Sandwell and West Birmingham Hospitals NHS

NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 19 December 2013; 1330h

Members

Mr R Samuda (RSM) [Chairman]
Ms C Robinson (CRO) [Vice Chair]
Dr S Sahota OBE (SS) [Non-Executive Director]
Prof R Lilford (RL) [Non-Executive Director]
Ms O Dutton (OD) [Non-Executive Director]
Mr H Kang (HK) [Non-Executive Director]
Mr T Lewis (TL) [Chief Executive]
Mr C Ovington (CO) [Chief Nurse]
Mrs L Pascall (LP) [Interim Chief Nurse]
Miss R Barlow (RB) [Chief Operating Officer]
Mr R White (RW) [Director of Finance]
Dr R Stedman (RST) [Medical Director]

In attendance

Miss K Dhami (KD) [Director of Governance]
Mr M Sharon (MS) [Director of Strategy & OD]
Mrs F Sanders (FS) [Interim Chief Information Officer]
Mrs C Rickards (CR) [Trust Convenor]

Secretariat

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

Time	Item	Title	Reference Number	Lead
1330h	1	**Apologies**	**Verbal**	**SGP**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 28 November 2013 a true and accurate records of discussions*	**SWBTB (11/13) 248**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (11/13) 248 (a)**	**SGP**
	5	**Questions from members of the public**	**Verbal**	**Public**
1340h	6	**Patient story**	**Presentation**	**LP**
1400h	7	**Chair's opening comments and Chief Executive's report**	**SWBTB (12/13) 250**	**RSM/ TL**
1410h	7.1	Data Quality	SWBTB (12/13) 250 (a)	TL
	7.2	Integrated Transformation Fund	SWBTB (12/13) 250 (b)	TL
		MATTERS FOR DISCUSSION		
	8	**Safety, Quality and Governance**		
1425h	8.1	Proposals for external support for 'Never Event' assurance	SWBTB (12/13) 251 SWBTB (12/13) 251 (a) SWBTB (12/13) 251 (b)	RST

Time	Item	Description	Paper	Lead
1440h	8.2	Abridged action plan in response to the Francis Inquiry and related national reports	SWBTB (12/13) 252 SWBTB (12/13) 252 (a)	KD
1450h	8.3	Update from the meeting of the Quality & Safety Committee in November 2013, minutes from the meeting held on 22 November 2013	SWBQS (12/13) 164	OD
1455h	8.4	Quality report	SWBTB (12/13) 253 SWBTB (12/13) 253 (a)	LP/ RST
1505h	8.5	Update Board Assurance Framework – Quarters 1 & 2 update	SWBTB (12/13) 254 SWBTB (12/13) 254 (a)	KD
1510h	8.6	Equality & diversity – interim position statement	SWBTB (12/13) 255 SWBTB (12/13) 255 (a)	LP
1520h	8.7	EPR procurement	SWBTB (12/13) 256 SWBTB (12/13) 256 (a)	RST
	9	**Finance & Performance Management**		
1530h	9.1	Monthly finance report – Month 8	SWBTB (12/13) 257 SWBTB (12/13) 257 (a)	RW
1535h	9.2	Monthly performance monitoring report	SWBTB (12/13) 258 SWBTB (12/13) 258 (a)	RW
1540h	9.3	Setting annual priorities for 2014/15	SWBTB (12/13) 259 SWBTB (12/13) 259 (a)	MS
1545h	**10**	**Update from the Committees**		
	10.1	Update from the meeting of the Configuration Committee held on 12 December 2013, minutes from the meeting held on 15 October 2013	SWBCC (10/13) 008	RSM
	10.2	Update from the meeting of the Charitable Funds Committee held on 12 December 2013, minutes from the meeting held on 9 May 2013	SWBCF (5/13) 018	SS
	10.3	Update from the meeting of the Workforce & Assurance Committee held on 16 December 2013, minutes from the meeting held on 30 September 2013	SWBWA (9/13) 030	HK
1600h	**11**	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
	12	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (12/13) 260**	
	13	**Foundation Trust application programme: monitoring report**	**SWBTB (12/13) 261**	
	14	**Details of next meeting** *The next public Trust Board will be held on 6 February 2014 at **1330h** in the Anne Boardroom, Sandwell Hospital*		

MINUTES

Trust Board (Public Session) – Version 0.2

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

Present

Mr Richard Samuda [Chair]
Ms Clare Robinson
Dr Sarindar Sahota OBE
Mrs Gianjeet Hunjan
Mr Harjinder Kang
Ms Olwen Dutton
Prof R Lilford
Mr Toby Lewis
Mr Robert White
Mrs Linda Pascall
Miss Rachel Barlow
Dr Roger Stedman

In Attendance

Miss Kam Dhami
Mr Mike Sharon
Mrs Chris Rickards

Guests

Mr Graham Seager [Director of Estates & New Hospital Project]
Mr Ajai Tyagi [Group Director – Surgery B]
Mr Manoj Sikand [Consultant, Orthopaedics]
Mr Mohammed Ramzan [Deloitte] (Observer)

Secretariat

Mr Simon Grainger-Payne

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
No apologies were received.	
2 Declaration of Interests	**Verbal**
There had been no declarations of interest made since the last meeting and no Board member declared an interest with any item on the agenda of the meeting.	
3 Minutes of the previous meeting	**SWBTB (10/13) 227**

The minutes of the Trust Board meeting held on 31st October 2013 were presented for consideration and approval.	
AGREEMENT: The minutes of the last meeting were approved	
4 Update on Actions arising from Previous Meetings	**SWBTB (10/13) 227 (a)**
The Board received the updated actions log. It was noted that an update on the reasons behind the cancelled operations would be presented at the next meeting.	
5 Questions from members of the public	**Verbal**
There were no questions.	
6 'Never Events' in Trauma & Orthopaedics and Ophthalmology	**SWBTB (11/13) 246** **SWBTB (11/13) 246 (a)**
The Board was joined by Mr Ajai Tyagi and Mr Manoj Sikand for this item. Dr Stedman reminded the Board that the Trust aimed to become better at becoming a learning organisation. He guided the Board through progress with the actions taken in connection with the 'Never Events' that had occurred year to date. The item was in front of the Board today because we have now reached four Never Events: An unprecedented and unacceptable position. Mr Tyagi advised that plans to introduce videoing procedures in the Eye Centre would commence from January 2014, with a view to learning from reviewing these filming. The purpose is to help teams explore group dynamics. Ms Dutton asked whether there was an impact on patient consent procedures in this respect. She was advised that this was the case and that staff consent would also need to be gained. Dr Stedman reported that all corporate actions in respect of the Plastic Surgery 'Never Event' had been completed. The Board was informed that a 'Never Event' had occurred in Orthopaedics and a table top review had been conducted. The detail of the event which involved a hip replacement was outlined. A number of contributory issues to the incident were reported to have been identified. It was reported that electronic templating would assist with the selection of the correct size implant prior to surgery, however this was not yet in place. In addition, the policy for checking implants in future would be formalised as a matter of priority. A further 'Never Event' was reported to have occurred in Ophthalmology, which fell into the category of wrong-site surgery and patient misidentification, which resulted in the incorrect patient receiving surgery in the Eye Hospital. It was reported that the checking procedures in the environment were not as extensive as those within an operating theatre. It was highlighted that there were a number	

of points of learning arising from this event. Ms Dutton advised that the matter had been discussed at the recent meeting of the Quality & Safety Committee and suggested that the incident exposed significant risk. She expressed concern at the nature of the situation and suggested that urgent action be taken to address the points of learning. Ms Robinson also expressed concern that it did not appear that it a courteous introduction between the patient and doctor was undertaken. Mrs Hunjan asked whether all patients involved were aware of the incidents. She was advised that the Trust has been open about the situations. Mr Lewis drew attention to the fact that urgent action was being taken to get to the safety culture we all seek. He reminded the Board of the quarter 3 audits being led by Ms Dhami. He then suggested that the discomforting thing about the position was the manner in which individuals and teams were not considering the implications of an incident elsewhere in the Trust on their practice. As such the external input he and Dr Stedman were commissioning would focus on team culture not on further policy adherence. It was highlighted that this work would involve identifying the teams that would benefit from adoption of best practice from areas identified as already having in place a robust safety culture. Ms Dutton sought clarity that robust patient identity checking to be implemented as a priority in advance of the wider measures in the form of the review and peer learning plans. Mr Lewis advised that this message had already been issued to the organisation and was within hours. Miss Dhami advised that a simple film would also be made available to staff outlining a set of tips for seeking positive identification. Mr Tyagi advised that in Ophthalmology the requirement to undertake the check had been reinforced with all staff across the area. Ms Barlow noted we would now be checking every outpatient procedure domain. Prof Lilford highlighted that an appropriately safety-focussed culture needed to be grown in targeted areas and on a phased basis. Mr Kang noted that the four Never Events were caused by a mixture of culture, systems and procedures and asked what changes were being made to address these areas. Mr Lewis advised that the video was designed to prompt consideration of the situation from a personal perspective. Mr Sikand advised that the change in culture would be achieved by fully engaging all staff in the area. Mrs Pascall advised that the newly appointed matron in Ophthalmology was driving consideration of personal reflection and delivery of more robust practice. Miss Barlow advised that the plans needed to be considered as part of the transformation agenda.	
ACTION: **Dr Stedman to present an outline of the proposed patient safety external review at the December 2013 meeting**	
7 Chair's Opening Comments and Chief Executive's report	**SWBTB (11/13) 229**

Mr Samuda advised that there had been a meeting with the local Clinical Commissioning Group in respect of data quality and plans for the new hospitals. It was reported that discussions had been held with the Trust Development Authority in terms of winter pressures and the need for support from Social Services. Mr Samuda advised that he had attended a dinner at which the new Chief Inspector of Hospitals had outlined the inspection regime and how performance would be triangulated and assessed.

Mr Lewis highlighted that compliance with the Emergency Care target had been achieved recently, however further work with discharges and resolving delayed transfers of care was needed. Ms Robinson noted that the Christmas period may be impacted by Social Services shut down during this period. Mr Lewis reminded the Board that at the Urgent Care Board shortly all local authority local closures would be visible to assess operational impact.

Ms Dutton highlighted that much corporate social responsibility was involved in achieving the recent Health Service Journal award for 'Learning Works'. The Chairman agreed that this was a key achievement.

In respect of data quality, Mr Lewis reported that a taskforce had been arranged to oversee a programme, jointly with the newly appointed internal auditors, to provide assurance on the quality of data. He added that a review of the quality of the information underpinning the reported Trust's performance against the CQC intelligent monitoring indicators was planned, the outline of which would be reported at the next meeting.

ACTION: Mr Lewis to provide a first report on data quality at the next Board meeting

8 Safety, Quality & Governance

8.1 Emergency Care	**SWBTB (11/13) 230**

Miss Barlow provided an overview of the current state of Emergency Care and the plans to improve the quality of processes and performance in the area, which she highlighted had been discussed at the recent Quality & Safety Committee meeting. It was highlighted that the achievement of the target month to date reflected that surges in attendance could be managed by the new systems and processes implemented. The Board was advised that in October, there was a high level of delayed discharges. The detail of the new model was presented, including the introduction of seven day social care support. It was noted that a significantly higher than usual attendance rate had been seen on Monday 25 November, which had been well managed by the new processes.

The Chairman asked how the funding was managed through the new integrated system. Miss Barlow advised that this was shared across the patient pathway and overseen by the Urgent Care Board. In the Trust it was reported that the funding would support respiratory care clinics and ambulatory care facilities.

Mr Kang asked whether the surges in demand were common across the region

and whether this was linked to the recent weather change. Miss Barlow advised that this was the case, however they could not be explained solely by the weather, but potentially the position reflected operational pressures in other organisations which resulted in the presentation of additional activity into the Trust. Dr Sahota asked how the position stood in terms of staffing Emergency Care. Miss Barlow advised that new clinical leadership was in place in the area and new consultants had been recruited. It was noted that there remained vacancies in key areas however. Ms Robinson asked what discussions had been held with on social services to ensure that adequate support was provided. Mr Lewis advised that every pressure was being borne to bear to ensure that there was a system that fully operated on a seven day a week basis. Ms Robinson asked what work was being undertaken in the community to ensure that appropriate patients were deflected to settings other than an acute environment. Miss Barlow advised that there was good communication and discussion with the CCG in this respect. The Chairman asked in terms of the overall Emergency Care trajectory, how the Trust stood. Miss Barlow advised that there was an expectation that the 95% target would be met from December onwards, with support from Social Services. Ms Dutton asked whether any discussions had been held with the CCGs about the integrated transformation fund. Mr Lewis advised that he had lots of discussions about the position with peers. The first draft guidance had implied acute sign off of plans. He agreed to provide a more general overview at the next Board meeting. Mrs Hunjan asked in terms of readmissions, whether GPs could assist with improving the position. Miss Barlow reported that a readmissions taskforce had been implemented and a risk assessment tool was being used to assess the risk of readmission. The Board was advised that GPs had been invited to join the group and that a process similar to that for mortality reviews would be implemented to assess reasons behind readmissions.	
Emergency preparation, resilience and response – self-assessment and improvement action plan	**SWBTB (11/13) 231** **SWBTB (11/13) 231 (a)** **SWBTB (11/13) 231 (b)**
Miss Barlow presented the Emergency preparation, resilience and response self-assessment and improvement action plan at the request of the West Midlands Emergency Planning Board. It was noted that the emergency planning post remained vacant at present, however a joint emergency planning team was being arranged with Birmingham Children's Hospital. It was reported that there was a likelihood that the position would be filled shortly. It was reported that the risk register would be updated to reflect this situation.	
8.2 Action plan in response to the Francis Inquiry and related national reports	**SWBTB (11/13) 232** **SWBTB (11/13) 232 (a)**

The Board was reminded that at the last meeting an update had been presented on the Trust's response to the Francis Inquiry and related reports. The wide ranging nature of the recommendations was noted. Miss Dhami highlighted that of the set of recommendations from the Francis Inquiry, 61 were directly relevant to the Trust and that these had been supplemented by the recommendations from the additional national reports. It was reported that there was a requirement to communicate the recommendations to the staff as part of the proposals. In terms of monitoring the delivery of the action plan, it was reported that the Board needed to be appraised on progress annually as a minimum and should be communicated publicly. The action plan to address the recommendations was considered. It was noted that a project plan would be developed to oversee the delivery of a number of the actions. The measures of success were highlighted and comments were invited. Mr Kang observed that given that the action plan would be considered by the Board annually and asked how the oversight of the actions would be monitored. Miss Dhami advised that this would be through the subcommittees of the Clinical Leadership Executive and to a degree through the Quality & Safety Committee. It was also noted that the discharge of the actions would be delivered through some of the routine business of the Board. Ms Dutton suggested that training and development needed to be reinforced in the action plan. In terms of improving experience in outpatients, it was suggested that this be strengthened to reflect the plans to address the recent 'Never Event'. Ms Dutton added that there was a need to deliver a more robust whistleblowing culture, however she doubted the citation of an increased number of whistleblowing notifications received as a measure of success. Mr Lewis suggested that a high level of success needed to be set for this work and that a greater level of granularity and robustness needed to be set against the delivery of the actions. He suggested that the timeframes set should be challenging. Mr Lewis recommended that the work be themed and that Non Executives took responsibility for providing oversight on a particular area. Ms Dutton suggested that the reports back to the Board needed to be themed over a number of months. Ms Robinson suggested that it was not clear from the report which were the key priorities and areas of concern on which the Board needed to be focussed. She noted that the success measures needed to be clarified in some cases. The Board agreed that the actions identified were appropriate however the priority and sequencing needed to be clarified. Dr Sahota urged that consideration be given to the need to capture the softer intelligence to judge performance and effective delivery of the actions.	
ACTION: **Miss Dhami to present a final and revised 'Francis' action plan at the next Board meeting**	

8.3 Update from the meeting of the Quality & Safety Committee held on 22nd November 2013 and minutes from the meeting held on 25th October 2013	SWBQS (10/13) 149
Ms Dutton's updated the Board on the key discussion points from the meeting of the Quality & Safety Committee that had been held on 22nd November 2013. Ms Robinson asked what measures were being undertaken to reduce the number of falls causing harm. Mrs Pascall advised that a 'heatmap' had been developed which identified that there were no specific trends, however some spot checks and a greater level of surveillance had been introduced. Better education was also reported to be implemented. Mrs Pascall advised that table top reviews had been undertaken on the six falls in October, which identified that one was preventable. Mr Lewis asked the Board to note that there was a reduction in falls overall, however the number that resulted in harm had increased.	
8.4 Quality Report	**SWBTB (11/13) 233** **SWBTB (11/13) 233 (a)**
The Board was asked to consider the Quality Report. In terms of thrombolysis, Miss Barlow reported that the clinical team for stroke had reviewed the reasons for patients not being treated within the 'golden hour' following a stroke, which had determined that the majority of breaches occurred out of hours. It was reported that several improvement measures were being delivered, including strengthening support from Imaging out of hours. Dr Stedman added that the indicators which triggered a stroke alert had been reviewed given that a significant number had been identified as false alerts, with a view to recalibrating the thresholds. It was agreed that an update would be brought back to a future meeting of the Quality & Safety Committee. Mr Kang asked for the reasons behind the improved the Friends and Family Test results. Mrs Pascall advised that text messaging had been introduced. It was noted however, that the score itself had deteriorated, which reflected the inclusion of the Accident and Emergency departments in the areas for which feedback was collected. Mr Lewis highlighted that the Trust was one of the few in the region that had a high level of feedback on experience in Emergency Care. Mrs Pascall advised that it had been identified that patients had difficulty sleeping at night and as such patients staying overnight would be provided with a 'pamper pack' which included an eye mask and ear plugs.	
8.5 Board Assurance Framework – Quarter 1 & 2 update	**SWBTB (11/13) 235** **SWBTB (11/13) 235 (a)**
Miss Dhami presented the Quarter 1 and 2 update on the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities. It was highlighted that further work was planned to refresh and reframe the Board	

Assurance Framework. Miss Dhami advised that discussions were planned with the Chair of Audit & Risk Management Committee and the Vice Chair to review the process and document. Ms Robinson suggested that the BAF could be used in future by the Board Committees to review the Trust's key risks. It was further suggested that the plans would be considered by the Audit & Risk Management Committee. Mrs Hunjan underlined the need for the document to be completed in full for this meeting.	
9 Finance & Performance Management	
9.1 Update from the meeting of the Finance & Investment Committee held on 22nd November 2013 and minutes from the meeting held on 20th September 2013	**SWBFI (9/13) 089**
Ms Robinson presented the key highlights from the meeting of the Finance & Investment Committee held on 22nd November 2013. She asked the Board to note that the financial position of the Medicine & Emergency had improved although this had been supported by some benefit from reserves for additional temporary staffing.	
9.2 Monthly Finance Report – Month 7	**SWBTB (11/13) 236** **SWBTB (11/13) 236 (a)**
Mr White advised that in October a surplus of £1.1m had been generated against a plan of £600k. It was reported that there had been a recasting of the PBC payable to the Department of Health and a benefit had been received in terms of the income from road traffic accident cases. It was noted that overall, the financial plan was being exceeded. The new continuity risk rating was reported to show a 4, with a rating of 3 expected by the year end. It was highlighted that should the year end forecast be expected to require amendment, this would need to be agreed shortly.	
9.3 Monthly Performance Monitoring Report	**SWBTB (11/13) 238** **SWBTB (11/13) 238 (a)**
The Board was asked to receive and accept the monthly performance monitoring report.	
10 Midland Metropolitan Hospital update	
10.1 Resolution to reapprove the Outline Business Case to commission the Midland Metropolitan Hospital	**SWBTB (11/13) 242**
The Chairman outlined that the climate had changed since the Board had last reviewed and approved the Outline Business Case.	

Mr Lewis drew the Board's attention to the resolution that it was being asked to approve, which covered the timeframe, financial capacity and mitigations in the event that the plans were not delivered as anticipated. He noted the prior discussions held over recent months as well as the intended discussion of commercial matters in the upcoming private Board.	
10.2 Submission to the TDA	**SWBTB (11/13) 242 (a)** **SWBTB (11/13) 242 (b)** **SWBTB (11/13) 242 (c)**
Mr Seager highlighted that a significant update of the Outline Business Case had been developed, which reflected the advent of PF2, particularly in chapters 11 and 12, which the Board was invited to consider. The Board was asked to note the checklist that had been completed in readiness for consideration by the Trust Development Authority. Mr Lewis highlighted that April 2014 was the final date that would allow the new hospital to open according to the timetable set out. In the event that this was not met, then the Board would need to reconsider the plans. Ms Dutton suggested that in this respect the word 'lapse' needed to be replaced by an alternative that reflected that this new consideration was needed. It was agreed that the wording should be discussed outside of the public meeting. [It was subsequently agreed that the clause be amended to 'This decision of the Board will be reconsidered.'] Mr Sharon asked whether there was clarity as to the individual parties in the TDA that needed to approve the submission. Mr Seager advised that a business case of this magnitude needed to be approved by the TDA's national board. The submission was agreed as an accurate reflection of updates since 2009.	
10.3 10 year LTFM, planning assumptions and outputs	**SWBTB (11/13) 245** **SWBTB (11/13) 245 (a)**
Mr White presented the Trust's Long Term Financial Model, the template for which he highlighted was designed by the Department of Health. The Board was reminded that it had concluded at its last meeting that a risk rating of three in the model was acceptable. The Board was advised that the model was predicated on the injection of £100m public dividend capital. The Board was asked to note that the LTFM took into account the financial influences of the new hospital programme. The year on year efficiencies were reviewed, which it was highlighted reflected a combination of national efficiencies and internally driven transformation improvements. Ms Robinson advised that the Finance & Investment Committee had reviewed the assumptions concerning the delivery of the LTFM. She advised that delivery of the transformation savings represented a key risk to the achievement of the LTFM. Mr White advised that external auditors had been asked to provide additional assurance on the accuracy of the information used to populate the model. Ms	

Robinson underlined the importance of gaining this independent review. Ms Dutton noted that there was much activity already underway and asked whether there was confidence that there was sufficient flexibility for the future. Mr Seager advised that there was a financial envelope which applied and that two models of hospital had been developed through an architectural refresh, both of which fitted within these parameters but allowed a degree of flexibility in a number of ways. Ms Dutton noted that this was reflective of the future plans to move work into the community. Mr Lewis added that there was physical flexibility associated with the outpatient areas. He added that the creation of NHS Properties and its power influenced the out of hospital NHS real estate and could introduce a degree of inflexibility. Prof Lilford highlighted that there was a risk that the hospital may be initially built too small and assurance was needed that flexibility was sufficient to adapt should there be a need to revise the model. Mr Kang noted that there was a need to clearly understand future health economy plans and financial projections to be able to finalise the model of the new hospital. Mr Sharon advised that there were a number of schemes and plans that the CCG could sign up to at present that would support this. Nothwithstanding this assurance, it was highlighted that this remained a risk. Mr Lewis advised that there was an expectation that there would be less acute-delivered outpatient work in future releasing clinicians to undertake acute service provision. It was noted that there was a degree of influence in terms of GP choice and that part was associated with ambulance conveyancing. In terms of element in the proposition that were not was not associated with beds, it was reported that there was considerable headroom by adjusting the timeframes over which the services were offered on a day to day basis. Mr Seager advised that with technical advisors, the core requirements through a schedule of accommodation had been built up and a model had been created, with a view to creating a degree of certainty in terms of cost. It was reported that a degree of expansion space had been allowed and that a comparison with other completed schemes had been undertaken to gain a view as to the benchmark. The capital requirements of these plans were reported to have been assessed, which included calculations in terms of inflation. It was highlighted that a financial close would need to be reached as part of the procurement process, at which point the risks associated with inflationary increase were transferred. Dr Sahota asked what impact a movement of Birmingham Children's Hospital might have on the new hospital scheme. Mr Lewis advised that the schemes were congruent however there may be slightly less flexibility in a landscape shift in Paediatrics service in future should this be the case. Mr Sharon noted the intention to retain a risk rating of three throughout the model and asked what sensitivity this was subject to. Mr White advised that contingency had been built into the model, however if all of this needed to be committed then there was significant sensitivity. It was noted that the provision of taper relief had been built into plans which should serve to act as additional flexibility. Mr Kang asked whether the scheme would be viable should the risk rating deteriorate to a two. He was advised that this was possible, given that	

there was a degree of flexibility incorporated into the plan. Mr Seager reported that an in-house team was in place to deliver the scheme, including a commercial manager, estates manager, service redesign director who were supported by external advisers and a legal team. The senior responsible owner for the project was reported to be the Chief Executive. It was reported that a project budget had been set to adequately resource the plans and identify successions for key team members and workstream leads. The Board was advised that there was confidence that there was sufficient capability to deliver the plan. Mr Lewis noted that the forthcoming Gateway review would test the capability to deliver the scheme and was a important check-point prior to advertisement. Based on the information presented it was agreed that the submission to the Trust Development Authority should be formalised and made.	
The Board: (i) **Accepted the revised Outline Business Case** to commission the Midland Metropolitan Hospital, with an opening date in Q3 2018. Noting that: - The OBC is consistent with the public consultation undertaken in 2006 and with prior agreed Right Care, Right Here strategies adopted by commissioners and partners - The OBC is based on a Long Term Financial Model [LTFM] base case of a regulatory 3 in line with Board resolution made in October 2013. This includes a PFI expenditure with a UP of not more than £27m per annum in its base year - That LTFM demands expenditure reductions which total £166m over ten years from 14-15 and it provides for up to £74m to be invested in equipment, maintenance and IT in the years ahead - Our expenditure reductions are based on the Trust's successfully implementing staffing levels safely provided elsewhere, but which are less expensive than our current paybill - The LTFM and OBC provide for up to £32m of capital investment in estate, on which the MMH configuration wholly depends. This will be funded through current cash reserves and future operating surpluses. - Land disposal for commercial benefit is not assumed in the LTFM base-case, but is part of our agreed Estate strategy September 2013, down-side mitigations, and post year 10 implied financing model. No assumption should be made by other parties that that land is available for their use. (ii) **Noted that the decision to proceed with PF2 as the funding mechanism is subject to satisfactory completion of the Value for Money analysis. If VfM is demonstrated the Trust would progress the development through the Private Finance 2 funding and construction route**, using procurement documentation that is consistent with national policy, but which reserves third party income within the	

building to the Trust or its nominated provider. The selection of this route is governed by a risk transfer assessment which has been subject to detailed Board member scrutiny, as well as external advice. This route is selected contingent upon published national policy by HMG which caps the elapsed time from advertisement to appointment of preferred bidder at no longer than 18 months. (iii) **Believed that the Trust has the capacity and capability to deliver the scheme,** and has an adequate governance system in place to oversee respectively procurement, construction, mobilisation, occupation, and operation. This capability will be routinely tested internally and by use of the Gateway process. We further are aware of the extensive partnership in place to deliver out of hospital transformation, in which we currently participate. (iv) **If the case being approved within it does not proceed to OJEU advertisement on or before April 30 2014 this decision of the Board will be reconsidered.** This would include evaluation by the Board of both the Long-Term Financial Model and the strategic alignment necessary to deliver a transformation on this scale. (v) **Required the Executive to report routinely [and never less than quarterly] to the Board,** through its committees and directly from April 14, on whole system progress to deliver the trajectories set out in this LTFM's activity model, as well as any material future system planning documents. We further note and adopt the proposal that a formal review of progress to the demand figures, bed numbers, and outpatient supply model in this OBC should be concluded not less than 15 months prior to the opening date. The results of which should trigger mutual provider and commissioner formal re-confirmation of the safety of those assumptions for the due date, together with any actions agreed to mitigate risk, and that this overall assessment of risk should be made publicly available.	
11 Any Other Business	**Verbal**
In the event that this might be Prof Lilford's last meeting he was thanked for his contribution to the work of the Board.	
Matters for Information	
The Board received the following for information: Midland Metropolitan Hospital Project: Monitoring Report Foundation Trust Application Programme: Monitoring Report Monitor Risk Assessment report	

Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 19th December 2013 and would be held in the Boardroom, Sandwell Hospital.	

Signed: ………………………………………………………………..

Name: ………………………………………………………………..

Date: ……………………………………………………………….

Next Meeting: 19 December 2013, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

22 November 2013, Anne Gibson Boardroom @ City Hospital

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

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

Apologies: None

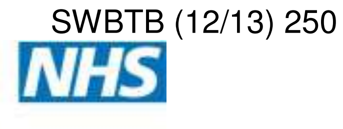
Secretariat: Mr Simon Grainger-Payne (SGP)

Last Updated: 13 December 2013

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.268	'Never Events' in Trauma & Orthopaedics and Ophthalmology	SWBTB (11/13) 246 SWBTB (11/13) 246 (a)	22-Nov-13	Present an outline of the proposed patient safety external review at the December 2013 meeting	RST	19/12/13	Included as an item on the agenda of the Dec-13 meeting	B
SWBTBACT.269	Chair's Opening Comments and Chief Executive's report	SWBTB (11/13) 229	22-Nov-13	Provide a first report on data quality at the next Board meeting	TL	19/12/13	Included as an item on the agenda of the Dec-13 meeting	B
SWBTBACT.270	Action plan in response to the Francis Inquiry and related national reports	SWBTB (11/13) 232 SWBTB (11/13) 232 (a)	22-Nov-13	Present a final and revised 'Francis' action plan at the next Board meeting	KD	19/12/13	Included as an item on the agenda of the Dec-13 meeting	B

KEY:

Status	Description
R	Action highly likely to not be completed as planned or not delivered to agreed timescale.
A	Action potentially will not delivered to original timetable or timing for delivery of action has had to be renegotiated more than once.
Y	Slight delay to delivery of action expected or timing for delivery of action has had to be renegotiated once.
G	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
B	Action that has been completed since the last meeting

Sandwell and West Birmingham Hospitals 

NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – December 2013

Today's Board meetings falls just three weeks since our last one. The focus of the organisation's effort in that intervening period has been on:

- Finalising specific safety culture proposals – visible in today's papers in our Never Events external support piece and the proposed final Francis Report response document.
- Maintaining our improved operational delivery position – reflected in continued minimum standard compliance in emergency care and the agreed 18-week trajectories at specialty level
- Tackling our data quality concerns – and the current state of progress is reflected in my report below

The Trust has well developed plans to manage surge and pressure over the new-year period. There is good senior leader cover on site throughout the next few weeks. The West Midlands Urgent Care Working Group, chaired by NHS England, has approved primary and social care work patterns over the holiday period. The risk is that with both public holidays falling mid-week this year, there is a slow start to discharge in the week beginning January 6th.

The basis for our Trust's improved performance in recent weeks – including 'recovering' from some days of sustained increased arrivals or admissions – has been grip to make sure that response and actions are timely. That creates some confidence going into the next few weeks. However, we continue to see around 5% of our medical bed base occupied by patients, whose best interests would be care elsewhere. Around half of that number is delayed pending health service led processes (notably continuing healthcare funding decisions) and half are pending social care actions. The four principal agencies are meeting on the day of our Board meeting at Chief Executive or Director-level to assess what more can be done by whom to eliminate this unacceptable – if regionally common – issue.

1. Our patients

It is encouraging that our hard work and new approaches to infection control are working so far. We remain below prior years for *c difficile*. And our MRSA position remains a strong one. There is still more to do to ensure that we have comprehensive per patient screening. Whilst delivery has leapt over recent months, as with VTE assessment, we want to make this normal and 100% across all our admitted care facilities. Disappointingly we did not achieve our 95% minimum benchmark for VTE in November. The executive are considering what further steps can proportionately be taken to support weekend admissions where the majority of the un-assessed patients lie.

There is no room for complacency on norovirus and some further communication approaches will be visible in the Trust over coming weeks reminding staff, patients and particularly visitors of the need for vigilance. Ward matron feedback on the doors/screens on bays at Sandwell reflects patient feedback that the wards feel calmer and quieter, which is welcome. The whole purpose of our bed

model changes has been to reduce night-time movement other than in certain key wards in order to help patients get a good night's sleep.

Most of the time we are delivering planned care short waits. But there remain a series of specialties were waits vary between teams or between months, or where waits across the board are too long. The Clinical Leadership Executive has reviewed the COO's proposals to tackle this. In some cases we have sub-specialty demand/supply imbalance. In other cases we have developed a 'backlog' but once that is tackled we would be able to maintain a good position. Overall the intention is to achieve specialty compliance with the incomplete, non-admitted and admitted obligations we have under the NHS Constitution by March 2014 in every specialty except orthopaedics, ophthalmology, and plastic surgery. The current trajectory in those three areas takes us into Q2 14-15. We are working with the Intensive Support Team (part of the DH) from January 2014, at our own instigation, to both review our 18-week data quality now that we have implemented revised protocols, and to examine whether there are further model of care innovations we could put in place in orthopaedics. The outpatient change programme for 2014 will identify specialties where we believe it is both desirable and possibly to reduce first appointment waits much further.

2. Our colleagues

We know that the future strength of our organisation will lie in leadership at all levels of the organisation. Our plan to respond to the Berwick report, Francis report, our own staff and patient surveys, focuses rightly on cultural changes. Those changes arise from behaviours and those behaviours are role-modelled by leaders, particularly those closest to most of our teams. The Board has considered before the need to invest in leadership development on a multi-professional basis, building on our high-profile action centred leadership initiative from two years ago, but organised compulsorily for senior leaders. This will commence in March 2014 and run through the succeeding year and beyond. It is a vital intervention to ensure that we have common cause, voice and calibre across our corporate functions and thirty plus directorates. If we mean what we say in discussing the best of SWBH becoming what we do consistently, then leadership consistency will be very significant. The first phase of our Your Voice programme is now complete. Sensing some survey fatigue with the national staff sampled survey too, we commence again in January 2014. We know that across the NHS we face issues of morale and disengagement in pockets, and the survey helps us to pinpoint those pockets within our own organisation. We continue to work well with our trade union colleagues and earlier this month held a joint event to think laterally and radically about how we reduce the stress and time-burden of employee relations processes in our Trust (grievances, disciplinary proceedings etc). More than fifty staff drawn from across the organisation participated in a Listening Into Action event, which I attended. We will deploy changes from April 2014 after we conclude the planning of them in Q4, led by Lesley Barnett. Our Board's Workforce and Organisational Development Committee will help to track impact, as will our monthly non-executive chaired JCNC.

Of course, our staff are a little safer this winter than last. This is because our flu uptake has leapt from 49% of patient-facing employees to over 70%. Efforts will continue until the middle of December to vaccinate even more of the team, and payslip inserts in November have further raised the profile of this serious issue for employees and patients in our care.

3. Our partners

We have been working intensively with primary care colleagues over the last three weeks on a range of joint initiatives to make sure that we fulfil the promises made locally under Right Care, Right Here. Early in 2014 we open a primary care assessment service for three months at Rowley Regis along with local GPs. And across SWB we deploy a new model for diabetes care, long talked about locally, but being executed through the determination of our diabetes specialist nurses and consultant staff alongside Dottie Tipton. Most routine clinic appointments will take place in GP surgeries, with consultant expertise focused alongside those GPs to help risk-stratified complex patients.

The Sandwell Local Medical Committee hosted a presentation from us about our plans for the future, including the Midland Metropolitan Hospital (MMH), this month. Feedback was welcome and was positive, with a recognition that care closer to home cannot mean 'more work for hard pressed GPs'. Our outpatient project to change the nature and pace of communication with practices next year will be important, as will maintaining the very positive view practices report of our pathology and imaging services – which remain by far the largest volume point of contact between primary and secondary care.

We continue to discuss with local CCGs to project to have MMH finally approved by the end of this financial year. As has always been the case we have strong support from local clinicians who recognise that the two ED model we have is not sustainable, and that a population of half a million people necessitates an acute care centre within SWB.

4. Our regulators

We continue to prepare for inspections of our safeguarding services. It was pleasing that the change in commitment and pace from our teams was specifically commended by the independent chair of the Sandwell Safeguarding Board. I am meeting with the chair in Birmingham prior to our Board meeting. I note that the City Council have just released a children's strategy for the city which we are scrutinising.

The board papers reflect continued compliance with the DH and Monitor performance frameworks. It remains unfortunately too common to concentrate on the small numbers of indicators where we are challenged. Overall, our organisation continues to deliver and remains in the top quartile of acute Trusts in the non-FT sector.

5. Feedback from Hot Topics

The key messages for December focused on familiar themes: data quality, ensuring patients feel involved in their care by writing to them after each outpatient contact, making sure that our discharges practices are high quality, flu jab status, and our drive to make sure everyone has their appraisal this financial year. Everyone acknowledges the pressure felt by many employees across the NHS at this time of year, and it is encouraging that our system of internal communication is beginning to build a tradition of frank feedback and safety openness. That continues to focus on readmissions and discharges and will help us to tackle the readmission rate issue that our Board identified and prioritised earlier this financial year.

Toby Lewis, Chief Executive
13 December 2013

Sandwell and West Birmingham Hospitals NHS

NHS Trust

DATA QUALITY

REPORT TO THE PUBLIC TRUST BOARD – 19 DECEMBER 2013

1 Purpose and context

1.1 *This note is provided to ensure all Board members are briefly aware of progress and outstanding issues with our data quality improvement plan*. This work is governed by a taskforce that I chair, which includes our Vice Chair and Audit Committee Chair as well as various executive directors. Our incoming internal auditors, Baker Tilly, provide external input. Claire Parker represents our principal commissioner. The work is due to complete by March 31 2014.

2 Findings and progress to date

2.1 We are following the work plan identified when we undertook our Board to Board with SWB CCG. Whilst Claire is on our taskforce, the accountable officer has indicated to me that progress will be tracked through the monthly CQRN meetings.

2.2 Notwithstanding that route we have responded to several data quality notices under the contract arising from the Board to Board. We have restated our Q2 ED results (an improvement - this predated the CCG involvement) and have now restated our single sex results (a deterioration - likewise). We are finalising the correct reporting for 52 week breaches YTD arising from the 18 week backlog issue(in likelihood this 'improves' the 13-14 position as currently all historic breaches of the standard are reported in this fiscal year). This work will be completed by January 11th as it requires some national clearance.

2.3 Most importantly, **we have settled on a kite-marking system for our data** across all types. This will be deployed from April 2014. It reflects advice on what is used in some other Trusts. In effect this would represent a red flag about data quality concerns that are either relatively innate (multiple systems) or reflect our state of enquiry (no recent external validation). The system will be circulated to Board members as part of briefings on our new performance reporting arrangements in Q4.

2.4 **The system whereby the COO signs off all Unify returns has been put in place** and indeed has delayed our November submission. This introduces a controlling mind what is submitted externally. The Director of Finance plays a similar role for 'FIMs' returns. We will work through as an executive any other equivalent gatekeeping roles we need to introduce.

2.5 We have cross referenced **the CQC data set** received in late October to understand which systems this information comes from. This has allowed us to select a sequence to DQ check

the data that lies behind that information. This check, which Baker Tilly will undertake, forms part of the 'Phase 2' of our DQ plan, which is in deployment now. It covers this work and national targets. The CQC component will conclude by mid-February.

2.6 **The IST framework** for assessing our 18-week position is in final draft, and the IST are due to start with us week beginning January 6th.

3 Work that is behind intended schedule

3.1 We aimed to conclude work on **standard operating procedures** by mid-November. It will now reach conclusion by December 20th. The work has been visible within the project but we wish to ensure that it is entirely accurate prospectively before it is issued for signed return to key personnel. The latter will occur on January 7th.

3.2 The CCG have agreed that we should **data quality test the Malling Health** information associated with urgent care. This process is being organised and will happen over the coming month.

3.3 I have not succeeded as yet in securing a clear position on **cross-system cancer waiting times** and will seek to do so through the CEO Forum in January. The Trust is reporting as others do, but not as other regions do in that there is no agreed share arrangement between secondary and tertiary providers.

3.4 The **re-organisation of the information department** is ready to commence staff consultation during January. This structure will report through the COO.

3.5 We have agreed that a **common set of standards for diagnostic waiting time** access arrangements need to be put in place. This drafting will be completed before December 31st and will be circulated using the SOP model outlined above. BT will audit against those new standards in both January (baseline) and March.

4 Project governance

4.1 Minuted meetings have taken place and are available for subsequent audit purposes. The TSO are now providing project management support and for our next meeting [January 7th] a project plan moving us from diagnosis to solution, including communication clarity, will be presented for consideration.

