Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 25 July 2013; 1530h

Members

Mr R Samuda	(RSM)	[Chairman]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Prof R Lilford	(RL)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Ms C Robinson	(CRO)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mr R White	(RW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]
Miss R Overfield	(RO)	[Chief Nurse]
Miss R Barlow	(RB)	[Chief Operating Officer]

In attendance

Mr M Sharon	(MS)	[Director of Strategy & OD]
Mrs F Sanders	(FS)	[Interim Chief Information Officer]
Mr G Seager	(GS)	[Director of Estates & New Hosp Project]
Miss K Dhami	(KD)	[Director of Governance]
Mrs J Kinghorn	(JK)	[Head of Communications & Engagement]
Mrs C Rickards	(CRI)	[Trust Convener]

Guests

Mrs L Pascall	(LP)	[Assistant Director of Nursing]
Dr D Robertson	(DR)	[Clinical Lead for Prevention]

Secretariat

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

Time	Item	Title	Reference Number	Lead
1530h	**1**	**Apologies**	**Verbal**	**SG-P**
	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 Pg 4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 27 June 2013 a true and accurate records of discussions*	**SWBTB (6/13) 138**	**Chair**
	4 Pg 15	**Update on actions arising from previous meetings**	**SWBTB (6/13) 138 (a)**	**SG-P**
	4.1	Paediatric waiting times	Verbal	RB
	4.2	Communication of Neurology test results	Verbal	KD
	4.3 Pg 18	IT Outage on 13 June 2013	SWBTB (7/13) 161 SWBTB (7/13) 161 (a)	FS
	5 Pg 20	**Chair's opening comments and Chief Executive's report**	**SWBTB (7/13) 144**	**Chair/ CEO**
	6	**Questions from members of the public**	**Verbal**	**Public**
1545h	**PRESENTATION**			
	7	**Patient story**	**Presentation**	**LP**

	MATTERS FOR APPROVAL			
1605h	**8** Pg 24	**Chair's action: application of Trust Seal to s106 documents for the Grove Lane site**	**SWBTB (7/13) 145**	**GS**
1610h	**9** Pg 25	**Board subcommittees revised Terms of Reference and revised future governance structure**	**SWBTB (7/13) 146** **SWBTB (7/13) 146 (a) - SWBTB (7/13) 146 (i)**	**TL**
1625h	**10** Pg 64	**Performance Management Regime – monthly submission**	**SWBTB (7/13) 147** **SWBTB (7/13) 147 (a)**	**MS**
	MATTERS FOR DISCUSSION			
	11	**Safety, Quality and Governance**		
1635h	11.1 Pg 77	Update from the meeting of the Quality & Safety Committee held on 19 July 2013, minutes from the meeting held on 21 June 2013	SWBQS (6/13) 100	OD
1640h	12.2 Pg 86	Quality report	SWBTB (7/13) 148 SWBTB (7/13) 148 (a)	RO/ RST
1650h	11.3 Pg 123	Health Informatics Services (HIS) – key decisions and timeline	SWBTB (7/13) 149 SWBTB (7/13) 149 (a)	FS
1710h	11.4 Pg 131	Future approach the risk management	SWBTB (7/13) 150 SWBTB (7/13) 150 (a)	KD
1725h	11.5 pg 138	Cultural change plan	SWBTB (7/13) 151 SWBTB (7/13) 151 (a)	TL
1740h	11.6 Pg 142	Health Promotion strategy	SWBTB (7/13) 152 SWBTB (7/13) 152 (a)	RST/ DR
1755h	11.7 Pg 161	Membership update	SWBTB (7/13) 153 SWBTB (7/13) 153 (a)	JK
	12	**Finance & Performance Management**		
1805h	12.1	Update from the meeting of the Finance & Performance Management Committee held on 19 July 2013	Hard copy	CRO
1810h	12.2 pg 171	Monthly finance report – Month 3	SWBTB (7/13) 155 SWBTB (7/13) 155 (a)	RW
1815h	12.3 Pg 181	Plans to address Medicine division's financial position	SWBTB (7/13) 156 SWBTB (7/13) 156 (a)	RB
1820h	12.4 Pg 184	Monthly performance monitoring report	SWBTB (7/13) 157 SWBTB (7/13) 157 (a)	RW
1825h	**13**	**Any other business**	**Verbal**	**All**

		MATTERS FOR INFORMATION	
Pg 195	14	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (7/13) 158**
	15 Pg 196	**Foundation Trust application programme: monitoring report**	**SWBTB (7/13) 159** **SWBTB (7/13) 159 (a)**
	16 pg 198	**NHS Performance Framework & FT Compliance Framework report**	**SWBTB (7/13) 160** **SWBTB (7/13) 160 (a)**
	17 pg 202	**Minutes from the FT Programme Board held on 27 June 2013**	**SWBFT (6/13) 062**
	18	**Details of next meeting** *The next public Trust Board will be held on 29 August 2013 at 1530h in the Boardroom, Sandwell Hospital*	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Boardroom, Sandwell Hospital **Date** 27 June 2013

Present	**In Attendance**	
Mr Richard Samuda [Chair]	Miss Kam Dhami	
Ms Clare Robinson	Mr Graham Seager	
Mrs Gianjeet Hunjan	Mrs Jessamy Kinghorn	
Dr Sarindar Sahota OBE	Mrs Chris Rickards	
Ms Olwen Dutton	Mr Bill Hodgetts	[Healthwatch]
Mr Harjinder Kang		
Prof Richard Lilford	**Guests**	
Mr Toby Lewis	Mrs Linda Pascall	[Assistant Director of Nursing]
Mr Robert White	Ms Cox	[Patient's relative]
Dr Roger Stedman	Ms Rasekhuta Lephala	[Acting Matron]
Miss Rachel Overfield	Ms Cynthia Dixon	[Matron]
Miss Rachel Barlow	Ms Liz Hudson	[Diabetic Specialist Nurse]
	Mr Ajai Tyagi	[Group Director – Surgery B]
	Secretariat	
	Mr Simon Grainger-Payne	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies were received.	
2 Declaration of Interests	**Verbal**
Mr Grainger-Payne advised that Mr Lewis had submitted a declaration of interest since the Board had last met in that he had accepted a directorship of a	

Wolverhampton University affiliated Technical College, Health Futures. The Board was informed that the register of interests had been duly updated.	
3 Minutes of the previous meeting	**SWBTB (5/13) 115** **SWBTB (6/13) 137**
The minutes of the Trust Board meeting held on 30 May and 6 June 2013 were presented for approval. Ms Robinson suggested a number of amendments to the minutes of 30 May 2013, which the Board agreed needed to be made. Subject to these amendments, the minutes were approved. Amendments were also suggested to the minutes of 6 June 2013, to reflect that approval of the annual accounts had been subject to review of the Audit Memorandum. It was suggested that the minutes needed to reflect that the accounting team had submitted the accounts before the required deadline.	
AGREEMENT: The minutes of the last meeting were approved subject to amendments suggested	
4 Update on actions arising from previous meetings	**SWBTB (5/13) 115 (a)**
The Board reviewed the meeting action log and noted that there were no matters requiring escalation or that needed to be raised for the Board's attention. In terms of the action concerning a response to the report by Robert Francis QC, Miss Dhami advised that although the Trust had developed an initial response, the national position on a number of recommendations was awaited and this, together with the views of the new Chief Executive would better inform a response which would be shared in September 2013. In terms of readmissions, Dr Stedman advised that he had commissioned a review of the position by the Mortality and Quality Alerts Committee (MQAC). It was reported that it had been identified that readmissions were higher than expected at Sandwell Hospital at 14%, with the Trustwide position being 10%. The diagnostic groups associated with this level of readmissions were highlighted to be predominantly elderly care, with heart and respiratory failure. It was reported that additionally, there appeared to be a specific issue at Sandwell Hospital in respect of pregnancy readmission rates. Dr Stedman advised that it was common for patients within the last six months of their life to be admitted to hospital c. three times, therefore there was a need to review End of Life care provision in the community. Dr Sahota noted that on occasion patients were reluctant to be discharged due to the social circumstances they faced when leaving hospital and asked how this impacted on the position. He was advised that the readmission position did not appear to be unduly influenced by social failures. Ms Robinson asked whether the analysis was considering instances where GPs were referring patients back to Accident and Emergency. She was advised that this was the case. It was agreed that further detail of readmissions be presented to the Quality &	

Safety Committee on 19 July 2013. Ms Robinson noted that the minutes of the Quality & Safety Committee referenced an IT failure and asked what measures were being taken to prevent such a reoccurrence. Miss Barlow advised that work was underway with the Health Informatics Service (HIS) team to identify the earliest point that an IT failure could be detected and that a root cause analysis was underway for the failures reported in the minutes. It was highlighted that the Audit Committee would be reviewing the resilience of the Trust's IT systems in due course.	
ACTION: **Dr Stedman to present further detail of readmissions at the Quality & Safety Committee planned for 19 July 2013** **ACTION:** **Mrs Sanders to provide an update on the IT outage that occurred on 13 June 2013**	
Never Event	**Verbal**
Mr Tyagi, Group Director for Surgery B joined the meeting for this item. Dr Steadman reported that during the previous four years, 13 'Never Events' had been reported by the Trust. It was reported that a further 'Never Event' had been reported recently which concerned the replacement of an incorrect intraocular lens during a procedure undertaken in the Birmingham and Midland Eye Centre (BMEC). Mr Tyagi advised that the error had been detected at the conclusion of the theatre list when irregularities in the stock of lenses were noted. The Board was informed that two versions of the World Health Organisation (WHO) checklist had also been in circulation within the area and although the checklist had been adequately completed, the out dated version had been used, meaning that a key further check that the correct lens had been implanted had not been undertaken. In terms of measures being taken to prevent a reoccurrence, the Board was advised that a refreshed algorithm had been developed which would be shared with other teams. Ms Dutton noted that it had taken some time to embed the use of the WHO checklist and asked whether the resistance to its use had been overcome in the Surgery B Group. Mr Tyagi advised that this was largely the case. Dr Sahota asked whether stock control was sufficient to be able to identify the incident in future. Dr Stedman advised that this was an important means of detecting errors and had been the case in this incident. Ms Robinson remarked that the presence of an external medical trainer in the theatre, who had taken a role in selecting the lens, appeared to be irregular. Dr Stedman advised that this was not uncommon, in that the individual may have been providing a demonstration for the use of a new piece of equipment or consumable. Mr Lewis reiterated the unfortunate and unacceptable nature of the incident and advised that the matter would be shared widely across the Trust. He advised that the controls associated with the previous 'Never Events' reported would be tested.	

Mr Lewis asked Mr Tyagi what conversations would be held on a multi-professional basis around the incident and he asked whether there was acceptance that procedures being undertaken by the teams in the BMEC should be filmed for a period in future. Mr Tyagi expressed his support for the proposed filming, noting the positive impact the same had had in the Accident and Emergency Department. In terms of the conversations about the event, the Board was advised that urgent discussions had been held on the day of the incident and that the out dated WHO checklist had been removed from circulation. It was reported that the details of the 'Never Event' had been sent to all in the area and that a comprehensive discussion about the matter would form a key item on the agenda of the Group Governance meeting in July. Mr Lewis underlined the need for the discussions to be of a multi professional nature. Mr Tyagi advised that conversations would be held at the regular theatre user meeting, which included a range of professions including nurses, medics and anaesthetists. He advised that a training programme would commence which would include the role of nurses in checking and control. Mr Lewis asked whether any assistance was needed from the Board. Mr Tyagi advised that the matter was in the control of the Group. He was thanked for his attendance.	
5 Chair's opening comments and Chief Executive's report	**SWBTB (6/13) 117**
The Chairman provided a summary of the key activities in which he had been involved since the Board had last met. He in particular congratulated the nursing team on a successful Ward Team Challenge event. Miss Overfield suggested that extending the invitation to these future events to a wider group of staff would be beneficial. Mr Lewis asked the Board to note his written update on key activities and points of interest to the Board, which was structured around patients; colleagues; partners; strategic priorities; the Trust's beacons; and feedback from leaders via the 'Hot Topics' forum. Dr Stedman asked the Board to note in particular that three specialities had been successful in the recent round of applications to be a Beacon Service: Breast Surgery; Gynaeoncology; and Gastroenterology. The Board extended its congratulations to the winning teams.	
6 Questions from members of the public	**Verbal**
There were no members of the public present.	
7 Patient story	**Presentation**
The Board was introduced to Mrs Cox, mother of Caden Cox, a Paediatric patient who had been treated by the Trust for Diabetic Ketoacidosis. The Board was appraised of the experience of Caden's treatment, which included a significant waiting time in Accident and Emergency before being admitted. Miss Overfield remarked that a waiting time of six hours was concerning. Mrs Cox advised that she was disappointed at the waiting time and that her son had deteriorated during this time. Mr Kang asked what day of the week Caden had been treated. He was advised that this was a Monday. Mr Sharon asked whether the parents	

had considered taking Caden to a GP instead of the Accident and Emergency Department. He was advised that given the seriousness of Caden's condition, a visit to Accident and Emergency seemed most appropriate. Ms Robinson asked whether during the waiting time, a member of staff had discussed the reasons for the delay or kept them up to date with progress. Mrs Cox advised that this was not the case. Dr Sahota asked whether Diabetic Ketoacidosis could have been identified earlier in the patient. Dr Stedman advised that this was not the case and that the way in which the diagnosis had been reached on this occasion was typical of the way in which the condition was identified. Mr Lewis noted that the family had been involved in a support network, including regular contact with a Diabetic Specialist Nurse and 24 hour telephone support if needed. Mrs Cox agreed that the service was informative and helpful. Mrs Cox and the nursing team were thanked for their attendance.	
ACTION: Miss Barlow to investigate the position regarding long waiting times for Paediatric patients in Accident & Emergency	
MATTERS FOR APPROVAL	
8 Quality Account 2012/13	**SWBTB (6/13) 119** **SWBTB (6/13) 119 (a)** **SWBTB (6/13) 119 (b)**
Dr Stedman presented the final iteration of the Quality Account 2012/13 for approval. He advised that the issue concerning the position relating to 28 day readmission rates questioned at the last meeting had been resolved. It was agreed that the Quality Account presented a digestible and coherent narrative. Dr Stedman advised that the Quality Account would be submitted to the Secretary of State and would be posted on the Trust's internet. Mrs Kinghorn advised that Heathwatch had reviewed the publication. Mr Lewis asked that care be taken to minimise the use of acronyms where possible.	
AGREEMENT: The Trust Board approved the Quality Account 2012/13	
9 Performance Management Regime – monthly submission	**SWBTB (6/13) 120** **SWBTB (6/13) 120 (a)**
Mr Sharon presented the proposed monthly Provider Management Regime (PMR) submission, which he advised was likely to change format shortly and include a revised set of Board Statements. It was reported that non-compliance was being declared against the Board statement relating to achievement of operational targets, reflecting that the current performance against the Emergency Care target remained someway short	

of the required position. In terms of the Single Sex Accommodation breaches, it was reported that the methodology for counting and reporting these in Critical Care was under review and a trajectory was being devised to eliminate all breaches. It was highlighted that an audit to determine breaches in April and May was to be conducted and that figures for June onwards would be reported in the July submission. It was highlighted that performance against MRSA screening targets was unsatisfactory at present and that measures were being taken to ensure that an improvement was delivered.	
AGREEMENT: The Trust Board approved the Performance Management Regime – monthly submission	
10 Safety, Quality & Governance	
10.1 Update from the meeting of the Quality & safety Committee held on 21 June 2013 and minutes from the meeting held on 24 May 2013	**SWBQS (5/13) 085**
Ms Dutton updated the Board on the key discussion points from the meeting of the Quality & Safety Committee that had been held on 21 June 2013. She highlighted that the Committee had noted the disappointing reversal in the Friends and Family Test score. It was also reported that Infection Control matters had been discussed at significant length, including the possibility of adopting a trustwide uniform. Ms Dutton emphasised the need for common issues and themes arising from complaints to be understood, shared and acted upon.	
10.2 Quality Report	**SWBTB (6/13) 121** **SWBTB (6/13) 121 (a)**
The Board was asked to consider the Quality Report, which it was advised had been discussed in detail at the Quality & Safety Committee on 21 June 2013. Miss Overfield highlighted that the last financial year had ended without any Grade 4 avoidable pressure sores, which was pleasing. The Board was advised that this reflected a better experience for patients staying with the Trust and that significant cost had been avoided. Regarding the complaints section of the report, it was highlighted that a patient had waited six weeks for results following a Neurology investigation. Dr Stedman agreed to investigate the reasons for the length of this waiting time. In terms of performance against the stroke services indicators, it was highlighted that the position was currently unacceptable against the brain imaging target. Dr Stedman advised that this reflected to some degree, the disturbance caused by reconfiguring stroke services and that it was anticipated that the position would be rectified shortly. Miss Barlow asked the Board to note that a number of indicators where performance had been previously judged to be at red or amber	

status had improved to green status. Mr Lewis advised that in relation to MRSA screening for elective patients, there was currently an issue with the capture of data from pre-admission clinics which was being investigated. He advised that the performance was not related to any investment required.	
ACTION: Dr Stedman to investigate the reasons behind the delay with a patient receiving results following a Neurology investigation	
10.3 Update from the meeting of the Audit Committee held on 6 June 2013	**Verbal**
Mrs Hunjan updated the Board on the key discussion points from the meeting of the Audit Committee that had been held on 6 June 2013, which it was noted had been dedicated to the consideration and approval of the Trust's annual accounts. It was reported that a tendering exercise was planned for the provision of Business Risk and Assurance Services and that a panel was being convened to receive the presentations from those companies shortlisted.	
10.4 Informatics Plan for 2013/14	**SWBTB (6/13) 122** **SWBTB (6/13) 122 (a)**
Dr Stedman presented an update on the delivery of the informatics plan for 2013/14, including the upgrade of the IT systems in Radiology and Accident & Emergency departments which was on track. Mr Lewis highlighted the significant range of work in progress. Ms Robinson noted that the introduction of some of the IT systems linked to the delivery of Transformation Savings Plans and therefore there was a need to ensure that the harmony between these was maintained. It was reported that progress with the development of the Electronic Patient Record would be presented to the Board in July, which would include the key decisions that would need to be taken as part of the plans.	
10.5 18 weeks 2013/14 and Data Quality review	**SWBTB (6/13) 123** **SWBTB (6/13) 123 (a)**
Miss Barlow reminded the Board that updates on the 18 weeks waiting time data quality issue had been previously presented to the Board and to the Audit Committee. She advised that following identification of irregularities concerning the reporting of 18 week waiting times, a manual validation of patients records from 2007 had been undertaken, with 30,000 records having now been validated from a set of 130,000. It was reported that a review of the records validated so far had not revealed any evidence that patient care had been affected by the administrative issues. The Board was provided with a refresh of the background to the 18 weeks waiting time data quality issue.	

It was reported that new operational processes had been designed to ensure accurate recording of the 18 week treatment outcomes and discharge processes.

In terms of the remaining open pathways, it was reported that a three phase approach be taken where referrals from January 2013 would be reported within the new operational processes; referrals made from April 2012 to December 2012 would be manually validated; and patients referred before April 2012 would be sent a letter to advise that they are to be discharged from the IT system, with the option of contacting the Trust should they feel that their treatment had not concluded.

It was reported that of the 30,000 records validated, 254 patients had been invited back for treatment.

Miss Barlow advised the regrettably, when validating the patient records, it had been identified that a number of patients had waited for treatment for in excess of 52 weeks and that as the validation work continued, there was a possibility that an additional number of patients waiting for this length of time might be identified. The Board was informed that these patients would be offered an urgent appointment to ensure that their care continued without any further delay. Mr Kang asked how the Trust compared with other trusts in respect of patients waiting in excess of 52 weeks. Miss Barlow advised that reporting any patients as waiting in excess of 52 weeks was unacceptable.

Dr Sahota noted that the issue had been identified some months ago and remarked that there had been an expectation that the measures to deliver accurate reporting would have been delivered sooner. Miss Barlow emphasised the need for the new processes to be as robust as possible and that the reporting mechanisms would ensure accuracy of reporting from the end of September 2013.

Miss Barlow reported that for patients referred for treatment from January 2013, 94% had been waiting 18 weeks or less for treatment, against an expectation of 92% minimum target.

Ms Robinson highlighted that patients waiting for an excessively long time to be seen might complain and asked in this respect if a cross check had been undertaken with formal complaints registered. She was advised that a cross check against mortality rates, complaints and admissions had been undertaken and there did not appear any clear correlation between the indicators.

Ms Robinson suggested that the communiqués issued in respect of this matter should be appropriately reviewed and approved, including the letters due to be issued to patients. Miss Barlow advised that complex communications planning was underway and that the Chief Executive would approve the communiqués to be issued. Ms Robinson suggested that the issuing of letters needed to be staggered. Mr Lewis remarked that the messages to be issued would seek to provide reassurance but not minimise the gravity of the issue. Miss Barlow advised that the patient demographic service would be used to address any change in patients' addresses. She was asked to ensure that letters were not

issued to patients who had died and that patients with same addresses be sent together. Mr Kang asked how the issue was being declared publicly. Mr Lewis advised that non-compliance was being declared in the current Provider Management Regime submission and that the Trust Development Authority had been appraised of the situation and rectification plan. The Chairman asked whether there was confidence that the situation and lack of control was not replicated in other parts of the Trust. Mr White advised that work was underway as part of the wider Data Quality agenda to test a set of high level indicators, tracing the information back to its originating source, an exercise that would provide a view of the robustness of Data Quality in other parts of the Trust. Mr Lewis advised that the lessons learned from the issue would be presented to the Trust Board in October 2013.	
ACTION: **Mr Grainger-Payne to schedule a discussion about 18 weeks data quality lessons learned onto the agenda of the October 2013 meeting**	
10.6 Ward leadership model evaluation	**SWBTB (6/13) 124** **SWBTB (6/13) 124 (a)**
Miss Overfield advised that it was apparent from the data and quality measures that the ward leadership model introduced in 2012 had generated a positive impact in the Trust. She advised that the operational pressures during Winter 2012 would have been likely to have been exacerbated, should the leadership model not have been in place. The Board was advised that there had been less success in terms of workforce finances, in particular that associated with the use of bank and agency staff. Miss Overfield suggested that the ward leadership model be expanded and maintained when the predicted bed base increase was implemented. It was advised that an entry had been made to the Health Service Journal awards for the ward leadership model. Dr Sahota asked what measures were being put in place to develop leadership capability. He was advised that scenario based work was undertaken alongside team leader development and the 'Rising Stars' scheme. It was reported that some elements of the leadership development programme were accredited with local universities.	
11 Performance Management	
11.1 Monthly finance report – Month 2	**SWBTB (6/13) 125** **SWBTB (6/13) 125 (a)**
Mr White reported that at present, the Trust was c. £40k ahead of plan, however	

there continued to be financial pressure experienced in the Medicine & Emergency Care; Surgery, Anaesthetics & Critical Care; and Sandwell Community Adult Heath Groups. It was highlighted that these areas were also experiencing challenges with the delivery of their Transformation Savings Plans, although the Board was advised that good progress had been made to identify the range of measures needed to deliver a balanced plan by the Surgery, Anaesthetics & Critical Care; and Sandwell Community Adult Heath Groups. In terms of the Medicine & Emergency Care Group, it was reported that work was underway to assess the underlying recurrent impact of its shortfall in delivery of the TSP concerned with the delayed bed closure programme. The cash position was reported to be strong at £45m.	
11.2 Draft minutes from the meeting of the Finance & Performance Management Committee held on 21 June 2013 and Chair's annual report	**SWBTB (6/13) 125** **SWBTB (6/13) 125 (a)**
Ms Robinson updated the Board on the key discussion points from the meeting of the Finance & Performance Management Committee that had been held on 21 June 2013. Dr Sahota highlighted that the use of bank and agency staff appeared to remain high. Mr Lewis advised that revised controls had been implemented from June 2013 which were anticipated to have an impact. Miss Overfield added that an evaluation of the resources required and practice to 'special' patients was underway which would also assist.	
11.3 Monthly performance monitoring report	**SWBTB (6/13) 126** **SWBTB (6/13) 126 (a)**
Mr White asked the Board to receive and note the monthly performance monitoring report. He advised that the position concerning ambulance fines remained to be resolved, however overall the Trust's liability for fines was confined to £1.5m for 2013/14.	
12 Any other business	**Verbal**
There was none.	
Matters for information	
The Board received the following for information: • Midland Metropolitan Hospital project: monitoring report • Foundation Trust application programme: monitoring report • NHS Performance Framework & FT Compliance Framework report • Minutes from the FT Programme Board held on 30 May 2013	
Details of the next meeting	**Verbal**

The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 25 July 2013 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 25 July 2013, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

27 June 2013, Boardroom @ Sandwell Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mr H Kang (HK), Mrs G Hunjan (GH), Ms O Dutton (OD), Prof R Lilford (RL), Mr T Lewis (TL), Mr M Sharon (MS), Mr R White (RW), Dr R Stedman (RST), Miss R Overfield (RO), Miss R Barlow (RB)

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

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 18 July 2013

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.245	Trust's initial response to the report of the Mid Staffordshire NHS Foundation Trust public inquiry	SWBTB (2/13) 032 SWBTB (2/13) 032 (a)	28-Feb-13	Present the baseline assessment against the recommendations within the 'Francis' report at the next meeting of the Quality & Safety Committee and Trust Board	KD	~~26/04/2013~~ ~~30/06/2013~~ ~~31/08/2013~~ 30/09/2013	Intention delay in response due to anticpation of national position against some recommendations and to give opportunity for new CEO to provide input into the response. In the meantime, measures that would address many of the recommendations are being delivered.	Y
SWBTBACT.260	Update from the Audit Committee held on 9 May 2013, minutes of the meeting held on 14 February 2013 and	SWBAC (2/13) 020 SWBAC (5/13) 036 (a)	30-May-13	Present an update on Internal Audit actions still outstanding at the next Audit Committee meeting	SG-P	~~12/09/2013~~ 25/10/2013	Date change due to revised meeting schedule	G
SWBTBACT.259	Mitigation Plan in response to IT systems failure	SWBTB (5/13) 088 SWBTB (5/13) 088 (a)	30-May-13	Provide a further update on the progress with implementing the resiliencies that had been developed and the new back up measures that had been implemented to prevent a further IT outage	FS	25/07/13	Included as a matter arising on the agenda of the meeting scheduled for 25/7/13	G
SWBTBACT.256	Single tender action: maintenance contract for Olympus video and ultrasonic endoscopes	SWBTB (5/13) 085	30-May-13	Arrange for the Trust's standard contract terms to be amended to include a warranty related to best NHS UK price	RW	30/09/13	When single tender actions are made, the proposer is reminded to seek an undertaking from the company that the best price is offered. The formal contract documentation is being reviewed however. ACTION NOT YET DUE.	G
SWBTBACT.261	18 weeks 2013/14 and Data Quality review	SWBTB (6/13) 123 SWBTB (6/13) 123 (a)	27-Jun-13	Schedule a discussion about 18 weeks data quality lessons learned onto the agenda of the October 2013 meeting	SG-P	31/10/13	ACTION NOT YET DUE	G

SWBTBACT.249	Questions from members of the public	Verbal	25-Apr-13	Schedule a discussion concerning EPR & longer term HIS strategy at the July 2013 meeting of the Trust Board	SG-P	25/07/13	Included on the agenda of the meeting planned for 25/7/13	B
SWBTBACT.253	Improving Emergency Care	Presentation	25-Apr-13	Determine what plans or pieces of work should be paused as a consequence of the planned focus on improving Emergency Care	Executive	30/06/13	The medicine group will focus their triumvirate efforts on maintaining safety, improving VTE and MRSA screening, financial balance and the actions required to deliver WMBB13 during Q2. Work to support the transformation of LTC will be progressed directly with directorates by the strategy and transformation teams. The executive team, including in particular our COO, will focus on national minimum standards, financial balance, our five quality priorities, LTFM/MMH and organisational development. If necessary additional project resource will be added over the summer to operations to ensure that the bandwidth required to deliver our agenda before winter is in place. Changes to the Community Services division will be frozen until October 2013.	B
SWBTBACT.255	Readmission rates at Sandwell Hospital	Verbal	30-May-13	Present the information concerning readmission rates at Sandwell Hospital to the Quality & Safety Committee	RB	19/07/13	Update provided at Quality & Safety Committee on 19/7/13	B
SWBTBACT.257	Update on actions arising from previous meetings	SWBTB (5/13) 115 (a)	27-Jun-13	Present further detail of readmissions at the Quality & Safety Committee planned for 19 July 2013	RB/RST	19/07/13	Linked to SWBTBACT.255	B
SWBTBACT.258	Update on actions arising from previous meetings	SWBTB (5/13) 115 (a)	27-Jun-13	Provide an update on the IT outage that occurred on 13 June 2013	FS	25/07/13	Linked to SWBTBACT.259	B
SWBTBACT.259	Patient story	Presentation	27-Jun-13	Investigate the position regarding long waiting times for Paediatric patients in Accident & Emergency	RB	25/07/13	Included as a matter arising on the agenda of the meeting scheduled for 25/7/13	B
SWBTBACT.260	Quality Report	SWBTB (6/13) 121 SWBTB (6/13) 121 (a)	27-Jun-13	Investigate the reasons behind the delay with a patient receiving results following a Neurology investigation	KD	25/07/13	Included as a matter arising on the agenda of the meeting scheduled for 25/7/13	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Sandwell and West Birmingham Hospitals NHS Trust - Informatics Network outage 13th June 2013**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis, Chief Executive**
AUTHOR:	**Fiona Sanders, Interim CIO**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

The Sandwell and West Birmingham Hospitals NHS Trust experienced a network outage on the 13th June 2013 as a result of the core network configuration being deleted.

This paper confirms the cause of the outage and the steps that have been introduced to the method statement to reduce the incidence of error.

REPORT RECOMMENDATION:

This report is for information purposes.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Not applicable

PREVIOUS CONSIDERATION:

Discussed at the Board meeting on 27 June 2013

SWBTB (7/13) 161 (a)

TRUST BOARD UPDATE: HI SYSTEM AVAILABILTY 13th June 2013

Date: 17th July 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

1. Background

The Trust has two networks one at City and one at Sandwell which is a legacy of the merger of City and Sandwell sites. Under the current configuration there are 7 points of failure in the network. A robust network with resilience and triangulation is essential to our future, the delivery of not only informatics service but the delivery of care to our patients. One of the core deliverables of the 2013/14 HIS Programme is the transfer from the existing network configuration to the new core network.

As part of this process the Trust needs to transfer each cabinet (which the network connections, UPS and power over Ethernet (PoE) switches) from the old network to the new core. As part of this process we are upgrading cabinets, including new PoE switches, wireless access points and cables. To complete this reconfiguration in excess of 100 cabinets will moved and upgraded to meet our planned needs and to provide flexibility with the network to support future service configurations. This is work is being undertaken on a phased approach and out of hours. Without a sustainable infrastructure our future operating model will be flawed.

2. Root cause

On the 13th June 2013 the Trust experienced a network outage as a result of work to configure and migrate network cabinets onto the new core network at Sandwell. An error was introduced into the routing configuration on the new core network which affected Sandwell. This was a result of the engineer deleting the core configuration.

3. Lessons learned

This outage was a result of human error, caused by the engineer deleting the configuration.

There is an agreed method statement for undertaking the upgrade and migration which is reviewed and signed off based upon the needs of each cabinet and upgrade. This is supported by a pre-transfer and post-transfer checklist.

As part of the method statement a second engineer will now provide a “review and confirmation check” prior to the migration from existing to the new core configurations.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – July 2013

A quarter of our financial year is gone. It may be helpful to reflect on our progress as well as on the journey we need to go on over the rest of the year. The 'story' below does not see us falling behind on our teams' prior successes and shows some evidence of improvement where focus has been deployed. Yet we want to pick up the pace of change in Quarters 3 and 4 as we try and bring system to improvements across quality, staff morale, and local service delivery in Medicine and Surgery. A more formal evaluation of Quarter 1 progress against our annual plan will be placed before the Board. We will consider at mid-year our delivery against our long term financial model and long term quality goals.

1. Our patients

We have maintained some important quality improvements throughout the first three months of the year. Notably the reduction in pressure damage delivered in 2012-13 has been sustained. Meanwhile, we remain broadly compliant with our infection control goals, though we have yet to see the improvement in MRSA screening rates that we seek. Improvement has been delivered in June in VTE assessment - for the first time we made the leap to 95% compliance. Our goal remains a ten out of ten model of care such that every inpatient receives a MRSA and pressure risk screen, a nutritional and VTE assessment, as well as consultant input within 12 hours of admission seven days a week. This is a high ambition not widely delivered within the NHS, but is wholly consistent with both best clinical practice and the cultural norms that we want to set in which improvements become systematic in how our departments and wards operate.

This change project demands some underlying fundamentals, of which learning from what we presently do is one of the most important. That is why it is encouraging that our mortality review system is showing good coverage now across the Trust. We undertook to deliver 80%+ during Quarter 2 (July-September - known by November 2013 because of a 42 day lag) and we appear to be on track, under Roger Stedman's leadership, to exceed that aim. The next aim is to ensure that our model of Mortality and Morbidity Review is embedded in each specialty in every part of our Trust through mandatory use of our governance half days to deliver multi-professional learning at a local level.

There is no complacency, and no scope for it. This is illustrated by two issues which will be tackled vigorously. June saw our best Emergency Care performance in over twelve months. July has seen that success maintained at Sandwell and in BMEC, but not at City. Though on ambulance handover data both our A&E departments now lead the city in performance. We believe that we know what works to deliver consistently the four hour minimum standard that our patients have a right to expect. We will work to make sure every shift at City has in place the systems and

the leadership to deliver. The recruitment of four new Emergency Department consultants will assist Trustwide, as will the appointment of Dr Nakash as our new Emergency Care Clinical Director. These steps show that we are determined to prepare to winter 2013, as does the opening of two additional wards through September, and the installation of doors on the bays of our main wards at Sandwell to reduce the risk of infection spread. Meanwhile, the Medical Director has written out across the Trust to draw colleagues' renewed attention to our policies on Do Not Resuscitate orders. It is encouraging that the CQC visit described below saw improvements in our practice and discipline, but the Rule 43 letter received in the Trust earlier in 2013 reminds us that we have more work to do to ensure consistent excellence.

The external assurance visit by the CQC has yet to be formally reported. Informal indications are that the three-day visit to our two acute sites gave considerable evidence to inspectors about inpatient and maternity care quality for adults. There is work to do on documentation in some wards and yet there was praise from inspectors about the attitude and drive of frontline teams to deliver, as well as validation that the matron model in which we invested was paying dividends and that the focus of the Trust's leadership on quality, safety and integrity was widely understood and welcomed.

Technology is an important tool for us in creating consistent practices. We will respond to the latest call for bids nationally, due at end of July, which will fund initiatives to place more data in the hands of patients, and to help us to join up care across organisational boundaries. We consider in today's Board progress towards important Electronic Patient Records decisions. We committed to seek to frame that decision this summer and we should consider what it will take to deliver on that timeframe. I believe that this issue is at least as important a long term enabler of change as service reconfiguration under MMH and we need to avoid a false choice between the two.

2. Our people

The ward team challenge annual event is a key part of the SWBH calendar. It allows multi-professional teams drawn from across the Trust to test their skills, team-working and knowledge against both each other and the expectations set by professional leaders. This year's event maintained the very high standards of prior years. Our stroke service was the overall winner - a service whose improving outcomes for patients we discussed last month at the Board. The departure of our Chief Nurse will not see the traditions of this event lessened, indeed its sustainable impact will be part of Rachel's legacy at the Trust.

Recruitment for the CNO role continues apace. Our selection day is on July 26th and I am confident of an appointment in the days that follow. A wide range of staff and other stakeholders are involved in the process for this important role. Healthwatch forms part of the final interview panel alongside Board leaders and external assessors. An indication of the key role we see for patient representatives in the governance of our organisation.

Over coming weeks, we begin preparation again for the annual staff survey undertaken NHS-wide. In parallel, we begin to deploy our own survey method with our employees, which will be monthly. The intention is that this gives local managers much more "real-time" data on morale, engagement, and attitude. Each will form part of the performance framework we operate corporately and for individual leaders in our organisation over coming years. Whilst obviously local views will reflect wider trends in staff opinion within national terms and conditions, we have cause to believe that good local management and team-working will bring the best results for our patients.

3. Our partners

We are fast approaching the ten year anniversary of 'Right Care, Right Here'. Internally we are marking that event with a renewed emphasis on the opportunity that we have to improve care across our patients' lifetime. Many partners will recognise the story of Maisy, which is retold this month on the front page of our staff newspaper (Heartbeat). Early intervention opportunities were missed by a range of bodies, and Maisy's own sense of how to get what she needed from those agencies was not well-developed. A different approach is needed if we are to create the behaviours needed to create better outcomes from the local health system. That need is evident in the health data we highlight in our health promotion discussion at the Board, as well as in the health economics our system will face - underscored again by recent comments from the outgoing Chief Executive of NHS England.

The 'Right Care, Right Here' Partnership Board met earlier this month. Building on past work, and recognising the impressive coalition in place for regeneration on the Windmill under MMH, we committed ourselves once again to work together to create a model of managed change for local residents. We will focus on long term conditions care and look to introduce substantial changes in the current pattern of outpatient service supported through hospital attendance.

As we know in April much of the external environment of the NHS altered. Part of that is the development of the Academic Health Science Network within the West Midlands, which holds its launch event in coming days. Another key part of the landscape is the LETB and LETC structure in education. I reported last month the success of this Trust in helping to develop the widening participation agenda of the former. Next month we will play our part in the development an overall regional workforce plan to ensure that education commissioning locally meets our longer-term needs; in particular our vision of integrated care across provider boundaries, enabled by technology being fully deployed. Neither presently form natural points of emphasis for provider educational bodies and we want to make both much more fundamental to what we buy as an NHS from educators locally.

4. Our regulators

The CQC visit is referenced above. Our compliance with the Monitor and TDA frameworks is described in the Board's papers. Likewise, today we consider our assurance statements with the new framework set out by the Trust Development Authority earlier this financial year. We need to be confident that our assurance runs Trustwide and has depth within the organisation if we are to support statements of assurance.

As a large organisation we are as strong as the weakest part of our system. It is however of some encouragement that where we do find error we are working quickly to correct it. We will need to retrospectively report single sex compliance breaches in April and May 2013 in our Critical Care units, but the data for June suggests successful action to improve quality of care. Similarly, the strategy of disclosure and action agreed last month for long wait patients under the 18 week pathway is being implemented with large numbers of patients being contacted in writing and supported through our dedicated call centre. It will be important for our Quality and Safety Committee to track in detail through Quarter 3 our incomplete compliance and our outcome form accuracy.

5. 'Hot Topics' - feedback from our senior leaders direct to the Board

The system of monthly participative meetings continues within our Trust. July's 'Hot Topic' is technology and will provide some important feedback for the HIS team as we reflect not only on what systems are valued but on how we best change the use of those systems. In June we discussed the ongoing Transformation Programme. Feedback suggested that in contrast to the prior year, we had successfully reduced anxiety about job losses and employment prospects internally. But we could not yet demonstrate that a culture of continuous improvement had deeply penetrated Trustwide. It is in that context that the Chief Operating Officer is looking to reframe the programme to more evidently support our key levers for change - workforce redesign, technology, and our estate rationalisation programme - whilst providing a more transparent trajectory of skills transfer into local teams. This month 'Hot Topics' was not entirely a CEO-production, with other leaders taking a key part. This is in line with a sustained effort to ensure that the organisation has a broad base of leadership, drawn from clinicians and from across the Executive.

In terms of feedback from that process for the Board, I would highlight more of the same themes from the first quarter of the year. A desire to clarify our long term plans for Rowley Regis and for outpatient services (we would expect to return to the board in October on both points); a concern that technology change is too slow in reaching community based teams (a point perhaps underscored by our patient story two months ago where communication broke down); and a developing sense that we could do even more to create a virtuous circle of local savings and new investments, which is understood widely across our organisation. As we commit the various reserves in line with our May financial plan we will be seeking to draw attention to the decisions made to spend additional funds on patient care and staff well being.

From September the timings of 'Hot Topics' will change to try and encourage greater participation in the process, notably among medical staff. We all want this Trust to be one in which 7500 colleagues know that their voice is heard.

Toby Lewis, Chief Executive – 25 July 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Ratification of Chair's action: application of Trust Seal to s106 documents for Grove Lane site**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager, New Hospital Project Director/Director of Estates**
AUTHOR:	**Graham Seager, New Hospital Project Director/Director of Estates**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

The Trust's Standing Orders require the Board's approval for application of the Trust Seal to a document.

When the outline planning permission for Grove Lane was renewed in June, there was a need to sign updated S106 agreements with Sandwell Council to a timescale that fell outside of the usual Board cycle. As such Chairman's action was granted to allow the Seal to be applied and the documents to be signed.

REPORT RECOMMENDATION:

The Board is asked to approve this Chair's action in retrospect.

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

MMH Project plans

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Board Subcommittee Terms of Reference & Future Governance Model
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Toby Lewis, Chief Executive & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	25 July 2013

EXECUTIVE SUMMARY:

The attached report summarises the plans for operationalising the revised Board governance model agreed by the Board at its last meeting.

Revised Terms of Reference for the Committees are attached for approval, where relevant.

A proposed retiming of the schedule of Board meetings is also outlined, a matter which the Board is asked to approve.

REPORT RECOMMENDATION:

The Trust Board is asked to ACCEPT the report and APPROVE the terms of reference attached and the proposal to change the timing of the Board schedule.

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

Accept	Approve the recommendation	Discuss
	X	

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

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

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

Supports good governance within the Trust

PREVIOUS CONSIDERATION:

Build on discussions held at the Board meeting on 27 June 2013.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

BOARD SUBCOMMITTEE TERMS OF REFERENCE AND FUTURE GOVERNANCE MODEL

Report to the Trust Board – 25 July 2013

At our last meeting we agreed some important changes to how we work as a Board. These were designed to ensure that committees and the Board achieve a better balance of time spent on the future and the present, whilst remaining focused on assurance not direction or decision. Non executive time should be released to support frontline visits and partnership work beyond our organisation. The eight revised subcommittees will operate from September, as agreed, and other meetings have been cancelled. New ones have not yet been diarised for reasons evident below. This note deals with operationalising the arrangements rapidly. To that end:

1. The subcommittee terms of reference have been to those committees that have met in July. Where that has happened and the chair is content, I propose that we approve the revised terms today. Where that has not happened we would target approval in August, aided, in the case of the PHDCE committee by the informal session that preceded this Board meeting. A similar gathering may be merited to discuss the revised role of the Audit Committee and how this will help to ensure that external and internal audit resource, including clinical audit, best serves the needs of a unitary board.

2. In working through the business cycle of a month, a further proposal for change has emerged, which has both my own support and the Chairman's. We will be implementing a data freeze across all forms of monthly information from working day 8. This falls in the second week. I have not seen a Trust better that pace. Given that we want the Board to be reviewing plans arising from the data, we want it to be have progressed smartly through local scrutiny, directorate review, clinical group (the new name for divisions) review, and Executive consideration. Those four stages all add value but need to happen in sequence. Our current timetable demands that they occur between mid-week 2 and late week 3 (or in the case of F&P and Q&S papers even sooner). Therefore in common with a lot of other Trusts, we are suggesting that the Board (effective from January 2014) moves to the first Thursday of the month (i.e. February 6th). This would see papers issued in week 4 (or 5 in a longer month) giving two to three weeks for data scrutiny.

3. Rhythm is important to how an organisation runs. The same things done every week or month bring the capability to make small adjustments on a strong platform. Bearing that in mind we will be changing our performance review cycle so that it happens every two months (alternating corporate departments and Clinical Groups). It will occur in an intense two day period so that we can gather as an Executive the collective implications of the plans of teams. Similarly, we propose that Board subcommittees are organised for the Thursday and Friday in the week before Trust Board, with the exception of Remuneration Committee and Charitable Funds Committee which would be on Board day. This is a very minor change from some current Tuesdays.

4. We are working intensively on the data model that is so important to the revised approach. Colleagues will recall this sees five changes of note:

- the same core data being visible at board, executive and frontline level on a monthly basis (regardless of whether an assurance committee is meeting).
- an integrated performance report will bring together data from across different domains, together with a standard format to how that is presented, rated and action planned. Qualitative commentary from directors will form part of that system.
- that data, from April 2014, being used to inform varied levels of autonomy within the organisation (this framework will return to TB in November for review)
- data at Board being reported consistently in a group taxonomy so that it is easier to see patterns across teams (for Executive review we are doing this at directorate level)
- Committee chairs are being asked to push for scrutiny of the longer term trends and trajectories (LTFM, long-term quality goals, our five year workforce plan etc.)

