences	Criteria identified and process commenced	Draft plans developed	Programme for wider strategy development not established Interim resource has resigned	Additional interim resource has been sourced	March 2014		9	6
STRATEGIC OBJECTIVE 3:		**CARE CLOSER TO HOME**									
Reconfigure a number of services across acute & community to provide integrated care	DSOD	MMH & Configuration CLE Sub Committee Configuration Board Committee	Delay in reconfiguration across & community will continue to: Duplicate services, assessment,	Change in management structures to combine specialist community services with relevant specialist	Bi-monthly reports to Configuration Board Committee (from Oct 13)		Clarify how new structures (in Medicine & Emergency Care and Community & Therapies) will deliver greater integration across	Q4	2013/14 annual priority: to reconfigure a number of services across acute &	**16**	**12**

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			investigations etc.; Offer patients disjointed services in an acute central service when care closer to home may be possible. Delay in acute service reconfiguration cross site could impact on sustainability of the service ahead of MMH. Reconfiguration itself may have an adverse impact on sustainability.	acute service & combine acute and community therapy services in one clinical group Agreed process for reconfiguration Early & on-going staff engagement & liaison with JHSC, CCG, GPs, patients and any other key external stakeholders Formal public consultation where appropriate External Benchmarking/ cross reference			acute and community. Ensure joint planning across directorates	Q3 & on-going	community to provide integrated care		
Implement a number of 'Right Care, Right Here' pathways	DSOD	MMH & Configuration CLE Sub Committee Configuration Board Committee	RCRH pathways are not implemented or delivered or activity significantly departs from the trajectory. Adverse impact on delivery of QIPP	QIPP Savings target embedded in 2013/14 contract along with broad scheme	Regular Joint Clinical Commissioning meetings with external stakeholders	Clear implementation plans at specialty level	Clear process for implementation of agreed POLCV agreed with CCG via Joint Clinical Commissioning	From Dec 13 Q4	Risk: 1107EXE09	**16**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			savings and relationships with GPs/CCG.	headings. Contract for 2013/14 includes block contracts with tolerance thresholds Income removed within SWBH financial plan & level of TSP takes account of this loss of income Agreed list of procedures of limited clinical value. . Activity reduction targets based on benchmarked data RCRH pathway review programme and governance	Bimonthly reports against RCRH trajectories to configuration Committee Activity underpinning LTFM agreed with CCG in December 14 New model of care in diabetes agreed along with implementation plan		Group Respond to new commissioning specifications for RCRH pathways - Dermatology. Implement new model of care in Diabetes.	Q4			

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				structure							
Implement a virtual ward in the community	COO	Clinical Group review	Optimising model to establish impact across the entire health and social care economy.	Virtual ward mechanism set up For formal review in Q4.	Activity review	Measuring well what we are doing through an integrated dashboard.	Dashboard to be developed to better measure what and how we are doing. .	Q4		**16**	**9**
Establishing 15 wte Health Visitors posts and reduce caseload	CN	Health Visitor Steering group	NHSE reported that there was a very poor legacy document from Sandwell PCT regarding financial agreements for HV plan. Resulted in NHSE not having sufficient funds to support HV growth and the service is using the vacancies to support newly qualified HV for January. Whilst we are on track against plan NHSE informed us that we are to count staff who are not in the HV establishment. For example named safeguarding nurses. This will NOT bring down the HV caseloads.	Issue reported through risk and governance processes in the Trust. Raised with NHSE at HV steering group.	Minutes from meetings Risk register We have negotiated with NHSE that 4 safeguarding posts should not be counted in the HV establishmen t and they have now agreed. Still discussing other posts.	Not applicable	Not applicable	Not applicable		**12**	**9**

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			This equates to an additional 2500 families that would need to be distributed to the HV service.								
STRATEGIC OBJECTIVE 4:		**GOOD USE OF RESOURCES**									
Deliver Year 2 of the Transformation Programme without compromising safety and quality of care	COO	Finance and Investment and Quality and Safety Committee	Capacity and capability to transform across an organisation	Review transformation plan for next 2 years with external support. Redefine work streams Develop with leadership programme development of transformation and change management skills	TPRS including QIAs Dashboard Committee reports	FYE not delivered Replacement schemes mitigated position	Review transformation and efficiency opportunities for 2014 Review and launch change programme for 21014- 2017	Q1 2014/15 Q1 2014/15		**12**	**6**
Deliver a 1-2% surplus	DFPM	Finance & Investment Committee	Unforeseen reductions in income where activity falls well below plan. Excessive costs owing to capacity and/or recruitment constraints. Non delivery of annual efficiency savings plans.	Risk sharing agreements with commissioners. Contract review meetings planned with main commissioner to review activity and performance as its position is	Preparation and presentation of detailed financial reports (TB) and transformation plan progress reports to F&I.	Routine focus on forecast position and early attention to necessary & sufficient remedial actions	Agreement of full year settlement with key commissioners. Re-focus routine financial management on forecast performance.	Q4 – 13/14	Use of Resources	**12**	**6**