5 Overall

5.1 We have made a good start with this work. The work reflects long-term concerns among us and recent issues raised by partners. It will be important to maintain momentum after the turn of the year and I will brief the full Board again when we meet next in the first week of February.

Toby Lewis
Chief Executive
13 December 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Background note on integrated transformation fund arrangements (now renamed Better Care)

REPORT TO THE PUBLIC TRUST BOARD – 19 DECEMBER 2013

1. This note provides additional information for the Board on the emerging changes to the commissioning landscape within the health and social care system. It reflects policy announced part way through 2013-14 to transfer expenditure from NHS to Local Authorities in 2015-16, but also substantial volumes of guidance briefed through CCGs and Local Authorities over the last six weeks. This guidance is broadly congruent with the TDA requirements regarding our annual plan submission in early 2014 for the next two financial years.

2. The expectation is that by February 14th returns are made to outline a plan to commit these transferred resources. This requires commissioning bodies first to identify the resources and then to suggest projects on which they may be spent. The latter is indicative in that some measure of tendering may be required to source providers, depending on the nature of the project.

3. It is clear that these monies will remain within NHS accounting practices. But must be spent to deliver certain national objectives (a list of performance indicators is emerging, but it includes typical metrics of interface delay such as delayed transfers of care). The money will be provided locally by DH (having been returned centrally from allocations) on successful execution of these plans.

4. The scale of ITF resources required has been known for some time, and is assumed in our discussions with the CCG about the affordability of MMH. We want to strongly support projects to control demand for secondary care – and our RCRH activity trajectories reflect that ambition and have for many years.

5. The risk for the broader system is that demand management is assumed in forward plans and fails to deliver. That would be then create a financial pressure for commissioners and a supply problem for organisations, including our own.

6. The timescale for plans and returns is clearly a challenging one. SWB is perhaps in a better place than some in addressing this issue because of the RCRH partnership. The CCG envisage that vehicle contributing to signing off proposals, either before or after Health and Wellbeing Boards.

7. More recent guidance clarifies the acute sector role as one of engagement and familiarity. Mike Sharon and myself have met with officers from both Local Authorities and the CCG. We have committed to participate in the development of the ITF but to distinguish that participation from any indication of support. We would clearly wish to provide a letter of support for ITF should that be feasible or indicate our concerns about sustainability should they arise. Myself and the Chairman will discuss that balance, but clearly our LTFM includes activity and income assumptions, and was

approved by the Board in November. As such we have a rather transparent position from which to commence engagement.

8. One of the complexities of the piece of work is what constitutes success. On the one hand it is simple. Successful delivery of the KPIs that in development. However, policy contains an assumption that community delivered care will better permit the system to do that. We have been explicit both that our Trust is an integrated provider and that community based care can be provided in any manner of physical locations. We have also sought to work with partners to ensure that any plans are provider neutral in terms of assumptions about who offers which types of service.

9. I believe that this programme is profoundly helpful to this Trust's ambitions. Helpful in that it is consistent with them and helpful in that it bolsters the partnership needed to transform care. Geography is an issue in planning. Sandwell wish at this stage to focus on adult services. Birmingham are working for adults around the 'natural boundaries of acute providers' and for children on a city wide basis. Separately the CCG have indicated that the unit of management they believe is relevant to local residents is Sandwell and West Birmingham.

10. Mike Sharon will take the lead in supporting the various external processes, with myself and Tony Waite also playing a decision making role. Nigel Trudgill will be asked to help marshall clinical engagement across different professionals groups alongside Fiona Shorney.

Toby Lewis
Chief Executive
13 December 2013

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Taking the Temperature: Measuring the State of Organisational Safety Culture
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Dr Roger Stedman, Medical Director
DATE OF MEETING:	19 December 2013

EXECUTIVE SUMMARY:

This paper outlines the proposed approach to answering questions raised by the Trust Board regarding the state of organisational safety culture following the recent run of never events.

REPORT RECOMMENDATION:

The Trust Board is asked to support the plans to bring about a step change in organisational safety culture through a program of self-assessment using the MaPSaF tool kit, invited external review of safety culture and processes from NHSLA and WMQRS and organisational development.

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	x
Clinical	x	Equality and Diversity		Workforce	

Comments:

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

High Quality Care and Good Use of Resources

PREVIOUS CONSIDERATION:

None

Taking the Temperature
Measuring the State of Organisational Safety Culture

Introduction

This paper outlines the proposed approach to answering questions raised by the Trust Board regarding the state of organisational safety culture following the recent run of never events.

The questions this program is aimed at answering are:

1) What is the current state of safety culture at Sandwell and West Birmingham Hospitals - in particular surgery and operating theatres, but also other safety critical areas - Emergency Care, Maternity, Outpatient and Ambulatory Procedures?
2) Do we have robust policies, procedures and processes in place in outpatient areas that conduct potentially high risk procedures?
3) What do the experts think of our safety policies, procedures and culture?
4) What are the organisational development needs that will help us achieve the desired state - a generative safety culture - where patient safety is an integral part of everything we do?

A four phased improvement cycle is proposed:

1) Organisational Self Assessment - mapping safety climate
2) External Review - NHSLA, WMQRS
3) Development program - closing the gap between current and desired state
4) Re-assessment

This work is entirely integral to the organisations objectives and obligations with respect to Francis, Keogh and Berwick. It will support the Trust's management of strategic risks associated with the inspection by the CQC and help preparations for foundation status.

Safety Culture - a definition

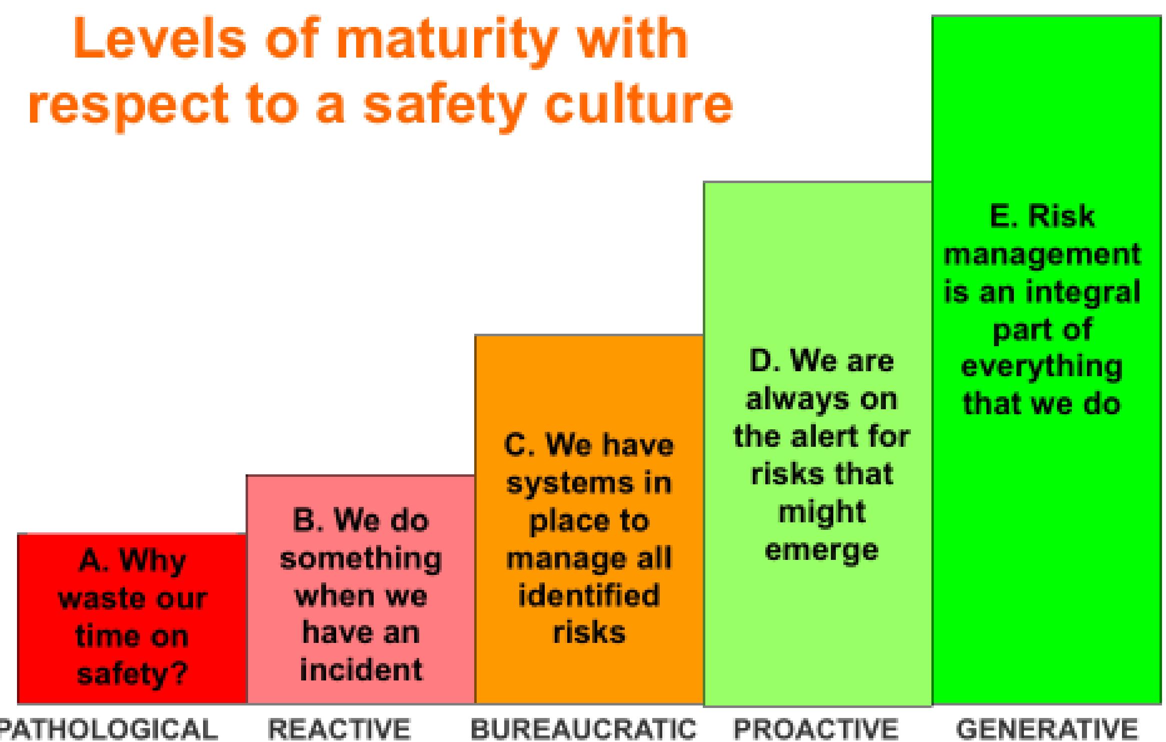
The culture of an organisation is very difficult to pinpoint, but is vital to address if the organisation's ambition is continuous improvement and learning. Organisational culture can be defined as the set of assumed understandings between the staff of an organisation: shared views on the way staff should work together and treat each other and their patients. If an organisation intends to develop a safety culture, it must embed the maxim 'first, do no harm'.

The main elements of a safety culture can be summarised as:

- Open and frequent communication
- High functioning multidisciplinary teams
- 'Just' culture (understanding of system errors vs. individual errors)

- Robust error reporting systems that 'close the loop'
- HR practices that support a culture of safety
- Leadership:
- Focus on 'never events'
- Willingness to address bad behaviours
- Accountability for improvement and safety at all levels
- Measurement

The level of safety culture 'maturity' of an organisation can be defined along a continuum -



from pathological to generative:

Organisational Self Assessment - Mapping our Safety Culture

In an organisation as large and diverse as ours it is inevitable that there will be variation in culture and attitudes to safety. The first phase of our response is to map our safety culture using a culture measurement tool - The Manchester Patient Safety Framework (MaPSaF).

MaPSaF is a tool to help healthcare organisations reflect on their progress in developing a safety culture. It is not a tool for regulators or reviewers and the framework has not been developed for this purpose. Rather, it aims to stimulate discussion about the patient safety culture in any given healthcare organisation and, in doing so, will help that organisation reflect on its progress towards developing a mature safety culture.

MaPSaF describes in words some of the key elements of an open and fair culture, previously described. MaPSaF can be used by boards, clinical governance teams, management teams, healthcare teams and others who would like to pause and reflect on

their safety culture and risk management processes. The tool is used in small group settings. Participants are given reading materials that describe in detail the 5 levels of safety maturity against ten dimensions of a safety culture.

Participants then answer a detailed questionnaire (see Appendix) - the results of which are discussed in pairs and then in the groups. Actions and development needs are drawn up.

Dimension	Description
1. Commitment to overall continuous improvement	How much is invested in developing the quality agenda? What is seen as the main purpose of policies and procedures? What attempts are made to look beyond the organisation for collaboration and innovation?
2. Priority given to safety	How seriously is the issue of patient safety taken within the organisation? Where does responsibility lie for patient safety issues?
3. System errors and individual responsibility	What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed – as an opportunity to blame or improve?
4. Recording incidents and best practice	Who investigates incidents and how are they investigated? What is the aim of recording the incident?
5. Evaluating incidents and best practice	How are any incidents evaluated? What recognition is there of safe practice? How is the resultant data used?
6. Learning and effecting change	What happens after an event? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
7. Communication about safety issues	What communication systems are in place? What are their features? What is the quality of record keeping to communicate about safety like?
8. Personnel management and safety issues	How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures?
9. Staff education and training	How, why and when are education and training programmes about patient safety developed? What do staff think of them?
10. Team working	How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?

We plan to launch the MaPSaF methodology at a patient safety summit on Thursday 13th February. This will be a major event to which will be invited clinical leaders and managers from safety critical areas of the Trust. We will use the tool with them and train them to use the tool which they will then be required to take out to their teams and repeat the exercise

at a local level - capturing all areas of the Trust. The outputs will be fed back to us and summarised for the Board - but more importantly it will be used by local teams to identify their development needs with respect to patient safety.

External Assurance

It is anticipated that the MaPSaF exercise will take several months, if not become a permanent feature of our learning culture.

In the mean time there is a need to seek more immediate assurance on our risk profile with respect to never events within the organisation. We have identified that there are two broad risk areas - for which a different approach is required.

Operating Theatres - These areas are broadly familiar with risks associated with never events and other potential serious incidents. There are already policies and processes in place designed to manage this risk (for example WHO checklist) - which we believe to be embedded. Nevertheless never events have occurred in these areas - either because of lapses in process or intrinsic gaps in process. We need to identify gaps in our processes and also identify risks on which we are currently unsighted (as well as assess the safety culture in these areas). To this end we have commenced dialogue with the NHSLA and its contract partner DNV international (A global risk management consultancy working in high risk industries such as energy, maritime, healthcare, oil & petroleum, aviation, food and IT). The NHSLA has risk management standards with respect to many healthcare risks

Overview of risk areas

Standard ⇨	1	2	3	4	5	6
Criterion ⇩	Governance	Learning from Experience	Competent & Capable Workforce	Safe Environment	Acute, Community and Non-NHS Providers	MH&LD
1	Risk Management Strategy	Clinical Audit	Corporate Induction	Secure Environment	Supervision of Medical Staff in Training	Clinical Supervision
2	Policy on Procedural Documents	Incident Reporting	Local Induction of Permanent Staff	Violence & Aggression	Patient Information & Consent	Patient Information
3	High Level Risk Committee(s)	Concerns & Complaints	Local Induction of Temporary Staff	Slips, Trips & Falls (Staff & Others)	Consent Training	Clinical Risk Assessment
4	Risk Management Process	Claims Management	Risk Management Training	Slips, Trips & Falls (Patients)	Maintenance of Medical Devices & Equipment	Physical Assessment & Examination of Patients
5	Risk Register	Investigations	Training Needs Analysis	Moving & Handling	Medical Devices Training	Observation & Engagement of Patients
6	Dealing with External Recommendations	Analysis & Improvement	Risk Awareness Training for Senior Management	Hand Hygiene Training	Screening Procedures	Dual Diagnosis
7	Health Records Management	Learning Lessons from Claims	Moving & Handling Training	Inoculation Incidents	Diagnostic Testing Procedures	Rapid Tranquillisation
8	Health Record-Keeping Standards	Best Practice - NICE	Harassment & Bullying	The Deteriorating Patient	Transfusion	Absent Without Leave (AWOL)
9	Professional Clinical Registration	Best Practice - National Confidential Enquiries & Inquiries	Supporting Staff Involved in an Incident, Complaint or Claim	Clinical Handover of Care	Venous Thromboembolism	Medicines Management Training
10	Employment Checks	Being Open	Stress	Discharge	Medicines Management	Medicines Management

Changes to criteria numbers: The criteria numbers from 2011-12 are mapped to the criteria numbers for 2012-13 listed at the beginning of each standard.

summarised here:

Interestingly - they don't have risk management standards specifically with respect to never events, but are keen to develop them and would like a partner to help them do so.

Outpatient Procedures - The most recent never event occurred in an outpatient setting. Our investigation revealed that this is an area of risk we were not previously 'sighted' on, and strongly suspect other healthcare providers aren't either. This is an area where there is potential for wider learning in the NHS. The management of 'never event risk' in these areas is much weaker than in the theatres setting - staffing is thinner, processes are less robust, standards are less well defined. This is a reflection of the fact that in general outpatients in the past has been a low risk area - however the relentless drive to move inpatient surgery to day-case and day-case to outpatients over recent years has led to an increase in potentially high risk procedures taking place routinely in these areas (such as laser eye surgery). The systems, processes and culture in those areas though have not caught up with this shift in activity. We believe it is time to develop a set of safety standards for outpatient procedures areas. We have previously worked with the West Midlands Quality Review Service (WMQRS) on developing quality standards for specific service areas (most recently in 2012 for Imaging services). WMQRS develops standards through consultation with providers, patients and other stakeholders - and then disseminates those standards through a process of supportive peer review. We believe that this is the ideal mechanism by which to identify and disseminate learning from this particular never event.

Linking to Organisational Development

Strengthening a culture of safety and risk management within an organisation is not just an exercise in self awareness (although this is a necessary first step) but also one of organisational development. Specifically there are attitudes, knowledge and skills that need to be more prevalent within the organisation in order to deliver the desired future state of a generative safety culture. This includes training in:

- Risk awareness and management
- Communication Skills
  - Structured Handover
  - Talk Back and teach back
  - Structured supportive critical feedback
  - Briefing and Debriefing skills
- Tools of improvement science
  - Root cause analysis
  - Process mapping
  - Time series analysis
  - PDSA rapid improvement cycles
  - Measuring and reporting performance
- Human Factors
  - Understanding and eliminating human error
  - Situational awareness
  - Team skills and Team based learning
  - Simulation training
- HR
  - Building high performing teams
  - Values based recruitment
- Leadership
  - Setting the tone - Psychological safety and a just culture
  - Flattening the hierarchy
  - Addressing bad behaviour

- Hearing the voices - of staff and patients
- Sharing learning

Re-assessment

It is recommended that we re-assess impact of the change management program on a regular basis using the same measurement tool kit.

Conclusion

It is proposed that we bring about a step change in organisational safety culture through a program of self assessment using the MaPSaF tool kit, invited external review of safety culture and processes from NHSLA and WMQRS and organisational development. This will require a sustained and concerted effort of the entire organisational leadership cadre.

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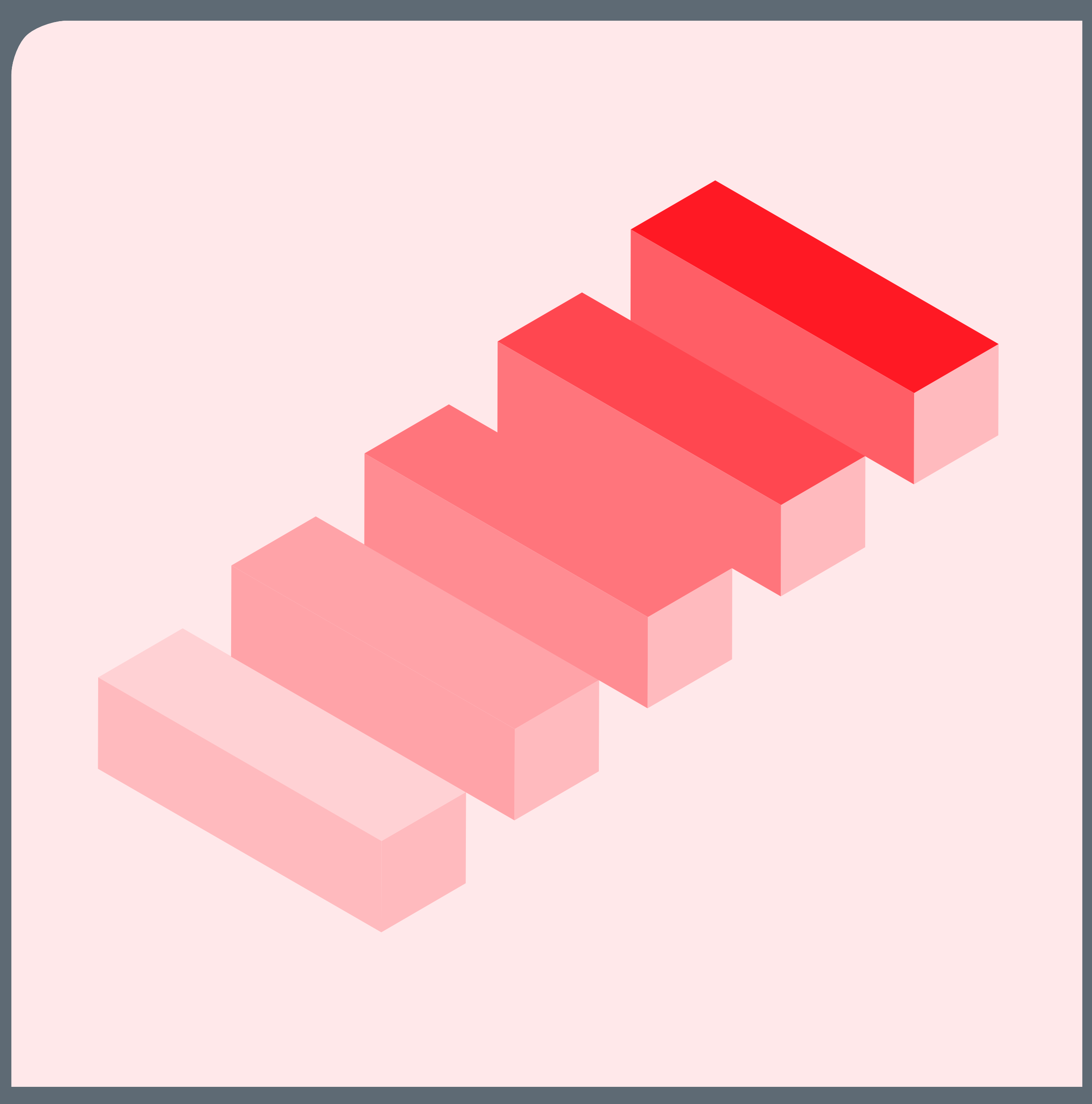
MANCHESTER
1824
The University of Manchester

NHS
National Patient Safety Agency

Manchester Patient Safety Framework (MaPSaF)
Acute



How to use MaPSaF

MaPSaF is best used as a team based self-reflection and educational exercise:

- it should be used by all appropriate members of your team;
- for each of the ten aspects of safety culture, select the description that you think best fits your organisation and/or team.
  Do this individually and privately, without discussion;
- use a T (team) or O (organisation) on the evaluation sheet to indicate your choices. If you really can't decide between two of the descriptions, tick both. This will give you an indication of the current patient safety culture profile for your organisation;
- discuss your profiles with the rest of your team. You may notice that there are differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach consensus;
- consider the overall picture of your organisation and/or team. You will almost certainly notice that the emerging profile is not uniform – that there will be areas where your organisation is doing well and less well. Where things are going less well, consider the descriptions of more mature risk management cultures. Why is your organisation not more like that? How can you move forward to a higher level?

What we mean by these terms

Patient safety incident (PSI): Any unintended or unexpected incident that could have or did lead to harm to one or more patients receiving NHS-funded healthcare.

Prevented patient safety incident (PPSI): Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to patients receiving NHS-funded healthcare.

Root cause analysis (RCA): A technique for undertaking a systematic investigation that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. Retrospective and multidisciplinary in its approach, it is designed to identify the sequence of events, working back from the incident.

Evaluation sheet (sample)

Dimension of patient safety culture	A	B	C	D	E
1. Commitment to overall continuous improvement					
2. Priority given to safety					
3. System errors and individual responsibility					
4. Recording incidents and best practice					
5. Evaluating incidents and best practice					
6. Learning and effecting change					
7. Communication about safety issues					
8. Personnel management and safety issues					
9. Staff education and training					
10. Team working					

T = Team O = Organisation

Manchester Patient Safety Framework (MaPSaF) – Acute

MaPSaF was originally developed by Dianne Parker, Sue Kirk, Tanya Claridge, Aneez Esmail and Martin Marshall in a collaborative project supported by the National Primary Care Research and Development Centre, University of Manchester. The original idea came from research funded by Shell International.

Why MaPSaF was developed

The safety of both patients and staff in a healthcare organisation is influenced by the extent to which safety is perceived to be important across the organisation. This 'safety culture' is a new concept in the health sector and can be a difficult one to assess and change. This framework has been produced to help make the concept of safety culture more accessible. It was originally designed for use by general practices and primary care organisations and has now been adapted for use in other sectors of healthcare provision to help these organisations understand their level of development with respect to the value that they place on patient safety. It uses ten dimensions of patient safety and for each of these describes what an organisation would look like at five levels of safety culture. The framework is based on an idea used successfully in non-health sectors. The content is derived from in-depth interviews and focus groups with a range of healthcare professionals and managers.

MaPSaF is designed to be used to:

- help your team recognise that patient safety is a complex multidimensional concept;
- facilitate reflection on the patient safety culture of a given healthcare organisation and/or team;
- stimulate discussion about the strengths and weaknesses of the patient safety culture in your team and/or organisation;
- show up any differences in perception between staff groups;
- help understand how an organisation with a more mature safety culture might look;
- help you evaluate any specific intervention to change the safety culture of your organisation and/or team.

MaPSaF is NOT designed to be used:

- for performance management or assessment purposes;
- to apportion blame when the results show that an organisation's and/or team's safety culture is not sufficiently mature.

MaPSaF and the National Patient Safety Agency (NPSA)

The NPSA has endorsed MaPSaF to help healthcare organisations reflect on their progress in developing a safety culture. The NPSA is not a regulator or a reviewer and the framework has not been developed for this purpose. Rather, it aims to stimulate discussion about the patient safety culture in any given healthcare organisation and, in doing so, will help that organisation reflect on its progress towards developing a mature safety culture.

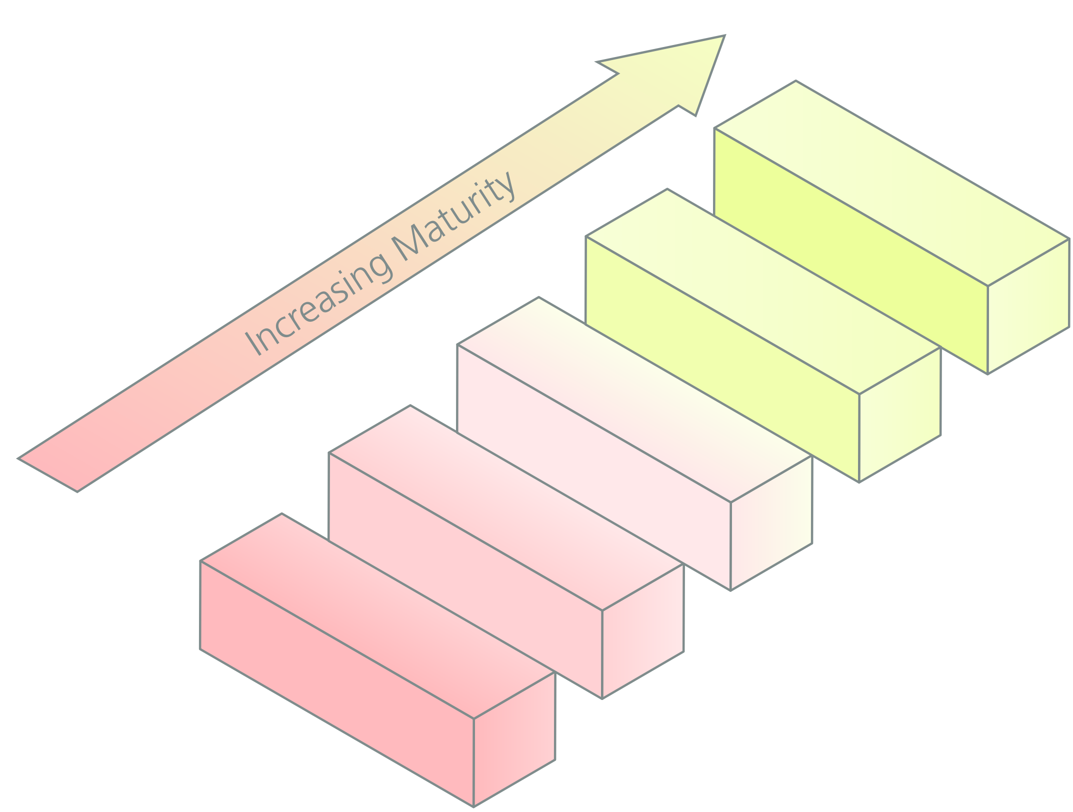
MaPSaF describes in words some of the key elements of an open and fair culture, previously described in the document, *Seven steps to patient safety*. MaPSaF can be used by boards, clinical governance teams, management teams, healthcare teams and others who would like to pause and reflect on their safety culture and risk management processes.

Public and patient involvement

It might seem that patient and public involvement in a maturing patient safety culture should be included as a eleventh dimension. However, the development of processes to ensure meaningful participation should be seen as being integral to all ten dimensions identified and this is how they have been integrated into the MaPSaF matrix.

The levels of patient safety culture explained

Level	Description
A – Pathological	Why do we need to waste our time on patient safety issues?
B – Reactive	We take patient safety seriously and do something when we have an incident.
C – Bureaucratic	We have systems in place to manage patient safety.
D – Proactive	We are always on the alert/thinking about patient safety issues that might emerge.
E – Generative	Managing patient safety is an integral part of everything we do.



MaPSaF is based on Parker and Hudson's (2001) application of Westrum's (1992) stage model of organisational culture maturity

References
Parker, D and Hudson, P (2001) *Understanding your culture*, Shell International Exploration and Production.
Westrum, R (1992) *Cultures with Requisite Imagination* in Wise, J, Hopkin, D and Stager, P (eds.), *Verification and validation of complex systems: human factors issues* (pp 401–416), Berlin: Springer-Verlag.

How the dimensions were developed

The dimensions are themes that emerged following:

- a literature review about patient safety in primary care and the NHS in general;
- feedback from opinion leaders and interviewees;
- consideration of the dimensions in terms of their comprehensiveness and appropriateness for primary care;
- focus group discussions with senior managers and clinical specialists from acute organisations with experience of patient safety issues. These groups refined and generalised the dimensions developed for the original MaPSaF for use with teams working in acute care in the NHS.

Defining the dimensions

Dimension	Description
1. Commitment to overall continuous improvement	How much is invested in developing the quality agenda? What is seen as the main purpose of policies and procedures? What attempts are made to look beyond the organisation for collaboration and innovation?
2. Priority given to safety	How seriously is the issue of patient safety taken within the organisation? Where does responsibility lie for patient safety issues?
3. System errors and individual responsibility	What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed – as an opportunity to blame or improve?
4. Recording incidents and best practice	Who investigates incidents and how are they investigated? What is the aim of recording the incident?
5. Evaluating incidents and best practice	How are any incidents evaluated? What recognition is there of safe practice? How is the resultant data used?
6. Learning and effecting change	What happens after an event? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
7. Communication about safety issues	What communication systems are in place? What are their features? What is the quality of record keeping to communicate about safety like?
8. Personnel management and safety issues	How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures?
9. Staff education and training	How, why and when are education and training programmes about patient safety developed? What do staff think of them?
10. Team working	How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?

The Manchester Patient Safety Framework (MaPSaF) research team, based at the University of Manchester, includes psychologists, healthcare researchers and healthcare professionals from both primary and acute care settings.

The development of MaPSaF is one part of an ongoing programme of patient safety research that draws on both our expertise working on safety issues in a range of high risk industries, and our extensive research and practical experience in healthcare in the NHS.

For further information about this project or the work of the MaPSaF team contact:

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For further information about the National Patient Safety Agency visit:
www.npsa.nhs.uk

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Manchester Patient Safety Framework (MaPSaF) – Acute

Increasing maturity

	A	B	C	D	E
01. Commitment to overall continuous improvement	No resources are invested in the identification of problems or areas of good practice. If any auditing occurs it lacks structure and there is no response to what is discovered. Whatever protocols or policies exist are there to meet the organisation's statutory requirements and are not used, reviewed or updated. Poor quality care is tolerated or ignored. This attitude is evident at Board level and throughout the organisation in the healthcare teams.	A continuous improvement framework is developed in response to specific directives or an imminent inspection visit. Auditing only occurs in response to specific incidents and national directives and does not reflect local needs. Little attempt is made to respond to any audit findings. The bare minimum of protocols and policies exist and these tend to be out-of-date and unused unless an incident occurs that triggers their review. Development of new protocols and policies occurs in response to incidents and complaints.	Frontline staff are not engaged in the improvement process and they see it as a management activity that is externally driven. Lots of auditing occurs but lacks an overall strategy linking with organisational or local needs. Staff are overloaded with protocols and policies (which are regularly reviewed and updated) that are rarely implemented. Patients and the public may be involved in quality issues but this is lip service rather than real engagement.	There is a genuine desire and enthusiasm throughout the organisation for continuous improvement. It is recognised that continuous improvement is everyone's responsibility and that the whole organisation, including patients and the public, need to be involved. Such organisations aim to be centres of excellence and compare their performance against that of others. Clinicians are involved in, and have ownership of, the auditing process which leads to continuous improvement. Protocols and policies are developed and reviewed by staff and are used as the basis for care and service provision. Patients and the public are formally involved in internal decisions – making it a patient-centred service.	A culture of continuous improvement is embedded within the organisation and is integral to decision making at all levels. The organisation is a centre of excellence, continually assessing and comparing its performance against others both within and outside the health service. Teams design and conduct their own outcome focused audit programme, in collaboration with patients and the public. Staff are alert to potential safety risks. This means that over time the need for protocols and policies is reduced as evidence-based practice is second nature and patient safety is constantly on everyone's mind. Patients and the public are involved in a routine, meaningful way with ongoing contribution and feedback.
02. Priority given to safety	A low priority is given to safety. There are some risk management systems in place, such as strategies and committees, but nothing is actually delivered. This is an organisation unaware of their risks, believing that if a patient safety incident occurs, insurance schemes can be used to bail them out.	Safety becomes a priority once an incident occurs, but the rest of the time only lip service is paid to the issue apart from meeting legal requirements. There is little evidence of any implementation of a risk management strategy. Safety is only discussed by the Board in relation to specific incidents. Any measures that are taken are aimed at self-protection and not patient protection. In order to meet financial constraints or government set targets, risks are taken.	Safety has a fairly high priority and there are numerous systems (including those integrating the patient perspective) in place to protect it. However, these systems are not widely disseminated to staff or reviewed. They also tend to lack the flexibility to respond to unforeseen events and fail to capture the complexity of the issues involved. Responsibility for risk management is invested in a single individual who does not integrate it within the wider organisation. It is an imposed culture.	Safety is promoted throughout the organisation and staff are actively involved in all safety issues and processes. Patients, the public and other organisations are also involved in risk management systems and their review. Measures taken are aimed at patient protection and not self-protection. Risks are proactively identified, using prospective risk assessments, and action is taken to manage them. There are clear accountability lines and while one individual takes the lead for patient safety in the organisation, it is a key part of all managers' roles.	Safety is the top priority in the organisation, and responsibility for safety is seen as being part of everyone's role including patients and the public. Staff constantly assess risks and look for potential improvements. Patient safety is a high profile issue throughout the organisation and is embedded in the activities of all staff, from the Board/senior managers through to healthcare teams who have day-to-day contact with patients, including support staff. Patient involvement in, and review of, patient safety issues is well established.
03. System errors and individual responsibility	Incidents are seen as 'bad luck' and outside the organisation's control, occurring as a result of staff errors or patient behaviour. There is a strong blame culture with individuals subjected to victimisation and disciplinary action.	The organisation sees itself as a victim of circumstances. Individuals are seen as the cause and the solution is retraining and punitive action. When incidents occur there is no attempt to support those involved, including the patients and their relatives.	There is a recognition that systems contribute to incidents and not just individuals. The organisation says that it has an open and fair culture but it is not perceived in that way by staff. Being open/open disclosure protocols have been written to ensure that staff and patients/carers receive support following an incident do exist, but they are not widely known about or used.	It is accepted that incidents are a combination of individual and system faults. The organisation has an open, fair and collaborative culture. Following a patient safety incident, a systems analysis is carried out and used to make decisions about the relative contribution of systems factors and the individual, e.g. the Incident Decision Tree. This process informs decisions about staff suspensions and so there is a consistent and fair approach to dealing with staff issues following incidents. The organisation is also open and honest with patients and/or their carers when a patient safety incident occurs that led to severe harm or death, but does not discuss all types of incidents.	Organisational and system failures are noted and staff are also fully aware of their own personal accountability in relation to errors and of their empowerment to report them. Integrated systems enable patient safety incidents, complaints and litigation cases to be analysed together. Staff, patients and relatives are actively involved and supported from the time of the incident. The organisation has a high level of openness and trust. The organisation is also open and honest with patients and/or their carers about all types of patient safety incidents, irrespective of the level of harm caused.
04. Recording incidents and best practice	Ad hoc incident reporting systems are in place but the organisation is largely in 'blissful ignorance' unless serious incidents occur or solicitors' letters are received. There is a high blame culture, with individuals subjected to victimisation and disciplinary action. No learning can occur.	There is an embryonic incident reporting system, although staff are not encouraged to report incidents. Minimal data on the incidents is collected but not analysed. There is a blame culture, so staff are reluctant to report incidents. When incidents occur, there is no attempt to support any of those involved.	A centralised anonymous reporting system is in place with a lot of emphasis on form completion. Attempts are made to encourage staff and patients to report incidents (including those that were prevented or led to no harm) though staff do not feel safe and patients do not feel comfortable reporting them. The organisation considers other sources of safety information alongside incident reports (e.g. complaints and audits).	Reporting of patient safety incidents at both a local and national level (e.g. the National Reporting and Learning System) is encouraged and they are seen as learning opportunities. Accessible, 'staff and patient friendly' reporting methods are used, allowing trends to be readily examined. Staff feel safe reporting all types of patient safety incidents, including those that were prevented. Staff, patients and/or their carers are supported from the moment of reporting.	It is second nature for staff to report patient safety incidents (including those that led to no harm or were prevented) as they have confidence in the investigation process and understand the value of reporting to both local systems and nationally (e.g. the National Reporting and Learning System). Patients are actively encouraged to report incidents. It is a learning organisation and robust systems exist in order to record best practice and compliments.
05. Evaluating incidents and best practice	Incidents and complaints are 'swept under the carpet' if possible. Incidents are superficially investigated by a junior manager with the aim of 'closing the book' and 'hiding any skeletons in the cupboard'. Information gathered from the investigation is stored but little action is taken apart from disciplinary action ('public executions') and attempts to manage the media. In this organisation there is little recognition of good safe practice.	Investigations are instigated with the aim of damage limitation for the organisation and apportioning individual blame. Investigations are cursory and focus on a specific event and the actions of an individual. Quick-fix solutions are proposed that deal with the specific incident, but may not be instigated once the 'heat is off'. Some investigations are not completed.	Senior managers are involved in the investigation, which is narrow and focuses on the individuals and systems surrounding the incident. There is a detailed procedure for the investigation process, which involves the completion of multiple forms – the investigation is conducted for its own sake and to placate patients/carers rather than examine root causes and support those involved. Staff are motivated to review procedures or how the procedures are implemented, but learning is variable.	The organisation is open to inquiry and welcomes external involvement in investigations in order to gain an independent perspective. The staff involved in incidents are involved in their investigation to identify root causes and interface issues. The aim of investigations is to learn from incidents and disseminate the findings widely. Data from incident reports are used to analyse trends, identify 'hot spots' and examine training implications. It is a forward-looking, open organisation. Patients are involved in the investigation process and their perceptions, experience and recommendations sought.	The organisation conducts both internal and external independent incident investigations that include the staff and patients involved. Incident investigations are seen as learning opportunities and focus upon improvement and include patient recommendations. The incident analysis process is systematically and regularly reviewed following consultation with all staff. Learning from best practice is shared across the organisation and nationally. It is a learning organisation as evidenced by a commitment to learn from incidents throughout all levels – from the Board/senior managers through to healthcare teams and support staff.
06. Learning and effecting change	No attempts are made to learn from incidents unless imposed by external bodies such as public enquiries. The aim after an incident is to 'paper over the cracks' and protect itself – the organisation considers that is has been successful when the media do not become aware of incidents. No changes are instigated after an incident apart from those directed at the individuals concerned.	Little, if any, organisational learning occurs and what does take place relates to the amount of disruption that senior staff have experienced. All learning is specific to the particular incident. Any changes instigated in the aftermath of an incident are not sustainable as they are knee-jerk reactions to perceived individual errors and are devised and imposed by senior managers. Consequently, similar incidents tend to recur.	Some systems are in place to facilitate organisational learning and this may include consideration of the patient perspective. The lessons learned are not disseminated throughout the organisation. Some enforced local changes relating directly to the specific incident are made. Committees and managers decide on any changes to be introduced, but lack of staff involvement leads to them not being integrated into working patterns. Patients are only involved so the organisation can prove to regulators that they have some commitment to patient and public involvement.	The organisation has a learning culture and processes exist to share learning, such as reflection and sharing patient perceptions. There is Board/senior management support for in-depth incident investigations, and changes instigated address underlying causes (e.g. systems factors). Staff are actively involved in the process and there is a real commitment to sustainable change throughout the organisation. The organisation 'scans the horizon' for learning opportunities and is keen to learn from others' experiences. Organisational learning following incidents is used in forward planning. It is an open, self-confident organisation.	It is a learning organisation. The organisation learns from internal and external information and experience and is committed to sharing this learning both within and outside the organisation. Patient safety incidents (including those that led to no harm or were prevented) are discussed in open forums where all staff are empowered to contribute. Both individual and organisational learning is evaluated. Improvements in practice occur without the trigger of an incident as the culture is one of continuous improvement. Patients play a key role in learning and contribute to subsequent change processes.
07. Communication about safety issues	Communication in general is poor; it comes from the top down and staff are not able to speak to their managers about risk. Events are kept in-house and not talked about. The organisation is essentially closed. What communication there is, is negative, with a focus on blame. Patients are only given information which must be legally provided and only after exerting a lot of pressure on the organisation to give them access.	Communication in general is directive with managers issuing instructions. Staff are only able to speak to their managers after something has gone wrong. Communication is ad hoc and restricted to those involved in a specific incident. The patient is given the information the organisation feels is appropriate in a one-way communication.	There is a communication strategy. Policies and procedures are in place, and lots of records are kept. There is a lot of information collected from staff, patients and other organisations but it is not effectively utilised. This leads to an information overload meaning that little is actually done with the information received by staff. A risk communication system is in place, but no-one checks whether it is working.	The communications system and record keeping are fully audited. There is communication across organisations facilitating meaningful benchmarking. All levels of staff are involved, and there are robust mechanisms for them to feedback to the organisation. Information is shared, there are regular briefing sessions where staff are encouraged to set the agenda. Effective communication regarding safety issues is made with patient and public involvement groups.	Everybody communicates safety issues and learns from the experiences of others (good and bad). It is a transparent organisation and includes patient participation in risk management policy development. Innovative ideas are encouraged and staff are empowered to implement them. This is an organisation that communicates good practice both externally and internally.
08. Personnel management and safety issues	Staff are seen just as bodies to fill posts. Recruitment and selection processes are rudimentary. The language used is negative and poor health and attendance records are seen as disciplinary matters. Staff feel unsupported and see Personnel as 'them' and not 'us'. There is a rudimentary staff policy, no structured HR development programme and no links with occupational health.	Job descriptions and staffing levels change only in response to problems, so there are good selection and retention policies in areas where the organisation has been vulnerable in the past. The atmosphere is of blame and punishment. Staff support is available, but is minimal and tokenistic. There is a very basic HR policy, but it is inflexible and developed in response to problems that have already been experienced.	Recruitment and retention procedures are in place and credentials are always checked. The language used to manage staff is generally formal and neutral and guided by policies and procedures. Mechanisms for staff support are governed by a lot of paperwork and policies. The procedures on appraisal, staff development and occupational health are there but are inflexibly applied, and so do not always achieve what they were designed for. These procedures are seen as a tool for management to control staff.	There is some commitment to matching individuals to posts. There are attempts to understand why poor performance occurs, and visible, flexible support systems exist tailored to the needs of the individual. Personnel management processes are reviewed and changes are made when necessary. There is genuine concern about staff health, and good systems of appraisal, monitoring and review. Patient/carer input on safety and staffing issues is actively sought. There is demonstrable evidence of proactive measures taken in some areas (for example by using the NPSA's Incident Decision Tree following an incident).	Job specifications are designed to identify competencies using a Knowledge and Skills Framework. Reflection and review (both positive and negative) occur continuously and automatically. The organisation is committed to its staff, and everyone has confidence in the personnel management procedures that include mentorship and supervision. Patients and the public have meaningful involvement in the development and implementation of any policies related to safety and staffing issues. Personnel management is not a separate entity but an integral part of the organisation. Following a patient safety incident, a systems analysis is used (for example by using the NPSA's Incident Decision Tree) to make decisions about the relative contribution of systems factors and the individual healthcare professional. This process informs decisions about staff suspensions and as such there is a consistent and fair approach to dealing with staff issues following incidents.
09. Staff education and training	Training has a low priority. The only training offered is that required by government. Staff education is seen by management as irritating, time consuming and costly. There are consequently no checks made on the quality or relevance of any education or training given with regards to career development of staff. Staff are seen as already trained to do their job, so why would they need more training?	Training occurs where there have been specific problems and relates almost entirely to high risk areas where obvious gaps are filled. It is the responsibility of the individual to read, act upon and fund their own educational needs. Education and training focus on maximising income and covering the organisation's back rather than the career development of the staff. There is no dedicated training budget and staff appraisals occur on an ad hoc basis.	The training programme reflects organisational needs so training is supported only if it benefits the organisation. No thought is given to actively involving patients in training. Basic Personal Development Plans are in place so everyone has their own file. However these are not very effective as they are not properly resourced or given priority. There are a large number of courses on offer, however not all of these are relevant to the career development of the staff expected to make use of them. Training is seen as the way to prevent mistakes and appraisals are focused around this.	There is an attempt to identify the training needs of the organisation, and of individuals, and to match them up. Educational opportunities are well planned and resourced and are available from and for all relevant agencies. Training and education are seen as integral to the career development of individuals and are linked directly to other organisational systems, such as incident reporting. Appraisals are staff centred and are built around the needs of the individual. Preliminary attempts to involve patients and the public in staff training are underway and the organisation is starting to learn lessons from their experiences.	Individuals are empowered and motivated to undertake their own training needs analysis and negotiate their own training programme. Learning is a daily occurrence and does not happen solely in a classroom environment. Education is seen as being integral to the organisational culture. The approach to training and education is flexible and seen as a way of supporting staff in fulfilling their potential. Appraisals are initiated and managed by the staff themselves. Patients are involved in staff training to aid understanding of patient perceptions of risk and safety.
10. Team working	Individuals mainly work in isolation but where there are teams they are uni-disciplinary and dysfunctional. There are tensions between the team members and a rigid hierarchical structure. They are more like a collection of people brought together under the direction of a nominal leader. Information is not shared between team members. The team operates secretively.	People only work as a team following a negative event and to respond to external demands. Individuals are not actually committed to the team. There is a clear hierarchy in every team, corresponding to the hierarchy of the organisation as a whole. There are multidisciplinary teams, but they have been told to work together, and only pay lip service to the ideals of team working. Information is cascaded to team members following an incident. The team operates defensively and newcomers are not welcomed.	Multidisciplinary teams are put together to respond to government policies, but there is no way of measuring how effective they are. Teamwork is seen by lower grades of staff as paying lip service to the idea of empowerment. Teams are given lots of written information about how they should function. There are official mechanisms for the sharing of ideas or information within and across teams but these are not used effectively. Teams operate behind the scenes and generally within a single organisation.	Teams are multidisciplinary and time and resources are devoted to team development processes. Team structure is fluid, with people taking up the role most appropriate for them at the time. There is evaluation of how effective the team is and changes are made when necessary. Teams are collaborative and adaptable. Teams are open and may involve members external to the organisation.	Regular and evaluated team resource management training is offered to fully integrated multidisciplinary teams. Team membership is flexible with a horizontal structure. Different people make equally valued contributions when appropriate. Teams are about shared understanding and vision rather than geographical proximity. Team working is the accepted way in the organisation. Teams are totally open, involving members from diverse organisations, locally, nationally and even internationally.