5. Finally, we are largely through making resultant revisions to the Executive committee structure. The primary decision making body (the Clinical Leadership Executive) meets monthly, with an additional quarterly strategy session, and has now met three times in that form (its efficacy will be externally assessed each October). Supporting this will be the Operational Management Committee and its supporting meetings which coalesce cross group issues (theatres, cancer etc.). In addition each Clinical Group is expected to hold a monthly formal board meeting. And thirteen cross-cutting Executive-chaired committees will be in place which report to CLE. These are decision making meetings intended to speed up the pace of change. They may have short life project groups reporting to them as required. The creation of new committees of longer than six months duration will be subject to gateway review by the Executive Group that I chair. All executive committees will have clear deliverables that they are seeking to achieve rather than merely territory that they monitor. An organogram will begin circulating in August setting this structure, which gives us chance to go through the process of retiring some committees as well as establishing information-sharing forums where these are valued. But equally importantly in September we will publish in Heartbeat a wall-chart style calendar of the meetings for the 18 months ahead, so that all our colleagues can see how this organisation makes our decisions. That is vital to great governance - anyone in our organisation can explain how we make our choices.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

AUDIT AND RISK COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

2. AUTHORITY

2.1 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3. PURPOSE

3.1 The Audit and Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls, corporate governance and financial assurance.

3.2 The Committee will assist the Trust Board with its oversight responsibilities and will independently and objectively monitor, review and report to the Trust Board on the processes of governance, assurance and risk management in place in the Trust and, where appropriate, facilitate and support through its independence the attainment of effective processes.

3.3 In fulfilling its responsibilities, the Audit and Risk Committee will work with the Quality & Safety Committee which has a specific focus on the quality of services provided by the Trust and the governance, risk management and internal control systems to ensure that the Trust's services deliver safe, high quality, patient-centred care.

4. MEMBERSHIP

4.1 The Committee shall comprise not less than three Non-Executive Directors, at least one of which should have recent and relevant financial experience. The Chairman of the Trust shall not be a member of the Committee.

4.2 The Chair of the Committee will be a Non Executive Director and will be recommended by the Chair of the Trust to the Trust Board for approval.

4.3 The Chair of the Trust's Quality & Safety Committee and Finance & Investment Committees should be Non Executive Director members of the Audit and Risk Committee.

4.4 A quorum shall be two members.

4.5 Members should make every effort to attend all meetings of the Committee.

5. ATTENDANCE

5.1 The Director of Finance & Performance Management, Director of Governance, Chief Nurse and appropriate representatives of Internal and External Audit shall generally attend routine meetings at the invitation of the Committee.

5.2 All other Non-Executive Directors shall be welcome to attend and all members of the Trust Board will receive papers to be considered by the Committee.

5.3 Other Executive Directors or any other individual deemed appropriate by the Committee may be invited to attend for specific items for which they have responsibility.

5.4 A representative of the local counter fraud service may be invited to attend meetings of the Committee.

5.5 The last part of each meeting of the Committee will normally be held with the Internal and/or External Auditors and without executive directors present.

5.6 The Trust Secretary shall be the secretary to the Audit and Risk Committee and will provide administrative support and advice.

The duties of the Trust Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers

- Taking the minutes and keeping a record of matters arising and issues to be carried forward

- Advising the Committee as appropriate

6. FREQUENCY OF MEETINGS

6.1 Meetings shall be held at least five times a year (to coincide with key dates in the Trust's financial reporting cycle), with additional meetings where necessary. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

7. REPORTING

7.1 Following each committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Audit and Risk Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

7.2 The Chair of the Committee will provide an oral report to the next Trust Board after each Committee meeting, draw to the attention of the Trust Board any issues that require disclosure to the full Board or require executive action. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters.

7.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to the Committee's work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of compliance with the CQC's Essential Standards of Quality and Safety. In doing so, it will in particular draw on the work undertaken and the assurances gained by the Quality & Safety Committee.

7.4 The Quality & Safety Committee will provide an annual report to the Audit and Risk Committee on the effectiveness of its work and its findings, including its review of the Board Assurance Framework and the Corporate Risk Register and audit reports covering areas within its terms of reference.

7.5 In addition, the Minutes of the latest Quality & Safety Committee meeting will be included on the Audit and Risk Committee agenda for

information and there will be a standing item on the agenda at each meeting for the Chair of the Quality & Safety Committee to report back on the work of that Committee. The Audit and Risk Committee will also receive a regular exception report covering issues escalated from the Risk Management Group. This will assist the Audit and Risk Committee in discharging its responsibility for providing assurance to the Trust Board in relation to all aspects of governance, risk management and internal control within the Trust.

8. REVIEW

8.1 The Terms of Reference should be reviewed by the Committee and approved by the Trust Board annually.

9. DUTIES

Governance, internal control and risk management

9.1 The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the Trust's activities that support the achievement of the organisation's objectives. The Audit and Risk Committee will be assisted in this duty by the Quality & Safety Committee, which will have responsibility for providing assurance in relation to clinical, research and development, and education and training governance and risk management.

9.2 In particular, the Committee will review – either directly or through the work of the Quality & Safety Committee – the adequacy of:

- The Trust's general risk management structures, processes and responsibilities. This will include an annual review of the Trust's Risk Management Strategy and Policy ahead of Trust Board approval.

- All risk and control-related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Essential Standards of Quality and Safety), together with any accompanying Head of Internal Audit Opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board.

- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- Policies for ensuring compliance with relevant regulatory, legal and conduct requirements.

- Policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

- The Trust's arrangements by which staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

9.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, and in particular the Quality & Safety Committee, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

9.4 This will be evidenced through the Committee's use of an effective Board Assurance Framework (BAF) to guide its work and that of the audit and assurance functions that report to it. The full BAF will be received by the Trust Board at least four times a year.

9.5 The Trust's Corporate Risk Register (risks scoring 15 and above) will be reviewed by the Audit and Risk Committee two times a year.

Internal Audit

9.6 The Committee shall ensure that there is an effective Internal Audit function put in place by management that meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the Internal Audit strategy, operational plan and detailed work programme, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework and the recommendations of the Quality & Safety Committee.

- Consideration of the major findings of Internal Audit work and the management response and ensuring coordination between the Internal and External Auditors to optimise audit resources. While the Quality & Safety Committee will lead on the review of audit reports covering patient safety, quality and patient experience,

education and research, the Audit and Risk Committee will receive assurance that they have been carefully reviewed by the Quality & Safety Committee. If there is any perceived ambiguity regarding the relative roles of the Audit and Risk Committee and the Quality & Safety Committee in this respect, the committee chairs will liaise to agree a satisfactory approach.

- Reviewing and monitoring management's responsiveness to auditor's findings and recommendations, assuring itself that the management of the Trust is implementing the agreed recommendations of Internal Audit reports in a timely and effective way.

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of Internal Audit carried out by External Audit. An in-depth review of Internal Audit will be carried out by External Audit on a three-yearly basis.

External Audit

9.7 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit.

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy.

- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- Review of External Audit reports, including agreement of the annual audit letter before submission to the Trust Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses. While the Quality & Safety Committee will lead on the review of external audit reports covering patient safety and quality risk and controls, the Audit and Risk Committee will seek assurance that they have been carefully reviewed by the Quality & Safety Committee.

- Assuring itself that the management of the Trust has implemented the agreed recommendations of External Audit reports in a timely and effective way.

Other assurance functions

9.8 The Audit and Risk Committee shall review as appropriate the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

9.9 In doing this, the Committee may review the work of other committees within the Trust whose work can provide relevant assurance to the Audit and Risk Committee's own scope of work. In particular, the Audit and Risk Committee will look to the assurance provided by the Quality & Safety Committee, which will report annually to the Audit Committee on its work. In reviewing clinical governance arrangements and issues around clinical risk management, the Audit and Risk Committee will wish to satisfy itself on the assurance that can be gained from the work of the Quality & Safety Committee.

Management

9.10 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

9.11 They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

Annual accounts review

9.12 The Audit and Risk Committee shall review the annual statutory accounts before they are presented to the Trust Board, to determine their completeness, objectivity, integrity and accuracy. This review will cover but not be limited to:

- The meaning and significance of the figures, notes and significant changes.
- Areas where judgement has been exercised.
- Changes in, and compliance with, accounting policies and practices.
- Explanation of estimates or provisions having material effect.

- The schedule of losses and special payments.
- Any unadjusted misstatements.
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved.

9.13 The Committee shall review the Annual Report and Annual Governance Statement before they are submitted to the Trust Board to determine completeness, objectivity, integrity and accuracy.

9.14 The Committee shall also ensure that the systems for financial reporting to the Finance and Investment Committee and the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

9.15 The Audit and Risk Committee will review on behalf of the Trust Board the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Scheme of Delegation and Standards of Business Conduct, including the maintenance of registers of interests.

9.16 The Committee will examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

9.17 Specifically, the Committee will receive regular reports on Waivers of Standing Orders and Losses and Special Payments.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY AND SAFETY COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Quality and Safety Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

2. AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Quality and Safety Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Quality and Safety Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

3.1 The purpose of the Quality and Safety Committee is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

3.2 To assure the Board through consultation with the Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health care.

3.3 To assure the Board that where there are risks and issues that may jeopardise the Trust's ability to deliver high quality health care that these are being managed in a controlled and timely way.

3.4 To monitor and ensure that appropriate arrangements are in place for measuring and monitoring clinical quality and the health and safety of patients, service users, visitors and staff.

3.5 Assure the Board that these arrangements are robust and effective, and support the delivery of the strategic objectives.

MEMBERSHIP

3.1 The Committee will comprise of not less than three Non-Executive Directors (including the Trust Chair), the Medical Director, the Chief Nurse, the Director of Finance, the Chief Operating Officer and Director of Governance.

3.2 The Chair of the Trust's Audit & Risk Committee will be a Non Executive Director member of the Quality & Safety Committee.

3.3 The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair. If the Chair is absent from the meeting then another Non-Executive Director shall preside.

3.4 A quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director.

3.5 Members should make every effort to attend all meetings of the Committee.

5 ATTENDANCE

5.1 The Associate Director of Governance, the Head of Clinical Effectiveness and the Assistant Director of Nursing (Quality) will attend the meetings.

5.2 All other Non-Executive Directors shall be welcome to attend and all members of the Trust Board will receive papers to be considered by the Committee.

5.3 Other Executive Directors or any other individuals deemed appropriate by the Committee may be invited to attend for specific items for which they have responsibility.

5.4 Chairs of Governance Committees, Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

5.5 The Trust Secretary shall be secretary to the Committee and will provide administrative support and advice.

The duties of the Trust Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held monthly, with additional meetings where necessary.

7 REPORTING

7.1 Following each committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Quality and Safety Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

7.2 The Chair of the Committee will provide an oral report to the next Trust Board after each Committee meeting.

7.3 The Chair of the Committee shall draw to the attention of the Trust Board and issues that require disclosure to the full Board or require Executive action.

7.4 The Quality and Safety Committee will provide an annual report to the Audit and Risk Committee and Trust Board on the effectiveness of its work and its findings, including its review of the quality-related elements of the Board Assurance Framework and the Corporate Risk Register and audit reports covering areas within its terms of reference.

7.5 Minutes of the Quality & Safety Committee will be included on the agenda of the Audit and Risk Committee agenda for information and there will be a standing item on the agenda at each meeting for the Chair of the Quality & Safety Committee to report back on the work of that Committee.

8 REVIEW

8.1 The terms of reference should be reviewed by the Committee and approved by the Trust Board annually.

9 DUTIES

9.1 To receive a rolling programme of reports on compliance with the Care Quality Commission's Essential Standards of Quality and Safety, grouped by key themes.

9.2 To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified

9.3 To ensure that the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the safety and quality of care

9.4 To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address these. This should include but not be limited to mortality outlier alerts.

9.5 To monitor and review the systems and processes in place in the Trust in relation to Infection Control and to review progress against identified risks to reducing hospital acquired infections.

9.6 To monitor and review the effectiveness of actions to support a safer environment for patients, staff and visitors, including Patient Environment Action Team (PEAT) assessments.

9.7 To review aggregated analyses of adverse events (including serious incidents), complaints, claims, inquests, Rule 43 notifications and litigation to identify common themes and trends and gain assurance that appropriate actions are being taken to address these.

9.8 To receive reports from the Parliamentary and Health Services Ombudsman regarding upheld complaint referrals.

9.9 To have a specific focus on the patient experience, reviewing Trust initiatives to learn more about and improve patient experience and spread best practice.

9.10 To advise the Trust Board on the appropriate quality and safety indicators and benchmarks for inclusion on the Trust quality & performance dashboard and keep these under regular review.

9.11 To monitor performance against external metrics, standards and frameworks set by the Department of Health and National Trust Development Authority

9.12 To monitor performance against a range of internally developed clinical, financial and operational indicators, through routine consideration of the Trust quality & performance dashboard

9.13 To monitor performance in achieving the Trust's quality and safety aims, including those set out in the Trust's Quality & Safety strategy and ensure actions are undertaken in a timely way to address any underperformance against targets.

9.14 To review the Trust's annual Quality Account and make recommendations as appropriate for Trust Board approval.

9.15 To receive clinical presentations based around the key annual priorities linked to the Trust's Quality & Safety Strategy.

9.16 To receive exception reports from Clinical Groups on progress in delivering Quality Development Plans and actions taken to enhance clinical quality and safety, including in response to the findings of internal and external reviews, audits and inspections.

9.17 To review the Internal Audit plan and work programme and to make recommendations, subject to Audit and Risk Committee approval, on the clinical aspects of the Plan.

9.18 To receive and review the findings of the Internal and External Audit reports covering patient safety, quality and experience, to assure itself that the management of the Trust is implementing the agreed recommendations in a timely and effective way. Through its reporting to the Audit and Risk Committee, the Quality and Safety Committee is informed of its work in this area and the levels of assurance received.

9.19 To review the annual clinical audit programmer and receive assurances from Internal Audit (including an in-depth review on a three yearly basis) regarding the effectiveness of the Trust's Clinical Audit function.

9.20 To receive by exception, details of national clinical audits where the Trust is identified as an outlier or potential outlier.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FINANCE AND INVESTMENT COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Finance and Investment Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

2. AUTHORITY

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3. PURPOSE

3.1 The Finance and Investment Committee shall undertake on behalf of the Trust Board objective scrutiny of the Trust's financial plans, investment policy and major investment decisions. The Committee will review the Trust's monthly financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board. Additionally, the Trust Board may request that the Committee reviews specific aspects of financial performance where the Board requires additional scrutiny and assurance.

4. MEMBERSHIP

4.1 The Committee shall comprise three Non-Executive Directors, the Director of Finance & Performance Management, the Chief Operating Officer and the Director of Strategy & Organisational Development.

4.2 The Chair of the Committee will be a Non Executive Director and will be recommended by the Chair of the Trust to the Trust Board for approval.

4.3 A quorum shall be three members, of which there should be at least one Non-Executive Director and one Executive Director.

4.4 Members should make every effort to attend all meetings of the Committee.

5. ATTENDANCE

5.1 Other Executive Directors or any other individual deemed appropriate by the Committee should be invited to attend for specific agenda items for which they have responsibility.

5.2 All other Non-Executive Directors shall be welcome to attend and all members of the Trust Board will receive papers to be considered by the Committee.

5.3 The Trust Secretary shall be the secretary to the Finance & Investment Committee and will provide administrative support and advice.

The duties of the Trust Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6. FREQUENCY OF MEETINGS

6.1 Meetings will normally be held during alternate months, with additional meetings where necessary.

7. REPORTING

7.1 Following each committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Finance & Investment Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

7.2 The Chair of the Committee will provide an oral report to the next Trust Board after each Committee meeting.

7.3 The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or require Executive action.

7.4 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

8. REVIEW

8.1 The terms of reference should be reviewed by the Committee and approved by the Trust Board annually.

9. DUTIES

9.1 Scrutinise the development of the Trust's annual financial plan and long-term financial strategy and plan (both revenue and capital plans), including the underlying assumptions and methodology used, ahead of review and approval by the Trust Board.

9.2 Review the Trust's monthly financial performance (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust Board, ensuring that the narrative links to implications of compliance with the shadow FT licence, in particular the financial risk rating and other licence conditions

9.3 Review at the request of the Trust Board specific aspects of financial performance where the Board requires additional scrutiny and assurance.

9.4 Conduct an annual review of service line reporting and discuss the implications for potential investment or disinvestment in services.

9.5 To consider the annual reference costs information, prior to submission

9.6 Approve and keep under review, on behalf of the Trust Board, the Trust's investment and borrowing strategy and policies.

9.7 To review proposals to enter into material contracts or service level agreements for the supply or services from financial and legal perspectives and to review the financial outcome of material contracts & SLAs.

9.8 Evaluate, scrutinise and recommend to the Trust Board for approval, the financial validity of major individual investment decisions, including, where appropriate, the review of Outline and Final Business Cases. Business cases will usually be referred to the Committee following initial review by an appropriate Executive body. The following investment decisions shall be subject to review by the Committee:

- All capital schemes (including leased assets and property) with an investment value in excess of £1 million.

- All revenue investment proposals with a cost implication in excess of £3 million over three years (or the equivalent for New Hospitals service variations in line with the Scheme of Delegation set out in Standing Financial Instructions).
- All proposed asset disposals where the value of the asset exceeds £1 million.

9.9 Review post-implementation investment evaluations undertaken by or on behalf of the Trust. These should be carried out 12 months after business case approval.

9.10 Monitor compliance with treasury policies and procedures.

9.11 To periodically consider changes required to the Trust's Standing Financial Instructions due to structural changes within the Trust, developments in the Monitor regime and the wider statutory/regulatory framework

9.12 Examine any matter referred to the Committee by the Trust Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

THE CONFIGURATION COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Trust Board hereby resolves to establish a Committee of the Board to be known as the Configuration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

2 AUTHORITY

2.1 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Trust Board to secure the attendance of individuals, special advisers and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3 PURPOSE

3.1 The Configuration Committee will undertake on behalf of the Trust Board to provide leadership and strategic direction to support the project to establish the Midland Metropolitan Hospital, making recommendations to the Trust Board on key project decisions when required.

3.2 It will maintain an overview of the 'Right Care, Right Here' (RCRH) Community Facilities Programme through receipt of regular reports to ensure that dependencies are managed effectively.

3.3 The Committee with provide oversight and assurance to the Board, of the reconfiguration changes across the identified services, ensuring that a Trustwide approach is adopted, and that in conjunction with the relevant external parties, project management is in line with Department of Health guidance and OGC gateway requirements.

4 MEMBERSHIP

4.1 The Committee shall comprise three Non Executive Directors, the Chief Executive, the Director of Estates/New Hospital Project, the Chief Operating Officer, the Director of Strategy & Organisational Development, the Director of Finance & Performance Management and the Medical Director.

4.2 The Chair of the Committee will be the Trust Chairman. In the absence of the Chairman, another Non Executive Director shall preside.

4.3 A quorum shall be four members, of which there shall be one Non Executive Director and one Executive Director.

4.4 Members should make every effort to attend all meetings of the Committee.

5 ATTENDANCE

5.1 The MMH Project Manager and RCRH Redesign Director will attend the meetings.

5.2 A representative from the local Clinical Commissioning Group (CCG) will be invited to attend meetings.

5.3 All other Non-Executive Directors shall be welcome to attend and all members of the Trust Board will receive papers to be considered by the Committee.

5.4 Other Executive Directors or any other individuals deemed appropriate by the Committee may be invited to attend for specific items for which they have responsibility.

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held during alternate months, with additional meetings arranged where necessary.

7 REPORTING

7.1 Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

7.2 The Chair of the Committee will provide an oral report to the next Trust Board after each Committee meeting.

7.3 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

7.4 The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or require escalation.

8 REVIEW

8.1 The terms of reference should be reviewed by the Committee and approved by the Trust Board annually.

9 DUTIES

9.1 Monitor development of the long term financial model (LTFM) and business case to facilitate Trust Board sign off prior to submission for approval at each stage.

9.2 Ensure active engagement with Clinical Commissioning Groups (CCGs), Trust Development Agency (TDA), Department of Health (DH), Monitor and HM Treasury (HMT) throughout the MMH project to support timely approvals at each stage.

9.3 Oversee preparation for the Competitive Dialogue (CD) process ensuring that best practice will be carried out in line with EU regulations.

9.4 Facilitate Trust Board approval of MMH project procurement documents by providing robust assurance and guidance as required.

9.5 Approve MMH and reconfiguration project plans and monitor progress against plan.

9.6 Approve MMH and reconfiguration project budgets and monitor expenditure against plan.

9.7 Consider and escalate risks to the Corporate Risk Register as they arise to ensure successful delivery of the project and reconfigurations.

9.8 Ensure relationships with key stakeholders are well managed to maintain positive support for the MMH Project and reconfigurations, including consultation where necessary.

9.9 Maintain awareness of how the broader political, economic and policy context may affect the MMH project and reconfigurations to ensure continuing alignment.

9.10 Undertake a continuous review of performance against the agreed activity and capacity model and clinical service model that underpins the MMH business case in order to provide assurance to the Trust that progress is in line with expected trajectories.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

WORKFORCE AND ORGANISATIONAL DEVELOPMENT ASSURANCE COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Workforce and Organisational Development Assurance Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Workforce and Organisational Development Assurance Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Workforce and Organisational Development Assurance Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

3.1 The Committee will enable the Board to obtain assurance that the Trust has the organisational capacity and capability to achieve the Trust's vision/strategic objectives and the right people with the right skills and values in the right places at the right time and, in particular, that adequate and appropriate workforce governance structures, processes and controls are in place throughout the Trust:

3.1.1 To improve the effectiveness, efficiency and capability of the Trust over the long term with special regard to workforce matters.

3.1.2 To promote and ensure a culture in which high quality staff deliver high quality safe patient care;

4. MEMBERSHIP

4.1 The Committee will comprise of two Non-Executive Directors, the Chief Executive, the Executive Lead for Workforce, Director of Strategy and Organisational Development and the Chief Operating Officer together with relevant Senior Trust staff:

- Deputy Director of Workforce (Operations)

4.2 The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair. If the Chair of the Committee is absent from the meeting then another Non-Executive Director shall preside

4.3 A quorum will be 4 members, of which there must be at least one Non-Executive Director and one Executive Director.

4.4 Members should make every effort to attend all meetings of the Committee.

5. ATTENDANCE

5.1 Trust Board members, who are not members of the Committee, may attend for all or part of the meeting by prior agreement with the Chair of the Committee.

5.2 Chairs of subgroups, Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

5.3 The Executive Assistant for the Director of OD & Strategy shall be secretary to the Committee and will provide administrative support. The duties of the Executive Assistant in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward

6. FREQUENCY OF MEETINGS

6.1 Meetings will be held ~~bi-monthly~~ quarterly, with additional meetings as necessary.

7. REPORTING

7.1 Following each committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Workforce & OD Assurance Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

7.2 The Chair of the Committee will provide an oral report to the next Trust Board after each Committee meeting.

7.3 The Chair of the Committee shall draw to the attention of the Trust Board and issues that require disclosure to the full Board or require Executive action.

7.4 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

8 REVIEW

8.1 The Terms of Reference should be reviewed by the Committee and approved by the Trust Board annually.

9 DUTIES

9.1 In particular, in respect of general governance arrangements:

9.1.1 To ensure that all statutory elements of workforce governance are adhered to within the Trust;

9.1.2 To agree Trust-wide workforce and organisational development priorities and give direction to the Trust's services and divisions;

9.1.3 To agree Trust-wide priorities for learning and development activity (including leadership development)

9.1.4 To ensure that strategies and plans are in place to ensure effective staff communication and to maintain and increase levels of staff engagement

9.1.5 To approve workforce and employment policies and procedures, ensuring that they support the delivery of the Trust's strategic objectives and are in line with relevant legislation and best practice;

9.1.6 To foster links with RCRH Partners, Sandwell and West Birmingham CCG, West Midlands Local Education and Training Board (LETB) and the Black Country Local Education Training Council (LETC), trade unions and other stakeholders as appropriate.

9.1.7 To receive and approve the annual work programme and plans for implementing the Trust's Workforce and OD Strategies (including strategic workforce planning, human resources management, learning and development and leadership development) ensuring consistency with the delivery of the Trust's strategic objectives;

9.1.8 To approve the Terms of Reference and membership of its reporting sub- committees (as may be varied from time to time at the discretion of the Workforce and Organisational Development Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the Committee in the sub-committees' Terms of Reference for consideration and action as necessary;

9.1.9 To consider matters referred to the Workforce and Organisational Development Committee by the Board;

9.1.10 To consider matters referred to the Workforce and Organisational Development Committee by its sub-committees;

9.2 In respect of Workforce and OD performance and assurance, in particular:

9.2.3 To ensure that internal standards and best practice are set and monitored

9.2.4 To ensure the most effective and efficient use of human resources through evidence-based and best practice;

9.2.5 To ensure that workforce and employment risks are minimised through the application of a comprehensive assurance and governance system including, without limitation:

- to review the Trust's Workforce and OD Strategies prior to their presentation to the Board of Directors for approval;
- to receive reports from the Trust's Senior Workforce and OD leads;
- to identify areas of significant workforce risk, set priorities and place actions using the Board Assurance Framework;

- to ensure the Trust incorporates the recommendations from external bodies as well as those made internally e.g. in connection with serious incident reports and adverse incident reports relating to employment practices and staffing issues, into practice and has mechanisms to monitor their delivery;
- to maintain and monitor the Trust's Human Resources policies and procedures;
- to ensure those areas of workforce risk within the Trust are regularly monitored and that effective contingency plans are in place;
- to ensure implementation of the effective workforce assurance methodologies including the TDA Workforce Assurance Tool
- to assure that there are processes in place that safeguard the health, safety and wellbeing of staff within the Trust; and
- to escalate to the Executive Team and/or Board any identified unresolved risks arising within the scope of these Terms of Reference that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

9.2.6 To agree the NHS Staff Survey action plan and monitor progress

9.2.7 To assure that the Trust has reliable, up-to-date workforce information so as to aid decision making, workforce planning and development and identify areas for improvement and ensure that these improvements are effected

9.3 In particular, in respect of efficient and effective use of human resources through evidence-based and best practice:

9.3.3 To agree the annual Workforce priorities and monitor progress;

9.3.4 To ensure that the Trust's approach to workforce planning and development, learning and development and human resources management (including leadership development, staff engagement and staff recognition) is based on evidence of best practice/national guidance;

9.3.5 To ensure that there is an appropriate process in place to monitor and promote compliance with Trust HR policies, procedures and processes ;

9.3.6 To assure the implementation of all new procedures and processes according to Trust policies;

9.3.7 To review the implications of changes in national policy and new directives and to endorse, approve and monitor the internal action plans arising from them;

9.3.8 To monitor trends in organisational effectiveness and human resources performance and commission actions in response to adverse trends where appropriate;

9.3.9 To generally monitor the extent to which the Trust meets the workforce requirements of commissioners and external regulators;

9.3.10 To identify and monitor any gaps in the delivery of the Trusts OD and workforce programmes ensuring progress is made to improve these areas;

9.3.11 To ensure that audits and reviews are prioritised, recorded, appropriately completed and action is taken to implement and sustain change

9.3.12 To ensure that there is an appropriate mechanism in place for action to be taken in response to the results of any relevant external reports (e.g. from the Care Quality Commission);

9.3.13 To oversee the processes within the Trust to ensure that appropriate action is taken in response to workforce planning risks, adverse employment trends, complaints and litigation and that examples of good practice are disseminated within the Trust and beyond if appropriate;

9.3.14 To ensure that where human resources practice is of high quality, that practice is recognised and propagated across the Trust; and

9.3.15 To ensure the Trust is outward- looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

9.3.16 To ensure the Trust has a realistic and relevant training and development plan.

9.3.17 To monitor spending on training and development activity.

9.3.18 To ensure the Trust influences the LETC and LETB to ensure appropriate staff training commissions and fair share of innovation funding.

9.3.19 To monitor all education monies via the Learning Development agreement.

9.3.20 To monitor the work of the Trust education faculty and Learning Works.

9.3.21 To monitor the Trusts Widening Participation Programme.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

PUBLIC HEALTH, COMMUNITIES AND EQUALITIES COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Public Health, Communities and Equalities Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

2 AUTHORITY

2.1 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

2.2 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3 PURPOSE

3.1 The Public Health, Communities and Equalities Committee will assure the Trust Board that the Trust is meeting its strategic objectives with regards to health inequalities, diversity and human rights, including but not limited to the establishment of a single equalities scheme covering service delivery, employment and compliance with the 2010 Equality Act and other national legislations.

3.2 The Public Health, Communities and Equalities Committee will oversee an ambitious agenda to generate a profound improvement in closing the health inequalities gap in Sandwell and West Birmingham, with a real commitment to engage a broad range of partners/stakeholders in this purpose.

3.3 The Committee will prioritise its work programme under the following themes:

- Better health outcomes and reduced inequalities
- Patient access and experience
- Staff health and wellbeing
- Our role as a partner within the local economy

4 MEMBERSHIP

4.1 The Committee shall be appointed by the Trust Board and be composed of:

- Not less than two Non Executive Directors
- Chief Nurse
- Chief Operating Officer
- Director of Strategy and Organisational Development
- Medical Director
- Clinical Lead for Prevention

4.2 The Chair of the Committee will be a Non Executive Director and will be recommended by the Chair of the Trust to the Trust Board for approval.

4.3 A quorum shall be three members, at least one of whom should be a Non Executive member of the Trust Board and at least one of whom should be an Executive Director.

4.4 Members should aim to attend all meetings of the Committee.

5 ATTENDANCE

5.1 Other Executive Directors and other individuals deemed appropriate by the Committee should be invited to attend for specific agenda items for which they have responsibility.

5.2 All other Non Executive Directors shall be welcome to attend and all members of the Trust Board will receive papers to be considered by the Committee.

5.3 The Trust Secretary shall be the secretary to the Public Health, Communities and Equalities Committee and will provide administrative support and advice.

The duties of the Trust Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers

- Taking the minutes and keeping a record of matters arising and issues to be carried forward

- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held three times a year.

7 REPORTING

7.1 Following each committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Public Health, Communities and Equalities Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

7.2 The Chair of the Committee will provide an oral report to the next Trust Board after each Committee meeting.

7.3 The Chair of the Committee shall draw to the attention of the Trust Board and issues that require disclosure to the full Board or require Executive action.

8 REVIEW

8.1 The Terms of Reference should be reviewed by the Committee and approved by the Trust Board annually.

9 DUTIES

9.1 To guide and oversee the Trust's approach to reducing health inequalities and promoting equality, diversity and human rights to support the delivery of the Trust's strategic objectives and the effective implementation of the organisation's values and behaviours. To monitor progress and receive assurance on the implementation of the Trust's Public Health Vision and the identified public health priorities being focused on.

9.2 To monitor national legislation and guidance on equalities and diversity and gain assurance that the Trust is compliant with all such requirements.

9.3 To monitor progress on the implementation of the Trust's Equality Delivery System, including the Single Equalities Scheme, and the achievement of key

performance indicators, including effectively communicating progress both internally and externally.

9.4 To monitor the progress of the Trust's Clinical Directorates in developing and delivering schemes and initiatives to address health inequalities and promote better health outcomes for all.

9.5 To review the effectiveness of the Trust's equalities and diversity training and equality impact assessment and screening processes.

9.6 To seek assurance that the Trust's services are accessible to all and designed and operated to meet the diverse needs of patients and members of the public.

9.7 To seek assurance that staff and potential employees of the Trust are treated with dignity and respect irrespective of their protected characteristic as defined by the Equality Act 2010 and the Human Rights Act 1998.

9.8 To monitor compliance with the Care Quality Commission's Essential Standards of Quality and Safety with regard to equality, diversity and human rights (specifically Outcomes 1, 4, 7, 12 and 17).

9.9 To review patient, staff and stakeholder feedback, including survey responses, incidents and complaints, related to equality and diversity issues and ensure that appropriate learning is undertaken and embedded.

9.10 To support the development of links with community groups around health inequalities and inequalities in service delivery and opportunity of employment.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REMUNERATION AND TERMS OF SERVICE COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Remuneration and Terms of Service Sub Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

2 AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3 PURPOSE

3.1 The purpose of the Committee is to advise the Trust Board on the terms and conditions of employment, including the remuneration packages, for the Chief Executive and the Executive Directors. The Committee will take due account of any National policy and/or guidance.

4 MEMBERSHIP

4.1 The Committee will comprise of all the Non Executive Directors of the Trust.

4.2 The Trust Chairman will chair the Committee. If the Chair is absent from the meeting then another Non Executive Director shall preside, which shall be the Vice Chair if present.

4.3 A quorum will be either the Trust Chair or the Vice Chair and two other Non-Executive Directors.

4.4 Members should make every effort to attend all meetings of the Committee.

5 ATTENDANCE

5.1 The Chief Executive will attend for all relevant discussions of the Committee other than those relating to the Chief Executive's own remuneration and terms and conditions of employment.

5.2 Other Executive Directors may be in attendance to provide appropriate advice as required by the Committee.

5.3 The Trust Secretary shall be secretary to the Committee and will provide administrative support and advice. The duties of the Trust Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 The Committee shall meet quarterly. The Trust Chair will call additional meetings when considered necessary.

7 REPORTING

7.1 Following each meeting of the Committee, the minutes will be drawn up and submitted to the Chair in draft format. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board. The draft minutes will be presented at the next Remuneration and Terms of Service Committee at which the person presiding will sign them.

8 REVIEW

8.1 The terms of reference of the Committee shall be reviewed by the Board annually.

9 DUTIES

9.1 The main duties of the Committee are as follows:

9.1.1 To recommend the remuneration and terms of conditions of employment for the Chief Executive and the Executive Directors

9.1.2 To recommend the remuneration and terms and conditions of employment for any employees who are not subject to national terms and conditions of service.

9.1.3 To scrutinise and agree any termination payments made to the Chief Executive and Executive Directors

9.1.4 To ensure the consistent application of the Trust policy on remuneration and terms and conditions of employment for the Chief executive and the Executive Directors.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

CHARITABLE FUNDS COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Charitable Funds Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

2 AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considered this necessary for or expedient to the exercise of its functions.

3 PURPOSE

3.1 The Committee shall provide the Board with a means of independent and objective review of the Trust's management of assets donated or bequeathed to the Trust's Charitable Funds, including in particular the arrangement made to invest the assets.

4 MEMBERSHIP

4.1 The Committee will comprise of six voting members of the Trust Board (the Trustees), who shall take responsibility for discharging the duties of the Trustees.

4.2 The Chair of the Committee will be a Non-Executive Director and will be recommended by the Chair of the Trust to the Trust Board for approval.

4.3 The quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director.

4.4 members should make every effort to attend all meetings of the Committee.

5 ATTENDANCE

5.1 The Head of Communications & Engagement and the Head of Fundraising will attend the meetings.

5.2 All other Trustees shall be welcome to attend and all Trustees will receive papers to be considered by the Committee.

5.3 Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

5.4 The Trust Secretary shall be secretary to the Committee and will provide administrative support and advice. The duties of the Trust Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be quarterly with additional meetings as necessary.

7 REPORTING

7.1 Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

7.2 The Chair of the Committee will provide an oral report to the next Trust Board after each Committee meeting.

7.3 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

7.4 The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or require escalation.

8 REVIEW

8.1 The terms of reference shall be reviewed of the Committee by the Committee and approved by the Board annually.

9 DUTIES

9.1 On behalf of all members of the Trust Board (being the Trustees in law under the terms of the Charities Acts) the Committee will:

9.1.1 Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.

9.1.2 Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds.

9.1.3 Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds.

9.1.4 Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds.

9.1.5 Together with such Brokers, recommend the investment strategy for such funds.

9.1.6 To receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds, prior to submission and to review the regular investment reports supplied by the Trust's brokers.

9.1.7 Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance.

9.1.8 Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds

9.1.9 To consider charitable fundraising for the new hospital

9.1.10 In accordance with the Scheme of Delegated Authority and authorisation limits, (see Standing Orders and Standing Financial Instructions) to consider all business cases involving the use of Charitable Funds prior to any required consideration by the Trust Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Provider Management Regime Return
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy & Organisational Development & Kam Dhami, Director of Governance
AUTHOR:	Mike Harding, Head of Performance Management & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	25 July 2013

EXECUTIVE SUMMARY:

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

The organisational risk ratings as reported for June 2013 are as follows:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	GREEN
Financial Risk Rating (Assign number as per SOM guidance)	3

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	X	Workforce	X

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Committee on 16 July 2013.

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
June 2013
NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each

NHS Trust Governance Declarations : 2013/14 In-Year Reporting

Name of Organisation:	Sandwell & West Birmingham Hospitals NHS Trust	Period:	June 2013

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	G
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	3

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

The Board is sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

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

Governance declaration 2

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by :	TO BE ADDED	Print Name :	Toby Lewis
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	
Signed by :	TO BE ADDED	Print Name :	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:	Chairman	

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**The Trust year to date is underperforming against Emergency Care target**
Action :	**An agreed trajectory to achieve compliance with this target by the end of Q2 is in place**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

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June 2013

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

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

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO	**TO BE ADDED**	**Toby Lewis**	**25/07/2013**
Chair	**TO BE ADDED**	**Richard Samuda**	**25/07/2013**

QUALITY

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Board Action
1	SHMI - latest data	Score	96.8	96.2	96.0	96.3	95.3	94.2	95.6	94.9	94.4	94.2	94.3	95.5	SHMI data relates to period March 2012 - February 2013 which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	91.4	87.5	91.0	91.5	91.7	90.2	91.5	91.0	86.1	90.8	92.5	95.3	
3a	Elective MRSA Screening	%	42.0	39.5	38.7	104.6	96.2	112.0	130.9	193.6	138.9	196.6	173.2	196.9	Data reported is screens not matched with patients. Screens matched to patients for the month is 67.2%.
3b	Non Elective MRSA Screening	%	68.0	69.1	66.1	66.0	78.6	78.4	80.7	82.3	76.8	79.2	82.2	81.3	Data reported is screens not matched with patients. Screens matched to patients for the month is 74.5%.
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	161	114	2	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	10	4	2	3	1	2	0	4	2	5	9	8	This includes any ward closures, grade 3 or 4 pressure sores, serious injuries following fractures and infection control issues.
6	"Never Events" occurring in month	Number	1	0	1	0	0	0	0	0	0	0	0	1	Never event reported during June relates to wrong lens being implanted in Ophthalmology.
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	14	9	10	8	5	4	3	10	10	5	5	3	3 open alerts. Spinal / Epidural needles remain a manufacturing problem. 1 alert under review.
9	RED rated areas on your maternity dashboard?	Number	4	3	3	2	4	4	2	2	3	2	3	1	June - Midwifery Staff Sickness Absence (7.2%).
10	Falls resulting in severe injury or death	Number	1	2	6	0	2	2	1	2	2	3	2	5	
11	Grade 3 or 4 pressure ulcers	Number	2	3	3	1	1	6	1	2	2	2	1	1	The pressure sore reported is being investigated so it is unknown if it is avoidable or not at this stage.
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.6% in June (3075 records compliant of 3087 total). All list and individual checklists are checked for completeness by staff at the end of the session and then entered onto a database.
13	Formal complaints received	Number	62	79	56	62	68	38	60	70	57	63	59	50	
14	Agency as a % of Employee Benefit Expenditure	%	1.9	2.2	1.8	2.3	2.45	2.91	2.62	4.57	6.41	4.29	4.28	2.6	
15	Sickness absence rate	%	4.16	4.10	4.18	4.51	4.47	4.58	4.86	4.42	4.55	4.36	4.01	3.94	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	71	79	84	83	87	86	88	81	77	77	78	77	These figures indicate the percentage of Consultant Appraisals that were completed at that time without reference to completed PDPs which are seen as a more dynamic document.

FINANCIAL RISK RATING

Sandwell & West Birmingham Hospitals NHS Trust

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	Note April technical adjustment no longer required following NTDA advice
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	4	4	4	4	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	3	3	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	Includes effect of assumed working capital facility.
Weighted Average		**100%**						**3.4**	**3.4**	**3.4**	**3.4**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

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

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

FINANCIAL RISK TRIGGERS

Sandwell & West Birmingham Hospitals NHS Trust

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

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	No	No	
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No	No	No	
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Escaltion processes in place and reported to Finance Committee which is monitoring progress.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No	No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No	No	No	
9	Capital expenditure < 75% of plan for the year to date	No	No	No	Yes	Yes	Yes	Yes	Updated programme plans have been requested from programme leads.
10	Yet to identify two years of detailed CIP schemes	Yes	No	No	No	No	No	No	

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	Yes	Yes	Yes	Yes	Yes	Yes	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		No	Yes	Yes	Yes	Yes	Yes	Yes	
			Patients dying at home / care home	50%		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	May 2013 performance confirmed from National Cancer Waiting Times system report. June performance projected.
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	May 2013 performance confirmed from National Cancer Waiting Times system report. June performance projected.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	May 2013 performance confirmed from National Cancer Waiting Times system report. June performance projected.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	May 2013 performance confirmed from National Cancer Waiting Times system report. June performance projected.
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No	Yes	No	Performance in June was 95.5% and 94.10% for the Quarter.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0								
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	There was 1 case of post 48 hour MRSA Bacteraemia (contaminant) reported during April.
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	No	No	No	No	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
			TOTAL			**2.0**	**1.0**	**1.0**	**1.0**	**1.0**	**0.0**	**1.0**	
						AR	AG	AG	AG	AG	G	AG	

RAG RATING :

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score greater than or equal to 1, but less than 2**
AMBER / RED	**= Score greater than or equal to 2, but less than 4**
RED	**= Score greater than or equal to 4**

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

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

			Historic Data			Current Data				
Overriding Rules - Nature and Duration of Override at SHA's Discretion										
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters								
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.								
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter								
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.								
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter								
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter								
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter								
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.								
		Adjusted Governance Risk Rating	**2.0**	**1.0**	**1.0**	**1.0**	**1.0**	**0.0**	**1.0**	
			AR	AG	AG	AG	AG	G	AG	

CONTRACTUAL DATA

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

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

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes	Yes		
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes		
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	No	No	No	No		
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes		
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No		
6	Might the dispute require third party intervention or arbitration?	No	No	No	N/a	N/a	No		
7	Are the parties already in arbitration?	No	No	No	N/a	N/a	N/a		
8	Have any performance notices been issued?	Yes	Yes	Yes	No	No	Yes		RTT Performance in T&O and Plastic Surgery and Mixed Sex Accommodation Breaches.
9	Have any penalties been applied?	Yes	Yes	Yes	No	No	No		

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Jul-13

Sandwell & West Birmingham Hospitals NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Board Action
1	Draft IBP and LTFM submitted	Aug-11	Fully achieved in time		
2	Assess and challenge IBP/LTFM	Sep-11	Fully achieved in time		
3	HDD stage 1	Dec-11	Fully achieved in time		
4	8 week public engagement completed	Mar-12	Fully achieved in time		
5	First cut Quality Governance self-assessment	May-12	Fully achieved in time		
6	BGAF process	Sep-12	Fully achieved in time		
7	Submit IBP/LTFM to SHA for review	Sep-12	Fully achieved in time		
8	Final cut Quality Governance self-assessment	Sep-12	Fully achieved in time		
9	Submission of key FT application documentation for review	Sep-12	Fully achieved in time		
10	External validation of final Quality Governance sef-assessment	Oct-12	Fully achieved in time		
11	FT readiness review with SHA	Oct-12	Fully achieved in time		
12	Final IBP/LTFM - SHA submission	Nov-12	Fully achieved but late		Agreed with SHA not to submit at this stage pending further discussion on TFA milestones.
13	BGAF validation	Nov-12	Fully achieved in time		
14	Board able to certify compliance with IG toolkit	Dec-12	Fully achieved but late		
15	SHA approval review	Dec-12	Fully achieved but late		Agreed with SHA pending further discussion on TFA milestones
16	HDD Stage 2	Dec-12	Fully achieved in time		
17	SHA FT quality assessment	Jan-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
18	Final submission of all key outstanding documentation to SHA	Jan-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
19	Final SHA Board to Board	Feb-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
20	Submission of FT application to DH	Mar-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
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Notes

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

Notes

Ref	Indicator	Details
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 21 June 2013; 1030h – 1330h

Members Present

Ms O Dutton [Chair]
Mrs G Hunjan
Dr S Sahota OBE
Miss R Overfield
Dr R Stedman
Miss R Barlow [Part]
Miss K Dhami
Mrs D Talbot

In Attendance

Ms A Binns

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Richard Lilford and Simon Parker.	
2 Minutes of the previous meeting	**SWBQS (5/13) 085**
The minutes of the Quality and Safety Committee meeting held on 24 May 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 (5/13) 085 (a)**
The updated actions list was noted by the Committee.	
3.1 Progress with finalising Medicine & Emergency Care division's TSP	**Verbal**
Dr Stedman advised that there was little further to report in terms of conducting quality impact assessment of the Medicine & Emergency Care division's TSP. It was highlighted that savings were still forecast, a proportion of which were associated with a reduction in the use of medical staffing, with other savings anticipated from	

a review of some of the division's specialities. Ms Dutton asked for clarification as to the reasons for the delay in constructing the plan. Miss Barlow advised that this was linked to the team's present capacity and capability, however she reassured the Committee that there was no activity progressing at present which was in an uncontrolled manner. Ms Dutton underlined the need for measures to be implemented to prevent a reoccurrence in 2014/15. Mr Lewis advised that the recurrent basis shortfall needed to be addressed and would be considered in the forthcoming month.	
MATTERS FOR DISCUSSION/DEBATE	
4 Update on 'Winter 2013 Must Be Better' programme	**Hard copy**
Miss Barlow updated the Committee on the progress with the 'Winter 2013 Must Be Better' programme, presenting the key highlights of the Urgent Care Scorecard. It was highlighted that there had been a sustained improvement against the ambulance waiting times target, a position which had been assisted by a joint performance meeting with West Midlands Ambulance Service. The Committee was asked to note that the number of instances that a patient had waited an excessively long time before being seen had reduced. The Committee was advised however, that the number of non-admitted patients discharged within two hours of arrival was currently less than 50% in both Emergency Departments therefore focus was being directed to implementing single triage and a rapid access and treatment service (RATS). It was highlighted that much preparation was underway for this as it represented a significant change for the organisation. Ms Dutton asked what measures were being used to ensure that no unintended consequences arose as a consequence of the plans. She was advised that re-attendances were being monitored. Mr Lewis advised that the re-attendance rate appeared high at present, although the position would be benchmarked against that of a number of other organisations and measures would be taken to reduce the levels. Miss Overfield added that patient satisfaction scores would also be reviewed as part of the work. Mrs Talbot advised that there were a significant number of patients who attended with regularity and suggested that handling this group should be tied into the plan to treat patients with mental health issues. Dr Sahota asked whether the group of re-attendances concerned patients attending within 30 days or for a different period. Mr Lewis advised that this would be determined. Ms Dutton asked whether the Trust was an outlier in terms of collecting patient satisfaction data in the Emergency Departments. He was advised that this was not the case and that the lack of data at present reflected that the 'tally boxes' used to register patient views had only been implemented in April 2013. Dr Sahota suggested that volunteers could be used in the area to prompt patients to register their views. Miss Overfield advised that this was already undertaken, however she asked the Committee to note that coverage by volunteers was largely limited to the working day period. Miss Barlow advised that a recruitment plan for nursing staff into Accident & Emergency was in place and that interviews for consultant positions was planned for 11 July 2013.	