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				under pressure. Use of contingency reserves. System of close monitoring and requirement to identify mitigating savings schemes.							
Enable clinically-led decision-making processes via SLR as part of SLM	DFPM	Clinical Leadership Executive	No decision on the systems required to support the absorption of SLR into performance management regime which supports the AAF. Inufficient personnel in place to move project forward.	SLR information provided to F&I Committee as well as incorporated into Group reviews and ultimately CD based reviews. Temporary staffing specification being scoped.	MD&FD finalised front end system procurement decision made. Technical group established.	Strategy for SLR to SLM development consistent with emergent OD programme & accountability framework	Internal resourcing case agreed. Establish SLM strategy & development programme.	Q1 2014-15	Use of Resources	**8**	**6**
STRATEGIC OBJECTIVE 5: 21ST CENTURY FACILITIES											
Refresh the financial modelling for MMH via PF2	DFPM	F&I committee 22nd November 2013, Trust Board 28th November 2013 Prospectively F&I & Trust Board as required	Inability to identify an affordable solution and identify acceptable efficiency levels. Ensuring sufficient capacity with central planning team.	Construction of base and mitigated downside LTFMs with robust assumptions and plan detail supporting plans. Incorporating a ceiling limit on MMH capex and resultant UP.	LTFM reported & considered by F&I and Board. LTFM considered by external bodies as part of business case approvals process. Routine financial	Not applicable	Not applicable	Not applicable	21st Century facilities	**8**	**6**

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				Identification & confirmation of sufficient cost improvement TSPs.	planning process updates financial outlook						
Maintain estates compliance with CQC Outcome 10 (Safety & suitability of premises) and 11 (safety, availability and suitability of equipment)	DENHP	CQC External Assurance – Capita	Failure to demonstrate compliance and/or actual failure of environmental issue impacting on patient care	Risk management and safe systems of works	Appointment of external assurance company	None identified	Not applicable	Not applicable		**9**	**6**
Invest in the estate through capital schemes to support clinical strategy and in particular Pathology, Endoscopy & Stroke	DENHP	Configuration Committee	Failure to meet capital programme and environmental improvement	Implementing robust project management arrangements	Project plans. Project cash flow	Not achieving planned cash flow	Performance management of Capital Project Leads	Ongoing		**6**	**4**
STRATEGIC OBJECTIVE 6: ENGAGED & EFFECTIVE ORGANISATION											
Deliver the milestones in the Foundation Trust timeline	DSOD	CLE FT Committee	Lack of clear process and timescales for FT application	Dedicated programme management in place Review of	Progress monitored and escalated via FT Programme	None identified	None identified	2015		**20**	**8**

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				milestone delivery monthly at FT programme Team and bimonthly at FT CLE Committee Continue to improve governance arrangements throughout the Trust Continue dialogue with TDA	Team and CLE Committee						
Improve the Trust's performance in the National Staff Survey	DSOD	Workforce & OD Committee	Reputational risk if staff do not advocate their service and place of work Poor regulatory performance ratings e.g. CQC	Implement Workforce strategy through annual work programme 2013/14 Continue to embed LiA methodology Your Voice and actions arising from it	Staff survey outcomes (annual NHS staff survey and monthly employee polling through 'Your Voice'	Poor response rates to staff surveys means that there is limited information available to gauge opinion	Enhance communication process for surveys Robust feedback and action planning process ('You said, we did')	31-Mar-14	National staff survey Reports presenting results of 'Your Voice'	**12**	**8**
Review of Health Informatics	MD	IT Committee	Network resilience	Network review in	Reporting to the IT Committee	No gaps identified at the	No applicable	Network Review will		**12**	**8**

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systems and capabilities			EPR Re-procurement: Exit and service transition to a new provider.	progress and planning is in place to upgrade the network. An EPR procurement team will be established in Q4 2014		moment		report in December 2013 and upgrade delivery will commence in Q4 2014 and complete in 2015.rt in December 2013 and upgrade delivery will commence in Q4 2014 and complete in 2015. Trust will re-procure EPR solution by July 2016			
Attain 10% better than the national mean for sickness/ absence rates	DSOD	Workforce and OD Assurance Committee	Adverse impact of sickness absence on quality of care, staff satisfaction and cost.	Detailed action plan. Including: Focused attention on hot spot areas. Rigorous delivery of key sickness absence stages. Management training. Case management of	Action plan monitored via Workforce Operational Committee. Group performance monitored via Group Reviews. Trust sickness % for nursing and	Key issue identified is timely and consistent management intervention in accordance with policy requirements and inability for current systems to easily record/report.	Delivery of IT system is seen as critical to support this and enable focused case management activity. An IT solution is being developed with Kronos Ltd through SMART.	Q2 2014/15	Reported in the corporate performanc e dashboard on a monthly basis	**9**	**6**