Sandwell and West Birmingham Hospitals
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Response to the Francis Inquiry and associated reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**19 December 2013**

EXECUTIVE SUMMARY:

Following discussions of the action plan in response to the Francis Inquiry & associated reports, at the Trust Board meeting in November, a number of supplementary actions were agreed which are summarised in the report attached.

The attached paper also provides a further update on the action plan to address the recommendations arising from the Francis Inquiry and the associated national reports that have been issued since.

REPORT RECOMMENDATION:

The Board is asked to:

Discuss and **APPROVE** the revised action plan.

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

Supports the Trust's plans to improve quality & safety

PREVIOUS CONSIDERATION:

The Trust Board has discussed the outcome of the Francis Inquiry on a number of occasions, including at the formal Board meetings in February 2013 and September 2013. The Board also received a further response to the Francis Inquiry & associated national reports at the meeting of the Board held in October & November 2013.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Trust response to the Francis Inquiry and associated reports

1. Introduction

1.1 At its meeting in November 2013 the Board revisited the Francis Report and in particular the actions being undertaken to take forward the recommendations relevant to the Trust and assessed as requiring attention

1.2 The list below details the follow-up work requested by members during the discussion.

Specificity about what will be achieved if the actions are successfully implemented
Clearer measures of success
Allocation of NEDs to action plan themes
Maintaining robust oversight of the action plan
How the plan be communicated to staff
Details of the Francis recommendations directed at others

This paper sets out the responses to the above points.

1.3 The action plan is split into the themes identified by Robert Francis, QC in his report. In line with our Board discussions over many months, and consideration at the Clinical Leadership Executive, we want to make sure that we have ambitious, substantial goals for our approach – including quantified measures of Trust-wide improvement that could be recognised by local people as a major improvement in quality. These overarching aims and theme measures are show in **Appendix 1**.

1.4 A revised version of the detailed plan that was presented last time is attached at **Appendix 2**. This explains what the end point will be for patients, staff, the organisation and wider community through delivering each action.

1.5 The suggestion to strengthen Board-ownership of the action plan through assignment of Non-Executive Director to each of the eight themes has been accepted. The theme NED will:

- act as a critical friend;
- challenge on spread of improvement;
- advise the Board about any additional steps; and
- make linkages for that theme across other Board conversations that are not Francis-specific

The Chairman is finalising assignment of NEDs to themes and will suggest the allocation at the Board meeting. The Chief Executive will identify a senior employee not in a management position to offer a source of frontline feedback to NED colleagues.

1.6 To support close Board oversight on progress with the action plan the quarterly update report will provide additional focus on one or more of the eight themes in turn. Our expected order of principle focus is as follows:

Quarter	Focus
Quarter 1 2014-15	Effective complaints handling Accurate, useful and relevant information
Quarter 2 2014-15	Medical education and training Compassionate, caring and committed nursing
Quarter 3 2014-15	Getting fundamental standards right Caring for the elderly
Quarter 4 2014-15	Creating the right culture Openness, transparency and candour

1.7 For the intended outcomes mentioned earlier to be achieved, it is essential that our staff and managers are aware of the Trust's response to the Francis Report, understand the work that is taking place or is planned and own the actions that involve them.

1.8 This will be achieved by communicating key messages through the Trust's established channels, some of which have already been revitalised and others are in the process of being. In particular:

The Chief Executive's Friday message
Connect (our intranet) which has a revised format with focus on patient feedback
Staff Bulletins and Hot Topics
Heartbeat

1.9 For our patients and the public we already make available our Board papers, including our responses to the Francis Inquiry, on the Trust website. We will include 'news' updates on progress in implementing the action plan and also tweet highlights and key messages.

1.10 Seeking the views of staff, patients, the public and our stakeholders is a key aspect of much of the work included in the action plan, although to those people it will not be badged as 'Francis'.

1.11 The majority of the 290 recommendations in the Francis Report are directed towards commissioners, regulators, the Department of Health and other parts of the system, which are likely to result in the need for the Trust to take action at a later stage to respond to new regulations, guidance, standards or training requirements. At the request of the Board, a list of the recommendations directed to others is being made available to members.

2. Recommendations

The Board is asked to discuss and **APPROVE** the revised action plan.

Kam Dhami
Director of Governance **December 2013**

APPENDIX 1

Continuously improving the quality of care provided: our overarching aims

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

Theme measures	
Creating the right culture with values that put patients first	Patient satisfaction with their care is substantially improved with '*Friends and Family'* rates above 80% - as staff morale and engagement improves (and we halve the proportion of disengaged employees)
Effective complaints handling	Linked complaint figures are reduced by 75% or more, and complaints raised with the Trust are responded to within 30 days consistently across our services. Staff report high levels of awareness of learning from complaints through Your Voice
Openness, transparency and candour	Patients are given the truth in all cases when mistakes occur, whether serious or not. Performance measures that are meaningful to patients are widely published, including failings and corrective actions being taken.
Caring for the elderly	Age sensitised analysis of complaints, satisfaction, incidents shows no material disadvantage to elderly patients.
Getting fundamental standards right	Outcome variation between sites and between in/out of hours is substantially reduced in emergency care and is in the national upper quartile
Medical education and training	Junior doctors report high engagement scores at JEST feedback. Involvement of junior doctors in the safety management of patients including – increased reporting of incidents, increased involvement in investigations, table top reviews and trust governance meetings. Engagement with safety processes such as the WHO check list and VTE assessment. Junior Doctors as vocal champions for patient safety – appointment of 'Chief Resident'
Compassionate, caring and committed nursing	National inpatient survey reports high levels of patient confidence in our nursing staff – improvements of 10%+ on base - and complaints associated with nursing staff attitude or communication are halved over two years
Accurate, useful and relevant information	Using the RAG rating system applied to each KPI within the IQPF report, ensure that the system of assurance and improvement of data quality delivers not less than an annual 25% reduction in red RAG rated indicators.

APPENDIX 2

Response to the Francis Inquiry and associated publications

Revised Action Plan

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
Creating the right culture with values that put patients first					*[Francis recommendations: 4, 7, 8 and 178]*
1.	Raise the profile of the Trust values and promises and align more closely to workforce practices and training.	June 2014	CEO	Improved staff and patient satisfaction scores Reduction in patient complaints related to poor communication and staff attitude	Staff know our values and our promises (if we retain both) and live them through their behaviours The values of prospective staff are tested and measured in an objective way PDR process sets and measures personal objectives that deliver our values and promises Leadership development at all levels linked to values
2.	Reinforce the requirement to abide by the NHS values and Constitution in staff recruitment, selection, appointment, training and development.	April 2014	CEO	Improve the quality of candidates submitting applications to the Trust Improvements in the quality of applicants shortlisted for interview. Reduced turnover consequent on 'poor fit'	

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
				at selection stage. Reduction in complaints linked to poor behaviours.	
3.	Strengthen standard statements in job descriptions and contracts of employment requiring an express commitment from staff to abide by both the NHS values and the Constitution.	Feb 2014	CEO	Statement included as a standard clause. Statement included within both medical and non-medical contracts of employment.	Trust Board declares compliance with licensing obligations
4.	Incorporate the requirement to abide by the NHS values and Constitution into SLA templates and approaches to procurement.	Q4 2014 / 15	DF	Evidence that revised NHSE contract is in use for sub-contracting providers. Wording to refer to NHS terms of trading inclusive of values / constitution. Standard wording (and URL link to NHS values and constitution) issued to procuring departments not later than end Q4 1314 as a requirement for inclusion in SLA templates. Arrange for assurance to be gained from 14/15 and rolling IA plan.	That the Trust is not transacting with suppliers that are not signed up to NHS values and standards. Where reference is made to these requirements in procurement documentation, that periodically the Trust seeks assurance from suppliers as to how they are communicating the values of the 'client' to their staff present within our healthcare facilities whether in face to face contact with patients (locums & agency where unavoidable) and firms working on-site or delivering goods and services.
5.	Finalise the culture programme for the Trust's organisational development	March 2014	CEO	Measurement improvement in leadership behaviours during 2014-15 as evidenced through 360-degree feedback and	More than 80% of Trust senior cadre credible level 4 high performers by March 2015

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
				development centre coaching reports Improved staff and patient satisfaction scores Positive CQC inspection outcomes Positive (scores to be defined) CQC banding indicator scores	Second evaluation of matron leadership investment shows further substantial improvements in care and mentoring Achieve level E in Manchester Patient Safety Framework – a Generative organisation CQC banding of 6
6.	Introduce 'Your Voice', an employee on-line survey of 2500 staff each month.	Sept 2013	DS	Increased levels of staff engagement	Halving of disengaged score among employees
7.	Launch the Patient Experience and Staff Engagement long-term strategy: Patient Knows Best	March 2014	CEO & CN	Positive feedback from patients and carers. Improved positive returns in FFT	80% in F&F family test Other measures to be agreed within strategy
8.	Pilot the 'Patient knows best' electronic system in selected specialities.	March 2014	CN	Reflected through patient feedback and increased positive returns in FFT	Patients will be well informed regarding details of their specific condition.
9.	Improve people's experience in outpatients (as this is where most have contact with the Trust) through implementation of eight outpatient standards.	Jan 2014 *(prog finalised)*	COO	OP standards met: All patients will be seen within 6 weeks of the hospital receiving their referral. All referral letters will be scanned into CDA within 24hrs of receipt. (June 2013) No patient will wait more than 20 minutes later than their appointment time to be seen (April 2013)	Effective and efficient access to outpatient services, giving an improved patient experience Timely communication to patients and GPs

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
				No patient will have their clinic appointment cancelled by the hospital (March 2014). All patients will have their first appointment for diagnostics within locally agreed targets (June 2014) A documented outcome of an outpatient visit will be available to the GP electronically within 2 working days. All communications will be easily accessible within the Electronic Patient Record. All patients will receive a copy letter within 5 working days (March 2014) All patients will be given an opportunity to comment on the outpatient service that they have received (March 2014)	
10.	Plans to be developed to reinforce leadership development in the Trust (see also 5)	April 2014	DS	Number of leaders/managers accessing development programmes Improved leadership quality scores in employee surveys	SWBH has recognised leadership brand Leadership offer evaluated and achieves high satisfaction scores from leaders at all levels.
11.	Introduce 360 degree appraisal for all staff, including Board members.	April 2014	DS	100% appraisal compliance Improved appraisal and leadership quality scores in employee surveys	Top 150-200 leaders have completed 360 degree appraisal by April 2014 Staff survey measures improving quality of leadership.
12.	Expand existing staff reward and recognition	July	CEO	Improved staff satisfaction scores measured	

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
	schemes, ensuring awards criteria linked to the NHS values and Constitution.	2014		via 'Your Voice' and national staff survey. Reduction in adverse HR indicators (sickness, turnover, complaints) Improvements in productivity.	
13.	Introduce arrangements to demonstrate to staff, patients and the public changes made as a direct result of staff and patient feedback.	May 2014	CN	'You said – we did' posters in place on ward measures boards Matron's clinics readily available Your Voice page on intranet and internet	Reflected through patient feedback and increased positive returns in FFT. Definitive evidence of transparency and engagement.
Getting fundamental standards right					*[Francis recommendations: 11 and 12]*
14.	Identify key areas of practice for development of standard operating procedures.		COO	Review register and determine gap analysis on areas without an SOP	Establish a register of SOPs for the Trust Delivery a programme to complete SOPs for identified gap areas.
15.	Improve the consistent application of existing standard operating procedures.		COO	Review register and determine gap analysis on areas without an SOP.	Implement a programme of audit against SOPs
16.	Review all relevant Quality Standards and produce a 'gap' analysis and associated development plans in line with commissioning requirements as part of the contracts.	April 2014	DF	Presence of SDIP (service development improvement plans) which feature as part of the preparation of the final contract documentation in any given year Evidence of item within series of provider:CCG commissioning meetings and agreement of final schedule gaps and improvement plans as part of contract sign-off documentation in March 2014	Through contract review meetings, there is visibility where quality standard thresholds are not being met and a contractual process for ensuring action is taken to rectify outside of the boundaries of the Trust, i.e. in minuted discussions with commissioning bodies with specific agreed improvement trajectories.

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
Effective complaints handling					*[Francis recommendations: 109 to 116 and 118]*
17.	Introduce a devolved model of complaints investigation and management, with responsibility transferring from the corporate Complaints team to Clinical Groups and directorates.	Nov 2013	DG	At least 70% of complaints being managed by the appropriate clinical groups and corporate directorates	Real time changes to service delivery or processes.
18.	Ensure the key performance indicators for the new devolved model are achieved, including meeting the response date agreed with the complainant.	On-going	DG	All process dates at each stage are met 100% of the time	Complainants receive their responses (meeting or written) within the agreed time frame.
19.	Assess the complainant's satisfaction with the process.	Dec 2013	DG	Reducing number of link complaints and greater returns and satisfaction. Continued low uptake of cases for investigation by PHSO.	Complainants are satisfied with both the timeliness and the outcome of their complaint.
20.	Capture action taken by clinical services following a complaint and to make this information available and share learning	Jan 2014	DG	All actions are captured on the complaints database and closed in a timely manner, reflected through dashboard data.	Transparency on changes made following complaints on the Web. Widespread change of systems and processes, not specialty specific.
21.	Publish the main issues patients complain about and what we are doing about them.	Jan 2014	DG	Information visible on both intranet and internet.	Transparency of information on internal and external websites.
22.	Publish themes and trends about compliments,	Jan	DG	Information visible on both intranet and	Transparency of information on

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
	concerns, complaints.	2014		internet.	internal and external websites.
23.	Devise a system to inform individual complainants what we have learned and what we will do differently as a result of their complaint.	Dec 2013	DG	Complaint responses identify lessons learned and action plans produced. These will be reflected in the letter sent to conclude the case.	Patients can actively see the results of their complaint, if a service or system, change. Reduction in similar complaints.
24.	Proactively share details of complaints (suitably anonymised) with the CQC, health scrutiny committees etc	Jan 2014	DG	Complaints database to show numbers of complaints shared across the wider health economy.	Increased dialogue with external agencies regarding positive approach to complaints management.
Medical education and training					*[Francis recommendation: 160]*
25.	Encourage openness on the part of medical trainees in relation to raising concerns and provide protection from any adverse consequences.	April 2014	MD	Available opportunities for open discussions and any concerns raised.	Increased reporting from this group of employees
26.	Junior doctors to routinely participate in the Trusts' mortality and morbidity review meetings.	Oct 2014	MD	Directorate and now specialty clinical governance meetings are expected to include mortality and morbidity review and learning as well as expect attendance from junior doctors at specialty level. Directorate and specialty level mortality information such as review performance data are regularly shared. Grand rounds to include Mortality case learning.	Raised awareness of method of mortality review and faster diffusion of learning from errors

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
				Junior Drs involvement of Mortality reviews when involved with patient care.	
27.	Develop ways in which to tap into the latent energy of junior doctors.	April 2014	MD	Junior Doctors Forum attendance. Use of IHI Open School	More service improvement projects within trainee audit obligations are visible and implemented in the Trust
Openness, transparency and candour					*[Francis recommendations: 173-177, 179 and 1 08]*
28.	Active promotion of Board meetings to encourage members of the public to attend.	Jan 2014	DG	Sustained increase in public attendance at monthly Board meetings. Questions received from members of the public at Board meetings Increased use of the enquiry facility on the Trust website	Patients, the public and external agencies view the Trust as an organisation that is approachable and honest.
29.	Only necessary items to be discussed in the private sessions of Board meetings and for clear guidance on what is considered 'private' to be agreed.	Jan 2014	DG	Reduction in the number of items on the private Board agenda. Adherence to the 'private' items agreed criteria.	Patients, the public and external agencies view the Trust as an organisation that operates in a transparent manner.
30.	Put in place a robust process to examine the aggregate analysis of incidents, claims and complaints to ensure all of this information is being triangulated effectively.	Jan 2014	DG	Integrated governance process identifying 'early warnings' to affected services or systems.	Clinical Groups and Corporate Directorates aware of issues and remedies taken to prevent them escalating
31.	Introduce a formal framework to support organisational learning from reported incidents,	Jan 2014	DG	Outcomes and learning from investigations shared across and beyond the Trust.	Minimising the risk of the event happening again.

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
	claims and complaints.			System redesign to prevent errors	
32.	Revise and re-launch the Whistleblowing Policy, making it easy and safe for staff to raise concerns.	Dec 2013	DG	Increasing number of concerns raised under the policy. Staff survey and other feedback routes show positive attitude and staff feel safe in reporting.	A workforce knowledgeable about Whistleblowing and unafraid to use the process.
33.	Check that all serious incidents are disclosed to those affected in a timely manner, appropriately reported and investigated, with the findings shared with those involved in accordance with the Being Open Policy.	Jan 2014	DG	Dashboard shows 100% compliance. Investigation and 'being open' process met within timeframes set out in Trust Policy.	Patients, relatives and staff are all informed of outcomes.
34.	Ensure all teams and services can demonstrate they share learning and the improvements or changes that have resulted.	Jan 2014	DG	Compliments on changes from patients. Prevention of similar issues in other services.	Reduced incidence of similar events occurring. Demonstrable changes in processes.
Compassionate caring and committed nursing	*[Francis recommendations: 185, 191, 194, 195, 199, 202, 204, 207 and 208]*				
35.	Participate in the 'Care Makers' campaign to embed the 6 Cs in practice.	Oct 2013	CN	Reduced complaints reflecting negative attitudes. Positive comments on FFT Visibility of 6Cs literature	Nursing workforce that demonstrates compassion and kindness in the delivery of care.
36.	Nursing competences and expectations to be explicit in job descriptions.	Jun 2014	CN	Each speciality has developed and implemented specialty specific competencies. Compliance of competencies audited through the ward review process.	A competent workforce well equipped to meet patients' care needs.

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
37.	Further embedding QUEST (an on-line competency framework) and expansion of clinical MOT.	May 2014	CN	Clinical MOT developed for the community setting Additional clinical modules developed and in use.	Nursing staff will have tools to help develop and demonstrate their competency and clinical skills.
38.	Introduce a process of sharing information on staff on duty, per shift, per grade with patients and carers.	Jan 2014	CN	Patients and carers feedback their views on staffing levels	Patients and carers able to identify staff on duty across all shift patterns.
39.	Strengthen the nurse recruitment process to incorporate more values based questions and activities such as discussion groups to explore behavioural responses to scenarios.	June 2014	CN	Recruitment process streamlined Turnover rates will be reduced in challenged specialties	Patients have confidence that the nursing workforce is kind and compassionate.
40.	Develop ways to harness the loyalty and innovation of student nurses, who move from ward to ward, so they become ambassadors for their hospital and for promoting innovative nursing practice.	August 2014	CN	Positive feedback in student evaluation HEI's feedback re: the Trust is positive	A pre-registration nursing population that evidences pride and loyalty to the Trust.
41.	Ward Nursing Leaders are visible and accessible to patients and carers out of hours.	Sept 2013	CN	Relatives feedback that there is ready access to the lead nurse in the event of issues of care. Relatives feedback that they are able to be involved an engaged in care at all appropriate times. Competencies developed to demonstrate effective role models.	Relatives and carers have free access to nursing leaders at times that are suitable to them.

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
42.	Ensure adequate supervision of non-registered nurses.	March 2014	CN	All wards have the appropriate number of qualified mentors pro rata the pre-registration students based there, i.e. no greater than 1:3. Local registration of HCS introduced with annual revalidation.	Non-registered nurses supervised by RNS 24/7 and in all areas of practice.
43.	Ensure care provided meets a minimum in relation to Quality, Safety and Experience.	March 2014	CN	Ward to Board assurance Framework is undertaken quarterly and clinical areas achieving progress or green status. Safety Thermometer scores are 95% plus consistently. All staff demonstrate competency through completion of QUEST and/or annual MOT. FFT reflects positive experience and the number of passive respondents decreases.	All nursing staff demonstrate their knowledge, skill and competency in delivery of care.
44.	Patients will know who is caring for them and regular monitoring will be achieved.	March 2014	CN	Intentional care rounding is the norm in all wards. Wards and departments participate in the 'Hello my name is' campaign. Each patient is assigned a key nurse who co-ordinates their care.	Patients and their carers experience consistency, compassion and competency in their care as evidenced through PSS and FFT.
Caring for the elderly					*[Franics recommendations: 236 to 243]*
45.	Develop our frail elderly services in partnership with SWB CCG in order to ensure safe, high	April 2014	COO	Decisions to take place	Positive FFT Reduced re-admission

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
	quality care, early senior assessment , alternative pathways to admission where clinically appropriate, integrated care and supported discharge.				
46.	Work with staff and patients / carers to decide on how the money secured (£904k) from the DH '*Enhancing the Acute Environment for Patients with Dementia*' fund is spent.	Dec 2014	CN	Completed upgrades on wards on the Sandwell and City sites	Positive FFT. Patient/carer feedback. CQUIN achieved.
47.	Implement the dedicated team to progress the dementia agenda to improve the patient and carer experience.	March 2014	CN	Dementia champion in place Therapy support appointment	Positive FFT. Patient/carer feedback. CQUIN achieved.
48.	Development of a 'dementia survival guide' for staff (based on a version produced by staff at Worcester University) and an information folder for all wards and departments.	March 2014	CN		Positive FFT. Patient/carer feedback. CQUIN achieved.
49.	Review and update the 'Managing Challenging Behaviours' policy to reflect best practice.	March 2014	CN	(awaiting appointment of key team members)	Positive FFT. Patient/carer feedback. CQUIN achieved.
50.	Standards of appropriate discharge to be set and effectively communicated and monitored.	March 2014	COO	Full compliance with the discharge standards A reduction in avoidable readmissions	Improved p[patient satisfaction and feedback with regard to discharge standards Reduction in readmissions

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
51.	Review current arrangements for ensuring consultant led care for every patient so that the patient and their supporters are clear who is in overall charge of a patient's care.	April 2014	COO	Electronic Bed Management System (eBMS) is updated and accurate throughout the patient journey. Patient and relatives communication of consultant changes.	
52.	Patients will know who is caring for them and regular monitoring will be achieved.	Dec 2013	CN		Positive FFT. Patient/carer feedback. CQUIN achieved.
Accurate, useful and relevant information				*[Francis recommendations: 244, 245, 252, 253, 255, 256, 262, 263, 268 and 269]*	
53.	The current quality and performance reports to be replaced with an Integrated Quality, Performance and Finance report	March 2014	DF	Draft format of report agreed Implementation during 13/14 for permanent embedding Quality & Safety committee to consider revised report alongside existing report in January 2014 as part of transition arrangements with shadow running in Feb&Mar prior to go-live in April '14.	The current quality and performance reports to be replaced with an Integrated Quality, Performance and Finance report
54.	Develop a system to provide an assessment of data quality so that the reader can understand whether weaknesses exist in terms of the robustness of the source and consistency	March 2014	DF	Single indicator influenced by a pre-agreed set of criteria regarding DQ resulting in visual assignment of rating to each KPI Task and Finish group concludes its work on specific actions required to improve data quality culminating in the determination of a system of rating reliability for incorporation into IQPF during Q4 with go-	Develop a system to provide an assessment of data quality so that the reader can understand whether weaknesses exist in terms of the robustness of the source and consistency

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
				live 1.4.1.4	
55.	Undertake rolling systematic audits of data quality, with various factors taken into account when ranking data quality.	April 2014	DF	Audit & Risk Management Committee in receipt of pre-planned timely output from rolling audits with recommendations and response plans in place. Inclusion of audits as part of formulating forward plan, to be agreed and presented in draft to A&RMC at its meeting on 30th January 2014 for final agreement at A&RMC 24.4.14 for whole programme.	Undertake rolling systematic audits of data quality, with various factors taken into account when ranking data quality.
56.	Improve systems which provide effective real-time information on the performance of each service, consultant and teams in relation to mortality, morbidity, outcome and patient satisfaction.	July 2014	DF	Use of comparative systems, e.g. Dr Foster access. Visibility of data across organisation e.g., Hospital Standardised Mortality Ratio data. SLR in place providing real time activity/costs of service/ward/ consultant. MQAC monthly meetings review performance or each service. Patient satisfaction results show an upwards trend. Following the implementation of the AAF in April 2014, ensure the content of Group Performance reviews draws upon current Dr Foster and CDA held data setting this within the standard reporting templates used for bi-monthly performance reviews which are to inform group reviews of	Improve systems which provide effective real-time information on the performance of each service, consultant and teams in relation to mortality, morbidity, outcome and patient satisfaction.

	Key action	Timeline	Exec Lead	Measures of success	Intended outcome
				clinical directorates.	
57.	Make available to all stakeholders in as near "real-time" as possible, results and analysis of patient feedback.	June 2014	CN	Meridian tool in use which gives real time feedback to clinicians Monthly stats update on ward measures boards	Positive FFT feedback
Coroners and inquests					*[Francis recommendation: 279]*
58.	Review compliance with the requirement that, as far as is practicable, the responsibility for certifying the cause of death is undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	Feb 2014	MD	Improved accuracy of death certification by ensuring senior input into the process	(We will agree a trajectory of improvement with both coroners during Q4 113-14)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 22 November 2013; 1030h – 1230h

Present
Ms O Dutton [Chair]
Mr R Samuda
Mrs G Hunjan
Dr S Sahota OBE
Mrs L Pascall
Dr R Stedman
Miss R Barlow
Mr R White
Miss K Dhami

In Attendance
Mr S Parker
Ms A Binns
Mr M Harding
Ms J Turton [Deloitte]

Secretariat
Mr S Grainger-Payne

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Prof Richard Lilford and Mrs Debbie Talbot.	
2 Minutes of the previous meeting	**SWBQS (10/13) 149**
The minutes of the Quality and Safety Committee meeting held on 25 October 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 (10/13) 149 (a)**
The updated actions list was received and noted by the Committee.	
MATTERS FOR DISCUSSION/DEBATE	
4 Update on 'Winter 2013 Must Be Better' programme and Emergency Care improvement plans	**Presentation**

Ms Barlow tabled a presentation summarising the progress with the 'Winter Must Be Better' programme. It was highlighted that there had been a significant rise in attendances at the Emergency Departments and work was reported to be underway to understand the reasons behind this. It was also highlighted that across a week, admissions were generally on forecast but surges and unexpected variations presented a challenge. Ms Dutton asked how the forecasts were conducted. She as advised that this was undertaken on a national basis centrally. Dr Stedman highlighted the complexities with forecasting and the influences on attendance. Miss Barlow highlighted that there had been a decrease in very long waiting times, associated with Psychiatric treatments. Ms Dutton asked for more detail of the number of non-admitted patients staying in excess of two hours. Miss Barlow advised that work was underway to ensure better use of the ambulatory assessment unit model to address this. It was highlighted that 80% of patients seen within two hours was the target in this respect. Ms Dutton asked when this target would be achieved. Miss Barlow advised that job plans and ambulatory care pathways were being reviewed to determine the position. She advised that the plan to achieve this would be prepared shortly. It was reported that the mental health assessment suite had been opened which was delivering a reduced number of waits and breaches. Ms Dutton asked whether there was sufficient capacity to handle psychiatric cases. She was advised that at present handling adolescent mental health cases was challenging and that better risk assessment of cases was planned. It was noted that the challenge was a national issue. It was highlighted that there had been an improvement in performance against the ambulance turnaround target. Dr Stedman reminded the Committee that the position represented a significant improvement to the position in 2012/13. Dr Sahota noted that the time not recorded was high, however Dr Stedman asked the Committee to note that the implementation of the dedicated ambulance handover area had led to a reduction in this. Mr White noted that as a result of the performance, the financial liability associated with fines had reduced. Ms Dutton noted that the unplanned reattendance rate was rising and asked for an explanation of this trend. Miss Barlow advised that this was audited and was found to relate to a number of psychiatric patient and gynaecology patients. Dr Stedman advised that some of the reattendances also related to some homeless individuals. It was reported that registration was undertaken for patients attending who were not registered with a GP at the time. Ms Dutton noted that the Friends and Family Test score was higher at City Hospital than at Sandwell Hospital Emergency Department. Mrs Pascall advised that work was underway to understand the reasons behind this. Miss Barlow reported that the introduction of the acute assessment model had occurred at City Hospital, although the effectiveness of the unit was slow to improve at present. It was reported that a Surgical Assessment Unit had also been opened at Sandwell Hospital. Ms Dutton asked how many patients presented with respiratory conditions. She was advised that a significant number of patients	

attended with these conditions. The Committee was advised that the bed base had been increased, with the Cardiology medically fit for discharge facility opening in December. It was reported that some medically fit for discharge patients were being treated at Rowley Regis Hospital. Ms Dutton asked how staff were embracing the plans for improving Emergency Care. She was advised that the staff understood the reasons for the plans and were supportive. Mrs Pascall advised that staff felt engaged, however they needed to become accustomed to the new pace and processes. Miss Barlow advised that some learning had been taken from the operation and turnaround measures from a local trust. The support from Social Services was highlighted to be critical to the plans. The number of Delayed Transfers of Care during October was noted to have been a significant issue. In terms of the use of the Urgent Care scorecard, it was highlighted that readmission rates were counted and time for patients to be admitted to emergency theatres were also counted, in addition to performance against the Emergency Care target. Ms Dutton suggested that a scorecard should be developed that would demonstrate that there was no compromise on quality and safety. Dr Sahota suggested that the supportive measures, such as completion and discharge summaries and To Take Out (TTOs) drugs needed to be effective for the entire system to work effectively. He also suggested that good communication with the patients' GP was needed. Dr Stedman reported that much work was underway to improve the efficiency of arranging TTOs. Miss Barlow advised that a revised Emergency Care trajectory would be prepared and submitted to the TDA and LAT.	
5 Quality Report	**SWBQS (11/13) 152** **SWBQS (11/13) 152 (a)**
The key highlights within the Quality Report were presented to the Committee. Mrs Pascall highlighted that much attention had been directed to the falls position. It was highlighted that the number of falls causing harm was concerning and the number of these classified as being preventable was high. It was reported that the staff awareness was improved, the tools that could be used to address the position were being reviewed and the linkage to dementia work was also being assessed. Ms Dutton noted that the position varied considerably between different locations in the Trust and suggested that these areas be prioritised for remedial measures. Mrs Pascall confirmed that surveillance was better focussed in these areas. Dr Sahota suggested that the use of pressure mats could be adopted where possible. Mrs Hunjan asked whether there was a time at which most falls occurred and was advised that there were no particular trends. In terms of the recent media coverage about displaying nurse staffing information, it was reported that e-rostering would be used to provide nurse staffing information and that a more comprehensive update would be presented at a future meeting. Ms Dutton asked whether this would address the mismatch	

between ESR and budget information. She was advised that work was underway to address the gap between these. Ms Dutton asked whether the current use of bank and agency staff represented a concern. She was advised that this related to the need to manage patients with a higher level of acuity. It was noted that there was currently a shortfall of 47 nurses, however recruitment initiatives were underway to address this. Miss Barlow advised that the intention to over recruit nurses ahead of winter had not been achieved. Dr Stedman advised that compliance with the WHO checklist was good and VTE risk assessment position had exceeded the 95% target. The Trust's HSMR position was noted to be significantly lower than that of peer organisations. Ms Dutton noted that caesarean section rates had increased and asked whether this placed the Trust as an outlier. Dr Stedman advised that this was within the accepted range.	
6 Cancelled outpatient appointments	**SWBQS (11/13) 153** **SWBQS (11/13) 153 (a)**
Miss Barlow asked the Committee to receive and note the update. Mrs Hunjan asked how the Trust compared with other organisations. Mr Harding suggested that gaining a benchmarked position would be difficult as the information was not available nationally. The variability between different specialities was noted. It was agreed an overview of the transformation plan and outpatient standards should be presented at a future meeting.	
ACTION: Miss Barlow to present an overview of the transformation plan and outpatient standards at a future meeting	
7 Readmissions	**SWBQS (11/13) 154** **SWBQS (11/13) 154 (a)**
Miss Barlow reported that the respiratory speciality remained focussed on the reducing readmission rates and had made some specific interventions to achieve this. It was noted that patients living alone needed to be given particular focus as this would inform discharge strategies. Miss Barlow reported that readmission reviews would be undertaken in the new year and would be classified as avoidable and non-avoidable. Mr Samuda asked what timeline was expected for GP engagement with the work. Dr Stedman reported that this would be incorporated within the overall GP engagement work and would pick up out of hours work particularly. Dr Sahota highlighted that the discussions needed to incorporate Social Services. Miss Barlow updated the Committee on the plans to undertake multi-disciplinary discussions remotely in a patient's home. It was agreed that a further update should be presented in February 2013.	