It was reported that a number of follow up meetings with Sandwell Social Services were planned, in addition to a meeting of the Urgent Care Network. Dr Sahota encouraged the position concerning the provision of services from Social Services be kept under review given the ongoing funding adjustments. He was advised that good dialogue was being held with the Local Authorities. Mr Lewis advised that in May, 44 people waited 48 hours for emergency surgery. Miss Barlow acknowledged that this was the case and agreed to provide an update on the reasons behind this position and the plan to address it at the next meeting. Miss Barlow left the meeting.	
ACTION: **Miss Barlow to identify within what period A & E re-attendances are reported e.g. 30 days after first attendance** **ACTION:** **Miss Barlow to provide an update on plans to address waiting times of up to 48 hours for patients requiring emergency surgery**	
5 Infection Control matters	**SWBQS (6/13) 090** **SWBQS (6/13) 090 (a)**
Miss Overfield presented a summary of the 'critical friend' review findings of Infection Control practice at the Trust. It was highlighted that the review had determined that the biggest issues concerned the ability to isolate and cohort patients. The Committee was advised however, that agreement had been reached to add doors to all ward bays at Sandwell Hospital which would assist with the position. It was reported that ensuite facilities would not be introduced, however the use of some mobile hand basins would be implemented. Mrs Hunjan asked whether these measures would influence the number of beds in the Trust. She was advised that this was not the case, however the use of these doors would prevent the need for entire wards to be closed to admissions and for cleaning by allowing robots to be used in single bays. The Committee was advised that at the recent meeting of the 'new' Trust Management Board, it had been agreed that non-clinical functions should be removed from ward areas. New policies and protocols covering the operation of the wards were reported to be under development, ready for approval in August 2013. The introduction of a seven-day microbiology service was reported to be subject to the development of an investment proposal to be agreed by the Investment Advisory Panel and 'new' Trust Management Board. Miss Overfield reported that the proposal to introduce a Trustwide uniform and a managed laundry service had been suggested as part of a recent 'Listening into Action' event. Ms Dutton asked whether the Executive Group would wear a uniform if the proposal to adopt a Trustwide uniform was approved. Mr Lewis advised that this, together with a number of considerations, would be thought through as part of the implementation plans for the proposal. Miss Overfield highlighted that there was no evidence to suggest that travelling to and from work in uniform delivered better infection control outcomes. It was reported that the need for better changing facilities had also been identified.	

Mr Lewis advised that in terms of the refurbishment of the Trust's operating theatres, Estates had prepared a plan which included a number of options that required further discussion. It was reported however, that it was likely that the work would be undertaken during the Christmas shut down period. Ms Dutton remarked that from previous discussions, it appeared that staff attitude appeared to be a barrier to good infection control practice in the Trust. Miss Overfield advised that this was addressed as part of the 'Listening into Action' event, alongside a discussion concerning the measures needed to raise the profile of infection prevention and control good practice. It was highlighted that key messages in this respect also needed to be diverted to the changeover of junior medical staff in August. Mr Lewis reported that there had been an instance of Pseudomonas infection in Endoscopy and that a Table Top Review of the incident was planned shortly. Miss Overfield was asked to circulate a note to the Committee to outline the details of the matter. The Committee was advised that the MRSA bacteraemia contaminant case previously reported to the Committee had recently been removed from the nationally declared statistics at the agreement of the Trust Development Authority and the Department of Health.	
ACTION: **Miss Overfield to circulate a note to the Quality & Safety Committee outlining the background to the Endoscopy Pseudomonas case and the outcome of the table top review of the case**	
6 Quality Report	**SWBQS (6/13) 091** **SWBQS (6/13) 091 (a)**
The key highlights within the Quality Report were presented to the Committee. In terms of mortality, Ms Dutton asked whether there were any specific incidents to highlight. She was advised that this was not the case, however key incident themes centred on failure to recognise and escalate suspected sepsis cases. He was asked whether there was a variation in mortality according to the day of the week. Dr Stedman advised that there was little variation in mortality rates between weekends and weekdays. Mr Lewis questioned the reason for the high perinatal mortality rates. Dr Stedman advised that the Hospital Episode Statistics (HES) data that was used to generate the position included maternal deaths within the position. It was highlighted that the perinatal mortality position for Birmingham as a whole was high, however compared to other organisations in the region, the Trust was performing well. Mr Lewis suggested that there was a need to get visibility of the information on a benchmarked basis. The Committee was advised that work would begin in July to revise the format and content of the Quality Report in July to include action plans to address areas of shortfall or in need of improvement. It was suggested that the ward quality dashboard could be extended to other areas of the Trust. Ms Dutton asked that report included an area by area breakdown of complaints, to include units and departments in addition to wards. It was suggested that the detail of the current	

maternity dashboard should be incorporated into the Quality Report. Dr Sahota asked that the detail of the areas reporting the highest levels of mortality should be included in the report. Dr Stedman advised that this detail was within the mortality development plan. Miss Overfield reported that there had been no Grade 4 pressure sores reported for several months. It was agreed that a presentation by the legal services department should be arranged for a future meeting. A dip in the performance against the End of Life target was highlighted, which was agreed to be disappointing.	
ACTION: **Mr Grainger-Payne to schedule a presentation by the Head of Legal Services onto the agenda of a forthcoming Quality & Safety Committee meeting**	
7 Quality & Risk Profile: June 2013	**Verbal**
Miss Dhami advised that the Quality & Risk Profile (QRP) had not changed significantly, the majority of assessments of non-compliance against CQC outcomes being low. Ms Dutton asked whether there was a possibility that the Trust could expect an inspection against standards. Miss Dhami advised that there was a possibility that the CQC might assess the Trust for compliance against the standards where there was currently reported to be a high likelihood of non-compliance.	
8 Corporate quality & Performance dashboard	**SWBQS (6/13) 093** **SWBQS (6/13) 093 (a)**
The Committee received and accepted the corporate quality & performance dashboard. It was highlighted that underperformance against the fractured neck of femur target was currently reported. Dr Sahota noted that despite attendances being low at the Trust's emergency departments, performance against the four hour waiting time target remained in need of improvement. Mr Lewis advised that the number of attendances was of little significance, as the position reflected capacity available to handle the patients. It was noted that the lower attendances were anticipated to be reflective of a higher number of patients being diverted into Primary Care facilities. The Committee was advised that the measures taken to improve areas of underperformance would be included in future versions of the dashboard.	
8.1 Complaints Key Performance Indicators	**SWBQS (6/13) 087** **SWBQS (6/13) 087 (a)**
The Committee was asked to note the proposed core and developmental indicators	

which would be used to monitor the effectiveness of complaints handling. Mr Lewis advised that it had been agreed at the meeting of the Finance & Performance Management Committee earlier in the day, that a further indicator would be monitored: the age of the oldest live complaint. Ms Dutton suggested that the key themes from complaints needed to be considered and that she was planning to undertake a 'deep dive' analysis into complaints.	
8.2 CQUIN 2013/13 outturn report and 2013/14 targets	**SWBQS (6/13) 088** **SWBQS (6/13) 088 (a)** **SWBQS (6/13) 089** **SWBQS (6/13) 089 (a)**
The Committee received and accepted the CQUIN 2013/13 outturn report and a report summarising the 2013/14 targets.	
9 Mortality development plan: update	**SWBQS (6/13) 094** **SWBQS (6/13) 094 (a)**
The Committee was asked to receive and accept the mortality development plan. It was highlighted that a subgroup of the Mortality & Quality Alerts Committee was considering the difference in mortality rates between different parts of the Trust. It was reported that the Trust appeared to be under reporting some co-morbidities and that there was a difference in the use of the palliative care code. General coding issues were reported to have been identified. Miss Overfield asked whether there appeared to be any linkages between deaths due to pneumonia and pulmonary embolisms with fractured neck of femur operations. She was advised that this was not the case. Mr Lewis asked whether the mortality information was available by clinician. He was advised that this was possible, however there was no areas of concern in this respect. Dr Stedman advised that there was an expectation that the overall level of mortality could be reduced, in line with the planned trajectory set out in the long term quality goals, where the position between the two major sites was to be normalised. It was highlighted that the mortality ratios were rebased annually and that an improvement trajectory had been set over a period of five years. Ms Dutton asked how lessons learned from mortality reviews were disseminated. She was advised that a summary of the outcome and lessons learned from the review process was circulated for this purpose.	
10 Patient story for the Trust Board	**Verbal**
Miss Overfield advised that the story that would be presented to the Trust Board on 27 June related to a Paediatric patient.	
11 Complaints development plan: update	**SWBQS (6/13) 095** **SWBQS (6/13) 095 (a)** **SWBQS (6/13) 095 (b)**
Ms Binns presented the latest version of the complaints development plan, the delivery of which she highlighted was largely on track. The Committee was asked to note that some actions had been grouped, given that they related to harmonisation of communications. It was reported that easy read patient views	

leaflets would be issued first and that posters to advise how to register a complaint would be displayed in the entrances to the hospitals. It was reported that the current timescales for recruiting staff into the complaints department presented a risk that the implementation of the devolved model might be delayed, given that the individuals would be needed to support the process. The Committee was advised that a complaints 'Listening into Action' event was planned. Miss Dhami advised that the devolution plans would be considered by the Trust Management Board in July. Dr Sahota remarked that in addition to complaints, some patients and visitors wished to register a suggestion. Ms Binns advised that work was underway to develop a website which could be used for this purpose and to ensure that forms were designed such that suggestions could be made.	
12 Serious Incident report	**SWBQS (6/13) 096** **SWBQS (6/13) 096 (a)**
Ms Binns advised that a revised Serious Incident report was being devised. It was reported that 24 Serious Incidents had been registered in the last month. Incident 'DP' was discussed in detail and further information on this was requested for next month. Mr Lewis suggested that the Committee needed to look in a focussed way at a small number of incidents in future with a view to better understanding the incident handling process. He asked that a briefing be provided on the case outstanding with the local Clinical Commissioning Group (CCG). He also asked, out of those registered with the CCG, how many investigations had been concluded. Ms Binns advised that this was not clear as the position reflected all pressure sores and falls. Mr Lewis suggested that the lessons learned from incidents needed to be disseminated as soon as possible. Ms Dutton noted that sepsis appeared to be a common theme to some of the incidents reported. Dr Stedman advised that the revisions to the shaded observation charts would assist in this respect.	
13 Serious graded complaints report	**SWBQS (6/13) 097** **SWBQS (6/13) 097 (a)**
The Committee was asked to receive and note the serious graded complaints report.	
MATTERS FOR RECEIPT AND ACCEPTANCE	
14 Clinical Audit forward plan: monitoring report	**SWBQS (6/13) 098** **SWBQS (6/13) 098 (a)**
Miss Dhami presented the Clinical Audit forward plan monitoring report for receiving and noting. She advised that the plan contained 79 audits and that at present, no significant delays envisaged. It was highlighted that monitoring the mortality rates by individual surgeon were planned on a national basis and that the	

Trust had submitted data in this respect.	
15 CQC action plan update	**SWBQS (6/13) 099** **SWBQS (6/13) 099 (a) -** **SWBQS (6/13) 099 (c)**
The Committee received the updated action plans to achieve compliance with Outcomes 2 and 16. It was highlighted that a view of when compliance was expected to be achieved would be built into the next version of the report.	
16 Foundation Trust Quality Governance	**Verbal**
Miss Dhami advised that the plans for the assessment against the Quality Governance Assurance Framework would be discussed at the forthcoming meeting of the Executive Group. It was highlighted that the assessment needed to include clinical groups.	
17 – 20 REPORT BACK FROM THE COMMITTEES	
A brief summary of key points of discussion at the Quality Committees was provided.	
MINUTES FOR NOTING	
21 Minutes from the Clinical Quality Review Group	
21.1 Minutes from the meeting held on 13 May 2013	**SWBQS (6/13) 104**
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 13 May 2013.	
22 Matters of topical or national media interest	**Verbal**
Ms Dutton asked whether there were any lessons to be learned from the recent publicity concerning the CQC investigation into shortfalls in the standards of care at University Hospitals Morecombe Bay NHS Foundation Trust. Miss Overfield advised that the findings of the report had been widely expected prior to the release of the official report and therefore action had been taken or was underway where necessary.	
23 Any other business	**Verbal**
Dr Stedman advised that a Never Event had been reported which concerned the replacement of an incorrect intraocular lens. It was highlighted that this was the second such event that had occurred. It was agreed that a note should be circulated, summarising the Never Events reported by the Trust to date.	
ACTION: Miss Dhami to circulate a note to the Quality & Safety Committee summarising the Never Events that had been reported by the Trust	

24 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 19 July 2013 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Quality Report
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Overfield (Chief Nurse), Dr Roger Stedman (Medical Director) and Kam Dhami (Director of Governance)
AUTHOR:	Suzie Hughes, EA to Chief Nurse & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	25 July 2013

EXECUTIVE SUMMARY:

The attached report presents a composite picture of performance against a number of key Quality metrics and qualitative information, responsibility for which currently sits within the remits of three members of the Executive Group.

- The Board is invited to accept the report, noting in particular the key points highlighted in Section 2 of the report.

REPORT RECOMMENDATION:

The Board is recommended to ACCEPT the contents of the report.

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

Accept	Approve the recommendation	Discuss
✓		

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:

- Improve and heighten awareness of the need to report and learn from incidents.
- NHSLA Acute and Community risk management standards – 'Learning from experience'
- Includes performance against a number of CQuIN targets and national & local targets and priorities
- Aligned to the priorities set out within the Quality Account

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 19 July 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY REPORT

A monthly report presenting an update on Patient Safety, Clinical Effectiveness and Patient Experience in the Trust

July 2013

Where EVERYONE Matters

CONTENTS

QUALITY REPORT

1 INTRODUCTION

This report presents a composite picture of the performance against the various key Quality metrics to which the Trust works, both in terms of those mandated at a national or regional level and those set by the organisation.

The report has been populated with latest performance information for the period up until this Board meeting, across a range of areas within three domains: patient safety, clinical effectiveness and patient experience.

2 KEY POINTS TO NOTE

The Trust Board's attention is drawn to the following this month:

PATIENT SAFETY

- Safety Thermometer scores rose in June to 95.3% with the biggest decreases in harm events being in pressure damage and catheter associated UTi's
- Falls in May remain fairly static with previous months and 50% of falls with harm continue to be preventable with key factors being repeat assessments and adjustments to care plans as a result of changes of condition.
- There have been no infection outbreaks this month. Blood contaminants at Sandwell have decreased from the previous month from 5.2% to 2.2%. The Infection Prevention Control Service continue to monitor practices and compliance.
- Pressure damage performance continues to be good although May data was not available at the time of writing the report.
- There has been a significant improvement in nutritional reassessment rates following targeted support. Other measures remain satisfactory.
- Nurse staffing ratios are not currently available pending further work/support from divisions. Bank/agency use fell in June. Recruitment for additional beds is going well.

CLINICAL EFFECTIVENESS

- Ward reviews for Q4 are included in this report with comparison to Q3 results. I have included the key this time to remind TB/Q&S of the domains used. The reviews suggest the following wards require further support/development:
    - L2 (General Surgery) – subject to an investment decision around staffing levels following extensive 'turnaround' work.
    - N3 & L3 (T&O) – Despite investment into staffing levels last year these wards continue to fail to consistently delivery expected standards. A leadership review is currently being undertaken.
    - P5, D16 & D18 – these wards are all experiencing pressure with frail elderly and dementia activity. Plans are in place to address some staffing and leadership issues.
- Ward dashboard (real time performance) is included on Pg 28. There continues to be some key themes where many wards are struggling to achieve expected standards.
  There are no wards currently in 'special measures'.
- Compliance with the use of the World Health Organisation (WHO) checklist was 99.6% across all lists.
- Performance during June was 95.28% which is an improvement on April's performance of 91.01 and meets the target.
- Mortality Reviews Performance for April was 74% which is below the target of 80%, but is a significant improvement on previous months.
- Fractured Neck of Femur being operated on within 24 hours of admission during June was 75% which exceeds the standard of 70% and demonstrates an improvement on April and May.
- The Trusts 12-month cumulative HSMR (88.9) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (98.0).

PATIENT EXPERIENCE

- FFT dropped to 61 in May (combined in patient and ED scores). Inpatient alone was 66 and ED was 49. Response rates continue to improve for inpatients and ED but the expected Q1 response rate of 15% for ED (CQuIN) was not achieved.
  Provisional results for June are a combined inpatient/ED score of 67. ED score of 50 with a 9% response rate which remains below target rate.
- End of Life Care indicator (preferred place of death) improved in May suggesting that April's low was not a particular concern.

3 TARGETED AREAS OF SUPPORT

None to report.

4 EMERGING TRENDS/NOTICEABLE PATTERNS

- None specifically

5 OF SPECIFIC NOTE

- The CQC conducted an unannounced visit of the Sandwell and City site week commencing 24th June. They visited 11 areas in total including Maternity. We are awaiting their formal report but verbal feedback was positive for all areas.

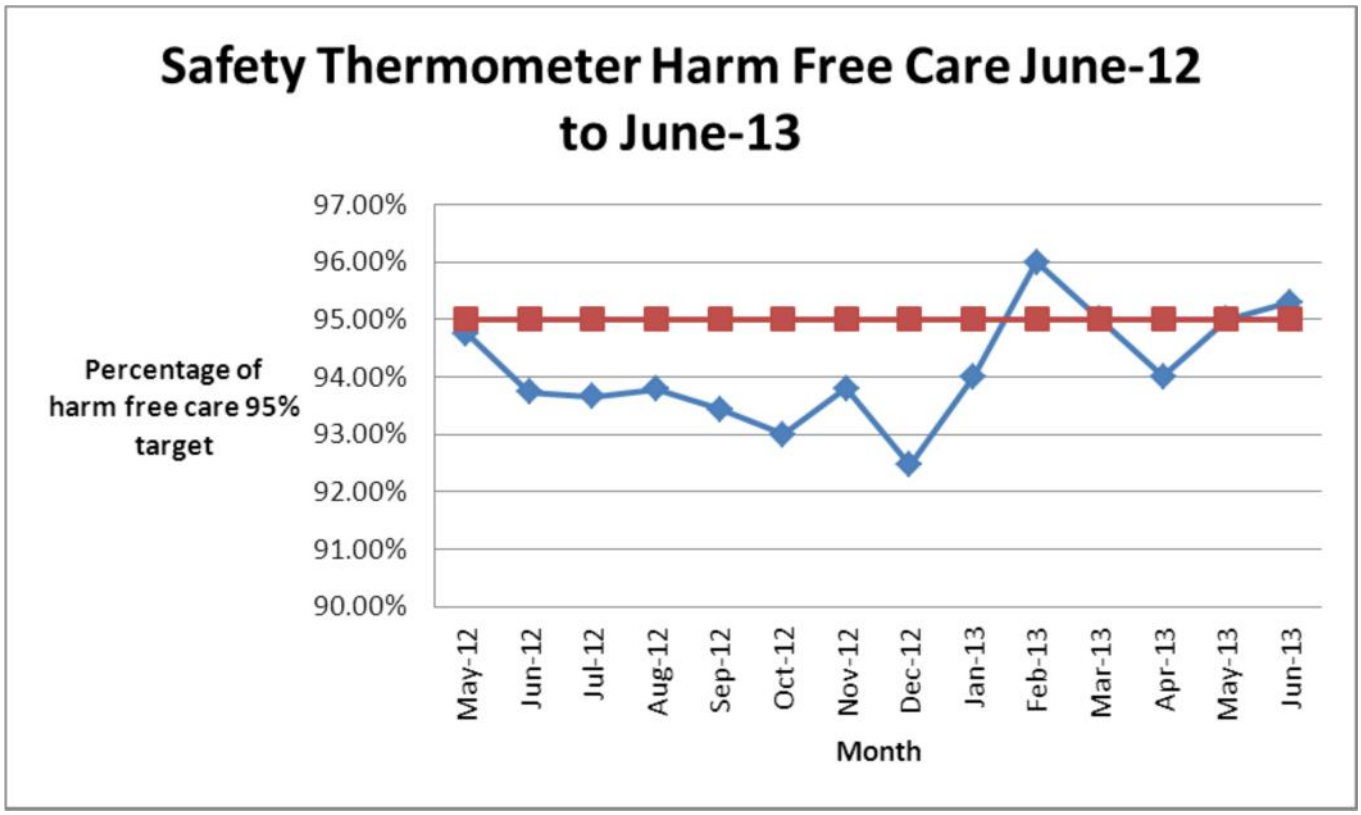
6 KEY CLINICAL RISKS

7 CARE QUALITY COMMISSION'S QUALITY AND RISK PROFILE

Next publication of the Quality & Risk Profile expected next month.

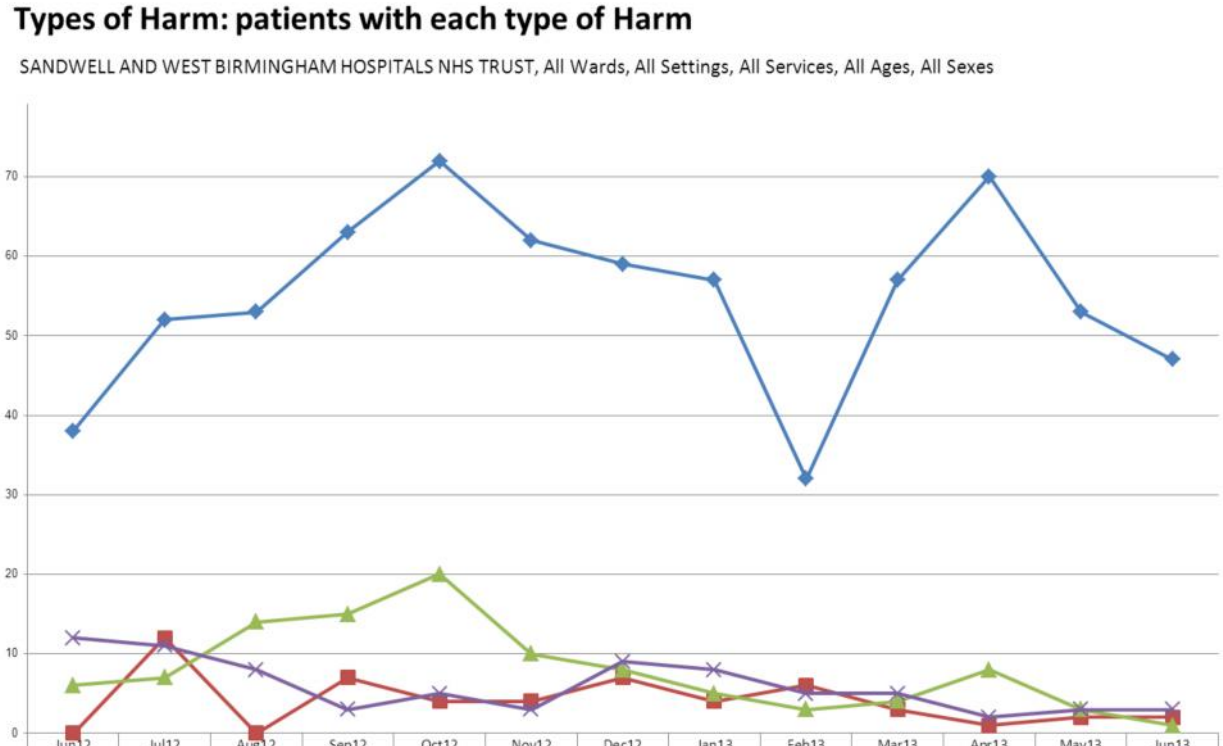
8 PATIENT SAFETY

8.1 Safety Thermometer



Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
95%í	93.5%í	94.83 %ë	95.3% ë									

Figure 1: *Harm free care trend*



	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13	Apr13	May13	Jun13
Pressure Ulcers	38	52	53	63	72	62	59	57	32	57	70	53	47
Falls	0	12	0	7	4	4	7	4	6	3	1	2	2
Catheter & UTI	6	7	14	15	20	10	8	5	3	4	8	3	1
New VTE	12	11	8	3	5	3	9	8	5	5	2	3	3
Patients	854	1210	1192	1278	1155	1237	1089	1200	1101	1188	1189	1161	1090

Figure 2: *Number of patients by type*

Acute Divisions **8** patients experienced **1 new harm**. **No** patients experienced **2, 3 or 4 harms**
Community Division **9** patients experienced **1 new harm**. **1** patient experienced **2 harms. No** patients experienced **3 or 4 harms.**

a) Falls

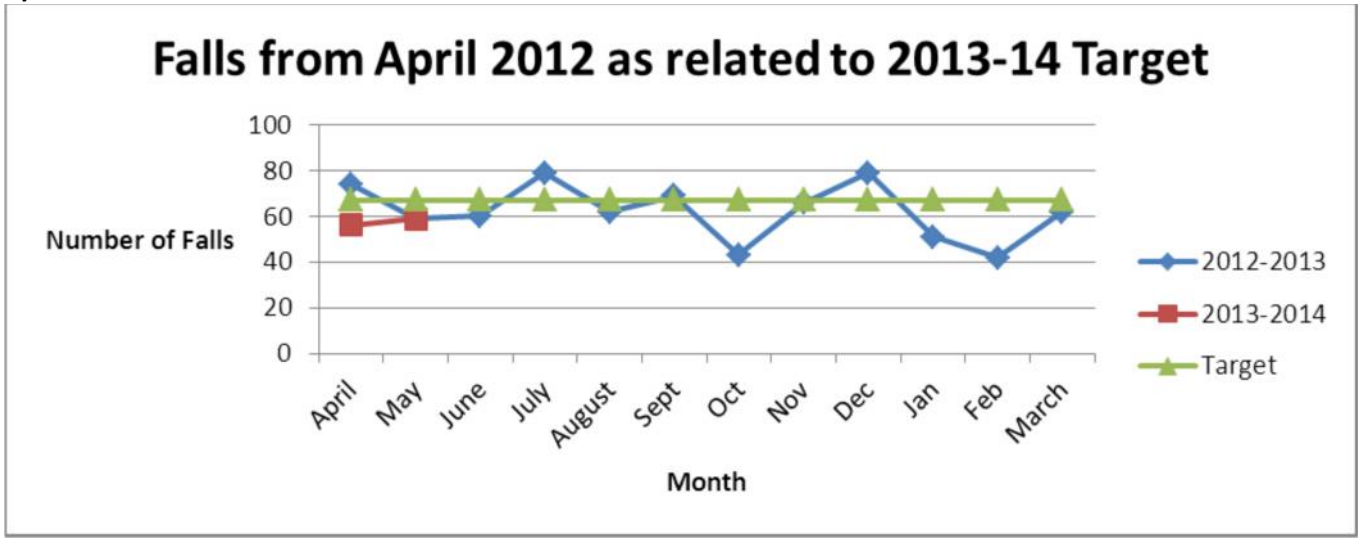


Figure 3: *Trend of falls April 2012 – May 2013*

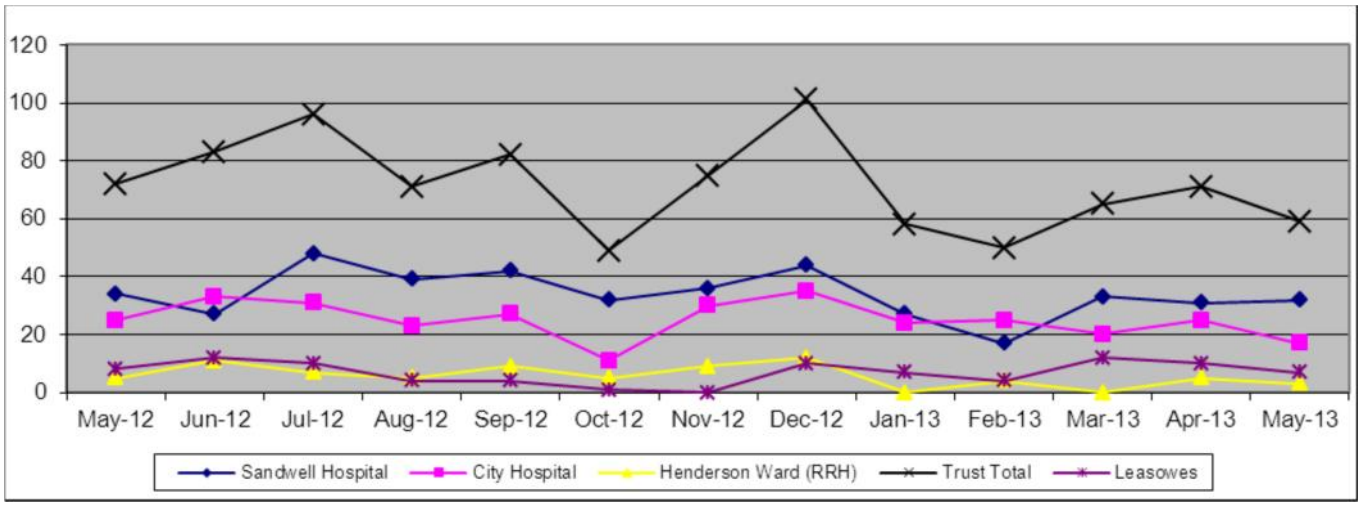


Figure 4: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

MONTH	Ward/Area	Grade of Fall	Injury	TTR outcome
April	N4	RED	# Ankle	Preventable
April	N2	RED	# Wrist and clavicle	Preventable
April	D21	RED	#Facial bones	Non-Preventable
May	Eye In patients	RED	#Humerus	Non-Preventable
May	MAU	RED	#NOF	Awaiting TTR
May	P3	RED	#GT Trochantor	Awaiting TTR

Figure 5: *Falls resulting in serious injury from April 2013- May 2013 (City and Sandwell Hospital)*

b) Pressure Damage

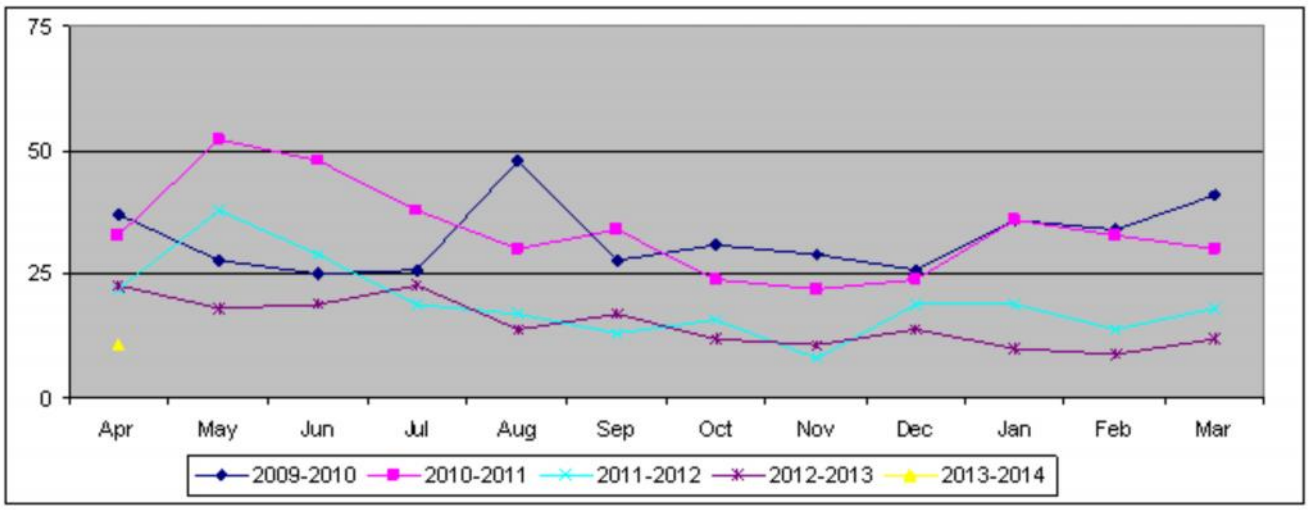


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 – April 2013*

Grade of Sore	2012-2013												2013 - 2014
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
Grade 1	-	-	-	-	-	-	-	-	-	-	-	-	-
Grade 2	21	16	17	21	11	14	11	11	11	7	9	9	10
Grade 3	2	2	2	2	3	3	1	0	3	3	0	3	1
Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0
Trust Total	**23**	**18**	**19**	**23**	**14**	**17**	**12**	**11**	**14**	**10**	**9**	**12**	**11**

Figure 7: *Table of avoidable hospital acquired pressure ulcers by grade*

In April there were 10 Grade 2, 1 Grade 3 and 0 Grade 4 avoidable hospital acquired pressure ulcers. There were 11 in total.

c) VTE Risk Assessment

The VTE Risk Assessment CQUIN target increased to 95%. Intensive work has gone into improving the VTE assessment position. Performance during June was 95.28% which is an improvement on April's performance of 91.01 and meets the target. The actions we have taken are review our cohort assessed patients, provided ward performance reports, supported junior doctors on the assessment units, added flashing VTE alerts into the EBMS.

We have also been trialling a checklist approach to post take ward rounds on the emergency medical assessment units. This has not yet been evaluated.

The Chief Executive is on a personal crusade to ensure that all eligible patients have a VTE assessment carried out and that we aim to assess 100% of patients.

The second part of the VTE CQUIN requires the Trust to carry out a root cause analysis on patients who have been identified as potentially having had a hospital associated thrombosis (DVT or PE). During Q1 the radiology team have been adding a BFG code to patients who have been radiologically diagnosed with a DVT or PE. This cohort of patients are then sorted into a group who have either been inpatients for more than 48hours or had been an inpatient during the previous 90 days of radiological diagnosis.

A review of notes to ascertain if this event could have been avoided is carried out. If it is identified that the patient's management was not as per recommended protocol, then a full root cause analysis is conducted on all these patients. It is planned to feedback to junior doctors and consultants in appropriate clinical meetings.

Improvement trajectories are to be agreed with the CCG this month. *CQUiN*

8.2 Nutrition/Fluids

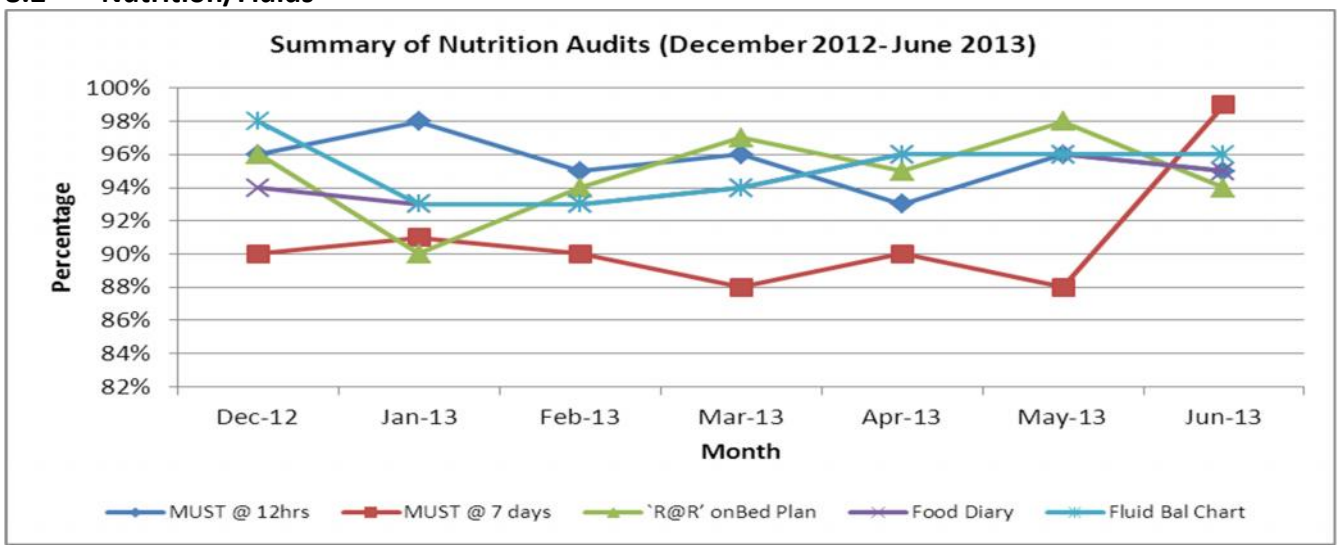


Figure 8: *Nutrition Audit Results*

8.3 Infection Control

MRSA

There were no post-48 hour MRSA bacteraemia for April. The total number of MRSA bacteraemia to date is 1.