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				non-nursing/midwifery long-term sickness cases from 3 months plus. Case management of nursing and midwifery long term sickness cases from 1 month plus Development of an IT solution to support managers. Table top review of cases longer than 9 months.	midwifery has deteriorated from 4.69% in April '13 to 5.07% in Sept '13 which triggered the decision to case manage nursing and midwifery sickness cases from one month. National information centre is currently reporting national sickness data up to March '13 - for nursing, midwifery and health visiting as 4.72%. Learning from Table Top Reviews shared with Group managers and HR team and where appropriate						

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					guidance material and training updated accordingly.						
Identify three Beacon Services: Gastroenterology Breast Gynae Oncology	MD	Autonomy & Accountability framework- Executive review	Services performance both in quality and performance terms drops below excellent standards. Services unable to access innovation funds due to financial constraints and bureaucracy. Prepare for the next round of Beacon Status services	Monitoring the Beacon Services performance across the qualitative and quantitative measures stipulated in their bids to attain Beacon status on quarterly basis. Planning the selection cycle well in advance of commencement of the required work. Working with Comms to ensure potential services are ready and prepared to submit bids.	The BSs are required to provide evidence to achieving performance targets against plan. Utilising the A&A Framework Patient feedback and patient experience work. Regular Exec review with MDO team Project plan generation and progress checking.	Specifically noting the services as BS's at their exec performance reviews (although we might be). Seeking plans for further improvement.	Cross reference performance issues across all domains in the Quality & Safety strategy as well as measuring against a variety of standards eg CNST, CQC, CQUINs, best practice standards.	Quarterly	Exec review action notes	**4**	**4**

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KEY:

CN	Chief Nurse
MD	Medical Director
COO	Chief Operating Officer
DENHP	Director of Estates/New Hospital Project
DSOD	Director of Strategy & Organisational Development
CIO	Chief Information Officer

RISK SEVERITY MATRIX

1. **LIKELIHOOD:** What is the likelihood of the harm/damage/loss occurring?

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may only occur in exceptional circumstances
2	Unlikely	The event is unlikely to occur (remote chance)
3	Possible	The event may occur occasionally (25-50% likelihood)
4	Likely	The event is likely to occur (above 50% likelihood)
5	Almost Certain	The event will happen (and frequently)

2. SEVERITY: **What is the highest potential consequence of this risk?** ***(If there is more than one level, choose the highest)***

Descriptor	Potential Impact on Individual(s)	Potential Impact on Organisation	Financial Impact	Number of people affected	The potential for complaint / Litigation
Insignificant **1**	No / superficial harm	▸ No impact	▸ No litigation ▸ Less than £100 to reduce risk ▸ Financial risk less than £50K	Only 1 person	Unlikely to cause complaint / litigation
Minor **2**	Short term injury / damage e.g. injury that is likely to be resolved within one month Increased level of care 1-7 days	▸ Minimal risk to organisation	▸ Litigation between £100-£25k ▸ £100-£10k to reduce risk ▸ Financial risk £51k - £500k	Greater than 1 but less than 5 people	Complaint possible Litigation unlikely
Moderate **3**	Semi-permanent injury / damage e.g. injury that may take up to 1 year to resolve. Increased level of care 8-15 days	▸ Some disruption in service with unacceptable impact on patient ▸ Short term sickness	▸ Litigation between £25k-£250k ▸ £10k-£50k to reduce risk ▸ Financial risk £501K - £2M	Greater than 5 but less than 50 people	High potential for complaint Litigation possible but not certain.
Major **4**	Permanent injury e.g. Loss of body part(s). Loss of sight. Increased level of care over 15 days	▸ Long term sickness ▸ Service closure ▸ Service/dept external accreditation at risk	▸ Litigation between £250k-£1m ▸ £50k-£250k to reduce risk ▸ Financial risk £2M - £4M	Greater than 50 but less than 200 people	Litigation expected / certain Multiple justified complaints
Catastrophic **5**	Death Suspected Homicide Suicide	▸ National adverse publicity ▸ External enforcement body investigation ▸ Trust external accreditation at risk	▸ Litigation greater than £1m ▸ Greater than £250k to reduce risk ▸ Financial risk greater than £4m	Greater than 200 people	Multiple claims or a single major claim

3. RISK RATING: Use the matrix below to rate the risk *(e.g. 2 x 4 = 8 = Yellow, 5 x 5 = 25 = Red)*

ELEMENT OF RISK	SEVERITY				
LIKELIHOOD	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM risk** **Red = HIGH risk**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 31 January 2014; 1030h – 1200h