ACTION: Miss Barlow to provide an update on readmissions at the meeting of the Quality & Safety Committee in February 2014	
8 Never Event	**Verbal**
Dr Stedman reported that since the last meeting two 'Never Event' table top reviews had been conducted, one of which was in Orthopaedics and the other in Ophthalmology. The background to the cases was presented. In terms of the Orthopaedics 'Never Event', it was reported that the implant selected was incorrect and there had been a failure to check the implant prior to use. It was noted that the harm caused by the Ophthalmology incident was low, however practices would be amended to make them more robust. Ms Dutton expressed her concern at the failure to check that the correct patient had undergone the procedure. Dr Stedman acknowledged that this was a failure in practice and indicated that there was a difference in culture between doctors and nurses, in that the medical staff were not aware of the checking procedure in place used by the nurses. The Committee was advised that the issue did not concern the resistance to the practice, however concerned lack of understanding and awareness of practice. It was agreed that a mindset change was needed in this respect around safety and culture, particularly in theatres. Ms Dutton reiterated her concern at the incident and suggested that due accountability needed to be applied.	
9 Cardiology turnaround plan	**SWBQS (11/13) 155** **SWBQS (11/13) 155 (a)**
Miss Barlow presented the background to the application of turnaround measures to Cardiology, including long waiting times, pockets of recruitment difficulties and poor team working. It was reported that a General Manager prepared a condition report which summarised the key issues, which the Committee was asked to note. Ms Dutton remarked that she was assured by the measures being taken to improve some of the fundamental operation of the speciality. It was noted that the action plan needed to be fully populated and would be presented at the next meeting. Mrs Hunjan noted the vacancies reported would be addressed in part by the successful appointment panel that had been convened earlier in the week. Mr Samuda asked whether benchmark information was available from national bodies to inform the position. Miss Barlow advised that this was the case. Dr Sahota suggested that the department should participate more readily in research. Dr Stedman advised that the area already participated heavily in the research agenda, however clarity was needed as to how the work was directed in future and its relationship to corporate research & development. It was reported that research & development would be built into the plans for the future.	
10 Corporate performance and quality dashboard	**SWBQS (11/13) 156** **SWBQS (11/13) 156 (a)**

Mr Harding reported that the TDA accountability framework and Monitor risk assessment framework were the key national tools used to judge performance at present. It was noted that further work was to be undertaken to refine the response to the TDA accountability framework. The Committee was asked to receive and accept the report. It was reported that a detailed review had been undertaken to assess performance against the CQUIN targets and that any concerns raised were being addressed at present. Dr Stedman highlighted that there were particular concerns around safe storage of medicine and dementia targets.	
10.1 Performance against stroke and thrombolysis targets	**SWBQS (11/13) 157** **SWBQS (11/13) 157 (a)**
It was reported that there had been work undertaken to implement measures to improve performance against the stroke care targets. Miss Barlow reported that in terms of thrombolysis, the main breaches related to out of hours cases and work was being undertaken regarding stroke alert processes with staff working during these shifts.	
11 Complaints	
11.1 Update on devolution plans	**SWBQS (11/13) 158** **SWBQS (11/13) 158 (a)**
Miss Dhami reported that the devolution process had gone 'live' as planned on 4 November. It was reported that since then 30 complaints lending themselves to this process had been received, the majority of which were less serious in nature. The Committee was reminded that devolved complaints needed to be processed within 30 days and that performance was being stringently monitored.	
11.2 Link complaints	**SWBQS (11/13) 159** **SWBQS (11/13) 159 (a)**
The Committee was asked to receive and accept the report. Miss Dhami reported that there had not been any emerging trends or themes identified and that more work was needed to better understand the expectations of patients prior to issuing the complaints responses.	
11.3 Red and amber complaints	**SWBQS (11/13) 160** **SWBQS (11/13) 160 (a)**
The Committee was asked to receive and accept the report.	
12 CQC intelligent monitoring	**Hard copy paper**
Miss Dhami reported that the first assessment by the CQC against the intelligent monitoring criteria had been published which rated the Trust as within category four (out of six). The Committee was asked to note how the Trust's internal understanding of	

performance mapped against that of the CQC, in terms of risk. It was highlighted that there were a minority of areas where it had been identified that there was known risk or a risk under management. Ms Dutton asked how this would be considered in future. Miss Dhami advised that any areas of concern would feature in the corporate performance dashboard.	
13 Serious Incident report	**SWBQS (11/13) 162** **SWBQS (11/13) 162 (a)**
The Committee was asked to receive and accept the report.	
14 Feedback from the HCA Conference	**Verbal**
It was agreed that this would be deferred to the next meeting.	
MATTERS FOR RECEIPT AND ACCEPTANCE	
15 Clinical Audit forward plan: monitoring report	**SWBQS (11/13) 163** **SWBQS (11/13) 163 (a)**
The Committee was asked to receive and note the report.	
16 Foundation Trust Quality Governance	**Verbal**
It was agreed that there was nothing further to report.	
OTHER MATTERS	
17 Matters of topical or national media interest	**Verbal**
It was agreed that there were no matters to raise.	
18 Any other business	**Verbal**
There was none.	
19 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 13 December 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):	Linda Pascall (Interim Chief Nurse), Dr Roger Stedman (Medical Director) and Kam Dhami (Director of Governance)
AUTHOR:	Various
DATE OF MEETING:	19 December 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 Committee is invited to accept the report, noting in particular the key points highlighted in Section 2 of the report.

REPORT RECOMMENDATION:

The Committee 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

QUALITY REPORT

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

December 2013

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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

The number of falls with fractures has increased in October with six patients recorded which is the highest number seen. These incidents are not confined to our area and each will be subject to TTR.

There is no IPC update at time of report.

CLINICAL EFFECTIVENESS

There are no ward review reports due to be completed for this quarter.

The ward dashboard is included but there are still IT issues to be resolved which means this data may be inaccurate.

Compliance with the use of the World Health Organisation (WHO) checklist was 99.73% across all patients who underwent surgery.

VTE risk assessments were carried out on 94.21% of admitted patients against a standard of 95%.

Mortality Reviews of September deaths was 77.7% reviewed within 42 days which does not meet the target of 80% for the month. The Quarter 2 performance was 80% which meets the standard.

The Trusts 12-month cumulative HSMR (93.2) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the now disestablished SHA Peer (101.4).

PATIENT EXPERIENCE

Maternity Services Friends and Family Test (FFT) survey started from 1st October 2013 as part of phased expansion of the national FFT programme.

The Trust made good improvements in response rates with the overall FFT responses (IP + ED) increasing to 23% (+10%) in October 2013 compared to the previous month. A total of 2,630 patients responded. A blended feedback approach of Ipads, SMS/texts and Token Survey Box (TSB) system is now used.

The overall October 2013 Trust FFT score (Inpatients + ED) was 54 (-4) which can be attributed to decrease in the ED FFT score for this month.

The October 2013 inpatient FFT score was 71 with a response rate of 29%. This score is same as the average national FFT score for this month.

The October 2013 ED FFT score was 46 (-5 compared to last month) with a response rate of 21%. This score was 9 points below the national average of 55.

The Maternity Services had a FFT score of 48 with a response rate of 9%.

3 TARGETED AREAS OF SUPPORT

T&O – infection control
Theatres – infection control

4 PATIENT SAFETY

4.1 Safety Thermometer

Overall Summary

Harm Free Care remained stable at **94%** for both October & November.

Pressure Ulcers –	Acute - Oct **1 PU** → Nov **2 PU's**
	Community – Oct **15 PU's** → Nov **17 PU's**
Falls – Acute –	Oct **9 Falls** → Nov **1 Fall**
	Community – Oct **11 Falls** → Nov **3 Falls**
UTI with Catheter –	Acute – Oct **0 UTI's** → Nov **2 UTI's**
	Community – Oct **0 UTI's** → Nov **0 UTI's**

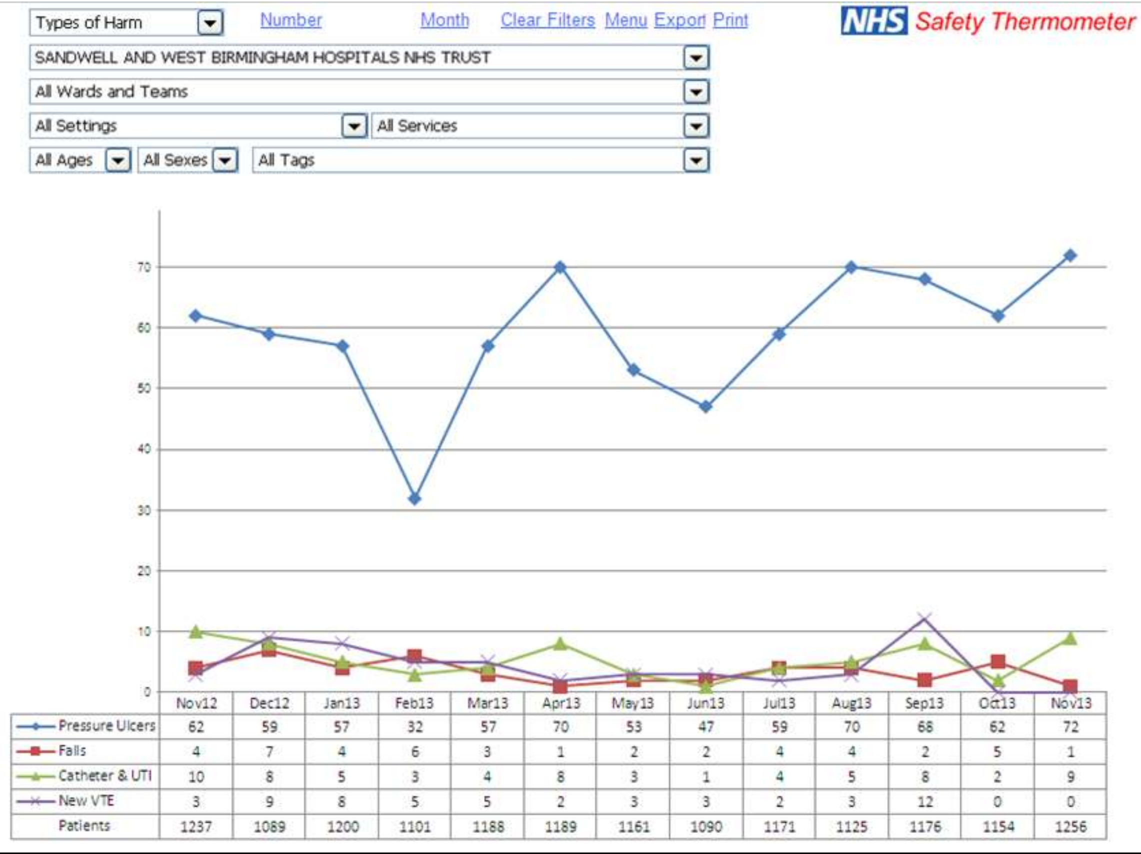
'Harm Free Care' Monthly Percentage - Acute and Community combined

1256 **patients were included in the data collection and** **1174** **were HARM FREE**

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%	93.5 %	94.8 %	95.3%	94.2 %	93%	93%	94%	94%				

18 patients experienced 1 New Harm across the Trust in November and 3 patients experienced more than 1 harm.

Figure 1: *Harm free care trend*



	Nov12	Dec12	Jan13	Feb13	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13
Pressure Ulcers	62	59	57	32	57	70	53	47	59	70	68	62	72
Falls	4	7	4	6	3	1	2	2	4	4	2	5	1
Catheter & UTI	10	8	5	3	4	8	3	1	4	5	8	2	9
New VTE	3	9	8	5	5	2	3	3	2	3	12	0	0
Patients	1237	1089	1200	1101	1188	1189	1161	1090	1171	1125	1176	1154	1256

Figure 2: *Number of patients by type*

a) Falls

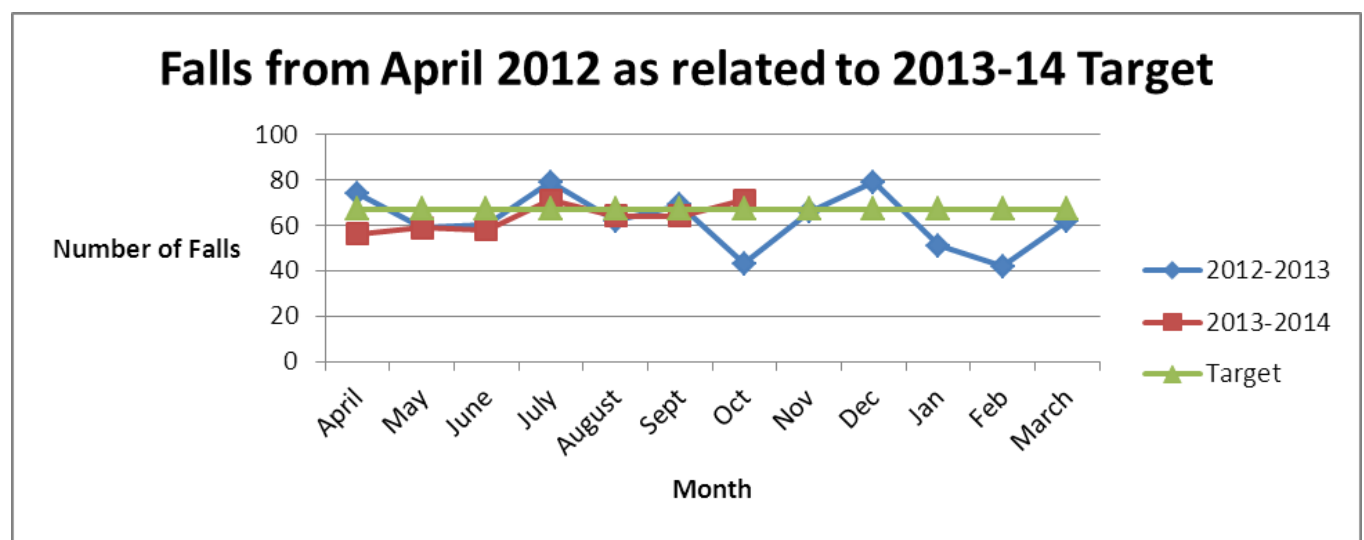


Figure 3: *Trend of falls April 2012 – October 2013*

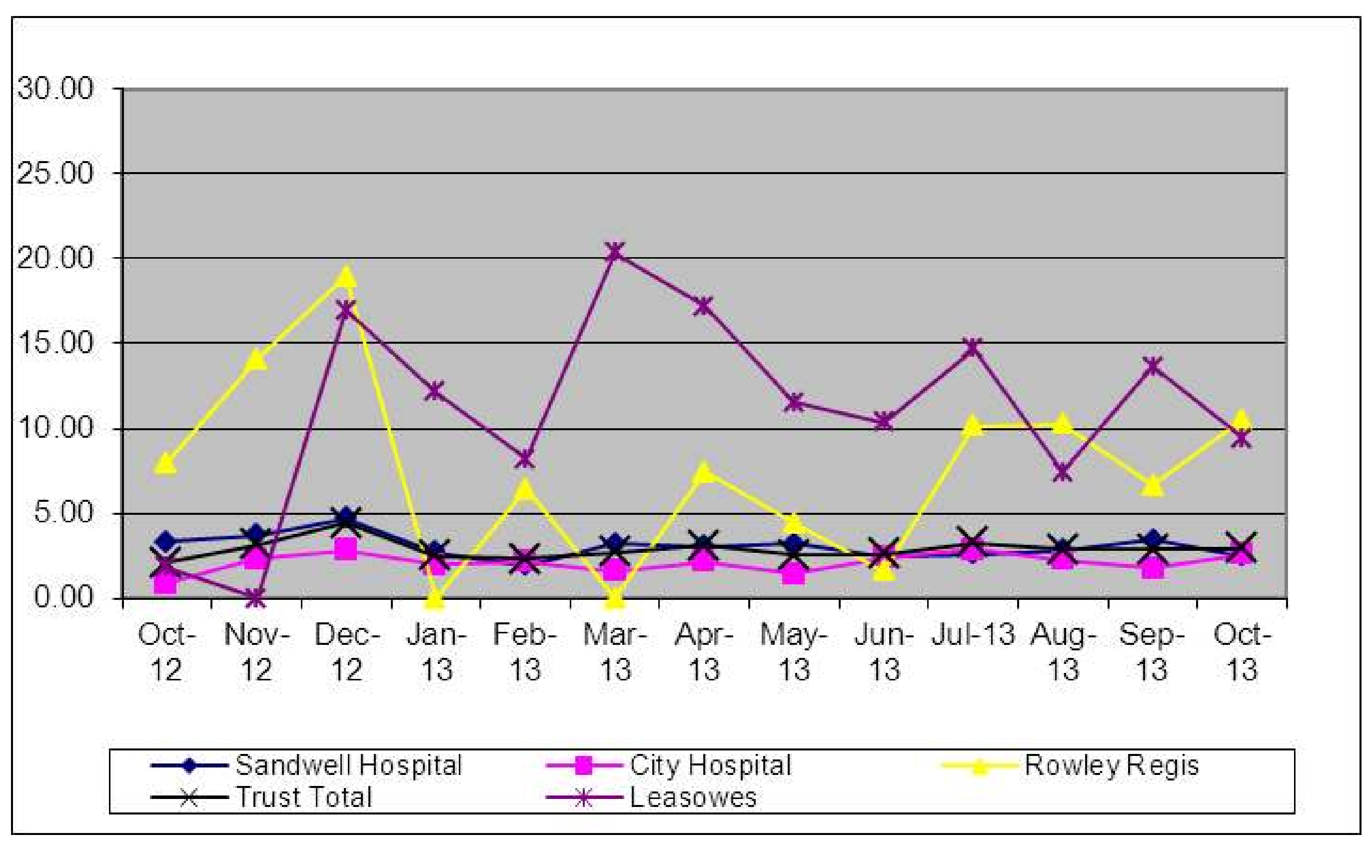


Figure 4: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

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	Preventable
May	P3	RED	Peri prosthetic #	Preventable
June	P3	RED	#Humerus	Preventable
June	MAU	RED	#Gt Trochanter	Non-Preventable
June	L5	RED	#Sub/Ex dural haemorrhage (RIP)	Preventable
June	P4	RED	#Rt NOF	Non-Preventable
September	P3	RED	#NOF	Non-Preventable
October	P3	RED	# NOF	Non-Preventable
October	ET	RED	Peri prosthetic #	Non-Preventable
October	ET	RED	# NOF	Non-Preventable
October	ED	RED	# FEMUR	Non-Preventable
October	P2	RED	Head Injury	Non-Preventable
October	N1	RED	#wrist	Preventable
November	CCU	RED	# pubic rami	

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

b) Pressure Damage

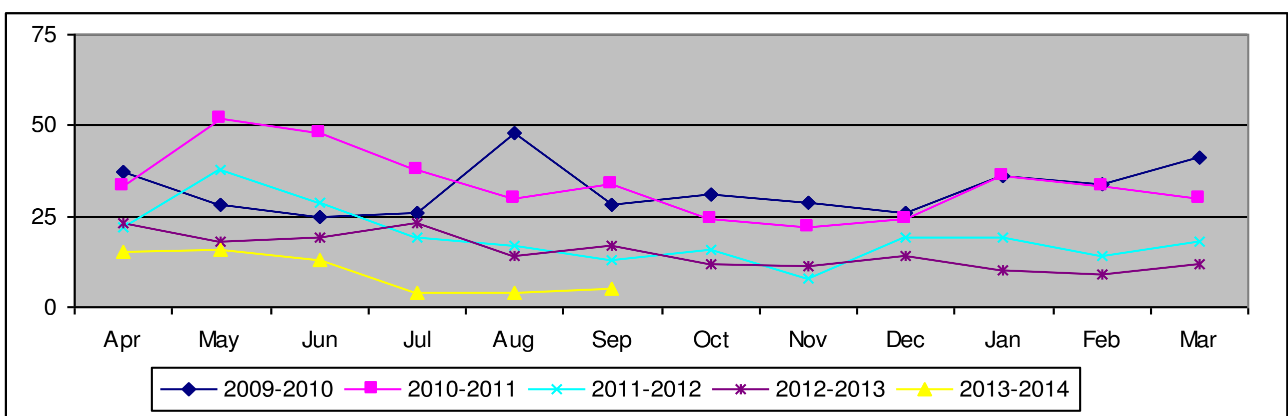


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 – September2013*

Grade of Sore	2013-2014						
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Total
Grade 1	-	-	-	-	-	-	-
Grade 2	13	15	12	2	3	4	49
Grade 3	2	1	1	2	1	1	8
Grade 4	0	0	0	0	0	0	0
Trust Total	**15**	**16**	**13**	**4**	**4**	**5**	**57**

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

c) VTE Risk Assessment

The VTE Risk Assessment CQUIN target is 95%. Intensive work has continued to improve the VTE assessment position. Performance during November was 94.21% which does not meet the target of 95%.

The particular areas of focus are the assessment units where many patients are admitted as emergencies. Further analysis has shown that the times when the VTEs are least likely to be completed in the assessment units are at weekends and out of hours (between 20.00hrs and 07.00). Further analysis is underway by the MDs Team.

4.2 Nutrition/Fluids

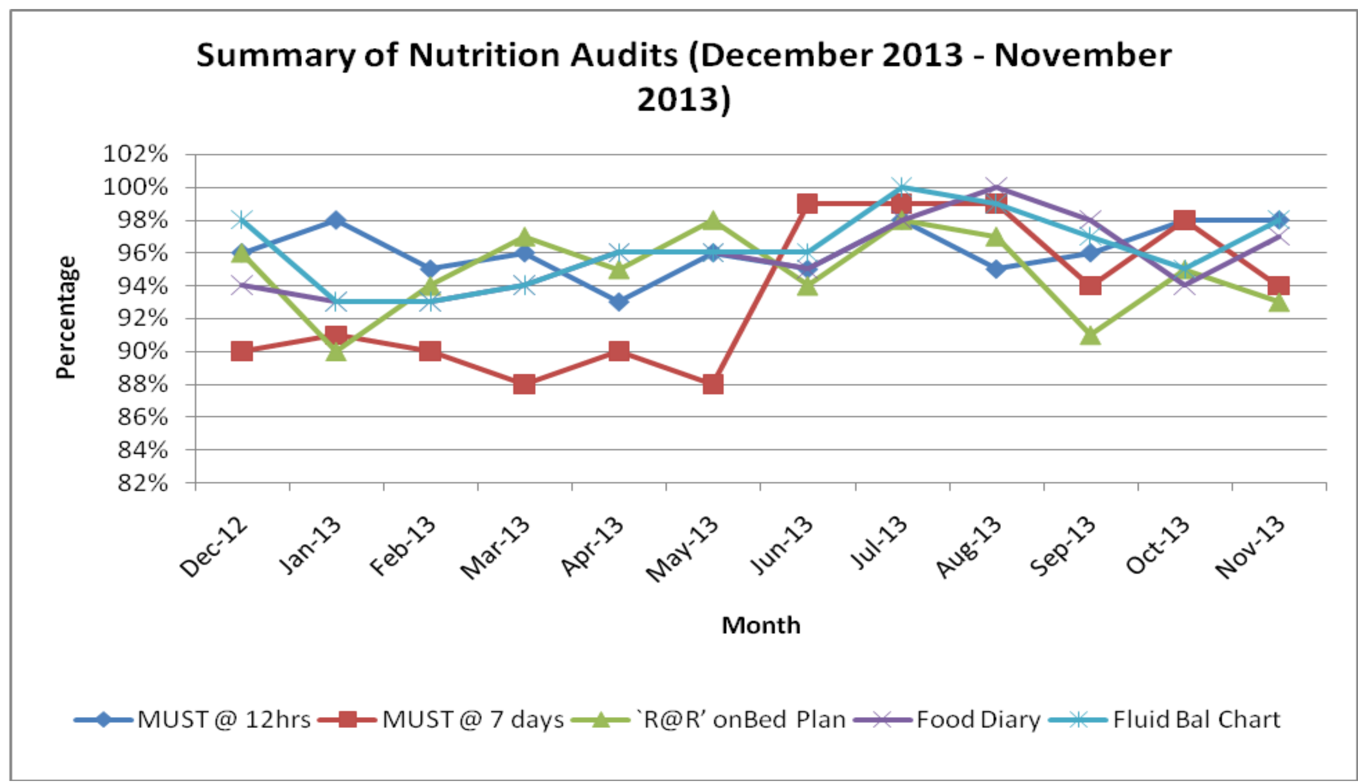


Figure 8: *Nutrition Audit Results*

4.3 Infection Control

MRSA

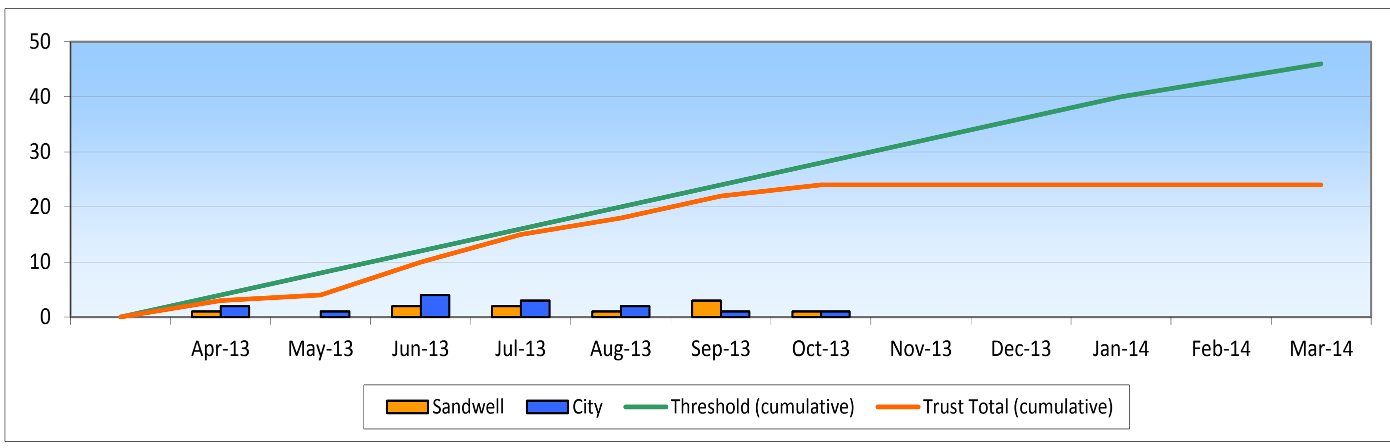
			To Date (*=most recent month)	TARGET	
				YTD	2013/14
MRSA Screening - Elective	Patient Not Matched	%	**226.9***	88	90
	Best Practice - Patient Matched	%	**73.2***	77	80
MRSA Screening -	Patient Not Matched	%	**91.7***	88	90

Non Elective	Best Practice - Patient Matched	%	92.4*	77	80

Figure 9: *MRSA screening eligibility*

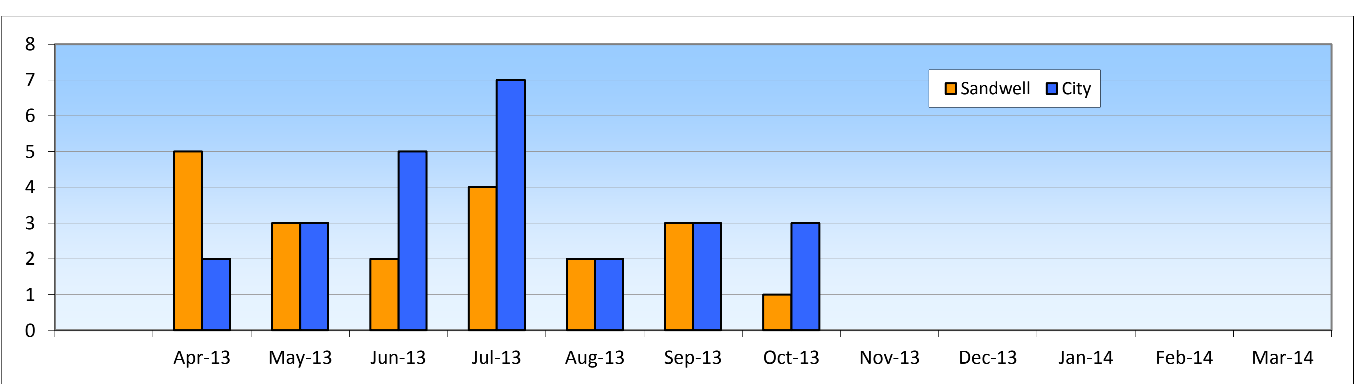
AN UPDATE OF THE FOLLOWING INFECTION CONTROL INFORMATION IS NOT AVAILABLE THIS MONTH.

<u>*Clostridium Difficile*</u>



	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	2	1	3	1						**10**
City	2	1	4	3	2	1	1						**14**
Trust	3	1	6	5	3	4	2	0	0	0	0	0	**24**
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	15	18	22	24	24	24	24	24	24	-
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	4	2	3	1						**20**
City	2	3	5	7	2	3	3						**25**
Trust	7	6	7	11	4	6	4	0	0	0	0	0	**45**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Trust Total (cumulative)	7	13	20	31	35	41	45	45	45	45	45	45	-

Figure 11: *Trust Best Practice Data*

Blood Contaminants

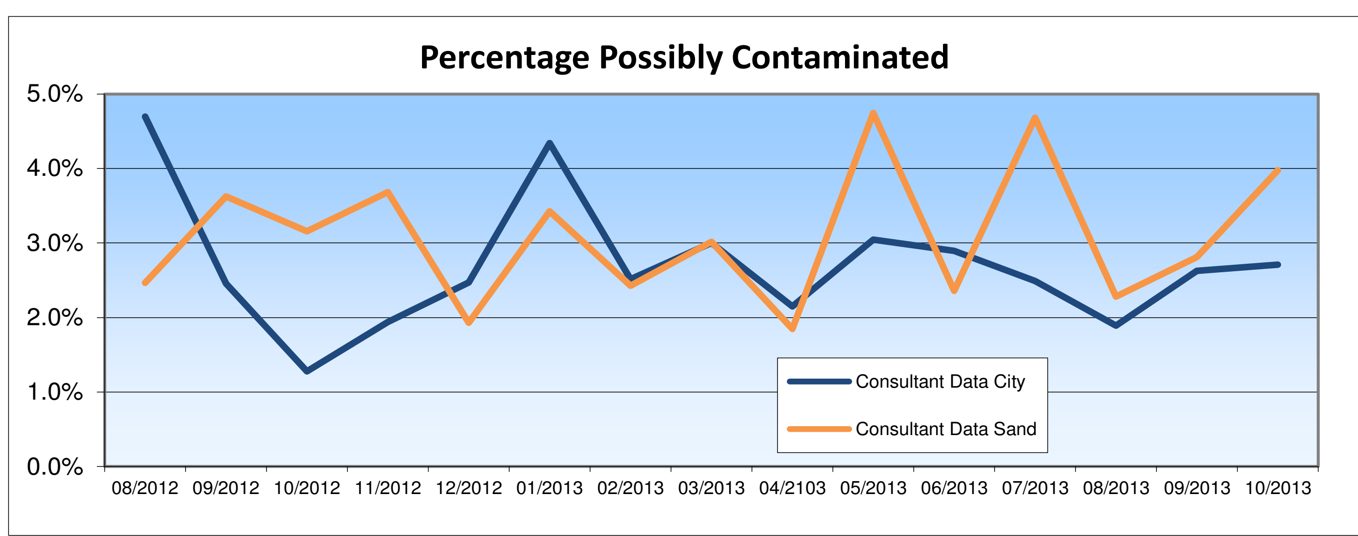


Figure 12: *Blood Contaminants*

E Coli Bacteraemia

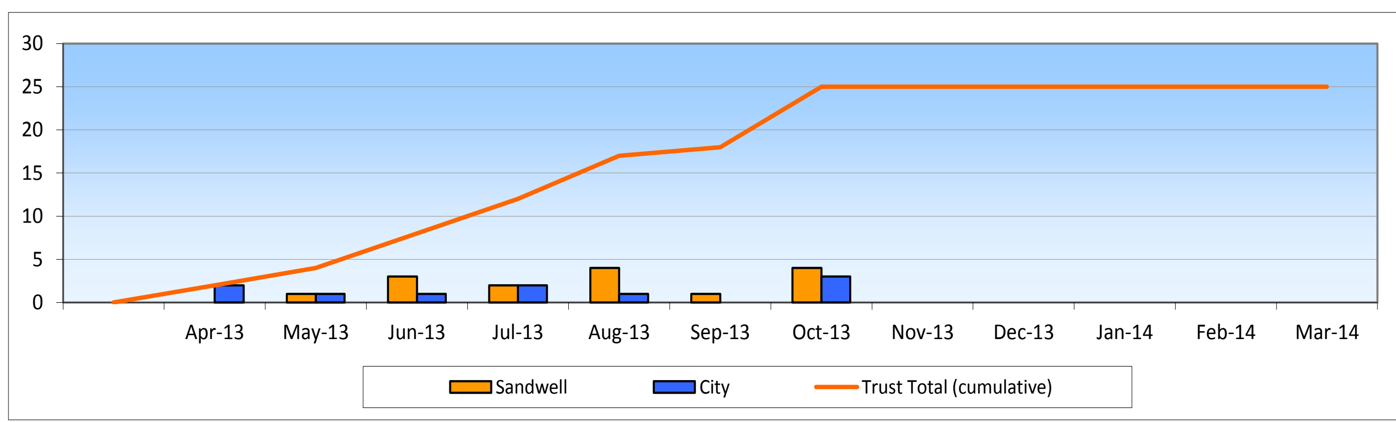


Figure 13: *E Coli Bacteraemia*

MSSA

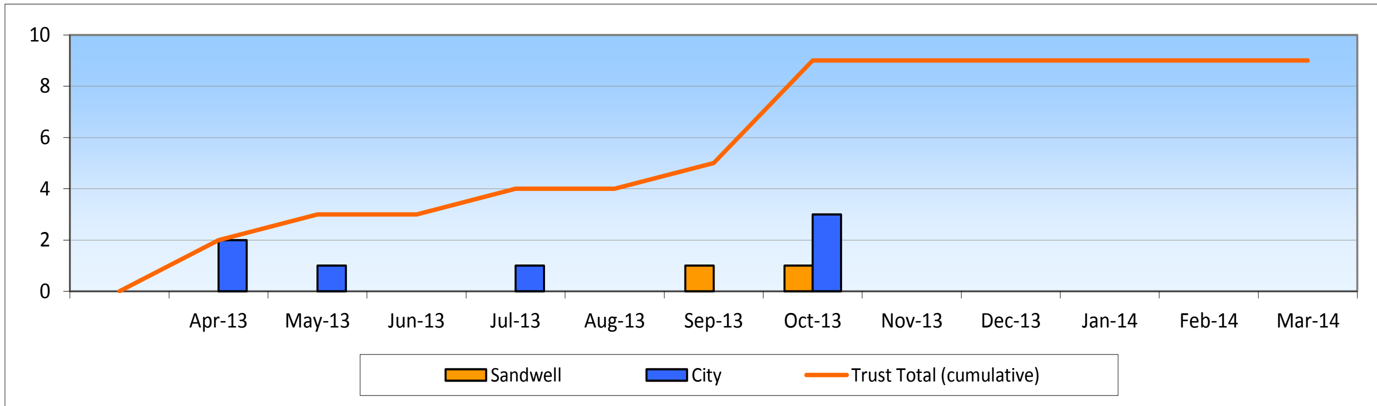


Figure 14: *MSSA*

4.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. An update is not available for this month.

Post-Partum Haemorrhage (PPH)(>2000ml): there were 0 patients recorded to have had a PPH of >2000ml in September.

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for September was 12.2 which was higher than the trajectory (8) and was higher than the previous month (5.9). 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 September was 29.0%, which is above the trajectory of 25% over the year and slightly higher than the previous month (25.5%).

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for September was 9% which is below the trajectory (15) and higher than the previous month (6%).

Community Midwife Caseload (bi-monthly): The community midwife caseload in September was 124, which is below the trajectory of 140 and is lower than the previous month (124).

4.5 Medicine Management (Last updated 25th July)

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

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.

4.6 Incidents

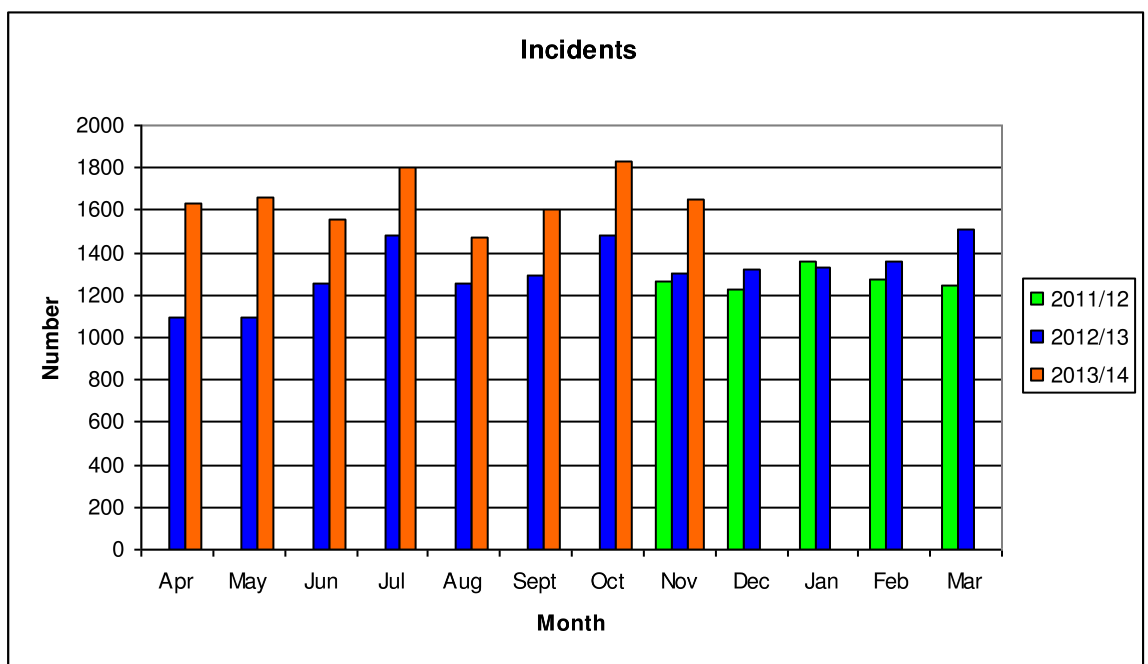


Figure 15: *Incidents 2011/12 – 2013/14*

Incidents in November 2013

Total Number of Incidents reported		**1654**
Of the total: *(* incidents still under investigation)*		
Near miss		263
No Harm		867
Low (minimal harm)		409
Moderate		106
Severe (permanent or long term harm)		5
*Death (related to the patient safety incident)		1
"Top 5" Reporters (Acute)		
1	Emergency Departments (both)	236
2	Labour ward	78
3	Priory 5	63
4	Acute Medical Unit (A) – old EAU	56
5	Priory 4	43

"Top 3" Reporters (Community)

1	Community Nurses Glebefields	16
2	Community Nurses Lyng	14
3	Community Nurses Mesty	13

"Top 5" Type**

1	Verbal abuse – Patient on Staff	105
2	Omitted Drug	63
3	Non SWBH pressure sore	56
4	Communication failure with patient/team	52
5	Medication error - other	30

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

4.7 Serious Incidents (SIs)

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

1 2013/32800 – Trauma & Orthopaedics
NEVER EVENT – wrong implant.

2 2013/33569 – Ophthalmology
NEVER EVENT – Procedure on the wrong patient

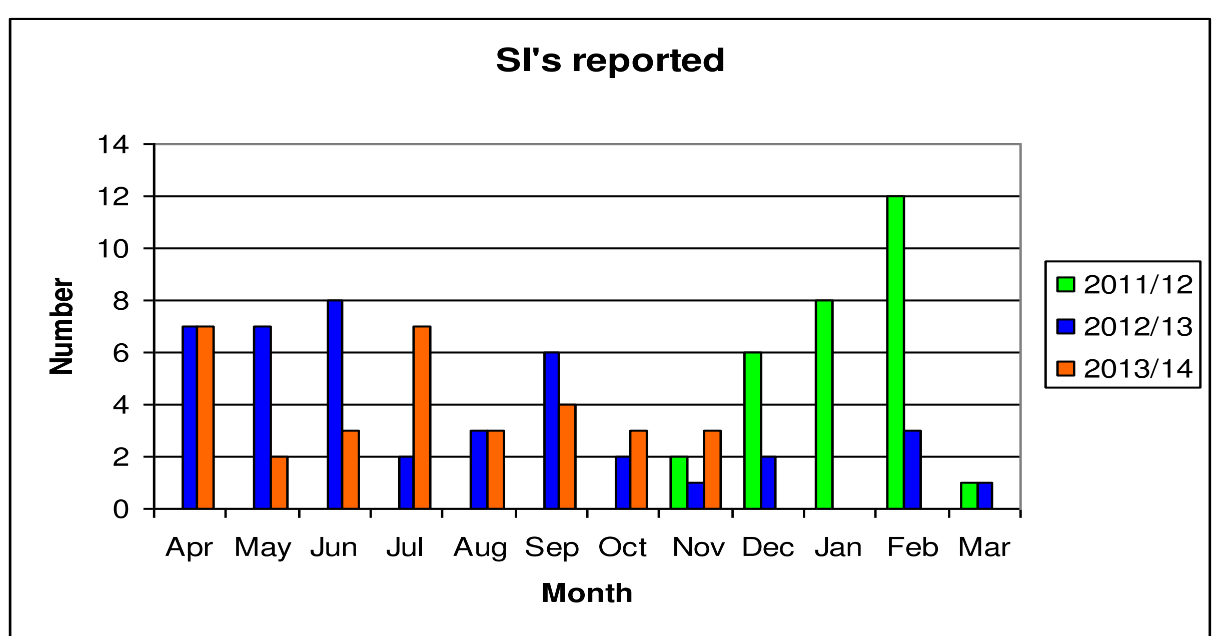


Figure 16: *Serious Incidents 2011/12 – 2013/14*

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

4.8 Patient Safety Walkabouts

The Patient Safety Walkabouts continue to take place. In November D5 and Priory 2 were visited. 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.