Quarterly counts of MRSA bacteraemia Pre& Post 48 hrs (NB only post attributable to Trust trajectories)

	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Acute Trust	**Total**	**Total**	**Total**	**Total**	**Total**
Heart of England NHS Foundation Trust	5	4	2	3	4
Royal Wolverhampton Hospitals NHS Trust	0	0	3	3	0
Sandwell & West Birmingham Hospitals NHS Trust	2	2	1	1	3
The Dudley Group of Hospitals NHS Foundation Trust	0	1	0	1	1
University Hospital Birmingham NHS Foundation Trust	5	1	5	4	0
University Hospital of North Staffordshire NHS Trust	5	2	1	1	0
University Hospitals Coventry & Warwickshire NHS Trust	0	0	2	0	3
Walsall Hospitals NHS Trust	1	1	1	1	2
Worcestershire Acute Hospitals NHS Trust	3	1	0	1	2

Quarterly counts of CDI by NHS Acute Trusts, West Midlands

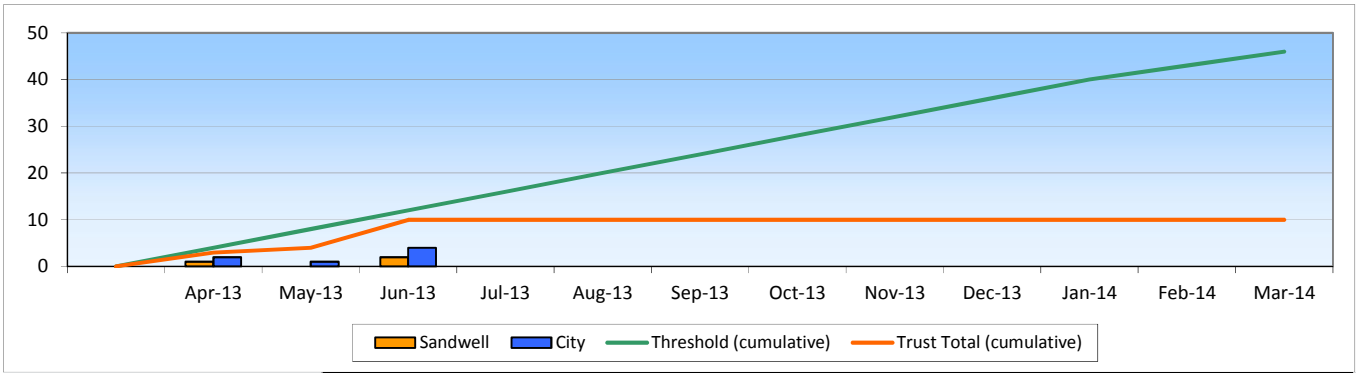
	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Acute Trust	**Total**	**Total**	**Total**	**Total**	**Total**
Heart of England NHS Foundation Trust	45	54	57	55	51
Royal Wolverhampton Hospitals NHS Trust	28	24	26	20	18
Sandwell & West Birmingham Hospitals NHS Trust	44	21	21	27	28
The Dudley Group of Hospitals NHS Foundation Trust	32	30	24	39	25
University Hospital Birmingham NHS Foundation Trust	41	40	39	36	30
University Hospital of North Staffordshire NHS Trust	48	49	48	38	35
University Hospitals Coventry & Warwickshire NHS Trust	37	39	47	41	46
Walsall Hospitals NHS Trust	28	7	7	8	12
Worcestershire Acute Hospitals NHS Trust	32	53	60	60	34

MRSA Screening

			To Date (*=most recent month)	TARGET	
				YTD	13/14
MRSA Screening - Elective	Patient Not Matched	%	**196.9***	85	90
	Best Practice - Patient Matched	%	**67.2***	71	80
MRSA Screening - Non Elective	Patient Not Matched	%	**81.3***	85	90
	Best Practice - Patient Matched	%	**74.5***	71	80

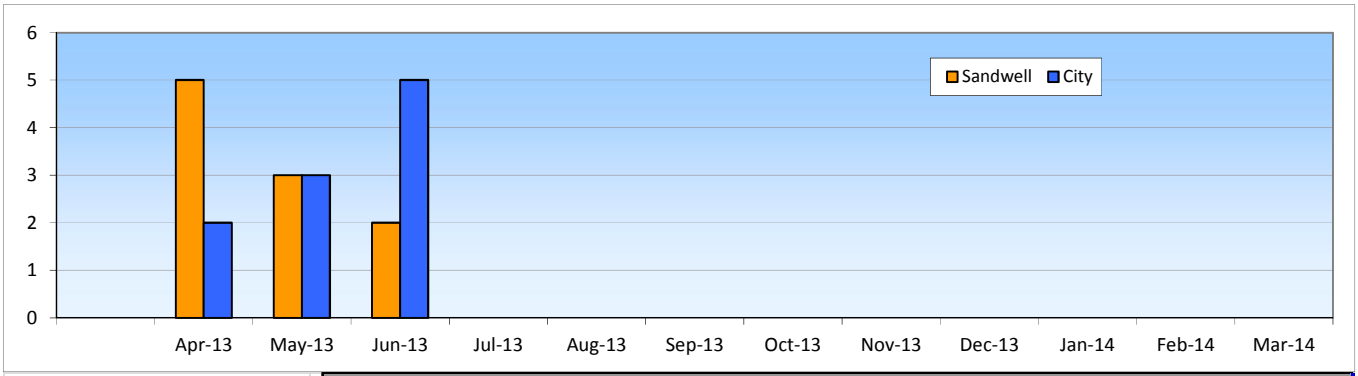
Figure 9: *MRSA screening eligibility*

Clostridium difficile



	2013-2014												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Sandwell	1	0	2										**3**
City	2	1	4										**7**
Trust	3	1	6	0	0	0	0	0	0	0	0	0	**10**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DoH Trajectory	4	4	4	4	4	4	4	4	4	4	3	3	**46**
Trust Total (cumulative)	3	4	10	10	10	10	10	10	10	10	10	10	-
Threshold (cumulative)	4	8	12	16	20	24	28	32	36	40	43	46	-

Figure 10: *SHA Reportable CDI*



	2013-2014												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Sandwell	5	3	2										**10**
City	2	3	5										**10**
Trust	7	6	7	0	0	0	0	0	0	0	0	0	**20**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Trust Total (cumulative)	7	13	20	20	20	20	20	20	20	20	20	20	-

Figure 11: *Trust Best Practice Data*

Blood Contaminants

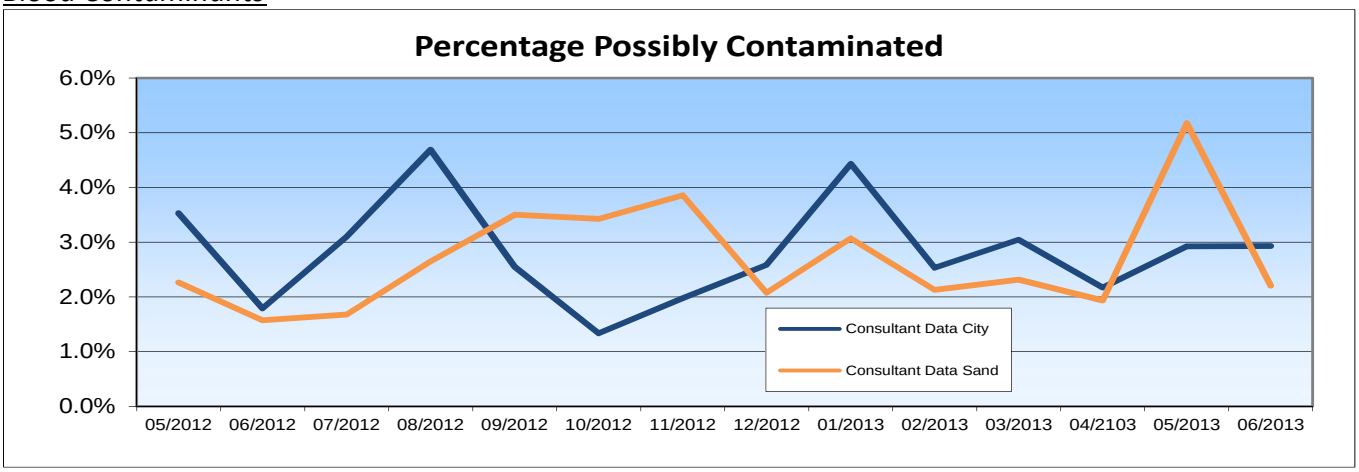


Figure 12: *Blood Contaminants*

E Coli Bacteraemia

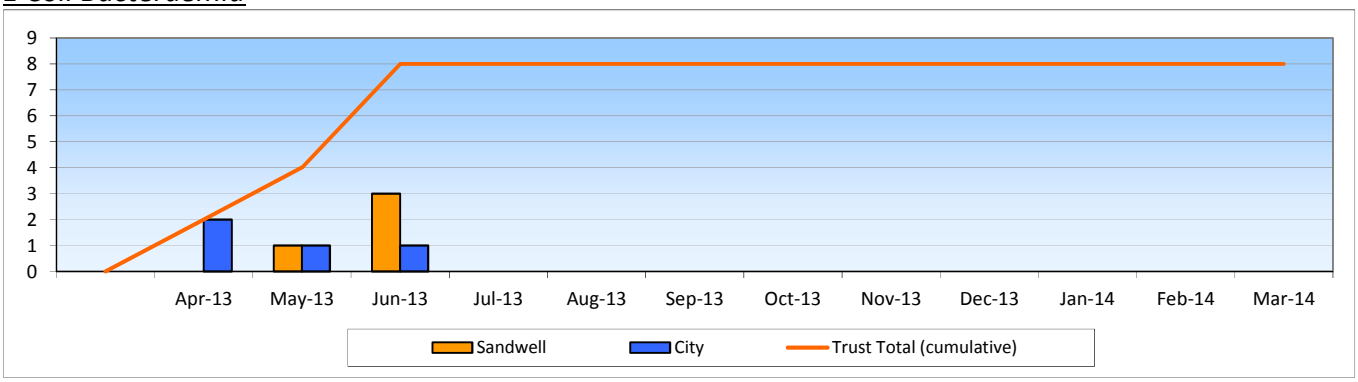


Figure 13: *E Coli Bacteraemia*

MSSA

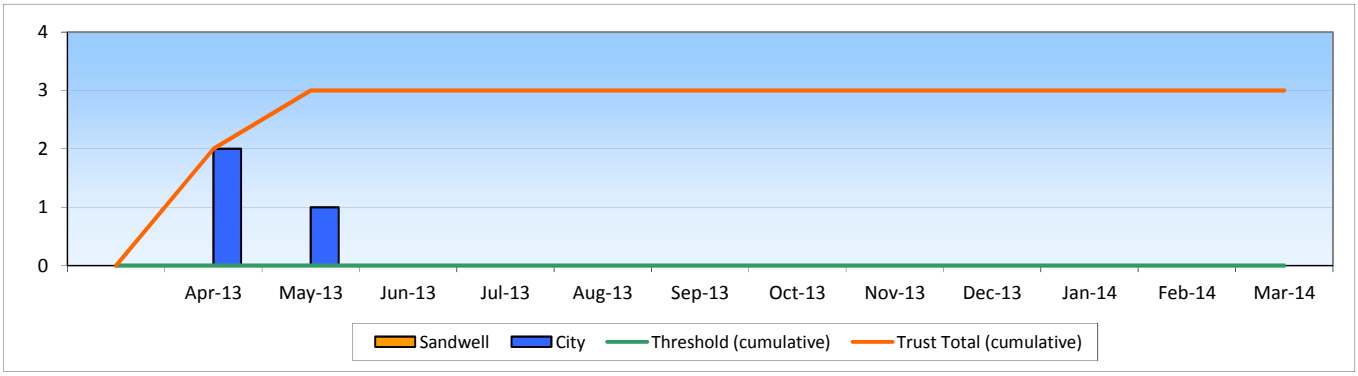


Figure 14: *MSSA*

8.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. Of note:

*Post-Partum Haemorrhage (PPH)(>2000ml): t*here was 1 patient recorded to have had a PPH of >2000ml in May.

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for May was 6.6 which was below the trajectory (8) and was lower than the previous month (11.7). Perinatal mortality rates must be considered as a 3 year rolling average due to the small numbers involved and the significant variances from month to month.

Caesarean Section Rate: the number of caesarean sections carried out in May was 27.2%, which is above the trajectory of 25% over the year and higher than the previous month.

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for May was 14% which is just below the trajectory (15).

Community Midwife Caseload (bi-monthly): The community midwife caseload in May was 130, which is below the trajectory of 140.

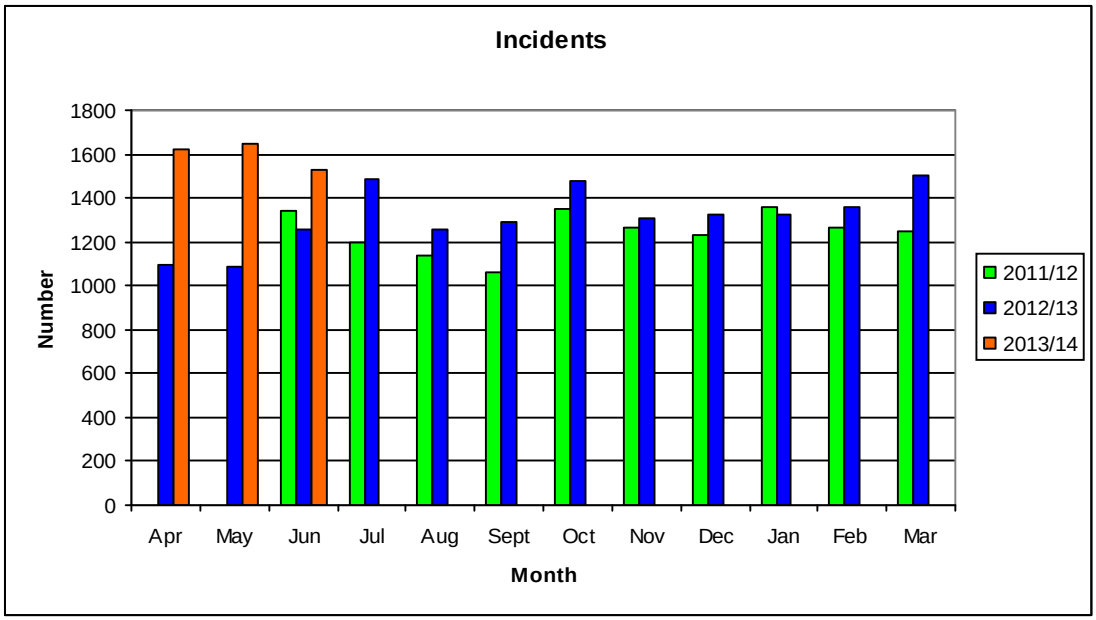
8.5 Medicine Management

The 2013/14 CQUINs include safe storage of medicines; the aim is to improve safe storage of medicines in ward areas.

The threshold for improvement is to be agreed following review of the Q1 baseline audit results.
Drug storage audits are being undertaken quarterly across inpatient areas in 2013/14 using a revised audit tool. Nursing and Pharmacy colleagues have developed the audit plan and a process for reviewing audit results. Following review of audit results action plans are being developed to deliver improvements. An improvement trajectory is to be agreed following review of the Q1 audit results.

The Q1 audits have been carried out and data quality checks are being done. The findings of the audits will be available for the next Quality Report and will be presented to the August meeting of the Medicines Safety Group.

8.6 Incidents



Incidents in June 2013

Total Number of Incidents reported	**1527**
Of the total: *(* incidents still under investigation)*	
Near miss	219
No Harm	836
Low (minimal harm)	378
Moderate	86
Severe (permanent or long term harm)	5
*Death (related to the patient safety incident)	3

"Top 5" Reporters (Acute)

1	Emergency Departments (both)	240
2	Labour Ward	62
3	Medical Assessment Unit	59
4	Emergency Assessment Unit	51
5	Priory 5	40

"Top 3" Reporters (Community)

1	Community Nurses Mesty	24
2	Community Nurses Cross	19
3	Community Nurses Mace	17

"Top 5" Type**

1	Verbal abuse (patient on staff)	79
2	Communication failure - with patient/team	37
3	Pressure sores – community acquired	34
4	Pressure sore – hospital acquired	26

5	Medication error	25

*** 431 incidents are not yet assigned to a causative group*

Issue/Risk	Action to take/taken	Who by	When by
Feedback on incident forms not always being sent to reporter	Contacting the company to identify if email can be sent automatically or the field for emailing needs to be made mandatory	Head of H&S	Aug 13

Figure 15: *Incidents reported in June 2013*

8.7 Serious Incidents (SIs)

In **June 2013** there were 3 new SI's reported to CCG

1 **2013/16842 – Acute Medicine**
Fatal head injury following a fall

2 **2013/17309 – Not disclosed**
Allegation against a HCP

3 **2013/17793 - Ophthalmology**
NEVER EVENT – wrong lens implanted

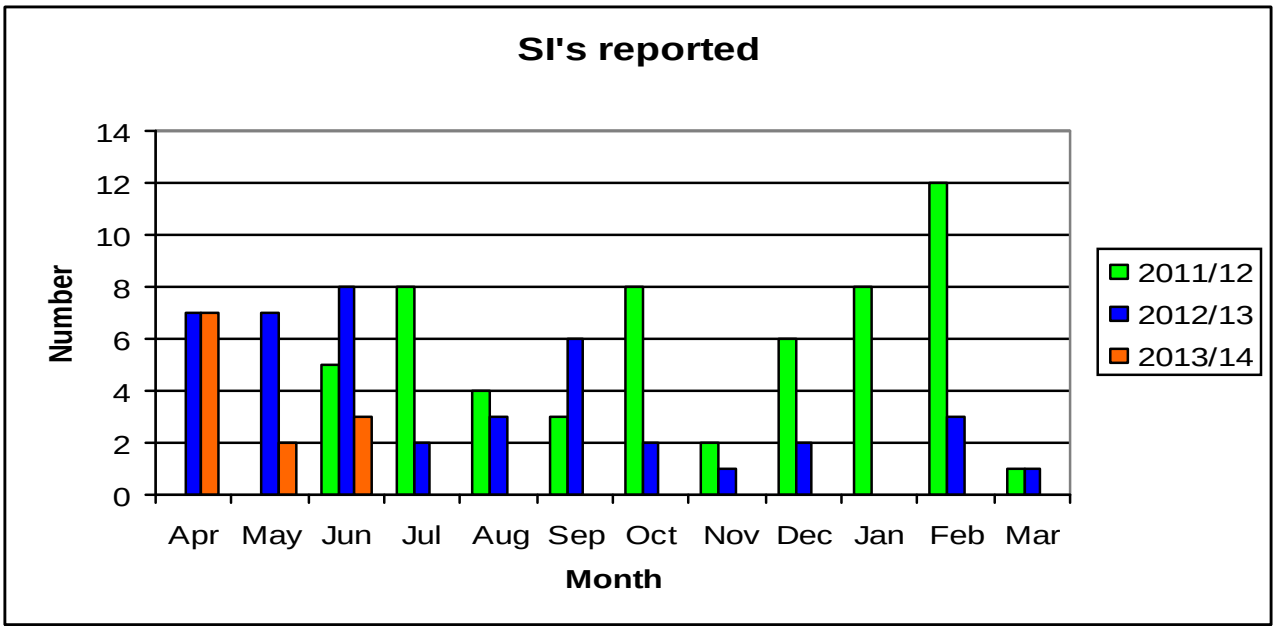


Figure 16: *Serious Incidents reported*

The serious incidents reported in the graph above do not include pressure sores, fractures resulting from falls, ward closures, some infection control issues or health and safety incidents.

Issue/Risk	Action to take/taken	Who by	When by
Attendance and participation of staff in the serious incident investigation process	Medical Director has written to all Consultants about his expectations. Review of current process and timings of the process for investigating serious incidents to take place	MD Head of Risk	June 13 Aug 13

8.8 Patient Safety Walkabouts

The Patient Safety Walkabouts continue to take place. In June Henderson Ward at Rowley Regis Hospital and Lyndon Ground/Lyndon 1 had visits. Again the visits proved extremely useful experiences for both staff and patients and highlighted some areas of good practice and some which require some action.

Themes continue with issues about the estate and some minor areas are about access to different drinks and more food.

The walkabouts continue with two more planned for July.

8.9 Inquests

During June 2013 **7** new Inquest cases were notified to the Trust.

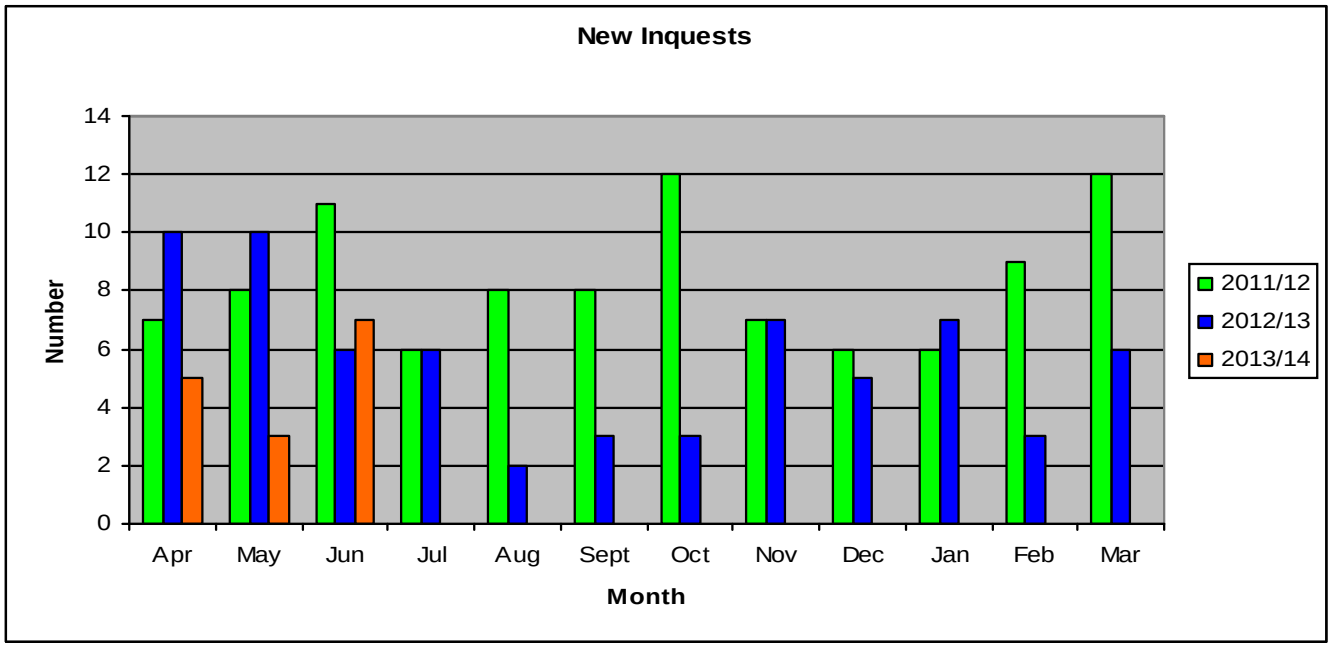


Figure 17: *Inquest cases*

During June 2013 **86** Inquest cases were closed.

- A large number of inquests were closed following a review of our cases. This review is ongoing however the number of closed files in July is likely to be significantly less as the review is coming to an end.

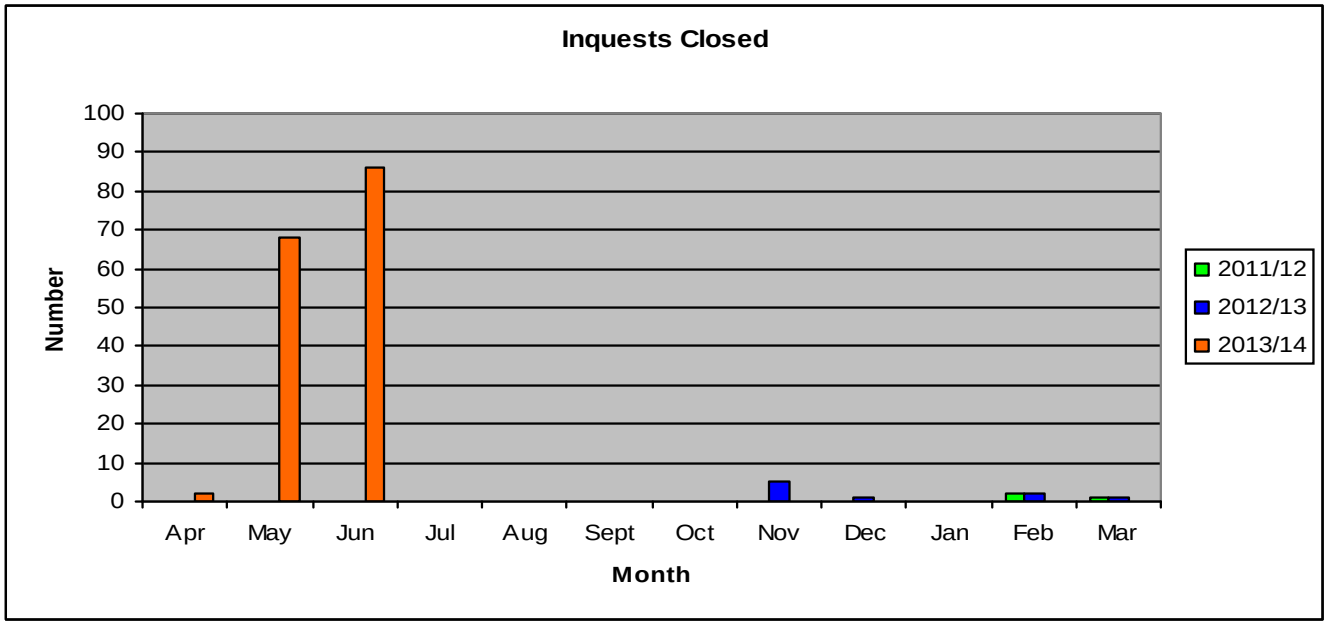


Figure 18: *Inquests closed*

Issue / Risk	Action to take / taken	Who by	When by
Change in process as directed by the coroner will mean inquests will be held within 3-6 months of the death.	• Use of checklists to meet requirements of coroner • Use of a robust 'bring forward system' • Early escalation processes when statements not received on time. • Audit of this process	Legal Services Manager	August 13

8.10 Claims

There were **16** new claims opened in June 2013.

The claims opened in June consist of 4 employer liability and 12 clinical negligence cases.

A large volume of claims were closed during May 2013 following a review of ongoing matters. This review is ongoing and 5 claims were closed during June, all of which were clinical negligence claims.

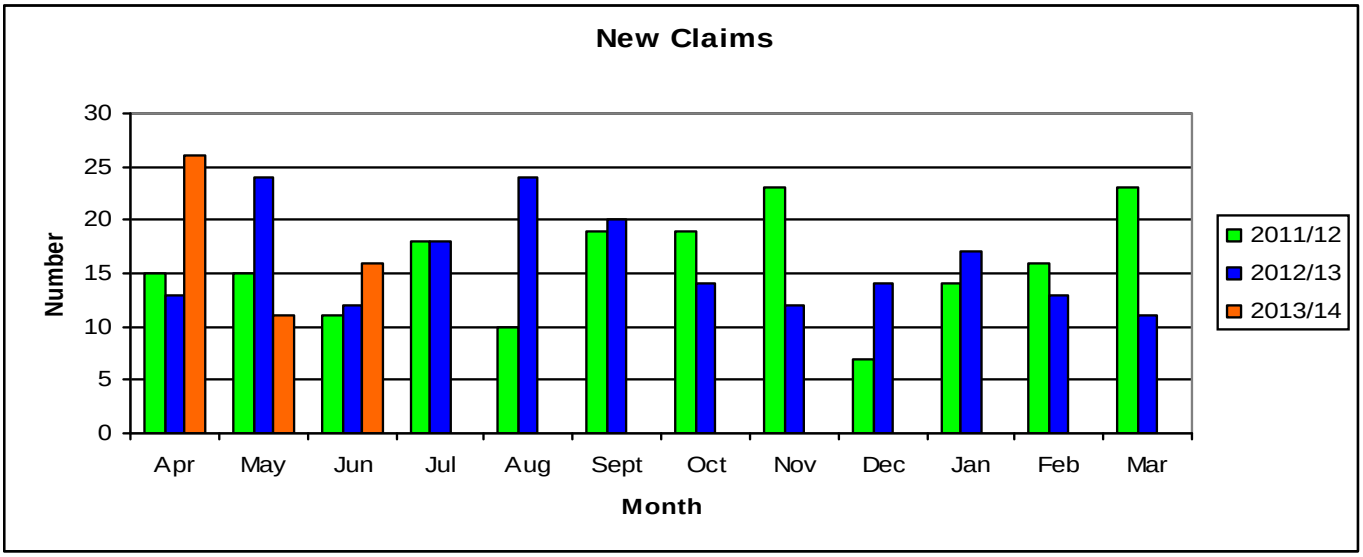


Figure 19: *New claims*

Issue / Risk	Action to take / taken	Who by	When by
The deadlines for completion of paperwork for small value employer and public liability claims has been reduced significantly.	• A checklist has been devised and introduced. • A central diary is used to bring forward all reminders for paperwork • Escalation processes have proven effective.	Legal Services Manager	June 13 – achieved.

8.11 Nurse Staffing Levels

Bank & Agency

The Trust's nurse bank/agency rates are detailed in the tables below and show year on year comparison from 2008/9 to date. Notably we are now using more nurse bank/agency than we have for the past 4 years.

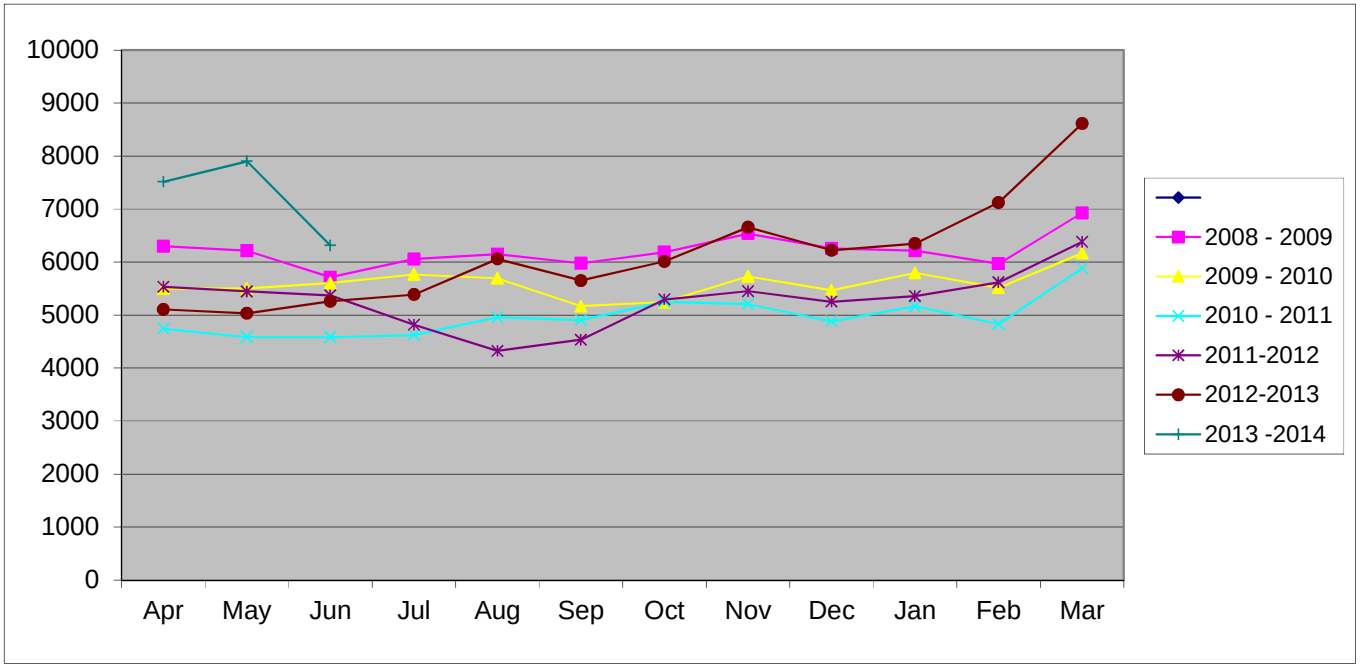


Figure 20: *Total Bank & Agency Use Nursing April 2008 –date.*

9 CLINICAL EFFECTIVENESS

9.1 Mortality

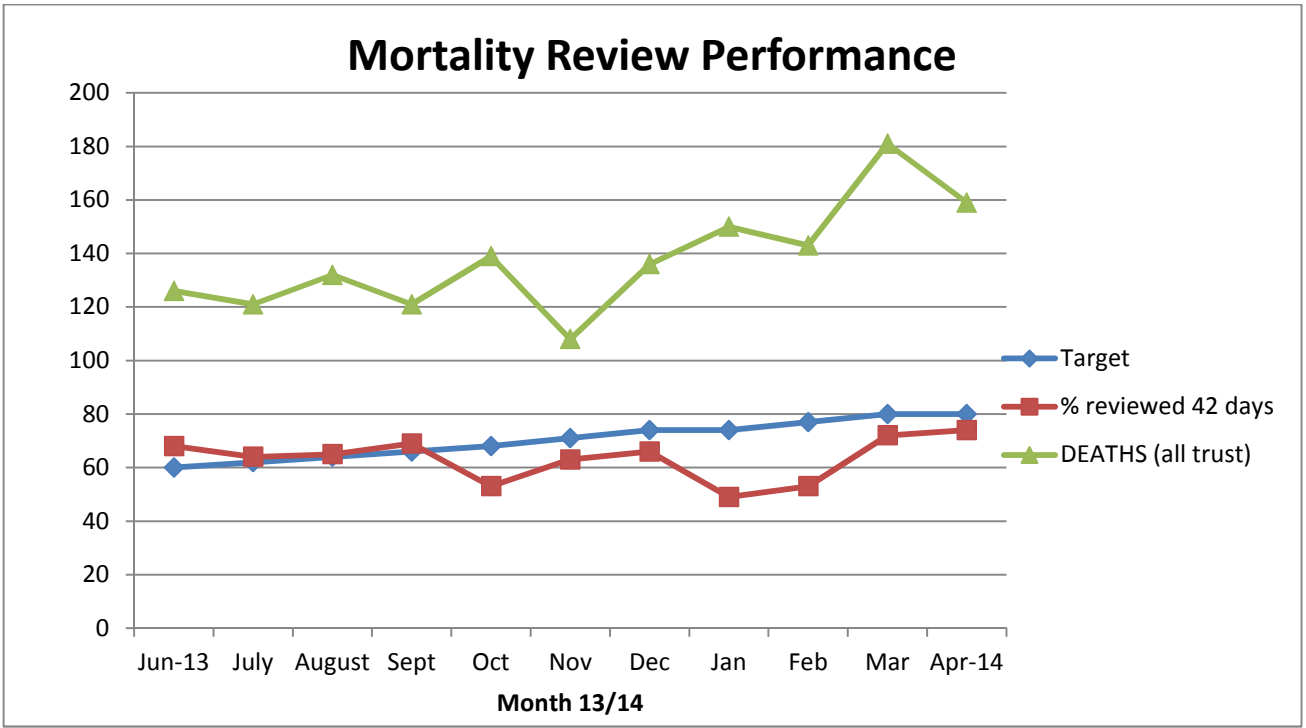
CQUIN Target

As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme with an end year target to review 80% of hospital deaths within 42 working days.

During the most recent month for which complete data is available (April 2014) the Trust reviewed 74% of deaths compared with a target trajectory for the month of 80%. The Trust has not met the trajectory for April but is continuing to review a higher % every month.

There is evidence that the new fairer mortality review system is working better, but we are continuing to find ways to improve it.

The Medical Director's Team is working closely with the Medical Clinical Managers to reinforce the importance of carrying out mortality reviews and learning from the findings.



2013/14	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Target	60	62	64	66	68	71	74	74	77	80	80
% reviewed 42 days	68	64	65	69	53	63	66	49	53	72	74
DEATHS (all trust)	126	121	132	121	139	108	136	150	143	181	159

HSMR (Source: Dr Foster)

The Hospital Standardised Mortality Ratio (HSMR) is a standardised measure of hospital mortality and is an expression of the relative risk of mortality. It is the observed number of in- hospital spells resulting in death divided by an expected figure.

The Trusts 12-month cumulative HSMR (88.9) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (98.0). The in-month (March 13) HSMR for the Trust has increased to 103.7, but remains within statistical confidence limits (Figure ( )).

12 month cumulative site specific HSMR's are 78.1 and 100.2 for City and Sandwell respectively, neither of which are currently in excess of upper statistical confidence limits.

Summary Hospital – Level Mortality Indicator (SHMI)

The SHMI is a national mortality indicator launched at the end of October 2011. The intention is that it will complement the HSMR in the monitoring and assessment of Hospital Mortality. One SHMI value is calculated for each trust. The baseline value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment was exactly the same as the number expected using the SHMI methodology. SHMI values have also been categorised into the following bandings.

1	where the Trust's mortality rate is 'higher than expected'
2	where the trust's mortality rate is 'as expected'
3	where the trust's mortality rate is 'lower than expected'

The last SHMI data was published on 24/04/13 for the period October 11 – September 12. For this period the Trust has a SHMI value of 0.97 and was categorised in band 2.

- 10 trusts had a SHMI value categorised as 'higher than expected'
- 18 trusts had a SHMI value categorised as 'lower than expected'
- 114 trusts had a SHMI value categorised as 'as expected'

In addition**,** the UHBT Healthcare Evaluation Data (HED) tool provides data in month based on the SHMI criteria. The SHMI includes all deaths up to 30 days after hospital discharge. The Trust SHMI for the most recent period for which data is available is 95.5.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Internal Data:												
Hospital Deaths	132	146	125	118	130	124	144	106	140	157	148	179
Dr Foster 56 HSMR Groups:												
Deaths	110	129	111	100	113	101	126	90	126	132	140	151
HSMR (Month) Trust	84.6	89.2	89.7	85.5	83.9	84.8	92.6	65.0	83.2	81.4	102.5	103.7
HSMR (Month) City	84.5	74.7	82.0	75.2	80.5	85.5	71.8	66.1	62.9	73.9	89.1	85.1
HSMR (Month) Sandwell	101.9	117.1	100.5	95.3	87.5	84.2	112.6	63.6	103.8	88.3	121.4	124.9
HSMR (12 month cumulative) Trust	89.7	88.3	96.4	95.5	94.2	93.1	92.7	90.5	89.1	87.8	88.1	88.9
HSMR (12 month cumulative) City	87.6	84.3	84.8	83.6	83.1	83.3	81.7	79.7	76.6	78.2	77.2	78.1
HSMR (12 month cumulative) Sandwell	109.1	109.0	108.8	107.9	105.9	103.5	104.1	101.7	101.9	99.7	99.3	100.2
HSMR (Peer SHA 12 month cumulative)	94.9	93.3	101.3	100.2	98.7	97.0	96.7	96.4	97.0	96.7	97	98.0
Healthcare Evaluation Data (HED) SHMI (12 month cumulative)	96.2	96.0	96.3	95.3	94.2	95.6	94.9	94.4	94.2	94.3	95.5	

Figure 21: *Mortality table 2012/13*

CQC Mortality Alerts received in 2012/13

No new mortality outlier alerts have been received.

Dr Foster generated alerts (Quality Investigator Tool)

In the data period May 2012 – April 2013 there were no new diagnoses groups alerting with a significant variation from the benchmark.

National Clinical Audit Supplier – Potential Outlier Alerts

No new potential outlier alerts have been notified.

9.2 Clinical Audit

Clinical Audit Forward Plan 2013/14

The Clinical Audit Forward Plan for 2013/14 contains 79 audits that cover the key areas recognised as priorities for clinical audit. These include both the 'external must do' audits such as those included in the National Clinical Audit Patient Outcomes Programme (NCAPOP), as well as locally identified priorities or 'internal must do' audits.

Status as at end of June 2013	Total
0 – Further Information requested	3
1 - Audit not yet due to start	18
2- Significant delay	0
3- Some delay - expected to be completed as planned	12
4- On track - Audit proceeding as planned	39
5- Data collection complete	2
6- Finding presented and action plan being developed	1
7- Action plan developed	3
D- Discontinued	1
Grand Total	79

The status of the audits that have been included in the plan as at the end of June 13 is shown in the table above. No audits have been indicated as experiencing a 'Significant delay'.

9.3 Compliance with the 'Five Steps for Safer Surgery'

Close monitoring of compliance with the WHOCL continues. Performance for June was 99.6%.

9.4 Stroke care

Performance against the principal stroke care targets was as outlined in the table below at the end of June, this is subject to change following final validation.

Stroke Care- Source- CDA Dashboard 11/7/13	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
% Spending >= 90% of stay on stroke unit	88.3	96.23 ▲	89.36▼									
% Admitted to stroke unit within 4 hrs of arrival at hospital	69.35 ▲	83 ▲	93.15									
% pts receiving brain imaging in 24 hrs of admission	93.18 ▲	90▼	87.23 ▼									
% Pts scanned within 1 hr of arrival at hospital	61.54 ▲	68.57 ▲	Data awaited									

% high risk TIA treated within 24 hours	66.67 ▼	63.16 ▼	84.38 ▲									
% low risk TIA treated within 7 days	74.07 ▲	88.37 ▲	88.24 ▼									

Figure 22: *Performance against stroke care targets (data CDA Dashboard 11/07/13)*

9.5 Treatment of Fractured Neck of Femur within 24 hours

The Trust has an internal Clinical Quality target whereby 70% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. Data for June (Source CDA –QMF Dashboard 10/7/13) indicates 75% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission. *Internal Priority*

9.6 Ward Reviews

Medicine Ward Review objectives overview for January and 2013

Medicine and Emergency Care					increase or decrease against key performance targets			
	Q4- April 2013				Q3- Jan 2013			
WARD	RED	AMBER	GREEN	WARD	RED	AMBER	GREEN	▲or ▼
D5	0	2	5	D5	0	3	4	
D7				D7	0	2	5	
D12	1	0	6	D12	1	0	6	
D15	1	0	6	D15	1	0	6	
D16	0	3	4	D16	0	3	4	
D18	0	3	4	D18	0	3	4	
D17	0	0	7	D17	0	0	7	
D41	0	1	6	D41	0	0	7	
MAU	0	1	6	MAU	0	1	6	
Endoscopy	Tool under review			Endoscopy	Tool under review			
Lyndon 4	0	2	5	Lyndon 4	0	4	3	
Lyndon 5	0	0	7					
Newton 1 / Priory 4				Newton 1	0	2	5	
Newton 4	0	2	5	Newton 4	0	0	7	
Newton 5	0	1	6	Newton 5	0	0	7	
Priory 5	0	3	4	Priory 5	0	5	2	
EAU	0	3	4	EAU	0	5	2	
CCU				CCU	0	0	7	
A&E- CHT				A&E- CHT				
A&E- SDGH	0	4	3	A&E- SDGH	0	4	3	
Total	2	25	78	Total	2	32	85	

	QUARTERLY ANALYSIS			
	RED	AMBER	GREEN	N/A
Q3 – Jan 2013	2	32	85	
Q4 - April 2013	2	25	78	

Surgery

Surgery Ward Review objectives overview for January 2013

Objectives	L 2	N 2	N 3	P 2	D21	D25	D6	L 3	ASU	Theatre City	Theatre SGH	SAU	SDU	Critical Care CHT	Critical Care SGH
1	R	G	A	A	G	A	G	R	R	A	R	G	G	G	A
2	R	G	A	G	A	A	G	A	G	G	A	G	G	G	G
3	G	G	G	G	G	G	G	A	A	G	G	G	G	G	G
4	A	G	R	A	G	G	G	A	G	A	A	G	G	G	G
5	G	G	A	G	G	G	G	A	G	G	A	G	G	G	G
6	R	G	R	G	G	G	G	R	R	A	A	G	G	A	G
7	R	A	R	A	A	A	G	R	A	A	A	A	A	A	A

Surgery Ward Review objectives overview for April 2013

Objectives	L 2	N 2	N 3	P 2	D21	D25	D6	L 3	ASU	Theatres City	Theatre SGH	SAU	SDU	Critical Care CHT	Critical Care SGH
1	R	A	R	G	G	A	G	R	G	A	A	G	G	A	A
2	R	G	G	G	G	G	G	A	G	G	A	G	G	G	G
3	G	G	G	G	G	G	G	A	A	G	G	G	G	G	G
4	A	G	R	G	G	G	G	A	G	A	A	G	G	A	G
5	G	G	G	G	G	G	G	G	G	A	A	G	G	G	G
6	R	G	A	G	A	G	G	R	A	A	A	G	G	G	G
7	R	A	R	A	A	A	G	R	A	A	A	A	A	R	A

Key

1	Matrons and ward managers are responsible for ensuring the patient environment is clean and Infection Control procedures are in place
2	Matrons and Ward Managers will ensure all patients will have their essential care needs met.
3	Ward Managers are responsible for ensuring nursing care is delivered with due regard to respect, Privacy and Dignity of those in their care
4	Matrons and Ward Managers ensure systems are in place to maximise patient experience by the wary they communicate with patients and their relatives.
5	Ward Managers will ensure the needs of the vulnerable person are recognised and met.
6	Matrons and Ward Mangers will ensure patient's safety needs are met.
7	Ward Mangers will make effective use of all resource and is able to effectively manager the workforce.
Red	Failure to or no attempt to implement objective/lack of knowledge of this objective
Amber	Work in progress to implement/results poor suggests not embedded in clinical practice
Green	Fully embedded in care/clinical practice

9.7 Quality Audits

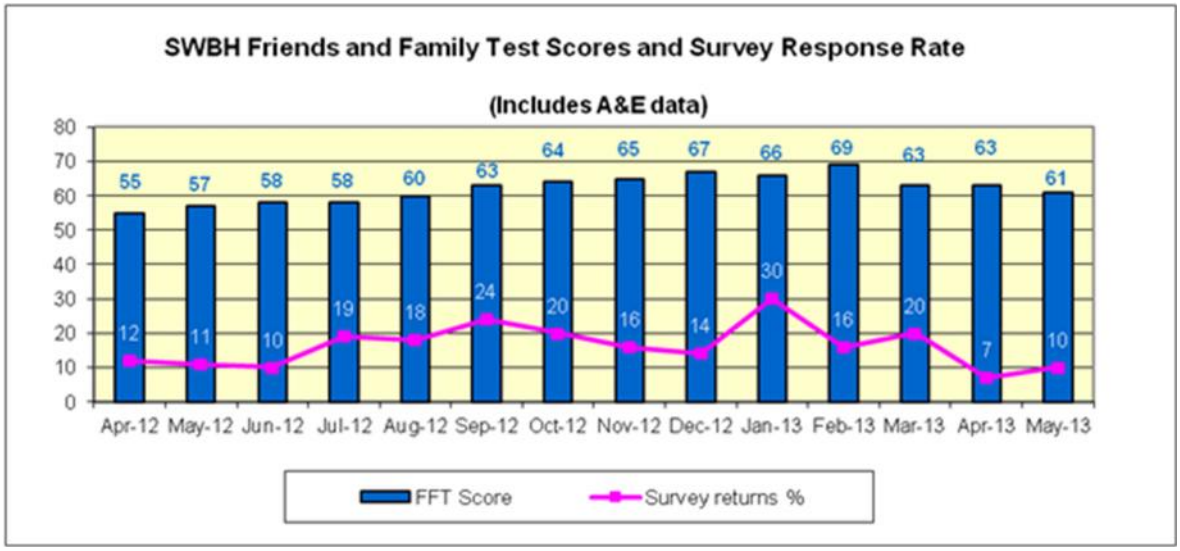
The Quality Audits are not due for reporting this month.