Present		**In Attendance**
Ms O Dutton	[Chair]	Ms A Binns
Mr R Samuda		Mr M Harding
Mrs G Hunjan		Ms K Trimble
Dr S Sahota OBE		
Dr R Stedman		
Miss R Barlow		
Mr R Waite		**Secretariat**
Miss K Dhami		Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Mrs Debbie Talbot. Ms Dutton declared an interest in the item concerning claims given that Bevan Brittain acts for the Trust on behalf of the NHSLA in respect of clinical negligence claims.	
2 Minutes of the previous meeting	**SWBQS (11/13) 164**
The minutes of the Quality and Safety Committee meeting held on 22 November 2013 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (11/13) 164 (a)**
The updated actions list was received and noted by the Committee.	
MATTERS FOR DISCUSSION/DEBATE	
4 Quality & Performance reports	

4.1 Corporate quality & performance dashboard	**SWBQS (1/14) 002** **SWBQS (1/14) 002 (a)**
Mr Harding reported that the areas driving the performance against the TDA Framework were several and included the number of open incidents and CAS alerts, performance against the 18 week referral to treatment time target, Never Events and sickness absence, which it was highlighted had plateaued. Ms Dutton noted that performance against the Emergency Care target had improved and offered congratulations, in the light of the recent increased admissions. Mr Harding reported that indications were that the 62 day cancer target might not be met for the month, however across the quarter this would not create an issue. Miss Barlow advised that the root cause of the breaches had been undertaken. Mr Harding reported that delivery of the CQUIN targets was encouraging, with the exception of the medicines management target, performance against which looked poorer than planned at present. Ms Dutton expressed her disappointment at this position given that the target was seen to be fundamental practice. Mr Ovington advised that clear focus was being directed to resolving this. Mrs Hunjan advised that work had been undertaken by Internal Audit which could assist with identifying the areas needing particular attention. Mr Harding reported that the Friends and Family Test CQUIN target represented a further threat although much work had been undertaken to improve the position. Dr Stedman advised that a new IT intervention as part of the VTE assessment process was delivering a good impact. He advised that further work was required to ensure that the performance against the stroke target was maintained and improved however. Miss Barlow noted that this was pleasing considering the challenges in terms of medical staffing in this area. In terms of pressure sores, it was noted that a Grade 4 had been reported and that the table top review of this incident was due shortly, with the matter being reported to the Trust Board at its next meeting. It was agreed that information such as this needed to be included within the new integrated performance report. Dr Sahota noted that there was deterioration in terms of ambulance turnaround times. Miss Barlow acknowledged that there had been a slight dip, however she noted that the current position remained significantly better than that experienced during the previous year.	
4.2 Draft integrated quality, finance and performance dashboard	**SWBQS (1/14) 003** **SWBQS (1/14) 003 (a)**
Mr Harding presented a draft integrated quality, finance and performance dashboard, which he highlighted had been developed further since the version included in meeting papers. It was reported that the report intended to flag areas where performance was off track or needed further focus.	

Mr Samuda asked what discussions had been held with the Executive to reconcile the focus on quality and finance. Dr Stedman highlighted that it was the intention of the integrated report to show outliers or trends, in addition to how Trust's performance compared with other organisations both in terms of financially and against national performance targets. Dr Sahota noted that the monitoring mechanisms internally should be such that outliers including the mortality indicator were noted prior to the CQC challenging the position. Ms Dutton suggested that there needed to be confident in the data when matters were progressing positively, however assurance needed to be provided in terms of the escalation processes and triggers for matters off track. Ms Dutton suggested that the report needed to be clearly focussed on the key indicators that should be used to determine when matters went off track. Mr Samuda suggested that there was a need to understand the monitoring processes at the Executive-level to be able to focus discussions on the most appropriate matters. Mr Ovington highlighted that the CQC intelligent monitoring information was somewhat outdated. Mrs Hunjan echoed the need to understand escalation levels and the need to be able to provide the necessary assurance to the Board. Ms Dutton noted that the assurance needed to come from dashboards but also from Executive-level discussions and processes throughout the organisation. It was agreed that a 'deep dive' into an indicator of concern was worth undertaking, such as mortality or admissions. Ms Dutton suggested that a rolling programme of indicators of focus was needed as part of the forward cycle of business. It was agreed that this would be picked up at the March 2014 Board Development session when the forward cycle of business for the Board and its Committees would be considered. Miss Dhami advised that the CQC would publish its further intelligent monitoring report in March. Mr Harding advised that measures were being developed to anticipate the outcome of the review.	
5 Performance against the 62-day cancer target	**Verbal**
It was agreed that this was covered as part of the discussion of the performance reviews.	
6 Readmissions update	**SWBQS (1/14) 005** **SWBQS (1/14) 005 (a)**
Dr Stedman reported that readmissions work concerned risk assessment and reviewing the root causes of readmissions from community units. It was reported that a retrospective audit by speciality had been undertaken. Dr Sahota asked whether the seven day working would improve the position and was advised that this was the case to some degree, given that the discharge practice would be considered as part of this work, including telephone 'follow through'. Dr Stedman advised that linkage with Primary Care for this work was critical. Ms Dutton asked whether the Better Care Fund was being factored into the work on readmissions. She was advised that this would be the case. It was also	