The walkabouts continue with two more planned for December.

4.9 Inquests

During November 2013 **1** new Inquest case was notified to the Trust.

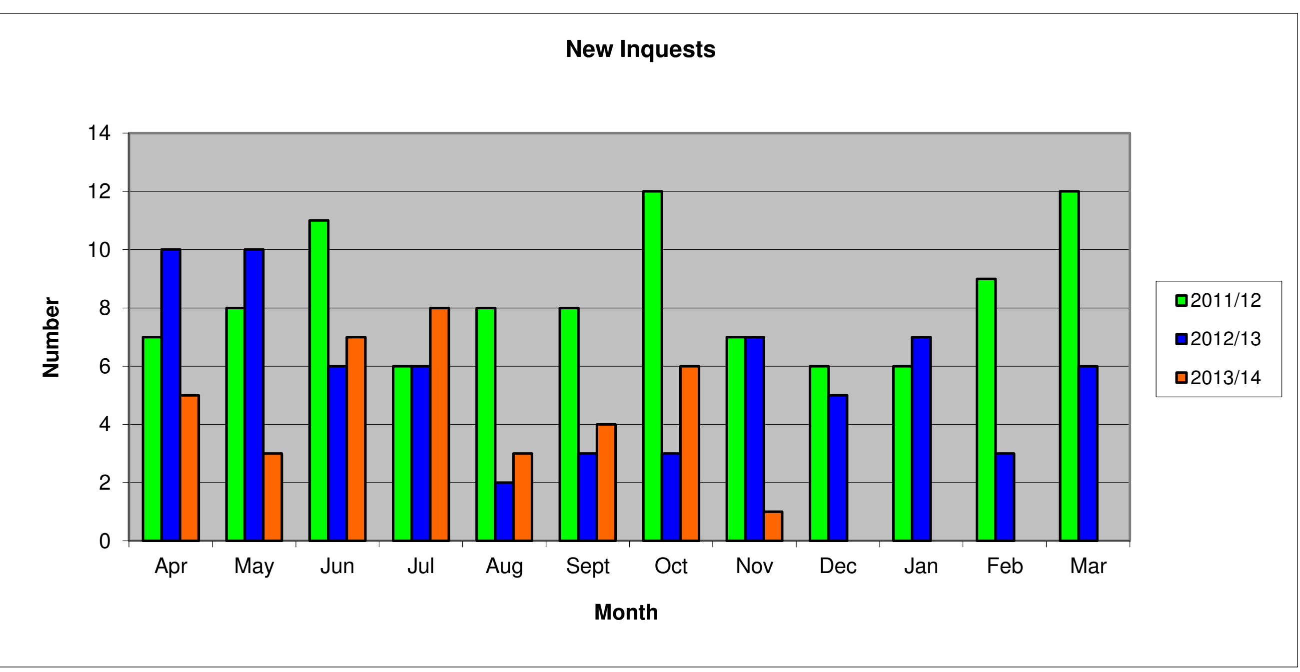


Figure 17: *New inquests 2011/12 – 2013/14*

During November 2013 **1** case was closed following Inquest.

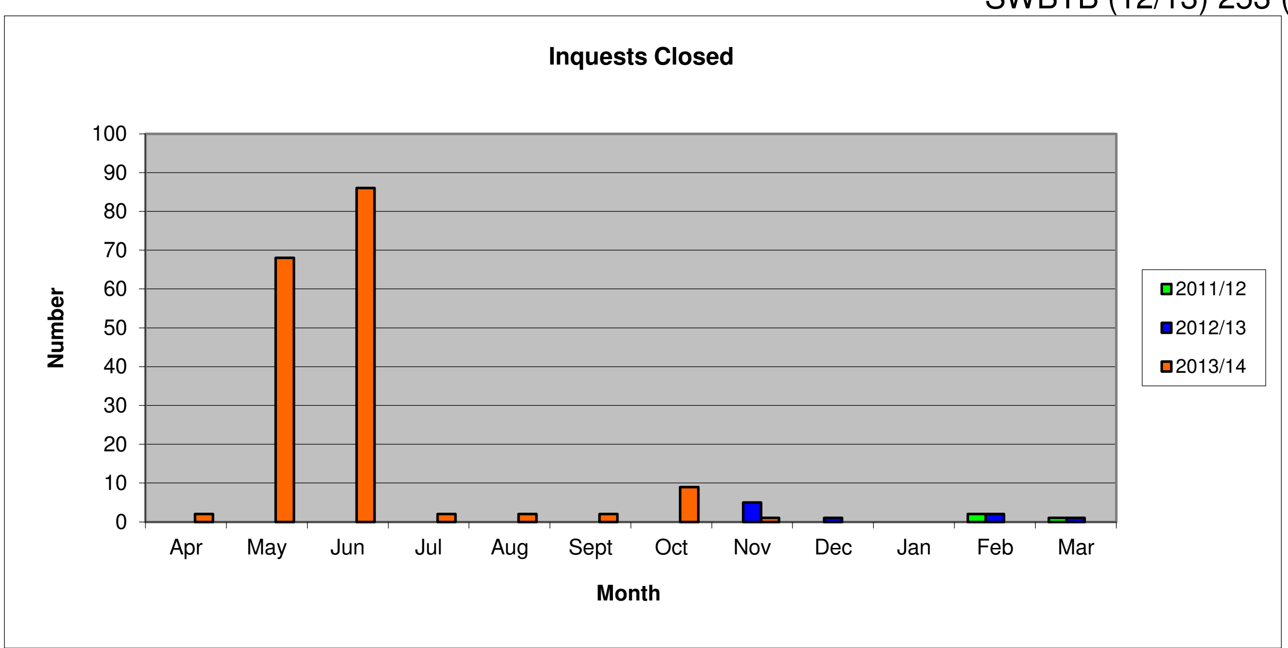


Figure 18: *Incidents closed 2011/12 – 2013/14*

Issue / Risk	Action to take / taken	Who by	When by
No new risks identified.			

4.10 Claims

There were 8 new claims opened in November 2013. 3 were employer/public liability and 5 were clinical negligence cases.

During November 2013 9 clinical negligence claims were closed and 1 employer/public liability claim was closed.

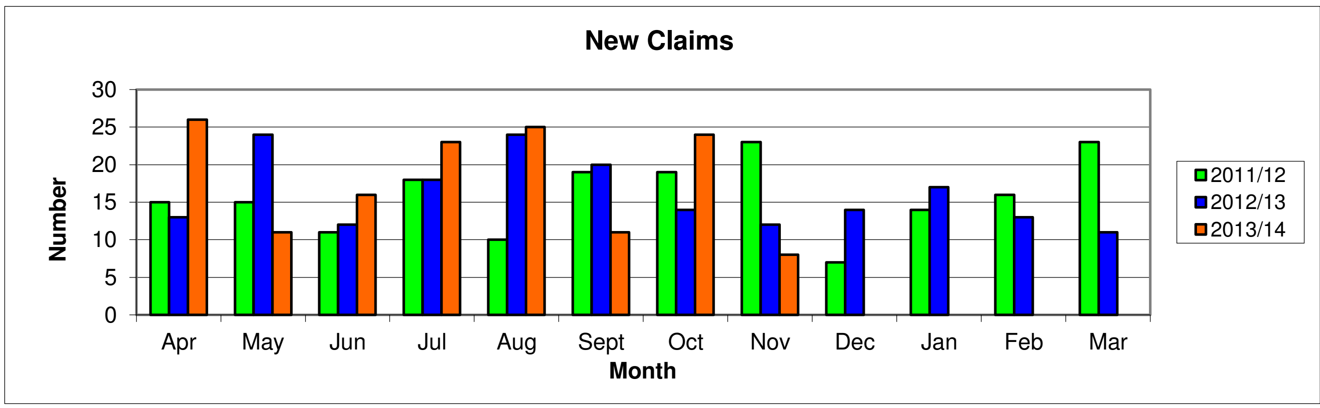


Figure 19: *New claims 2011/12 – 2013/14*

Issue / Risk	Action to take / taken	Who by	When by
No new risks identified.			

4.11 Nurse Staffing Levels

Bank & Agency

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

Total Bank & Agency Use NURSING - November 2013

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011-2012												
Total Bank usage	4812	4611	4740	4529	4097	4289	4936	4877	4619	4592	4825	5511
Total Agency usage	721	834	629	287	226	246	356	572	632	764	792	869
Total Trust usage	5533	5445	5369	4816	4323	4535	5292	5449	5251	5356	5617	6380
2012-2012												
Total Bank usage	4451	4461	4682	4898	5389	5007	4908	5437	4839	4981	5213	6361
Total Agency usage	654	569	577	491	674	642	1103	1219	1381	1455	1909	2250
Total Trust usage	5105	5030	5259	5384	6059	5649	6011	6656	6220	6346	7122	8511
2013-2014												
Total Bank usage	4912	5009	4548	4840	5457	5265	5257	5134				
Total Agency usage	2605	2893	1764	1842	1514	1579	2449	2589				
Total Trust usage	7516	7902	6312	6682	6971	6844	7706	7723				

Figure 20: *Bank and agency nursing2011/12 – 2013/14*

Figure 21: *Total Bank & Agency Use Nursing*

5 CLINICAL EFFECTIVENESS

5.1 Mortality

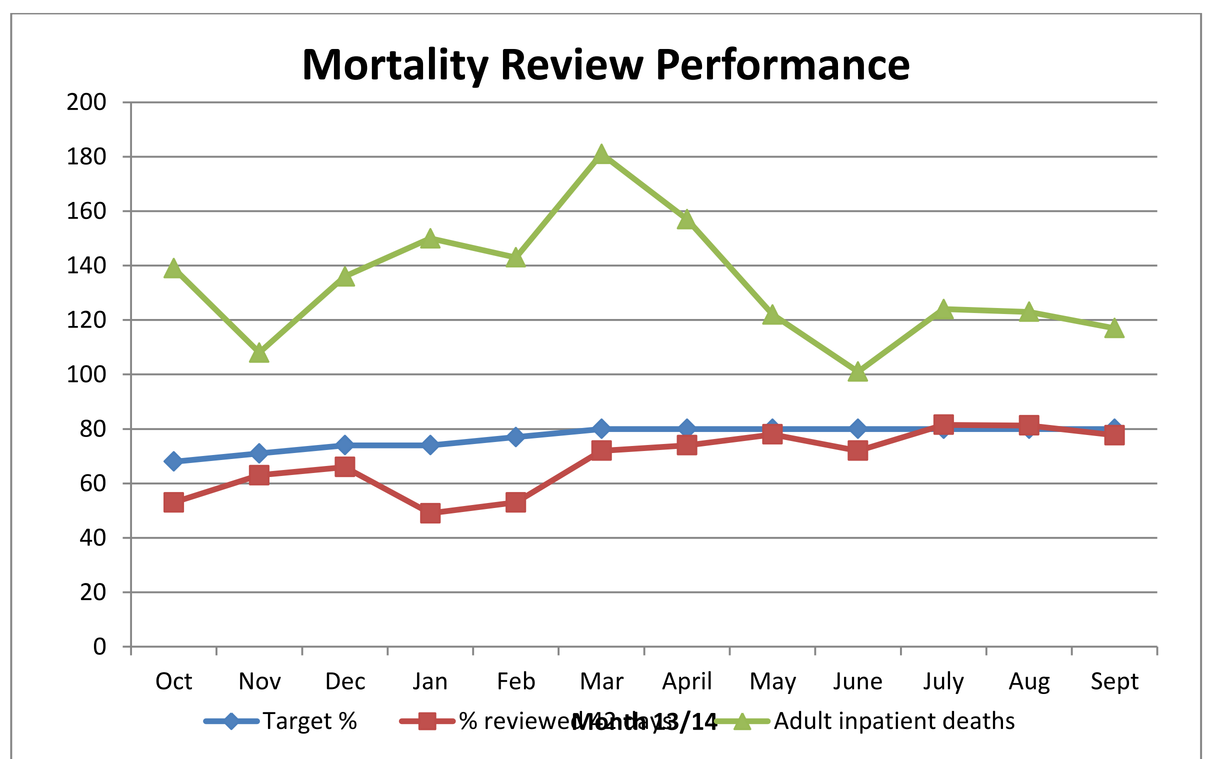
CQUIN Target

As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme which requires the Trust to review 80% of adult inpatient deaths within 42 working days. 42 days have to elapse after the end of the reported month so that all deaths which occurred within the month can be included.

At the end of November the mortality reviews for deaths during the month of September were completed. This is the most recent month for which complete data is available. The Trust reviewed 77.7% (91 of 117) of deaths within 42 days compared with a target trajectory for the month of 80%. A further few deaths were reviewed within the 5 days following the 42 day period which took the total reviewed to 82%.

The % reviewed within 42 days across Quarter 2 was 80%.

Work to understand why this has occurred has revealed that there are specific consultants who are repeatedly not carrying out reviews in a timely fashion. The Clinical Group Director of the Medicine Division is performance managing these few individuals. The impact of their non-compliance is more marked in months where the number of deaths was relatively low.



2013/14	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept
Target %	68	71	74	74	77	80	80	80	80	80	80	80
% reviewed within 42 days	53	63	66	49	53	72	74	78	72	81.5	81.3	77.7
Adult inpatient deaths	139	108	136	150	143	181	157	122	101	124	123	117

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 Trust's HSMR for the most recent 12-month cumulative period is 93.2 and remains beneath the lower statistical confidence limit. The City site HSMR is also beneath lower statistical confidence limits (80.6) and the Sandwell site HSMR (105.9) remains within 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 29/10/13 for the period April 12 – March 13. For this period the Trust has a SHMI value of 0.97 and was categorised in band 2.

7 trusts had a SHMI value categorised as 'higher than expected'
17 trusts had a SHMI value categorised as 'lower than expected'
118 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 is currently 98.1 for the most recent period for which data is available, and this is consistent with recent reporting periods.

Mortality table

		2012/13			2013/14				
		Jan	Feb	Mar	Apr	May	June	July	Aug
Internal Data:									
Hospital Deaths	Trust	157	148	179	158	123	103	126	123
	City	64	69	75	64	44	43	46	56
	Sandwell	92	79	104	94	79	60	80	67
Dr Foster 56 HSMR Groups:									
HSMR (Month)	Trust	81.4	102.5	103.7	93.9	82.9	87.8	94.8	94.5
	City	73.9	89.1	85.1	75.1	66.4	77.9	65.9	95.2
	Sandwell	88.3	121.4	124.9	112.0	98.4	98.7	124.4	94.0
HSMR (12 month cumulative)	Trust	87.8	88.1	88.9	89.1	88.4	92.2	92.7	93.2
	City	78.2	77.2	78.1	77.5	77.3	80.6	79.9	80.6
	Sandwell	99.7	99.3	100.2	101.2	100.1	104.2	105.9	105.9
HSMR (Peer SHA 12 month cumulative)		96.7	97	98.0	97.5	97.6	101.9	101.7	101.4
Healthcare Evaluation Data (HED) SHMI (12 month cumulative)		94.3	95.5	95.9	99.2	98.1	97.2	97.8	98.1

CQC Mortality Alerts received in 2013/14

The Trust received notification from the CQC of being an outlier for the Maternity indicator ‘puerperal sepsis and other puerperal infections within 42 days of delivery’. The Commission has requested further information from the Trust in order to investigate the matter further. This includes conducting a case note review of a sample of relevant cases. This work has commenced and the deadline for the submission of relevant information is 12/12/13.

Dr Foster generated alerts)

In the data period September 2012 – August 2013 there were no new diagnoses groups within the HSMR basket alerting with a significant variation from the benchmark.

National Clinical Audit Supplier – Potential Outlier Alerts

No new potential outlier alerts have been notified.

5.2 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 October 2013	Total
0 – Further Information requested	3
1 - Audit not yet due to start	2
2- Significant delay	1
3- Some delay - expected to be completed as planned	14
4- On track - Audit proceeding as planned	34
5- Data collection complete	11
6- Finding presented and action plan being developed	2
7- Action plan developed	11
D- Discontinued	1
Grand Total	79

The status of the audits that have been included in the plan as at the end of November 13 is shown in the table above. No further audits have been identified as experiencing 'significant delay'.

5.3 Compliance with the 'Five Steps for safer surgery'

Compliance with the use of the World Health Organisation (WHO) checklist was 99.73% across all areas where patients underwent surgery or intervention. A theatre plan audit has been added to the ward audit cycle. Qualitative spot checks have been carried out by the senior theatre nurses focussing on communication and the use of the WHOCL. Findings have been encouraging with good participation in the process by theatre teams.

5.4 Stroke care

Performance against the principal stroke care targets was as outlined in the table below at the end of September. No update is yet available for October.

Month 2013/14	target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
% Spending >= 90% of stay on stroke unit	83%	88.3	96.23	91.5	95	91.5	94.6	NA					
% Admitted to stroke unit within 4 hrs of arrival at hospital	90%	69.35	84.1	92.3	92.1	76.3	72.1	NA					

% pts receiving brain imaging in 24 hrs of presentation	100%	93.18	86.1	85.2	85	95.7	97.7	NA					
% Pts scanned within 1 hr of presentation	50%	61.54	63.2	67.3	64.1	71.4	67.5	NA					
% high risk TIA treated within 24 hours	60%	66.6	63.2	81.3	83.3	72	75.9	NA					
% low risk TIA treated within 7 days	60%	74.07	88.4	88.2	91.2	92.5	87.9	NA					

Figure 22: *Performance against stroke care targets (data Trust Performance Report16/10/13)*

5.5 Treatment of Fractured Neck of Femur within 24 hours

The Trust has an internal Clinical Quality target whereby 85% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. Data for November is not yet available (11/12/13)

5.6 Ward Reviews

The Ward Review results are not for reporting this month.

5.7 Quality Audits

The Quality Audits are not due for reporting this month.

5.8 Nurse staffing establishments

A discussion between the Chief Executive, Chief Nurse and Deputy Chief Nurse to finalise nurse staffing establishments is planned shortly.

6 PATIENT EXPERIENCE

6.1 Friends and Family Test

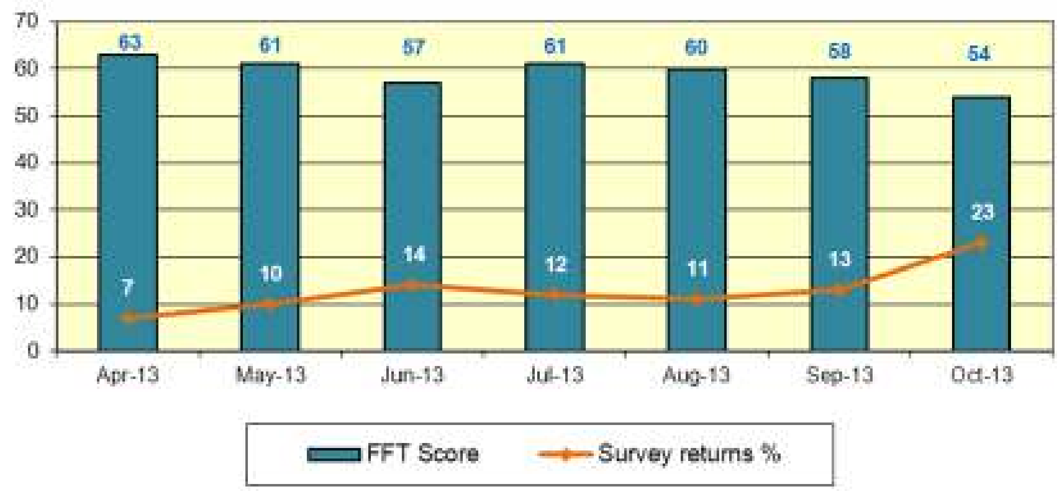
SWBH NHS Trust's Friends and Family Test (FFT) results – October 2013

Inpatient FFT score 71 with a response rate of 29%

ED FFT score 46 with a response rate of 21%.

Trust combined (Inpatients + ED) FFT score was 54 with a response rate of 23%.

SWBH Friends and Family Test Scores and Response Rates %
(Inpatients + ED combined)



The Trust has made good improvements in response rates with the overall FFT responses increasing by 10% in October 2013 compared to the previous month. This can be largely attributed to the blended patient feedback approach now being used which includes electronic surveys via I-pads on the inpatient wards, SMS/text solution and Token Survey Box system on the Emergency departments and a postal/SMS/I-pads combination for the Maternity Services.

The overall October 2013 Trust FFT score (Inpatients + ED) dropped by 4 points to 54 which reflected the decrease in the ED FFT score for this month.

Adult Inpatients, Emergency Department and Maternity Services

Comparison of FFT Scores

Note: The Maternity Services joined the FFT survey programme from October 2013.

The inpatient FFT score did not show much movement and remained stable at 71 tracking the national average of 71. This month's 5-point drop in ED's FFT score left it 9 points below the national average.

Comparison of FFT response rates

The inpatient response rate climbed back up by 10% this month followed closely by a rise of 9% in ED's response rate which largely reflects success of the blended feedback approach. The Maternity Services response rates fell short of the minimum requirement of 15% during the first month of feedback collection.

Breakdown of inpatient FFT results from the Clinical Groups – October 2013

6.2 Complaints

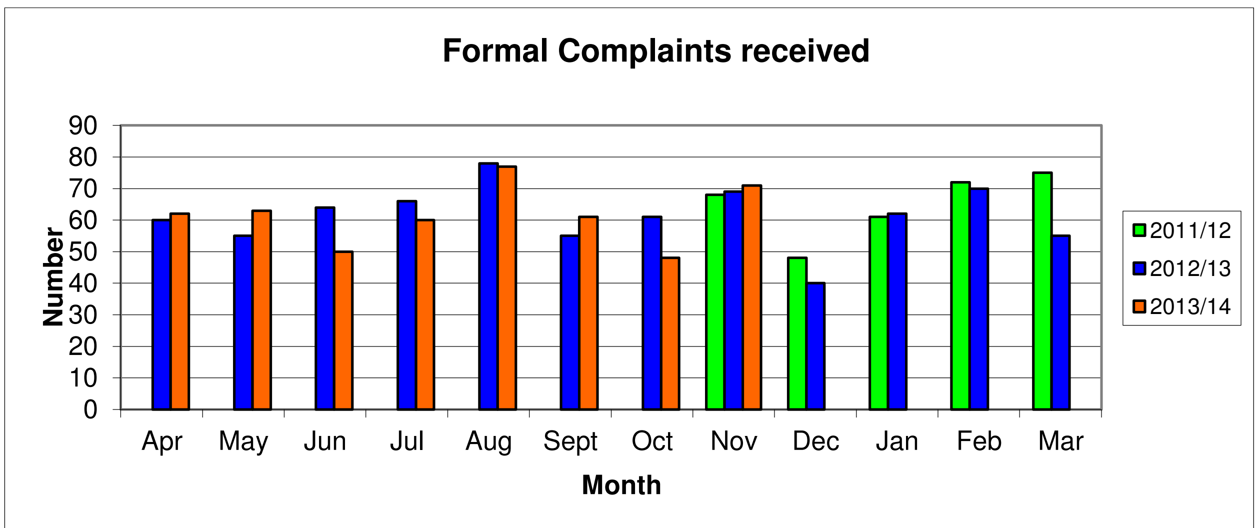
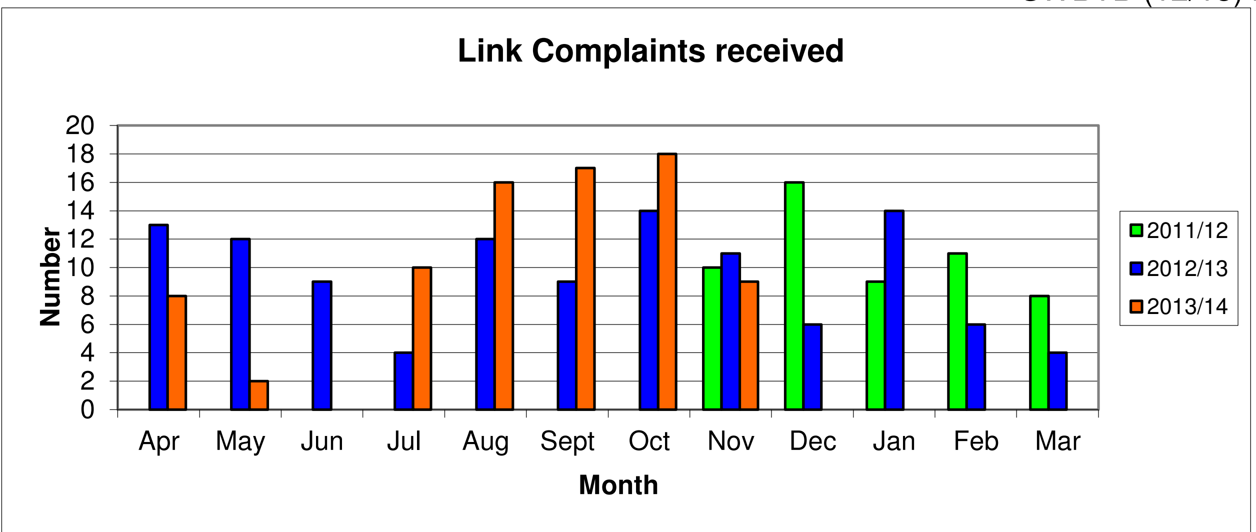


Figure 23: *Complaints received 2011/12 – 2013/14*



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

Figure 24: *Link complaints received 2011/12 – 2013/14*

Complaints comparative data

Context

The total formal and link complaints received requiring a response in November 2013 (n =80) has increased compared with October 2013 (n = 66).

November 2013 shows a slight increase in formal complaints received when compared with the same month last year (n = 69). There is a noted decrease in the link cases.

Categorisation

The 71 formal complaints received in November 2013 were graded as follows:

Level 4	1	Level 3	17	Level 2	24	Level 1	29

Themes
The top 5 themes are: Dissatisfied with Medical treatment (n = 14) Attitude of staff (n=10) Dissatisfied with Nursing care (n = 6) Breakdown in communication (n = 6) Failure/Delay in Diagnosis (n = 6)

Learning
The complaints received in November are in the process of being investigated. Learning from complaints October include: Patients have on occasion been given incorrect information about Consultants to be seen, and the appropriate site for follow up appointments. Discussions have taken place with various senior out-patient nurses to ensure that the correct communication is provided to relatives and patients and when necessary the doctor to be contacted to clarify any queries. Nursing staff have also been reminded to check all patients' notes are available the day before the appointment, ensuring all patient notes are available for the consultation.

6.3 Parliamentary and Health Service Ombudsman (PHSO)

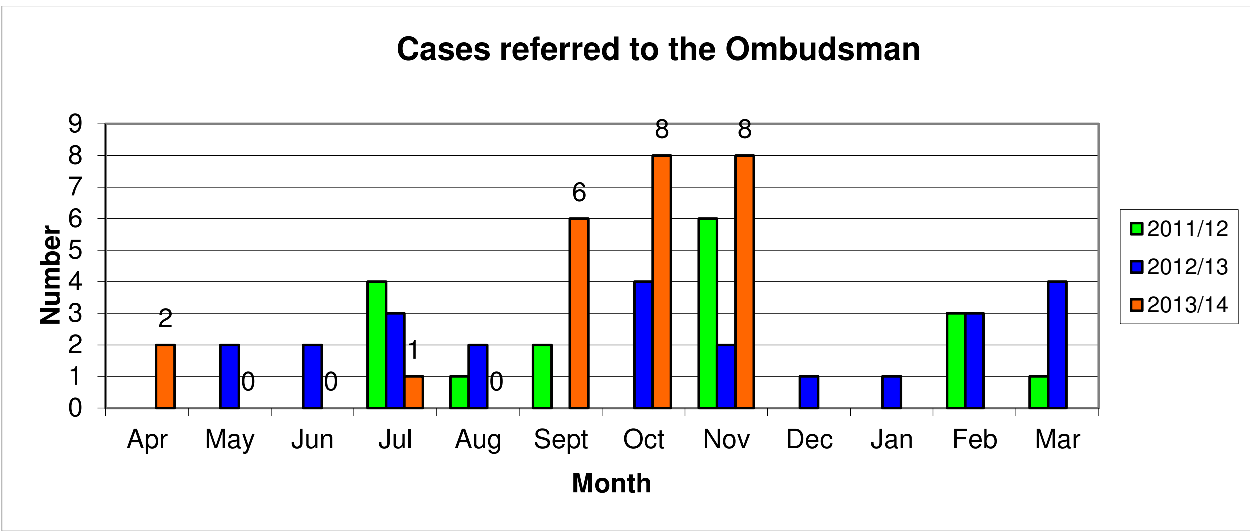


Figure 24: *PHSO referrals 2011/12 – 2013/14*

The Trust currently has 7 active cases with the PHSO

6.4 PALS

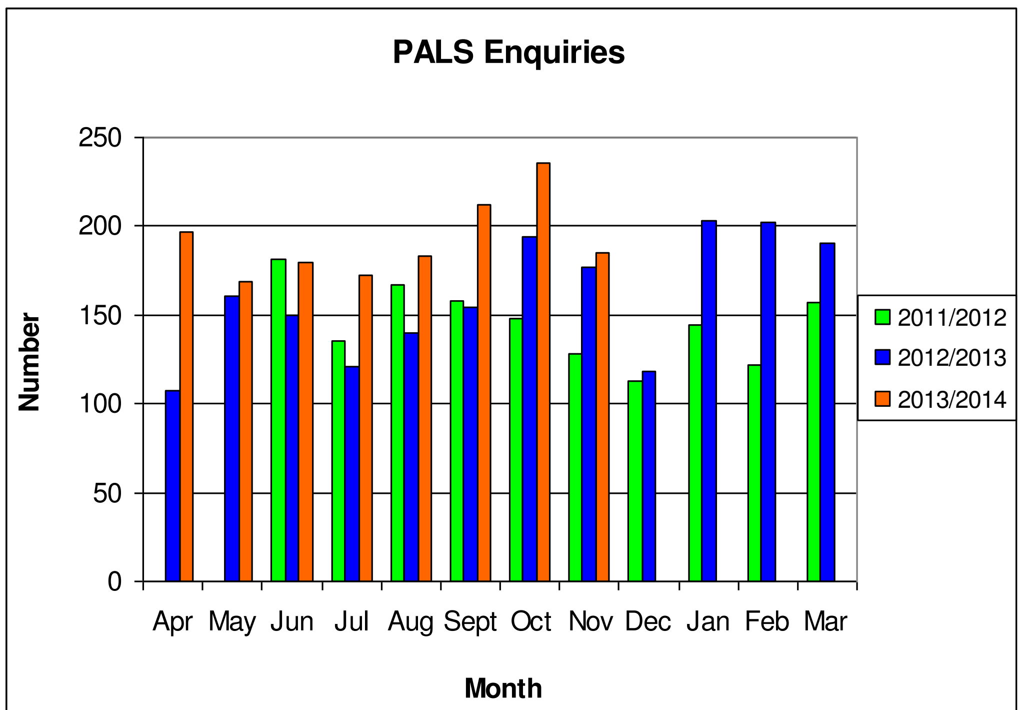


Figure 25: *PALS enquiries 2011/12 – 2013/14*

Context

Total PALS enquiries received in November 2013 (n=185) have reduced in comparison to October 2013 (n=236). There were 2 PALS cases related to the community.

November 2013 also shows an increase compared with the same month last year (n =177). However, the Patient Support Centre also deals with general enquiries and these have reduced significantly, November (2012/13 n = 194 compared with November 2013/14 n = 90).

Themes

The top 5 themes are:

- Issues relating to clinical treatment
- Cancellation of appointments, mainly relating to cancellation, delays and notification of appointments.
- Attitude of staff
- Lack of communication, mainly with relatives.
- Formal Complaints, mainly regarding advice, process or referral.

Learning

In November 2013, PALS have investigated concerns and have assisted with a number of initiatives to improve the patient experience including:

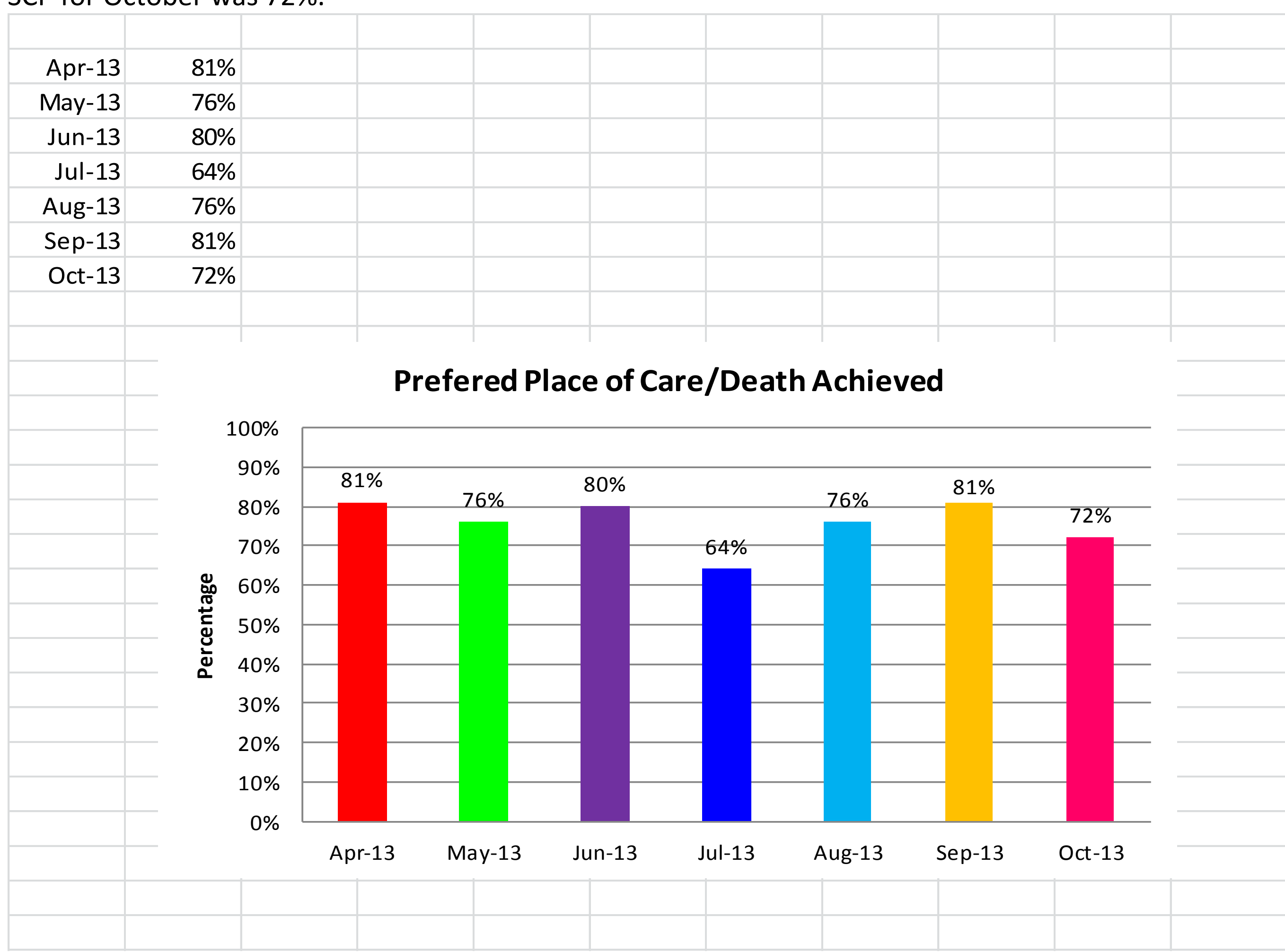
Patient contacted hospital switchboard felt that operator was unhelpful and lacked people skills. Manager of switchboard investigated issue, with details of when call was made, unfortunately she was unable to identify which member of staff took call. As a result all staff reminded of expected protocol and service delivery when taking calls. Staff also reminded of Trust values, with expectations of delivering a service of excellence. Apology given to patient.

Patient left waiting to have blood taken for unacceptable length of time. Phlebotomy Manager advised that she was in the process of recruiting 5 phlebotomists which would alleviate this problem. A notice to be prominently displayed detailing other blood test centres.

6.5 End of Life

End of Life Report

The number of patients achieving their preferred place of care/death irrespective if they were on the SCP for October was 72%.



Apr-13	81%
May-13	76%
Jun-13	80%
Jul-13	64%
Aug-13	76%
Sep-13	81%
Oct-13	72%

Figure 26: *Preferred place of death/care April 13 – Oct-13*

7 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* *MAU* *D* *L* *N* *P* *A&E* *ITU* *NNU*	 Emergency Assessment Unit Medical Assessment Unit Dudley Lyndon Newton Priory Accident & Emergency Intensive Therapy Unity 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:	Board Assurance Framework – Quarter 1 & 2 update
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	19 December 2013

EXECUTIVE SUMMARY:

The combined Quarter 1 & 2 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities is attached. This version of the report includes the entries that were omitted when the Board considered the BAF in November 2013.