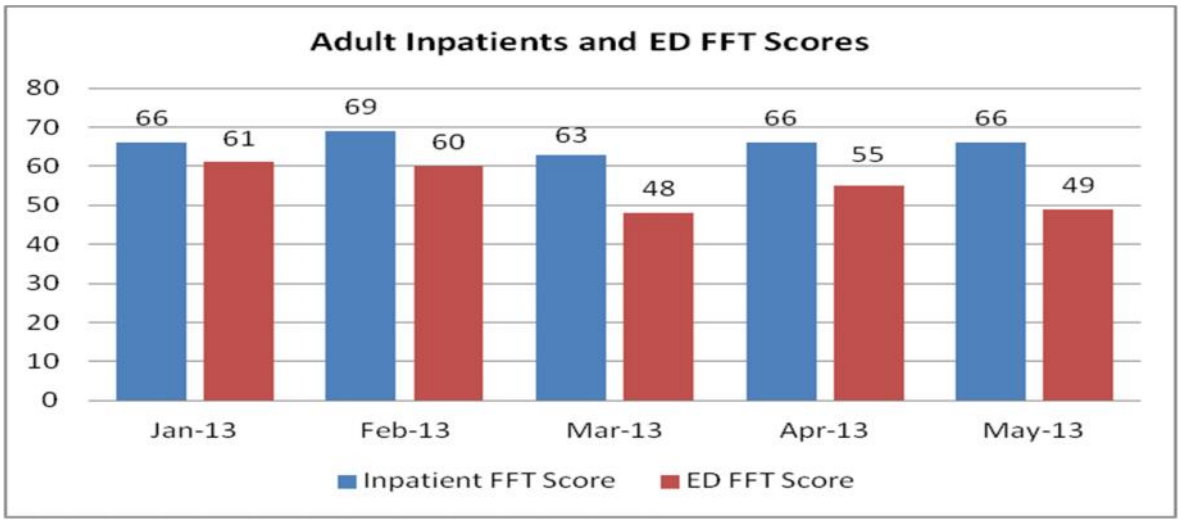
9.8 Ward Clinical Dashboard

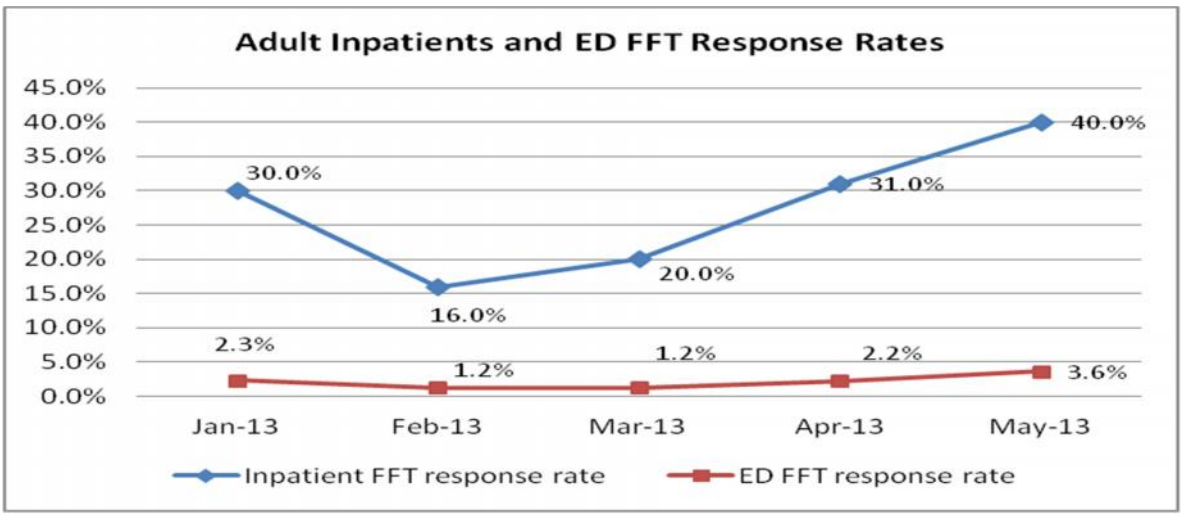
	MRSA bacteraemias (post 48 hours) - No	C.Difficile Cases (post 48 hours) - No	MRSA Screening - Elective %	MRSA Screening - Non Elective - %	Hand Hygiene - %	Red Incidents - No	Amber Incidents - No	Falls - Total (Acute) hosp acquired avoidable - No	MUST - Avoidable Weight Loss - No	MUST - within 12 hours of admission - %	Pressure Ulcers - hosp acquired avoidable grade 3	Phlebitis rate - %	VIP monitoring - %	Safety Thermometer - Harm Free - %	Safety Thermometer - Catheters & UTIs - %	Safety Thermometer - New Harms - %	Complaints - No	Pt Exp - Friends and family recommendation - %	Mandatory Training Rate - %	Sickness Absence - %	PDR Completion Rate - %	Trained Nursing Staff - %
BTC - Adult Surgical Unit	0■	0■	93▼	■	0■	0▼	0▼	0■	■	■	0■	■	■	■	■	■	0■	52▼	85▼	5▲	50▼	75▼
CCS - Critical Care Services - City	0▼	0■	■	100▲	98▼	0■	0▼	0■	■	■	1■	0■	84■	75▼	0■	100■	0■	84▲	91▼	3▲	81▲	■
Coronary Care Unit - City	0■	0■	■	100▲	0■	0■	0■	0■	■	■	0■	0■	100■	■	■	■	0■	74▲	92▼	0▲	69▲	100▼
Coronary Care Unit - Sandwell	0■	0■	80▲	100▲	0■	0■	0▼	0▲	■	■	0■	0■	86■	100■	0■	100■	1▼	98▼	90▼	3▼	81■	93▼
Critical Care - Sandwell	0■	0■	■	100■	98▲	0■	3▲	0■	■	■	1■	0■	66■	100▲	0▲	100▲	0■	100■	93▼	7▲	76▲	■
D12 - Isolation	0■	0■	50▲	100▲	0▼	0■	0■	0■	0■	100■	1■	0■	79■	100■	0■	100■	1▲	100▲	89■	4▲	20▼	70▼
D15 - Medical	0■	0■	100▲	42▲	91▲	0■	0■	1▼	1■	80▲	0■	7■	46■	100■	0■	100■	1▲	56▼	76▼	2▼	47▲	61▼
D16 - Medical	0■	0■	■	100▼	48▼	0■	0■	5▼	0▲	86▼	0■	16■	47■	95▼	0■	100■	1▲	32▲	74▼	3▲	79▲	43▼
D17 - Medical	0■	0■	■	0▼	86▼	0■	1▲	1■	0■	100▲	0■	0■	47■	100▲	0■	100■	0■	-8▼	82▼	4▲	85▼	64▼
D18 - Medical	0■	0■	■	100■	98▲	0■	4▼	3▲	0■	100■	1■	0■	94■	100▲	0■	100■	0■	87▲	83▼	5▲	76■	47▼
D21 - Male Surgery ENT/Urology	0■	1▼	100■	75▼	69▼	0▼	1■	3▼	1▼	100■	0■	0■	91■	100▲	0▲	100■	0■	76▼	92▼	4▲	82▲	57▼
D25 - Surgical (Female)	0■	0■	100■	33■	0■	0■	4▼	1▲	■	100■	0■	0■	100■	100■	0■	100■	0■	60▼	90▼	5▲	51▼	57▼
D27 - Oncology	0■	0■	■	33▲	95▼	0■	0■	0■	0■	100■	0■	7■	71■	93▼	0■	93▼	0■	80▲	82▼	6▲	66▲	73▼
D30 - Winter pressures	0■	0■	■	100▲	99▲	0■	0■	0▲	0▲	89▼	0■	25■	66■	78▼	0■	94▼	0■	100▲	0■	0■	0■	■
D41 - Medical Short Stay Unit	0■	0▼	0■	50▲	96▲	0■	1▲	0▲	■	100■	1■	0■	100■	100▲	0■	100▲	0■	59▲	92▼	0▲	90▲	73▼
D7 - Medical	0■	0■	■	0■	100■	2▼	1■	1■	2▼	95▲	0■	0■	88■	87■	0■	95■	0■	52▲	75▼	3▲	33▼	34▼
Day Treatment Unit - Sandwell	0■	0■	66▼	■	0■	0■	0■	0■	■	■	0■	■	■	■	■	■	0■	0■	83▼	4▲	57▲	■
EAU - Sandwell	0■	0■	■	79▲	0■	0■	1▲	2■	■	90▼	0■	0■	45■	100▲	0■	100■	2▲	68▼	77▼	3▲	49▼	55▼
Lyndon 2	0■	0■	0▼	64▼	96▼	0■	1▲	0■	0■	95▼	0■	9■	62■	100▲	0▲	100▲	0■	50▲	79▼	19▲	63▲	49▼
Lyndon 3	0■	0■	94▼	■	98▼	0■	2▼	2▼	1▼	100▲	1■	0■	84■	100■	0■	100■	1▼	65▼	83▼	5▼	48▼	58▼
Lyndon 4	0■	0■	■	■	100▼	0■	0▼	1▲	1▲	88▲	0■	0■	66■	94▲	0■	100■	0■	■	83▼	0▲	72▲	31▼
Lyndon 5	0■	0■	■	■	90▼	0■	0▼	6▲	2▲	97▲	2■	0■	61■	88▲	0▲	100■	0■	33▲	82▼	4▲	56▼	39▼
MAU - Mau Transfer - City	0▼	0■	0▼	71▲	0■	0■	1■	2■	■	90▲	0■	0■	39■	100■	0■	100■	3▼	■	89▼	5▼	77▲	53▼
Neonatal Unit - City	0■	0■	■	■	0■	0■	0■	0■	■	■	0■	0■	83■	100■	0■	100■	0■	■	90▼	2▲	81▼	■
Newton 1 Short stay unit	0■	0■	■	0▼	0■	0■	0■	1▼	■	90▼	0■	0■	78■	100▼	0▼	100▼	0■	■	0■	0■	100■	■
Newton 2	0■	0■	93▼	51▼	100▲	0■	0▼	0▲	0■	87▼	0■	0■	55■	100▲	0■	100■	3▼	83▲	88▼	4▲	61▲	70▼
Newton 3	0■	0■	80▼	96▲	100■	0■	0▼	2▲	0■	100■	1■	0■	66■	100■	0■	100■	0▼	64▼	83▼	5▼	26▼	59▼
Newton 4 - Stroke rehab	0■	0■	■	66▲	0▼	0■	0▼	3▲	0▲	92▼	0■	0■	33■	100■	0■	100■	0▼	100▲	85▼	0▲	92▲	49▼
Newton 5	0■	0■	■	100■	98▲	0■	0▼	2▼	0■	100■	0■	0■	100■	80▼	0■	100■	0■	■	94▼	4▼	82▲	65▼
Ophthalmology Main Ward - City	0■	0■	48▲	58▼	0■	0■	0■	1▼	0■	100■	0■	0■	100■	83▼	0■	83▼	0■	91▲	82▼	9▲	25▼	78▼
Planned Admissions Unit (D6)	0■	0■	94▼	■	0■	0■	0■	0■	■	100■	0■	■	■	■	■	■	0■	0■	95■	8▼	88▼	86▼
Post Coronary Care - City	0■	0▼	■	■	95▼	0■	0■	0▲	■	100▲	0■	■	■	100■	0■	100■	0■	0■	0■	0■	0■	■
Priory 2	0■	0■	88▼	28▼	98▲	0■	3▼	1▼	2▼	90▲	1■	0■	53■	85▲	10▼	90▼	0■	83▲	82▼	11▼	93■	48▼
Priory 3	0■	0■	■	■	91▼	0■	1■	5▼	1▲	100▲	2■	0■	100■	100▲	0■	100▲	0■	50▲	77▼	8▲	33■	47▼
Priory 4 - acute stroke unit	0■	0▼	0■	89▲	99▲	0■	1▲	3▼	1▼	100▲	0■	■	■	96■	0■	96▼	0■	81▲	84▼	7▼	78▼	75▼
Priory 5	0■	0■	40▲	66▲	91▲	0▼	13▼	3▲	0▲	100▲	2■	0■	69■	90▲	0■	100■	0▼	-12▼	81▼	2▲	85▼	30▼
Surgical Assesment Unit (D42) - City	0■	0■	■	94▲	0■	0■	1■	0▲	■	100■	0■	0■	100■	0■	0■	0■	0■	50▼	94▼	2▼	90▲	83▼

10 PATIENT EXPERIENCE

10.1 Net Promoter



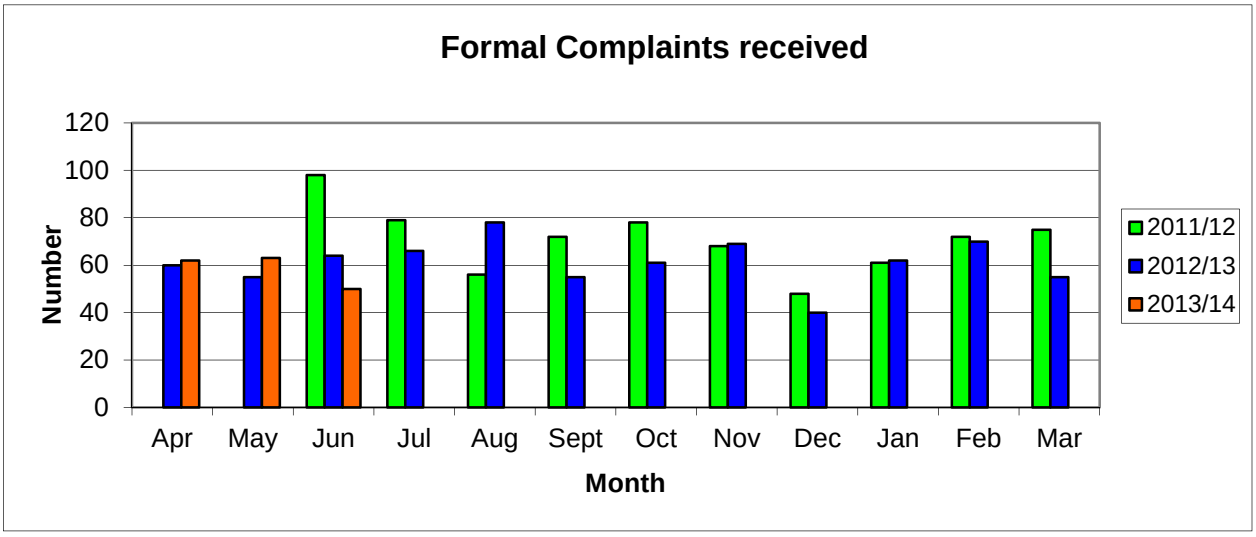


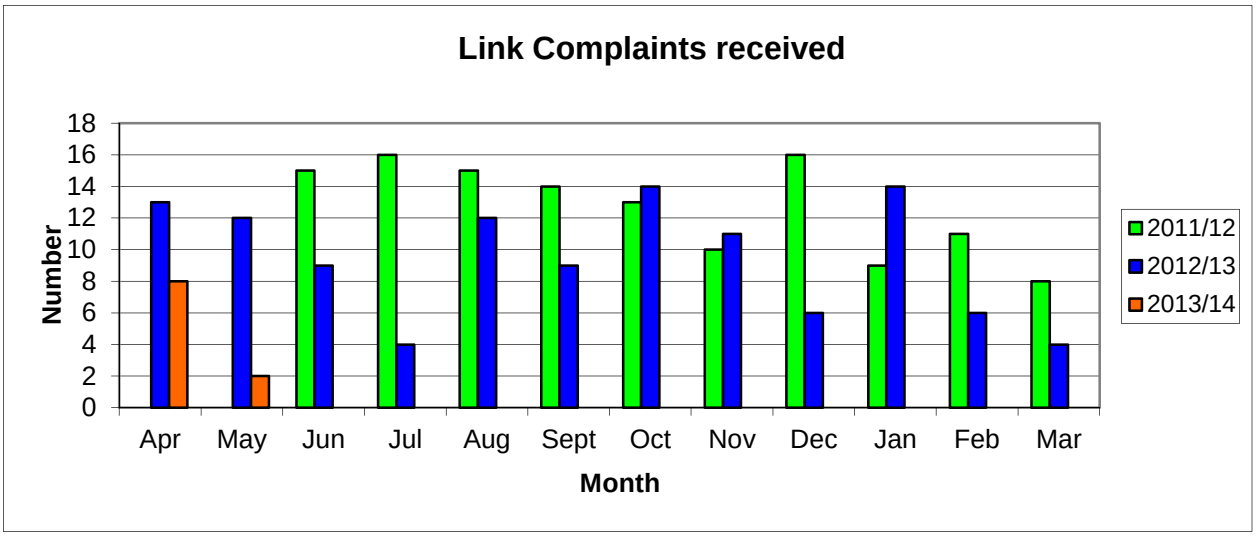


Division	NPS Score	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know	Movement
Medicine and EC	62	581	385	166	20	6	2	2	↑
Surgery and CC	69	497	363	107	9	5	10	3	↓
Surg B	92	12	11	1	0	0	0	0	↑
W & CH	81	48	40	5	1	1	0	1	↑

Figure 23: *Net Promoter position & Friends and Family Test*

10.2 Complaints





***Link complaint**: the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied and/or require additional clarification.*

Mortality table 2012/13

Figure 24: *Complaints received*

Context

The total formal and link (0) complaints received requiring a response in June 2013 (n =50) has reduced significantly when compared with May 2013 (n = 65).

June 2013 shows a 31% decrease compared with the same month last year (n = 73).

Categorisation

The 50 formal complaints received in June 2013 were graded as follows (11 are still waiting to be graded and are being reviewed by the Head of Department):

Red	1	Amber	6	Yellow	21	Green	11

Themes	Learning
The top 5 themes are: • All aspects of clinical treatment (n = 24) • Attitude of staff (n = 6) • Communication/information to patient (n = 6) • Appointments delay/cancellation (inpatient) (n = 1) • Cleanliness/Hygiene (n = 1)	All complaints received in June are in the process of being investigated. Learning from complaints closed in May include: • Ensure clear communication with patients • Offer an apology when things haven't gone as expected

10.3 Parliamentary and Health Service Ombudsman (PHSO)

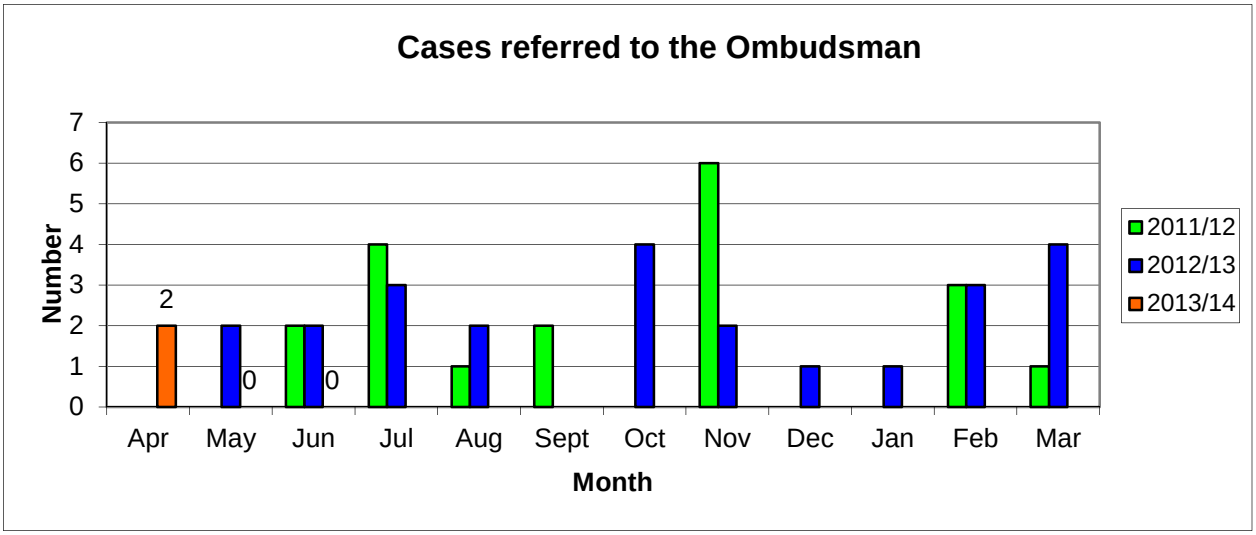


Figure 25: *Cases referred to the Ombudsman*

The Trust currently has 7 active cases with the PHSO

10.4 PALS

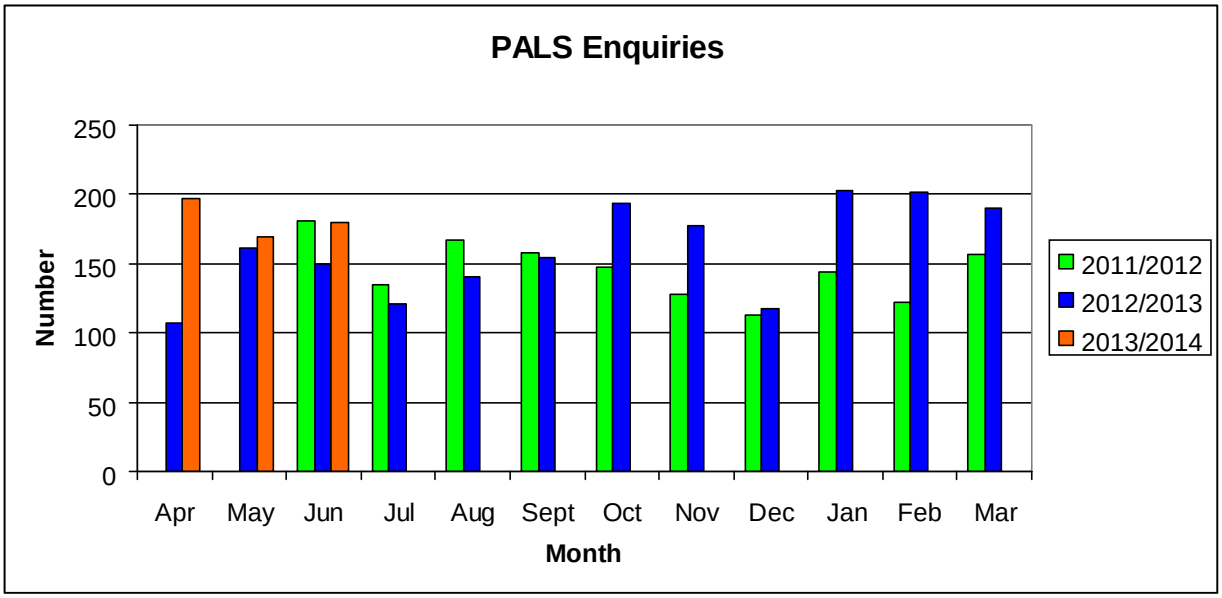


Figure 26: *PALS enquiries*

Context

Total PALS enquiries received in June 2013 (n=180) have increased when compared to May 2013 (n = 169). There were 6 PALS cases related to the community.

June 2013 shows a significant increase compared with the same month last year (n = 150). However, the Patient Support Centre also deals with general enquiries and these were significantly increased (2012/13 n = 183 compared with 2013/14 n = 317).

Themes	Learning
The top 5 themes are: ▪ Issues relating to clinical treatment ▪ Cancellation of appointments, mainly relating to cancellation, delays and notification of appointments. ▪ Issues relating to the request for formal complaints advice. ▪ Lack of communication, mainly with relatives. ▪ General enquiry issues, mainly relating to general advice and information.	In June 2013, PALS have investigated concerns and have assisted with a number of initiatives to improve the patient experience including: • Patient's relative was extremely dissatisfied with the level of care his grandfather received, also raised concerns about attitude of senior staff on ward. Matron contacted patient's relative and offered a meeting to discuss issues and also had a detailed telephone conversation with enquirer, which resulted in the relative being reassured that appropriate action would be taken to ensure that issues of concern were addressed. • Patient's relative raised concerns about temporary ward having 5 chairs for visitors for 16 bedded ward. Relative had witnessed elderly people standing during visiting. PALS contacted Matron who immediately arranged for temporary ward to be provided with another supply of chairs. Explained that the ward patient had been moved from was being deep cleaned, and apology given. • Patient attends BMEC finds waiting times and communication in particular to be an issue of concern. Divisional Lead arranged for an LIA to take place where discussion took place about setting up a working group to address issues to improve patient experience. Immediate action was to provide a communication board for clinics which would provide up-to-date information about delays etc. In addition Division will look at having a messaging service displayed on TV screens in the main waiting areas.

10.5 End of Life

End of Life Report

Preferred Place of Care/Death of Patients on SCP

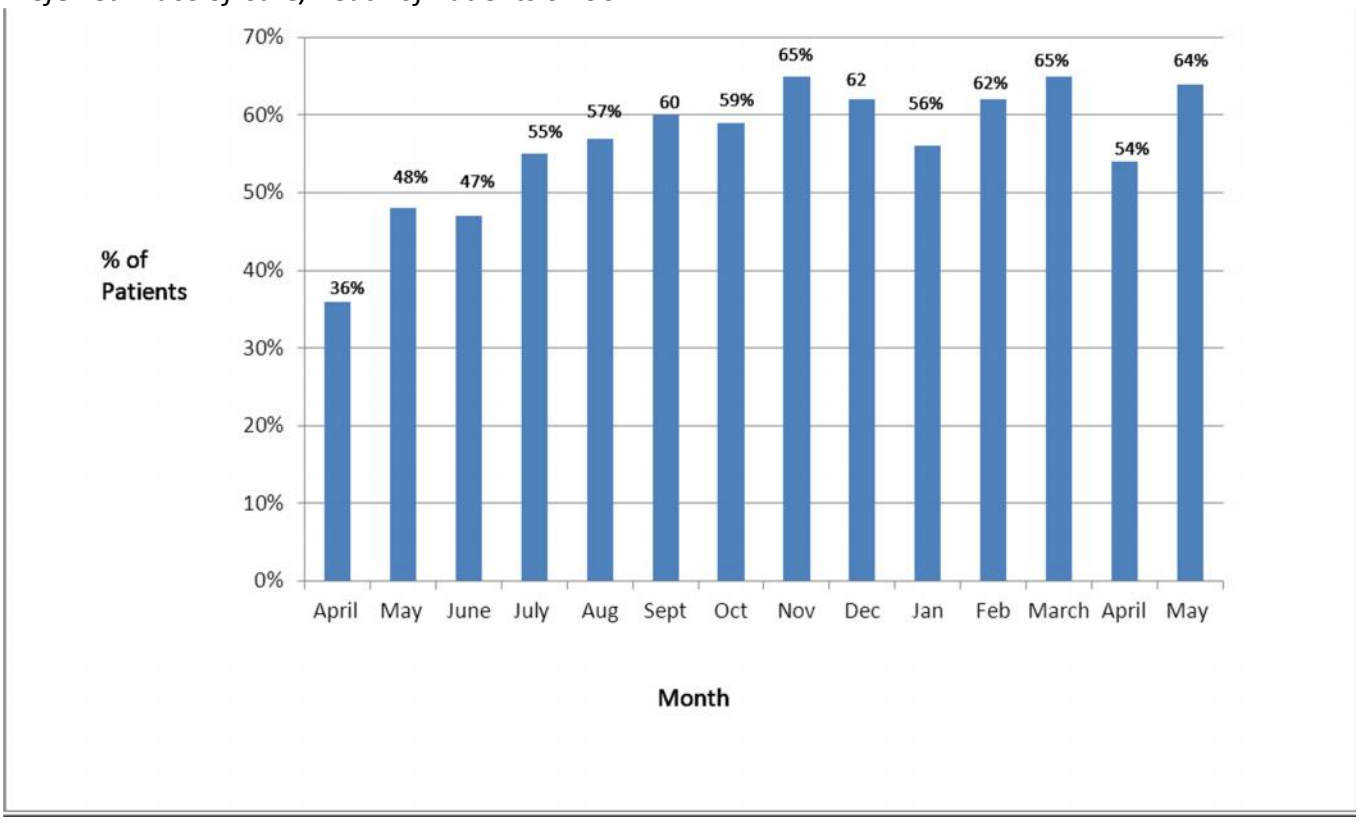


Figure 27: *Preferred place of death/death of patients on SCP*

11 RECOMMENDATION

The Trust Board is asked to:

- **NOTE** in particular the key points highlighted in Section 2 of the report and **DISCUSS** the contents of the remainder of the report.

APPENDIX 1

Glossary of Acronyms

Acronym	Explanation
CAUTI	Catheter Associated Urinary Tract Infection
C Diff	*Clostridium difficile*
CRB	Criminal Records Bureau
CSRT	Clinical Systems Reporting Tool
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
ED	Emergency Department
DH	Department of Health
HED	Healthcare Evaluation Data
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ID	Identification
LOS	Length of Stay
MRSA	Methicillin-Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NPSA	National Patient Safety Agency
OP	Outpatients
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
RAID	Rapid Assessment Interface and Discharge
RTM	Real Time Monitoring
SHA	Strategic Health Authority
SHMI	Summary Hospital-level Mortality Indicator
TIA	Transient Ischaemic Attack ('mini' stroke)
TTR	Table top review
UTI	Urinary tract infection
VTE	Venous thromboembolism
Wards:	
EAU	Emergency Assessment Unit
MAU	Medical Assessment Unit
D	Dudley
L	Lyndon
N	Newton
P	Priory
A&E	Accident & Emergency
ITU	Intensive Therapy Unity
NNU	Neonatal Unit
WHO	World Health Organisation
WTE	Whole time equivalent
YTD	Year to date

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Sandwell and West Birmingham Hospitals NHS Trust Health Informatics Strategy: Delivering the Informatics Strategy, next steps**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis, Chief Executive**
AUTHOR:	**Fiona Sanders, Interim CIO**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

This paper provides a summary of the pre-procurement planning that is underway and provides a briefing on interfaced and integrated EPR genres.

This paper is presented to inform a preliminary discussion around interfaced and integrated EPR options. This will inform the development of the procurement strategy

REPORT RECOMMENDATION:

This report is for information purposes.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Supports the achievement of the Trust's long term strategy and MMH plans

PREVIOUS CONSIDERATION:

Clinical Leadership Executive on 16 July 2013

Trust Board: Delivering the Informatics Strategy

Date: 17th July 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

1. EPR procurement background

The Sandwell and West Birmingham Hospitals NHS Trust (The Trust) Informatics Strategy was agreed in September 2012 and sets a five-year framework for transforming the Trusts capability and capacity for informatics. In 2013 NHS England established challenging targets for establishing digital communication between secondary and primary care by 2015 and for the NHS to be paper-free by 2018. In parallel to our key corporate and national objectives face contract renewals on a number of core systems.

Delivery of the Informatics Strategy has already commenced with core projects already initiated for the replacement of radiology, A&E along with infrastructure projects. However we have a number of other digital solutions proposed and we are now approaching the most significant start, the delivery of our integrated digital record, the foundation of which will be our EPR solution

What is imperative is that this decision is clinically led with comprehensive buy-in from everyone including doctors, nurse, allied health professionals and those working in service departments. However for this endeavour to be succeed clinical leadership and technical advances must be in step if the benefits are to be maximised.

We are in the pre-procurement planning phase for delivery of the EPR solution. In order to achieve the Trust's business and operational objectives, support the transition to our future operating model and to ensure compliance with NHS England's timetable to be paper free by 2018 we have targeted deployment by completion at 2017. In order to achieve our overall plan and objectives, as defined by the by the Informatics Strategy we must commence the development of our procurement strategy.

The Health Informatics Service has already commenced pre-procurement planning; the high level tasks are detailed in section 3 of this paper. Through June and July a number of education sessions and site visits to various EPR solutions and suppliers have been undertaken. The objective of these visits has been to build clinical awareness and education and inform the first stage of our pre-procurement planning which is the definition of the strategic outline case. In developing the strategic outline case the options appraisal is the primary deliverable. In researching the options available to meet our strategic and operational needs we have identified seven options. The seventh option has been recently added in response to the emerging guidance from NHS England. Seminal to the development of the strategic outline case is the decision as to whether the Trust will procure an interfaced or an integrated solution

2. Integrated versus interface

The electronic patient record is defined as the core, organisational record on which other forms of data exchange and secondary usage can be built. It is the central repository for recording patient activity at the point of care. It must support safe high quality care delivered in partnership between

Trust Board: Delivering the Informatics Strategy
Date: 17th July 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

patients and professionals. In addition to supporting the delivery of clinical care there are many other uses for data captured as a by-product of that clinical care.

2.1. Interfaced solutions

A best of breed, interfaced solution takes the best solution from different or the same supplier and creates an Electronic Patient Record through interfacing of these systems and sharing a common view by a portal which the clinicians access. An interfaced solution relies upon the ability of the identified systems complying with interoperability standards. Interoperability standards define the standard by which physical connections between systems are made and how data is exchanged. There are dependencies on the type and frequency of data exchange and these dependencies are based up internal messaging standards, system ability to send, receive and display information.

2.2. Integrated solutions

An advanced integrated EPR is one where the entire core of the EPR remains intact and is procured from one supplier. Some legacy systems, such as core departmental solutions such as Radiology & Pathology and some specialist systems will then be interfaced to the CORE EPR. The Core consists of very advanced functionality and usually consists of as a minimum, patient master index, patient administration, requesting tests and investigations; EPMA, Pharmacy (for closed-loop medication, clinical decision support, TTOs/eDischarges, assessments and clinical observations, clinical guidelines, protocols, scheduling, theatres, integrated care pathways and advanced clinical decision support. An integrated solution has a reduced dependency on interoperability standards although interfacing of core departmental systems would still remain. It should be noted that only a limited number of supplier meet this criteria.

2.3. Options appraisal

In developing the options for procurement the Trust has identified seven options which essential divides into two genres of EPR – interfaced versus integrated.

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Date: 17th July 2013
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Authors: Fiona Sanders (Interim CIO)

3. The options explained

3.1. Option 1 - Do Nothing/Minimum – Retain iCM

iCM is the legacy EPR in place and has been installed since 2003. Currently implemented are eRequesting of tests and investigations; TTO Prescribing with eDischarge letter; alerts; health issues; allergies; VTE; Think Glucose; Think Alcohol assessments and smoking cessation referrals, as well as some specialty letters. In its time it was a leading EPR, but following a break-up of contractual relationships with Eclipsys Corporation (now Allscripts) and iSoft's focus on Lorenzo there has been limited development of the functionality in UK. In addition, there has been constant hardware and technical issues, which has meant roll-out of any additional functionality been extremely difficult. CSC who bought out iSoft PLC is no longer focusing on iCM as a major development.

3.2. Option 2 – Lorenzo Regional Care

Lorenzo Regional Care is the product from CSC Corporation as part of the National Programme for IT (NPfIT). Since the cessation of NPfIT, it is no longer a requirement of Trusts to take Lorenzo, but in part of the renegotiations of the contract with CSC, a number of financial incentives have been agreed for the initial Trusts who still decide to take Lorenzo as their strategic choice for an electronic patient record. Within the agreed contract is only a limited functionality in terms of a complete EPR.

Option 3 – Best of Breed EPR

A best of breed is to take solution the best solution different or from the same supplier and create an Electronic Patient Record through interfacing of these systems and sharing a common view by a portal which the clinicians access.

Interfaced	Integrated
Option 1 Do nothing/do minimum Retain iCM as the future EPR	1. **Option 4** – Integrated advanced EPR • Allscripts • Cerner • Epic
Option 2 Procure Lorenzo Regional Care	2. **Option 7** –NHSVistA
Option 3 Best of Breed EPR	
Option 5 Develop in-house EPR solution	
Option 6 UHB/CSE Solution	

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Date: 17th July 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

3.3. Option 4 – Integrated Advanced EPR

An advanced integrated EPR is one where the entire core of the EPR remains intact and is procured from one supplier. Some legacy systems, such as departmentals like Radiology & Pathology and some specialist systems will then be interfaced to the CORE EPR. The Core consists of very advanced functionality and usually consists of as a minimum, areas such as requesting tests and investigations; EPMA, Pharmacy (for closed-loop medication, clinical decision support, TTOs/eDischarges, assessments and clinical observations, clinical guidelines, protocols, scheduling, theatres, integrated care pathways and advanced clinical decision support. These are very advanced EPRs and are usually only delivered by certain suppliers.

3.4. Option 5 – Develop an EPR in-house

This would build on our current capabilities with the development of the Clinical Data Archive (CDA) and the eBMS systems to develop them into a full EPR solution.

3.5. Option 6 - UHB/CSE Solution

The UHB solution is an in-house development called PICS which generally includes EPMA for inpatients including decision support, including eRequesting & Results Reporting, assessments and clinical observations. They have a contractual relationship with a supplier called CSE to market PICS and a reciprocal contractual relationship to work with CSE to develop their OCEANA system. OCEANA has been implemented in their ED department and they are currently working on designing a PAS system.

3.6. Option 7 - NHSVistA

NHSVistA has been launched by NHS England in their document "Safer Hospitals; Safer Wards – achieving an integrated Digital Care Record" issued on the 1st July as part of their Technology Fund of £260m which Trusts can bid against. VistA is the internationally acclaimed open-source system used throughout the Veterans' Association (VA) in the United States. NHS England intends to create from the US source code a Gold Standard which will become NHSVistA. They are inviting expressions of interests from Trusts or a formal bid to the Technology fund to be more actively involved with the Gold Standard and pilot of this Electronic Health Record.

4. The Next steps

Following a decision by the Trust Board on the preferred EPR genre, interfaced or integrated we will proceed to agreement of the procurement strategy and high level plan. A summary of these steps are identified in the table below. summarised below and identify the some of the major activities

Phase Headline	Activity	Why are we doing this?

Trust Board: Delivering the Informatics Strategy

Date: 17th July 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

Phase Headline	Activity	Why are we doing this?
Pre-procurement	Identify and define Strategic Outline Case (SOC)	**Why do we need to do this and what is our business justification?**
	Decision on procurement route: Restricted procedure versus Competitive dialogue	**How are we going to buy a solution to meet our needs** Historically restricted procedure is the approach that has been taken but competitive dialogue originally developed for use where requirements and solutions were less defined but facilitates early engagement with the with suppliers.
	Options appraisal	**What options do we have?** This is a major component of the SOC and looks at the options open to us for achieving our integrated digital care solution. We have identified 5 options: Option 1: Do nothing Option 2: CSC Lorenzo Option3: Best of breed Option 4: Fully integrated advance EPR Option 5: Develop EPR in house Option 6: Procure UHB
Procurement Strategy	**Resources** Establish a procurement team that includes financial, legal and procurement expertise AND has clinical leadership which is there to ensure that the solution is procured is meets the needs of clinical and non-clinical	**Who will do this?** This is team is vital, they must be representative of stakeholders and ensure that they are empowered and representative of the organisation

Trust Board: Delivering the Informatics Strategy

Date: 17th July 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

Phase Headline	Activity	Why are we doing this?
	stakeholders	
Requirements	High Level Business Requirements	**Do we know what we want?** This is effectively all Trust business processes -admin and clinical. We will use this to develop our evaluation criteria and to evaluate It must be aligned to and support the Transformation Programme and the MMH project.
Benefits	High Level Benefits Identification	**Do we know what benefits we will achieve?** This is effectively all Trust business processes -admin and clinical. Again it must be aligned to and support the Transformation Programme and the MMH project.
Business case	Outline Business Case, (workshops with stakeholders and initial documentation of OBC)	**Can we justify this?** NTDA business case model is to both justify and approve the procurement It must be aligned to and support the Transformation Programme and the MMH project.
	Evaluation Requirement, prequalification Criteria and Expression of interest	**How do we know we are buying the right solution?** Procurements of this size attract interest; we will use this solution for the next 10 to 15 years. It will support the delivery of our services and is essential to high quality safe patient care.

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Date: 17th July 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

Phase Headline	Activity	Why are we doing this?
Evaluation	Evaluation of the responses we receive. There will be a slightly different mechanism depending on whether we take a restricted approach or competitive dialogue	**Choosing our integrated digital care provider?** Making the right choice our procurement team will need to evaluate the responses against the core components that we have defined in our procurement strategy.
Selection	Complete the contract negotiations and agree BAFO Complete the business case approval Obtain board approval Obtain NTDA approval	**Choosing our integrated digital care provider?** Ensuring we procure a solution that meets our needs: 1. Those of our local health community 2. Those of our patients 3. Is future proof
Implementation **(Deployment)**	Delivering the vision and taking advantage of the capabilities and benefits offered by our informatics strategy	**Taking advantage of the capability?**

5. Action required

This paper is presented to the Trust Board for information and to advise the board of the status of pre-procurement planning and advise the board that a decision regarding the EPR genre will be required from the Trust Board in September

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Future Approach to Risk Management**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

Through a series of questions, this paper sets out an approach for embedding risk management and creating an improved risk culture for Board members to consider and discuss.

It is proposed that the Trust achieves the required risk culture through a change management programme approach.

REPORT RECOMMENDATION:

The Board is invited to consider the questions set out in the paper and to comment on the proposed way forward for developing the organisation's risk culture.

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

Accept	Approve the recommendation	Discuss
	X	X

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

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

Comments:

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

Outlines the future approach to risk management in the Trust

PREVIOUS CONSIDERATION:

None

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Future Approach to Risk Management

A discussion paper for Board members

1. Introduction

1.1 The Trust's Risk Management Strategy was reviewed and updated last year to ensure continued compliance with NHSLA requirements and in response to recommendations raised by Deloitte as part of their external review of the Trust's Quality Governance arrangements in support our Foundation Trust application. The Board approved the revised Risk Management Strategy in August 2012.

1.2 Although time has been spent in developing the risk management framework and implementing the supporting policies and procedures, with some areas of good practice, the overall approach requires strengthening. This is evidenced by inconsistent risk identification, variable quality risk assessments and irregular upkeep of risk registers. The need for improvement applies at all levels across the organisation from the Board to the frontline.

1.3 So although a rudimentary infrastructure is in place, that can relatively easily be developed, the culture is weak. No matter how good the risk infrastructure is, risk management is essentially a people issue, because people take responsibility for managing risk.

1.4 Creating a culture where effective risk management is an integral, and natural part of the way most people work – embedding risk management – is a priority aim for the Trust. It is possible to establish leadership, direction, policies and risk processes relatively quickly, but embedding risk management into core business processes (such as business planning or performance management) will take longer and full culture change is expected to take several years. The key issue is **"how do we make as much progress as possible with cultural change, as quickly as possible, and sustain momentum?"**

1.5 It is proposed that the following four key questions, which are set out in more detail below, need to be answered when considering the risk culture:

What does a good risk culture look like?	What do we mean by risk culture?	Why is risk culture so important?	What can the Board do about risk culture?

1.6 The purpose of this paper is to set out an approach for embedding risk management and creating an improved risk culture for Trust Board members to consider and discuss.

2. What does a good risk culture look like?

2.1 An effective risk culture is one that enables and rewards individuals and groups for taking the right risks in an informed manner.

2.2 A successful risk culture would include:

a	A distinct and consistent tone from the Board and senior management in respect of risk taking and avoidance (and consideration of tone at all levels).
b	A common acceptance through the organisation of the importance of continuous management of risk, including clear accountability for and ownership of specific risk and risk areas.
c	Transparent and timely risk information flowing up and down the organisation with bad news rapidly communicated without fear of blame.
d	Encouragement of risk event reporting and whistleblowing, actively seeking to learn from mistakes and near misses.
e	No process or activity too large or too complex or too obscure for the risks to be readily understood.
f	Appropriate risk taking behaviours rewarded and encouraged and inappropriate behaviours challenged and sanctioned.
g	Risk management skills and knowledge valued, encouraged and developed, with a properly resourced risk management function.
h	Sufficient diversity of perspectives, values and beliefs to ensure that the status quo is consistently and rigorously challenged.
i	Alignment of culture management with employee engagement and workforce strategy to ensure that people are supportive socially but also strongly focused on the task in hand.

3. What do we mean by risk culture?

3.1 Risk culture is a term describing the values, beliefs and knowledge and understanding about risk shared by a group of people with a common purpose, in particular the employees of an organisation or of teams or groups within an organisation.

3.2 Risk culture refines the concept of organisational culture to focus particularly on the collective ability to manage risk, but the wider organisational culture itself is an active backdrop determining, and itself influence by, risk culture. The use of a simple A-B-C approach (*Institute of Risk Management*) is helpful in understanding how culture, hence risk culture, works in practice. Taking each step in the model:

Risk attitude	Risk behaviour	Risk culture
The chosen position adopted by an individual or group towards risk, influenced by risk perception and pre-disposition	Comprises external observable risk-related actions, including risk-based decision-making, risk processes, risk communications etc.	Is the values, beliefs, knowledge and understanding about risk, shared by a group of people with a common intended purpose, in particular the leadership and employees of an organisation

3.3 One of the many challenges in addressing culture is that people naturally gravitate to others like themselves so the culture of an organisation can self-propagate if recruitment processes and environment remain unchallenged.

3.4 Every organisation has a risk culture (or indeed cultures): the question is whether that culture is effectively supporting or undermining the longer-term success of the organisation.

4. Why is risk culture so important?

4.1 All organisations need to take risks to achieve their objectives. The prevailing risk culture within an organisation can make it significantly better or worse at managing these risks. Risk culture significantly affects the capability to take strategic risk decisions and deliver on performance promises.

4.2 Organisations with inappropriate risk cultures will inadvertently find themselves allowing activities that are totally at odds with stated policies and procedures or operating completely outside these policies.

4.3 An inappropriate risk culture means not only that certain individuals or teams will undertake these activities but that the rest of the organisation ignores, condones or does not see what is going on. At best this will hamper the achievement of strategic, tactical and operational goals. At worst it will lead to serious reputational, clinical and financial damage.

4.4 Risk culture is not always about taking too much risk: certain cultures may be so good at developing and implementing formal processes and frameworks that they stifle the risk-taking necessary for successful innovation. In other situations, the prevailing culture can make it virtually impossible to embed the risk attitudes and behaviours that guide appropriate action outside of rules and policies, ultimately leading to uncontrolled risk-taking.

4.5 Over recent years significant progress has been made in developing rules, frameworks, processes and standards for managing risks. These disciplines are not in themselves sufficient to make a tangible difference to the success or failure of organisations. Rules can be misunderstood and misapplied, inadvertently or deliberately. Understanding how to balance risk and reward successfully in decision-making is the organisation's risk culture.

5. What can the Board do about risk culture?

5.1 Corporate governance requirements are increasingly demanding that boards of organisations should understand and address their risk cultures. The board has a responsibility to set, communicate and enforce a risk culture that consistently influences, directs and aligns with the strategy and objectives of the organisation and thereby supports the embedding of its risk management frameworks and processes.

This starts with the risk behaviours, attitudes and culture of the board itself and reaches down through the organisation. The Board needs to ask:

What is the current risk culture in our organisation and how do we improve risk management within that culture?	How do we want to change that culture?	How do we move from where we are to where we want to be?