highlighted that elderly care work was being dovetailed into the plans.	
7 Complaints devolution update	**SWBQS (1/14) 006** **SWBQS (1/14) 006 (a)** **SWBQS (1/14) 006 (b)**
Miss Dhami reminded the Committee that the devolved complaints model had been introduced in November 2013 and that the process had been well received and was working well, albeit that there had been a number of embedding issues. It was highlighted that although there had been a number of breaches, the issuing of complaints was now more speedily. Ms Dutton suggested that learning points needed to be harnessed from the complaints handled. Ms Dutton asked what percentage of complaints was in relation to the number of patient seen. It was agreed that this information would be provided by speciality at a future meeting. It was also suggested that the improved performance against key indicators needed to be analysed in terms of the impact on complaints. It was agreed that the Committee should receive a KPI-based dashboard and any exceptions in future.	
ACTION: Miss Dhami to present complaints as a percentage of patients seen by speciality at a future meeting	
8 Claims update	**SWBQS (1/14) 007** **SWBQS (1/14) 007 (a)**
Ms Dutton declared an interest in this item and asked Mr Samuda to oversee the report. She left the meeting. Ms Trimble presented an overview of the legal claims data, including clinical negligence data and the employer and public liability claims. A number of the cases were reported to have been raised to the NHSLA. In terms of the comparison with the regional and national average, it appeared that the Trust claims position was higher nationally, however was in line with those in the other local trusts. It was pointed out that there were no key trends in terms of claims across specialities. It was agreed that the experience of the new legal services providers needed to be garnered to ensure that any good practice in respect of claims handling was adopted. It was suggested that further work could be undertaken to understand that Trust's relative position in terms of numbers and interface with the NHSLA and that this would be brought as part of the next update on claims to be presented to the Committee. Ms Trimble reported that in terms of employer liability claims, the most prevalent matters concerned falls, slips and needlestick injuries. Mrs Hunjan noted that although there was likely to be a higher incidence of violence and aggression, the	

position did not correlate to a higher level of claims in this respect.	
9 Never Events controls audit	**SWBQS (1/14) 008** **SWBQS (1/14) 008 (a)**
Miss Dhami reported that 17 Never Events had been reported since 2009 and that an audit programme had been arranged to assess the level of assurance against the controls in place to prevent a reoccurrence. It was highlighted that in some areas the second assessment of assurance appeared to show an improvement and evidenced good compliance. Assurance against patient information was highlighted to be poor, suggesting that leaflets were not routinely distributed or documented. Assurance against the completion of the consent form was reported to be highlighted to need strengthening. The Committee was asked to note the proposed future actions to improve the levels of assurance. Dr Sahota asked what action was taken for areas of low compliance. Miss Dhami advised that clear focus was given to these areas and that the areas would be reaudited. It was reported that an external body would be engaged with delivering an improvement to the patient safety culture as part of the forthcoming Patient Safety Summit.	
10 2014/15 TSP – Quality Impact Assessment	**SWBQS (1/14) 009** **SWBQS (1/14) 009 (a)**
Mr Waite provided an overview of the plans for the development of the Transformation Savings Plan and the integral involvement of the quality assessment process. The Committee was asked to assess whether the process for quality impact assessment was accepted as being robust and the programme was consistent with the Trust's level of risk appetite. Ms Dutton asked for an indication of timescales for some of the significant schemes and the delivery of the impacts anticipated. Mr Waite advised that the matter had been considered by the Finance & Investment Committee who was concerned with the financial impact of the programme. It was agreed that a set of measurable indictors were needed to assess how risks created by the programme were being managed. Dr Stedman advised that there were already a number of indicators in place which measures the safety and effectiveness of the quality of care delivered and that these needed to be mapped against the schemes. Dr Stedman and Mr Ovington confirmed their contentment with the approach that had been taken to the assessment and evaluation notwithstanding that addition work needed to be undertaken to the articulation and management of the risks. Mrs Hunjan noted that the summary had been presented more robustly and more timely than previous years.	