Work remains planned to consider how the BAF may be more strategically used in future and in particular the linkage to the work planned to strengthen the Trust's risk management culture and Board's focus on key risks.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

Routine quarterly update

BOARD ASSURANCE FRAMEWORK 2013/14 – QUARTERS 1 & 2 UPDATE

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

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				board level scrutiny of quality and safety issues of concern and debate are escalated to Trust board. The Trust is also scrutinised by the CCG at the CQRM		development eg Public Health, community Development & Equality committee					
Deliver all CQUINs	MD/CN	Mortality, VTE, Sepsis, MQuAC Quality & safety Committee	Non achievement of CQUINs. This can be due to lack of focus on the achievement of patient safety measurements e.g. VTE, sepsis six, think alcohol, Mortality reviews	Significant resources are going into supporting clinicians to carry out data recording and developing computer-aided systems to reduce bureaucracy.	Quarterly CQUIN confirm & challenge meeting with execs	No framework yet in place for the meetings and CQUINs at different stages of development.	Ensure frameworks are developed and action plans are rigorously followed up.	By end Q3	National CQUIN and local contract agreements	**12**	**12**
Improve emergency readmission rates	COO	Readmission Taskforce, Quality and Safety Committee, Trust Board	Readmission rates remain high Risk of not having whole system engagement	Readmission Taskforce in place with supporting programme	Readmission activity Audit	Not yet working with primary care and social services	Inviting to be members of taskforce	Review End Q4		**16**	**12**
STRATEGIC OBJECTIVE 2: ACCESSIBLE & RESPONSIVE CARE											
Consistently achieve the national A & E targets	COO	Winter will be better 2013 programme group Urgent Care Board,	Underperformance Sustained delivery of new ways of working Engagement of social services and	Winter 2013 programme and Urgent Care Board improvement	Urgent care scorecard Delivery of programme	Enhanced Control centre to establish hourly review of sites and	Social services to attend weekly urgent care board meeting /	December – Q4		**20**	**16**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
		Quality and Safety Committee, Trust Board	community bed capacity Recruitment of ED medical staff, ward nurses	programme agreed. Programme governance in place. Monitor and escalate KPI from score card Establish control centre Escalation of issues and risks at executive level to partner organisations.		flow	conference call				
Waiting times in at least 90% of specialities will be at least as good as neighbours	COO	OMC Transformation	Difficulty in accessing data Capacity to recover 18 week position post validation for some non admitted specialities will dominate improvement trajectory / profile .	Improvement plan at speciality level to achieve maximum 6 week standard for March 2014. OP will be a major transformation work stream next 2 years and will prioritise at specialty level a further improvement	OP score card Patient survey	Benchmarking against top quartile / local competitors	Benchmark to be completed	Q4		**20**	**16**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				trajectory. Cardiology in turnaround programme to support improvements.							
Deliver Year 1 of the Dementia Strategy and support to carers	CN	Quality and Safety	Environmental works not being completed by deadline of 31st March 2014. Delay in recruitment of Activity co-ordinators and use of DTRS software. Non-achievement of quality and CQUIN standard of 90% in 3 consecutive months of the memory screening tool.	Project team continues to negotiate with Group directors and contractors timescales. Staff have been booked as agency staff to increase activity and DTRS delivered to MFFD ward for use. Waiting EBMS icon All adults to be asked memory screening question	2 weekly environmental meetings Weekly audit instead of monthly Confirm and challenge meetings with CN	N/A	N/A	By end of Quarter 4	DH conditions on environmental monies received. CQUIN agreements	**15**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			Survey of carers developed and distributed to wards - poor uptake and return.	On-going raising awareness of carer survey							
Increase the range of alternative models to face to face contact	COO	Clinical Group review	Lack of engagement of multi professional team including those across organisations. Lack of robust of IT systems to facilitate change Resistance to change Lack of leadership capacity and capability to deliver changes	Review of District Nursing teams for 2014 with an new MDT approach to providing care across localities. New technology to support contact with patients in homes (with health and social care) . Readmissions taskforce redesign: new professionals and contacts designed as part of discharge pathway eg psychologist for long term respiratory patients	Review/ reporting of development programmes eg pace setting board, readmissions taskforce. The new Clinical Group of Community and therapies was established in October. This group needs time to establish but will be pivotal to leading this objective.	There is not a programme approach to managing mong terms conditions	Programme approach to long terms conditions – will be established for transformation theme in 2014.	Review Q4		**16**	**12**
Pilot the process of developing GP letters with a view to providing	COO	Elective access meeting	Management of the backlog of letters Management of change	Digital dictation and electronic sign off process tested with	Specialty level score card developed.	The digital dictation system needs full roll out	Schedule roll out for Q4	Q4		16	9

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
patients and GPs with clinical letters within two working days			and acceptance of technology	good outcomes OP standard agreed.							
Develop comprehensive marketing plans for at least three services	DSOD		Failure to develop comprehensive marketing plans for at least three services resulting in the inability to actively promote and target services to particular audiences	Criteria identified and process commenced	Programme commenced and initial work in developing marketing strategies has started	Programme for wider strategy development not established	Additional interim resource to support this process secured	March 2014		9	6
STRATEGIC OBJECTIVE 3: CARE CLOSER TO HOME											
Reconfigure a number of services across acute & community to provide integrated care	DSOD	MMH & Configuration CLE Sub Committee Configuration Board Committee	***Delay in reconfiguration across & community will Continue to:*** Duplicate services, assessment, investigations etc.; Offer patients disjointed services in an acute central service when care closer to home may be possible. ***Delay in acute service reconfiguration cross***	Change in management structures to combine specialist community services with relevant specialist acute service & combine acute and community therapy services in one clinical group Agreed process for reconfiguration Early & on-going	Bi-monthly reports to Configuration Board Committee (from Oct 13)		Clarify how new structures (in Medicine & Emergency Care and Community & Therapies) will deliver greater integration across acute and community. Early identification (via Specialty Strategies) of potential reconfiguration. Oversight by MMH & Configuration	Q4 Q3 & on-going Bi monthly from Nov 13	2013/14 annual priority: to reconfigure a number of services across acute & community to provide integrated care	**16**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			site could impact on sustainability of the service ahead of MMH. ***Reconfiguration itself*** may have an adverse impact on sustainability.	staff engagement & liaison with JHSC, CCG, GPs, patients and any other key external stakeholders Robust project management methodology & reporting with relevant external Gateway Reviews Formal public consultation where appropriate External Benchmarking/ cross reference			CLE Committee.				
Implement a number of 'Right Care, Right Here' pathways	DSOD	MMH & Configuration CLE Sub Committee Configuration Board Committee	RCRH pathways are not implemented or delivered or activity significantly departs from the trajectory. Adverse impact on delivery of QIPP savings and relationships with GPs/CCG.	QIPP Savings target embedded in 2013/14 contract along with broad scheme headings. Contract for 2013/14 includes block contracts with	Regular QIPP scheme meetings with external stakeholders	Corporate overview of progress Clear implementation plans at specialty level	Bi-monthly reports against RCRH trajectory to Configuration Board Committee Clear process for implementation of agreed POLCV agreed with CCG via Joint Clinical	From Dec 13 Q4	Risk: 1107EXE09	**16**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				tolerance thresholds Income removed within SWBH financial plan & level of TSP takes account of this loss of income Agreed list of procedures of limited clinical value. . Activity reduction targets based on benchmarked data RCRH pathway review programme and governance structure			Commissioning Group Respond to new commissioning specifications for RCRH pathways - Dermatology. Agree revised Activity and Capacity Model that underpins LTFM with CCG. Implement new model of care in Diabetes.	 Q4 Q3 Q3			
Implement a virtual ward in the community	COO	Clinical Group review	Optimising model to establish impact across the entire health and	Virtual ward mechanism set up	Activity review	Measuring well what we are doing	Dashboard to be developed to better	Q4		16	9

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			social care economy.	For formal review in Q4.		through an integrated dashboard.	measure what and how we are doing. .				
Establishing 15 wte Health Visitors posts and reduce caseload	CN	Health Visitor Steering group	NHSE reported that there was a very poor legacy document from Sandwell PCT regarding financial agreements for HV plan. Resulted in NHSE not having sufficient funds to support HV growth and the service is using the vacancies to support newly qualified HV for January. Whilst we are on track against plan NHSE informed us that we are to count staff who are not in the HV establishment. For example named safeguarding nurses. This will NOT bring down the HV caseloads. This equates to an additional 2500 families that would	Issue reported through risk and governance processes in the Trust. Raised with NHSE at HV steering group.	Minutes from meetings Risk register	Not applicable	Not applicable	Not applicable		**12**	**9**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			need to be distributed to the HV service.								
STRATEGIC OBJECTIVE 4: GOOD USE OF RESOURCES											
Deliver Year 2 of the Transformation Programme without compromising safety and quality of care	COO	Finance and Investment and Quality and Safety Committee	Capacity and capability to transform across an organisation	Review transformation plan for next 2 years with external support. Redefine work streams Develop with leadership programme development of transformation and change management skills	TPRS including QIAs Dashboard Committee reports	Not applicable	Not applicable	Not applicable		**12**	**6**
Deliver a 1-2% surplus	DFPM	Finance & Investment Committee considers this ad other financial risks as a standing item on its routine agendas	Unforeseen reductions in income where activity falls well below plan. Excessive costs owing to capacity and/or recruitment constraints. Non delivery of annual efficiency savings plans.	Risk sharing agreements with commissioners. Use of contingency reserves. System of close monitoring and requirement to identify mitigating savings schemes.	Preparation and presentation of detailed financial reports (TB) and transformation plan progress reports to F&I.	Contract review meetings planned with main commissioner to review activity and performance as its position is under pressure.	Gaining clarity internally and externally on final winter pressure allocation funds and outturn forecasts so that each party can executive financial management strategies.	Q4 – 13/14	Use of Resources	**12**	**6**
Enable clinically-led decision-making	DFPM	Clinical Leadership	No decision on the systems required to	SLR information provided to F&I	MD&FD finalised front	Timeline in development for	Internal resourcing case agreed.	6 month implementati	Use of Resources	**8**	**6**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
processes via SLR as part of SLM		Executive via the AAF (autonomy & accountability framework)	support the absorption of SLR into performance management regime which supports the AAF. Sufficient personnel in place to move project forward.	Committee as well as incorporated into Group reviews and ultimately CD based reviews. Temporary staffing specification being scoped.	end system procurement decision made. Technical group established.	integration of costing systems with front-end SLR reporting.	Consider secondments and/or use of temporary external personnel	on planned.			
STRATEGIC OBJECTIVE 5: 21ST CENTURY FACILITIES											
Refresh the financial modelling for MMH via PF2	DFPM	F&I committee 22nd November 2013, Trust Board 28th November 2013	Inability to identify an affordable solution and identify acceptable efficiency levels. Ensuring sufficient capacity with central planning team.	Construction of base and mitigated downside LTFMs with robust assumptions and plan detail supporting plans. Incorporating a ceiling limit on MMH capex and resultant UP.	Culminating presentation of detailed planning papers at committee and Trust Board with disclosure of planning parameters and costs	Further work ongoing on vfm elements of PF2	Project Director preparing output of risk transfer work to compliment other considerations by the Board	Q3-13/14	21st Century facilities	**8**	**6**
Maintain estates compliance with CQC Outcome 10 (Safety & suitability of premises) and 11 (safety, availability and suitability of equipment)	DENHP	CQC External Assurance – Capita	Failure to demonstrate compliance and/or actual failure of environmental issue impacting on patient care	Risk management and safe systems of works	Appointment of external assurance company	None identified	Not applicable	Not applicable		**9**	**6**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Invest in the estate through capital schemes to support clinical strategy and in particular Pathology, Endoscopy & Stroke	DENHP	Configuration Committee	Failure to meet capital programme and environmental improvement	Implementing robust project management arrangements	Project plans. Project cash flow	Not achieving planned cash flow	Performance management of Capital Project Leads	Ongoing		**6**	**4**
STRATEGIC OBJECTIVE 6:	**ENGAGED & EFFECTIVE ORGANISATION**										
Deliver the milestones in the Foundation Trust timeline	DSOD	FT Programme Team	Failure to deliver milestones and adhere to key timescales as agreed with the TDA. This will result in escalation of the Trust's progress with the FT application to the NTDA respectively	Dedicated programme management in place Review of milestone delivery fortnightly at FT programme Team Monitor delivery of Integrated Development Plan (IDP) on a monthly basis which looks to incorporate	Progress monitored and escalated via FT Programme Team on a fortnightly basis	None identified	None identified	July 2014		**20**	**8**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				all areas of work/actions required to support delivery of a successful FT application							
		FT Programme Team	Alignment of the Trust's FT application with MMH timescales given the overlap between required outputs for both processes	A review of timescales for both processes has been undertaken A high level project plan incorporating both programmes has been developed to ensure key activities and dependent activities are aligned A revised timeline for FT has been developed and informally	Progress monitored and escalated via FT Programme Team on a fortnightly basis	None identified	None identified	July 2014		**20**	**16**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				agreed with the NTDA which ensure the scheduling of key deadlines for both processes are harmonised.							
Improve the Trust's performance in the National Staff Survey	DSOD	Workforce Delivery Committee Workforce & OD Committee	Reputational risk if staff do not advocate their service and place of work Poor regulatory performance ratings e.g. CQC	Implement Workforce strategy through annual work programme 2013/14 Continue to embed LiA methodology Implement staff survey improvement action plan	Staff survey outcomes (annual NHS staff survey and monthly employee polling through 'Your Voice'	Poor response rates to staff surveys means that there is limited information available to gauge opinion	Enhance communication process for surveys Robust feedback and action planning process ('You said, we did')	31-Mar-14	National staff survey Reports presenting results of 'Your Voice'	**12**	**8**
Review of Health Informatics systems and capabilities	MD	IT Committee	Network resilience EPR Re-procurement: Exit and service transition to anew provider.	Network review in progress and planning is in place to upgrade the network. An EPR procurement team will be	Reporting to the IT Committee	No gaps identified at the moment	No applicable	Network Review will report in December 2013 and upgrade delivery will commence in Q4 2014 and complete in		**12**	**8**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				established in Q4 2014				2015.rt in December 2013 and upgrade delivery will commence in Q4 2014 and complete in 2015. Trust will re-procure EPR solution by July 2016			
Attain 10% better than the national mean for sickness/ absence rates	DSOD	Workforce and OD Assurance Committee	Adverse impact of sickness absence on quality of care, staff satisfaction and cost.	Detailed action plan. Including: Focused attention on hot spot areas. Rigorous delivery of key sickness absence stages. Management training. Case management of non-nursing/midwifery long-term sickness cases from 3 months plus. Case management of	Action plan monitored via Workforce Operational Committee. Group performance monitored via Group Reviews. Trust sickness % for nursing and midwifery has deteriorated from 4.69% in April '13 to 5.07% in Sept '13 which triggered the decision to case	Key issue identified is timely and consistent management intervention in accordance with policy requirements and inability for current systems to easily record/report.	Delivery of IT system is seen as critical to support this and enable focused case management activity. An IT solution is being developed with Kronos Ltd through SMART.	Q2 2014	Reported in the corporate performance dashboard on a monthly basis	**9**	**6**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				nursing and midwifery long term sickness cases from 1 month plus Development of an IT solution to support managers. Table top review of cases longer than 9 months.	manage nursing and midwifery sickness cases from one month. National information centre is currently reporting national sickness data up to March '13 - for nursing, midwifery and health visiting as 4.72%. Learning from Table Top Reviews shared with Group managers and HR team and where appropriate guidance material and training updated accordingly.						
Identify three Beacon Services: Gastroenterology	MD	Autonomy & Accountability framework-	Services performance both in quality and performance terms	Monitoring the Beacon Services performance	The BSs are required to provide	Specifically noting the services as BS's	Cross reference performance issues across all	quarterly	Exec review action notes	**4**	**4**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Breast Gynae Oncology		Executive review	drops below excellent standards. Services unable to access innovation funds due to financial constraints and bureaucracy. Prepare for the next round of Beacon Status services	across the qualitative and quantitative measures stipulated in their bids to attain Beacon status on quarterly basis. Planning the selection cycle well in advance of commencement of the required work. Working with Comms to ensure potential services are ready and prepared to submit bids.	evidence to achieving performance targets against plan. Utilising the A&A Framework Patient feedback and patient experience work. Regular Exec review with MDO team Project plan generation and progress checking.	at their exec performance reviews (although we might be). Seeking plans for further improvement.	domains in the Quality & Safety strategy as well as measuring against a variety of standards eg CNST, CQC, CQUINs, best practice standards.				

KEY:

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

RISK SEVERITY MATRIX

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

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

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

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

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

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Equality & diversity – interim position statement
SPONSOR (EXECUTIVE DIRECTOR):	Linda Pascall – Interim Chief Nurse
AUTHOR:	Linda Pascall – Interim Chief Nurse
DATE OF MEETING:	19 December 2013

EXECUTIVE SUMMARY:

This report summarises the Trusts position in delivering the framework for Equality and Diversity (E&D) and continues with a summary of the implications of the changes in Legislation relating to Equality as a consequence of the introduction of the Equality Delivery System [EDS].

REPORT RECOMMENDATION:

The Trust Board is asked to receive and accept the report, noting that it will be asked to sign off the declaration of compliance against the Equality Delivery System [EDS].

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:

Statutory compliance with Equality legislation

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	***Equality & Diversity – interim position statement***
Meeting	***Trust Board***
Author	***Linda Pascall, Interim Chief Nurse***
Exec Lead	***Linda Pascall, Interim Chief Nurse***
Date	***11th December 2013***

1. Executive summary

This report summarises the Trusts position in delivering the framework for Equality and Diversity (E&D) and continues with a summary of the implications of the changes in Legislation relating to Equality as a consequence of the introduction of the Equality Delivery System [EDS].

In Quarter 4 2-13-14 the Board will be asked to sign off its annual declaration of compliance. This report is therefore background preparatory material for that. We would anticipate that, via the new Board Committee on Public Health, Community Development and Equality a revised strategy and set of objectives for 2014 onwards will be proposed to the full Board in due course.

2. Progress from Original Framework

The Equality Act 2010 came into force on 1st October 2010 included a Public Sector Equality Duty [PSED] which requires Organisations to publish their equality monitoring data and Equality Objectives. The change in legislation has resulted in the introduction of the Equality Delivery System [EDS] which was developed for the NHS with the aim to "drive up equality performance and embed equality into the mainstream of NHS Business and assist compliance of duties under the Equality Act".

The Trusts original approach to E&D was through agreeing 6 objectives to allow a focus on key service delivery elements. Delivery of these objectives was monitored by the E&D steering group chaired by the Chief Nurse. However this group was subsequently dissolved on the basis that the Divisional leads [now Clinical Groups] would be responsible for monitoring delivery.

Originally, there were three subgroups reporting into the E&D steering group; Workforce, Policies and Assessment and Local Interest Group formerly known as 'Independent Living' each chaired by a senior manager. This structure provided leadership, monitoring and reporting functions to give assurances to Trust Board. These groups have also ceased to meet. The sub-structure beneath the CLE sub-committee on equality will be confirmed at its meeting in January.

Current objectives

Establish Robust Governance structure and process to support the delivery of Equality, Diversity and Inclusion.

The Trust has a duty to ensure that its service and policies meet the requirements of the Equality act and this responsibility is delegated to managers of a service to ensure they are compliant. A Toolkit has been developed and implemented to support managers in completing assessments in line with the general duty.

A monitoring system is in place which ensures that all policies have a completed EqIA prior to ratification. Existing policies are EqIA at their review.

As part of the Transformation Reporting System a comprehensive database has been developed which will hold all EqIA information in the future, thereby replacing the existing central database.

An Escalation protocol is in place to ensure outstanding issue/adverse impact identified following a full EqIA assessment is resolved or reasonable adjustment put in place to minimise the impact of the issue. This action is the responsibility of the Division now Clinical Groups to ensure that their services meet the requirements within the Act.

I would suggest our position on this is relatively strong.

Improve the Trust Service Users' Equality Monitoring data and completion rates.

Patient information can be disaggregated based on ethnicity, gender, age, marital Status and religion. Information on sexual orientation, disability and gender reassignment is not captured on a regular basis due to constraint on the current national Patient administration System [PAS] and therefore the data is limited.

Improvements in the level of monitoring are as a result of focus staff awareness training and monitoring. However analysis of the data supports the need for continued training and monitoring building staff confidence to address the sensitivity within this field.

The Equality and Diversity adviser continues to work closely with Health Informatics to actively address the gaps in equality monitoring across the organisation.

I would suggest that this needs enhanced work to be picked up within our data quality workstream/

Improve the Trust Equality Monitoring data for Staff

[awaiting feedback from Lesley B]

I would suggest major improvements have been made in the last 18 months.

Ensure Equality, Diversity & Inclusion is embedded at all levels throughout the trust

In April 2012 Equality & Diversity training became part of the Trust Mandatory training programme. This is complemented by other training programmes such as Trust Induction, Conflict resolution, harassment & bullying continues to deliver components of E&D within their contents. An E-Learning Module is also available for staff the uptake of which is predominantly from within the medical staff groups.

In addition to this the E&D adviser delivers E&D awareness training sessions throughout the organisation

EqIA education is delivered on a rolling basis for all relevant managers.

Delivery is tracked within our mandatory training framework – see below.

Ensure staff are culturally competent and confident in the provision of care delivery, promoting and maintaining dignity, respect and inclusion at all times.

As referenced earlier in April 2012 Equality and Diversity became one of the Trust Mandatory training programs with a trajectory target of 95% compliance by March 2015. The current overall Trust compliance is 87.89% which equates to 6341 out of a total of 7215 staff who are currently compliant.

Ensure that services are designed and delivered in ways that meet the needs of our service users to ensure quality of outcomes and experiences in the Trust.

Rollout of the Equality Delivery System: The Services that have gone through the formal equality performance RAG rating workshops during 2012, have been graded as Amber (developing) or Green (Achieving), where there are Red (underdeveloped) ratings, action plans have been developed to address issues/concerns. The overall ratings at appendix 1 below illustrate that compliance within the equalities agenda is visible however there is no room for complacency as there is much work to be done.

3.Current Service provision

Following the decision of the Band 8a Head of E&D to take Voluntary Early Retirement [VER] in June 2013, the proposal is to create a new post as a result of combining the roles of Head of E&D and Patient Experience Lead.

The team, which is currently being managed on a temporary basis by Glynis Fenner – Manager of the Trust Nurse/Interpreter bank supports the Trust to achieve Equality legislation compliance. The team has been successful in raising the profile of Equality & Diversity within the organisation, as part of embedding the principles into practices and behaviours. Over the last couple of years some of the key successes for the E&D team have included:

- An internal audit review 2011/12 of Equality and Diversity was completed by the Audit Committee. The outcome was that significant assurance can be given on the design and operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives.

- An established system is in place to support the Equality Impact Assessment process for all services, policies and function. The toolkit, developed by the team, is regularly reviewed in line with user feedback and legislative changes. There is an established Equality Impact Assessment database which is maintained centrally by the team. The database currently has a total of 768 completed EIA's which comprise of 177 services, 295 policies, 5 functions and 291 TSP's.

- Rollout of the Equality Delivery System. The Services that have gone through the formal equality performance RAG rating workshops during 2012, have been graded as Amber (developing) or Green (Achieving), where there are Red (underdeveloped) ratings, action plans have been developed to address issues/concerns. The overall ratings at appendix 1 below illustrate that compliance within the equalities agenda is visible however there is no room for complacency as there is much work to be done.

- Supporting improvements in the workforce equality monitoring data through staff questionnaire.

- Supporting improvements in service user monitoring data through awareness training and target campaigns.

- Influencing service and care delivery through community engagement user feedback.

4.0 Activity

Currently the team (which currently comprises of 1 band 5 member of staff) is responsible for ensuring that the trust is kept abreast of relevant legislative changes, national and regional updates including any specialist E&D information. The E&D adviser provides one-to-one support to staff, training and awareness sessions and act as a conduit for information exchange which includes:

- Trust Induction Training
- E&D mandatory training programs [KSF levels)
- Bespoke E&D training session
- Equality Delivery System workshops and Assessments
- Group support with Equality Impact Assessments training
- Equality Impact Assessments reviews and approval, including TPRS schemes.
- Evaluation of Training programs
- Community Engagement program
- Equality & Diversity Resource Pack
- Sandwell and West Birmingham local demography report.
- Organisational support of health promotion events
- Individual staff support
- Update & maintain Equality & Diversity Information boards
- Provide progress/assurance reports
- Support the 'Staff Equality Reference Group'
- Manage E&D Website
- Plan, organise, deliver and evaluate annual E&D Staff conference.
- A member of the Sandwell Interagency Group.
- A member of the Sandwell EU Community Network group.
- A member of the Sandwell Equality Leads Network group.
- Roll out of the Equality Delivery System.

5.0 Transformation Plans [TPRS]

This is a 5 year plan designed to improve the quality and safety of the Trust's services whilst meeting demanding national efficiency targets.

The Plan also helps us to deliver our part of the Right Care Right Here Programme and plans for the new hospital, but the scale of the overall challenge is the same across the whole of the NHS. The scale of the Transformation Plan is ambitious in that it aims to save £125m over 5 years i.e. £25m per year.

The Plan is made up of large scale projects, each with targets to achieve in each of the 5 years all of which are held on a central TPRS database. Each of these schemes need to include a completed and approved Equality Impact Assessment. A breakdown by year is as follows

- 2014-15 List of Projects with Equality Impact Assessment = 350
- 2014-15 List of Projects without Equality Impact Assessment = 19
- 2015-16 Number of Projects without Equality Impact Assessment = 28
- 2015-16 Number of Projects with Equality Impact Assessment = 112

Total = 509

6. Changes in Legislation

The Equality Act 2010 came into force on 1st October 2010; it has harmonised existing discrimination law and also strengthened the law to support progress on equality. The Act established a new public sector Single Equality Duty which has replaced and simplified three separate duties that require government departments, local authorities and other public bodies to take into account gender, race and disability equality both as employers and when making policy decisions and delivering services. The duty also extends protection to cover age, religion & belief, sexual orientation and gender reassignment.

As a public body organisation we have a **general duty** when carrying out our functions to have due regard to the need to:

- eliminate unlawful discrimination, harassment or victimisation;
- advance equality of opportunity; and
- foster good relations

The general duty is underpinned by a number of specific duties requiring us in the main to publish equality monitoring data.

In line with the Public Sector Equality Duty the Trust published its 4-year Equality Objectives in April 2012. The priorities were based on the grading of the equality analysis supported by the implementation of the EDS framework. We will review those goals again in Q4 2013-14.

The EDS is a set of nationally agreed objectives and outcomes comprising of 18 outcomes grouped under the following 4 objectives:

Better health outcomes for all
Improved patient access and experience
Empowered, engaged and well-supported staff
Inclusive leadership at all levels

The grades are RAG rated according to the following categories:

Excelling	-	Purple
Achieving	-	Green
Developing	-	Amber
Undeveloped	-	Red

The EDS programme was piloted within two community services and went through the grading sessions with both the internal SWBH Local interest group and the Black Country Cluster. Both services were graded as achieving **[Green**] overall. Based on the success of the pilot programme, the implementation plan is currently being rolled-out across all divisional areas within the Trust, clinical and non-clinical.

The implementation of the EDS delivery framework is supported by the SWBH Local Interest Group [formerly the Independent Living subgroup] and its progress was monitored by the Equality and Diversity Steering Group.

The SWBH Local Interest Group [LIG] membership consists of members of the public, service users and staff. Their function is to support and influence organisational compliance with the Equality legislation which includes working with and influencing the Trust equality performance assessment EDS goals.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD

DOCUMENT TITLE:	EPR Procurement
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Fiona Sanders, Interim CIO
DATE OF MEETING:	19 December 2013

EXECUTIVE SUMMARY:

The attached paper outlines the role of the EPR procurement team the re-procurement of the Trust's replacement EPR. It is presented for information purposes.

REPORT RECOMMENDATION:

The Board is invited to receive and accept the report.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

Financial	**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:

The submissions to the NHS Technology Fund are in line with the :

1. Informatics Strategy
2. The Trust Annual Plan
3. Right Care Right Here
4. Transformation Plan

PREVIOUS CONSIDERATION:

The Sandwell and West Birmingham Hospital NHS Trust Informatics Strategy 2012 to 2017 Version 0.2 was presented to the Trust Board in September 2012.

SWBTB (12/13) 256 (a)

Trust Board: Delivering the Informatics Strategy

Date: 9th December 2013
Version: 2.0
Authors: Fiona Sanders (Interim CIO)

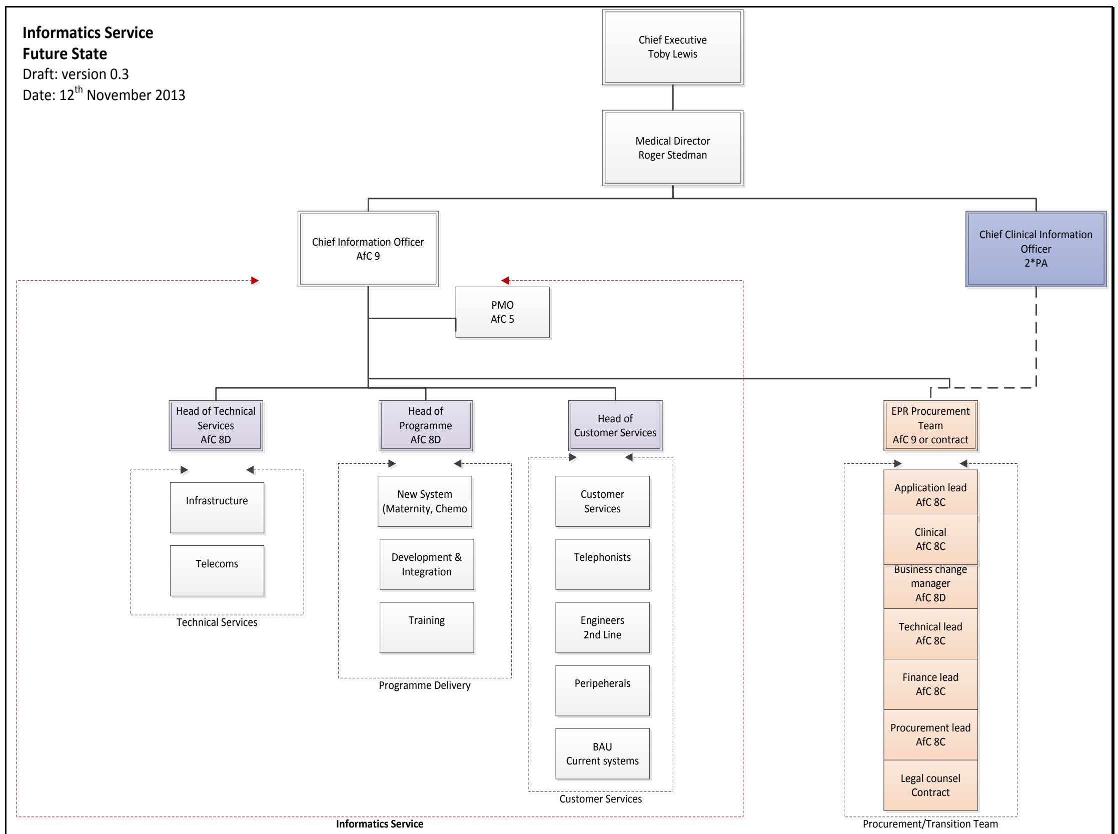
1. EPR procurement Team

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.

The Trust is in the process of establishing the procurement team that will lead the re-procurement of the EPR solution. This procurement team will be responsible for overseeing the full procurement lifecycle. Funded from within the HIS lifetime financial model it will be a team developed to ensure that the EPR meets the clinical and technical needs of the Trust and that it meet our future operating model. Representative of stakeholders and supported by technical, financial and legal skills this team will be responsible for reprocurement and alignment of benefits. In addition this team will also be responsible for the transfer of service provision between our current supplier to our new supplier.

2. Procurement Team Structure

As part of the ongoing re-configuration of HIS to meet the needs of the Trust, the Trust will establish and resource an EPR procurement team. This team will report to the Chief Informatics Officer and also the Chief Clinical Informatics Officer. The team structure is illustrated in the organisation chart below,



3. Role of the EPR Procurement Team

The EPR procurement team, subject to IAP approval will be responsible for managing the procurement from requirements, through the competitive dialogue and through to supplier selection. A summary of these steps are identified in the table below, along with the outline tasks

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	**Who will do this?** This is team is vital, they must be

Phase Headline	Activity	Why are we doing this?
	clinical leadership which is there to ensure that the solution is procured is meets the needs of clinical and non-clinical stakeholders	representative of stakeholders and ensure that they are empowered and representative of the organisation
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

Phase Headline	Activity	Why are we doing this?
		our services and is essential to high quality safe patient care.
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?**

4. Action required

This paper is presented to the Trust Board for information and to advise the board of the status of the procurement team.

Sandwell and West Birmingham Hospitals
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – November 2013
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White / Chris Archer
DATE OF MEETING:	19th December 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust, clinical groups and corporate directorates for the period to 30th November 2013.

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

Measured against the DH target, the Trust generated an actual surplus of £82,000 during November against a planned surplus of £57,000. This performance remains consistent with the annual planned surplus of £4,600,000 agreed with the Local Area Team of NHS England.

The cash balances at 30th November stood at £43.2m, £3.0m higher than the planned figure

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Good use of Resources

PREVIOUS CONSIDERATION:

Monthly at Clinical Leadership Executive, Performance Management Committee and by the Finance & Investment Committee on alternate months.

Sandwell and West Birmingham Hospitals
NHS Trust

Financial Performance Report – November 2013

EXECUTIVE SUMMARY

• For the month of November 2013, the Trust delivered a "bottom line" surplus of £82,000 compared to a planned surplus of £57,000 (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 £3,392,000 compared with a planned surplus of £3,073,000 so generating a favourable variance from plan of £319,000, above the Trust's year to date target.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 313 below planned levels. After taking account of the impact of agency staff, WTE's were 53 below plan. Total pay expenditure for the month, inclusive of agency costs, is £303,000 above the planned level, which includes some year to date adjustments.

• The month-end cash balance was £43.2m. Year to date spend on capital is £5.9m.

•The forecast year end I&E position includes an estimate of impairments to fixed assets. This is treated as a technical adjustment and does not affect delivery against the DH target surplus of £4.6m.

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	25	319	>=Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(10)	(7)	>=Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(303)	135	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(274)	(2,223)	<=Plan	<=Plan	>1% above plan
WTEs Actual v Plan	53	(79)	<=Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	3,043	3,043	>=Plan	>=95% of plan	<95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets		
Target	Year to Date	
	Plan £000	Actual £000
Income and Expenditure	3,073	3,392
Capital Resource Limit	13,604	13,604
External Financing Limit	---	3,043
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at November 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	392,651	32,916	33,300	384	261,809	263,474	1,665	392,651
Other Income	38,644	3,279	3,462	183	26,226	26,642	416	38,644
Operating Expenses	(405,573)	(34,377)	(34,954)	(577)	(270,881)	(272,969)	(2,088)	(405,573)
EBITDA	25,722	1,818	1,808	(10)	17,154	17,147	(7)	25,722
Interest Receivable	100	8	11	3	67	89	22	100
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(1,164)	(1,164)	0	(9,308)	(9,308)	0	(16,462)
PDC Dividend	(5,027)	(419)	(389)	30	(3,352)	(3,071)	281	(5,027)
Interest Payable	(2,232)	(186)	(184)	2	(1,488)	(1,465)	23	(2,232)
Net Surplus/(Deficit)	**4,601**	**57**	**82**	**25**	**3,073**	**3,392**	**319**	**2,101**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	2,500
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,601**	**57**	**82**	**25**	**3,073**	**3,392**	**319**	**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 Trust

Financial Performance Report – November 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 £82,000 in November against a planned surplus of £57,000. The resultant £25,000 favourable variance results in a year to date return on income of 1.2%, in line with the plan of a 1.1% return.

Performance of Clinical Groups and Directorates

- Medicine costs for waiting list initiatives and queue busting sessions continue to overspend alongside additional capacity costs.
- Corporate in month reflects a review of security costs at Grove Lane.
- The Central position reflects contingency release and will continue to do so for the remainder of the year where not directed towards specific agreed pressures.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**	**Budget £000**
Medicine	(534)	(1,146)	102,742
Surgery A	(59)	(30)	62,287
Women & Child Health	22	(86)	50,429
Surgery B	(46)	3	25,850
Community & Therapies	(41)	(175)	27,624
Pathology	(44)	(30)	19,902
Imaging	85	296	17,930
Corporate	227	332	86,333
Central	378	832	17,077

Sandwell and West Birmingham Hospitals

NHS Trust

Financial Performance Report – November 2013

The Trustwide in-month favourable variance of £25,000 shows further benefit from overperformance on patient income, including pass through drugs.

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

The Nursing overspend continues to reflect premium rate costs of capacity and issues associated with supporting acuity.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	384	1,665
Other Income	183	416
Medical Pay	(286)	(1,149)
Nursing	(160)	756
Other Pay	143	528
Drugs & Consumables	(387)	(1,440)
Other Costs	113	(783)
Interest & Dividends	35	326

Sandwell and West Birmingham Hospitals

NHS Trust

Financial Performance Report – November 2013

Paybill & Workforce

- Workforce numbers, including the impact of agency workers, are 53 below plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 313 below plan.
- Total pay costs (including agency workers) are £303,000 above budgeted levels for the month.
- Overspends on healthcare assistants and medical staff continue which are partly offset by underspending management and scientific staff budgets.
- Expenditure for agency staff in November was £928,000 which shows no improvement on the previous two months.

Analysis of Total Pay Costs by Staff Group

	Year to Date to November					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	51,025	49,598	0	2,576	52,174	(1,149)
Management	10,271	9,386	0	0	9,386	885
Administration & Estates	21,282	19,161	1,569	833	21,563	(281)
Healthcare Assistants & Support Staff	21,317	19,024	2,780	728	22,532	(1,215)
Nursing and Midwifery	61,042	54,679	2,813	2,794	60,286	756
Scientific, Therapeutic & Technical	29,128	27,912	0	266	28,178	950
Other Pay	203	14	0	0	14	189
Total Pay Costs	194,268	179,774	7,162	7,197	194,133	135

Sandwell and West Birmingham Hospitals
NHS Trust

Financial Performance Report – November 2013

Balance Sheet

•Cash balances at 30th November stood at £43.2m, £3.0m higher than the planned figure. The forecast cash flow for the next twelve months is shown overleaf.

•The forecast balance sheet assumes impairment in the value of tangible assets also reflected in the I&E statement.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013 £000	Balance as at end November 2013 £000	Forecast at 31st March 2014 £000
Non Current Assets	Intangible Assets	924	525	1,421
	Tangible Assets	216,669	213,617	222,401
	Investments	0		
	Receivables	1,048	966	1,000
Current Assets	Inventories	3,604	3,508	3,600
	Receivables and Accrued Income	10,432	15,777	11,500
	Investments	0	0	
	Cash	42,448	43,234	38,335
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(44,857)	(44,434)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(1,111)	(914)
	Provisions	(10,355)	(10,053)	(11,401)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	(3,000)	(2,000)	(1,000)
	Borrowings	(29,263)	(28,164)	(28,706)
	Provisions	(3,168)	(2,668)	(2,648)
		183,385	186,776	187,154
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	161,135
	Revaluation Reserve	34,356	34,355	33,320
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(20,260)	(16,868)	(16,359)
		183,385	186,776	187,154

Sandwell and West Birmingham Hospitals NHS Trust

NHS

Financial Performance Report – November 2013

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT November 2013

ACTUAL/FORECAST	Nov-13 £000s	Dec-13 £000s	Jan-14 £000s	Feb-14 £000s	Mar-14 £000s	Apr-14 £000s	May-14 £000s	Jun-14 £000s	Jul-14 £000s	Aug-14 £000s	Sep-14 £000s	Oct-14 £000s	Nov-14 £000s
Receipts													
SLAs: SWB CCG	20,721	20,700	20,700	20,700	20,700	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978
Associates	6,309	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600
Other NHS income	1,554	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Specialised Service (LAT)	4,547	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750	3,750
Education & Training	4,835		4,750			4,700	0	0	4,700	0	0	4,700	0
Loans													
Other Receipts	2,387	2,400	2,400	2,400	2,400	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800
Total Receipts	40,353	34,650	39,400	34,650	34,650	39,028	34,328	34,328	39,028	34,328	34,328	39,028	34,328
Payments													
Payroll	13,714	13,700	13,700	13,700	13,700	14,200	14,200	14,200	14,200	14,200	14,200	14,200	14,200
Tax, NI and Pensions	9,399	9,400	9,400	9,400	9,400	9,550	9,550	9,550	9,550	9,550	9,550	9,550	9,550
Non Pay - NHS	1,221	1,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200
Non Pay - Trade	11,700	6,600	7,540	7,540	10,104	7,625	7,625	7,625	7,625	7,625	7,625	7,625	7,625
Non Pay - Capital	616	1,257	2,063	2,771	3,793	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308
PDC Dividend					2,075						2,750		
Repayment of Loans					1,000						1,500		
Interest					15	0	0	15	0	0	15	0	0
BTC Unitary Charge	422	428	428	428	428	225	225	225	225	225	225	225	225
Other Payments	867	500	500	500	500	92	92	92	92	92	92	92	92
Total Payments	37,939	33,085	35,831	36,539	43,215	35,200	35,200	35,215	35,200	35,200	39,465	35,200	35,200
Cash Brought Forward	40,820	43,234	44,799	48,368	46,479	37,914	41,742	40,870	39,983	43,811	42,939	37,802	41,629
Net Receipts/(Payments)	2,414	1,565	3,569	(1,889)	(8,565)	3,828	(872)	(887)	3,828	(872)	(5,137)	3,828	(872)
Cash Carried Forward	43,234	44,799	48,368	46,479	37,914	41,742	40,870	39,983	43,811	42,939	37,802	41,629	40,757

Sandwell and West Birmingham Hospitals

NHS Trust

Financial Performance Report – November 2013

Capital Expenditure

- Year to date capital expenditure is £5.9m, mainly on blood sciences, statutory standards and estates rationalisation. Spending has begun on the medical equipment programme, “Winter Must Be Better” and “Dementia Friendly Environment” programmes of ward works and on the HIS programme.
- A review of the programme has been undertaken to accommodate the bringing forward of expenditure in relation to Grove Lane within a pre-existing agreed overall sum.

Continuity of Service Risk Rating

- The previous Monitor Financial Risk Rating has now been retired and has been replaced by the new Continuity of Service Risk Rating. The new financial risk rating position is shown below (out of 4). Revised threshold for liquidity have been published by Monitor which are now reflected in the rating below.
- The in month score of 4 reflects the improved I&E position and increased current assets.
- The forecast year end score is now 3 which reflects a reduced liquidity position.