6. Changing a risk culture

6.1 It is possible for an organisation to drive change in its risk culture. This requires a clear understanding of the current culture and the desired 'target' culture. It requires recognition that this is a major change programme and requires discipline to see it through.

6.2 The culture change should be treated as a change management project in its own right, with appropriate allocation of board time and resources. A culture cannot be rewritten simply by mandating that the values or ideology of an organisation have changes.

6.3 The organisation must approach the risk culture change as a project, with a set of objectives, a design for intervention and with regular review of both progress and outcomes.

6.4 There is a range of well recognised tools and approaches that have been proven in certain situations to be valuable in supporting and sustaining culture change. It is recommended that these resources are included within the work of those leading the change programme.

6.5 Successful change ultimately requires awareness that the board itself, and the executive management, are an integral part of the existing risk culture. Sustained change in the risk culture needs to start at the top and may require a reappraisal of approaches consistent with bringing greater diversity of thinking at board-level.

7. Ten questions the Board should ask itself

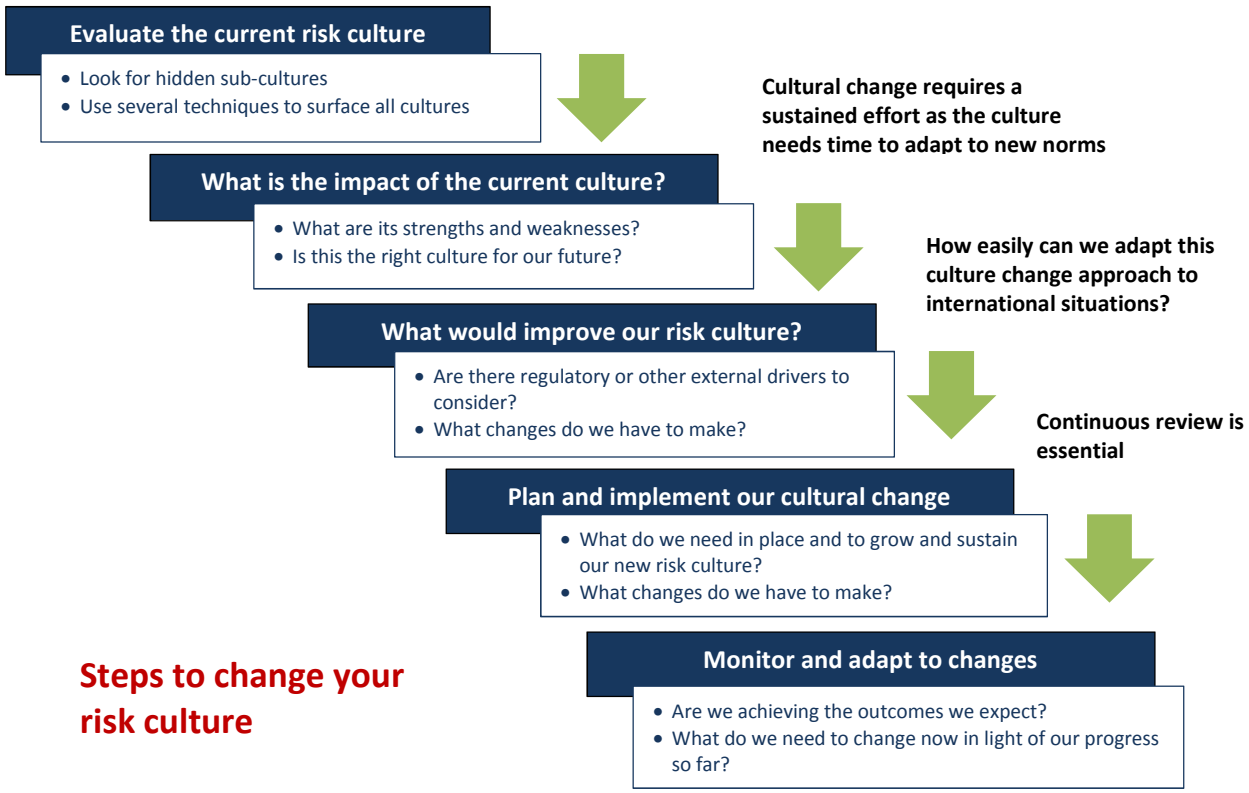
1	What tone do we set from the top? Are we providing consistent, coherent, sustained and visible leadership in terms of how we expect our people to behave and respond when dealing with risk?
2	How do we establish sufficiently clear accountabilities for those managing risks and hold them to their accountabilities?
3	What risks does our current corporate culture create for the organisation, and what risk culture is needed to ensure achievement of our corporate goals? Can people talk openly without fear of consequences or being ignored?
4	How do we acknowledge and live our stated corporate values when addressing and resolving risk dilemmas? Do we regularly discuss issues in these terms and has it

	influenced our decisions?
5	How do the organisation's structure, process and reward systems support or detract from the development of our desired risk culture?
6	How do we actively seek out information on risk events and near misses – both ours and those of others – and ensure key lessons are learnt? Do we have sufficient organisational humility to look at ourselves from the perspective of stakeholders and not just assume we are getting it right?
7	How do we respond to whistleblowers and others raising genuine concerns? When was the last time this happened?
8	How do we reward and encourage appropriate risk taking behaviours and challenge unbalanced risk behaviours (either overly risk averse or risk seeking)?
9	How do we satisfy ourselves that new joiners will quickly absorb our desired cultural values and that established staff continue to demonstrate attitudes and behaviours consistent with our expectations?
10	How do we support learning and development associated with raising awareness and competence in managing risk at all levels? What training have we as a Board has in risk?

8. What do we do next

8.1 Having established a problem with our risk culture, it is essential to establish exactly where or what the problem is. So while it is tempting to dive in and start making changes, an assessment is a good place to start. Finding out where our strengths and weaknesses are – the facts, not just intuition – and building a prioritised plan from there is the proposed way forward.

8.2 Set out below are the steps suggested to start on a programme of risk culture change.



Steps to change your risk culture

9. Conclusion

9.1 The Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. We cannot achieve our objectives without taking risks. The question is how much risk do we need to take? Yet, taking those risks without consciously managing those risks can lead to the organisations downfall.

9.2 Bringing about fully effective risk management in the Trust will require a cultural change, to embed risk management in the behaviour and activity of all staff.

9.3 It is proposed that the Trust achieves the required risk culture through a change management programme approach. Subject to the Board's agreement, a detailed plan will be drawn up and presented to the Audit and Risk Committee for 'sign-off' in October 2013. In the short term, we will continue to focus on improving risk management within the existing culture to ensure that risks are identified and appropriately managed.

10. Recommendation

10.1 The Board is invited to consider the questions set out in this paper and to comment on the proposed way forward for developing the organisation's risk culture.

Kam Dhami
Director of Governance

July 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Update on the overall thinking behind a cultural change plan for SWBH
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Toby Lewis, Chief Executive
DATE OF MEETING:	25 July 2013

EXECUTIVE SUMMARY:

The attached report summarises the emerging culture change programme that we are developing as an Executive, alongside our clinical leaders.

The paper lists the key drivers for change and articulates the 'what' and 'how' elements of the plans.

REPORT RECOMMENDATION:

The Trust Board is asked to ACCEPT the report.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Cuts across a number of Trust priorities and objectives.

PREVIOUS CONSIDERATION:

The context to our cultural adaptation has been discussed formally and informally previously by the Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

UPDATE ON THE OVERALL THINKING BEHIND A CULTURAL CHANGE PLAN FOR SWBH

Report to the Trust Board – 25 July 2013

1. This note summarises the emerging culture change programme that we are developing as an Executive, alongside our clinical leaders. The programme is a work in progress and I am content that the right time to 'launch' is in quarter three of 13-14. It needs to be owned not only by the board as a whole, but by the Clinical Leadership Executive. At this stage we are trying to frame the 'what' – armed with that we can rehearse, road-test, and improve the best way to make this work emotionally connected internally and externally (though currently the label 'common-sense' might applied to our plan). The strategic communications review will consider how we might get a message and promise across.

2. The context to our cultural adaptation has been rehearsed formally and informally in the Board. To précis again the five key drivers for change:
    i. The NHS as a whole has yet to fulfil the promise to look **out not up** and to hear from and act upon local ambitions with as much vigour as it pursues national priorities. Patients' voices need to be salient in what we choose to focus upon.
    ii. The future of our organisation will be one in which the boundary of what we do and others do will be ever more permeable, not only in health but in social or personal care. As such, service level leadership, innovation at pace, and risk management will be core competencies, **distributed more widely in our Trust** than at present.
    iii. We think we know that high quality care comes from high quality teamwork. That demands a culture in which **individuals see their place in a collective endeavour**. But as care models change most people will need to be part of several teams at once, breaking down traditional distinctions of place and purpose defined by profession or location.
    iv. Motivated engaged people contribute **discretionary effort**. Put differently 'happy staff go the extra mile'. Though SWBH has led the NHS on staff engagement activity, and although we are upper quintile for management/employee connections, we remain far behind international health norms.
    v. Change and improvement will come less through great ideas than through embedding the **habits of improvement in the DNA of SWBH**. This is long term work, from which the immediate can easily distract us. But if we get our people to know how to execute experiments locally then we can unlock innovation in a way we cannot top down.

3. The risk of an attempt to culturally adapt the Trust is that it becomes an act of process change where we deliver symbolic alteration but do not shift the key metrics that we, our staff/colleagues and our patients/partners believe are most important. In other words the 'what' and the 'how' get confused. That is a substantial risk in any change programme, but more so when culture is about how. So, we want to change the how of our work, but need

that to deliver a set of results as we do so. Bearing that in mind, we are setting out to improve our reported patient experience results and drive up the nine indicators of staff engagement derived from the Macleod review. The non-exhaustive frame of reference we are using to try and develop a culture programme focuses in at least five areas:

What we intend to change	**How we intend to change**
1. Our patients' experiences of care will be consistently high quality and exhibit 6Cs	2. Leadership qualities will be evident widely in our Trust and those competencies will be consistent and reinforcing in all disciplines
3. Our colleagues' sense of their contribution to the organisation will be positive and engaged.	4. What success looks like round here will be known, and the rewards for success and consequences for failure will be explicit, accepted and consistent in all disciplines.
	5. How the organisation is managed will reflect the reality of the care we are providing and our intelligence about that care will be reported in that reality, not in a form dictated by technology or history

4. These ideas reflect areas where we sense we have further work to do. Crucially, we need to add into our thinking the areas where we believe we need to reinforce current strengths. Typically in building a cultural plan, large organisations look to create a set of internal values and external commitments. In SWBH we have statement of five values and a set of nine promises which have been developed over many years and are widely understood across the organisation. Subject to wider comment, my sense is that these need restating and re-publicising – in other words becoming embedded in how we work - rather than changing or starting again. We have the opportunity to make a virtue of continuity and create a sense of permanence, though we might consider whether a tenth promise around the wider determinants of health has merit both for patients and those we employ.

5. Since we discussed our culture in late April, we have spent time on the three 'how' proposals tabulated above. This has given rise to seven specific changes we are planning:

i. Agreement within CLE to create a single leadership development model, into which all our development investment would be channelled, grounded in the LQF, but ultimately building towards a local faculty able to support on ongoing programme of internal learning.

ii. A commitment to change our appraisal model so that it is (a) grounded in our values and behaviours and (b) reflects for our leaders a 360-degree model of assessment.

iii. An emerging autonomy and accountability framework to govern the relationship between differing tiers of the organisation but also to underpin our reward strategy and our approach to poor performance at the Trust.

iv. The provision of a standard-form data set in clinics, wards, directorates and externally (as well as points between) so that that definition of success is quantitatively visible not less than monthly in our Trust and probably more regularly still.

v. An emerging view that we need to fast-track a route to level four self-assessment on Monitor's performance management framework, and in parallel simplify our approach to Service Line Reporting and Management.

vi. Revising our improvement team (our TSO) so that not only is its focus broader and more connected to our strategic agenda, but it develops a teaching and training platform designed to spread skills inside the organisation in a managed way. The TDA are kindly agreeing to fund a small project on experience-led care redesign, and meanwhile we are also building a relationship with Unipart as an organisation notably successful for having undertaken this type of change.

vii. Revising our approach to risk management, so that we can have greater confidence that risks are reported from across our organisation but also that they are mitigated and managed not just recorded.

6. These themes have a place in individual director's objectives as well as a focus as a standing item now in CLE. As we develop them we can identify a trajectory for each but also an impact analysis for what we want to gain from the changes. This list leaves unexplored our 'whats'. And the broader agenda on how we truly become a clinically led organisation. This should flow from the focus we give to clinicians' broader priorities within the framework but also in how we expand our bandwidth of engaged clinical leaders through the development programme (not only in how it coaches existing leaders but how it takes in next generation leaders).

   CLE in August will focus its time on our patient experience priorities arising from Clinical Groups' analysis of what the current plethora of data tells us. This will provide an introduction for the new CNO to our approach to patients' experiences – an agenda which needs to not be solely owned by our nursing teams. In 13-14 our focus will remain on our outpatient standards and on the Friends and Family Test – both its spread and on pushing our results into the 70s.

   There is a need to reflect with JCNC and others on what matters most in staff morale. Our LiA events continue, but those focused on this question, as well as the 'Hot Topics' segment of the same vein, did not produce a conclusive sense of the key steps we need to take – beyond creating more of a sense of local decision making. From next month we will begin more routine local polling of employees, which should give us richer data on what will make a different to perception.

7. The next time the Board sees this thinking we might expect:
   - Proposed final metrics on patient experience and staff engagement, as well as the baseline and local trajectories
   - A timeline for the seven interventions outlined above, including our autonomy and accountability framework, and work building on Kam's note about risk management
   - An overall communication approach that weaves together what we wish to conserve and what we need to change
   - Confirmation of which groups in our new structure will look after which elements of this programme, and how they will know the whole picture of the work

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Health Promotion Strategy**
SPONSOR (EXECUTIVE DIRECTOR):	**Roger Stedman, Medical Director**
AUTHOR:	**Dr Doug Robertson, Clinical lead for Prevention and Lisa Carroll, Assistant Head of Nursing for Medicine & Emergency Care**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

Attached is a draft version of the first Health Promotion Strategy specifically for the Trust, which will inform the direction for us to improve health across the Sandwell and West Birmingham Health Economy.

The strategy sets out how the Trust proposes to improve the health and wellbeing of its patients, visitors, staff, Trust members and the local community. It recognises current activity and seeks to build on this. By taking a co-ordinated approach the entire organisation will be able reinforce consistent health-promoting messages and support policies of major worth in this area.

REPORT RECOMMENDATION:

The Board is asked to consider and accept the draft strategy.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Not specifically

PREVIOUS CONSIDERATION:

The strategy has been developed in consultation with stakeholders across the acute and community sectors which included a Strategy Development event on the 24th April 2013.

Health Promotion Strategy for Sandwell and West Birmingham Hospitals NHS Trust

July 2013

Document Control	
Document Status:	Draft
Document Author(s):	Dr Douglas Robertson Lisa Carroll
Owner:	Clinical Health Promotion Steering Group
Client:	Sandwell and West Birmingham Hospitals NHS Trust
File Ref:	Annual Strategy July 2013

The Health Promotion Strategy for Sandwell and West Birmingham Hospitals NHS Trust

Statement from Chief Executive

It gives me great pleasure to present our first Health Promotion Strategy.

Toby Lewis
Chief Executive

Contents

1. Introduction

This is the first Health Promotion Strategy specifically for Sandwell and West Birmingham Hospitals NHS Trust (SWBH) and will inform the direction for us to improve health across the Sandwell and West Birmingham Health Economy. It has been developed in consultation with stakeholders across the acute and community sectors which included a Strategy Development event on the 24th April 2013.
It sets out how SWBH proposes to improve the health and wellbeing of its patients, visitors, our staff, Trust members and the local community. It recognises current activity and seeks to build on this. By taking a co-ordinated approach the entire organisation will be able reinforce consistent health-promoting messages and support policies of major worth in this area.

2. National Policy

The need for engagement with prevention to mitigate rising NHS costs was identified in the Wanless report (2004), and further developed by NICE (2007). Prevention, Health and Wellbeing and Health Inequalities are now key national and regional priorities for the NHS. Although health has improved for many people, there are still major inequalities in health in England. The scale of the problem is highlighted in the Marmot Review, 'Fair Society, Healthy Lives' (2010), which suggests that these inequalities have significant human and economic costs, are mostly avoidable and that the role and impact of ill health prevention must be strengthened.

The cost of health inequalities can be measured in human terms, years of life (preventable, total and active life lost); and in economic terms, by the cost to the economy of additional illness. If everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life. They would, in addition, have had a further 2.8 million years free of limiting illness or disability. It is estimated that inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year (Marmot Review, 2010). Addressing this by systematic prevention efforts is now a major workstream in QIPP.

These themes were adopted in the Public Health Outcomes Framework for England 2013-2016 (2012, DH). Key areas identified by the Chief Medical Officer for England in her recent report (DH 2012), using the WHO Health risk toolkit (WHO 2009) are:

• tobacco use • harmful alcohol use • high blood pressure • high cholesterol • overweight & obesity	• physical inactivity • illicit drug use • low fruit and vegetable intake • occupational risks • poor sexual health

3. Health promotion in Hospitals.

As a provider organisation we strive to treat patients safely and effectively, efficiently, and to a high standard. However, many of the diseases we deal with are determined by the choices made by individuals: particularly around smoking, alcohol consumption, diet and exercise. We see people with long term conditions every day, often with their families, and may be able to engage with those who do not access other parts of the health care system.

Locally we have been successfully addressing many issues concerning acute provision and national targets, but falling behind in areas that are affected by lifestyle choices. The link between lifestyles and ill health need to be better communicated to our population to engage them individually in investing in their own future.

The WHO recognises that hospitals are places where health is the overarching goal, and much expertise is concentrated. Hospitals generally have a high prestige with their patients and interact with them at a point where they may be amenable to behavioural change (WHO HPH 2007).

The concept has been clearly delineated by the WHO's Europe office.

"A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment, and actively cooperates with its community" (Groene & Garcia-Barbero, 2005).

In aspiring to this, the Midlands and East Strategic Health Authority (SHA) required commissioning organisations to take an evidence based, health promoting approach in dealings with providers: reflected locally in CQUINs around prevention (predominantly involving VTE, smoking, and identifying excessive alcohol consumption). We now have systems delivering the CQUIN targets in these areas, but the SHA developed further initiatives with providers, including 'Making Every Contact Count (MECC)' based on the WHO Health Promoting Hospital programme (WHO HPH) (Groene, 2006), behavioural economics (Thaler & Sunstein, 2008) and simple pragmatism (see Appendix). The role of a Clinical Champion for Prevention for each acute Trust was funded by the SHA and appointed to in SWBH in September 2012. The main functions of the role were to promote the implementation of the programme 'Making Every Contact Count', but also to establish the features of a health promoting hospital in SWBH.

4. Benefits of a formal Health Promotion strategy in SWBH

An explicit health promoting strategy describes the relevance and rationale for a health promoting hospital as conceived by the WHO. Those features when implemented can be broken down into the following benefits for SWBH:

1. To understand public health policy and relate it to our current clinical activity
2. To obtain executive support for health promotion activity
3. To mandate prevention in all our care pathways and contacts with patients
4. To establish information systems to measure clinical health promotion activity
5. To ensure SWBH is a healthy place to work
6. To be explicit about health promotion in job descriptions, policies and procedures
7. To embed health promotion in the Trust's culture
8. To improve partnership working with other organisations with similar aims
9. To make a positive impact on the health of our community

5. Strategy Development

This strategy was developed in the following way:

1. Review of international, national and local guidance/strategies for public health.
2. Review of other Health Promotion strategies, particularly from acute hospitals elsewhere in the UK
3. Benchmarking against organisational standards including the 2006 WHO Health Promoting Hospitals and the 2011 National Health Promotion in Hospitals Audit.
4. Debate at monthly Prevention Steering Group meetings from October 2012
5. Development workshop – 24th April 2013. This was attended by more than 40 members of interested organisations in the local Health Economy
6. Consultation with senior staff by feedback from output of strategy development at SWBH Leadership Conference 30th April 2013.
7. Incorporation of themes from the most recent Sandwell and Birmingham Public Health Strategies, the draft Sandwell Health & Wellbeing strategy 2013-2015 (Sandwell JHWS) and the draft 2014 SWBH Staff Health and Wellbeing strategy.
8. Writing workshop in June 2013
9. Subsequent feedback from the members of the strategy development group was incorporated into the final document.

6. Current State

It is recognised that this isn't a comprehensive list and one of the actions that this strategy recommends is systematic identification of current health promotion activities.

Organisational

There is a nominated Clinical Champion for Prevention, who chairs a monthly Prevention Steering Group, with wide representation from acute and community SWBH staff groups, local public health and the CCG. It currently reports directly to the Medical Director, who is the Board level Sponsor. It works closely with the Staff Health and Well-being Committee. The two committees share the services of a full-time facilitator. SWBH is now an individual member of the Health Promoting Hospitals Network (in the absence of a functioning English national network), and has sent a representative to that organisation's 2013 annual meeting.

Clinical assessment

A baseline audit of Clinical Health Promotion activity in one of the assessment units was carried out in September 2012 and reviewed at the Prevention Steering Group. A more comprehensive audit of the assessment units is underway with a redesigned screening tool.. The Trust's clinical ED and admission documentation is being redesigned and a version of this tool is being incorporated to support screening and brief intervention.

Smoking

The Trust has a No Smoking Policy which means it is smoke free apart from minimal provision of designated smoking shelters. Patients, visitors and staff have access to stop smoking support. A smoking group, led by Dr Abuswiril is in communication with local public health departments which commissions providers of smoking cessation support, initially in outpatients and for staff, but with plans to extend to inpatients. An electronic referral system is in place which is planned to be upgraded in the near future.

Alcohol.

There is an active alcohol pathways group, led by Dr Fogden, which is well-attended and has a diverse membership. There is a CQUIN in place around an electronic assessment and referral tool ('Think Alcohol'). There are teams from the local specialist alcohol agencies on site at the hospitals.

Lifestyle.

The staff Health & Wellbeing group co-ordinates a range of activities to support healthier choices/activities for staff. There are screening programmes and awareness days for staff covering the main cardiovascular risk factors.
Lifestyle referral to local providers (MyTime Health in Sandwell, Health Exchange in Birmingham) are made through a single referral number Lifestyle coaches are visiting

acute assessment units to offer support to behavioural change.

MECC & Training

Brief intervention training (including MECC training) to around 1000 of the workforce (15%) has taken place as part of a CQUIN and staff are raising lifestyle issues such as smoking and alcohol with patients and referring on to support services where appropriate.

Communications

The Communications Department is a particularly engaged and helpful part of the Trust in Health Promotion. Already includes a daily staff Health & Wellbeing e-mail to all mailboxes, a regular health-related article in the Trust monthly magazine Heartbeat and on the Trust external website (Engage). They are using social media: Facebook, Twitter 'chats' and Pinterest to promote health-related messages. Supporting DH sponsored prevention programmes directly, and with Health and Wellbeing, such as the Stoptober smoking cessation campaign.

Physical environment:

There is a Sustainability Working Group, reporting to the Board Quarterly. It works to specific Carbon Management and Sustainability Action Plans.

Community served by hospital:

SWBH is an acute and community Trust. It is the largest single employer in Sandwell Borough, but as yet, has no formal outreach programme related to Health Promotion.

The Trust is actively involved with the local Regeneration projects through the CCG's Regeneration Group, and individual projects related to its own estate.

There is a programme related to providing work placements and accommodation for the young homeless which is in development.

7. Future state: Health Improvement in SWBH

Vision Statement. For Sandwell and West Birmingham Hospitals NHS Trust to be an recognised leader of Health Promotion activity in an NHS provider, and to:

1. Acknowledge that Health Promotion is central to its purpose in all dealings (clinical or non-clinical) with patients, families and carers
2. Have staff who widely support the principles of clinical health promotion.
3. Develop partnerships to promote and deliver comprehensive integrated services to improve the health of the local community
4. Have a positive and increasing impact on health and the social determinants of health of the community it serves

Priorities:

These are based on those items highlighted in the CMO's 2012 report which are not already covered by clinical management programmes (hypertension & cholesterol) or by external agencies (drug use, sexual health, occupational risks). These form the core of clinical health promotion:

Tobacco smoking
Excessive alcohol consumption
Obesity & overweight
Diet low in fruit and vegetables
Insufficient physical activity

An additional local priority relates to social determinants of disease and involves providing accommodation and work directly to people at risk of homelessness whilst supporting local public health strategies and regeneration projects with our partners.

Objectives

1. To collect baseline information to identify good practice and gaps in activity.
2. To have a comprehensive strategy for Health Promotion which evolves in depth and sophistication over the next few years
3. To produce an action plan to produce implementation of the strategy
4. To ensure patients & their families/carers are offered interventions on lifestyle
5. To integrate clinical health promotion assessments and interventions into all clinical pathways to ensure systematic delivery and measurement.
6. To further develop a healthy workplace and staff
7. To collaborate with partners in health promotion in the wider community
8. To further develop activities consistent with being a good corporate citizen
9. To demonstrate the Trust's contribution as a key partner in health promotion locally and nationally.
10. To communicate clear health promotion messages to multiple members of the public, through multiple vehicles: in person, in print, by electronic means, using social media.

Processes

- To take this strategy forward a Clinical Health Promotion Steering Group has been proposed which will be responsible for developing and monitoring an action plan. Progress will be reported to the Clinical Effectiveness Committee, as well as to staff throughout the organisation.
- Use our membership of the WHO Health Promoting Hospital Network to advance the Health Promotion agenda and promote change locally, regionally and nationally.
- Survey current practice, perform a baseline assessment and identify areas for development in areas with greatest potential to make an impact on patients.
- Ensure effective implementation of MECC using resources available,
- Assist the development of electronic systems to refer and report on prevention activity
- Generate internal and external communications of health promotion agenda, using a wide range of media.

Outcomes

These are grouped into 4 key areas:

1. Improving health – patients and their families, visitors

More people are living with chronic conditions and have reduced life expectancy and quality of life. The risk of these diseases and the worsening of them, once established, can be reduced with positive changes to lifestyle with support. There is the evidence that health professionals delivering brief interventions are effective (Appendix).

- Systematically recording public health activity in patient records to monitor the Trust's contribution to overall public health activity.
- Inclusion of clinical health promotion activity in all care pathways in SWBH
- Delivery of brief interventions on lifestyle issues to patients and referral to support services where appropriate (e.g. Making Every Contact Count) to encourage patients to make improvements to their lifestyle.
- SWBH letters and leaflets to have standard no smoking policy messages as well as information about stop smoking services to further encourage a culture of no smoking in Trust premises.

2. Workforce

Benefits of improving staff health include improved productivity and performance, reduced absenteeism, improved staff morale and staff retention. To this end, this document aims to extend and complement the Workforce strategy. In addition, engagement with the principles of this strategy will provide role models for healthy lifestyles in the community.

- Staff to be aware of and involved in the Health Promotion Strategy.
- Inclusion of health promotion activity (Making Every Contact Count, etc) in job descriptions to encourage this activity as standard practice.
- Occupational Health Service to include a focus on prevention and early intervention approaches and be seen by staff as a “Staff Health and Wellbeing Service”
- Developing a green travel approach which encourages walking or cycling to work.
- Improved results in the annual staff survey in particular with regard to wellbeing

3. Corporate citizenship

This recognises that SWBH as a major local employer has an impact on the wider community. For example as an employer, purchaser of goods and services, manager of transport, energy, waste and water, landholder and commissioner of building work and as influential neighbour to local businesses and communities.

4. Wider responsibilities

Networking is a valuable support mechanism and a major intervention tool of organisational development. An important feature of networking is that it redraws, in a productive way, the boundaries between professional groups, levels of a hierarchy, decision-makers and the people affected. Networking occurs in a variety of ways and on a number of levels (i.e. locally, regionally, nationally and internationally).

The national and international perspective for SWBH so far has been under the auspices of the HPH Network. This, more formally the International Network of Health Promoting Hospitals and Health Services works to support all health care organisations in their efforts to be health-oriented and to ensure that prevention, treatment and rehabilitation be viewed from a health perspective. As a member of this network, SWBH commits to the objectives of the organisation (see Appendix).

10. Next steps

1. Re-launching the Prevention Steering Committee as the Clinical Health Promotion Steering Group, monitoring the implementation of this Strategy and reporting to the Clinical Effectiveness Committee. Terms of reference currently under consideration by the Clinical Effectiveness Committee.
2. Insertion of Health Promotion messages to the Trust's Mission statement and objectives. Specific Health Promotion statement to be made in 'Customer Promises' or equivalent.
3. Formal launch of the Health Promotion strategy as part of a staff engagement programme.
4. Involvement of external commercial and charitable organisations in sponsorship and partnership working within SWBH and in the wider community.
5. Insertion of Health Promotion requirements in policies and procedures, job descriptions and staff training programmes.
6. Identification of a nominal budget for Health Promotion.
7. Re-starting of MECC training programme on a sustainable basis.
8. Extensive networking externally to raise SWBH profile in Health Promotion at Local, Regional and National Level.

Doug Robertson
Clinical Champion for Prevention
Sandwell and West Birmingham Hospitals NHS Trust

July 2013

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Sandwell Health and Wellbeing Board Joint Health and Wellbeing Strategy (JHWS) 2013-2015.

Appendix.

Making Every Contact Count (MECC)

This is an approach sponsored first by the Midlands and East SHA and now by Public Health England that aims to help create a healthier population and reduce NHS costs. Every day NHS employees make numerous contacts with people that could make a positive difference to their health, if combined with 'brief interventions'. These involve giving opportunistic advice, discussion, negotiation or encouragement designed to promote a particular behaviour in the recipient. They can be delivered by anyone whose has been trained in their use, not just healthcare professionals. For instance, brief interventions have consistently been found to be a cost effective way to increase the number of people who successfully quit smoking, and reduce alcohol intake.

For a relatively modest investment in training, MECC offers a way of giving employees the knowledge and skills they need to support people in making healthier choices. It fits well with work already being delivered - but the training is intended to embed a greater awareness of the possibilities to promote change, and the knowledge to signpost support services. It is felt by the public health community to be an effective tool in organisational cultural change.

The International HPH Network

This organisation has developed over the last 20 years from a project by WHO Europe into a self-sustaining network of around 1000 hospitals and integrated care organisations worldwide.

- to provide leadership on matters critical to health promotion in hospitals and health services and engaging in partnership where joint action is needed
- to shape the research agenda and stimulate the generation, translation and dissemination of valuable knowledge
- to set norms and standards and promote and monitor their implementation
- to articulate ethical and evidence-based policy options
- to provide technical support, catalyse change and build sustainable institutional capacity
- to monitor the development of health promotion in hospitals and health services.

Many countries are organised with national or regional networks which have a vote in the organisation's General Assembly which meets at the annual conference. Currently in the UK, only Northern Ireland has an active network. England never had such an arrangement, and has around a dozen member hospitals and Health Scotland has withdrawn its support, although five individual hospitals in Scotland remain members.

2014 Staff health and wellbeing strategy

Executive Summary

Staff Health and Wellbeing has previously achieved much, particularly in implementing national guidance for good practice. Evaluation of previous work has also received good feedback locally and nationally. Now however with the appointment of a Prevention champion to look at Health and Wellbeing opportunities in the community there is an opportunity to pool resources and expertise.
As such the Health and Wellbeing committee and the Prevention steering group have merged and one co-ordinator works across both areas. It is recognised however that there are some health and wellbeing issues which are staff specific and it is important for the staff and the wider needs of the Trust that these are not neglected.
Therefore staff Health and Wellbeing in 2014 will have two strands; the first aligning with the work of the prevention Champion to tackle the big health issues (smoking, alcohol etc.) in staff and patients, and the second using Trust generated data to base a more responsive strand of work on trends and issues specifically affecting staff.

Introduction

In December 2008 NICE provided guidance on promoting good health and preventing and treating ill health and most UK Trusts are audited regularly on how they apply certain of these standards to staff by the Health and Work development unit, a branch of the Royal College of Physicians. The audited standards which have always underpinned HWB activity for staff in the Trust are as follows:

- Obesity (joint clinical and public health guideline)
- Physical Activity and the Environment
- Smoking cessation
- Physical activity in the workplace
- Mental Health and the workplace

NICE's guidance is also in tune with other important guidance such as the Boorman Report- Health and Wellbeing an NHS Review and Healthy lives, healthy people: our strategy for public health in England - A white paper published in November 2010 which sets out the Government's long-term vision for the future of public health in England. Even the recent Francis report into the failings at Mid Staffordshire NHS Trust mentions issues of staff health and wellbeing as being contributory to failings in patient care.

The SWBH staff Health and Wellbeing agenda has had notable success in recent years with excellent feedback from staff and from partner organisations and national organisations. Previously this was achieved with a committee deciding on a quarterly theme for Health and Wellbeing initiatives which were then evaluated against their objectives.

We have always recognised that a large part of the workforce are from or have links with the areas surrounding the hospitals which have some of the worst Public Health indicators in the United Kingdom. Isolated initiatives at work are helpful, but what would be more helpful would be a joined up approach with those tackling the same problems in the community. This could also be considered a social and moral obligation for a large healthcare organisation to address. Over the

last year then two distinct strands of Health and wellbeing work have emerged which have given rise to a new strategy for 2014. This aims to use all of the health promotion work and resources available throughout the Trust with combined working, while maintaining a needs based approach and continuing to support the wider Workforce agenda, particularly attendance management and work related ill health.

Strand One – Health promotion

This strand of work runs throughout the year and recognises that the "big issues" facing patients and staff who are largely locally based are the same and local resources can be shared. As part of this strand the current Health and wellbeing committee will merge with the Prevention steering group to become the Clinical health improvement committee. The table below illustrates how the two groups' work is aimed to be aligned. As it is recognised that the patient agenda is likely to take some time to become fully active whereas the staff group is smaller and easier to tackle we have included both a "baseline" aim which we are committed to achieving for staff in 2014 as well as an "aspirational" aim which we will be working towards with the wider group but which may take longer to achieve.
The aim will be to build on previous work especially where there has been previous data collection to inform need analysis – and to collect that screening type data where it has not been done before.
Each aim will be tackled as previously – with an individual project plan, SMART objectives and analysis. These are beyond the scope of this strategy and will need to be finalised through the rest of 2013.

Outcomes

As previously during the staff Health and Wellbeing work, these aims will be accompanied with a detailed implementation plan including SMART objectives. Achievement against these will be reported as a standing agenda item at the health improvement committee as well as bi-annually at the workforce operational committee. In addition standardised feedback and Equality and Diversity data monitoring forms will continue to be used for each event or initiative and analysed and reported as part of the workforce operational committee exception reporting structure, and used to modify future events.

Strand Two – Health response

This strand of work recognises that unlike some of the bigger issues facing the local and national population, there are some reliable and useful data sources that can help identify more specialist areas of health problems facing healthcare practitioners. Also this strand recognises that these specific problems are often a cause of absenteeism, presenteeism, performance issues and considerable distress to the organisation's most valuable resource – its staff. These issues may not be as closely in alignment with the local public health agenda as strand one issues but are as important to tackle and keep as high profile within the organisation.
The aim for 2014 will be to continue structured review of data including from the following sources to identify and target key issues

- NICE / NHS employer guidance / research
- Divisional sickness absence
- ESR sickness absence data trends
- Health and Safety accidents / incidents
- Feedback from previous HWB events / initiatives
- Equality and diversity figures from Occupational Health and Wellbeing and Health and Wellbeing initiatives
- Hot topics / survey monkey feedback
- Manager / staff / HR requests and feedback
- BDMA counselling data
- Physiotherapy data
- Infection control data
- Occupational Health divisional outcome data and DNAs

There is a data presentation schedule where each of these will be looked at monthly by a sub group comprising of the OH consultant, the HWB / prevention coordinator and an HR manager looking at each of these regularly. Trends or exceptions will then determine the main targeted priority interventions for each quarter as well as feeding monthly into the sickness plan for the Trust which will be a live document.

Outcome

This work will be reported in relation to the changed to the sickness absence plan monthly at the workforce operational committee as well as a quarterly evaluation summary at the clinical health promotion committee and bi-annually as part of the HWB report for the workforce operational committee.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**FT shadow public membership 2013**
SPONSOR (EXECUTIVE DIRECTOR):	**Jessamy Kinghorn, Head of Communications and Engagement**
AUTHOR:	**Jeanette Howes, Membership Manager**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

The Trust's membership was launched in 2008 since when it has grown to over 8,200 public members. Patients and the public choose to become members while staff members are automatically opted in but can choose to opt out.

We have an active, nationally recognised programme of membership involvement and have been invited to present at Foundation Trust Network events, particularly regarding our digital interaction with members.

This paper outlines some highlights over 2008-2013, reminds the board of the 2013/14 membership priorities and next steps, provides constituency and demographic information regarding the membership, and sets out a high level comparison with other trusts.

REPORT RECOMMENDATION:

The Board is invited to discuss future membership strategy and advise on membership activity and recruitment.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	X

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

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

Comments:

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

An active membership reflective of our population is required to progress to FT status.

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Membership

Trust Board Report

25 July 2013

1.0 Introduction and background

This report provides an update on delivery of the membership strategy, reflecting the continuing growth and development of the Trust's membership profile.

1.1 Highlights

Year	Membership Growth	Highlights
2008	200	• consulted staff and members of the public on our plans to become an NHS Foundation Trust, our vision, strategy and values; During the consultation we distributed over 20,000 full consultation documents and attended over 100 community meetings. We had 332 responses from staff, patients and other members of the public and 9 from local organisations, which compares favourably to similar organisations. • launch of foundation trust newsletter, database, membership cards, membership forms and calendar of events • began recruitment within initial base of 200 members by August Recruited 500th member, December 600th member exceeding Board's target of recruiting 1% of our population that we serve • Most successfully attended AGM to date as a result of membership over 500 attendees (hosting 2 AGMS)
2009	7,488	• Membership was runner up for best community engagement at the National AHC awards • Paediatric event for 11-16 year olds redesign patient information and soft play area • Launch of annual NHS careers workshops for our young members (a day in the life) • Members are involved in reading panels, new hospital, mixed wards, branding for the Trust
2010	7,487	• Launch of members diabetes focus group and signposted to existing focus groups within the Trust

		• Members involved in outpatient events and health promotion roadshows
2011	7,556	• A member survey led to more joint staff and patient events and a 'feedback' event. • A 'you said, we did' campaign was run • Some focused work with community and minority groups took place • Plans were developed to use social networking and digital media in membership • The membership strategy was redeveloped
2012	7,297	• From 30th January 2012 to the 30th March 2012, the Trust conducted an engagement exercise with patients, staff, volunteers, shadow members, partners and members of the public about our plans to become a Foundation Trust (FT). This report presents the feedback received during the engagement period. • Launch of engage website • Launch of twitter chats • Presented at local FTN event
2013	8241	• Re launch of members diabetes focus group • Launch of new database and migration of data to new software, now compliant with monitor regulations • Presented at national FTN event • Launch of Youth Education Scheme • Exceeded the Board's target of achieving 8,000 members by March 2013

Since 2008 membership has steadily increased from 200 to 8241 members and has retained the majority of its members as a result of listening to their needs and ensuring membership remains meaningful to the individual. The Trust's initial recruitment target was 1% of our population that we serve however this figure was increased as the Trust wanted a large public than staff membership. As a result of merging with provider arm of PCTs, our staff numbers grew, which then gave us the new recruitment target of over 8000.

2.0 Engagement

Members continue to remain engaged and dependent on their preferred level of involvement can participate in a broad spectrum of activities allowing us to capture public and staff feedback:

- 3 Foundation Trust newsletters per year
- Annual members survey
- Members long term conditions focus groups (cardio, diabetes, stroke, rheumatology)
- On line discussions via Engage community website
- Twitter chats with clinicians

- calendar of events, showcasing 3-4 health talks each month reflecting the topics identified from our member's survey
- Invitations to corporate events such as AGM and Trust Priorities; branding workshops
- Service redesign workshops (paediatrics, new hospital, maternity, clinical haematology etc.)
- Youth membership scheme (access to members NHS careers programme)
-

Main conclusions from member's survey results 2013 (further detailed analysis available)

- Members are pleased with the current choices of location for the meetings (City & Sandwell) with an equal spread between the two.
- The preferred times for the meetings appear to be mornings and afternoons.
- The preference of topics for the featured articles mirrors the preferences for both the health seminars and the corporate events suggested in the survey. Primarily, members want as much information on patient feedback as possible, including how the trust responds to certain issues. The second most popular idea continues to be information on practical, healthy lifestyle tips.

2.1 Youth Engagement

In March 2013 the membership office launched its Youth Education Scheme (YES). Following feedback from both our young members and students across the West Midlands it was apparent that sourcing relevant health and social care experience was a real issue, particularly for those under 16 years of age, resulting in UCAS applications being declined. As a result of these findings the membership office created YES to enable young people to obtain relevant health experience via their membership with the Trust.

The pilot is still very much in its infancy and has been a relatively slow process so far due to lack of resources (1.5 WTE) and time constraints by way of meeting with Headteachers, generating awareness with students via school assemblies and the preparation of lesson planners for class based activities alongside running the remainder of the membership. However once year groups/classes have signed up to become members, the membership office can then deliver a rolling programme of NHS careers allowing students to talk to a healthcare professional about a day in the life of their job, obtain key skills for life (CV writing and interviews techniques), CPR and health promotion within the classroom setting. So far we have received initial sign up from 4 secondary schools within the West Midlands, and interest from sixth form students and colleges for those studying science and health and social care.

As a result of introducing YES in March 2013 we have increased young membership of 11-21 year olds by 347 and continue to forge excellent relationships with schools, colleges and universities within the West Midlands.

The membership office is continuing to work with community groups, staff and partner organisations to provide an update on our Foundation Trust application and promote the Engage website.

3.0 Next Steps aims for 2013/14

Building the membership base:

- Targeted recruited campaigns for hard to reach demographics once census data fully received in 31 July 2013

Managing active membership:

- Prepare members for elections to the Council of Governors, ensuring enough public and staff candidates stand.
    - Produce material and arrange events to encourage members to stand as Governors
    - Provide information to enable members to participate in the elections
- Develop clear communication channels for Governors to communicate to members
- Arrange membership activities to increase the accessibility of the Trust Board to members
- Introduce clear route for member feedback to influence key decisions and strategy

Communicating with members:

- Involve members and shadow Governors in setting the annual priorities for 2014/15
- Continued increase of the number of membership activities from 2011/12, 2012/13 to 2013/14
- Continued engagement with staff members
- Producing governor information in preparation for elections
- Embed membership into the culture of the organisation via HR, Fundraising, Volunteers

Playing a key community role:

- Increase the number of members using 'www.swbhengage.com' by 25%
- Increase the number of schools signed up to our new schools membership scheme by 1 per quarter
- Continue to deliver programme of membership activities to promote healthy lifestyles and NHS careers
- Build on our programme of activities
- Create a bank of members who are interested in taking part in strategic work with the Trust such as panel members (Beacon) will also help with preparing for elections seeking out potential governors
- Create and run a bank of member volunteers 16 +
- Look at generating income for the membership office
- Involve members as health ambassadors as part of the Trust's approach to health promotion and as a 'Health Promoting Trust.'

Working with other membership organisations:

- Improve the link between membership and stakeholder organisations

Further next steps:

- The activities described above will continue to see the size of the membership increase, but the Board may wish to set a new target for overall membership numbers.

- Prior to the first elections, further work needs to take place on developing the role of the Governor, encouraging members to stand as Governors and preparing them to take part in elections.

- Consideration should also be made with regard to establishing a 'shadow' Council of Governors prior to authorisation as a Foundation Trust.

4.0 Recommendation

The board is asked to discuss and accept the contents of this report and appendices.

Appendix A

Demographics

Staff are automatically opted into membership. No staff are currently opted out, although staff will need to be given the choice prior to elections.

Membership at June 2013 is broken down by constituency below. A full demographic breakdown is produced annually in the December Communications and Engagement report and will reflect the new census results published in July 2013.

Membership at December 2011 is broken down by constituency below at figure 12. A demographic breakdown of the membership follows at figure 13.