Dr Sahota encouraged a focus to be kept on the bed closure programme as part of the Medicine & Emergency Care Group's plan.	
11 Cardiology turnaround plan	**SWBQS (1/14) 010** **SWBQS (1/14) 010 (a)**
Dr Stedman reported that the progress with the delivery of the turnaround plan for the Cardiology speciality was pleasing.	
12 Response to the CQC regarding puerperal sepsis maternity outlier alert	**SWBQS (1/14) 011** **SWBQS (1/14) 011 (a)** **SWBQS (1/14) 011 (b)** **SWBQS (1/14) 011 (c)**
The Committee received and accepted the report.	
13 Serious Incidents report	**SWBQS (1/14) 012** **SWBQS (1/14) 012 (a)**
The Committee received and accepted the report.	
14 Clinical audit forward plan: monitoring report	**SWBQS (1/14) 013** **SWBQS (1/14) 013 (a)**
The Committee received and accepted the report.	
OTHER MATTERS	
15 Matters of topical or national media interest	**Verbal**
It was agreed that there were no specific matters to raise. Miss Binns advised that a firm of solicitors was giving significant interest to patients who had undertaken gynaecological mesh procedures undertaken by the Trust.	
16 Any other business	**Verbal**
Miss Dhami reported that a task and finish group had been established to oversee the cancelled operations performance. Dr Sahota reported that some of the issues raised by the Patient Safety Walkabouts needed to provide a discipline in terms of reporting back on the actions raised. It was suggested that the matters could be considered as part of the Group performance reviews. It was suggested that and update on theatres safety should be presented at the next meeting.	
ACTION: Dr Stedman to provide an update on the theatres safety review at the next meeting	
17 Details of the next meeting	**Verbal**

The date of the next meeting of the Quality and Safety Committee was reported to be 28 February 2013 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Configuration Committee – Version 0.2

Venue D29 Meeting Room, City Hospital **Date** 12 December 2013 at 1200h

Members present		In attendance	Secretariat
Mr R Samuda	[Chair]	Mr G Seager	Mr S Grainger-Payne
Ms C Robinson		Mrs J Dunn	
Mr T Lewis			
Mr M Sharon			
Mr R White			
Dr R Stedman			

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies for absence were received from Prof Lilford, Mr Sharon and Ms Lewsley.	
2 Minutes of the previous meetings	**SWBCC (10/13) 008**
The minutes of the meeting of the Configuration Committee held on 15 October 2013 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCC (10/13) 008 (a)**
The Committee received and noted the updated actions log.	
4 MMH Project Plan to OJEU	**Hard copy**
Mr Seager presented the project plan to OJEU. He advised that OJEU was likely to be reached by April 2014 and that procurement documentation was being prepared at present. A key risk to this deadline was reported to concern the approval of the business case by relevant external bodies, including the CCG. TL asked for an outline of the means of oversight of the procurement documentation in terms of the requirements of both the Trust Board and the bidders who would be responding. Mr Seager advised that a number of bidders had	

been consulted with a view to canvassing interest informally. He advised that there was also a formal means of engaging with the bidders market in February, in advance of the notice being issued, to allow any changes to the specification suggested to be incorporated. It was reported that this provided a benefit in that the market could be aligned to the bid when the specification was released. Mr White asked for an indication as to the level of detail of the scheme provided at the informal stage and was advised that detail provided was sufficient to enable thoughts of efficient design to be harnessed, while retaining the confidentiality of the key aspects. Mr Lewis suggested that early in the New Year, the Board needed to be appraised of the proposed evaluation model to ensure that any input required could be incorporated. Mr Lewis underlined the need for the assessment to be in line with the criteria published and that the criteria should not be changed once issued. Ms Robinson suggested that learning from other organisations and schemes should be canvassed to inform the development of the criteria. Resources to support the process were confirmed to be in place. Ms Robinson suggested that independent assurance should be used to provide validation that the assessment had been executed accurately and with propriety, which was agreed should be explored further. It was noted that the assessment could be phased to apply criteria incrementally. Mr Lewis asked how the financial feasibility and due diligence of the organisations bidding would be tested, which he noted would most likely occur in Spring 2014. It was agreed that Deloitte should be approached by the end of January 2014 to determine how this would be undertaken. Ms Robinson added that a forward looking view of the companies was also needed. It was noted that this should form an early assessment criteria and agreed that the major subcontractors and FM providers that would be included within the bid should also be considered as part of the assessment.	
ACTION: **Mr Seager to provide a briefing report for the Board early in the New Year regarding the proposed evaluation model for the new hospital proposals**	
5 Clinical reconfiguration summary update	**SWBCC (12/13) 010** **SWBCC (12/13) 010 (a)**
Mrs Dunn presented an overview of the key clinical configurations underway or undertaken. In terms of metrics being used to judge performance against stroke targets and effectiveness of the stroke reconfiguration, it was highlighted that the data reported by the Trust and to be used by commissioners needed to be harmonised. It was reported that much work was underway to improve the thrombolysis position at present. Mr Lewis advised that the investment process (IAP) should provide for an additional medical registrar out of hours at Sandwell and this should also support overnight cover for thrombolysis if needed. Mr Lewis also highlighted	