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	2.11	3	2.52	4	2.64	4
Liquidity	Cash for liquidity purposes * 360/annual operating expenses	0.85	4	0.87	4	-7.91	2
Overall Rating			**4**		**4**		**3**

Transformation Programme

- Governance arrangements for reviewing the deliverability and quality impact assessments of future year’s TSP programmes is being updated in preparation for presentation to the Quality and Safety committee at its meeting in January. Against a target of £20.8m, there is 90% value delivery and the Clinical Leadership Executive has reviewed the position on QIA and EIA status with efforts to complete this work in December underway as part of 14/15 preparations.

NHS Trust

Financial Performance Report – November 2013

Performance Against Service Level Agreement Target

- Performance for April to October is ahead of plan overall , including pass through high cost drugs and direct access imaging and pathology work for GPs. A&E activity is below plan as is the number of births.
- Commissioners have raised a number of queries on the performance to date which are being discussed in the context of the likely year end position on a number of issues such as BPT and the referrals based risk mechanism. Dialogue has also begun about plans for 2014/15.

Sandwell and West Birmingham Hospitals
NHS Trust

Financial Performance Report – November 2013

Key risks

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

• The Trust has been notified that it has been unsuccessful in bidding to retain the school nursing services contract. Officers are working on how to manage the transition to the new provider ensuring the appropriate level of costs are transferred to the new provider.

•Winter plans are being brought into action in conjunction with commissioners. Capacity continues to be run at a premium cost which remains a cause of concern and is the focal point for a number of targeted measures within Medicine.

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

External Focus

•Monitor and NHS England are making 'minor final amendments' to the 2014/15 national tariff document, which it is due to publish before Christmas.

•. Monitor, the NHS Trust Development Authority and the Care Quality Commission has written to the NHS on securing sustainable services for patients. The letter published by Monitor offers an update on the changes to the processes for developing and assessing NHS trusts as they move to foundation status. A CQC inspection is now the first formal part of the assessment process and trusts cannot move to the next stage without a 'good' or 'outstanding' rating. Applications will then move to the TDA and finally Monitor for assessment.

•The Department of Health has published 'Guidance for consolidation of NHS charity accounts into NHS local accounts'. The joint Department/ NHS Trust Development Authority guidance examines a number of areas, including materiality and accounting policy disclosure.

•NHS England has released a further £150m to help trusts ease winter pressures on their A&E departments. The funding, which is in addition to the £250m announced by the Department of Health earlier this year, will be distributed across England, including trusts not deemed the most at-risk. The additional money will come from NHS England's expected surplus for the current financial year.

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:	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:	19 December 2013 (Report prepared 11 December 2013)

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Trust Board is asked to NOTE the report and its associated commentary.

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

PREVIOUS CONSIDERATION:

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

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

EXECUTIVE SUMMARY

External Assessment Frameworks

Performance against metrics contained within the NHS TDA Accountability Framework:

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

Access Metrics:

Emergency Care 4-hour wait performance during November improved on both sites to 95.2% overall for the month. Year to date performance, April - November improved to 94.38%.

Outcome Metrics:

Infection Control - The number of cases of C Diff reported during the month was 3, with number for the year to date increasing to 27, both values being within the respective thresholds. Reported cases of MSSA and E. Coli for the month and year to date are now expressed as a rate per 100,000 bed days, in line with the NTDA metric definition. Both values for the year to date are within operational thresholds.

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

During the month (November) there were 6 **Open Serious Incidents Requiring Investigation**, 6 **Open Central Alerting System** (CAS) Reports identified and 2 **Never Events** recorded.

The Trust failed to meet the operational threshold of 95.0% for **VTE Assessment** during the month, with 94.2% Assessments recorded. Overall compliance by Clinical Group is; Surgery A (93.6%), Surgery B (96.6%), Women & Child Health (92.2%) and Medicine (94.2%).

Performance against all 3 reported components of the **WHO Safer Surgery** Checklist improved during the month of November.

Quality Governance:

A total of 9 **Mixed Sex Accommodation** breaches were reported during the month of November comprising; Coronary Care Sandwell (4), Critical Care Sandwell (3) and Critical Care City (2).

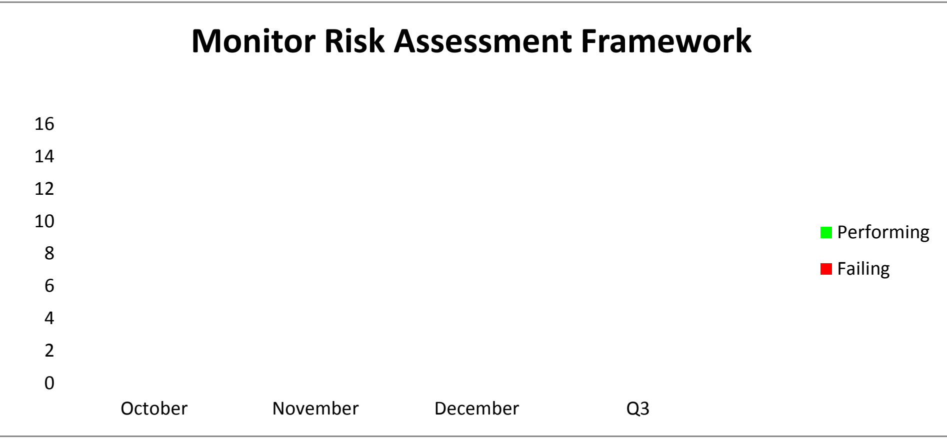
During November the overall **Friends and Family Test** Response Rate decreased slightly to 21.0%, influenced by a reduction in the rate from patients attending the Emergency Department. The overall Score derived from responses increased slightly to 56.

Staff Turnover remains at approximately 11%, well within a relatively wide range defined by the NTDA.

Performance against metrics contained within the Monitor Risk Assessment Framework

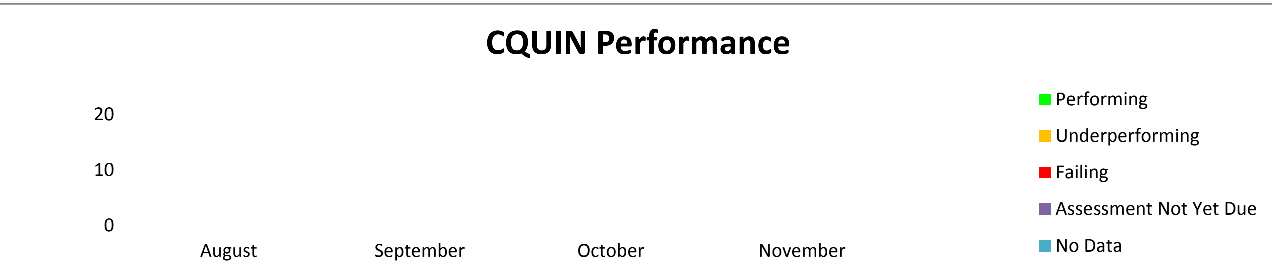
Monitor introduced its ***Risk Assessment Framework*** for NHS Foundation Trusts with effect from 1 October 2013, which replaces its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The metrics are identified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

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



The Trust met / is projected to meet the required operational thresholds for each of the Access and Outcomes indicators. As such the overall weighted score for the month is 0.0, which attracts an GREEN Governance Rating.

CQUIN



CQUIN - A summary of the current performance against the various acute, community and specialised CQUIN schemes is reflected in the table above. Of the 20 summary schemes,15 are performing, with either year to date targets being met or progress in accordance with plan. 3 schemes are currently failing, the expansion of the Friends and Family Test to Maternity services required a 30% response rate during the month of October. The actual response rate was 9.04%, although this has improved slightly during November to 12.3%. A response rate of 65% is required by the end of March 2014 to meet the second milestone for this scheme. The use of sms text messaging, successful elsewhere, is being implemented to improve performance. The second scheme currently failing is Dementia (Find, Assess & Refer), with only 1 of the 3 components of this scheme being met during the month of November. Delivery of this CQUIN requires all 3 components being met at 90% or more, for 3 consecutive months. The assessment process of this scheme is to occur as early as possible within the patient's episode of admitted care, and is now included as part of nursing documentation. Additionally, weekly snapshot audits have commenced, effective late November, the 2 audits undertaken to date show significant improvement in all 3 components; week commencing 27 Nov (Find 91%, Assess 97%, Refer 92%) and week commencing 4 Dec (88% / 93% / 100%). Formal assessment remains monthly. The third scheme failing during the month is VTE Assessment, with 94.2% of patients reported as being assessed during the period. Storage of Medicines is underperforming, the scheme requires improvement from a base of 19.5% wards being fully compliant with all aspects of this standard, to 75% by end Quarter 3 and 90% by end Quarter 4. Compliance assessed at the end of Quarter 2 was 46%. All non-compliant wards are being asked for an action plan to achieve full compliance and action at Corporate level, such as installation of locks on all clean utility areas has taken place. The next formal audit is scheduled to take place this month, although more frequent 'spot' audits are taking place with increased frequency. An initial delay in procurement of equipment and appointment of staff impacted adversely upon progress with certain components of the Dementia Patient scheme, this has now been addressed by the Nursing Directorate, with equipment in place and in use, supported by appropriate personnel. One remaining scheme, Annual Staff Survey, is not yet due for assessment.

Clinical Quality & Outcomes

MRSA Screening - 'Patient Matched' Non-Elective screening performance remains in excess of 90%. Elective performance reduced to 73.2% during the month; performance by Clinical Group was, Surgery A 85.9% (873 eligible patients), Surgery B 92.9% (120), Women & Child Health 98.4%(192) and Medicine 21.7% (346).

WMAS - during November there is a marked reduction in the overall number of ambulances subject to turnaround delays in excess of 30 minutes as reported by WMAS. Particularly delays in excess of 60 minutes improved on both sites. The proportion of clinical handovers completed within 15 minutes continues to remain above the 85% operational threshold, and the average turnaround time, has shown improvement on both sites.

Patient Experience

Cancelled Operations - Elective Admissions cancelled at the last minute for non-clinical reasons remains stable numerically (64) and as a percentage (1.3%). Of the 64 cancellations by Clinical Group, 14 related to Surgery B, 35 Surgery A, 13 Women / Child Health and 2 Medicine. There were no breaches of the 28-day guarantee following cancellation, reported during the month.

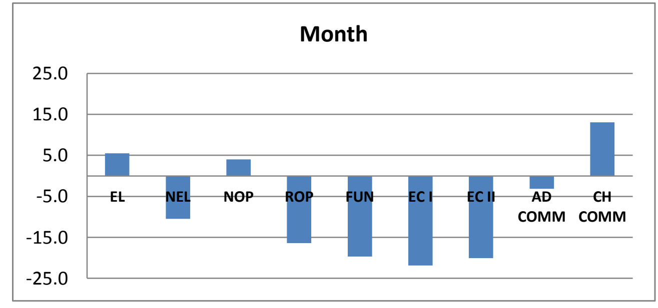
Imaging Turnaround Times - all 4 modalities (Plain Radiography, Ultrasound, MRI and CT) continue to exceed the 90% performance threshold for requests generated by ED. Of particular note is the significant improvement in MRI reported percentages.

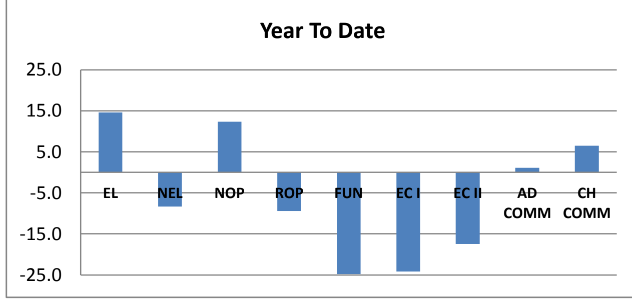
Staff Experience

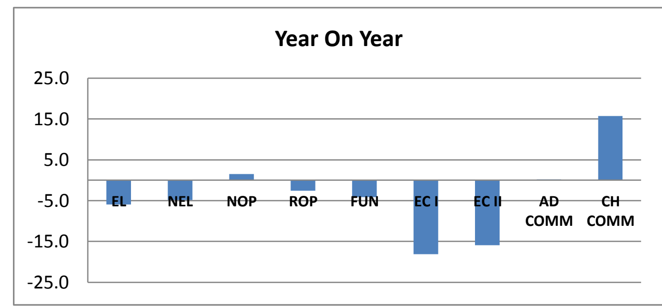
PDR - reported overall compliance is showing limited sign of improvement, and is currently 79.9%. The Clinical Groups overall compliance is 79.6% (range 73.9 - 89.7%) and the Corporate Directorates overall compliance is similar at 80.5% (range 51.2 - 92.6%). **Mandatory Training** compliance remains stable at 86.6%, the range for Clinical Groups is 81.7 - 92.0% and for Corporate Directorates 87.3 - 97.7%. **Nurse Bank and Agency** use continues to remain higher than the corresponding period last year.

Activity & Contractual

Activity - Variance expressed as a percentage between actual activity and planned (contracted) activity is reflected for the month and year to date in the graphs below. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time. High level Elective activity continues to exceed the plan for the month (+5.5%) and year to date (+14.6%), although remains (-6.0%) less than that delivered during the corresponding period last year. Non-Elective activity is currently 8.3% less than the plan for the year to date, and 4.8% less than the corresponding period last year. Overperformance against the New Outpatient activity plan for the year to date (+12.4%) and an underperformance against the Review OP activity plan for the year to date (-9.4%), gives a Follow Up:New OP Ratio of 2.17 for the year to date, significantly less than the ratio derived from plan (2.71), and that for the same period last year (2.26). Type I and Type II Emergency Care activity to date remains significantly less than plan and for the corresponding period in 2012 / 2013. Adult Community and Child Community activity is currently exceeding plans forthe year to date by 1.1% and 6.5% respectively.







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

Exec Lead	KPI Source	Data Source	Category / Indicator			July		August		September		October						November						To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Access Metrics			Trust		Trust		Trust		S'well		City		Trust		S'well		City		Trust			YTD	13/14	Green	Amber	Red			
RB	B*	1	Cancer	2 weeks	%	94.0	▲	95.5	▲	93.9	▼	→				95.8	▲	→						94.5	=>93	=>93	No variation		Any variation	●	94.8	94.7
	B*			2 weeks (Breast Symptomatic)	%	96.2	▲	96.6	▲	97.8	▲	→				93.6	▼	→						95.5	=>93	=>93	No variation		Any variation	●	95.8	95.9
	B*			31 Day (diagnosis to treatment)	%	100	▲	100	■	99.4	▼	→				100	▲	→						99.2	=>96	=>96	No variation		Any variation	●	99.5	99.5
	B*			31 Day (second/subsequent treatment - surgery)	%	100	▲	100	■	99.0	▼	→				100	▲	→						98.7	=>94	=>94	No variation		Any variation	●	100.0	99.2
	B*			31 Day (second/subsequent treatment - drug)	%	100	■	100	■	100	■	→				100	■	→						100	=>98	=>98	No variation		Any variation	●	99.2	99.8
	B*			31 Day (second/subsequent treat - radiotherapy)	%	n/a		n/a		n/a		→				n/a		→						n/a	=>94	=>94	No variation		Any variation	●	100	100
	B*			62 Day (urgent GP referral to treatment)	%	86.2	■	85.3	▼	85.2	▼	→				88.0	▲	→						87.9	=>85	=>85	No variation		Any variation	●	86.9	87.1
	B*			62 Day (referral to treat from screening)	%	96.0	▼	100	▲	93.8	▼	→				96.3	▲	→						97.9	=>90	=>90	No variation		Any variation	●	98.5	96.9
	A*			62 Day (referral to treat from hosp specialist)	%	83.3	■	94.1	■	92.0	▼	→				100	▲	→						89.1	=>85	=>85	No variation		Any variation	●	91.6	93.2
RB	B*	2	Emergency Care 4-hour waits		%	94.7	■	95.5	■	94.7	■	91.7	▼	93.3	▼	92.6	▼	94.9	▲	95.3	■	95.2	■	94.38	=>95	=>95	=>95		<95	●	95.38	92.54
RB	B*	2	Referral To Treatment	Admitted Care (RTT <18 weeks)	%	92.5	▲	92.3	▼	90.1	▼	→				91.8	▲	→						91.8*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
	B*			Non-Admitted Care (RTT <18 weeks)	%	96.9	▼	96.6	▼	95.1	▼	→				96.2	▲	→						96.2*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
	B*			Incomplete Pathway (RTT <18 weeks)	%	92.8	▼	92.2	▼	92.6	▲	→				93.8	▲	→						93.8*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
				Treatment Functions Underperforming	No.	8	▼	7	▲	11	▼	→				10	▲	→						10*	0	0	0 / month	1 - 6 / month	>6 / month	●	10 (Q4)	11 (Q4)
	A			Waits >52 weeks	No.	57	▼	29	▲	20	▲	→				66	▼	→						66*	0	0	<0		>0	●		
RB	A*	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.57	▲	0.61	▼	0.42	▲	→				0.44	▼	→						0.44*	<1.0	<1.0	<1.0	1.0 - 5.0	>5.0	●	0.99	0.88
RB	A	2	Cancelled Operations	28 day breaches	No.	1	▲	0	■	0	■	→				0	■	→				0	■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
	A	2		No. of second or subsequent urgent operations cancelled	No.	0	■	0	■	0	■	→				0	■	→				0	■	0	0	0	<0		>0	●		0
			Outcome Metrics																													
LP	B*	4	Infection Control	C. Difficile (DH Reportable)	No.	5	▲	3	■	4	▼	1	■	1	■	2	▲	1	■	2	▼	3	▼	27	32	46	No variation		Any variation	●	95	37
	A*			MRSA Bacteraemia	No.	0	■	0	■	0	■	0	■	0	■	0	■	0	■	0	■	0	■	1	0	0	No variation		Any variation	●	2	1
	A			MSSA Bacteraemia (rate per 100,000 bed days)	No.	4.6	▼	0.0	▲	4.8	▼	→				17.6	■	→				4.5	■	5.8	=<9.02	=<9.02	No variation		Any variation	●		
	A			E Coli Bacteraemia (rate per 100,000 bed days)	No.	18.5	▲	24.0	▼	4.82	▲	→				30.7	▼	→				35.9	▼	19.1	=<94.9	=<94.9	No variation		Any variation	●		
RB	A	6	Emergency Readmissions (CCS Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Elective or Non-Elective Admission	%	→		→		9.05	Jan'13 - Mar'13	→				→		→				→		9.05*								
	A			Following an initial Elective Admission	%	→		→		3.59		→				→		→				→		3.59*								
	A			Following an initial Non-Elective Admission	%	→		→		13.12		→				→		→				→		13.12*	10.9	10.9	No variation		Any variation	● ●		
RS		3	Mortality Reviews within 42 working days		%	82	■	81	▼	78	■	→						→						78*	80	80	No variation		Any variation	●	66.9	
RS	A	6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate	HSMR	89.1	May'12 to Apr'13	88.4	Jun'12 to May'13	92.2	Jul'12 to Jun'13	→				92.7	Aug'12 to Jul'13	→				93.2	Sep'12 to Aug'13	93.2	100	100	No variation		Any variation	●	88.9	90.5
				Peer (SHA) HSMR	HSMR	97.5		97.5		101.9		→				101.7		→				101.4		101.4								
				Peer (National) HSMR - Quarterly	HSMR	→		→		98.1		→				→		→				→		98.1								
	A	19		SHMI	SHMI	99.2	May'12 - Apr'13	98.1	Jun'12 - May'13	97.2	Jul'12- Jun'13	→				97.8	Aug'12- Jul'13	→				98.1	Sep'12- Aug'13	98.1	100	100	No variation		Any variation	●	96.8	95.9
RS	A	12	Obstetrics	Caesarean Section Rate - Elective and Non-Elective	%	25.7	▼	25.5	▲	26.3	▼	→				23.6	■	→				25.2		25.3	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	A			Caesarean Section Rate - Elective	%	11.2		10.7		8.8		→				10.9		→				10.3		11.2								
	A			Caesarean Section Rate - Non-Elective	%	14.5		14.8		17.4		→				12.7		→				14.9		14.1								
	A			Maternal Deaths	No.	0	■	0	■	0	■	→				0	■	→				0	■	0	0	0	No variation		Any variation	●		
LP	A*	8	Patient Safety Thermometer - Harm Free Care		%	94.2	■	93.0	▼	93.0	■	→				94.0	▲	→				93.7	▼	93.7*	=>92	=>92	=>92		<92	●		

Exec Lead	KPI Source	Data Source	Category / Indicator		July	August	September	October			November			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Outcome Metrics (Cont'd)		Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14	Green	Amber	Red			
KD	A	14	Medication Errors causing serious harm	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	No variation		Any variation	●		
KD	A	14	Open Serious Incidents Requiring Investigation (SIRI)	No.	11 ▼	8 ▲	6 ▲	→		9 ▼	→		6 ▲	6*	0	0	No variation		Any variation	●		2
KD	A	14	Never Events - in month	No.	0 ■	1 ■	0 ■	→		0 ■	→		2 ■	4	0	0	No variation		Any variation	●		2
KD	A	14	Open Central Alert System (CAS) Alerts	No.	6 ▼	6 ■	8 ▼	→		7 ▲	→		6 ▲	6*	0	0	No variation		Any variation	●		10
RS	A*	3	VTE Risk Assessment	%	95.9 ▲	94.4 ■	95.1 ■	→		95.0 ▼	→		94.2 ■	94.2*	95	95	=>90		<90	●	92.4	90.8
RS	A	3	WHO Safer Surgery Checklist / Audit - 3 sections	%	99.8 ▲	99.2 ▼	99.6 ▲	→		99.5 ▼	→		99.7 ▲	99.7*	100	100	=>98		<98	●		
RS		3	WHO Safer Surgery Checklist / Audit - 3 sections and brief	%	92.6 ▲	89.5 ▼	91.6 ▲	→		91.7 ▲	→		94.5 ▲	94.5*	100	100	=>95		<95	●		
RS		3	WHO Safer Surgery Checklist / Audit - 3 sections, brief and debrief	%	76.0 ▲	76.3 ▲	78.4 ▲	→		80.2 ▲	→		85.9 ■	85.9*	100	100	=>85		<85	●		
RB	C	11	Data Quality / Data Completeness Community Services	%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50	=>50		<50	●		>50
LP	C	8	Access to healthcare for people with Learning Disability (full compliance)	Y / N	Y ■	Y ■	Y ■	→		Y ■	→		Y ■	Yes	Full	Full	Y		N	●	N	Y
			Quality Governance																			
RB	A	2	Mixed Sex Accommodation Breaches / As percentage of completed FCEs	%	0.00 ■	0.00 ■	0.06 ■	→		0.13 ▼	→		0.07 ▲	0.08	0.0	0.0	0.00		>0.00	●		
RB	A*	2	Mixed Sex Accommodation Breaches / Numerical	No.	0 ■	0 ■	7 ■	→		17 ▼	→		9 ▲	83	0	0	0		>0	●		
RB			Mixed Sex Accommodation Breaches / Chargeable Days	No.	0 ■	0 ■	13 ■	→		29 ▼	→		17 ▲	161	0	0	0		>0	●		
LP	B	8	Patient Satisfaction (Friends & Family) / Response Rate / Inpatient Wards	%	36.0	31.4	18.7	→		29.2	→		31.4	31.4*								
LP	B	8	Patient Satisfaction (Friends & Family) / Response Rate / Emergency Care Department	%	5.0	5.3	11.6	→		21.1	→		17.1	17.1*								
LP	B*	8	Patient Satisfaction (Friends & Family) / Response Rate / IP Wards plus Emergency Care Department	%	12.0	10.7	13.4	→		23.4	→		21.0	21.0*								
LP	B	8	Patient Satisfaction (Friends & Family) / Score / Inpatient Wards	No.	68	67	72	→		71	→		70	70*								
LP	B	8	Patient Satisfaction (Friends & Family) / Score / Emergency Care Department	No.	49	50	51	→		46	→		47	47*								
LP	B*	8	Patient Satisfaction (Friends & Family) / Score / IP Wards plus Emergency Care Department	No.	61	60	58	→		54	→		56	56*								
RB	B	7	Sickness Absence / Long Term (> 28 days)	%	2.64 ▼	2.78 ▼	2.79 ▼	→		2.78 ▲	→			2.74	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
RB	B	7	Sickness Absence / Short Term (<28 days)	%	1.49 ▼	1.33 ▲	1.49 ▼	→		1.54 ▼	→			1.49	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
RB	B	7	Sickness Absence / Total	%	4.13 ▼	4.11 ▲	4.28 ▼	→		4.32 ▼	→			4.23	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
RB	A	7	Staff Appraisal / PDRs (12-month rolling)	No. (%)	5374 (72.9) ▲	5779 (78.8) ■	5887 (79.6) ▲	→		5925 (79.7) ▲	→		5975 (79.9) ▲	5925 (79.7)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS	A	14	Staff Appraisal / Medical Appraisal and Revalidation	%	81	81	81	→		84	→			84*	No. Only	No. Only						77
LP	A		Nursing Staff / Registered Nurses as percentage of Nurses	%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
LP	A		Nursing Staff / Nurse : Bed Ratio	Ratio	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
MS	B		Staff Turnover / All Staff (Excluding Medical & Dental) - rolling 12 months	%	11.11 ■	11.04 ■	11.09 ■	→		10.92 ■	→			11.07	2.7 - 18.8	2.7 - 18.8	2.7 - 18.8		<2.7 or >18.8			

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

NOVEMBER 2013	CQUINs

Exec Lead	KPI Source	Data Source	Indicator					July	August	September	October			November			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	(green)	(amber)	(red)			
RS	D	3	VTE	Risk Assessment		224	%	95.9 ▲	94.4 ■	95.1 ■	→		95.0 ▼	→		94.2 ■	94.2*	95	95	=>90		<90	●	92.4	90.8
RS	D	5		Root Cause Analysis		224	%	→	→	100 ■	→		→	→		→	100	100	100	100		<100	●		
LP	D	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers	ACUTE	224	%	4 ▲	4 ■	5 ▼	→			→			57	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
LP	D				COMMUNITY	224	%	0 ■	0 ■	0 ■	→		1 ▼	→			3						●		
LP	D	8	Dementia	Find, Investigate and Refer		269	%	1 of 3 met	0 of 3 met	2 of 3 met	→		2 of 3 met	→		1 of 3 met	1 of 3 met*	90% (F, I and R) for 3 consec. months		No variation		Any variation	● ●		
LP	D			Clinical Leadership		45		→	→	→	→			→			Identified	In Place	In Place	No variation		Any variation	●		
LP	D			Supporting Carers of People with Dementia		135		On Track	Survey Undertaken	Survey Undertaken	→		Survey Undertaken	→		Survey Undertaken	Survey Undertaken	Monthly Audit		No variation		Any variation	●		
LP	D	8	Friends & Family Test	Phased Data Collection Expansion - Maternity		137	%	→	→	→	→		9.04	→		12.30	12.30	30	65				● ●		
LP	D			Increased Response Rate (Emergency Care plus All Wards)		175	%	→	10.7	13.4	→		23.4	→		21.0	21.0		>20				●		
LP	D			Improve Performance on Staff FFT		137	Score	→	→	→	Autumn Annual Staff Survey			Autumn Annual Staff Survey				Improvement from 12/13							
RB	D	20	Safe Storage of Medicines			1105	%	→	→	46 ■	→		→	→		→	46	60	90	No variation		Any variation	●		
LP	D	8	Dementia Patient Stimulation			1138		→	→	Progress Delayed	→		On Track	→			On Track	Compliance		No variation		Any variation	●		
RS	D	9	Use of Pain Care Bundles			1138	%	→	On Track	On Track	Baseline August - October		Base identified	→			Base identified	To be agreed		No variation		Any variation	●		
RS	D	4	Use of Sepsis Care Bundles			1105	%	→	On Track	On Track	Baseline Sept. - November		On Track	Baseline Sept. - November		Base identified	Base identified	5% improvement trajectory		No variation		Any variation	●		
LP	D	11	Community Risk Assessment & Advice			1105	%	→	→	Base identified	→		On Track	→			On Track	10% improvement trajectory		No variation		Any variation	●		
RS	D	8	Recording DNAR Decisions			1105	%	→	→	95 Base	→		→	→		→	95 (Base)	Improvement on Q2 base		No variation		Any variation	●		
RS	D	Oct-13	Specialised Commissioners (Quarterly Returns)	Clinical Quality Dashboards		60		→	→	Compliant	→		→	→		→	Compliant	Compliance		No variation		Any variation	●		
RS	D	22		Behcets Highly Specialised Service		60		→	→	On Track	→		→	→		→	On Track	Compliance		No variation		Any variation	●		
RS	D	12		HIV - Communication with GPs		180		→	→	Compliant	→		→	→		→	Compliant	Compliance		No variation		Any variation	●		
RS	D	12		Neonatal - Retinopathy Of Prematurity (Screening)		180		→	→	Compliant	→		→	→		→	Compliant	Compliance		No variation		Any variation	●		

NOVEMBER 2013	CLINICAL QUALITY & OUTCOMES

Exec Lead	KPI Source	Data Source	Area	Indicator	Unit	July Trust	August Trust	September Trust	October S'well	October City	October Trust	November S'well	November City	November Trust	To Date (*=most recent month)	Target YTD	Target 13/14	Thresholds (green)	Thresholds (amber)	Thresholds (red)	13/14 Forward Projection	11/12 Outturn	12/13 Outturn
RS	D	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit	%	95.0	91.5	94.6	→		90.5	→			91.8	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	D			Pts admitted to Acute Stroke Unit within 4 hrs	%	92.1	76.3	72.1	→		68.1	→			73.7	90	90	No Variation	0 - 2% Variation	>2% Variation	●	68.7	59.1
	D			Pts receiving CT Scan within 24 hrs of presentation	%	97.7	96.0	98.1	→		95.9	→			93.0	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	D			Pts receiving CT Scan within 1 hr of presentation	%	72.7	71.1	71.7	→		69.4	→			67.9	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	D			Admission to Thrombolysis Time (% within 60 mins)	%	33.0	67.0	0.0	→		0.0	→			18.2	85	85	=>85		<85	● ● ●		
	D			Admission to Thrombolysis Time (% over 90 mins)	%	33.0	0.0	0.0	→			→			38.9	0	0	0		>0	● ●		
	D			Stroke Admissions - Swallowing assessments (<24h)	%	100.0	100.0	100.0	→		100.0	→		100.0	98.0	100	100	=>98		<98	●		
	D			TIA (High Risk) Treatment <24 h from initial presentation	%	83.3	72.0	75.9	→		65.5	→			72.6	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	D			TIA (Low Risk) Treatment <7 days from initial presentation	%	91.2	92.5	87.9	→		81.1	→			85.7	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RB		3	Infection Control	MRSA Screening - Elective: Patient Not Matched	%	249.9	217.1	253.3	Numerator = 3683	Denominator = 1476	249.5	Numerator = 3523	Denominator = 1553	226.9	226.9*	89	90	No variation		Any variation	●		138.9
				MRSA Screening - Elective: Best Practice - Patient Matched	%	80.7	75.9	89.5	Numerator = 1209	Denominator = 1476	81.9	Numerator = 1137	Denominator = 1553	73.2	73.2*	78	80	No variation		Any variation	●		59.5
				MRSA Screening - Non Elective: Patient Not Matched	%	84.1	87.1	87.9	Numerator = 2090	Denominator = 2336	89.5	Numerator = 2176	Denominator = 2372	91.7	91.7*	89	90	No variation		Any variation	●		76.8
				MRSA Screening - Non Elective: Best Practice - Patient Matched	%	72.6	77.3	90.9	Numerator = 2090	Denominator = 2271	92.0	Numerator = 2176	Denominator = 2355	92.4	92.4*	78	80	No variation		Any variation	●		64.9
LP		14		Falls Resukting In Severe Injury or Death	No	0	0	1	→		7	→		2	20	0	0	No variation		Any variation	●		22
LP		8		Grade 3 or 4 pressure ulcers - avoidable	No	1	1	0	→		0	→			6	0	0	No variation		Any variation	●		
LP		8	High Impact Nursing Actions	Inpatient Falls reduction: Acute	No	57	54	53	→		59	→			379	385	660	=<55/m		>55/m	●		737
				Inpatient Falls reduction: Community	No	8	10	11	→		12	→			73	84	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	0	0	0	→		0	→		0	2	24	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU	%	9.2	9.5	11.0	→			→			9.7	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
				Adjusted Perinatal Mortality Rate (per 1000 babies)	/1000	8.0	5.9	12.2	→			→			12.2*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
	D			Early Booking (Completed Assessment <12+6 weeks): National Definition	%	152.0	110.0	137.0	→			→			137.0*	=>90	=>90	=>90	75-89	<75	●	76.0	78.0
	D			Early Booking (Completed Assessment <12+6 weeks): SWBH Early Booking (Bookings > Births)	%	79.0	78.0	70.0	→			→			70.0*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
LP		2	Infant Health & Inequalities	Maternal Smoking Rates	%	→	→	7.83	→		→	→		→	8.6	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
				Breast Feeding Initiation Rates	%	→	→	76.7	→		→	→		→	76.9	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6
RB		3	Hip Fractures	Operation <24 hours of admission	%	63.0	85.7	81.8	→		89.5	→			89.5*	82.0	85.0	No Variation	0 - 2% Variation	>2% Variation	●	66.4	76.7
RB	D	3	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	93	92	93	→		93	→		92	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES	%	6.8	6.7	7.1	→		6.8	→		9.2	7.2	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)	h : m	4:56	4:34	5:05	→		5:45	→		4:46	5:06	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)	mins	18	16	16	→		20	→		17	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)	mins	51	42	41	→		48	→		43	47	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate	%	8.31	5.75	5.44	→		6.16	→		6.09	6.66	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate	%	4.73	3.35	3.44	→		3.47	→		2.96	3.70	=<5.0	=<5.0	=<5.0		>5.0	●	4.83	4.67
	D			Emergency Care Trolley Waits >12 hours	No.	0	0	0	0	0	0	0	0	0	1	0	0	0		>0	●		
RB	D	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes	%	85.4	85.1	84.9	85.7	89.3	87.7	90.3	89.2	89.7	89.7*	=>85	=>85	=>85		<85	●		71.3
	D			Average Turnaround Time	m : s	27:52	27:57	28:46	30:47	28:01	29:02	26:30	27:21	26:59	26:59*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	D			30 - 60 minutes: All Journeys	No.	1376	1333	1301	748	757	1505	498	755	1253	10868	0	0	0		0	● ● ●		22089
	D			30 - 60 minutes: Hospital Fines (WMAS report)	No.	294	252	123	181	109	290	57	65	122	2194	0	0	0		0	● ● ●		
	D			In Excess of 60 minutes: All Journeys	No.	24	32	50	54	17	71	4	1	5	351	0	0	0		0	● ● ●	1256	2354
	D			In Excess of 60 minutes: Hospital Fines (WMAS report)	No.	12	21	16	44	10	54	1	1	2	203	0	0	0		0	● ● ●		

Exec Lead	KPI Source	Data Source	Indicator		Unit	July Trust	August Trust	September Trust	October S'well	October City	October Trust	November S'well	November City	November Trust	To Date (*=most recent month)	TARGET YTD	TARGET 13/14	THRESHOLDS Green	THRESHOLDS Amber	THRESHOLDS Red	13/14 Forward Projection	11/12 Outturn	12/13 Outturn
RB		21	Reporting Times of Imaging Requests from Emergency Care - % reported within 24 hours / next day	Plain Radiography	%	99 ■	99 ■	98 ▼	→		99 ▲	→		100 ▲	99*	90	90	No variation		Any variation	●		99
				Ultrasound	%	100 ▲	100 ■	100 ■	→		100 ■	→		100 ■	100*	90	90	No variation		Any variation	●		100
				MRI	%	70 ■	84 ▲	65 ▼	→		100 ■	→		93 ▼	100*	90	90	No variation		Any variation	●		84
				CT	%	99 ▲	99 ■	99 ■	→		99 ■	→		100 ▲	99*	90	90	No variation		Any variation	●		99
KD	D	14	Complaints	No. of Complaints Received formal and link)	No.	72	94	86	→		65	→		82	648	No. Only	No. Only					834	724
				No. of Active Complaints in the System (formal and link)	No.	272	254	238	→		201	→		201	201*	No. Only	No. Only						
				No. of First Formal Complaints received / 1000 episodes of care	No.	0.45	0.88	0.52	→		0.36	→		0.45	0.45*	No. Only	No. Only						
				No. of Days to acknowledge a formal or link complaint (% within 3 working days)	%	94 ▲	97 ▲	76 ▼	→		97 ▲	→		99 ▲	99*	100	100	100		<100	●		
				No. of responses which have exceeded their original agreed response date (% of total active complaints)	%	36 ▼	25 ▲	22 ▲	→		33 ▼	→		29 ▲	29*	0	0	0		>0	● ●		
				No. of responses sent out	No.	128	73	78	→		109	→		59	59*	No. Only	No. Only						
				Oldest' complaint currently in system	Days	165	147	150	→		107	→		174	174*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.	13089	11250	13181	→		13978	→			88298	No. Only	No. Only					111793	150454
				Average Length of Queue	mins	0.25 ▼	0.22 ▲	0.39 ▼	→		0.27 ▲	→			0.27*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins	15.5 ■	17.2 ▼	17.3 ▼	→		13.0 ▲	→			13.0*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.	71422	67671	70460	→		76416	→			436561	No. Only	No. Only					849502	901987
				Calls Answered	%	92.2	91.2	91.0	→		90.5	→			91.0	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%	73.8	70.6	72.0	→		71.3	→			68.9	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%	85.4	83.4	84.1	→		83.5	→			81.5	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs	12.3	13.8	12.9	→		13.1	→			13.1*	No. Only	No. Only					25	18
				Longest Ring Time	Secs	411	280	433	→		341	→			341*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days	3.5 ▼	3.5 ■	4.0 ▼	4.1 ■	3.2 ▲	3.6 ▲				3.6	4.3	4.3	No Variation	0 - 5% Variation	>5% Variation	●	4.2	3.8
				Day of Surgery (IP Elective Surgery)	%	96.6 ▲	92.7 ▼	94.9 ▲	95.3 ▼	93.8 ▲	94.4 ▼	91.9 ▼	95.7 ▲	94.1 ▼	94.2	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%	82.5 ■	83.9 ▲	83.7 ▼	82.3 ■	84.5 ▼	83.7 ▼	79.0 ■	83.4 ▼	81.8 ▼	84.4	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.	745	740	754	→		786	→		774	774*								
RB		2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.8 ■	0.8 ■	1.4 ■	1.4 ▼	1.2 ▲	1.3 ▲	2.2 ▼	0.8 ■	1.3 ■	1.0	<0.8	<0.8	<0.8	0.8 - 1.0	>1.0	●	0.6	0.7
	D			28 day breaches	No.	1 ▲	0 ■	0 ■	→		0 ■	→		0 ■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
	D			No. of second or susequent urgent operations cancelled	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	<0		>0	●		0
				Sitrep Declared Late Cancellations	No.	41 ▼	36 ▲	66 ▼	26 ▼	38 ▲	64 ▲	38 ▼	26 ▲	64 ■	382	213	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	2 ▲	9 ▼	10 ▼	1 ▲	6 ▲	7 ▲	4 ▼	1 ▲	5 ▲	5*	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%	12.1 ▲	18.6 ▼	13.6 ▲	→		12.4 ▲	→		13.3 ▼	13.3*	4.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	5.8 ▲	5.3 ▲	5.6 ▼	→		5.7 ▼	→		5.5 ▲	5.5*	3.9	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty: Door To Balloon Time (90 mins)	%	75.0 ■	100.0 ■	90.9 ▼	→		100 (S) ▲	→			88.5	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
				Primary Angioplasty: Call To Balloon Time (150 mins)	%	88.9 ▼	100.0 ▲	95.0 ▼	→		100 (S) ▲	→			92.8	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain	%	100 ■	100 ■	100 ■	→		95.0 ■	→		97.9 ■	98.6	100	100	=>98	96.0 - 97.9	<96	●	99.1	95.7
RB		12	GU Medicine	Patients offered app't within 48 hrs	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	=>98	=>98	=>98	95-98	<95	●	100	100

Exec Lead	KPI Source	Data Source	Indicator			July	August	September	October			November			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	Green	Amber	Red			
MS	D	7	Staff in Post	Establishment	wte	6948	7008	7139	→			→			7139*								
				Staff In Post (contracted)	wte	6490	6496	6528	→		6545	→			6545*								
				Staff In Post (headcount)	no.	7478	7484	7502	→		7527	→			7527*								
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		1.15	→			1.15*								
				Variance (Establishment - Staff In Post)	wte	458	512	611	→			→			611*								
				Qualified Nursing Variance (FIMS)	wte	143	181	236	→			→			236*								
				Posts Advertised in Month (NHS Jobs)	wte	258	178	105	→		158	→			158*								
			Induction		%	93	95	86	→			→			86*	100	100	=>85		<85			91.3
RB	D	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5374 (72.9)	5779 (78.8)	5887 (79.6)	→		5925 (79.7)	→		5975 (79.9)	5925 (79.7)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation		5348	5127
RS		14		Medical Appraisal and Revalidation	%	81	81	81	→		84	→			84*	No. Only	No. Only						77
MS		3		Mandatory Training Compliance	%	87.9	86.4	86.1	→		85.2	→		86.6	86.6	100	100	=>95	90 - 95	<90		71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	2.64	2.78	2.79	→		2.78	→			2.74	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.49	1.33	1.49	→		1.54	→			1.49	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.13	4.11	4.28	→		4.32	→			4.23	<3.15	<3.15	<3.15	3.15-3.75	>3.75		3.90	4.38
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	76.8	78.0	75.9	→		75.0	→		76.0	75.8	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	4842	5457	5265	→		5256	→		5109	40505	31320	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation		56396	60463
				Nurse Agency Shifts covered	No.	1880	1514	1586	→		2452	→		2554	17687	2553	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation		6948	12874

NOVEMBER 2013 | ACTIVITY & CONTRACTUAL

Exec Lead	KPI Source	Data Source	Indicator			July	August	September	October			November			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	Green	Amber	Red			
RB		2	Spells	Elective IP	No.	786	640	726			764			802	5859	6850	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4495	3804	4062			4452			4141	33965	27154	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	5281	4444	4788			5216			4943	39824	34004	50339	No Variation	0 - 2% Variation	>2% Variation		64295	62471
				Total Non-Elective	No.	4687	4537	4402			4742			4562	36522	39568	60931	No Variation	0 - 2% Variation	>2% Variation		55675	56982
			Outpatient Attendances	New	No.	16158	12948	14415			15991			14642	117367	102869	152466	No Variation	0 - 2% Variation	>2% Variation		159051	171540
				Review	No.	32671	29244	30313			32500			30360	254747	278707	410406	No Variation	0 - 2% Variation	>2% Variation		421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	13510	12180	12006	5540	6661	12201	5296	6464	11760	100317	124581	184483	No Variation	0 - 2% Variation	>2% Variation		177201	171701
				Type II (BMEC)	No.	1786	2061	2189		1944	1944		1847	1847	16273	19114	28304	No Variation	0 - 2% Variation	>2% Variation		36362	26649
				All - Contracted plus Non-Contracted	No.	21401	19883	20026	8474	11646	20120	7976	11104	19080	162078	139995	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	49577	46370	45642			49810				328700	325156	540982	No Variation	0 - 2% Variation	>2% Variation		493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	16106	12147	14855			17857				106352	99488	165757	No Variation	0 - 2% Variation	>2% Variation		143400	155412
			Contract	Improvement Notices	No.	0	0	0			1			0	0*	0	0						
RB	D	2	Delayed Transfers of Care	Acute	%	2.7	3.7	3.9	2.3	5.2	3.6	1.6	3.9	2.6	3.3	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0		5.2	2.9
				Pt's Social Care Delay	No.	5	9	14	3	6	9	3	7	10	10*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	13	11	7	5	5	10	4	5	9	9*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.02	2.26	2.10	2.28	1.91	2.03	2.19	2.00	2.07	2.17	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation		2.65	2.23
				DNA Rate - New Referrals	%	12.9	13.9	12.4			12.9			12.2	11.7	10.0	10.0	No variation		Any variation		11.8	11.3
				DNA Rate - Reviews	%	12.3	11.9	12.4			12.6			12.5	10.7	10.0	10.0	No variation		Any variation		11.9	10.3

LEGEND

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

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

FORWARD PROJECTION ASSESSMENT	
● (green)	Maintain (at least), existing performance to meet target
● (red)	**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	
▲ (green)	Fully Met - Performance continues to improve
■ (green)	Fully Met - Performance Maintained
▼ (green)	Met, but performance has deteriorated
▲ (amber)	Not quite met - performance has improved
■ (amber)	Not quite met
▼ (amber)	Not quite met - performance has deteriorated
▲ (red)	Not met - performance has improved
■ (red)	Not met - performance showing no sign of improvement
▼ (red)	Not met - performance shows further deterioration

Sandwell and West Birmingham Hospitals
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Setting Annual Priorities for 2014/15
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy and Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy and Organisational Development
DATE OF MEETING:	19 December 2013

EXECUTIVE SUMMARY:

This report outlines the context for agreeing the Trust's annual priorities for 2014/15 and sets out suggested priorities.