Constituency	Governor seats	Minimum member target	Members 2013	Population (Census 2011)	Change since last report
Ladywood	3	900	**994**	126693	↑
Edgbaston & Sparkbrook	1	300	**406**	104016	↑
Perry Barr	3	900	**1217**	107090	↑
Erdington	1	300	**443**	97778	↑
Wednesbury & West Bromwich	3	900	**1145**	113222	↑
Oldbury & Smethwick	3	900	**1399**	105807	↑
Tipton & Rowley Regis	3	900	**770**	89034	↑
Wider West Midlands	2	600	**1832**	4858207	↑
Not Specified	0		**65**		
Total	19		**8271**	5601847	

	Over minimum target	↑	Increase, or no reduction in membership size
	Within 5% of target	→	Reduction in members by less than 10 members per Governor seat
	More than 5% below target	↓	Reduction in members by more than 10 members per Governor seat

Public constituency	Members 2011	Members 2012	**Members 2013**	Number	**Proportion of membership 2013**	Eligible members**	Over / Under represented 2011*	Over / Under represented 2012*	Over / Under represented 2013**	(Excl. wider West Midlands)
Age (years)**:										
11-16	432	423	**488**	↑	**5.9%**	420389	-3.7%	-3.7%	**-2.8%**	**-4.9%**
17-21	486	470	**584**	↑	**7.1%**	382008	-0.9%	-0.9%	**-0.8%**	**-4.3%**
22+	6,638	6,404	**7,199**	↑	**87.0%**	4053239	4.70%	4.6%	**3.6%**	**9.2%**
Unclassified	-	-	**88**		**1.1%**				**1.1%**	**1.3%**
Ethnicity**:										
White	4,379	4,215	**4,575**	↑	**55.3%**	4633669	-30.8%	-31.0%	**-27.4%**	**-2.6%**
Mixed	128	125	**152**	↓	**1.8%**	131714	0.30%	0.3%	**-0.5%**	**-2.5%**
Asian or Asian British	1,744	1,708	**2,036**	↑	**24.6%**	604435	15.8%	16.1%	**13.8%**	**-0.9%**
Black or Black British	805	770	**930**	↑	**11.2%**	182125	8.70%	8.6%	**8.0%**	**1.6%**
Other	191	179	**238**	↓	**2.9%**	49904	2.00%	1.9%	**2.0%**	**0.4%**
Unclassified	-	-	**340**		**4.1%**				**4.1%**	**4.0%**
Socio-economic groups:*										
ABC1	2,827	2,730	**2,923**	↓	**35.7%**	1913858	-9.6%	-9.6%	**-11.1%**	**-4.9%**
C2	1,230	1,208	**1,356**	↓	**16.3%**	685541	-0.6%	-0.3%	**-0.4%**	**-0.5%**
D	1,602	1,548	**1,767**	↓	**21.3%**	794461	1.6%	1.6%	**1.9%**	**-2.0%**
E	1,924	1,839	**2,150**	↓	**25.9%**	700084	8.2%	7.9%	**8.8%**	**6.4%**
Unclassified	-	-	**68**		**0.8%**				**0.8%**	**1.1%**

Gender analysis**:										
Male	2,923	2,820	**3,106**	↓	**37.6%**	2763187	-10.2%	-10.2%	**-11.8**	**-11.6%**
Female	4,483	4,334	**5,003**	↓	**60.5%**	2838660	8.2%	8.3%	**9.8**	**9.7%**
Unclassified	-	-	**162**		**2.0%**				**2.0%**	**1.9%**

*2001 Census data
*2011 Census data
NB 2011 Census data is becoming available throughout July. The latest socio-economic census data was not available at the time of writing. For continuity with previous papers, 2011 and 2012 membership numbers have not been re-run against the new census data.

	Within 5% variance from population	↑	Improvement in relative proportion of members to population
	5-10% variance from population	→	No change in relative proportion of members to population
	More than 10% variance from population	↓	Decrease in relative proportion of members to population

Monitor requires membership analysed in the categories above. However, we also monitor more detailed information on the age of our members.

Additional Age Analysis (full membership 2013**)	**Members 2013**	**Proportion of membership 2013**	Eligible members**	Over / Under represented 2013**	(Excl. wider West Midlands)
11-16	**488**	**5.9%**	420389	**-2.8%**	**-4.9%**
17-21	**584**	**7.1%**	382008	**-0.8%**	**-4.3%**
22-40	**1,944**	**23.5**	1371648	**-4.7%**	**-10.9%**
41-60	**2,429**	**29.4**	1462826	**-0.8%**	**3.7%**
61-70	**1,281**	**15.5**	598244	**3.2%**	**6.9**
71-79	**874**	**10.6**	361354	**3.1%**	**5.1%**
80+	**583**	**7.0**	259167	**1.7%**	**5.1%**
Unclassified	**88**	**1.1%**		**1.1%**	**1.3%**

Appendix B

Trust comparison

High level membership information has been compared to a selection of Foundation Trusts and other aspirant Foundation Trusts. All operate from multi-sites.

Trust	Turnover	Local catchment	WTE Staff	Public / patient membership	Public governors	Patient Governors	Staff Governors	Partner Governors
Blackpool Teaching Hospitals NHS Foundation Trust	£273m	330,000	4128.2	5,921	17	N/A	6	10
Bolton NHS Foundation Trust	£280m	260,000	5,700	4,920	23	N/A	6	11
Bradford Teaching Hospitals NHS Foundation Trust	£356.6m	500,000	5,200	50,000	10	2	4	3
City Hospitals Sunderland NHS Foundation Trust	£306m	350,000	4,388	14,414	9	2	5	2
Derby Hospitals NHS Foundation Trust	£454.5m	600,000	7,000	10,500	15	N/A	5	6
Heart Of England NHS Foundation Trust	£265m	1,00,000+	11,000	91,061	26	2	5	11
Royal Free London NHS Foundation Trust	£577m	600,000+	5,275	10,811	6	7	5	6
SWBH	£430m	500,000	7,000	8,271	19	N/A	11	7
The Dudley Group NHS Foundation Trust	£284m	450,000	4,544	12,505	13	N/A	8	4
Wirral University Teaching Hospital NHS Foundation Trust	£274m	400,000	6,000	9,000 public	13	N/A	5	6

In some cases patient / public membership may include staff membership.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – May 2013
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White / Chris Archer
DATE OF MEETING:	25 July 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the period to 30th June 2013.

The Trust's Monitor financial risk rating for April is 3 which is satisfactory.

Measured against the DH target, the Trust generated an actual surplus of £180,000 during June against a planned surplus of £156,000. . This performance is consistent with the annual planned surplus of £4,600,000 agreed with the Local Area Team of NHS England.

The cash balance of £39.2m is £3.7m lower than plan as at 30th June.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Clinical Leadership Executive on 16 July; Finance & Performance Management Committee on 19 July

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2013

EXECUTIVE SUMMARY

• For the month of June 2013, the Trust delivered a "bottom line" surplus of £180,000 compared to a planned surplus of £156,000 (as measured against the DoH performance target). Actual in month performance is consistent with the year end target of 1.1% of turnover.

• For the year to date, the Trust has produced a surplus of £1,132,000 compared with a planned surplus of £1,073,000 so generating a positive variance from plan of £59,000, again in line with the Trust's target.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 160 below planned levels. After taking account of the impact of agency staff, WTE's were 21 above plan. Total pay expenditure for the month, inclusive of agency costs, is £60,000 above the planned level.

• The month-end cash balance was £39.2m. Year to date spend on capital is £1.2m against a £20.5m annual programme.

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	24	59	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	19	49	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(60)	(168)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(19)	1	<= Plan	<1% above plan	>1% above plan
WTEs Actual v Plan	21	(116)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	(3,737)	(3,737)	>= Plan	>=95% of plan	<95% of plan
Note: positive variances are favourable, negative variances unfavourable					

Performance Against Key Financial Targets		
Target	Year to Date	
	Plan	Actual
	£000	£000
Income and Expenditure	1,073	1,132
Capital Resource Limit	2,094	2,094
External Financing Limit	---	(3,737)
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at June 2013	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	391,559	32,627	32,653	26	98,036	98,044	8	391,559
Other Income	36,929	3,250	3,322	72	9,630	9,838	208	36,929
Operating Expenses	(402,766)	(34,295)	(34,374)	(79)	(101,312)	(101,479)	(167)	(402,766)
EBITDA	25,722	1,582	1,601	19	6,354	6,403	49	25,722
Interest Receivable	100	8	15	7	25	36	11	100
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(942)	(942)	0	(3,491)	(3,491)	0	(13,962)
PDC Dividend	(5,027)	(306)	(306)	0	(1,257)	(1,257)	0	(5,027)
Interest Payable	(2,232)	(186)	(188)	(2)	(558)	(559)	(1)	(2,232)
Net Surplus/(Deficit)	**4,601**	**156**	**180**	**24**	**1,073**	**1,132**	**59**	**4,601**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,601**	**156**	**180**	**24**	**1,073**	**1,132**	**59**	**4,601**

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

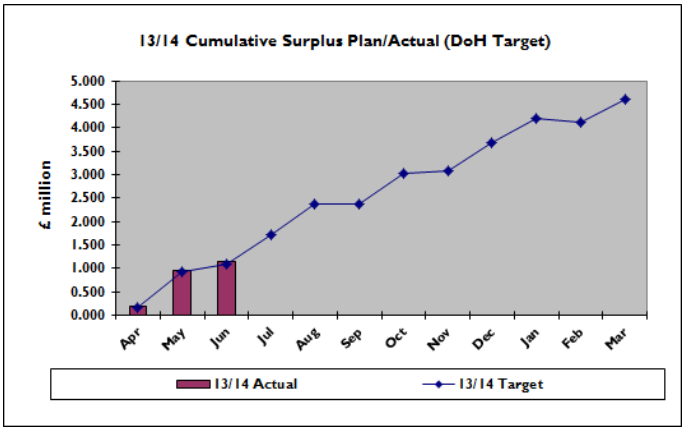
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2013

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the graph. Net bottom-line performance delivered an actual surplus of £180,000 in June against a planned surplus of £156,000. The resultant £24,000 positive variance is consistent with the plan submitted to the NTDA.



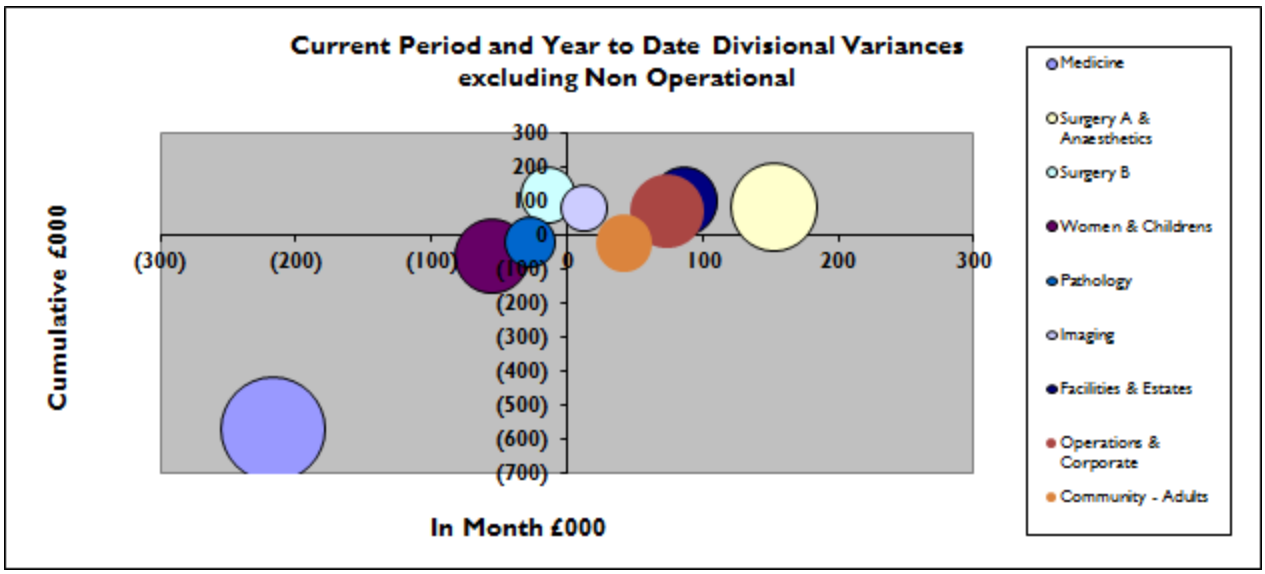
Divisional Performance

•Divisional performance now includes contract income performance for April and May.

• Reserves have been distributed , including the bulk of capacity funding to Medicine. The division remains overspent, due to the premium costs of capacity incurred during quarter 1.

Divisional Variances from Plan

	Current Period £000	Year to Date £000	Budget
Medicine	(217)	(573)	87,295
Surgery A & Anaesthetics	153	82	62,434
Surgery B	(14)	117	24,310
Women & Childrens	(56)	(60)	43,866
Pathology	(27)	(20)	20,163
Imaging	12	78	16,962
Facilities & Estates	86	101	36,168
Community - Adults	42	(23)	26,192
Operations & Corporate	73	73	44,587
Non Operational	(34)	274	28,329



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2013

Patient income is on line overall for April and May. Other income includes R&D income over-recovery which is matched by pay overspends in that Division.

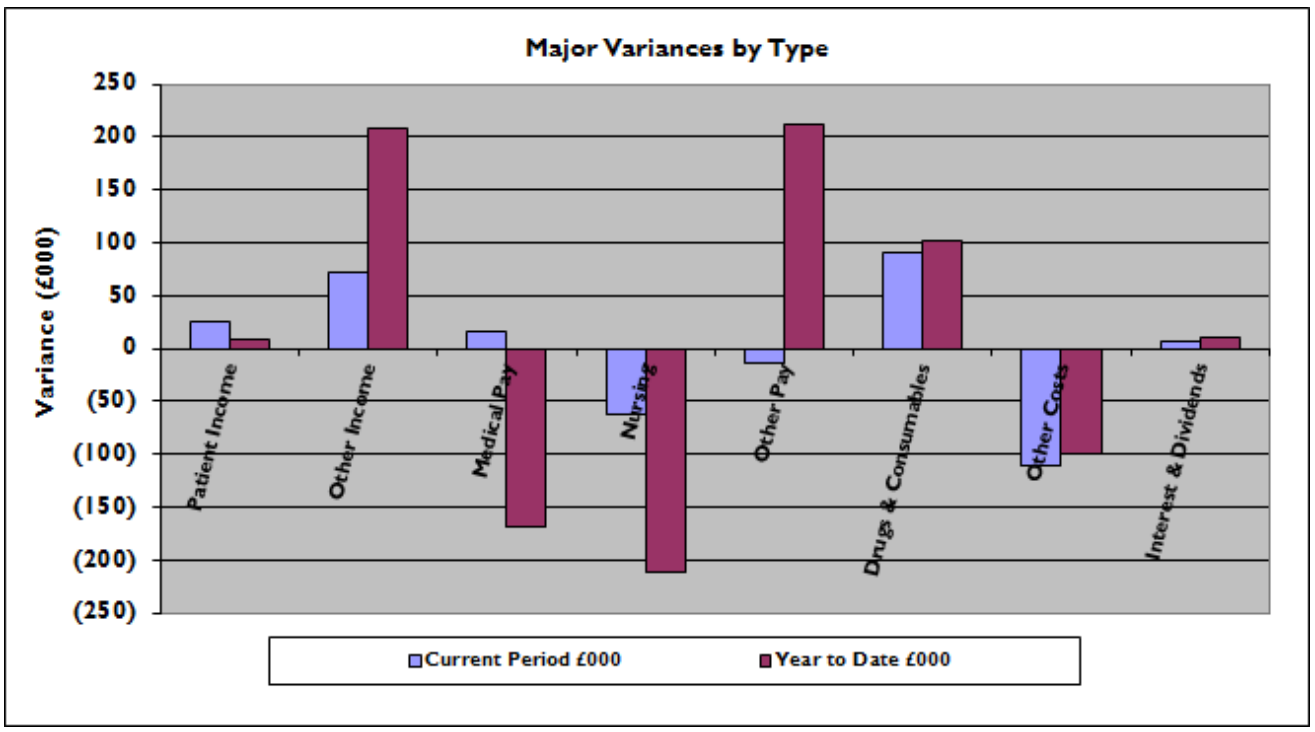
The medical staffing overspends in Medicine are partly offset by underspending in Surgery A and Women & Children.

Nursing costs (mainly agency) are premium costs associated with vacancies and additional capacity.

The consumables variance is mainly influenced by the profile of orthopaedic prostheses.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	26	8
Other Income	72	208
Medical Pay	16	(168)
Nursing	(62)	(212)
Other Pay	(14)	212
Drugs & Consumables	91	101
Other Costs	(110)	(100)
Interest & Dividends	7	11



Capital Expenditure

• Year to date capital expenditure is £1.2m, mainly on Blood Sciences and on release of retentions. Scheme lead officers have been asked to provide an up to date plan for expenditure through the year.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

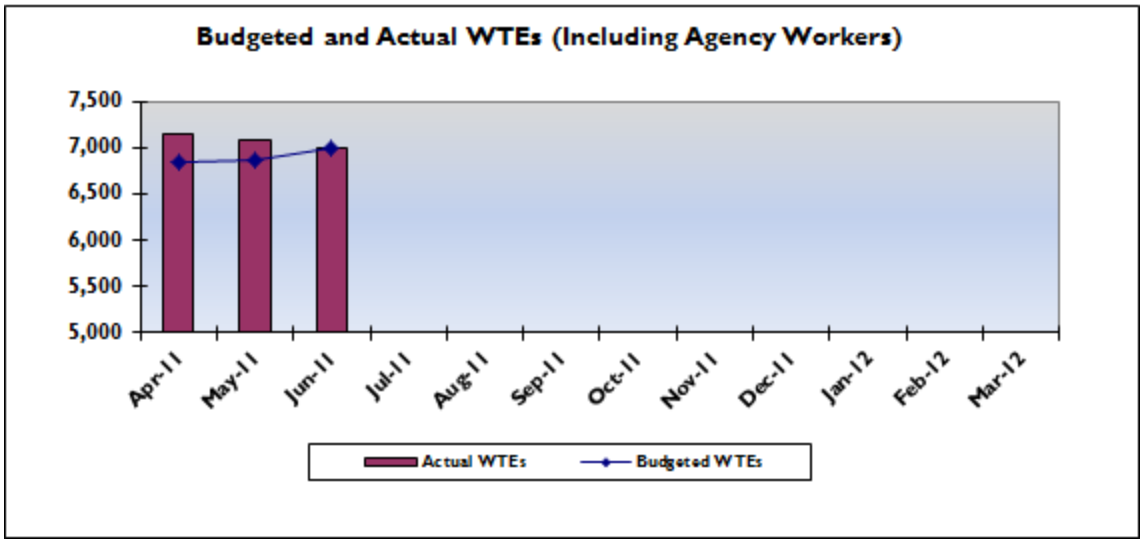
Financial Performance Report – June 2013

Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are 21 above plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 160 below plan.

• Total pay costs (including agency workers) are £60,000 above budgeted levels for the month, reflecting premium rates of agency staffing. Nursing shows an overspend in month of £62,000 (including agency).

•Expenditure for agency staff in May was £622,000 , a reduced run rate compared with March April and May. This partly reflects a review of sessional rate assumptions for shifts in the Adult Community Division.



Analysis of Total Pay Costs by Staff Group

	Year to Date to June					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	19,277	18,538		907	19,445	(168)
Management	3,817	3,588		0	3,588	229
Administration & Estates	7,834	7,266	474	193	7,933	(99)
Healthcare Assistants & Support Staff	7,884	7,124	913	28	8,065	(181)
Nursing and Midwifery	22,834	20,595	1,000	1,451	23,046	(212)
Scientific, Therapeutic & Technical	10,874	10,517		136	10,653	221
Other Pay	47	5			5	42
Total Pay Costs	72,567	67,633	2,387	2,715	72,735	(168)

NOTE: Minor variations may occur as a result of roundings

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2013

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2013.

• Cash balances at 30th June stand at £39.2m in part reflecting slippage on the capital programme in 2012/13 and 2013/14.

Sandwell & West Birmingham Hospitals NHS Trust

STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013	Balance as at end June 2013	Forecast at 31st March 2014
		£000	£000	£000
Non Current Assets	Intangible Assets	924	859	1,421
	Tangible Assets	216,669	214,481	227,997
	Investments	0	0	
	Receivables	1,048	966	1,048
Current Assets	Inventories	3,604	3,810	3,604
	Receivables and Accrued Income	10,432	15,717	10,432
	Investments	0	0	
	Cash	42,448	39,195	38,335
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(43,404)	(43,039)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(914)	(914)
	Provisions	(10,355)	(9,583)	(10,049)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	
	Loans	(3,000)	(3,000)	(1,000)
	Borrowings	(29,263)	(29,080)	(28,706)
	Provisions	(3,168)	(2,530)	(2,474)
		183,385	184,517	194,655
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231
	Revaluation Reserve	34,356	34,356	39,120
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(20,260)	(19,128)	(13,754)
		183,385	184,517	194,655

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2013

Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below. The projection will be revised once detailed capital expenditure plans have been reviewed by project leads.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT June 2013

ACTUAL/FORECAST	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Receipts												
SLAs: SWB CCG	**20,736**	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684
Associates	**6,652**	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884
Other NHS income	**660**	655	655	655	655	655	655	655	655	655	655	655
Specialised Service (LAT)	**3,492**	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372
Education & Training		4,429			4,429			4,429			4,429	
Loans												
Other Receipts	**3,367**	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620
Total Receipts	**34,907**	38,643	34,214	34,214	38,643	34,214	34,214	38,643	34,214	34,214	38,643	34,214
Payments												
Payroll	**13,638**	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100
Tax, NI and Pensions	**9,508**	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500
Non Pay - NHS	**2,556**	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400
Non Pay - Trade	**12,659**	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500
Non Pay - Capital	**1,246**	2,281	2,248	2,128	2,157	2,115	2,257	1,663	1,271	421	421	421
PDC Dividend				2,854						2,854		
Repayment of Loans				1,000						1,000		
Interest				20						15		
BTC Unitary Charge	**425**	400	400	400	400	400	400	400	400	400	400	400
Other Payments	**236**	188	188	188	188	188	188	188	188	188	893	893
Total Payments	**40,268**	35,369	35,336	39,090	35,245	35,203	35,345	34,751	34,359	37,378	34,214	34,214
Cash Brought Forward	**44,556**	39,195	42,469	41,347	36,472	39,870	38,882	37,751	41,643	41,498	38,335	42,764
Net Receipts/(Payments)	**(5,361)**	3,274	(1,122)	(4,875)	3,398	(989)	(1,131)	3,892	(145)	(3,163)	4,429	0
Cash Carried Forward	**39,195**	42,469	41,347	36,472	39,870	38,882	37,751	41,643	41,498	38,335	42,764	42,765

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2013

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.9%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	100.8%	5
Net Return After Financing	Surplus after dividends over average assets employed	2.1%	4
I&E Surplus Margin	I&E Surplus as % of total income	1.0%	3
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	21.8	3
Overall Rating			**3.4**

Financial Risk Rating

- The table shows the Monitor risk rating score (out of 5) for the Trust based on performance at June.
- The liquidity score includes an assumed working capital facility.

Continuity of Service Risk Rating

- The proposed new financial risk rating position is shown below (out of 4).

Risk Ratings		Current Month		Year to Date		Forecast Outturn	
Measure	**Description**	**Value**	**Score**	**Value**	**Score**	**Value**	**Score**
Capital Service Capacity	Revenue available for debt service/capital servicing costs	2.285	3	2.623	4	2.631	4
Liquidity	Cash for liquidity purposes * 360/annual operating expenses	-0.884	4	-0.884	4	-6.467	3
Overall Rating			**3**		**4**		**3**

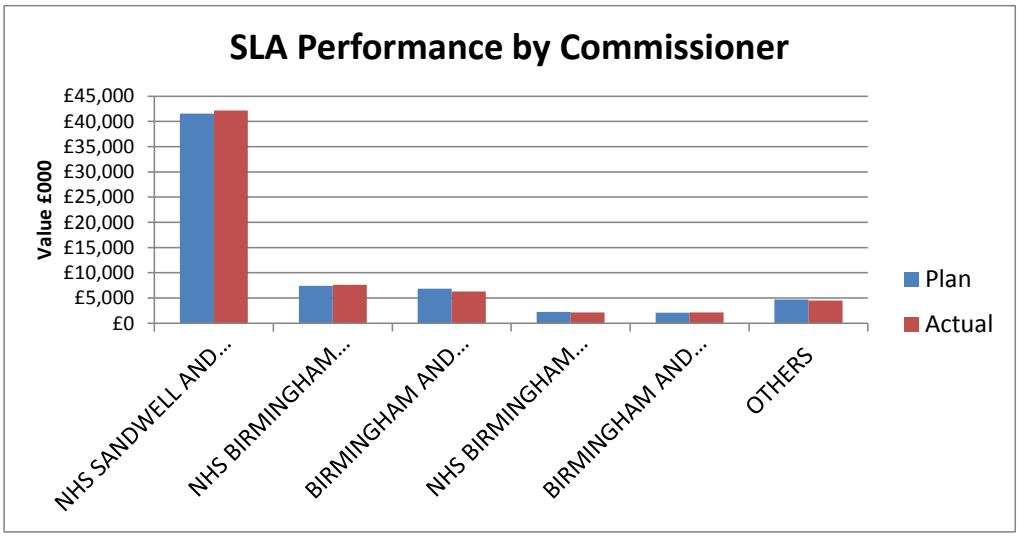
Sandwell and West Birmingham Hospitals NHS

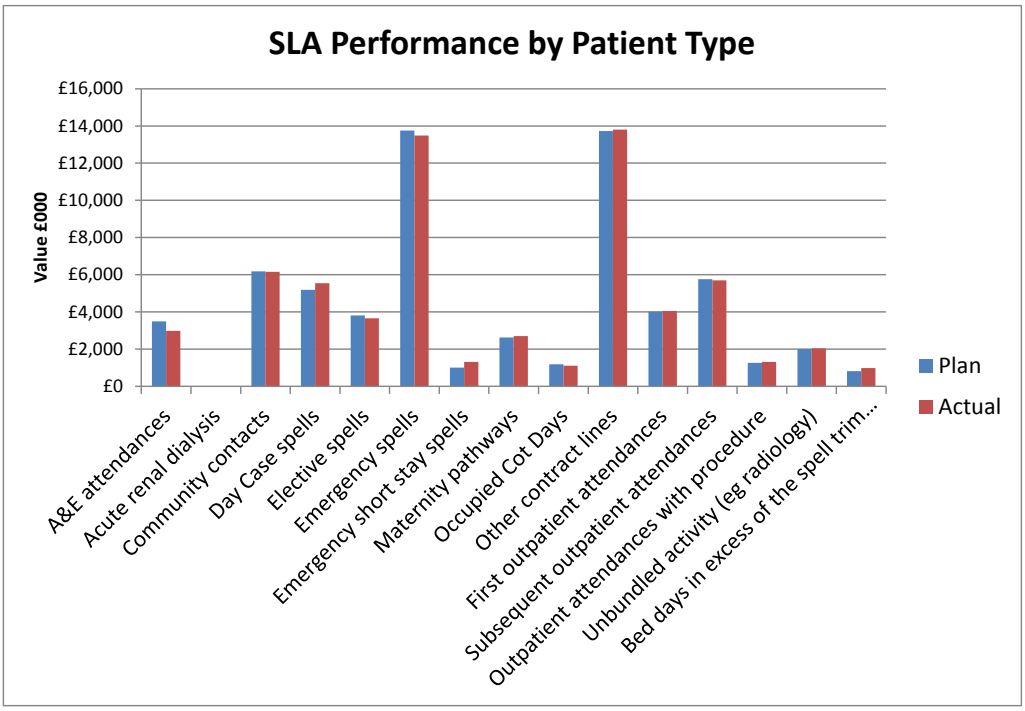
NHS Trust

Financial Performance Report – June 2013

Performance Against Service Level Agreement Target

•Performance for April and May is broadly on line overall with a shortfall in Women & Children's contract income (on maternity pathway and neonatal care offset by over-recovery in Surgery A and B).





Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2013

Transformation Programme

•An update on TSP progress is provided separately. Key issues remain to be resolved around the final determination of bed capacity as part of planning for next winter including reconfiguration changes considered in 12/13 (as paused).

Key risks

• The uncertainties associated with the new commissioning landscape are yet to settle, including specialised services commissioning, the intentions of Sandwell MBC particularly in respect of school nursing, the operation of the new maternity pathway tariff and exposure of the Trust to contractual penalties.

•The revised bed plan once finalised will impact operationally as well as on delivery of previously planned Transformation Savings Plan targets. In the meantime additional capacity remains open.

External Focus

• There is a growing recognition in the NHS that seven-day provision of services is part of the wider solution to improving efficiency, according to NHS England medical director Sir Bruce Keogh. In an update on the work on the seven-day service, Sir Bruce said the scale of the task was huge but there were 'compelling arguments' for moving to whole-week working. A report from the Seven Day Services Forum, which is co-ordinating the work, is due in the autumn.

•The Department of Health has confirmed its intention to work with Monitor and NHS England to widen the scope of payment by results; introduce further best practice and care pathway tariffs; and use the tariff to incentivise the shift of care away from acute settings. The Department's 'Business plan 2013-2015' added that the new value-based pricing system for branded medicines would be implemented and that it would continue to support the NHS to release efficiency savings up to and beyond 2014/15

Recommendations

The Trust Board 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.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Update on Medicine Group Financial Recovery Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow – Chief Operating Officer**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

REPORT RECOMMENDATION:

This brief paper summarises the financial position of the Medicine Group as reported to the Finance & Performance Management Committee on Friday 19th July 2013.

At the end of Month 3 the Group has posted a deficit of £573k inclusive of an adverse movement in June of £217k. These additional costs have arisen during the planning period for winter and reflect the premium costs, principally pay related, of continuing to keep beds open from the 2012/13 financial year in part with a higher than anticipated use of bank and agency staff.

The Medicine Group's original TSP target of £3.3m, it is able to identify all but £900k of this but continues to pursue schemes aimed at reducing this gap.

The focus of the next few weeks is:

- Full budget review
- Additional expenditure controls – particular focus on pay forecast and controls
- Service reviews for transformational savings

Stabilisation of the position for the Group is a priority and the range of measures considered and reported to the Finance & Performance Management Committee have merit and promise.

It is intended to bring a final paper to the Committee and Trust Board in August.

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		Workforce	
Comments:					

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

Performance standards

PREVIOUS CONSIDERATION:

Finance & Performance Management Committee on 19 July 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

UPDATE ON MEDICINE GROUP FINANCIAL RECOVERY PLAN

Report to the Trust Board - 25th July 2013

1.0 Introduction

This brief paper summarises the financial position of the Medicine Group as reported to the Finance & Performance Management Committee on Friday 19th July 2013. The Group is being paid additional attention as it was unable to identify a fully compliant set of TSPs (transformation savings plans) prior to the start of the 2013/14 financial year. At the same time, the Group has been assessing the costs of preparing for the winter period in a concerted effort to ensure sufficient capacity is in place to improve patient experience and access to services in a timely fashion.

To this end, additional resources are being provided to the Group as part of preparing for Winter 2013 but it must balance these resources with the forecast expenditures and its existing cost base.

2.0 Current Position

At the end of Month 3 the Group has posted a deficit of £573k inclusive of an adverse movement in June of £217k. These additional costs have arisen during the planning period for winter and reflect the premium costs, principally pay related, of continuing to keep beds open from the 2012/13 financial year in part with a higher than anticipated use of bank and agency staff.

In terms of the Group's TSP target of £3.3m, it is able to identify all but £900k of this but continues to pursue schemes aimed at reducing this gap. There has been progress since May when a total of £1.5 million TPS was identified, to a total TSP identified of £2.4 million identified by the Clinical Group in July. The Board will be aware that as part of the May 2013 stocktake of potential risks and available resources, non recurrent provision was made for a shortfall on the target.

A discrete review by the recently appointed finance team has identified a risk in terms of the current trend line in premium staffing costs continuing during the year, c. £160k per month from month 4 excluding EDAT (Emergency Department Action Team) allocations.

The overspend YTD is not because of unmet TSP - this has been funded non-recurrently nor is it because of the additional bed plan which been funded. The overspend is due to EDAT spending at a rate of £1.8k per annum (£450k spent in Q1) but funding received at £1.2M per annum (Q1 = £300k causing a £150k pressure). This variance accounts for 26% of the overspend. The remaining and more significant pressure is due to nurse expenditure over and above funded levels £413k (74% of the overspend). Strengthened controls on pay spend are being put in place with immediate affect.

In respect of this additional risk, the Group will be applying a range of mitigations to deal with this additional risk, but this will require use of the TSP stretch to compensate for the shortfall against the original efficiency target. Board members will recall that the 'stretch' represented an additional 10% of efficiency plans over and above those required to balance the overall financial plan. Part of this is being applied to the Medicine Group with other allocations to other Groups where efficiency plans were paused as part of the Board's decision to continue with the 12/13 bed capacity.

3.0 Measures taken & next steps

The Group is addressing the position through a number of measures some of which will be moved to weekly monitoring (e.g. forecast and review of expenditure on bank and agency, ward staffing levels and non-pay expenditure). Use of the recently implemented e-rostering system will be enhanced to ensure that the original benefits of matching demand with capacity are realised. The level at which decisions can be taken regarding expenditure decisions has also been raised. The details of the plan have been discussed with the Finance & Performance Management Committee.

Ultimately, the objective is to ensure the Group is well supported and has deliverable discrete mitigation plans to manage emerging risks especially given the separate allocations in respect of capacity.

Other actions planned:

- Complete line by line budget review with new SFM, Divisional leadership team and all budget holders
- Weekly pay controls assurance including forecasted expenditure against establishment by the Divisional team to report to COO
- Post level review of ED and ward recruitment plans to advise forecast
- Complete medical team job plan reviews
- Consider option for managed services
- Review all non stock call off orders
- Service level reviews for efficiency opportunities through transformation, 4 priority areas identified

4.0 Summary & recommendations

No further time can be lost in identifying a stable position for the Group and the range of measures considered and reported to the Finance & Performance Management have merit and promise. Despite the absence of any prima facie concerns regarding quality and safety issues, the governance aspects of signing off plans must be completed during the next 3 weeks. It is intended to bring a final paper to committee and Board in August as part of moving to the next stage. This process must be completed for the next available Quality & Safety Committee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	25 July 2013 (Report prepared 18 July 2013)

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

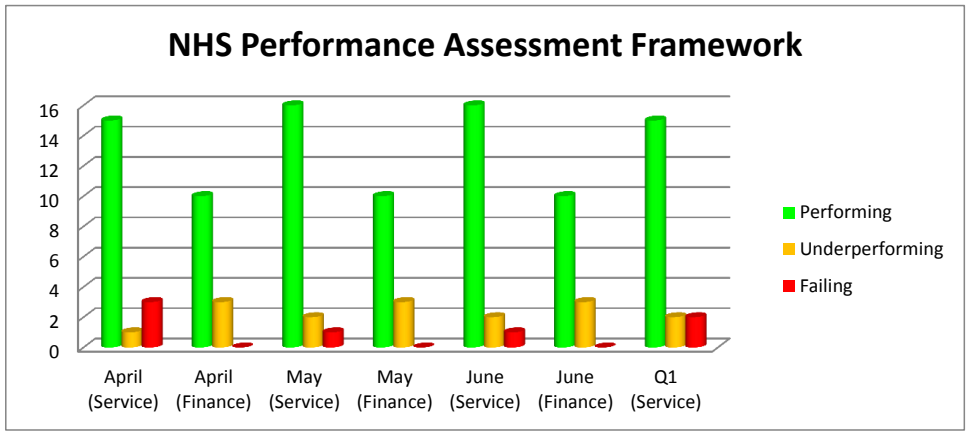
Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

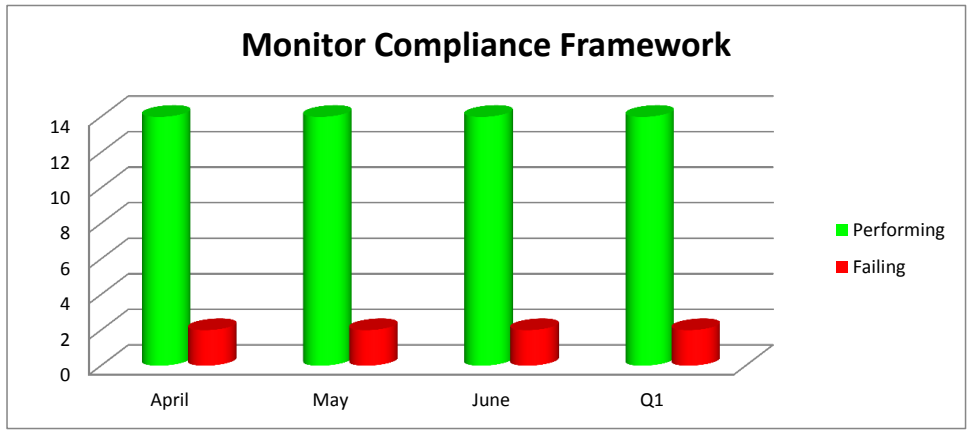
PREVIOUS CONSIDERATION:

Performance Management Board, Clinical Leadership Executive and Finance & Performance Management Committee

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

EXECUTIVE SUMMARY

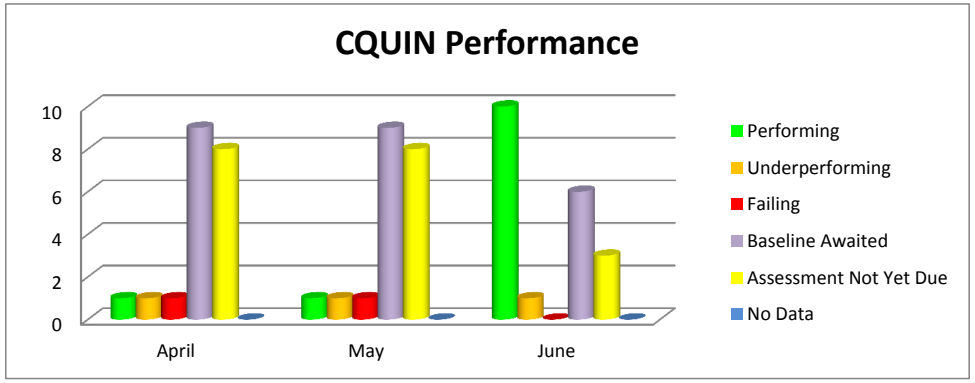




Service Performance - during the month (June) there were 2 actual (C Diff cases reported (6) exceeded trajectory (4) and Mixed Sex Accommodation Breaches (2 breaches equivalent to 0.02% of completed FCEs)) and 1 projected (RTT Delivery in All Specialities) areas of underperformance. For Quarter 1, areas of underperformance are; Emergency Care 4-hour waits, MRSA Bacteraemia (1 in April), Mixed Sex Accommodation Breaches and RTT Delivery in All Specialities. For month and Quarter the Trust is projected to attract a **PERFORMING CLASSIFICATION**.

Financial Performance (June) the weighted overall score is 2.90 with underperformance reported in 3 areas; Better Payment Practice Code (Value), Better Payment Practice Code (Volume) and Creditor Days. The classification for the month of June remains **PERFORMING.**

Monitor Compliance Framework - The Trust underperformed against the C Diff Objective during the month, with 6 cases being reported compared with a trajectory for the month of 4. For the quarter there were a total of 10 cases, compared with a trajectory of 12. Monitor's annual de minimis limit for cases of MRSA Bacteraemia reflecting a governance concern is set at 6, and as such the MRSA Bacteraemia reported (during April) for the year to date does not contribute to the overall score for the month or quarter. The Emergency Care 4-hour wait target for the month was met, with actual performance of 95.5%, although performance across the quarter was 94.10%. The overall score for the month and quarter remains 1.0 and for both periods attracts an **AMBER / GREEN** Governance Rating. The Trust is projected to meet performance thresholds for all high level RTT and Cancer targets for the month and quarter.



CQUIN - A summary of the current performance against the various acute, community and specialised CQUIN schemes is reflected in the table opposite. Data has been gathered for a number of schemes which require a baseline assessment. Validation of the data is progressing, upon completion of which a target and improvement trajectory will be agreed with commissioners. Underperformance is currently reported against the nationally mandated Dementia CQUIN, which requires the identification, assessment and referral for formal diagnostic assessment of patients aged 75 or over, who are admitted as an emergency, and identified as possibly having dementia.

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Clinical Quality & Outcomes

Stroke Care - the percentage of stroke patients receiving a CT Scan within 24 hours of presentation remains less than 100% (87% during June). Timeliness of scan request and transfer of patient to Imaging have been cited as problems. Appropriate staff from Imaging and Medicine have been asked to conduct a Root Cause Analysis of the delays and identify actions to improve by 15 July. Actions have also been identified by Speech and Language Therapy, centered around communication with Stroke Alert Nurse Specialists, to ensure all patients receive a swallowing assessment within 24 hours of admission.

MRSA Screening - gradual improvement in 'Patient Matched' rates for both Elective and Non-Elective admissions has occured. Further action within the Women & Child Health Division to ensure screens undertaken are being matched to patients requiring screens, and a focus on pre-assessment procedures within Surgery have been identified.

Readmission Rates - readmissions following an initial Non-Elective admission remain high. Detailed work to identify more specifically in which areas these are occuring is on track, and is to be presented to DGMs at the next Chief Operating Officer's Performance meeting.

Emergency Care - performance during June was such that the Trust met the monthly and year to date improvement trajectory. Further marked improvement however is necessary to continue to meet this trajectory, with performance for July of 97.2% required. Focus on improvement in the main units is on staffing, escalation processes and early diagnosis. Work in BMEC is focused on a demand and capacity model, due for review on 17 July.

WMAS - Ambulance turnaround times are improving and delays reducing on both sites. Plans to implement an Ambulance Assessment Bay at Sandwell, similar to that at City, will create more capacity an assist in reducing delays further.

Patient Experience

Cancelled Operations - the number and proportion of last minute cancellations for non-clinical reasons has reduced, although the number of patients experiencing more than one cancellation has increased. The frequency of monitoring of cancellation numbers and reasons has been increased and any potential on-day cancellations are being escalated within Surgery A. Data from the Division, by specialty and consultant, is to be reviewed at the next Chief Operating Officer's Performance meeting, with actions identified to reduce numbers.

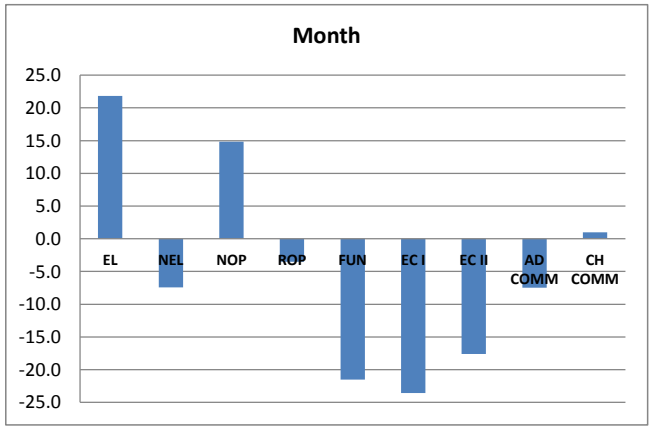
Staff Experience

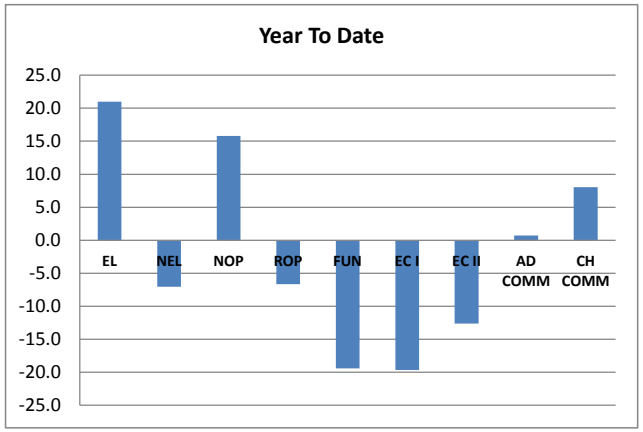
PDR rates have shown a marginal improvement from May (70.3%) to June (71.5%), with a range by Division of 48 - 93%. All DGMs have been tasked with providing improvement trajectories by 24 July to the Chief Operating Officer, with plans to deliver 100%.