that future the strategic stroke review and surgery reconfigurations might be competing for the same accommodation. Mrs Dunn advised that this was dependent on the outcome of the Strategic Review, the number of Hyper Acute Stroke Units (HASUs) that would be designated and the associated number of beds that would need to be provided to support these plans. Ms Robinson asked how the reconfigurations linked into the Transformation Programme. Mrs Dunn advised that the transformational aspects were mainly confined to outpatients work, whereas to date the reconfigurations have primarily concerned inpatient services however there was a close link with the Transformation Support Office. Mr Lewis advised that the potential discontinuity between the various programmes would be discussion by the Executive as part of the 'Time Out' session planned for Spring 2014. Mr White advised that the work was also linked into the contractual negotiations and agreement of performance improvement trajectories. It was highlighted that the designated Major Trauma Centre at QEH was experiencing higher than expected demand particularly in relation to cases that could have appropriately been managed by Trauma Units and so the Trauma Network are proposing to review the ambulance triage criteria so that more cases are triaged to the Trauma Units . In terms of diabetes reconfiguration, it was reported that progress was good and there was clear alignment between the Trust's consultants and GP practices.	
ACTION: **Mrs Dunn to write a paper for MMH & Reconfiguration CLE Committee for April 2014, outlining the potential bed requirements for the Sandwell site across the ongoing reconfiguration projects and consider available bed capacity on the Sandwell site**	
6 Cardiology strategic case for change	**Verbal**
It was agreed that Committee members should respond to Mr Sharon's e-mail, even if a nil return, which requested comments on the proposed course of action, in relation to resolving the issues raised by the Configuration Committee over the Cardiology Clinical Case for Change.	
ACTION: **All to respond to Mr Sharon's e-mail concerning resolution of issues regarding the Cardiology Clinical Case for Change**	
7 Strategic review of stroke services	**SWBCC (12/13) 012** **SWBCC (12/13) 012 (a)**
It was noted that the number of Hyper Acute Stroke Units (HASU) was still to be finalised, which would be clarified by the review project and CCGs in August. It was noted that the strategic review was requesting information from providers about current stroke services, alignment with the proposed specification and potential requirements to become a HASU for a wider population under a scenario of fewer	

designated HASUs. It was reported that to date the Trust had submitted financial data and that if the review concluded there are to be fewer designated HASUs a competitive process would be put in place allowing providers to submit applications to become one of the a designated HASUs. It was agreed that the Board would need to consider whether to submit an application under this scenario and that a paper to this effect would be required around April 2014 although exact date would be confirmed once review project dates were clearer. The economics behind the treatment of stroke were discussed.	
ACTION: Mrs Dunn to present a paper to a future Committee meeting (c. April 2014 but date to be confirmed) outlining implications of the Trust submitting an application to become a designated HASU if the outcome of the Strategic Stroke Review is a reduce number of HASUs	
8 'Right Care, Right Here' summary activity and capacity assumptions monitoring report including bed capacity	**SWBCC (12/13) 011** **SWBCC (12/13) 011 (a)**
Mrs Dunn provided an update on the 'Right Care, Right Here' summary activity and capacity assumptions monitoring including bed capacity. It was reported that an update against the corporate trajectories would be provided at the February 2014 meeting.	
ACTION: Mrs Dunn to provide an update against corporate 'Right Care, Right Here' trajectories at the February 2014 meeting	
9 Any other business	**Verbal**
There was none.	
10 Details of the next meeting	**Verbal**
The next meeting is to be held on 28 February 2014 at 0800h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……

Date ……

Midland Metropolitan Hospital Status Report February 2014

Activities Last Period

- Approval process -NTDA approved
- Engagement with DH
- Architectural Refresh Finalised
- Vacant Possession of Land achieved
- GVD3 launched
- PIN fro Pre Market Engagement launched
- OBC refreshed for publication

Planned Next Period

- DH Approval
- Progress Grove Lane site clearance plan
- Complete GVD3
- Agree PF2 commercial documentation with HMT
- Pre Market Bidder engagement events

Issues for Resolution/Risks for Next Period

Finalise Approvals before agreement to advertise scheme

FT Programme Monitoring Status Report

Activities This Month

- Clinical Group Governance audit paper presented to February CLE
- FT risk register redefined following Risk Management Committee feedback
- Awaiting confirmation of CIH visit – confirmed that this will not take place in Q1 (14/15)

Planned Next Month

- IBP chapters redeveloped in line with OBC in readiness for submission to the TDA in June 2014
- 'Get Involved in Leading the Trust' events planned for April & May (membership)

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SUSTAINABLE DEVELOPMENT MANAGEMENT PLAN UPDATE

Report to the Trust Board – 6 March 2014

1. Introduction

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

2. Sustainable and Healthy Travel

As part of the Public Health Strategy, the Trust will work to improve the current use of alternative (i.e. more sustainable and healthy) modes of transport to work and between our hospital sites 10-20% by 2017.