REPORT RECOMMENDATION:

The Board is asked to discuss and agree priorities for 2014/15.

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

Accept	Approve the recommendation	Discuss
	x	x

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

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

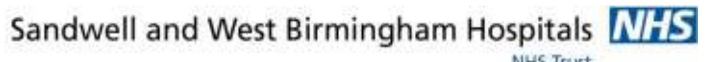
Comments:

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

All priorities are aligned to the Trust's strategic objectives and serve to highlight key areas of focus that will ensure mitigations against key risks are in place.

PREVIOUS CONSIDERATION:

Board seminar discussion of key concerns/risks in October 2013



REPORT TO THE PUBLIC TRUST BOARD

Setting Priorities for 2014/15

Introduction

The purpose of this paper is to seek Board agreement on the priorities for the Trust for the next year. These priorities will inform the production of the detailed Annual Plan for the Trust.

The paper provides context for this discussion as well as proposed priorities

Context

The Trust's Annual Plan serves a number of purposes:

To provide a clear statement to staff and stakeholders of where the Trust's main efforts will be directed over the coming year

To assure the Board that there are plans to deliver the priorities

To ensure that progress is being made towards the long term goals set out in the Trust's Integrated Business Plan

The TDA requires Trusts to submit an Annual Plan. It will issue guidance covering the content of the Plan during the week of 16 December. The first draft return date is 13 January 2014 and the final plan is due on 4 April.

Process for developing the Annual Plan

The final Annual Plan will broadly be driven by:

Delivery of our strategic objectives
Addressing key corporate risks
Directorate annual plans

It will also take into account:

Views of our staff
Views of our Members
Developments in our external environment and the local strategic plan being developed by Sandwell and West Birmingham CCG

At the Trust's Annual General Meeting in September 2013, Members were asked to set out their top 3 priorities for 2014/15. The key themes arising from this feedback include:

Reducing mortality rates
A&E waiting times
Improving infection control
Communication between hospital, GP & Community
Support for frail elderly
Prevention (including education in schools)
Improved links with GPs
Work towards MMH
Communication in connection with service reconfiguration

In addition to Member feedback, the Trust Board Seminar held in October 2013 also focused on areas of significant priority and risk for the organisation. The outputs from this session have also informed the draft list of priorities for 2014/15.

Priorities for 14/15

Following Executive Group discussion, member feedback & Board seminar feedback, the suggested priorities for 2014/15 are as follows:

Safe High Quality Care

Embed a culture of continuous improvement
No never events
Reducing readmissions
Reducing SSI
Friends and Family Test improvements in every service
Rapid response to complaints
Delivery of reliable standardised pathways to improve outcomes e.g. sepsis bundles, screening rates and discharge planning

Accessible & Responsive

Delivery of all waiting time standards – including A&E, RTT, diagnostics, cancelled operations
Deliver reliable urgent care
Quicker, more reliable and standardised communications between hospital , patient and GP patient

Care Closer to Home

Increasing range and quantity of services at Rowley
Devolved model of care for outpatients starting with diabetes
Deliver a new modeal

21st Century Infrastructure

Procure MMH
Develop community facilities strategy
Procure EPR

Good Use of Resources

Deliver current and future TSPs
Improve SLR position
Deliver budget

An Engaged & Effective Organisation

Improved staff engagement scores
Improve uptake of clinical trials
Full uptake of leadership development programme
Compliance with PDR and mandatory training standards
Improved Autonomy and Accountability framework scores

Recommendations:

The Trust Board is asked to:

Discuss and **Agree** priorities for 2014/15

Configuration Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 15 October 2013 at 1300h

Members present		In attendance	Secretariat
Mr R Samuda	[Chair]	Mr G Seager	Mr S Grainger-Payne
Prof R Lilford		Ms D Lewsley	
Mr T Lewis		Mrs J Dunn	
Mr M Sharon			
Mr R White			

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Ms Clare Robinson and Dr Roger Stedman. It was noted that Mrs Hunjan would be joining the membership of the Committee from the New Year 2014.	
2 Minutes of the previous meetings	**SWBCC (10/12) 001**
The minutes of the meeting of the Clinical Reconfiguration Committee held on 9 May 2013 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**Verbal**
Mrs Dunn provided an update on the actions from the last meeting of the Clinical Reconfiguration Committee. It was agreed that Dr Berg should provide an update on lessons learned from the reconfiguration of Pathology services at a future meeting of the Clinical Leadership Executive. Mrs Dunn was asked to provide an evaluation report on the outcome of the vascular services reconfiguration and in particular to outline any ongoing issues and the realisation of the benefits anticipated as part of the initial business case. It was agreed this should be presented at the meeting of the Committee scheduled for February 2014.	
ACTION: Mrs Dunn to provide an evaluation report on the vascular services reconfiguration at the February meeting	

ACTION: **Mr Grainger-Payne to arrange for Dr Berg to present an update on lessons learned from the Pathology services reconfiguration at a future meeting of the CLE**	
4 Terms of Reference – Configuration Committee	**SWBCC (10/12) 003** **SWBCC (10/12) 003 (a)**
The Committee received and adopted its approved terms of reference, which were noted to have been approved by the Trust Board in August 2013.	
5 MMH Project Director's report including status update	**SWBCC (10/12) 004** **SWBCC (10/12) 004 (a)** **SWBCC (10/12) 004 (b)**
Mr Seager presented a detailed project director's report which he advised covered all aspects of the pre-OJEU plan. The Committee was pleased to learn that the organisation's engagement with the architectural redesign of the MMH scheme had been good. It was highlighted that the Clinical Leadership Executive would be presented with an update on the work to date at its forthcoming meeting. In terms of resources, it was reported that there were no major issues to highlight. Regarding the interactions with bidders as part of the procurement process, it was reported that dedicated accommodation was yet to be identified. The premarket engagement was reported to be planned to commence in December 2013. Mr Seager reported that despite an initial view that a full OBC refresh was not needed, it had been decided that a more fundamental refresh may now be required. Mr Lewis reported that an approvals checklist would be made available from the Trust Development Authority (TDA) that referenced back the 2009 business case, which it noted would provide an opportunity to highlight the differences to the revised version. It was noted that the approval bodies needed to take a view on how this was presented in the most effective way. Prof Lilford highlighted the risks with changing the design following the commencement of the building works. Mr Seager advised that although a 10% reduction could not be made across the entire scheme, there were certain elements that could be changed without compromising the overall building plans. Mr Lewis advised that it was possible that bidders may suggest variations to the scheme, some of which may be accepted however if not, the bidders would be obliged to build according to the original proposals. Prof Lilford suggested the due consideration needed to be given to the accommodation due to be developed for the provision of education services. Mr Seager provided reassurance that this consideration was being built into the plans for post and undergraduate students. In terms of assurance, a central repository of evidence was reported to have been created and was currently being populated.	

Mr Lewis reported that in terms of financing, this would be discussed in the context of achieving a Financial Risk Rating (FRR) of 3. It was noted that there was a variance from this position at present, however plans were in place to ensure that the required score would be achieved and was being worked through by the Executive Group at present. It was noted that there would be further discussion of the position at the meetings of the Trust Board in October beyond. It was noted that the discussions and approval needed to synchronise with the timing of the TDA Board meetings. The Committee was advised that the work ongoing with the schemes incorporated the management of the capital plan. Mr Lewis advised that particular focus needed to be given to non-PFI capital expenditure approval. Mr Sharon advised that this should be reviewed as part of the consideration of the Trust's Long Term Financial Model. Mr Samuda asked how car parking was built into the scheme. Mr Seager advised that an underground car parking facility had been incorporated into the model. He added that build costs and income assumptions in respect of car parking had been built into the plans. Prof Lilford suggested that consideration be given to engaging a local provider of car parking facilities. It was highlighted that the support by commissioners for 80% of the planned income would be gained during November. Mr Seager advised that there were no specific unresolved infection control issues that needed to be highlighted, however he acknowledged that dialogue regarding this were ongoing with users and advisers. Mr Sharon reported that in terms of the workforce challenges associated with the scheme, a submission had been made to the Department of Health, based on both 'bottom up' and 'top down' modelling. It was reported that an initial response had requested further detail on the outcome of the 'bottom up' modelling. The Committee was advised that this scale of workforce change was challenging. Mr Sharon advised that the reduction in the number of beds would deliver a significant reduction of costs in terms of workforce. It was noted that renegotiation of the Agenda for Change terms and conditions did not represent a significant opportunity for the Trust to achieve its workforce challenge. It was reported that the proposed seven day working plans was unlikely to facilitate a reduction in pay costs, however the benefits in terms of single out of hours rotas in the new scheme were highlighted. The Committee was advised that lessons from the University Hospitals Birmingham NHS FT PFI scheme were being built into plans where possible. The Committee was advised that the PF2 procurement documentation that had been developed by HM Treasury was being updated to suit the needs of the health service and the Trust's application. In terms of the land acquisition, it was reported there had been no need to evict	

any parties from the Grove Lane site recently. The costs for 'demolition to slab' were reported to be being worked through at present. It was reported that a Freedom of Information request had been received from the Express and Star in terms of how the land purchase was being handled.	
6 Clinical Reconfiguration summary update	**SWBCC (10/12) 005** **SWBCC (10/12) 005 (a)**
Mr Sharon presented a summary of the reconfiguration work that had been undertaken in the past number of months. It was noted that in terms of the stroke reconfiguration, the Trust Board would receive an update on performance against the thrombolysis targets at its next meeting. Mr Sharon advised that the benefits of the reconfiguration were yet to be fully realised, however an improvement in performance across a number of stroke indicators had been seen, albeit not to a level initially anticipated, particularly in terms of thrombolysis times. Mr Sharon reported that the Trust had been shortlisted for a HSJ award for reconfiguration, which included the work on maternity and stroke services. It was reported that the tendering process for Pathology services had been abandoned, however any future partnerships with local providers remained to be agreed. A tender for Phlebotomy services was reported to be planned. Other reconfigurations discussed included Clinical Haematology, Cardiology, Bradbury Day Hospice, Surgery and T & O, Rowley Regis and Diabetes. In connection with the Bradbury Day Hospice, it was noted that there were some concerns over the CCG palliative care process and that work would be undertaken to resolve the issues. It was reported that the Surgery A group was working up a different model for EAU/SAU model at Sandwell Hospital. Mr Lewis advised that a key consideration as part of the plans was the management of head injuries. Mr Sharon reported that there was an appetite to use Rowley Regis Hospital to accommodate community services staff for the immediate present, however work was ongoing to finalise the plans. It was reported that all clinical groups had been asked to contribute to the development of a map showing the provision of services in community settings.	
7 Cardiology strategic case for change	**Hard copy**
Mrs Dunn provided an overview of the clinical case for change for Cardiology services. It was reported that there was a trend for the creation of bigger PPCI and PCI centres. It was reported that there were a number of drivers for change, including efficiencies in terms of treatment times expected as a result of the configuration. A further driver was cited as being the achievement of NICE and National British Cardiac Intervention Society guidance around minimum numbers of PCI and PPCI cases and two catheter labs per centre. A key issue for the Trust in terms of meeting these standards was highlighted to be whether the Trust was deemed to	

be one Centre with cross site working or two Centres. The position in comparison to the Trust's neighbouring Trusts was outlined. Consistency in practice was reported to be a further driver for change, as was recruitment and retention of specialist staff, improvement in performance in non-interventional Cardiology and catheter lab capacity and robustness. The options for the future configuration of Cardiology Interventional Services were outlined, which were highlighted to be threefold: the optimisation of the current two site model; reconfigured two site model; and one interventional Cardiology site model. It was suggested that locating two catheter labs at Sandwell Hospital in close proximity with a CCU and/or close to ED would be challenging and costly to arrange. It was noted that at City Hospital there would be a need to replace the existing catheter lab and a business case for its replacement would be considered by the Trust Board in October 2013 subject to the Committee's agreement. The plans for consultation and pre-consultation engagement were outlined. Prof Lilford asked whether the Cardiologists were supportive of the plans. Mrs Dunn advised that this was now the case and that they had been involved in developing the options. Mr Lewis highlighted that there was a pressing need to recruit Cardiologists to ensure that the Cardiology service provision was maintained by the Trust and that the reconfiguration plans would facilitate this. He noted that there was a need to understand how the option for a single interventional Cardiology site model might look. Mrs Dunn advised that there were a number of models already in existence which the Trust could review. Mr Lewis emphasised the need for the reconfiguration to deliver financial efficiency through the re-engineering of staffing rotas for instance and that this needed to be quantified. Mr Sharon asked whether the anticipated capital costs were prohibitive to arranging two catheter labs at Sandwell Hospital. The possibilities were discussed and agreed that the costs associated with this would be likely to be high in the light of the current configuration including the CCU, however the merits of collocating two catheter laboratories were agreed to be clear. It was agreed that the proposed recommendations should be accepted subject to further clarification within the next four weeks as to Option 6 (single interventional Cardiology site model) and in particular arrangements for the non-interventional site, the financial savings expected and a view of the practicalities and costs of including two co-located catheter labs at Sandwell Hospital using the existing CCU space and relocating CCU elsewhere. It was agreed that the Committee should receive this information by email.	
ACTION: **Mrs Dunn and Service Redesign Team to work with the Clinical Groups and speciality to clarify Option 6 (single interventional Cardiology site model) and in particular arrangements for the non-interventional site and also the financial savings expected from the**	

option **ACTION:** **Mr Seager to explore the practicalities and costs of including two co-located catheter labs at Sandwell using the existing CCU space and relocating CCU elsewhere**	
8 'Right Care, Right Here' summary activity and capacity assumptions	**SWBCC (10/12) 006** **SWBCC (10/12) 006 (a)**
Mrs Dunn presented a paper outlining the 'Right Care, Right Here' summary activity and capacity assumptions, which she noted had been considered by the Trust Board previously. It was noted that the assumptions had been further updated based on discussions with Clinical Groups since this consideration. Mr Lewis suggested that the impact of changing assumptions about catchment loss to retain more activity would be to create a higher requirement for beds which could be possible to accommodate from moving length of stay assumptions to upper decile to upper quartile. Mrs Dunn was asked to quantify potential bed capacity from moving length of stay assumptions to upper quartile and upper decile and to check that the loss of income associated with assumptions around excess bed days had been factored into the LTFM plans.	
ACTION: **Mrs Dunn to quantify potential bed capacity from moving length of stay assumptions to upper quartile and upper decile and to check that the loss of income associated with assumptions around excess bed days had been factored into the LTFM plans.**	
9 Monitoring of the 'Right Care, Right Here' summary activity and capacity assumptions	**SWBCF (2/13) 007** **SWBCF (2/13) 007 (a)**
Mrs Dunn suggested a means of tracking progress against the trajectories concerning activity and capacity leading up to the opening of the MMH, which were suggested to include oversight by the Clinical Leadership Executive via the MMH and Reconfiguration Committee, a link into the Transformation Programme, building the trajectories into the Clinical Group annual plans and consideration as part of the annual contract negotiations with commissioners. It was also suggested that an annual review of progress against trajectory at Clinical Group and Speciality level should be undertaken at the Clinical Group performance review meetings, with additional reviews being undertaken at key project milestones. This monitoring arrangement was agreed as being practical, subject to monitoring against the activity and capacity and related performance indicator trajectories reported at the recent Board to Board meeting with the CCG being reported to the Committee on a bimonthly or at least 3 times a tear basis. Mr Lewis felt the Committee should see these trajectories as a way of monitoring progress against the LTFM.	
ACTION: **Mrs Dunn to arrange for a monitoring report/graphs against RCRH/LTFM activity trajectories to be presented to the next**	

meeting	
10 Any other business	**Verbal**
There was none.	
11 Details of the next meeting	**Verbal**
The next meeting is to be held on 12 December 2013 at 1200h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……………………………………………………………………………………………………..

Print ……………………………………………………………………………………………………..

Date ……………………………………………………………………………………………………..

Charitable Funds Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 9 May 2013 at 0930h

Trustees Present
Dr S Sahota [Chair]
Ms C Robinson
Mr T Lewis
Mr R White

In attendance
Mrs J Kinghorn
Mrs C Jones
Mr M Burgess [Barclays Wealth]

Secretariat
Mr S Grainger-Payne

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Richard Samuda, Rachel Overfield and Peter Smith. Dr Sahota welcomed Mr Lewis to his first meeting as the newly appointed Chief Executive and Trustee.	
2 Minutes of the previous meetings	**SWBCF (2/13) 010**
The minutes of the meeting held on 14 February 2013 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCF (2/13) 010 (a)**
The Committee received and noted the updated actions log.	
4 Investment update – Barclays Wealth	
4.1 Investment review and valuation from Barclays Wealth for the three month period 1 January 2013 to 31 March 2013	**SWBCF (5/13) 012**
The Trustees were asked to receive and note the investment review and valuation from Barclays Wealth for the three month period 1 January 2013 to 31 March	

2013.

Mr Burgess advised that the equity markets had strengthened since the Committee had last met and the performance of the FTSE had also improved markedly over the last 12 months having seen an improvement by 1200 points. He was asked for the reason behind the deteriorating position in terms of 10 year government bonds and advised that investors had used these previously as a means of security, however as the economic outlook was now more positive these were not as attractive as other investment options. It was reported that although there were clearly financial challenges in the next 12 months the corporate environment was expected to remain robust globally. The Committee was advised that the most challenged sector appeared to be mining. It was reported that there was an expectation that markets in China and the Far East would continue to grow in future.

Dr Sahota asked what expectations were set around the Japanese climate. Mr Burgess advised that currency movements had been significant in Japan, in line with the political incentive to keep interest rates low. It was highlighted that this effect was reflected in the element of the portfolio that related to Japanese assets.

Dr Sahota asked how the FTSE 350 was performing. He was advised that performance was positive. Dr Sahota asked whether, in terms of the risk categorisation of the portfolio, consideration should be given to embracing a medium level from the current medium/low position. Mr Burgess suggested that this should not be considered at present as to do so would expose the portfolio unnecessarily to volatility in the economic environment and that the current 5% cash allowed opportunities to be taken when available.

Dr Sahota asked what the outlook was seen to be for the emerging markets. Mr Burgess advised that the last 12 months had not been positive, however should there be adequate economic movement, measures could be taken to take advantage of these. At present it was noted that the position was heavily influenced by the US economy.

Mr Lewis asked in terms of the balance between UK and international components of the portfolio, how this stood with comparable investment funds. He was advised that the breakdown was typical.

Ms Robinson noted that the interest rate offered on the cash was poor and suggested that consideration should be given to looking to invest in a longer term account and to investing rates offered by other accounts. Mr Burgess offered to review the position.

Ms Robinson highlighted that the investment of 3.1% in Royal Dutch Shell appeared to be an anomaly and suggested that this element could be liquidated if necessary. Mr Burgess asked the Committee to note that the investment in the oil sector was the most significant within the portfolio and cautioned that liquidating this could lead to unnecessary exposure.

Mr Lewis asked for the reasons for holding 5% cash in the portfolio. Mr Burgess advised that typically, investment portfolios would contain 2 – 8% cash. It was agreed that consideration of the cash position should be given at the next meeting. Ms Robinson asked whether cash had been used to support some of the recent transactions. Mr Burgess advised that a mixture of government bonds and cash had been used for the purchases. He was asked to present an update showing the impact on the return on the portfolio associated with those elements that had recently changed against those that had remained the same. Ms Robinson suggested that greater clarity should be given to setting out the brokerage charges associated with managing the portfolio and asked that an annual schedule be provided in future.	
ACTION: Mr Burgess to report back on potential means of securing a higher rate of interest for the cash element of the investment portfolio **ACTION: Mr Grainger-Payne to include an item on the agenda of the next meeting to prompt discussion of the cash element of the investment portfolio** **ACTION: Mr Burgess to arrange for a schedule of brokerage charges to be provided to Trustees on an annual basis**	
5 Quarterly finance report	**SWBCF (5/13) 013** **SWBCF (5/13) 013 (a) -** **SWBCF (5/13) 013 (d)**
Mr White presented the finance report for the Charitable Funds which it was noted covered the period 1 February 2013 – 31 March 2013. He reported that the cash position stood at £622k overall, however a credit to the exchequer account to the value of £27.8k was required, leaving a c. £594k balance. It was highlighted that the income was £406.8k, of which £342.7k was individual receipts of £1000 or above, including a legacy of £124k. Expenditure was reported to be £147.8k for the period, including £110.1k of expenditure items of £1000 and above. Dr Sahota asked whether legacies were restricted or unrestricted. He was advised that usually legacies bequeathed were restricted, however that received during the period since the last meeting had been given for unrestricted purposes. Mr Lewis asked what proportion of the general outgoings related to salaries and whether for the individuals associated with these payments, contract end dates had been set. It was agreed that this information would be provided at the next meeting. Dr Sahota asked when dormant funds would be reviewed next. Mr White advised that all fund holders had been asked to prepare a spending plan previously and that there was a need to ensure that the review identified those plans that had not	

been delivered as expected. Mr Lewis noted that consolidation of funds could be arranged by different levels, such as by area or by general purpose. He suggested that at present, there was a need to consolidate by area to ensure that there was local recognition of funds. Dr Sahota advised him that some funds previously dormant had been merged.	
ACTION: **Mr White to arrange for the detail of the contract payments made from Charitable Funds and end dates associated with these to be made available at the next meeting**	
6 Fundraising strategy	**SWBCF (5/13) 014** **SWBCF (5/13) 014 (a)**
Mrs Jones presented an initial draft of the fundraising strategy, highlighting that income targets had been set based on benchmarking information and expected growth in investment. It was reported that legacies were being handled as a separate income stream. The strategy was noted to cover a three year period. Mr Lewis highlighted that the strategy represented work in progress and that work should be undertaken to identify the reasons why the sources of income were unknown previously. Mr White agreed that this could be investigated and that this would then inform the options as to how the handling of charitable funds might be structured in future. Ms Robinson suggested that there was a need to clarify in terms of the income targets, whether these were annual or were expected to be achievable after the three year term of the strategy. She was advised that the targets were expected to be achieved by the end of the three year period. Ms Robinson remarked that in terms of the comparison to benchmarks, the targets were not sufficiently challenging. Mrs Jones agreed that the approach was cautious. Mr Lewis added that the approach reflected that some elements were within the remit of staff other than the Head of Fundraising to handle. Mrs Jones offered to review the strategy with a view to making it more ambitious where possible. Ms Robinson suggested that there was a need to identify how the fundraising strategy linked into other activities in the Trust such as volunteering plans. Dr Sahota noted that the strategy could draw on the established FT membership. Mrs Jones advised that in terms of weaknesses at present, the understanding of front-line staff on fundraising law was minimal and that the recording of income at present was more geared more to accounting needs than fundraising requirements. Mr Lewis suggested that colleagues' contribution to corporate partnerships as part of the work would be welcome where possible.	
7 Fundraising progress update	**SWBCF (5/13) 015** **SWBCF (5/13) 015 (a)**
Mrs Jones presented a report detailing progress on key fundraising activities.	

Ms Robinson asked whether Mrs Jones was being given sufficient support to resolve the issues concerning gift aid claims. She was advised that the key issues were being worked through and related to the information held in the current database and the paucity of information recorded for previous donors. Mr Lewis agreed that further work with teams was needed. Mrs Jones agreed to scope the benefits that could be gained by harnessing gift aid claims and undertaking a retrospective review of donations received.	
ACTION: **Mrs Jones to scope the benefits that could be gained by harnessing gift aid claims and undertaking a retrospective review of donations received**	
8 Charity logo survey results	**SWBCF (2/13) 016** **SWBCF (2/13) 016 (a) -** **SWBCF (2/13) 016 (g)**
Mrs Jones presented the results of the recent staff consultation on the charity logo. It was suggested that there was a need to test the logo with donors and members as a next step, however the logo should reflect a linkage to the Trust yet should be sufficiently distinctive to identify the charity as a separate entry. It was agreed that a further update should be presented at the next meeting.	
ACTION: **Mrs Jones to provide an update on the consultation on the charity logo at the next meeting**	
9 Charitable Funds Committee Chair's annual report	**SWBCF (5/13) 017** **SWBCF (5/13) 017 (a)**
The Committee was asked to receive and note the Charitable Funds Committee's annual report. It was agreed that the report should be presented to the Trust Board at its next meeting.	
10 Any Other Business	**Verbal**
Mr Lewis asked to be briefed on the exclusions to investment that had been agreed, with a view to a discussion at the next meeting. It was agreed that the discussion should be informed by a list of common exclusions, such as gambling, tobacco and arms.	
ACTION: **Mr Grainger-Payne to add an item to the agenda of the next meeting to prompt discussion of exclusions to investment**	
11 Details of the next meeting	**Verbal**
The next meeting is to be held on 12 September 2013 at 0930h in the D29	

(Corporate Suite) Meeting Room, at City Hospital.	

Signed ....

Print ....

Date ....

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SWBWAC (9/13) 030

MINUTES

Workforce & Organisational Development Committee

Venue Meeting Room, D29, City Hospital

Date Monday 30th September 2013, 10.30am – 12.30am

Present

Mr. Harjinder Kang	**[Chair]**	**HK**
Mr. Mike Sharon		**MS**
Mr. Toby Lewis		**TL**
Miss. Rachel Barlow		**RB**

Secretariat

Rosie Fuller **RF**

Guest

Miss Emma Moulds, Trainee Healthcare Scientist, shadowing Chief Executive

Minutes	Reference
1. Apologies for Absence	
Apologies were received from Mrs. L. Barnett, Mrs. G. Deakin & Mr. J. Pollitt	
2. Minutes from the previous meeting – 29th July 2013	**SWBWAC(7/13) 026**
Mr. Lewis introduced Miss Emma Moulds, Trainee Healthcare Scientist who would be shadowing him today. The minutes from the Workforce and Organisational Development Assurance Committee were accepted as a true record with the following exception. Item No. 6 – Chair's Report from JCNC Mr. Kang gave his impression that the relationship between the Trust and local Unions is basically sound. Future workforce challenges would require an open and honest dialogue about the reasons for change and how change could be achieved.	
3. Actions from previous meeting – 29th July 2013	**SWBWAC(7/13) 026(a)**

Minutes	Reference
The action log has been complete and updated.	
4. Revised Terms of Reference ▪ Revised memberships for information	**SWBWAC(9/13) 028** **SWBWAC(9/13) 028(a)**
The revised terms of reference were noted.	
5. Workforce	
5.1 Long Term Workforce Change Opportunities	**Presentation tabled**
Mr. Sharon tabled a presentation that he emailed to the Committee on Friday 27th September. The paper noted the key workforce challenges following a review by a former Deputy Director of HR. The review has as taken into consideration the LTFM and the clinical strategy. It was noted that the Trust's workforce profile looked typical to other organisations. Mr. Lewis has sought guidance from Miss Rachel Barlow and Dr. Roger Stedman on what specialties would be within a 24/7 service and these have also been included within the model. Mr. Sharon noted that the Trust will need to demonstrate that the workforce assumptions and the LTFM are consistent. Mr. Sharon went through the tabled paper noting that the paper set out a challenging view of best practice in a number of areas, and the Assurance Committee made the following comments: Consultant Job Planning – clarity was sought regarding this line. Mr. Sharon explained that the review. The average number of PAs excluding waiting list PAs at this Trust was 9.8 compared to the national average of 11.2, this makes the Trust better than the national average. However with the spend on waiting list initiatives this drives the PAs to 11.3 but there is no data from other Trusts on this element, but it was acknowledged that the desire is to reduce premium rate working. Agency spend is relatively high. Mr. Kang asked was it known which areas bank and agency were being used. Miss Barlow stated nursing is high but Locums are also high especially in difficult to recruit areas i.e. Emergency Medicine and radiology. Mr. Lewis informed the Assurance Committee that by the end of the month the true establishment of the Trust would be known which would include both medical and non medical staff groups. The sickness rate of medics needed to be looked at as it was thought this area may be under recorded. Turnover and sickness. This is high compared with best practice. Mr. Sharon informed the Assurance Committee that the Trust's sickness level was greater than 3% but a focused effort would need to be undertaken to reduce it further. The turnover is high compared to best practice of 7.5%. Mr. Lewis noted that if the	

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turnover rate is evenly distributed across the organisation that was not necessarily a bad thing but if it was high in one or two areas then this would be a worry. Mr. Kang was concerned that the Trust may be losing staff it wanted so having a robust retention policy was necessary for the future of the Trust. Terms & Conditions. This related to our policies and how pay protection compares with other Trusts. It was reported that pay protection is negotiated locally as there is currently no national agreement. Mr. Lewis stated the pay protection issue will be relevant as the Trust is looking at reducing its workforce by 1,300 over the next few years Unit Labour costs. This increased during 2013/14, no explanation as to what is driving this increase but it could be linked to agency spend which has remained high during the year. Appraisal and Mandatory Training. Recognised as below best practice. Mr. Lewis informed the Assurance Committee that a lot of time and effort has been spent on mandatory training. It was suggested as a start point 95% should be achieved with a zero tolerance in the long term. Recruitment Pathway. The pathway looked at how long to it took to recruit, the pathway was 90 days but best practice should be 30 days. Mr. Lewis reported that a discussion took place at CLE and it was noted that it would be better to report the maximum number and not an average, but certain elements of the process were beyond our control e.g. CRB checks, however from April 2014 the process of obtaining multiple signatures on a request form weather by paper or electronic means would be reduced to one after the establishment control form was approved. Mr Lewis also stated an audit on the recruit route has been completed and once the draft is published it should give a clear idea of where process was failing. The Assurance Committee asked Mr. Lewis to present this report at a future meeting. Diversity. Mr. Sharon reported that the Trusts workforce at a senior level would probably be white; the exception would be our consultant level which would reflect the diverse population. Mr. Lewis suggested going down a level of the population to check the diversity. Mr. Kang was mindful to note that equality was for all. Mr. Lewis indicated that he would like to see the separated numbers at senior level for male, female, disabled etc. Consultant Levels per bed – this line was medicine and not nursing. It was noted that consultants per bed in Keogh reviews trusts was 19.7 and at the Trust was 28.5. however no figures were available for nursing and midwifes. Mr. Lewis suggested we needed to find other Trusts with a better HMR rate than ours and how they compared with us. NHS Productivity. Mr. Lewis noted if more work was undertaken in the Community	

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or if we see patients in a shorter time that will increase our proportion of doctors to beds, but stated the Trust needed to commit to an undertaking of getting better but our doctors per bed numbers needed addressing. Mr. Sharon agreed to follow up outside of this meeting. Corporate Functions – This looked at the corporate function at FT and what were the lowest costs to run the function. Mr. Lewis was keen for the Trust to develop a marketable product that could be sold to other Trusts, however any outsourcing would need to be carefully considered as not all corporate functions could be reduced in this way. Agency Staffing - £3.5m reflected the reduction of premium staff. Incremental Drift – it was noted that each year historically all Agenda for Change staff get paid more on an incremental scale but there was no stipulations on gaining the next incremental pay point. Nationally this was the same across the majority of all trusts but this may change in the future. Service Developments – the model assumes 1% growth but may want to push further. Merit Award Cost – a small saving opportunity was noted. Others – Mr. Kang asked Mr. Sharon to check for any double counting of opportunities. Reducing Staff sickness to 1% which would be a saving of £1.8m. Staff turnover – reducing to 9% for Agenda for Change staff would save £0.5m. Mr. Lewis noted that that the establishment has been completed and was concerned about any double counting on bank and sickness data as some areas were not reading correct. Once checked we will be in a position to know about any real gains that can be made. Pay terms and conditions – the Committee accepted that most terms and conditions are nationally negotiated. The reported highlighted areas that would be negotiated locally. Mr. Sharon stressed that there was a long lead time for local policy renegotiation benefits to be realised. Role Redesign – Mr. Sharon informed the Assurance Committee that there would be scope for redesigning roles and skill mix. The Trust was to note that pay protection would apply for any AfC staff leaving a higher grade post to a lower one. It was noted again that for any savings to be achieved next year work would have to commence now. The Assurance Committee accepted the report and agreed that its conclusions	

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would be fed into a long term workforce paper to go to the Trust Board in October.	
Actions: ➢ **Mr. Lewis to request Recruitment Pathway report to be presented to a future meeting of the Assurance Committee.** ➢ **Mr. Sharon to obtain a breakdown of the diversity numbers at a senior level showing male, female, and disability.** ➢ **Mr. Sharon to find a cohort of trusts with a better HMR rate than this Trust to compare and find out how to get better.** ➢ **Methodology – workforce optimisers – Mr. Sharon to check the staff turnover for any double counting.**	
5.2 Workforce Dashboard ▪ Workforce Assurance HR Balanced Scorecard (new revised version)	TO FOLLOW
The Assurance Committee asked Mr. Sharon and Mrs. Barnett to discuss and refine as necessary outside of this meeting.	
5.3 Workforce Strategy Work Programme update	**SWBWAC(9/13) 029**
The Assurance Committee noted the Workforce Strategy Work Programme update but due to time pressures this document may be represented again to another meeting if necessary.	
5.4 Workforce Risks ▪ Workforce Risk Register	Verbal
This item was deferred to the next meeting.	
Actions: ➢ **Workforce Risk Register to be agenda at the next meeting**	
6. Learning & Development Report	
6.1 Learning & Development Report	**Verbal**
Due to time constraints this item will be presented again at the next meeting.	
7. Chair's Report from JCNC meeting : 29th July and 19th August 2013	**Verbal**
Mr. Kang reported both Unions and Trust Management were looking forward to	

Minutes	Reference
working closely together on a number of projects. There was a willingness to work together but as at yet no items had been identified.	
8. Any Other Business	**Verbal**
No items were discussed.	
9. Details of next Meeting	
The next meeting is scheduled for Monday 16th December 2013, 2pm – 4pm, D29 Meeting Room, City Hospital	

Signed ……………………………………………………………………………………………..

Print ……………………………………………………………………………………………….

Dated ……………………………………………………………………………………………..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Midland Metropolitan Hospital Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**New Hospital Project Director**
AUTHOR:	**Graham Seager Director of Estates/New Hospital Project Director**
DATE OF MEETING:	**19 December 2013**

EXECUTIVE SUMMARY:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital Status Report December 2013

Activities Last Period

- Approval process with NHSTDA commenced
- Architectural refresh being finalised
- Further engagement with DH /NHSTDA
- Nearing vacant possession of Grove Lane site
- Demolition of contaminated/ unsafe structures in progress
- PF2 Value for Money assessment being reviewed

Planned Next Period

- Achieve vacant possession of Grove Lane
- Progress Grove Lane site demolition plan
- Agree PF2 commercial documentation with HMT
- Initiate bidders for pre market engagement
- Refresh procurement documentation
- Agree final approval process

Issues for Resolution/Risks for Next Period

Final approvals and commissioner support before agreement advertise scheme in OJEU

REPORT RECOMMENDATION:

Discuss and Accept status report

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

Accept	Approve the recommendation	Discuss
X		x

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

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

Comments:

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

21st Century Facilities

PREVIOUS CONSIDERATION:

Routine monthly update.

FT Programme Monitoring Status Report

Activities This Month

- External consultant continuing with review of Groups' governance procedures
- Redevelopment of IBP commenced
- Updated HIS strategy to go to December Trust Board
- Board to complete BGAF self-assessment
- New guidance from TDA on FT process. Includes confirmation that CIH visit will take place before BGAF, QGAF, and HDD external assessment processes

Planned Next Month

- Continue IBP development
- Interim Clinical Group Governance audit report to CLE

Issues for Resolution/Risks for Next Month

- Continue to make progress on A&E target in line with rectification plan to NTDA
- Plan agreed to address 18 weeks performance