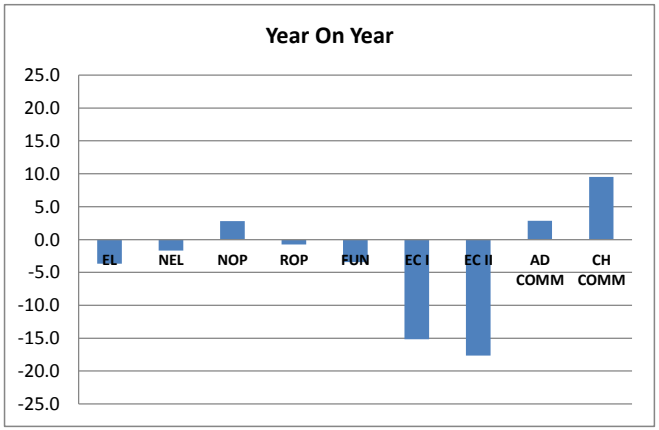
Nurse Bank and Agency Use has improved but remains high. The imminent agreement of a detailed bed plan for the Trust will provide clarity of staffing numbers required, by ward. Recruitment to existing vacant posts is underway, with the intention that this reduces the need for the current level of nurse bank and agency staff.

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. Overall high level Elective activity is currently exceeding the plan for the month and year to date, although is 3.7% less than that delivered during the corresponding period last year. Non-Elective activity is currently 7.1% less than the plan for the year to date, and 1.7% less than the corresponding period last year. Significant overperformance against the New Outpatient activity plan and an underperformance against the Review OP activity plan, gives a FollowUp:New OP Ratio of 2.26 for the year to date, significantly less than the ratio derived from plan, and that for the same period last year. Type I and Type II Emergency Care activity to date is considerably less than plan and for the corresponding period in 2012 / 2013. Adult Community and Child Community activity is currently exceeding plan for the first month of the year by 6.3% and 16.7% respectively.







Exec Lead	KPI Source	Data Source	Indicator			February	March	April	May		June			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						
R0	A	4	Infection Control	C. Difficile (DH Reportable)	No.	9	1	3	0	1	1	2	4	6	10	12	46	No variation		Any variation		95	37
	A			MRSA Bacteraemia	No.	0	0	1	0	0	0	0	0	0	1	0	0	No variation		Any variation		2	1
RB	A	1	Cancer	2 weeks	%	95.7	95.0	93.2	→		95.3	→			94.3	=>93	=>93	No variation		Any variation		94.8	94.7
	A			2 weeks (Breast Symptomatic)	%	94.9	93.2	96.9	→		93.1	→			95.2	=>93	=>93	No variation		Any variation		95.8	95.9
	A			31 Day (diagnosis to treatment)	%	100	99.3	100	→		96.1	→			98.2	=>96	=>96	No variation		Any variation		99.5	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	100	98.9	100	→		94.2	→			97.2	=>94	=>94	No variation		Any variation		100.0	99.2
	A			31 Day (second/subsequent treatment - drug)	%	100	100	100	→		100	→			100	=>98	=>98	No variation		Any variation		99.2	99.8
	A			31 Day (second/subsequent treat - radiotherapy)	%	n/a	n/a	n/a	→		n/a	→			n/a	=>94	=>94	No variation		Any variation		100	100
	A			62 Day (urgent GP referral to treatment)	%	85.6	94.8	90.8	→		91.8	→			91.2	=>85	=>85	No variation		Any variation		86.9	87.1
	A			62 Day (referral to treat from screening)	%	91.7	100	100	→		100	→			100.0	=>90	=>90	No variation		Any variation		98.5	96.9
	H			62 Day (referral to treat from hosp specialist)	%	100	86.5	85.2	→		93.3	→			86.8	=>85	=>85	No variation		Any variation		91.6	93.2
	A	2	Emergency Care 4-hour waits		%	91.4	85.9	92.4	96.8	92.8	94.4	96.4	94.9	95.5	94.10	=>95	=>95	=>95		<95		95.38	92.54
RB	A	2	Referral To Treatment	Admitted Care (RTT <18 weeks)	%	94.0	93.7	92.2	→		92.5	→			92.5*	=>90.0	=>90.0	=>90.0	85-90	<85.0		93.2	93.7
	A			Non-Admitted Care (RTT <18 weeks)	%	99.3	98.6	97.8	→		98.3	→			98.3*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0		97.5	98.6
	A			Incomplete Pathway (RTT <18 weeks)	%	95.4	95.3	95.6	→		96.4	→			96.4*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0		97.2	95.3
	E			Treatment Functions Underperforming	No.	4	4	3	→		4	→			6*	0	0	0 / month	1 - 6 / month	>6 / month		10 (Q4)	11 (Q4)
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.88	0.88	0.50	→		0.91	→			0.50*	<1.0	<1.0	<1.0	1.0 - 5.0	>5.0		0.99	0.88
	G	11	Data Quality	Data Completeness Community Services	%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50	=>50		<50			>50
RO	G	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
RB	C	2	Delayed Transfers of Care		%	2.5	2.6	3.1	2.4	4.2	3.2	2.5	3.0	2.7	2.7	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0		5.2	2.9
RB	B	2	Mixed Sex Accommodation Breaches	As percentage of completed FCEs	%	>0.00	>0.00	1.30	→		0.89	→		0.02	0.02*	0.0	0.0	0.00	0.00 - 0.50	>0.50		0.07	
				Numerical	No.	>0	>0	161	→		114	→		2	2*	0.0	0.0	0		>0			
RS	A	3	VTE Risk Assessment		%	91.0	86.1	92.9	→		94.7	→		95.3	95.3*	95	95	=>90		<90		92.4	90.8

Financial Metrics - NHS Performance Assessment Framework

RW	E	16	Initial Planning - Planned Outurn as a proportion of turnover		%	0.57	0.58	0.05	→		0.57	→		0.00	0.00	0-3.0	0-3.0	0-3.0		=>-2.0			
			Year To Date	YTD Operating Performance	%	1.45	1.48	0.00	→		0.01	→		0.01	0.01	0-3.0	0-3.0	0-3.0		=>2.0			
				YTD EBITDA	%	6.70	6.19	11.29	→		6.69	→		5.44	5.44	=>5.0	=>5.0	=>5.0		<1.0			
			Forecast Outturn	Forecast Operating Performance	No.	0.01	0.01	0.00	→		0.00	→		0.00	0.00	0-3.0	0-3.0	0-3.0		=>-2.0			
				Forecast EBITDA	%	6.66	6.19	6.88	→		6.46	→		6.32	6.32	=>5.0	=>5.0	=>5.0		<1.0			
				Rate of Change in Forecast Surplus of Deficit	%	0.00	0.00	0.00	→		0.00	→		0.00	0.00	=<3.0	=<3.0	=<3.0		>2.0			
			Undrelying Financi	Underlying Position	%	1.48	1.48	1.46	→		1.07	→		0.92	0.92	=>0.0	=>0.0	=>0.0		>-2.0			
				EBITDA Margin	%	6.66	6.19	6.88	→		6.46	→		6.32	6.32	=>5.0	=>5.0	=>5.0		<1.0			
			Financial Processe	Better Payment Practice Code Value	%	93.00	93.00	90.60	→		92.60	→		93.84	93.84	=>95	=>95	=>95		<60			
				Better Payment Practice Code Volume	%	97.00	95.00	94.90	→		94.40	→		92.76	92.76	=>95	=>95	=>95		<60			
				Current Ratio	ratio	1.14	1.00	1.09	→		1.02	→		1.05	1.05	=>1.0	=>1.0	=>1.0		<0.5			
				Debtor Days	Days	16.03	9.73	12.31	→		12.97	→		13.29	13.29	<=30	<=30	<=30		>60			
				Creditor Days	Days	42.45	38.54	40.44	→		44.79	→		39.03	39.03	<=30	<=30	<=30		>60			

JUNE 2013	CQUINs

Exec Lead	KPI Source	Data Source	Indicator					February	March	April	May			June			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	A	3	VTE	Risk Assessment		224	%	91.0 ▼	86.1 ■	92.9 ▲	→		94.7 ▲	→		95.3 ■	95.3*	95	95	=>90		<90	●	92.4	90.8
RS	H			Root Cause Analysis		224	%	→	→		Baseline Assessment during Q1			Base established			Base established						●		
RO	H	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers	ACUTE	224	%	→	→	Data Submitted	Improvement trajectory to be derived from baseline		Data Submitted	Improvement trajectory to be derived from baseline		Data Submitted	Data Submitted						●		
RO	H	8			COMMUNITY	224	%	→	→	Data Submitted			Data Submitted			Data Submitted	Data Submitted						●		
RO	H	8	Dementia	Find, Investigate and Refer		269	%	Meeting Q4 req's	Met Q4 req's	2 of 3 met	→		2 of 3 met	→		2 of 3 met	2 of 3 met	90% (F, I and R) for 3 consec. months		No variation		Any variation	●		
RO	H			Clinical Leadership		45		→	→		→			→			Identified			No variation		Any variation			
RO	H	8		Supporting Carers of People with Dementia		135		→	→		→			→				Monthly Audit		No variation		Any variation			
RO	H	8	Friends & Family Test	Phased Data Collection Expansion - Maternity		137	%	→	→		By October with 30% response rate			By October with 30% response rate											
RO	H	8		Increased Response Rate (Emergency Care All Wards)		175	%	→	→		Baseline Assessment during Q1			Base established			Base established						●		
RO	H	8		Improve Performance on Staff FFT		137	Score	→	→		Autumn Annual Staff Survey			Autumn Annual Staff Survey											
RB	H	20	Safe Storage of Medicines			1105	%	→	→		Baseline Assessment during Q1			Baseline Assessment during Q1						No variation		Any variation			
RO	H	8	Dementia Patient Stmulation			1138		→	→		Baseline Assessment during Q1			Baseline Assessment during Q1						No variation		Any variation			
RS	H		Use of Pain Care Bundles			1138	%	→	→		Baseline Assessment during Q1			Baseline Assessment during Q1						No variation		Any variation			
RS	H		Use of Sepsis Care Bundles			1105	%	→	→		Baseline Assessment during Q1			Baseline Assessment during Q1						No variation		Any variation			
RO	H	11	Community Risk Assessment & Advice			1105	%	→	→		Baseline Assessment during Q1			Baseline Assessment during Q1						No variation		Any variation			
RS	H		Recording DNAR Decisions			1105	%	→	→		Bi-Annual Ward Audit / Improvement			Bi-Annual Ward Audit / Improvement											
RS	H		Specialised Commissioners	Clinical Quality Dashboards		60		→	→	→	Populate & Demonstrate Use			Populate & Demonstrate Use			Data available to submit						●		
RS	H	22		Behcets Highly Specialised Service		60		→	→	→	Annual Workshop & Report			Annual Workshop & Report			On Track			No variation		Any variation	●		
RS	H	12		HIV - Communication with GPs		180		→	→	→	Quarterly Assessment			Data available to submit			Data available to submit			No variation		Any variation	●		
RS	H	12		Neonatal - Retinopathy Of Prematurity (Screening)		180		→	→	→	Quarterly Assessment			Data available to submit			Data available to submit			No variation		Any variation	●		

JUNE 2013	CLINICAL QUALITY & OUTCOMES

Exec Lead	KPI Source	Data Source	Indicator				February	March	April	May		June		To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	S'well	City	Trust	YTD	13/14						
RS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	82.1 ▼	70.6 ■	83.3 ■	→		→		96.2 ▲	91.5 ▼	90.9	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	H			Pts admitted to Acute Stroke Unit within 4 hrs		%	42.9 ▼	42.6 ▼	69.4 ▲	→		→		85.7 ▲	93.0 ■	82.0	90	90	No Variation	0 - 2% Variation	>2% Variation	● ●	68.7	59.1
	H			Pts receiving CT Scan within 24 hrs of presentation		%	93.3 ■	89.8 ▼	93.2 ▲	→		→		89.7 ▼	87.0 ▼	89.4	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	H			Pts receiving CT Scan within 1 hr of presentation		%	48.2 ■	51.4 ■	63.4 ▲	→		→		68.6 ▲		65.8	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	H			Admission to Thrombolysis Time (<60 minutes)		%	→	→		→		→					100	100	=>85		<85			
	H			Stroke Admissions - Swallowing assessments (<24h)		%	→	→	91.7 ■	→		→		100.0 ■	91.7 ■	94.0	100	100	=>98		<98	●		
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	57.1 ■	83.3 ■	66.7 ▼	63.2 ▼	→	81.3 ▲	→	63.2 ▼	81.3 ▲	72.7	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	81.2 ▲	70.3 ▼	74.1 ▲	88.4 ▲	→	88.2 ▼	→	88.4 ▲	88.2 ▼	84.6	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RO		4	Infection Control	MSSA Bacteraemia		No.	0	1	2	0	1	1	0	0	3	No. Only	No. Only					12	15
				E Coli Bacteraemia		No.	6	2	2	1	1	2	3	1	4	8	No. Only	No. Only					50	48
	F	3		MRSA Screening - Elective	Patient Not Matched	%	193.6 ▲	138.9 ▼	196.6 ▲	Numerator = 3055	Denominator = 1764	Numerator = 3236	Denominator = 1643	173.2 ▼	196.9 ▲	196.9*	85	90	No variation		Any variation	●		138.9
	F				Best Practice - Patient Matched	%	72.4 ▲	59.5 ▼	67.9 ▲	Numerator = 1056	Denominator = 1764	Numerator = 1104	Denominator = 1643	59.9 ▼	67.2 ▲	67.2*	71	80	No variation		Any variation	●		59.5
	F			MRSA Screening - Non Elective	Patient Not Matched	%	82.3 ▲	76.8 ■	79.2 ▲	Numerator = 2435	Denominator = 2964	Numerator = 2343	Denominator = 2882	82.2 ▲	81.3 ▼	81.3*	85	90	No variation		Any variation	●		76.8
	F				Best Practice - Patient Matched	%	64.6 ▼	64.9 ▲	67.4 ▲	Numerator = 2680	Denominator = 3691	Numerator = 2644	Denominator = 3547	72.6 ■	74.5 ▲	74.5*	71	80	No variation		Any variation	●		64.9
RS	H	3	WHO Safer Surgery Checklist	Audit - 3 sections		%	99.9 ▲	99.4 ▼	99.9 ▲	→		→		99.9 ■	99.6 ▼	99.6*	100	100	=>98		<98	●		
	H	3		Audit - 3 sections and brief		%	95.8 ▲	95.5 ▼	94.1 ■	→		→		93.9 ▼	90.4 ▼	90.4*	100	100	=>95		<95	●		
	H	3		Audit - 3 sections, brief and debrief		%	83.7 ▼	82.1 ▼	79.6 ▼	→		→		80.5 ▲	75.3 ▼	75.3*	100	100	=>85		<85	● ●		
KD	F	14	Never Events - in month			No.	0 ■	0 ■	0 ■	→		→		0 ■	1 ■	1	0	0	No variation		Any variation			2
			Medication Errors causing serious harm			No.				→		→												
	F		Open Serious Incidents Requiring Investigation (SIRI)			No.	4	2	5	→		→		9	8	8*	No. Only	No. Only						2
	F		Open Central Alert System (CAS) Alerts			No.	10	10	5	→		→		5	3	3*	No. Only	No. Only						10
RO	D		Falls Resukting In Severe Injury or Death			No	2 ▼	2 ■	3 ▼	→		→		2 ▲	5 ▼	10	0	0	No variation		Any variation			22
RO	D	8	Grade 3 or 4 pressure ulcers - avoidable			No	2	2	2	→		→		1	1	4								
RO	H	8	High Impact Nursing Actions	Inpatient Falls reduction	Acute	No	42 ▲	53 ▼	56 ▼	→		→		49 ■		105	110	660	=<55/m		>55/m	●		737
	H				Community	No	→	→	15 ■	→		→		10 ■		25	24	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	0	12	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU		%	12.8 ■	12.2 ▲	10.5 ■	→		→		10.0 ■	8.1	9.5	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
				Admissions of full term babies to Neonatal Care		No.				→		→												
				Adjusted Perinatal Mortality Rate (per 1000 babies)		/1000	13.2 ■	4.5 ■	11.7 ■	→		→		6.6 ■	6.0 ▲	6.0*	<8.0	<8.0	<8	8.1 - 10.0	>10	●	11.9*	4.5
				Caesarean Section Rate	Elective and Non-Elective	%	24.7 ▼	25.4 ■	24.6 ■	→		→		27.2 ■	25.1 ▲	25.6	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	H				Elective	%	→	→	9.1	→		→		13.5	12.6	11.8								
	H				Non-Elective	%	→	→	15.5	→		→		13.7	12.6	13.8								
	H			Early Booking (Completed Assessment <12+6 weeks)		%	77.0 ▼	78.0 ▲	78.0 ■	→		→		80.0 ▲	79.0 ▼	79.0*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates		%	→	9.3 ▲	→	→		→		→	9.4 ▼	9.4	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
				Breast Feeding Initiation Rates		%	→	74.4 ▲	→	→		→		→	77.0 ▲	77.0	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6

Exec Lead	KPI Source	Data Source	Indicator				February	March	April	May			June			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	H	3	Mortality Reviews within 42 working days			%	54 ▲	73 ▲	74 ▲	→			→			74*	80	80	No variation		Any variation	●	66.9	
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	90.5 Dec'11 to Nov'12	89.1	87.8 Feb'12 to Jan'13	→		88.1 Mar'12 to Feb'13	→		88.9 Apr'12 to Mar'13	88.9								
				Peer (SHA) HSMR		HSMR	96.4	97.0 Jan'12 to Dec '12	96.7	→		97.0	→		98.0	98.0								
				Peer (National) HSMR - Quarterly		HSMR	→	94.6	→	→		→	→		94.0	94.0								
	D	19		SHMI		SHMI	94.4 Dec'11-Nov'12	94.2 Jan'12-Dec'12	94.3 Feb'12-Jan'13	→		95.5 Mar'12-Feb'13	→			95.5								
			Maternal Deaths			No.	0	0	0	→		0	→		0	0								
RO	H	8	End of Life Care			%	62 ▲	65 ▲	54 ■			64 ■				64*	63	63	No variation		Any variation	●		
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	128 ■	124 ■	112 ■	→		148 ■	→		99 ■	359	366	1463	No Variation	0 - 5% Variation	>5% Variation	●	1463	1587
				Following initial Elective Admission		%	1.28 ■	1.18 ■	1.08 ■	→		1.38 ■	→		0.97 ■	1.15	1.15	1.15	No Variation	0 - 5% Variation	>5% Variation	●	1.15	1.25
				Following initial Non-Elective Admission		No.	550 ■	572 ■	609 ■	→		667 ▼	→		586 ■	1862	1710	6842	No Variation	0 - 5% Variation	>5% Variation	●	6842	7528
				Following initial Non-Elective Admission		%	5.50 ▲	5.46 ▲	5.88 ■	→		6.23 ▼	→		5.76 ▲	5.96	5.38	5.38	No Variation	0 - 5% Variation	>5% Variation	●	5.38	5.91
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	71.4 ▼	83.3 ▲	71.4 ■	→		55.6 ▼	→		83.3 ■	83.3*	77.0	85.0	No Variation	0 - 2% Variation	>2% Variation	●	66.4	76.7
RB		3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	94 ■	93 ▼	93 ■	→		93 ▼	→		93 ■	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES		%	6.5 ▲	6.6 ▼	7.8 ▼	→		6.8 ▼	→		6.6 ▲	6.6	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	5 : 43 ▼	7:52 ▼	6:02 ▲	→		5:07 ▲	→		4:39 ▲	5:15	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	17 ■	18 ▼	15 ■	→		18 ■	→		18 ■	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)		mins	55 ▼	51 ▲	50 ▲	→		53 ▼	→		50 ▲	51	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	7.61 ▼	7.26 ▲	7.89 ▼	→		8.23 ▼	→		8.38 ▼	8.17	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate		%	4.35 ▼	4.54 ▼	3.82 ▲	→		4.02 ▲	→		4.03 ▼	3.96	=<5.0	=<5.0	=<5.0		>5.0	●	4.83	4.67
			Emergency Care Trolley Waits >12 hours			No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0	0	0	0		>0	●		
RB	H	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes		%	75.6 ▲	71.3 ▼	81.4 ▲	82.0 ▲	86.9 ▲	84.89 ▲	78.3 ▼	87.8 ▲	83.90 ▼	83.90*	=>85	=>85	=>85		<85	●		71.3
	H			Average Turnaround Time		m : s	35:48 ▼	40:13 ▼	29:44 ■	29:08 ■	29:04 ▲	29:06 ▲	27:36 ▲	27:27 ▲	27:30 ▲	27:30*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	H			30 - 60 minutes	All Journeys	No.	1855 ▲	2177 ▼	1459 ▲	611 ▲	793 ▲	1404 ▲	520 ▲	717 ▲	1237 ▲	4100	0	0	0		0	● ● ●		22089
	H				Hospital Fines (WMAS report)	No.	→	→	451 ■	195 ▲	229 ▼	424 ▲	144 ▲	94 ▲	238 ▲	1113	0	0	0		0	● ● ●		
	H			In Excess of 60 minutes	All Journeys	No.	228 ▼	351 ▼	90 ▲	23 ▲	33 ▲	56 ▲	10 ▲	13 ▲	23 ▲	169	0	0	0		0	● ● ●	1256	2354
	H				Hospital Fines (WMAS report)	No.	→	→	57 ■	14 ▲	14 ▲	28 ▲	5 ▲	8 ▲	13 ▲	98	0	0	0		0	● ● ●		

JUNE 2013	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator				February	March	April	May			June			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	K	21	Reporting Times of Imaging Requests from Emergency Care - % **reported within 24 hours / next day**	Plain Radiography	%		100 ▲	99 ▼	99 ■	→		100 ▲	→		99 ▼	99*	90	90	No variation		Any variation	●		99
	K			Ultrasound	%		100 ■	100 ■	100 ■	→		100 ■	→		95 ▼	95*	90	90	No variation		Any variation	●		100
	K			MRI	%		57 ▼	84 ▲	79 ▼	→		88 ▲	→		90 ■	90*	90	90	No variation		Any variation	●		84
	K			CT	%		100 ■	99 ▼	99 ■	→		99 ■	→		97 ▼	99*	90	90	No variation		Any variation	●		99
KD	F	14	Complaints	No. of Complaints Received formal and link)	No.		70	57	63	→		65	→		50	178	No. Only	No. Only					834	724
	K			No. of Active Complaints in the System (formal and link)	No.					→		302	→		336	336*	No. Only	No. Only						
	K			No. of Complaints received / 1000 episodes of care	No.					→			→		0.625	0.625*	No. Only	No. Only						
	K			No. of Days to acknowledge a formal or link complaint (% within 3 working days)	%					→		97 ■	→		78 ▼	78*	100	100	100		<100	● ●		
	K			No. of responses which have exceeded their original agreed response date (% of total active complaints)	%					→		28 ■	→		32 ▼	32*	0	0	0		>0	● ●		
	K			No. of responses sent out	No.					→		17	→		5	5*	No. Only	No. Only						
	K			Oldest' complaint currently in system	Days					→		197	→		155	155*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.		12421	12509	12925	→		12188	→		11687	36800	No. Only	No. Only					111793	150454
				Average Length of Queue	mins		1.06 ■	0.25 ■	0.23 ▲	→		0.23 ■	→		0.22 ▲	0.22*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins		26.6 ▲	14.2 ▼	6.4 ■	→		6.2 ▲	→		11.2 ▼	11.2*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.		69754	77745	76726	→		73866	→		65266	150592	No. Only	No. Only					849502	901987
				Calls Answered	%		91.5	91.2	88.1	→		92.1	→		92.0	90.7	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%		67.9	64.2	54.3	→		66.2	→		74.3	64.6	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%		80.3	78.0	69.4	→		79.6	→		85.5	77.9	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs		16.2	18.0	24.3	→		17.1	→		12.3	12.3	No. Only	No. Only					25	18
				Longest Ring Time	Secs		403	349	601	→		397	→		366	366	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days		4.0 ▼	4.1 ▼	3.6 ▲	4.6 ■	3.1 ■	3.8 ▼				3.7	4.3	4.3	No Variation	0 - 5% Variation	>5% Variation	●	4.2	3.8
				Day of Surgery (IP Elective Surgery)	%		92.6 ▼	93.6 ▲	92.1 ▼	95.0 ▲	93.5 ▲	94.0 ▲	95.6 ▲	94.0 ▲	94.7 ▲	93.7	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%		85.3	84.8 ▼	84.6 ▼	82.9 ▼	82.1 ▼	82.4 ▼	82.1 ▼	82.7 ▲	82.5 ▲	82.5	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.		747	779	739	→		738	→		742	742								
RB	H	2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%		1.2 ▲	1.0 ■	0.6 ■	0.9 ■	0.9 ■	0.9 ■	0.4 ■	0.7 ■	0.6 ■	0.7	<0.8	<0.8	<0.8	0.8 - 1.0	>1.0	●	0.6	0.7
	H			28 day breaches	No.		0 ■	1 ■	0 ■	→		0 ■	→		0 ■	0	1	3	3 or less	4 - 6	>6	●	1	2
				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 ▼	43 ▲	38 ■	15 ■	29 ▼	44 ▼	7 ■	22 ▲	29 ▲	111	80	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.		10 ▲	6 ▲	5 ▲	2 ▲	4 ▼	6 ▼	3 ▼	3 ▲	6 ■	6*	0	0	No variation		Any variation	● ●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%		15.2 ▲	15.2 ■	17.7 ▼	→		12.5 ▲	→		17.3 ▼	17.3*	9.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%		8.4 ▼	7.2 ▲	6.8 ▲	→		5.8 ▲	→		6.0 ▼	6.0*	4.9	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty	Door To Balloon Time (90 mins)	%	85.9 ▲	85.4 ▼	85.0 ▼	100.0 ▲	66.7 ■	90.9 ▲				87.1	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
					Call To Balloon Time (150 mins)	%	85.7 ▼	92.9 ▲	81.3 ▼	100.0 ▲	100.0 ■	100.0 ▲				87.5	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain		%	92.6 ▼	97.1 ■	96.5 ▼	100 ■	96.3 ■	98.0 ■				97.2	100	100	=>98	96 - 97.9	<96	● ●	99.1	95.7
RB	H	12	GU Medicine	Patients offered app't within 48 hrs		%	99.8 ▼	100 ▲	100 ■	→		100 ■	→		100 ■	100	=>98	=>98	=>98	95-98	<95	●	100	100

Exec Lead	KPI Source	Data Source	Indicator			February	March	April	May			June			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		7	Staff in Post	Establishment	wte			6851	→			→			6851*								
				Staff In Post (contracted)	wte	6582	6567	6542	→		6549	→			6549*								
				Staff In Post (headcount)	no.	7589	7577	7543	→		7545	→			7545*								
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		1.15	→			1.15*								
				Potential Vacancies (All)	wte			309	→			→			309*								
				Potential Vacancies (Qualified Nursing)	wte			26	→			→			26*								
				Posts Advertised in Month (NHS Jobs)	wte	100	117	103	→		167	→			167*								
				Proportion Temporary Staff - Clinical	%				→			→											
				Proportion Temporary Staff - Non Clinical	%				→			→											
			Nursing Staff	Registered Nurses as percentage of Nurses	%				→			→											
				Nurse : Bed Ratio	Ratio				→			→											
			Staff Turnover	Leavers	wte	177	204	130	→		101	→		117	348	No. Only	No. Only						1064
				Starters	wte	175	130	139	→		78	→		80	297	No. Only	No. Only						862
				Induction	%	93.2 ▼	94.5 ▲	94.5 ■	→		94.5 ■	→			94.5	100	100	=>85		<85			91.3
RB	K	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5195 (69.5) ▼	5127 (69.2) ▼	5191 (70.0) ▲	→		5211 (70.3) ▲	→		5293 (71.5) ▲	5293 (71.5)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS	F	14		Medical Appraisal and Revalidation	%	81	77	77	→		78	→		77	77	No. Only	No. Only						77
MS	K	3		Mandatory Training Compliance	%	not available	86.4 ▼	87.7 ▲	→		88.2 ▲	→		88.6 ▲	88.6	100	100	=>95	90 - 95	<90	● ●	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	3.38 ▲	3.58 ▼	3.34 ▲	→		3.24 ▲	→		3.13 ▲	3.24	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.04 ■	0.96 ■	1.03 ■	→		0.77 ■	→		0.82 ▼	0.87	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.42 ▲	4.54 ▼	4.37 ▲	→		4.01 ▲	→		3.94 ▲	4.11	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
				Nursing Staff	%			4.67 ■	→		4.51 ▲	→			4.59	<3.15	<3.15	<3.15	3.15-3.75	>3.75			
				Midwifery Staff	%			7.16 ■			6.48 ▲	→			6.81	<3.15	<3.15	<3.15	3.15-3.75	>3.75			
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	76.4	75.5	72.1	→		76.8	→		74.7	74.6	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	5210 ▼	6186 ▼	4912 ▲	→		5009 ▼	→		4548 ▲	14469	11745	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	56396	60463
				Nurse Agency Shifts covered	No.	1910 ▼	2153 ▼	2605 ▼	→		2893 ▼	→		1764 ▲	7262	958	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	6948	12874
				Agency Spend as % Employee Benefit Expenditure	%	4.57	6.41	4.29	→		4.28	→		2.60	2.60*								

JUNE 2013	ACTIVITY & CONTRACTUAL

Exec Lead	KPI Source	Data Source	Indicator			February	March	April	May			June			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.	671 ▲	723 ▲	722 ▲	→		791 ▼	→		748 ■	2200	2490	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4409 ▲	4362 ▼	4255 ▲	→		4246 ▼	→		4088 ▲	12750	9869	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	5080 ▲	5085 ▼	4977 ▲	→		5037 ▼	→		4836 ▲	14950	12359	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4310 ▲	4810 ▲	4609 ▼	→		4773 ▲	→		4567 ▼	13949	15007	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	13514 ▲	13214 ▼	13588 ▲	→		14346 ▲	→		13784 ▲	42167	36409	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	29500 ▲	29442 ▼	32513 ■	→		30945 ▼	→		30650 ▲	95438	102232	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	12491 ▲	12703 ▼	12527 ▼	5943 ▼	7362 ▼	13305 ▼	5709 ■	7114 ▲	12823 ▲	38655	48095	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	1854 ▲	1986 ▼	2158 ▲	→	2224 ▼	2224 ▼	→	2067 ▼	2067 ▼	6449	7379	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	15464 ▲	17811 ▲	20081 ▲	8376 ▲	12569 ▲	20945 ▲	8211 ▲	9181 ▲	17392 ▲	61566	53390	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	40519 ▼	41481 ■	45560 ■	→		47015 ■	→			92575	91904	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	14059 ▼	13963 ■	14617 ■	→		15496 ▼	→			30113	27870	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
		16	Contract	Improvement Notices	No.	0 ■	0 ■	0 ■	→		0 ■	→		2 ■	2*	0	0				●		
RB	C	2	Delayed Transfers of Care	Acute	%	2.5 ▲	2.6 ▼	3.1 ▼	2.4 ▲	4.2 ▼	3.2 ▼	2.5 ▼	3.0 ■	2.7 ▲	2.7	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
				Pt's Social Care Delay	No.	18 ■	7 ■	13 ▼	9 ▼	6 ■	15 ▼	4 ▲	5 ▲	9 ▲	9*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	5 ▲	8 ▼	10 ■	4 ■	5 ■	9 ■	5 ▼	2 ■	7 ▲	7*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.18 ▼	2.23 ▼	2.39 ■	2.51 ▲	2.02 ▲	2.16 ■	2.43 ▲	2.14 ▼	2.22 ▼	2.26	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	11.9 ▲	13.1 ▼	11.6 ▲	→		13.6 ▼	→		11.7 ▲	11.7	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	11.2 ▲	12.7 ▼	10.8 ▲	→		12.5 ▼	→		10.8 ▲	10.3	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 Informatics
5	Histopathology Department
6	Dr Foster
7	Workforce
8	Nursing Division
9	Surgery A Division
10	Medicine Division
11	Adult Community Division
12	Women & Child Health Division
13	Neonatology
14	Governance Division
15	Operations Division
16	Finance Division
17	Nurse Bank
18	West Midlands Ambulance Service
19	Healthcare Evaluation Data Tool (HED)
20	Pharmacy Department
21	Imaging Division
22	Surgery B Division

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

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:	**Midland Metropolitan Hospital Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager, Director of Estates/New Hospital Project Director**
AUTHOR:	**Daphne Lewsley, Commercial Manager MMH Project**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital Status Report

Amber

Activities Last Period	Planned Next Period
• Review project resources in light of retained estates programme and changes since project halt • Initial financial affordability work completed and issued to DH • MMH Outline Planning refresh approved • Further HMT PF2 guidance issued	• Community Facilities estate requirements being developed • Implementation of approach to vacant possession of Grove Lane • Detailed activity and capacity modelling work to be updated to allow scenario modelling to be undertaken • Planned Assurance work to be undertaken • Develop detailed plan for procurement phase • Develop plans for pre market engagement and PSC refresh

SWBMMH(07/13) 026 1

REPORT RECOMMENDATION:

Discuss and accept status report

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		x

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

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

Comments:

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

21st Century Facilities

PREVIOUS CONSIDERATION:

Routine monthly update

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**25 July 2013**

EXECUTIVE SUMMARY:

The report gives an update on:

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

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Routine monthly update

FT Programme Monitoring Status Report

Amber

Activities Last Month

- Updated financial model submitted to DH
- Refresh of LTFM based on 12/13
- Draft downside position produced
- Commenced re-development of supporting strategies
- Revisited previous BGAF & QGAF assessment to determine areas of change: actions assigned to Exec Leads to achieve compliance
- Agreement with TDA and DH to run a joint MMH evaluation process
- Secured external support for development of other tiers of the organisation

Planned Next Month

- Commence development of IBP v9
- Evidence compilation ahead of BGAF self-assessment / QGAF self-assessment
- Draft base case LTFM to include results of bottom up workforce modelling
- Commence fortnightly risk & downside workshop sessions
- Detailed reconciliation of FT & MMH timelines
- Strategic communications review
- Ensure appropriate project management and reporting in new managerial arrangements

Issues for Resolution/Risks for Next Month

- Agreement from TDA on revised TFA milestones ('Key milestones to achieve sustainability')
- Continue to make progress on A&E target in line with rectification plan to NTDA
- Outline 15/16 TSPs to be developed
- Achieve consistency between FT & MMH project plans
- Assess impact of MMH on risk and downside mitigations
- Assess impact of revised draft Monitor financial risk ratings
- Agree detailed timetable of approvals /activities required by the Board for MMH and FT

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Mike Harding, Head of Performance Management and Chris Archer, Associate Director of Finance
DATE OF MEETING:	25 July 2013

EXECUTIVE SUMMARY:

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

Service Performance (June): - during the month there were 2 actual (C Diff cases reported (6) exceeded trajectory (4) and Mixed Sex Accommodation Breaches (2 breaches = 0.02% of completed FCEs) and 1 projected (RTT Delivery in All Specialities) areas of underperformance. For Quarter 1, areas of underperformance are; Emergency Care 4-hour waits, MRSA Bacteraemia (1 in April), Mixed Sex Accommodation Breaches and RTT Delivery in All Specialities. For month and Quarter the Trust is projected to attract a **PERFORMING CLASSIFICATION**.

Please Note:- the inclusion of the number of actual Mixed Sex Accommodation Breaches in the report for April 2013 reduced the overall weighted score to 2.29, which attracts a PERFORMANCE UNDER REVIEW classification for the month of April.

Financial Performance (June):
-The weighted overall score is 2.90 with underperformance reported in 3 areas; Better Payment Practice Code (Value), Better Payment Practice Code (Volume) and Creditor Days. The classification for the month of June remains **PERFORMING.**

Foundation Trust Compliance Summary Report (June):

Within the Service Performance element of the Risk Rating for the month of May, the Trust underperformed against the C Diff target, with 6 cases reported compared with a trajectory for the month of 4. During the Quarter, the 10 cases of C Diff reported were within the trajectory of 12. Emergencu Care 4-hour wait performance for the month improved to 95.50%, although across the quarter was 94.10%, and as such beneath the operational threshold of 95.00%. Monitor's annual de minimis limit for cases of MRSA Bacteraemia reflecting a governance concern is set at 6, and as such the MRSA Bacteraemia reported (during April) for the year to date does not contribute to the overall score.

The score for the month and Quarter (1) remains 1.0 which attracts an **AMBER / GREEN Governance Rating**.

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

REPORT RECOMMENDATION:					
The Trust Board is asked to NOTE the report and its associated commentary.					
ACTION REQUIRED - The receiving body is asked to receive, consider and:					
Accept		**Approve the recommendation**		**Discuss**	
				x	
KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**x**	Environmental		Communications & Media	
Business and market share		Legal & Policy	**x**	Patient Experience	**x**
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money					
PREVIOUS CONSIDERATION:					
Performance M'ment Board, Clinical Leadership Executive and Finance & Performance M'ment Committee					

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2013/14

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Score 2	Underperforming (Score 0)	April 2013/14	Score	Weight x Score	May 2013/14	Score	Weight x Score	June 2013/14	Score	Weight x Score	Quarter 1 2013/14	Score	Weight x Score
Emergency Care Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	92.40%	0	0.00	94.42%	2	2.00	95.50%	3	3.00	94.10%	2	2.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	0	0.00	0	0	3.00	0	0	3.00	1	0	0.00
Clostridium Difficile	1.00	0		>1.0SD	3	3	3.00	1	3	3.00	6	0	0.00	10	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	92.2%	3	3.00	92.5%	3	3.00	>90.0%*	3	3.00	>90.0%*	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	97.8%	3	3.00	98.2%	3	3.00	>95.0%*	3	3.00	>95.0%*	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	95.6%	3	3.00	96.3%	3	3.00	>92.0%*	3	3.00	>92.0%*	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	3	2	2.00	6	2	2.00	1-6*	2	2.00	1-20*	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	0.50%	3	3.00	0.91%	3	3.00	<1.0%*	3	3.00	<1.0%*	3	3.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	93.2%	3	1.50	95.3%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	96.9%	3	1.50	93.1%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	100.0%	3	0.75	96.1%	3	0.75	>96.0%*	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	94.2%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	90.8%	3	1.50	91.8%	3	1.50	>85.0%*	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	100.0%	3	1.50	100.0%	3	1.50	>90.0%*	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	<3.5%	3.5 - 5.00%	>5.0%	3.10%	3	3.00	3.20%	3	3.00	2.70%	3	3.00	3.00%	3	3.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	1.30%	0	0.00	0.89%	0	0.00	0.02%	2	2.00	0.74%	0	0.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.90%	3	3.00	94.70%	3	3.00	95.30%	3	3.00	94.29%	3	3.00
Sum (all weightings)	**14.00**															
Average Score (Integrated Performance Measures)							**2.29**			**2.64**	* projected		**2.64**	* projected		**2.43**

CQC Registration Status

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

Overall Quality of Service Rating

							Performance Under Review			**Performing**			**Performing**			**Performing**

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2013/14

Financial Indicators				SCORING			2013 / 2014			2013 / 2014			2013 / 2014		
Criteria	**Metric**	**Weight (%)**		**3**	**2**	**1**	**April**	**Score**	**Weight x Score**	**May**	**Score**	**Weight x Score**	**June**	**Score**	**Weight x Score**
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	**0.05%**	**3**	**0.15**	**0.57%**	**3**	**0.15**	**0.00%**	**3**	**0.15**
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	**0.00%**	**3**	**0.6**	**0.01%**	**3**	**0.6**	**0.01%**	**3**	**0.6**
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	**11.29%**	**3**	**0.15**	**6.69%**	**3**	**0.15**	**5.44%**	**3**	**0.15**
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	**0.00**	**3**	**0.6**	**0.00%**	**3**	**0.6**	**0.00%**	**3**	**0.6**
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	**6.88%**	**3**	**0.15**	**6.46%**	**3**	**0.15**	**6.32%**	**3**	**0.15**
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	**1.46%**	**3**	**0.15**	**1.07%**	**3**	**0.15**	**0.92%**	**3**	**0.15**
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	**6.88%**	**3**	**0.15**	**6.46%**	**3**	**0.15**	**6.32%**	**3**	**0.15**
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	**90.60%**	**2**	**0.05**	**92.60%**	**2**	**0.05**	**93.84%**	**2**	**0.05**
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	**94.90%**	**2**	**0.05**	**94.40%**	**2**	**0.05**	**92.76%**	**2**	**0.05**
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	**1.09**	**3**	**0.15**	**1.02**	**3**	**0.15**	**1.05**	**3**	**0.15**
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	**12.31**	**3**	**0.15**	**12.97**	**3**	**0.15**	**13.29**	**3**	**0.15**
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	**40.44**	**2**	**0.1**	**44.79**	**2**	**0.1**	**39.03**	**2**	**0.1**
						Weighted Overall Score			**2.90**			**2.90**			**2.90**

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

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

MINUTES

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Board – Version 0.1

Venue Boardroom, Sandwell Hospital **Date** 27 June 2013 @ 1300h

Present:

Mr Richard Samuda
Ms Clare Robinson
Mr Toby Lewis
Mr Mike Sharon
Mr Robert White
Miss Kam Dhami
Mrs Jessamy Kinghorn
Miss Neetu Sharma

Secretariat: Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies were received.	
2 Minutes of the previous meeting	**SWBFT (5/13) 053**
The minutes of the previous meeting were accepted as a true and accurate record of the discussions held on 30 May 2013.	
AGREEMENT: The minutes of the previous meeting were approved.	
3 Update on actions arising from previous meetings	**Verbal**
Mr Grainger-Payne advised that there were no matters arising that remained outstanding.	
4 FT Timeline update	**Verbal**
Mr Sharon circulated the proposed timeline for the Trust's application for Foundation Trust, which he highlighted had been discussed with the Trust Development Authority. The Board was guided through the key milestones which would need to be achieved. Mr Sharon advised that the programme would be very challenging, particularly in terms of Quality Governance. Miss Dhami reported that in connection with the assessment against the Quality Governance Assurance Framework, the previous external assessment with Deloitte would be revisited, however the Clinical Groups would also need to be included in the assessment process. Ms Robinson highlighted the need to demonstrate that the Trust was a learning organisation with a culture of continuous improvement. Mr	

Lewis agreed that there was a risk that the current focus on complaints at present, obscured the attention to learning lessons from these. He advised that this matter would be discussed in more detail at one of the future Board development or 'Time Out' sessions. The programme was reported to be consistent with the timescales for the new hospital project. It was reported that according to the timetable, the earliest that the Trust could be authorised was Christmas 2014. The cultural change associated with the work was highlighted. The future seminar programme for the Board was discussed, which the Board agreed covered the key elements and priorities for the Board. Ms Robinson suggested that the information that would be considered as part of the sessions should be prepared and distributed in advance. Mr Lewis reported that the Trust's FT expertise and capacity would be strengthened by securing additional resources who would act in an advisory capacity.	
5 FT Programme Monitoring report	**SWBFT (6/13) 055** **SWBFT (6/13) 055 (a)**
Mr Sharon asked the Board to receive and accept a summary of progress and key issues related to the application for Foundation Trust status.	
6 FT Programme Risk Register	**SWBFT (6/13) 056** **SWBFT (6/13) 056 (a)**
Miss Sharma presented the latest version of the FT Programme risk register, which she highlighted had been refreshed by relevant Executive leads. It was noted that in line with the request at the last meeting, the risk log had been ordered by risk score severity. It was highlighted that the highest scoring risk related to workforce plans & assurance, with the second highest relating to the 18 weeks data quality issue. Mr Sharon drew the Board's attention to the risks included within the Tripartite Formal Agreement submission.	
7 Integrated Development Plan	**SWBFT (6/13) 057** **SWBFT (6/13) 057 (a)**
Mr Sharon presented the key issues for noting within the Integrated Development Plan (IDP), highlighting that this represented much ongoing work including matters to support the Board's BGAF and QGAF assessments. It was noted that the development of a robust risk management process featured as a key action within the plan. Mr Lewis advised that a revised approach would be presented to	

the Trust Board in July.	
8 FT Compliance Framework	**SWBFT (6/13) 058** **SWBFT (6/13) 058 (a)**
Mr White advised that the position against the FT Compliance Framework was at amber/green.	
9 Matters for information	
9.1 Substantive Guidance on Procurement, Patient Choice & Competition Regulations: consultation document	**SWBFT (6/13) 059** **SWBFT (6/13) 059 (a)**
The Board received and noted the Substantive Guidance on Procurement, Patient Choice & Competition Regulations: consultation document. Mr White advised that the draft response from the Foundation Trust Network did not suggest that the guidance would present a significant issue for the Trust.	
9.2 Enforcement Guidance on Procurement, Patient Choice & Competition Regulations: consultation document	**SWBFT (6/13) 060** **SWBFT (6/13) 060 (a)**
The Board received and noted the Enforcement Guidance on Procurement, Patient Choice & Competition Regulations: consultation document.	
9.3 Monitor FT Bulletin – May 2013	**SWBFT (6/13) 061**
The Board received and noted Monitor's FT bulletin from May 2013.	
10 Any other business	**Verbal**
There was none.	

Signed ……..

Print ……..

Date ……..