To progress work towards this target, the Trust has signed up to the 'Smarter Network, Smarter Choices' programme. This scheme provides match funding to support a move towards more sustainable and healthy modes of travel (e.g. walking, cycling, and public transport). As part of this programme, the Trust will be progressing work to engage staff in sustainable and healthy travel, whilst also providing suitable facilities to support this (e.g. cycle shelters, cycle parking, training, etc.)

The scheme should bring a number of benefits, including saving money for the Trust and staff, improving the health and wellbeing of staff, and enhancing the environmental reputation of the Trust through reducing transport related carbon emissions.

3. Waste Recycling Management

The Trust continues to separate paper, plastic and cardboard recyclable waste from general waste. At City and Sandwell Hospitals, infrastructure is in place to facilitate staff in segregating this recyclable waste and work is being undertaken so this can commence at Rowley Regis Hospital.

In line with the Public Health Strategy, the Trust is working to reduce the amount of waste sent to landfill by increasing the amount of waste we recycle 5% by 2017.

4. Energy Efficient Lighting

Following the successful implementation of LED lighting within the Libraries at City and Sandwell, the Trust has continued to install energy efficient LED luminaires and controls at the Birmingham Midland Eye Centre, Rowley Regis Hospital and Sandwell OPD. The Estates Engineers have concentrated on ensuring all circulation areas within these sites are fitted with LED luminaires as this will offer the greatest energy and carbon savings due to the continual requirement for lighting during opening hours. Controls are also being installed which offer presence detection and daylight dimming to make best use of any available natural daylight.

It is expected that the widespread implementation of LED lighting throughout the Trust will realise significant savings in electricity, aiming towards the goals of our Carbon Management Plan.

5. Solar Panel Electricity Installation - City (BMEC) and Rowley Regis

The Trust has installed solar panels on the roof of the Birmingham and Midland Eye Centre (BMEC) at City Hospital. Solar panel electricity systems, also known as solar photovoltaics (PV), capture the sun's energy and convert this into electricity.

Through installing solar panels on the BMEC, the Trust will save around 43,000 kWh of electricity each year (that's about 13 UK household's yearly use of electricity). This will save the Trust over £8,000 and 23 tonnes of carbon each year.

The Trust has very recently installed solar panels onto the roof of Rowley Regis Hospital with similar annual energy and carbon savings.

6. Furniture Recycling Open Days

The Trust held three very successful open days last year where furniture which is no longer required (arising from the estates rationalisation programme or other departmental moves) is offered to other wards and departments for re-use within the Trust. There are more planned for later in the year.

Even condemned furniture doesn't go to waste. We explore ways of donating to third world charities that can make good use of items which are no longer suitable for our hospital environments.

7. Carbon Reduction Commitment (CRC)

The Carbon Reduction Commitment (CRC) is a mandatory carbon emissions reduction scheme in the United Kingdom. The Trust successfully submitted information as mandated by the government and calculated our CRC carbon emissions as 17,617 tonnes for 2012-13.

8. Upcoming Events

The Trust is running a 'Turn it off' campaign during Climate Week (3rd-9th March) to get staff to reduce energy consumption. During the week, to promote sustainable travel the Trust has also recruited the help of 'Bike right' to offer staff support on cycling and provide free bike assessments.

The Trust is supporting the NHS Sustainability Day (27th March) and is hoping to plant some trees via NHS Forests at Rowley Regis and Leasowes to mark this occasion.

9. NHS Good Corporate Citizenship

The Trust continues to submit a bi-annual self-assessment to the NHS Good Corporate Citizenship and is steadily improving in performance. As part of the Public Health Strategy, we will improve on our performance score 5% by 2017.

10. Sustainability Champions

The Trust currently has a team of around 100 Sustainability Champions. These valued Sustainability Champions promote environmental awareness, personally champion 'greener' working, and encourage colleagues to act sustainable (e.g. reduce energy water and waste). They also act as a point of contact and provide feedback.

As part of the Public Health Strategy, the Trust has committed to increasing the number of Sustainability Champions across the Trust 40% by 2017.

11. Next Steps

Continued work on sustainability and carbon management (energy, waste, water)
Move forward with work on sustainable and healthy travel in order to reach the Public Health Strategy target
Continue with waste reduction and recycling initiatives across the Trust
Annual CRC reporting
NHS Good Corporate Citizenship score improvements
Sustainability Champions – further engagement

12. Recommendations

The Trust Board are asked to:

Note the current progress in relation to sustainable and healthy travel, waste recycling management, energy efficient lighting, solar panels, furniture recycling open days, carbon reduction commitment (CRC), upcoming sustainability events/campaigns, NHS Good Corporate Citizenship and Sustainability Champions
Continue supporting on-going sustainability projects

Fran Silcocks, Sustainability Officer & Rob Banks, Deputy Director of Estates